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

WHSSC Joint Committee Meeting held in public
Tuesday 26 September 2017 at 9.30am

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

Agenda

Item	Lead	Paper/ Oral
Preliminary Matters		
1. Welcome, Introductions and Apologies - To open the meeting with any new introductions and record any apologies for the meeting	Chair	Oral
2. Declarations of Interest - Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for the meeting	Chair	Oral
3. Patient Story - To hear a patient story.	Director of Nursing and Quality Assurance	Oral
4. Accuracy of Minutes of the Meeting held 25 July 2017 - To **agree** and **ratify** the minutes.	Chair	Att.
5. Action Log and Matters Arising - To **review** the actions for members and consider any matters arising.	Chair	Att.
6. Report from the Chair - To **receive** the report and consider any issues raised.	Chair	Oral

Item	Lead	Paper/ Oral
7. Report from the Managing Director - To **receive** the report and consider any issues raised.	Managing Director, WHSSC	Att.
Items for Decision and Consideration		
8. Thoracic Surgery Review: Project Update - To **note** and **approve** **Contact:** - Managing Director – Sian.Lewis100@wales.nhs.uk	Managing Director, WHSSC	Att.
9. Positron Emission Tomography (PET) Policy development - To **note** and **approve** **Contact:** - Sian.Lewis100@wales.nhs.uk	Managing Director, WHSSC	Att.
10. Risk Management Framework – Alternative Augmentative Communication Service - To **note** and **agree** **Contact:** Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
11. Adult Cystic Fibrosis service: Update - To **note** **Contact:** Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
12. Risk Sharing **Contact:** Director of Finance – Stuart.davies5@wales.nhs.uk	Director of Finance, WHSSC	**To Follow**
13. Cardiac Magnetic Resonance Imaging (CMRI) – future planning responsibilities - To **note** and **approve** **Contact:** Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
14. Development of the Integrated Commissioning Plan 2018-21: Commissioning Intentions - To **approve** **Contact:** Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.

Item	Lead	Paper/ Oral
15. Restructuring of Staffing Models within the Welsh Health Specialised Services Team - To **approve** **Contact:** Managing Director – Sian.Lewis100@wales.nhs.uk	Managing Director, WHSSC	Att.
16. Governance for Clinical Networks - To **approve** **Contact:** Committee Secretary – Kevin.Smith3@wales.nhs.uk	Committee Secretary, WHSSC	Att.

Routine Reports and Items for Information

17. Integrated Commissioning Plan (ICP) 2017-18 Risk Management Framework - To **note** **Contact:** Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
18. Integrated Performance Report - To **note** **Contact:** Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
19. Financial Performance Report - To **receive** the report and consider any specific corrective action to reduce any forecast overspending. **Contact:** Director of Finance – Stuart.Davies5@wales.nhs.uk	Director of Finance, WHSSC	Att.
20. WHSSC Joint Committee Annual Self Assessment - To **note** and **consider** any actions required **Contact:** Committee Secretary– Kevin.Smith3@wales.nhs.uk	Committee Secretary, WHSSC	Att.
21. Reports from the Joint Sub-committees - To **receive** the report and consider any issues raised. **Sub Committees** 21.1 Audit Committee 21.2 All Wales Individual Patient Funding Request Panel 21.3 Integrated Governance Committee 21.4 Quality and Patient Safety Committee 21.5 Welsh Renal Clinical Network 21.6 WHSSC Management Group	Joint Sub Committee and advisory group Chairs	Att.

Item	Lead	Paper/ Oral
Advisory Groups 21.7 NHS Wales Gender Identity Partnership Group 21.8 Wales Child and Adolescent Mental Health Services and Eating Disorder Network		
Concluding Business		
22. Date of next meeting - 28 November 2017, 1.30pm - Health and Care Research Wales, Castlebridge 4, 15 - 19 Cowbridge Road East, Cardiff, CF11 9AB	Chair	Oral

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

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

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

held on 25 July 2017
at Health and Care Research, Castlebridge 4,
Cowbridge Road East, Cardiff

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Members Present

Ann Lloyd	(AL)	Chair
Lyn Meadows	(LM)	Vice Chair (via Videoconference)
Marcus Longley	(ML)	Independent Member
Chris Turner	(CT)	Independent Member/ Audit Lead
Alexandra Howells	(AH)	Acting Chief Executive, Abertawe Bro Morgannwg UHB
Gary Doherty	(GD)	Chief Executive, Betsi Cadwaladr UHB
Steve Moore	(SM)	Chief Executive, Hywel Dda UHB (via Videoconference)
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB
Len Richards	(LR)	Chief Executive, Cardiff and Vale UHB
Allison Williams	(AW)	Chief Executive, Cwm Taf UHB
Stuart Davies	(SD)	Acting Managing Director of Specialised and Tertiary Services Commissioning, WHSSC
Carole Bell	(CB)	Director of Nursing and Quality, WHSSC
Sian Lewis	(SL)	Acting Medical Director, WHSSC
Chris Koehli	(CK)	Interim Chair of Quality and Patient Safety Committee

Apologies:

Carol Shillabeer	(CS)	Chief Executive, Powys THB
John Williams	(JW)	Chair of Welsh Renal Clinical Network
Tracey Cooper	(TC)	Chief Executive, Public Health Wales
Steve Ham	(SH)	Chief Executive, Velindre NHS Trust

In Attendance

Claire Nelson	(IL)	Acting Assistant Director of Planning, WHSSC
Kevin Smith	(KS)	Committee Secretary & Head of Corporate Services, WHSSC

Minutes:

Juliana Field (JF) Corporate Governance Officer, WHSSC

The Meeting opened at **9.30am**

JC17/027 **Welcome, Introductions and Apologies**
The Chair formally opened the meeting and welcomed members and the public.

JC17/028 **Declarations of Interest**
There were no declarations to note.

The Chair informed members that this would be her last meeting at WHSSC as she had commenced her role as Chair of Aneurin Bevan University Health Board and noted that she would withdraw should any conflict be identified during the meeting.

JC17/029 **Accuracy of Minutes of the meeting held 27 June 2017**
Members reviewed and approved the minutes of the meeting held on 27 June 2017 as a true and accurate record.

JC17/030 **Action Log and Matters Arising**

Action Log

JC002 – WHSSC Integrated Commissioning Plan 2017-20
Members noted that the All Wales NHS Chairs' meeting had been cancelled. It was confirmed that the Chair had written to the Individual Health Board Chairs to provide clarity regarding services included within the ICP.

JC006 – CB had provided input on engagement to the 2017-20 ICP.

JC009 – Provision of Specialised Neurosciences in NHS Wales
Work was ongoing. It was anticipated that a final paper would be presented to Members in March 2018.

JC17/031 **Report from the Chair**
Members received a report from the Chair; the following areas were highlighted:

Meeting with Cabinet Secretary
Members noted that the Cabinet Secretary was keen for the timely delivery of a sustainable and efficient thoracic surgery model. A meeting had been scheduled for early August 2017 in relation to the Gender Pathway work to finalise arrangements and a written statement on this was to be produced; the Chair extended her thanks to CB and representatives from the Health Boards for their work on this project. The Chair had been asked to get WHSSC to look further at the revenue

funding for the proposed new Cystic Fibrosis unit.

The Chair had raised concerns with the Cabinet Secretary relating to the latest All Wales Medicines Strategy Group (AWMSG) decision on Ivacaftor. WHSSC officers had been liaising with AWMSG in relation to this matter.

Appointment of New Chair
Professor Vivienne Harpwood had been appointed as the Chair of WHSSC for a period of 12 months succeeding AL. It was noted that Professor Harpwood would retain her position as Chair of Powys Teaching Health Board and that conflicts of interest would be fully considered. It was confirmed that Professor Harpwood officially commenced her role on 26 June 2017 and that this would be AL's last meeting as Chair of WHSSC.

Members **resolved** to

- **Note** the content of the report

JC17/032 **Report from the Acting Managing Director**
Members received a report from the Acting Managing Director; the following areas were highlighted:

Genomics for Precision Medicine
Welsh Government launched its strategy in June 2017. Members noted that WHSSC retained a commissioning role via the hosting and commissioning group which was responsible for the development of a Commissioning Strategy. Whilst a £6.8m five year budget had been outlined within the strategy, it was unclear what the implications were for recurrent and non-recurrent funding. Members noted that WHSSC would be working closely with the All Wales Medical Genetics Service and Welsh Government.

Members discussed the funding situation further and whether this would be from Health Boards via the ICP or direct from Welsh Government and noted their concerns regarding the current financial position within NHS Wales. It was agreed that WHSSC would seek clarification on the funding arrangements from Welsh Government.

Action:

- **SD to write to Welsh Government to seek clarification of the funding arrangements for the Genomics Strategy**

Interventional Neuroradiology
Since the report had been written, the first locum had resigned and left. A second locum would be joining the service shortly and a substantive consultant was expected to return to active duty shortly.
It was noted that the Walton Centre might be able to take emergency

cases in addition to its commitment to take ten elective cases.

Members enquired as to the level of confidence in the service being able to continue in the current position and the financial implications relating to the arrangements with the Walton Centre. It was noted that any charges would initially be paid by WHSSC but recharged to CVUHB. as ultimate responsibility for continuity of the service remained with CVUHB.

Gary Doherty joined the meeting at approximately 9.50am

A question was raised as to the likelihood of any outsourcing costs going beyond those planned in the WHSSC ICP. It was explained that this was unlikely and there was ample opportunity for CVUHB to absorb additional costs. Members received assurances that should there be any changes to this, a paper would be presented to Management Group for scrutiny and to the Joint Committee for a decision.

Transcatheter Aortic Valve Implantation (TAVI)
Members noted that the number of patients on a previously undeclared waiting list at ABMUHB was still being validated. Concern was noted around the mortality risks for these patients whilst on the waiting list. It was noted that TAVIs were subject to prior approval in line with Policy and that this process had recently been reinforced. A query was raised around application of thresholds within the policy and overall impact across cardiac waiting lists. A discussion followed around waiting list management, concerns around surgical operability and lessons that could be learned relating to management of waiting lists.

Posture and Mobility
Members noted that more information was awaited from CVUHB regarding its proposal for increased investment to replace obsolete wheelchairs. A question was raised regarding the wider impact of replacement of obsolete wheelchairs and it was agreed that a note would be provided on the current position for north Wales but it was explained that this was less of an issue that for south Wales.

Paediatric Rheumatology
Members noted that Welsh Government had asked WHSSC to review the provision of paediatric rheumatology services for Wales. An initial scoping report was available for the meeting.

Cardiac Ablation
Work had begun on developing the case for investment on economic grounds as a curative treatment for certain indications. It was noted that waiting lists had started to build up and that referral to treatment issues were anticipated within the next six months.

Members **resolved** to

- **Note** the content of the report

JC17/033 **Patient Story (video)**

Members watched a video in which members of PMH Cymru shared their experience of Perinatal Mental Health and services in Wales.

JC17/034 **Perinatal Mental Health**

CB presented an overview of the report which considered the national context of perinatal services including investments in both England and Wales. The appended options paper, which had been considered by the All Wales Perinatal Mental Health Steering Group, outlined a shortlist of three preferred options for the future configuration of tier 4 specialised perinatal mental health services in Wales. The three options were broadly (1) build upon IPFR process through a secured contract; (2) establish a single regional Mother and Baby Unit (MBU) for the whole of Wales; and (3) establish a regional MBU for south Wales and contract for an English provider for a north Wales service.

A query was raised regarding the governance and scrutiny of the report presented. It was noted that the All Wales Perinatal Mental Health Steering Group reported directly to the Child and Adolescent Mental Health Services and Eating Disorders Network Steering Group, who report directly to the Joint Committee and therefore the report had not been considered by the WHSSC Management Group. It was further noted that the Welsh Government had commissioned the All Wales Perinatal Mental Health Steering Group to undertake this work.

Members suggested that consideration was required as to the rationale for decommissioning the Cardiff service in 2013, the wider work being around early intervention in Mental Health Services, what the evidence suggested regarding centralised treatment versus local services and patient outcome and service sustainability given current workforce pressures in mental Health Services. It was noted that further detail was required in order for a decision regarding investment to be made.

It was noted that evidence had been presented to the National Assembly for Wales' Children, Young People and Education Committee relating to the current Perinatal Mental Health inquiry.

A discussion was held around the work undertaken by the All Wales Perinatal Mental Health Steering Group, the potential required investment, and opportunity to improve commissioning arrangements and the requirement to understand the competency and demand of the existing pathway and underpinning detail before moving forward to a

decision.

It was suggested that consideration could be given to a review of available evidence on the impact of service proximity to patient outcomes and levels of activity. Further to this, it was suggested that there was a need for leadership and coordination of IT systems across Wales to ensure consistency of coding and data capture, and provide a cohesive and joined up approach across Wales.

It was agreed that Members comments would be fed back to C Shillabeer as Chief Executive lead for Mental Health and Chair of the Child and Adolescent Mental Health Services and Eating Disorders Network Steering Group for further consideration and a clear recommendation on how to proceed. Members recognised the sensitivities in relation to the service and the need to ensure that expectations were appropriately managed.

Members **resolved** to

- **Note** the information presented within the report;
- **Provide** C Shillabeer as Chief Executive Lead for Mental Health, and Chair of the Child and Adolescent Mental Health Services and Eating Disorders Network Steering Group, with feedback from the discussions.

JC17/035 **Integrated Commissioning Plan 2017-20: Risk Management Framework**

Members received a paper describing the implementation of the ICP Risk Management Framework to date and the progress made to date on the population of it from both a WHSSC and Health Board perspective. The paper also sought approval of the commissioning of three service areas.

Members noted that the Management Group Workshop had undertaken considerable work to review baseline scores and had supported the recommendation for funding the schemes detailed within the paper.

A query was raised in relation to the 2017-20 ICP and provision for the three services. It was noted that these were not specifically identified in the ICP; however it was explained that if the procedure and drugs were not commissioned it was highly likely that patients would proceed through the individual patient funding request (IPFR) route. Members noted that the Management Group workshop had considered the financial implications and that provision had been sourced from the IPFR; consequently the financial impact would effectively be neutral.

Assurance was sought that there would not be a significant increase in demand for the services once commissioned. It was noted that given the rarity of the conditions it was unlikely that there would be an increase in

demand. Members noted that NICE had undertaken detailed policy work in relation to volume and budget impact and held further discussions around financial implications. It was acknowledged that there needed to be a robust policy with clear access criteria.

Clairty was requested as to what the Joint Committee was being asked to approve and whether this was to: adopt a new commissioning policy aligned to English policy, recognising that there may be minimal cost implications with some services cost neutral.

Members were advised that WHSSC endeavoured to follow correct governance process and that rigorous scrutiny had been undertaken of the services during the Management Group workshop session which supported the recommendations as detailed within the report.

Members approved the commissioning of the three services and requested that a future evaluation be undertaken of the impact of changing from the IPFR approval process to a Commissioning Policy.

Members **resolved** to

- **Note** the progress made to date on implementing the ICP Risk Management Framework and the next steps for completion; and
- **Approve** the commissioning of:
  - Complex Obesity Surgery for Paediatrics
  - The use of Plerixafor for Stem Cell mobilisation
  - The use of Pasireotide for Cushings Disease

Commissioning Arrangement for Positron Emission Tomography (PET) Scans

Members noted that all Health Board CEOs had received a letter from the Director General regarding commissioning arrangements for PET scans. Members were advised that the Management Group had held recent discussions and identified areas of risk to implementing a commissioning policy. It was noted that a paper had been provided to Management Group for consideration at its next meeting, scheduled for 27 July 2017. The paper set out a potential basis to mitigate the lack of agreed funding in the 2017-20 ICP for PET scans in respect of new indications. This was based on projections for lower demand than had been budgeted for PET scans on existing approved indications.

Chief Executives were reminded that the prioritisation process utilised in the ICP was evidence based, although new schemes were restricted by an overall lack of funding. A discussion was held around the decision making process and challenge presented by the Welsh Government in relation to the decision to continue to manage through IPFR. It was agreed that a single response would be drafted to the Director General regarding the matter.

Action:

- **Single response to be drafted on behalf of all Health Boards and WHSSC regarding the commissioning arrangements for PET Scans (Chair/JP)**

JC17/036 **Value Based Commissioning: Progress Report**

Members received the report which provided an update on progress in the development of WHSSC's approach to value based commissioning as part of the 2017-20 ICP.

The paper considered value based healthcare from a commissioning perspective that than the more familiar provider perspective, using a systematic approach with three components: technical efficiency, allocative efficiency and patient value.

Members were advised that the WHSS team would be undertaking work to review commissioned services against the Framework, some of which had already commenced within the finance and planning teams. It was noted that this work would be expanded upon following the appointment of the new associate medical directors, establishment of programme teams to support the working closely with the Management Group to identify and test opportunities.

It was suggested that consideration be given as to how Public Health Wales (PHW) may be included in supporting the process and how to engage with Health Boards to avoid duplication of work. Members were advised that the service level agreement between WHSSC and PHW had been terminated and that WHSSC was recruiting a 0.2WTE Associate Medical Director for Public Health and work was being carried out with Cwm Taf University Health Board (CTUHB) in relation to informatics. It was noted that concerns had been raised with Welsh Government around strategic issues and the gap in provision of services from PHW. It was also noted that a discussions were ongoing with Welsh Government and that the Chair had raised concerns with the new Chair of PHW.

A discussion followed around the analytical capability of PHW, importance of the value based work, the necessity to consider the whole pathway rather than simply the specialised services element and the need to commence identification of specific services. Members noted that a Right Value Commissioning Group had been formed that had already met several times and started looking at high cost low volume areas.

A further discussion was held around harnessing clinical engagement and leadership within this work and how value based commissioning linked

with the principles of the prudent healthcare agenda.

Members **resolved** to

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

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JC17/037 **Inherited Bleeding Disorders**

Members received a paper which described a proposal outlining the management resource requirements and potential offsetting efficiency savings to facilitate the development of an all Wales commissioning strategy for Inherited Bleeding Disorders (IBD).

Members were reminded of previous discussion on IBD and noted the current request for an additional 0.5WTE resource for a period of 12 months to support the development of an all Wales commissioning strategy. It was noted that the estimated savings from repatriation of IBD services from Liverpool to BCUHB, through reduced administration charges alone, would more than cover the additional resource requirement in WHSSC but that the saving would not be achieved without pursuing this initiative.

Members held a discussion around the work being carried forward in north Wales in relation to repatriation of services, the ability to achieve savings without the need for investment, and the additional resource being used to accelerate the achievement of saving and allow reinvestment in other local services.

The discussion continued around the proposal for an all Wales Commissioning strategy for IBD which would be brought under WHSSC as a single commissioner. Members requested that more detail was required in relation to the benefits/dis-benefits and gains made though a single commissioning lead. Greater clarity was required around the problem to be addressed. It was noted that the current arrangements were fragmented and the aim was to commission a more coherent model. Members suggested that further scrutiny was required though Management Group.

Members resolved to

- **Note** the potential savings which would offset the resource required to increase WHSSC's commissioning capacity; and
- **Support** the outline proposal for repatriation of IBD services from Liverpool to BCUHB and referred the outline proposal to bring commissioner responsibility and funding under WHSSC as a single commissioner of IBD services across Wales to Management Group for further review.

JC17/038 **Paediatric Rheumatology Services in South Wales**

Members received a paper which described the current service provision and referral process for paediatric rheumatology services in Wales. It also described the services around the United Kingdom, the standards of care and provided benchmarking with particular regard to composition of tertiary multi disciplinary teams (MDT). It also made recommendations regarding future actions required to progress commissioning of the service.

Members noted that WHSSC had been approached by Welsh Government to review the current service provision and make recommendations. It was identified that Wales was the only country within the UK that did not have a specific paediatric rheumatology service. Services for Welsh patients were commissioned currently commissioned from Alderhey, Bristol and Bath and managed through a gatekeeper, funded by the individual Health Boards.

Members were presented with an overview of the detail provided within the paper including benchmarking against larger English centres, outline scope of the review and recommendations of the British Society for Rheumatology and the National Rheumatoid Arthritis Society.

Following a discussion regarding the information provided and funding arrangements, it was agreed that the paper should be shared with Welsh Government and the matter referred back to Welsh Government requesting its guidance on what was required next and noting that an improved service would require additional funding.

Members **resolved** to

- **Note** the paediatric rheumatology service provision for the population of south Wales, the position around the UK and the recommendation of The British Society for Rheumatology (BSPAR) and the National Rheumatoid Arthritis Society (NRAS); and
- **Agree** for the paper to be referred to Welsh Government requesting guidance on what was required next and noting that an improved service would require additional funding.

JC17/039 **Integrated Commissioning Plan (ICP) 2016-17 Closure Report**

Members received a report that set out the progress and outcomes against the delivery of the 2016-17 ICP schemes approved during 2016-17, highlighted where further action was required for schemes that had not been completed, and summarised the key lessons learned.

It was noted that 62 schemes had been delivered and 75 schemes were recorded as 'In progress' or 'Not commenced', a summary of which was provided within the report. Members were informed that a number of

services had not been completed, including Proton Beam Therapy and other policies that were being evaluated by NICE, due to limited resources. These schemes were to be managed via the 2017-20 ICP Risk Management Framework.

The full year financial effect of 2016-17 developments was £1.5m lower than the 2016-19 year 2 provision. Providers would be challenged as to whether they have spent the approved investment and on achieved outcomes.

Members **resolved** to

- **Note** the work completed in the WHSSC 2016-17 ICP;
- **Note** the lessons learned; and
- **Note** the closure of the Integrated Commissioning Plan (ICP) 2016-17.

JC17/040 **Annual Performance Report 2016-17**

Members received the report for 2016-17, which provided a summary of the performance of providers throughout the year and details of the actions undertaken to address areas of non-compliance. Cardiac, Plastic, Paediatric, Neuro and Bariatric surgery failed to achieve 100% compliance with the 36 week RTT targets and Thoracic surgery only achieved its 36 week RTT target once during the year. However Plastic, Paediatric and Bariatric surgery improved their performance during the course of the year. Lung cancer data previously provided by the Cancer Network ceased during Q4. It was noted that additional investment had been provided for Cardiac, Neuro and Thoracic surgery during the year and it was therefore particularly disappointing that they had not achieved their targets.

Members **resolved** to

- **Note** the performance over 2016/17

JC17/041 **Financial Performance Report**

Members received the report which set out the estimated financial position for WHSSC for the third month of 2017/18. No corrective action was required at this point. The financial position was reported against the 2017/18 baselines following provisional approval of the 2017/18 Technical Plan by the Joint Committee in March 2017.

Members noted a year to date over spend of £988k and a forecast under spend to year-end of £236k. The largest in year movement was a deterioration of £1.273m against NHS England contracts; this was due to previously disclosed HRG4+ PbR rates dispute.

A discussion was held around the HRG4+ concerns and members noted that a working group had been established to review the Health Boards' positions. The Directors of Finance were now making judgements and providing for the impact of the increased rates. Discussions continued around financial risks, related provider performance and patient experience. It was noted that discussions had been held with Welsh Government and that the main risk on HRG4+ was for BCUHB and PTHB because of their heavy reliance on English providers.

It was agreed that a letter from WHSSC would be sent the Welsh Government setting out the concerns as discussed and the potential risks as identified by the Joint Committee. It was noted that an update would be presented to the Joint Committee in September 2017.

Action:

- **Letter to be sent to Welsh Government highlighting the Joint Committee concerns.**
- **Update paper to be provided at the September 2017 meeting**

Members discussed the requirement for a consistent approach to payment of HRG4+ contracts and requested that the WHSS Team agree an approach with Management Group colleagues at their next meeting scheduled for 27 July 2017.

Action:

- **Management Group members to agree a consistent approach to payment of HRG4+ contracts.**

Members **resolved** to

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

JC17/042 **Reports from the Joint Sub-committees and Advisory Group Chairs**

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

Sub Committees

Child and Adolescent Mental Health Service and Eating Disorders Network Steering Group

Members noted the update from the meeting held 23 June 2017.

JC17/043 **Items of Any Other Business**

Neonatal Workforce

SL advised that a letter had been received from the South Wales Programme Neonatal Task & Finish Group explaining that Chairs and CEOs were currently looking at how the regional planning committee arrangements would work and that this might have some impact on whether or not the current South Wales Programme had the appropriate governance arrangements in place. In turn this might impact on the responsibilities that the Joint Committee delegated to the Task & Finish Group in March 2017 in relation to implementation of the Neonatal Alliance workforce model. At present the Task & Finish Group was continuing its work and it would keep the Joint Committee informed of any developments.

JC17/044 **Date and Time of Next Meeting**

It was confirmed that the next meeting of the Joint Committee would be held on 26 September 2017.

The public meeting concluded at approximately **12.05pm**

Chair's Signature: .....

Date: .....

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

2017/18 Action Log
Joint Committee Meeting

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
30/05/2017	JC009	**JC17/009 - Provision of Specialised Neurosciences in NHS Wales** Detailed paper to be presented to a future Management Group meeting regarding the Neuro-rehabilitiation pathway/service specification.	Acting Director of Planning	July 2017	**27.06.2017** It was noted that a Neurosciences Strategy Group had been established and had held its first meeting at which it agreed a timeline and prioritised the consideration of sub speciality services; members requested that the proposed timescales agreed. It was anticipated that an update paper would be presented to the Management Group in July 2017. 25.07.2017 Work was ongoing. It was anticipated that a final paper would be presented to Members in March 2018 – Item to be added to forward plan for March 2018 – Action Closed	CLOSED

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
30/05/2017	JC011	**JC17/009 - Provision of Specialised Neurosciences in NHS Wales** Details regarding patient and public engagement to be included in the final neurosciences strategy paper when presented to the Joint Committee	Acting Director of Planning	Sept 2017	Not commenced	OPEN
30/05/2017	JC012	**JC17/009 - Provision of Specialised Neurosciences in NHS Wales** IL to ensure that that the Strategy paper clearly differentiates the commissioning responsibilities of WHSSC and those of the Health Boards	Acting Director of Planning	Sept 2017	Not commenced	OPEN
27.06.2017	JC013	**JC17/019 – Neurosciences Strategy Group timescales** Timescales for work agreed by the Neurosciences Strategy group to be circulated to member of the Joint Committee for information	Acting Director of Planning	June 2017		OPEN

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
25.07.2017	JC014	JC17/035 - **Commissioning Arrangement for Positron Emission Tomography (PET) Scans** Single response to be drafted on behalf of all Health Boards and WHSSC regarding the commissioning arrangements for PET Scans (Chair/JP)	Chair, WHSSC	Aug 2017		OPEN
25.07.2017	JC015	JC17/041 - **Financial Performance Report HRG4 +** A letter from WHSSC to be sent the Welsh Government setting out the concerns as discussed and the potential risks as identified by the Joint Committee.	Director of Finance, WHSSC	Sept 2017		OPEN
25.07.2017	JC016	JC17/041 - **Financial Performance Report** Update on the HRG4+ position to be presented in September 2017.	Director of Finance, WHSSC	Sept 2017		OPEN
25.07.2017	JC017	JC17/041 - **Financial Performance Report** JC tasked Management Group members to agree a consistent approach to payment of HRG4+ contracts.	Director of Finance, WHSSC	Sept 2017		OPEN

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

		Agenda Item	7
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	Report from the Managing Director		
Author (Job title)	Managing Director, Specialised And Tertiary Services Commissioning, NHS Wales		
Executive Lead (Job title)	Managing Director, Specialised And Tertiary Services Commissioning	Public / In Committee	Public

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

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

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

Considerations within the report (tick as appropriate)

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

1.0 Situation

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

2.0 Updates

2.1 **Managing Director Post**

I started in my new role on 4th September. During the next 3 months I intend to take forward two main streams of work. The first has an internal focus and is about making sure that we have the right people and processes in place to provide the organisation with strong foundations for the future. The second is about our approach to the development of the strategy for WHSSC.

Regarding our internal development, we are about to go to advert for a part-time Medical Director and part-time Deputy Medical Director, a Director of Planning and an Information Manager. Also with the help of Cwm Taf UHB we are planning to recruit a part-time Associate Medical Director - Public Health. Later in the agenda the Committee will be presented with a paper which describes an internal restructuring which will deliver a team to support the quality framework. Importantly alongside the structural changes we are continuing to address the recommendations from the Culture Review that was undertaken in November 2016 – we have just had Andy Evans (who conducted the review) back to take a 'temperature check' and assess our progress against the recommendations. As a corollary to this we will be embarking on a programme of organisational development in the near future.

Related to this internal development we will also be work on strengthening our processes such as the Escalation Process and development of the ICP. Because of this I have delayed presenting the results of the Management Group Review which will now be accompanied by a second document outlining a proposal for ways of working which better reflects these enhanced processes.

Secondly, to support the development of the strategy, I will be meeting with all our organisational stakeholders, including the CEOs of the LHBs, independent members of WHSSC, Welsh Government representatives and representatives of the CHCs. These meetings will allow scoping of the strategy in preparation for wider engagement.

2.2 **Neonatal Transport**

The requirement to provide 24/7 dedicated neonatal transport is a standard within the Welsh Neonatal Standards, however the provision in South Wales is currently for 12 hours per day, from 8am to 8pm. This has been

highlighted by Bliss in their reviews of Neonatal services in Wales. In recognition of this, WHSSC and the Neonatal Network have been in discussion with the service in Bristol, NEST, to provide an out of hours service for South Wales on a cost per journey basis. It was ultimately determined, however, that they could only provide ad-hoc cover on an estimated 40-80% of nights and it was not felt that this would provide a safe or sustainable solution.

The Network have highlighted their concerns regarding the ongoing lack of out of hours service in South Wales and discussions have taken place between WG, WHSSC, the Network and EASC as to how this discussion can be progressed. It has been agreed that the Network will develop a draft service specification, outlining their proposal for how a 24/7 service should be delivered. They have also been tasked with pulling together evidence regarding the risk related to the current service model and the impact that this ultimately has on patient outcomes. This is particularly important, since no Health Boards have raised this to WHSSC as a risk or priority either through formal routes e.g. risk registers, IMTPs etc or through more informal mechanisms. In conjunction with the work that the Network are leading, WHSSC are undertaking a review of how the services are delivered against the funding allocation to each Health Board, in order to determine whether any resource may be available from this. Initial review would appear to demonstrate that not all of the posts originally included are being used to support the transport service, however further work with the provider organisations will be needed to confirm this. The structure of the service is also under review, with the current understanding that the 3 provider Health Boards each receive their own budget and hold governance responsibility for the service during the weeks that they deliver the service. This is overseen by the neonatal network, with no single organisation responsible for the planning, delivery or governance of the service.

All of this information will be brought together in order to determine the risk associated with the current service and whether there is a case to seek to develop an out of hours service. If it is determined that the risk is such that a case does need to be developed, then this will be supported by the information gained for the review of the current funding and by the new service specification so that an appropriate proposal can be developed to feed in to the WHSSC ICP prioritisation process for 2018/19.

2.3 **Gender Identity Services in Wales**

Oversight and development of Gender Identity Services is overseen by the All Wales Gender Identity Partnership Group which reports directly into the Joint Committee. The scope of the group extends beyond the services commissioned by WHSSC and includes reviewing primary and secondary care services provided and commissioned by Local Health Boards.

WHSSC funds access to specialised gender identity services, including assessment services and gender confirmation surgery. Endocrinology services, drug costs associated with hormone replacement therapy, speech

and language, hair removal from surgical site are planned and funded by Local Health Boards.

On Friday 25 August 2017, to coincide with Pride Cymru, the Health Secretary announced a significant step forward in healthcare for transgender people, with the establishment of specialist adult gender services to be delivered in Wales. In May 2017, Welsh Government officials approached Cardiff & Vale University Health Board to establish a gender service. Since that time members of the All Wales Gender Identity Partnership Group have been actively working with Welsh Government and CVUHB in designing a new pathway using £500k funding announced as a result of the Budget Agreement with Plaid Cymru in November 2016. This pathway will improve community-based care with a network of General Practitioners across Wales with a specialist interest in gender identity healthcare able to provide more care closer to people's home, which will improve access and experience for people needing care. Stakeholders, third sector representation and the BMA have been fully involved in the work.

Discussions remain ongoing to confirm the detail around the proposed pathway and further work will be required in line with the recommendations endorsed by the Joint Committee in November 2016 to secure a long term model supported by education, training and revised service specifications. Work is also ongoing on strengthening the Children's pathway. A project lead is currently in the process of being appointed to support and lead both pieces of work.

NHS England launched a consultation on specialised gender identity services for adults (17 and above) on 7 July 2017. They are seeking views on two proposed service specifications: one for how Gender Identity Clinics will deliver specialised outpatient services; and another for how surgical units will deliver surgical interventions. A public workshop event is planned for Cardiff on 28 September 2017.

2.4 **All Wales Blood**

The Acting Managing Director's report to the June 2017 Joint Committee informed members of the successful completion of the All Wales Blood Service Programme, which was established to deliver the transfer of the existing blood services for north Wales from National Health Service Blood and Transplant (NHSBT) to the WBS.

The All Wales Blood Service Programme Closure report has been received by WHSSC; a copy of which is provided for information at annex (i).

3.0 Recommendations

3.1 Members are asked to:

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

4.0 Annexes and Appendices

4.1 Annex (i) All Wales Blood Service Programme Closure 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		

WHSSC Joint Committee Meeting
26 September 2017
Agenda Item 5 - Annex (i)

Gwasanaeth Gwaed Cymru
Welsh Blood Service

All Wales Blood Service Programme

Programme Closure Report

Version: 2.0

"REFLECTING ON THE PROGRAMME"

Author: Sarah Richards, Programme Manager

February 2017

WHSSC Joint Committee Meeting
26 September 2017
Agenda Item 5 - Annex (i)

Document Control

This document is only valid on the day that it was printed.

The source of the document is to be found in the following folder:
E:\Project Management\All-Wales Blood Service\Project Closure\Project Closure Report

Version History

Version	Date	Author	Brief Description of Key Changes
0.1D	21/06/2016	Sarah Richards	Document commenced
0.1D	07/07/2016	Sarah Richards	First Draft
0.2D	13/07/2016	Alan Prosser	Drafting changes
0.3D	18/07/2016	Cath O'Brien	Drafting changes
0.4D	20/07/2016	Sarah Richards	Drafting amendments/inclusions
0.5D	26/07/2016	AWIG	Drafting amendments
0.6D	29/07/2016	Sarah Richards	Inclusion of Strategic Stakeholder Board Meeting actions
1.0	18/08/2016	Sarah Richards	Version 1.0
2.0	16/02/2016	Sarah Richards	Version 2.0 – updated for Gateway 5 Review

Document Reviewed by:

Version	Date	Reviewer	Reviewer Role
0.4D	25/07/2016	AWIG	AWBS Implementation Group
05.D	29/07/2016	Strategic Stakeholder Board	Strategic Oversight Group

Contents

Acronyms

All Wales Blood Service	AWBS
All Wales Blood Service Programme	AWBSP
All Wales Implementation Group	AWIG
Betsi Cadwaladr University Health Board	BCUHB
Blood Establishment Computer System	BECS
Did Not Attend	DNA
Donor Contact Centre	DCC
Environmental Monitoring System	EMS
Good Manufacturing Practice	GMP
Laboratory Information Management System	LIMS
Local Health Board	LHB
Medicines and Healthcare products Regulatory Agency	MHRA
Mobile Donation Clinic	MDC
National Health Service Blood and Transplant	NHSBT
Programme Management Office	PMO
Red Blood Cells	RBC
Stock Holding Unit	SHU
Senior Management Team	SMT
Senior Responsible Officer	SRO
Service Level Agreement	SLA
Transfer of Undertakings (Protection of Employment) Regulations 2006	TUPE
Venue Risk Assessment	VRA
Welsh Blood Service	WBS
Welsh Government	WG
Welsh Health Specialised Services Committee WHSSC	WHSSC
Workstream	WS

1.0 Summary

In June 2012, the Welsh Government gave the Welsh Blood Service (WBS) a unique opportunity to become an all Wales service by May 2016. This resulted in the transfer of existing services from National Health Service Blood and Transplant (NHSBT) to the WBS, as planned, on 2nd May 2016. The All Wales Blood Service Programme (AWBSP) was established to deliver the required service changes.

The new national service for Wales will allow the WBS to plan better and build further resilience to ensure the long term security of collection, processing, testing and supply of blood and associated components in Wales. It will enable seamless alignment with NHS Wales and Welsh Government policy such as the initiative to establish a culture of prudent healthcare, improve national service resilience, facilitate service alignment and integration and enable benefits realisation from national programmes such as Laboratory Information Management System (LIMS) and other service modernisation initiatives. In addition, there are forecasted annual revenue cash releasing saving of circa £589K following initial investment.

As part of the delivery of the AWBSP, the WBS were required to provide a Good Manufacturing Practice (GMP) compliant Stock Holding Unit (SHU) in north Wales for storage of blood products prior to distribution to Betsi Cadwaladr University Health Board (BCUHB) hospitals. Blood collected from the two teams based in north Wales is returned to this unit for temporary storage prior to shipping to Talbot Green for processing and testing. Team bases have been provided for both the Wrexham and Bangor teams. The SHU will act as a central store for processed blood and commercial products for north Wales Hospitals, co-ordinating delivery to and from hospital blood banks on a regular and emergency basis 365 days per year and an Environmental Monitoring System (EMS) has been installed to ensure the cold chain.

The AWBSP planned, developed and implemented all of the workforce and organisational change functions in support of the transfer of the 43 staff from NHSBT into Velindre NHS Trust via Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE). An additional 16 roles have been created in Wales to support the changing service model. In addition, a significant data transfer of over 52,000 donor records have been securely transferred from NHSBT to the WBS.

The AWBS programme was delivered to time, under budget and fully met the project brief and objectives.

Delivery of this programme of work showcased an excellent collaborative approach to ways of working between WBS, BCUHB and NHSBT in the planning, implementation and transition phases of a major transfer of service that will continue beyond the closure of the project. Regular and robust engagement with all key stakeholders has resulted in the smooth transition from NHSBT to WBS and a high level of service provision for both donors and customer hospitals in north Wales is being maintained post transfer.

Post go live, the WBS will undertake a sense check of the systems, processes, staff role and resource allocation to ensure these are aligned with the service model, provide operational resilience and meet the needs of the donors and customer hospitals prior to the full review which is planned circa six months' post go live. This sense check will be led by the Programme Management Office (PMO) and will formally report to the SMT.

2.0 Introduction & Background

2.1 Purpose of the Report

This report sets out to inform the All Wales Implementation Group (AWIG) and the Programme Stakeholder Board on how the AWBSP has performed against the objectives and deliverables outlined in the Programme Blueprint (V0.21) and the Business Case (V0.7).

In addition, it will document the background to the AWBSP and reiterate the purpose and objectives of the programme. This report will also record any outstanding work and identify areas of strength and weakness in the implementation of this programme, to help provide lessons learnt for future reference and consideration.

2.2 Scope of the Report

The scope of this report is limited to the AWBS programme of work, however it is recognised that an allied programme was delivered by NHSBT.

It should be noted that NHSBT are carrying out their own programme closure and lessons learnt activity and this work is not referenced in this report although there is mention of the collaboration between the two organisations on delivery of the new national service for Wales.

2.3 Background

On the 13th of June 2012 Lesley Griffiths, the then Minister for Health and Social Services, produced a written statement announcing the Welsh Government's (WG) intention to establish an All Wales Blood Service (AWBS) by 2016.

At that time, the collection, processing and distribution of blood products in Wales was carried out by two high quality organisations – Velindre NHS Trust facilitated by the WBS and NHSBT each of which is regulated by the Medicines and Healthcare Products Regulatory Agency (MHRA). NHSBT served north Wales and England.

The Health Minister confirmed the plan to put in place arrangements that aligned more closely with Wales's national aspirations for its Health Service as outlined in the WG "Together for Health" vision. The main drivers of this vision are the streamlining, integration and modernisation of services whilst acknowledging some of the demographic challenges faced in Wales. It will also complement the WBS Long Term Vision for Delivering Services and the Velindre NHS Trust Integrated Medium Term Plan 2015-18.

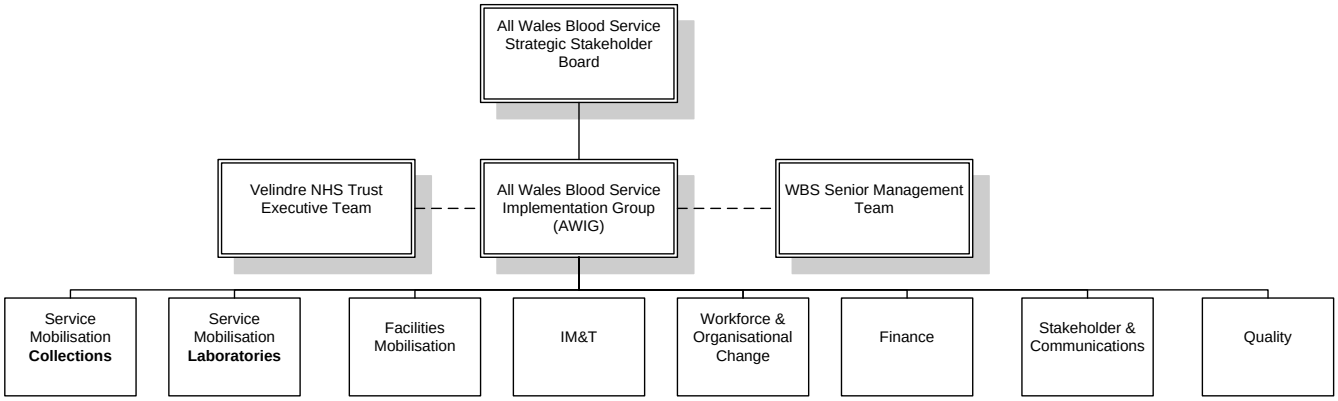
The Minister strongly believed that the formation of an AWBS would allow the WBS to plan better and build further resilience to ensure the long term security of collection, processing, testing and supply of blood and associated components in Wales.

As such, in addition to its current operations, the WBS will:

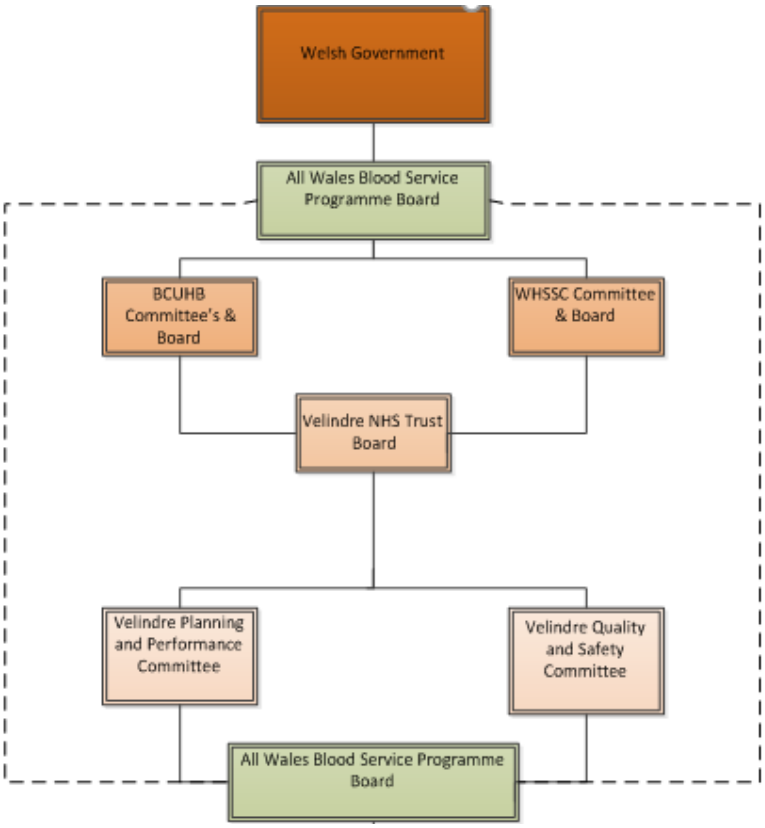
- Serve an additional 676,000 citizens in Wales largest Health Board.
- Manage an increase in demand for blood components of approximately 25%.
- Increase its footprint by 1/3rd.
- Operate a stock holding unit in the Wrexham area.
- Collect blood donations from donors in North Wales.
- Become the third largest blood service in the Anglo Irish Blood Alliance.

The AWBSP was established to deliver the required service changes to support the transfer of service for North Wales from NHSBT to WBS.

The programme management structure adopted by Velindre NHS Trust is outlined below.



The flow chart of the AWBS approvals is outlined below.



The programme vision statement states:

"We will work closely with our donors, staff and customer hospitals to provide a sustainable and high quality supply of blood components on an all Wales basis by 2016. Ensuring that the right blood components are available at the right time and in the right place to meet patients' clinical needs".

The new national service went live, as planned, on 2nd May 2016. Existing NHSBT staff were transferred to WBS via TUPE on 1st May 2016 and routine operation commenced on 3rd of May 2016.

3.0 Project Brief & Objectives

The Welsh Government gave the WBS a unique opportunity to become an all Wales service by May 2016. This allowed the WBS to put into place arrangements that will better support our donors, patients, and customer hospitals from 2016 and well into the future.

The approved programme objectives are defined below. The objectives for the programme have been delivered, however, other elements outlined within the objectives support ongoing future developments within the WBS (these are indicated in italics).

Objective 1 The All Wales Blood Service Programme will deliver a national blood service by 2016 as mandated by the Minister of Health and Social Services in 2012.	**100%**
Objective 2 The WBS will continue to supply life saving and life enhancing blood components to the NHS. The programme will ensure that the supply of blood products is not affected by the service changes, and that *post 2016 the WBS will work towards a sustainable service in Wales with minimal reliance on external partners.*	**100%**
Objective 3 The AWBS Programme will achieve value for money for the people of Wales whilst maintaining a high quality, inclusive, and customer focused service. *Once the service has been established and reached a "steady state" it will be possible to drive efficiencies in certain areas of the service by implementing new ways of working*.	**100%**
Objective 4 The AWBS Programme will maintain effective relationships with its donors, patients and staff, customer hospitals, regulators and the citizens of Wales.	**100%**

4.0 Key Milestones / Deliverables

The key milestones/deliverables of the AWBSP are outlined below. All were successfully implemented on or before the 2nd May 2016 with the exception of one which was part delivered and highlighted as appropriate. This milestone was subsequently delivered in full in January 2017.

Some of the key milestones / deliverables, whilst complete at the point of transfer, are developmental and will be reviewed and measured on an ongoing basis.

The AWBS programme dovetailed into the Donor Contact Centre (DCC) programme of work and was closely linked to the work of the DV02 workstream however, the key milestones / deliverables of that programme are not included below.

Key Milestones / Deliverables	% Complete
Staffing	
The WBS will plan, develop and implement all of the workforce and organisational change functions in support of the transfer of 43 staff from NHSBT into Velindre NHS Trust via TUPE**.**	**100%**
An additional 16 roles to be created in Wales to support the changing service model.	**100%**
Collections	
The donor panel in north Wales will be expanded to meet the shortfall left when the Wrexham team stops collection of blood in England.	**100%**
The WBS will develop relationships with business and institutions in north Wales to encourage donation, more frequently visit some venues and increase capacity of some clinics by moving from a mobile unit to venues.	**100%**
Collection team equipment will be transferred from NHSBT to WBS as part of the transfer of service.	**100%**
IM&T	
A significant data transfer of over 52,000 donor records will need to be securely transferred from NHSBT to the WBS.	**100%**
Configuration to the Blood Establishment Computer System (BECS) will be required to support the new national service, in particular the creation of a second issuing site in north east Wales.	**100%**
The WBS will develop a system to enable the north Wales hospitals to order their stock requirements through a web portal.	**100%**
The WBS will need to consider and manage the north Wales donor expectations as donors in this region are able to manage their demographic details and book appointments on line and in post donation care ***(part delivered at go live – the donor facing online appointment system was delivered in January 2017)***.	**100%**
Estates Development	
The WBS are required to provide a Stock Holding Unit (SHU) in north Wales for storage of blood products prior to distribution to BCUHB hospitals. Blood collected from the two teams based in north Wales will need to be returned to this unit for temporary storage prior to shipping to Talbot Green for processing and testing.	**100%**

Team bases will be required for both the Wrexham and Bangor teams. A long term lease for the existing Bangor team base will be transferred to the WBS from NHSBT as part of the transfer of service and the Wrexham team will be co-located in the SHU under a long term commercial lease.	**100%**
Blood Supply Chain and Cold Chain Requirements	
The distribution of blood and blood products to hospitals in BCUHB and the storage of blood donations awaiting transport back to the WBS headquarters at Talbot Green will be undertaken through a SHU in north east Wales.	**100%**
The SHU will act as a central store for processed blood and commercial products for north Wales Hospitals, co-ordinating delivery to and from hospital blood banks on a regular and emergency basis 365 days per year.	**100%**
The SHU will ensure that blood collected in north Wales is held within controlled temperature conditions and returned to the WBS headquarters at Talbot Green for processing to help ensure a regulated cold chain is maintained.	**100%**
Processing and Logistics	
Blood collected in north Wales will be delivered to a new SHU unit in north east Wales. The SHU will be staffed by a multi-skilled workforce that has responsibility for the management and safe distribution of the blood products.	**100%**
From the SHU, donated blood will be transported to our headquarters in Talbot Green, south Wales for processing in our laboratories. Processed blood will be sent to the north Wales SHU for distribution to the three customer hospitals in north Wales, namely Wrexham Maelor, Glan Clwyd and Ysbyty Gwynedd.	**100%**
Each customer hospital will hold an increased amount of blood components, which will increase resilience, reduce ad hoc and emergency deliveries, and ensure that each hospital has access to sufficient quantities of safe blood components to meet their needs.	**100%**
Transport	
The WBS will replace the leased vehicles in the NHSBT vehicle fleet with purchased vehicles which mirror those operated in south Wales.	**100%**
The Mobile Donation Clinic (MDC) unit is owned by NHSBT and will be transferred to the WBS as part of the agreed transfer of assets.	**100%**
All transfer of collected blood to the processing facilities in Talbot Green will be undertaken in a temperature controlled vehicle. The vehicle will be required to be fitted with a suitable bespoke racking and tracking system in order carry blood donation units.	**100%**
Donor Engagement	
Donor engagement, recognition, support and retention will be provided by a mixture of local action and the use of existing functions and structures already servicing our donor panels.	**100%**
Strategic marketing and communications will be based at the WBS headquarters at Talbot Green and will include engagement with donors and social media.	**100%**

Clinical Services & Training	
Clinical advice to be available from the WBS for all areas of Wales.	**100%**
The WBS will be responsible for ensuring that all staff receive the appropriate training to be able to carry out their role safely and effectively.	**100%**
There will be a requirement to transfer training records between NHSBT and the WBS.	**100%**
The Better Blood Transfusion Team will provide support for education and audit and support the effective, safe and appropriate use of blood and alternatives across Wales.	**100%**
Special Circumstances	
To meet the need to provide urgent specialist blood products for patients with very rare and bespoke requirements, relevant mechanisms need to be in place with NHSBT to cater for these circumstances when they arise.	**100%**

5.0 Monitoring Post Go Live

A post go live 100 day monitoring plan has been developed and covers the following:

- Talbot Green/SHU/BCUHB Stock Levels – Red Blood Cells (RBC)
- Talbot Green/SHU Stock Levels – Platelets
- Issues to BCUHB Hospitals – RBC & Platelets
- Wastage (Time Expired) – Platelets
- Collection Figures (Wrexham & Bangor Collection Teams)
- Did Not Attend (DNA) Rate
- Ad Hoc/Blue Light Calls
- Datix Incidents
- Concerns

The monitoring information is collated from ePROGESA and by SHU and clinical staff. Concerns information is collated from both concerns and compliment cards, telephone and emails via WBS Business Support Manager and social media contact data.

A dashboard for monitoring performance has been set up and a review of trends is presented to AWIG on a monthly basis for the duration of the monitoring period.

Post go live, the WBS will undertake a sense check of the systems, processes, staff role and resource allocation to ensure these are aligned with the service model, provide operational resilience and meet the needs of the donors and customer hospitals prior to the full review which is planned circa six months' post go live. This sense check will be led by the Programme Management Office (PMO) and will formally report to the SMT.

It has been agreed that existing monitoring arrangements will continue post the 100 day plan to support the post go live sense check process.

6.0 Benefits Review

A benefits realisation review was undertaken following the implementation of the AWBS. The review was carried out with staff across each workstream, the Senior Management Team (SMT) and Clinical Services. Further discussion took place at the All Wales Implementation Group (AWIG) meeting on 20th June 2016. The findings are outlined in the table below. Please note that intangible benefit realisation is based on perceived achievement.

It is proposed that a Welsh Government Gateway 5 - Benefits Realisation review will be undertaken following completion of the transitional period.

Benefit Ref	Definition	Type	Certainty	Cash Releasing	Owner	Comments
B1	Achieves national identity and improves brand recognition as being an All Wales Blood Service	Tangible	Definite	No	Senior Responsible Owner (SRO) / Programme Director	Started to talk as a national service with commissioners, the Welsh Government, donors, pathology service colleagues, Local Health Boards (LHBs), for example in the development the NHS Wales Blood Health Plan, developed with NHS Wales to ensure a strategic approach to prudent blood use & developing a Regenerative Medicine plan for Wales. Delivering national donor campaigns such as 'Missing Type' and Welsh Rugby Union coverage. All Welsh residents now have the opportunity to donate in Wales.
B2	Greater access and inclusion for the citizens of Wales. Greater ability for citizens of Wales to donate blood.	Tangible	Expected	No	SRO / Programme Director	Collection teams in north Wales will now collect exclusively within Wales. There has been 19 new 'panels' introduced and capacity has been increased in a further 14 existing clinic.

Benefit Ref	Definition	Type	Certainty	Cash Releasing	Owner	Comments
B3	Ability to plan better and meet variations in demand as a national service.	Intangible	Anticipated	Yes (longer term)	SRO/ Programme Director	WBS has used the establishment of a national service to commence discussions with LHBs on a more refined approach to service planning for both LHBs and WBS. This will be delivered in 3 phases: a. WBS planning with LHBs – step 1 review 2017/18 – 2018/19. b. 2018/19 – 2020/21 – improved national planning. c. Creating a flexible internal planning tool in WBS 2018/19. ***February 2017 Update*** This in underpinned by the intent in the NHS Wales Blood Health Plan and its action plan and includes discussion on product range, ordering, waste, O negative stock utilisation, emergency planning, technical and clinical support. The Blood Health Plan has created an opportunity for WBS to consider how it provides support services on clinical use on a pan Wales basis. As a result, an internal work programme is mapping LHB engagement and will result in a new programme of meetings, Key Performance Indicators (KPIs), waste etc. In addition, internal work on the Blood Health Plan has identified longer term development needs of IT systems to capture data on clinical use in the next phase of LIMS.

Benefit Ref	Definition	Type	Certainty	Cash Releasing	Owner	Comments
						Initial planning was based on north Wales and south Wales self-sufficiency planning based on historic BCUHB usage to ensure transfer with minimal disruption. WBS is now starting to plan on a pan Wales basis throughout 2017/18. This will link to the Blood Supply Chain 2020 initiative to start to harmonise north and south and identify additional efficiencies.
B4	Additional processing of north Wales blood improves organisational efficiency by 6% to 8%.	Tangible	Expected	No	SRO / Programme Director	Increased efficiency achieved as processing and testing north Wales stock with existing staff. 25% uplift in blood picking and issuing to SHU being managed within existing staffing levels.
B5	Improves service resilience by having sight of, and manage an end to end supply chain, thus improving efficiency and reducing wastage. (See B3 above)	Tangible	Anticipated	Yes (2020/21)	SRO / Programme Director	WBS have demonstrated improvements in shortage scenarios and in emergency planning exercises e.g. Red Kite. The WBS now has the ability to move red blood cells between north and south Wales allowing them to be utilised until expiry date.
B6	Forecasted annual revenue cash releasing saving of circa 589K following initial investment.	Tangible	Expected	Yes	SRO / Programme Director	Remains as forecast.

Benefit Ref	Definition	Type	Certainty	Cash Releasing	Owner	Comments
B7	Increasing blood component stocks at hospitals and at the SHU places blood components nearer to the patient.	Tangible	Expected	No	Head of Laboratory Services	Realised prior to go live in SHU stocking exercise and immediately post go-live in hospital uplift activities. Freezers have been purchased for customer hospitals to hold additional stock and hospitals are being encouraged to log issues and wastage on the Blood Management System to monitor going forward. The WBS and BCUHB continue to monitor requirements to ensure blood is always available where required.
B8	Greater ability through effective research and education to improve the prudent use of blood components on a National basis. Link the use, and appropriateness of blood component use with the latest proven clinical research.	Intangible	Anticipated	Yes (longer term)	SRO / Programme Director	Engagement with clinicians and scientists on prudent use of blood has commenced as part of Blood Health Strategy development plan. National clinical audits ensure sharing of best practice across Wales. Events held in north Wales i.e. Blood Stocks Management Roadshow.
B9	Improved offering to customer hospitals by issuing all routine platelets as irradiated, and red cells as required at no extra cost.	Tangible	Definite	No	Head of Laboratory Services	This has been realised. NHSBT used to charge extra to BCUHB hospitals for irradiated stock. This is now being supplied by WBS for no extra cost.
B10	Greater range of commercial products available at cost price.	Tangible	Definite	No	Head of Laboratory Services	Benefit realised at go live. Previously BCUHB ordered and stocked a limited range of commercial products. A greater range is now available to BCUHB direct from the WBS at cost price.

Benefit Ref	Definition	Type	Certainty	Cash Releasing	Owner	Comments
B11	Enables easier integration with national ICT programmes such as LIMS.	Tangible	Definite	No	Associate Director ICT	This is a future benefit in terms of any system integration for planning B3.

It was identified that additional benefits have been realised as part of the successful implementation of the AWBS are these are outlined below.

- Development of an improved Donor Contact Centre (DCC) and increase Welsh language capacity enabled a comprehensive all Wales approach to 'local' donor recruitment based on 'local' Welsh needs which will be aligned with future donor recruitment strategy.
- The WBS has increased access to Welsh language provision in both North and South Wales in accordance with the Welsh Language Act, following targeted recruitment of Welsh language call handling staff.
- The WBS has developed a Blood Health Plan working with stakeholders from across NHS Wales. The advantage of an all Wales blood service means this strategy development can involve discussions around all Wales solutions. The all Wales position of the blood service means it is now in a stronger position to drive changes needed to deliver the plan and engage in a streamlined way across Wales.
- In considering the training we have delivered in north Wales, we have been able to develop our overall thinking about what is our education offering to NHS Wales as a whole. As such we will be developing a revised all Wales education package to health boards.
- The move to an all Wales service allows us to respond to the Wellbeing and Future Generations Act, it will allow us to deliver a more bespoke response to the diverse needs of communities across Wales, recognise the broader value to communities the Blood Service can deliver.
- Hospitals in BCUHB are now using 'blue light' deliveries a sixth less than expected (for period May 16 – Jan 17: 12 against an expected figure of 18) based on historical NHSBT figures and are having approximately half the number of standard ad hoc deliveries.
- An additional 85 donors from north Wales have been added to the Welsh Bone Marrow Donor Register since September 2016 (bone marrow samples were not collected until 6 months post 'go live' to allow a bedding in period).

7.0 Finance Report

The reported financial position for the transitional revenue budget for AWBS at the end of March 2016 ended with a cost verses revenue neutral position following a return of funding to Welsh Government of £130k.

The table below gives the final position summarised over income, staff and non staff. In addition, the year end variance is shown.

Table – Transitional Financial Performance 15/16

All Welsh Blood Service Budget Variances 2015/16	Annual Budget £	Ytd Actual £	Ytd Variance £
Income	(637,699)	(507,772)	129,927
Staff	90,679	55,773	(34,906)
Non Staff	547,020	451,999	(95,021)
Subtotal - Core Budgets	**0**	**0**	**0**

Staff
The overall underspend of £35k primarily related to the delay in recruiting. This was particularly the case in laboratory services and the transport element of collections

Non-Staff
The £95k underspend primarily related to collections where anticipated costs for printing and stationery and postage & carriage were significantly lower than originally expected.

AWBS Transitional Financial Performance 16/17
The funding of £433k for the transitional period is still under review and will be finalised in the forthcoming months. Performance against budget is still being reviewed.

AWBS Capital Expenditure 15/16 – 16/17
The total capital expenditure for the project in 15/16 amounted to £1.453.3m against the revised £1.457m following adjustments being made totaling £589k against the original budget of £2.046m.

As a result, £181k has been approved to be carried over into 16/17 to cover known outstanding commitments. Current expenditure as at the end of June is £67k. The overall expenditure plan is shown in the table below. The total saving against the original plan is £411.4k.

Capital Expenditure Plan

AWBS Capital	Original Budget £		Revised Cost 2015/16 £	2016/17 £	Total £
SHU - Fees & Capital Costs	1,301,182		806,853	7,859	814,712
SHU Equipment	38,240		22,941	0	22,941
Vehicles	347,980		248,622	80,812	329,434
IT Hardware/software	315,765		319,564	85,331	404,895
Other Purchases	42,500		0	6,998	6,998
Additional I.T	0		55,308	0	55,308
Total	**2,045,667**		**1,453,288**	**181,000**	**1,634,288**

8.0 Outstanding Risks & Issues

This section is to advise that a number of the programme workstreams still have some outstanding risks and issues that need to be handed over to the organisation. These have been summarised by workstream and attached as appendix 1.

During the 'go live' stage an incident room was set up and manned by programme staff to provide ongoing support and to record/progress issues as they arose. An incident/issue log was established and regularly reviewed, including at each AWIG meeting. Any outstanding issues captured on the log are considered as follow on actions and will be handed over to the relevant department. These have been attached as appendix 2.

The outstanding risks and issues will be managed by the Senior Management Team (SMT) at WBS, who will formally review them on a monthly basis as part of their ongoing organisational management. This monitoring will form an integral part of the post go live sense check being led by the PMO.

9.0 Outstanding Actions

This section is to advise that a number of the programme workstreams still have some outstanding tasks within the early adoption phase of transition. These are to be considered as follow on actions and will be handed over to the relevant departments. These have been summarised by workstream and attached as Appendix 3.

In addition, the AWIG still have several actions that remained open at their last meeting on 25th July 2016. These are to be considered as follow on actions and will be handed over to the relevant departments. These have been summarised and attached as Appendix 4. Similarly, outstanding actions from the final Strategic Stakeholder Board meeting on 29th July 2016 will also be handed over to the relevant departments and have been attached as Appendix 5.

The completion of all outstanding tasks will be managed by the SMT at WBS, who will formally review progress on a monthly basis as part of their ongoing organisational management. This monitoring will form an integral part of the post go live sense check being led by the PMO.

10.0 Lessons Learned

As part of the project closure phase, a comprehensive lessons learned exercise was planned consisting of a facilitated workshop event with key internal stakeholders, plus a paper based survey circulated electronically to a wide range of stakeholders, both internal and external. The aim was to capture feedback from individuals connected with the project to gain an understanding on how well the project had been delivered.

The survey document asked participants to evaluate both positive and negative experiences, the impact(s) that these had on the programme and suggestions(s) for improvement or valuable practices. It was circulated electronically to a wide audience, which included staff, customer hospitals, WG and other key stakeholders. We received 12 responses in total, two of which were from staff in north Wales and one from NHSBT, the remainder were from internal WBS stakeholders

The workshop was held on the 6th of July 2016 and good quality feedback was gathered from the 17 internal WBS stakeholder attendees.

Staff from north Wales were invited to attend the workshop and were also offered a session in north Wales. However, the preference was to feedback via the survey.

A detailed interactive spreadsheet has been collated with findings of the Lessons Learned exercise and this will be publicised widely amongst Project Management Office staff, the Senior Management Team and will be available to all staff on the shared drive so that the findings can influence the conduct of future projects.

Based on the responses via all formats, the main positive and improvement findings that the Trust needs to note are as follows.

Positive Elements / Best Practice

1. Utilisation of an ‘implementation team’, drawn from staff across the organisation, was pivotal to the successful delivery of the new national service. Regular, informal ‘keeping in touch’ meetings for this team were used to share milestones and project progress and were the focus for each workstream to engage with other areas of the project. The result was a highly motivated team working together collaboratively with a willingness to support each other. There was good cross pollination and a move away from silo working.

2. The use of shared services central procurement for purchasing non capital items was invaluable for the ordering of equipment. This was the first programme to utilise this approach and the purchasing process was much more efficient as a result.

3. WBS were able to meet some of the IM&T elements required for the new national service through in-house, green-field development. As a result, WBS was able to meet

the essential requirements in a short-timescale, to flex resources in response to changing needs and had full control of delivery.

4. Including a member of the collections staff in ePROGESA qualification for the NOMAD was beneficial as they offered a different perspective. Collections staff reported that they felt more involved in the process, and that they would be able to provide more support when the changes went live.

5. The use of Agile methodologies throughout the implementation stage of the programme took the focus off formal structures/processes and placed it on delivering the objectives within timescale in a very interactive, visual way.

6. Training of the new staff was executed by highly professional trainers and delivered with passion and drive ensuring well trained and motivated staff at point of 'go live'.

7. Learning lessons from the BECs implementation resulted in WBS reducing the bleed post go live and ramping up in a phased approach. This ensured that new collection team staff were and overloaded and reduced stress around working with new processes. It also ensured a smoother process for the donors.

Improvement Opportunities

1. A heavy emphasis was placed on implementation and getting over the line for 'go live' and we lost sight of some early operational challenges for the new service.

2. Validation deliverables need to be started early, particularly for those staff that are not familiar with the validation process and therefore require more support from the validation team. The resulting delays meant that the validation team was supporting the ePROGESA qualification at the time that other staff working on the AWBSP required more support.

3. Slow decision making processes during some stages of the programme e.g. delay in decision of staffing structure in the SHU. Contributed to avoidable delays which impacted on project plans, in turn pushing timelines and increasing risk.

4. The change management process should have been constructed across the programme in a more structured way. Change Control status was not driven from within the project plans.

5. Lack of user involvement in the user requirement spec / testing phase of the ePROGESA release i.e. HEV meant that the work requiring user input was delayed, resulting in increased pressure close to delivery deadlines.

6. The requirement to maintain 'business as usual' while utilising staff to implement a programme carried risks of normal operation suffering. Much effort and resource was spent in managing expectations / workload and in diverting resource to unplanned urgent requests.

7. The planning phase didn't identify all items of equipment which required validation or when these would be delivered/available for validation activities. Validation

requirements were identified later in the project, leading validation activity being delayed towards the end of the programme. The deadlines for completion were very tight and staff were under a lot of pressure to complete work within the required timeframe, including documentation.

11.0 Acknowledgements

The WBS would like to acknowledge the help and support of BCUHB and NHSBT in delivering the transfer of service.

We would also like to thank our key stakeholders who have worked closely with us to ensure we put into place arrangements that will better support our donors, patients, and customer hospitals from 2016 and well into the future. These include:

Community Health Councils, Welsh Government, Trade Union representatives, Welsh Health Specialised Services Committee (WHSSC).

Appendix 1 – Outstanding Workstream Risks as at August 2016

The outstanding risks will be managed by the Senior Management Team (SMT) at WBS, who will formally review them on a monthly basis as part of their ongoing organisational management.

All-Wales Blood Service
Risk & Issue Log

ID	Date Raised	Originator	Description	Description of Potential Impact	Owner	Risk Rating	Last reviewed	Mitigation Actions	Risk Rating (revised)	Open / Closed
Collections 028	24/11/2015	Professional Lead Nurse	Risks associated with current RN staffing model in N Wales	There is a risk that the current RN staffing model on N Wales teams may not have enough resilience in regard to the increase in RN referrals that will happen as a consequence of introduction of ePROGESA.	Professional Lead Nurse	16	26/04/2016	Following SMT decision, recruitment has commenced for two 0.5 wte band 5 RNs, fixed term for 9 months, one per team. These recruitment measures should ensure minimum of 2 RNs per team until review of process post transition.	8	Open
Facilites 020	19/05/2016	Facilities Manager	Signing of FM Contract	There is a risk that the failure to agree the current FM contract with Kier will result in potential need for a retendering process to be undertaken.	Facilities Manager, Head of Estates	12	19/05/2016	Month by month contract in place. New contract currently being reviewed by legal teams.	9	Open
Comms 013 (Transferred from IMT)	03/06/2015	Publicity & Marketing Manager	Impact of SAHH for Welsh language donors	SAHH translated into Welsh although may have impact for north Wales donors where interpretations of the Welsh language may differ.	Publicity & Marketing Manager	12	27/04/2016	Being investigated with Welsh Language Officer.	12	Open (Transferred from IM&T)

Appendix 1A – Outstanding Workstream Risks as at February 2017

The outstanding risks are being managed by the Senior Management Team (SMT) at WBS as part of their ongoing organisational management.

All-Wales Blood Service Risk & Issue Log - February 2017 Update										
ID	Date Raised	Originator	Description	Description of Potential Impact	Owner	Risk Rating	Last reviewed	Mitigation Actions	Risk Rating (revised)	Open / Closed
Collections 028	24/11/2015	Professional Lead Nurse	Risks associated with current RN staffing model in N Wales	There is a risk that the current RN staffing model on N Wales teams may not have enough resilience in regard to the increase in RN referrals that will happen as a consequence of introduction of ePROGESA.	Professional Lead Nurse	16	21/02/2017	Recruitment of new Nurse Manager role imminent	4	Open
Facilities 020	19/05/2016	Facilities Manager	Signing of FM Contract	There is a risk that the failure to agree the current FM contract with Kier will result in potential need for a retendering process to be undertaken.	Facilities Manager, Head of Estates	12	21/02/2017	Month by month contract in place. New contract currently being reviewed by legal teams.	9	Open
Comms 013 (Transferred from IMT)	03/06/2015	Publicity & Marketing Manager	Impact of SAHH for Welsh language donors	SAHH translated into Welsh although may have impact for north Wales donors where interpretations of the Welsh language may differ.	Publicity & Marketing Manager	12	21/02/2017	Risk did not materialise.	12	Closed

Appendix 2 – Outstanding Programme Issues from Incident Log

The outstanding issues will be managed by the Senior Management Team (SMT) at WBS, who will formally review them on a monthly basis as part of their ongoing organisational management.

All-Wales Blood Service Incident Log									
ID	Description of Incident	Open Issue	Raised By	Date	Time	Escalated to	AWIG	Comments	Action Taken/Result
076	Identified that additional admin support required for Operations Manager particularly around HR tasks.	Y	Head of North Wales Operations	16.05.2016	09.00	Deputy Director, Associate Director of Planning & Performance	Y	Review of DRM processes to identify if capacity available within team as some work now centralised. A session was held with team to map processes/functions. Report indicates resource available.	Work with DRM team to release one member of staff to support NW Ops Manager. Ad hoc support from SW Ops Managers has been implemented in the short term.
109	Concerns raised by customer hospitals in NW regarding high level of short expiry platelets.	Y	Responsible Person	27.06.2016	13.30	Head of Laboratories	Y	Longer term - investigating change in bacteriology protocol to provide longer dated platelets.	Reviewing SHU stock levels in the short term.

Appendix 2A – Outstanding Programme Issues from Incident Log (February 2017 Update)

The outstanding issues are being managed by the Senior Management Team (SMT) at WBS as part of their ongoing organisational management.

All-Wales Blood Service Incident Log									
ID	Description of Incident	Open Issue	Raised By	Date	Time	Escalated to	AWIG	Comments	Action Taken/Result
076	Identified that additional admin support required for Operations Manager particularly around HR tasks.	N	Head of North Wales Operations	16.05.2016	09.00	Deputy Director, Associate Director of Planning & Performance	Y	Review of DRM processes to identify if capacity available within team as some work now centralised. A session was held with team to map processes/functions. Report indicates resource available.	Capacity identified within existing DRM team. Some re-alignment of staff has taken place to accommodate. Further review included within Blood Supply Chain Initiative. Ad hoc support from SW Ops Manager has been implemented in the short term.
109	Concerns raised by customer hospitals in NW regarding high level of short expiry platelets.	N	Responsible Person	27.06.2016	13.30	Head of Laboratories	Y	Longer term - investigating change in bacteriology protocol to provide longer dated platelets.	This was not found to be accurate in practice. However, longer term plan in place to increase to 7 day platelets as more efficient for WBS.

Appendix 3 – Outstanding Programme Actions by Workstream

The completion of outstanding actions will be managed by the Senior Management Team (SMT) at WBS, who will formally review progress on a monthly basis as part of their ongoing organisational management.

Source	Task	SMT Owner	Comment	By When?
Collections WS	Ensure cleaning contract in place for north Wales vehicles.	**Planning & Performance**	Plan to be circulated to Steve Hough and procurement to be commenced.	**August 2016**
Collections WS	Second TCV in process of snagging.	**Planning & Performance**	Vehicle to be returned to GRP for snagging issues.	**August 2016**
Collections WS	DRM Training on delivery vehicles	**Planning & Performance**	Dates being finalised for August.	**August 2016**
Collections WS	Conversion of second MDC	**Planning & Performance**	After remaining in north Wales to provide generator resilience for the bloodmobile in operation, the vehicle has now been returned to Talbot Green and work is underway to make the required conversions. Currently out to tender for work.	**August 2016**
Collections WS	Changes to Venue Risk Assessments (VRAs) – wider service review.	**Planning & Performance**	Determine whether changes to VRAs are required to incorporate checking of water sources for legionella etc. If these changes are required, then ensure that they are reflected in north Wales practices.	**March 2017**
Facilities WS	Facilities Maintenance (FM) Contract finalised and live.	**General Services**	Contract agreement is still not in place. Negotiations around terms and conditions of the contract are still on-going. Currently month to month orders are being placed with the supplier.	**Subject to agreement between both parties aiming towards end of July 2016.**
Facilities WS	Completion of work on Pembroke House snagging list.	**General Services**		**August 2016**

Source	Task	SMT Owner	Comment	By When?
Finance WS	Finalise capital purchases.	**Finance**	Ongoing review of 16/17 funding of £181k that was carried over has identified a current forecasted underspend of circa £6.5k. Circa £100k still outstanding of which £57k relates to MAK.	**October 2016**
Finance WS	Update Trust asset register with any capital transfers.	**Finance**	Awaiting documentation.	**August 2016**
Finance WS	Finalise asset and equipment transfer.	**Finance**	Governance wrap in the form of NHSBT being strengthened.	**August 2016**
Finance WS	Finalise BCUHB/WBS SLA for IT support.	**General Services**	IT SLA with BCUHB still required to be signed - some ongoing discussion to finalise financial impact.	**August 2016**
IM&T WS	Identify and develop 'IT Champions' for both teams in N Wales	**General Services Planning & Performance**	Ongoing requirement to support teams.	**October 2016**
IM&T WS	Donor facing online appointment system developed, tested and launched.	**General Services**	Development work nearing completion, translation underway and user testing scheduled for early August 2016. Launch planned in August 2016.	**August 2016**
Labs WS	Close out of validation of cold rooms, equipment and TCV.	**Head of Laboratories**		**August 2016**
Quality WS	Review and update Quality Manual.	**Head of QA**	Has been handed over to Andy as new Head of QA.	**August 2016**
Quality WS	Closure of change controls	**Head of QA**	Several remain open – some awaiting validation report close out. Undertaken as business as usual for QA and being chased up by Quality Champions.	**August 2016**
Comms WS	Introduce donor award events in north Wales.	**Director**	Agreement required on whether to invite donors who have reached their milestones whilst donating with the WBS or identify donors who missed out on attending a donor awards evening since the introduction of the NHSBT donor loyalty scheme.	**August 2016**

Appendix 3A – Outstanding Programme Actions by Workstream (February 2017 Update)

The completion of outstanding actions is being managed by the Senior Management Team (SMT) at WBS as part of their ongoing organisational management.

Source	Task	SMT Owner	Comment	By When?
Collections WS	Ensure cleaning contract in place for north Wales vehicles.	**Collections**	**COMPLETE**	**August 2016**
Collections WS	Second TCV in process of snagging.	**Collections**	**Ongoing** – vehicle in validation process.	**April 2017**
Collections WS	DRM Training on delivery vehicles	**Collections**	**COMPLETE**	**August 2016**
Collections WS	Conversion of second MDC	**Collections**	**Ongoing** - vehicle is currently being converted.	**April 2017**
Collections WS	Changes to Venue Risk Assessments (VRAs) – wider service review.	**Collections**	**Ongoing** - determine whether changes to VRAs are required to incorporate checking of water sources for legionella etc. If these changes are required, then ensure that they are reflected in north Wales practices.	**March 2017**
Facilities WS	Facilities Maintenance (FM) Contract finalised and live.	**General Services**	**Ongoing** - contract agreement is still not in place. Negotiations around terms and conditions of the contract are still on-going. Currently month to month orders are being placed with the supplier.	**April 2017**
Facilities WS	Completion of work on Pembroke House snagging list.	**General Services**	**COMPLETE**	**August 2016**
Finance WS	Finalise capital purchases.	**Finance**	**COMPLETE**	**October 2016**
Finance WS	Update Trust asset register with any capital transfers.	**Finance**	**COMPLETE**	**August 2016**
Finance WS	Finalise asset and equipment transfer.	**Finance**	**COMPLETE**	**August 2016**
Finance WS	Finalise BCUHB/WBS SLA for IT support.	**General Services**	**COMPLETE**	**August 2016**

Source	Task	SMT Owner	Comment	By When?
IM&T WS	Identify and develop 'IT Champions' for both teams in N Wales	**General Services Collections**	**Ongoing** – discussions underway to take this forward.	**April 2017**
IM&T WS	Donor facing online appointment system developed, tested and launched.	**General Services**	**COMPLETE** - launched in January 2017.	**August 2016**
Labs WS	Close out of validation of cold rooms, equipment and TCV.	**Head of Laboratories**	**Ongoing** – equipment (including cold rooms) currently in last stages of validation. 1st TCV in Performance Qualification (operational state) and 2nd TCV will be operational in next 10 days and will undergo final validation at that point.	**April 2017**
Quality WS	Review and update Quality Manual.	**Head of QA**	**Ongoing** – currently being updated.	**April 2017**
Quality WS	Closure of change controls	**Head of QA**	**Ongoing** - overarching project change remains open as some technical equipment in still in validation process.	**April 2017**
Comms WS	Introduce donor award events in north Wales.	**Director**	**Ongoing** - Agreement reached to invite donors who have reached their milestones whilst donating with the WBS. Events to be held in north Wales – no dates confirmed as yet.	**June 2017**

Appendix 4 – Outstanding Actions from the All Wales Implementation Group

The completion of outstanding actions will be managed by the Senior Management Team (SMT) at WBS, who will formally review progress on a monthly basis as part of their ongoing organisational management.

Meeting Date - Minute Ref	Action	By Whom	By When	Completed	Evidence
22.01.16 Item 6	**Donor Concerns** - Process map for NW provided previously, some amendments to be made with further discussions to take place outside of the meeting.	Business Support Manager	August 2016	**Yellow Ongoing**	Action outstanding, further update required.
25.04.16 Item 4.6	**FM Contract** – STA in process until end of July 2016. Contract still to be finalised.	Head of Estates	July 2016	**Yellow Ongoing**	Awaiting contact from supplier – issues remaining around agreement of T&Cs. In the short term STA to be extended, current STA ends at the end of July 2016.
13.05.16 Item 5	**Commissioning of freezers at BCUHB** – WBS to support moving this forward. Discussed at Transfusion Lab Managers Meeting in June 2016.	Head of Labs	August 2016	**Yellow Ongoing**	BCUHB awaiting a date from supplier to complete the validation work.
27.05.16 Item 5	**BCU SLA for IT Support** – still experiencing issues regarding some elements of the contract and the SLA is still not signed off.	General Services	August 2016	**Yellow Ongoing**	Issues now finalised and SLA will be signed off when Deputy Director returns from leave. Cost pressure noted and agreed.
27.05.16 Item 5	**Post 'Go Live' Sense Check** – Director requested a sense check of the systems, processes, staff role and resource allocation to ensure these are aligned with the service model, provide operational resilience and meet the needs of donors and customer hospitals prior to the full review that is planned circa six months' post go live.	Director/ PMO	July/ August 2016	**Yellow Ongoing**	This sense check will be led by the Programme Management Office (PMO) and will formally report to the SMT. Comms strategy required for this process.
20.06.16 Item 4	**Admin Support – Ops Manager –** Sense check review completed and options to provide admin support internally are being explored.	Head of Performance & Planning	August 2016	**Yellow Ongoing**	Ops Manager has been seconded to support in NW and part of his

					remit is to explore this further. Work with HR to progress.
20.06.16 Item 7	**Donor Attrition –** Director requested an ongoing review of donor panels to monitor donor attrition going forward.	Head of Planning & Performance	August 2016	**Yellow Ongoing**	Currently underway - being progressed by DCC.
20.06.16 Item 8	**Haemochromatosis Patients** – request list from NHSBT to enable WBS to advise WBS don't currently provide this service.	Medical Director	August 2016	**Yellow Ongoing**	NHSBT advised we can identify donors in transferred data. 28 donors found but not clear if all were identified. Medical Director to contact NHSBT to progress.
25.07.16 Item 9	**KPI Monitoring –** continue with existing KPI monitoring plan post 100 day and undertake a full analysis of the trends.	PMO	September 2016	**Yellow Ongoing**	Continue to monitor up until end of September and present to Trust Executive Board meeting in September 2016.

Appendix 4A – Outstanding Actions from the All Wales Implementation Group (February 2017 Update)

The completion of outstanding actions is being managed by the Senior Management Team (SMT) at WBS as part of their ongoing organisational management.

Meeting Date - Minute Ref	Action	By Whom	By When	Completed	Evidence
22.01.16 Item 6	**Donor Concerns** - Process map for NW provided previously, some amendments to be made with further discussions to take place outside of the meeting.	Business Support Manager	August 2016	**Green Complete**	NW donors included within existing process.
25.04.16 Item 4.6	**FM Contract** – STA in process until end of July 2016. Contract still to be finalised.	Head of Estates	April 2017	**Yellow Ongoing**	Issues remaining around agreement of T&Cs. Month by month contract in place. New contract currently being reviewed by legal teams.
13.05.16 Item 5	**Commissioning of freezers at BCUHB** – WBS to support moving this forward. Discussed at Transfusion Lab Managers Meeting in June 2016.	Head of Labs	August 2016	**Green Complete**	Freezers now commissioned.
27.05.16 Item 5	**BCU SLA for IT Support** – still experiencing issues regarding some elements of the contract and the SLA is still not signed off.	General Services	August 2016	**Green Complete**	SLA completed and reviewed.
27.05.16 Item 5	**Post 'Go Live' Sense Check** – Director requested a sense check of the systems, processes, staff role and resource allocation to ensure these are aligned with the service model, provide operational resilience and meet the needs of donors and customer hospitals prior to the full review that is planned circa six months' post go live.	Director/ PMO	July / August 2016	**Green Complete**	Sense check was led by the Programme Management Office (PMO) and formally reported to the SMT. Now being taken forward as part of ongoing organisational management.
20.06.16 Item 4	**Admin Support – Ops Manager –** Sense check review completed and options to provide admin support internally are being explored.	Head of Collections	April 2017	**Yellow Ongoing**	Ops Manager has been seconded to support in NW. Some re-alignment of staff has taken place to accommodate. Further review included within Blood Supply Chain Initiative.

20.06.16 Item 7	**Donor Attrition –** Director requested an ongoing review of donor panels to monitor donor attrition going forward.	Head of Collections	August 2016	**Green Complete**	Being taken forward as part of the Blood Supply Chain Initiative.
20.06.16 Item 8	**Haemochromatosis Patients** – request list from NHSBT to enable WBS to advise WBS don't currently provide this service.	Medical Director	August 2016	**Green Complete**	WBS development in Intermediate Medium Term Plan (IMTP) in 2018.
25.07.16 Item 9	**KPI Monitoring –** continue with existing KPI monitoring plan post 100 days.	PMO	September 2016	**Green Complete**	Built into WBS Performance Management Framework.

Appendix 5 – Outstanding Actions from the Strategic Stakeholder Board

The completion of outstanding actions will be managed by the Senior Management Team (SMT) at WBS.

Minute Ref	Action	By Whom	By When	Completed	Evidence
14 Mins 29.04.2016	AT confirmed that BCUHB have asked for a formal update for their Board, approximately 6 months after go live.	**Director**	November 2016	**Yellow Ongoing**	A formal update will be completed and distributed following the Welsh Government Gateway 5 Review in November 2016. The formal update will be presented at BCUHB Board Meeting in January 2017. JG to liaise with BCUHB to confirm dates.
5 Mins 29.07.2016	The PMO will liaise with Matt Jones, NHSBT to receive a copy of their project closure documentation. The PMO will then forward both the WBS and NHSBT reports to JT along with confirmation of the dates of the Gateway Review.	**PMO**	August 2016	**Yellow Ongoing**	

Appendix 5A – Outstanding Actions from the Strategic Stakeholder Board (February 2017 Update)

The completion of outstanding actions is being managed by the Senior Management Team (SMT) at WBS.

Minute Ref	Action	By Whom	By When	Completed	Evidence
14 Mins 29.04.2016	AT confirmed that BCUHB have asked for a formal update for their Board, approximately 6 months after go live.	**Director**	March 2017	**Yellow Ongoing**	A formal update will be completed and distributed following the Welsh Government Gateway 5 Review in March 2017. JG to liaise with BCUHB to confirm dates.
5 Mins 29.07.2016	The PMO will liaise with Matt Jones, NHSBT to receive a copy of their project closure documentation. The PMO will then forward both the WBS and NHSBT reports to JT along with confirmation of the dates of the Gateway Review.	**PMO**	August 2016	**Green Complete**	Report received and distributed. Gateway 5 Review confirmed as 1st – 3rd March 2017.

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

		Agenda Item	8
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	Thoracic Surgery Review: Project Update		
Author (Job title)	Project Manager Thoracic Surgery Review		
Executive Lead (Job title)	Managing Director	Public / In Committee	Public

Purpose	The purpose of this paper is to: • Provide an update on the progress to date of the Thoracic Surgery Review project; • Confirm the time line for the Joint Committee to make a decision regarding the number and location of future services in South Wales; • Seek approval for the process and documentation underpinning the Joint Committee's decision.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☐	☐	☒

8

Sub Group /Committee	Thoracic Surgery Project Board	Meeting Date	04/09/2017
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the update to the Thoracic Surgery Review project; • **Approve** the process and documentation underpinning the final decision by the Joint Committee regarding the number and location of future services in South Wales.		

Considerations within the report (tick as appropriate)

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

1.0 Situation

There have been four reviews of Thoracic Surgical services over the last 5 years which have raised concern regarding both short term risks and long term sustainability of services in South Wales. Two of the reviews were carried out in the last 12 months, one commissioned by WHSSC from the Royal College of Surgeons and the other commissioned by ABMUHB to address local operational and delivery issues. Specific issues include:

- Breaches of the 62 day cancer target for patients requiring potentially curative surgery for lung cancer during the last 12 months. This position has only improved due to weekend working
- Non-cancer patients being treated without surgical input because of the long delays
- Outcome evidence which shows patients with lung cancer requiring surgery have better outcomes if treated in larger centres
- Increasing complexity of thoracic surgery such that surgeons are no longer being dual trained for cardiac and thoracic surgery. This means that in the future out of hours cover will require stand-alone thoracic teams.

2.0 Background

2.1 Progress to date:

i. A Thoracic Surgery service specification for Wales has been agreed through a formal WHSSC process including public consultation.

ii. Legal advice has been taken from Welsh Health Legal Services and there has been discussion with the CHCs regarding the need for public consultation on any change to the number and location of services in South Wales. The CHCs have indicated that a process of engagement is appropriate at this stage however consultation may be required following the final decision. The requirement for formal consultation will be informed through the feedback obtained during the engagement process.

iii. It was agreed by the Joint Committee in July 2017 that there would be a single engagement process regarding both the question of whether there should be one or two sites and if there is to be one, the location of that site.

iv. The recommendations to the Joint Committee would however come through two separate recommendation processes. The first recommendation will from the Project Board regarding the number of sites. If a single site model is recommended, the second recommendation will be made by an Independent Panel on the location

The final decision will be made by the Joint Committee and informed by the recommendations of the Project Board and Independent Panel and underpinned by a financial assessment of provider proposals.

v. A process of pre-engagement has been undertaken involving the CHCs, the HB engagement leads and 3rd sector organisations which have informed the current process.

vi. The requirement to submit the engagement documentation to individual HBs for consideration has meant that documentation was circulated prior to the planned closure of the pre-engagement process and it has been agreed with the engagement leads that outstanding issues will be fed in formally through the HBs and public engagement events.

vii. The Project Board met on the 4th of September and in light of the changes to the planned process agreed the following updated documentation:

- Updated Project Initiation Document
- Updated Project Board Terms of References
- New Engagement Document
- Updated Engagement Plan
- Terms of Reference and draft membership of the Independent Panel.

The Project Board have asked for amendments to the wording of the engagement document however advice from the HB Engagement leads is that whilst some of these issues can be picked up via an FAQ document, others should not be included. Appendix 1 provides feedback received from the Engagement Leads and Steering Group's response.

viii. The Project Board also considered the draft criteria to be used by the Independent Panel and have agreed to provide further feedback on the evidence template which will be used by providers.

3.0 Assessment

3.1 Formal support is now required from the Joint Committee regarding the process and documentation related to the engagement, recommendation and decision making process.

3.1.1. Engagement Documentation:

- Feedback has already been received from the engagement leads from all the South Wales Health Boards regarding both the Engagement

Plan and the Engagement Document (see appendix 2 for version circulated to Health Boards).

- Amendments to the Engagement Plan have already been incorporated into a new version and have been circulated to the Project Board for final sign off. This version now provides the agreed Plan (appendix3)
- The Engagement Document has been updated in response to the feedback described above and a provider identified for a plain English document, along with Welsh and Easy Read versions.
- Because of the steps described above and the pre-engagement process it has been assumed that minimal redrafting will be required following review by the Boards of the Health Boards. It is recognised, however, that there is less than 24 hours before the last Board meeting and the proposed start of the engagement exercise. Therefore, should further amendments be needed following review by the Boards of the Health Boards, there is some flexibility around the start of engagement.

3.1.2 Recommendation Process:

3.1.3 The recommendation regarding the need for one or two sites will be made by the Project Board (see appendix 4 for TOR).

- The evidence on which this recommendation will be made is being considered through the engagement process. The suggested evidence sources are listed below:
  - Expert Professional Advice : Royal College of Surgeons of England in relation to an Invited Review of Thoracic Surgery Services in Wales
  - Changes in Thoracic Surgery in the UK
  - Specialised Services Service Specification : Thoracic Surgery
  - Service Delivery : Service resilience & benefits of scale

- It is therefore possible that new evidence requirements will be identified through the engagement process. The steering group however have access to a much wider evidence base which is being developed to support the second recommendation. It is therefore anticipated that any additional evidence requirements could be easily met
- The Project Board will aim for consensus regarding the recommendation and if this is not possible then a narrative describing the issues of disagreement will be provided to the Joint Committee. A majority decision will however be sufficient for the process to move directly to the second recommendation step.

3.1.4 The recommendation on location of a single site if this is needed will be made by an Independent Panel (see appendix 5 for the TOR and draft membership).

- The criteria which will be used by the panel are currently part of the engagement process. The suggested criteria are:
    - **How easy will it be for patients to access care at that unit?** To measure this we will look at travel times/distance and the availability of public transport
    - **How easy will it be for the unit to meet the standards required of a high quality unit (these standards are described in the Service Specification)?** By Standards we mean whether they have the staff, equipment, space, particularly surgical theatre space etc which are necessary to deliver high quality care. To measure this we will look at the current standard of service, the gaps between the current services and the standards described in the Service Specification.
    - **How sustainable is the unit? By this we mean how likely is the unit to be able to meet our needs in the future?** We will want to know if the unit could increase their capacity (the number of patients they can treat) in the future if needed. We want to know if the unit has problems recruiting staff at the moment and if they do what are their plans for the future. Also whether there other developments planned at the site which may have an effect on the delivery of thoracic surgery.
    - **Will the unit help improve the standards of care across South Wales?** To measure this we want to know if the unit has links with universities or colleges. Does the unit have other experts (non-surgeons) or links with other experts who will help develop new services this includes services for patients who are being treated in local hospitals outside the centre
- It is therefore possible that the criteria may change however the project team are working with providers to develop an extensive evidence base and it is anticipated that this would be sufficiently comprehensive to match the requirements of any changed criteria
- The current process does not include a step whereby the final criteria are approved by the Joint Committee. This is currently delegated to the Thoracic Surgery Project Board. Joint Committee is asked to approve this process
- A Chair will be appointed to manage the Independent Panel who will have the responsibility to oversee the panel process ensuring it is fair and equitable. Joint Committee is asked to approve the appointment of a Chair
- A draft membership, modelled on the membership used for the previous Neonatal Workforce Independent Panel and agreed by the

Joint Committee, will be presented to the independent Chair for final sign off

- The methodology used by the Independent Panel to reach a recommendation will be based on EDEM (Evidence and Value: Impact on Decision-Making) methodology and supported by the Swansea Centre for Health Economics. This will replicate the methodology previously used by the Neonatal Workforce Independent Panel
- The output of the Panel will be a recommendation on which of two sites should be prioritised for relocation of a single Thoracic Surgery service
- If the engagement process identifies serious issues related to the criteria and the evidence base is insufficient to support the Independent Panel then process will be paused and the issues returned to the Joint Committee.

3.1.5 Decision making Process

The decision will be made by the Joint Committee who will receive recommendations on the whole process:

1. First they will consider the recommendation on whether there should be one site or two. To make this decision they will take into account the recommendation of the Project Board and a narrative as to why the recommendation has been reached
2. If the recommendation is two sites and the Joint Committee endorses this recommendation then the decision making process is complete. WHSSC officers will then consider the gap analysis of the centres against the service specification and a proposal will be taken forward into the 2019-20 ICP
3. If the recommendation is one site and the Joint Committee endorses this recommendation the committee will need to consider the second recommendation as well as the Financial Assessment. On the basis on this information the Joint Committee will decide on which site future services should be located
4. Following this decision WHSSC officers will undertake, in liaison, with the CHCs a review of the engagement feedback and come to a collective view as whether full consultation is needed. This will be reported to the January 2018 meeting of the Joint Committee. Implementation planning will be agreed when the need for formal consultation is decided.

Engagement process timeline

29 September – 10 November	Stakeholder Engagement
10 – 14 November	Analysis of Stage One Engagement Feedback Preparation of paper for Project Board
22 November	Recommendation following stakeholder engagement to Thoracic Surgery Review Project Board Meeting
27 November	Independent Panel
8 December	Recommendation following Independent Panel to Thoracic Surgery Review Project Board Meeting
19 December	Joint Committee Meeting

4.0 Recommendations

4.1 Members are asked to:

- **Note** the update to the Thoracic Surgery Review project;
- **Approve** the process and documentation underpinning the final decision by the Joint Committee regarding the number and location of future thoracic surgery services in South Wales. Specifically:
  - Updated PID
  - Updated Project Board TOR
  - Engagement Document (version circulated to Health Boards)
  - Updated Engagement Plan
  - TOR and draft membership of the Independent Panel. Confirmation of final membership to be delegated to the Chair of the Independent Panel
  - Chair of the Independent Panel
  - Delegate sign off of the final criteria to be used by the Independent Panel to the Project Board

5.0 Appendices / Annexes

Appendix 1 – Engagement Lead feedback
Appendix 2 – Engagement Document (version circulated to Health Boards)
Appendix 3 - Updated Engagement Plan
Appendix 4 - Updated Project Board TOR
Appendix 5 - TOR and draft membership of the Independent Panel
Appendix 6 - Updated PID

Link to Healthcare Objectives	
Strategic Objective(s)	Implementation of the Plan
Link to Integrated Commissioning Plan	Delivery of the thoracic surgery review.
Health and Care Standards	Safe Care Effective Care Timely Care
Principles of Prudent Healthcare	Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Improving Patient Experience (including quality and Satisfaction)
Organisational Implications	
Quality, Safety & Patient Experience	The thoracic surgery review aims to make recommendations to ensure the future safety and quality of the service, providing a positive patient experience.
Resources Implications	Resource implications relating to implementing the public engagement are raised within the paper. Additional capacity within WHSSC is required to support delivery.
Risk and Assurance	The paper highlights risks to delivery of the engagement process, and wider review, within agreed timescales.
Evidence Base	n/a
Equality and Diversity	The engagement process will be designed according to good practice to ensure equality and diversity obligations are met.
Population Health	This paper does not directly address issues of population health.
Legal Implications	The paper concerns the implementation of public engagement. Specific legal issues or advice is not considered within this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	17/07/17	Approved to go forward to Joint Committee with amendments.

Appendix

Key issues arising from meeting with Engagement Leads

Issue	**Response**
Engagement Document	
Amendments suggested following Project Board	
Page 3 – "This doesn't mean there's a problem with the skill of our surgeons but may mean our systems for looking after patients do not work as well as they should" The group advised that information on clinical outcomes should be included in FAQs	This sentence will not be included and a FAQ paper prepared
Page 5 – "They will look at the Royal College of Surgeons Review but will also look at some other aspects of the service which we think are important to patients and the running of the service." The group advised that this sentence could be interpreted as discounting the views of patients and other stakeholders.	This sentence will not be included
Page 10 – "*The service specification recommends that ideally there should be co-location with cardiac surgery."* The group advised that this should not be used as it needs to mirror the statement from the service specification	*"ideally"* will not be included
Page 11 – "*Thoracic surgery services therefore should*	This sentence will not be included

ideally be located on a site where there is cardiac surgery but they are not dependent on any other major services." The group advised that this could be interpreted as being inconsistent with the options presented within paper.	
Additional amendments	
The consultation process used for the service specification needs to be clarified	Paragraph to be included to describe the WHSSC process for developing policies and service specifications.
Review of tone, particularly when discussed stage two	These changes have been made
"If the first step recommends one centre then we will move directly into the second step, we will not pause whilst the Joint Committee considers the recommendation. The reason for this is that: *1. We do not want to introduce any unnecessary delay. Our doctors and nurses tell us that our patients do not always receive the care they should and the longer we take to make a decision the more patients will be affected.* *2. The Health Boards have advised us because there is strong evidence in favour of a single centre and believe the Project Board is likely to recommend a single centre, a more streamlined process is appropriate."* The group advised that this could be interpreted that the outcome is a foregone conclusion section, and	Remove, and clarify actual areas of influence, as opposed to support e.g. influence development of criteria, support for process, etc

therefore need set out the actual areas of influence as distinct from those in which the Project Board is looking for support of the process, criteria, etc.	
The group advised that the document needed to describe potential requirement for consultation	An additional sentence will be included
The group expressed concern about the time available to make changes to the engagement document following the feedback from the Health Board and CHC meetings.	Reference to the timescale is included within the Joint Committee paper and clarity on the process provided to Engagement Leads
The group asked for clarification on the process for CHCs to provide feedback	Engagement leads notified of process
Engagement Process	
The group suggested the invitation letter to engagement events is a joint letter between WHSSC MD and HB CEO for that area	Agreed
The group advised that some organisations may not be content with the proposed engagement period and queried what contingencies where in place to accommodate any request to extend the engagement period.	This has been addressed and the period will be 6 weeks
The group advised of the need to negotiate the number of public meetings with CHCs, and meetings with interest groups	Agreed, further discussion will take place with engagement leads
The group advised that current practice was to meet with staff in advance of the public meeting	
The group advised that it was not advisable to include thoracic surgery and major trauma on the same meeting agenda.	Agreed

The group recommended that processes are put in place to facilitate collection of feedback from engagement events	Discussion at the engagement events will not be captured. There will be opportunity for those present to complete the stakeholder response forms and registration sheets will be available.
Proactive engagement with AMs	Agreed
Engagement mechanisms	The stakeholder response form has been amended to include a postal address. Consideration of other mechanisms will take place.
Coordination of process, feedback and analysis by WHSSC	Agreed

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

The Future Shape of Thoracic Surgery Services In South Wales

Stakeholder Engagement

8

1 INTRODUCTION

The purpose of this stakeholder engagement exercise is to obtain views and feedback from the public, patients and patient support groups, and professionals in the health service, to help us to decide whether we need both Morriston Hospital, Swansea (for the population of South West Wales) and University Hospital of Wales (for the population of South East Wales) to continue to provide two separate thoracic surgical services for their local population, or whether one of those hospitals should provide a larger combined service for the whole of South Wales.

This document explains the background to why the change is being considered, what the change means and how we intend to make the decision. We are looking for your help in providing feedback on the type of information we need to consider, and the process we are using, to make this decision.

It is really important we get the process right so that we make the best decision for our patients. This means we really require your input.

1.1 Who are 'we'?

We are the Welsh Health Specialised Services Committee (WHSSC), a part of the NHS in Wales. Our Board is a Joint Committee made up of the Chief Executives of all seven Health Boards in Wales, WHSSC Officers, independent members and an independent Chair.

We work on behalf of the seven Health Boards, to commission specialised medical services for the people of Wales. These are services which are provided for less common conditions and are usually only delivered by our larger hospitals or sometimes from only a few centres in the UK. We aim to provide access to safe, sustainable and effective services which offer the best experience for our patients. Thoracic surgery is one of the specialised services we commission for the population of Wales.

1.2 What is thoracic surgery?

Thoracic surgery involves operations on all parts of the chest including the chest wall, the contents of the chest and the lungs, but not the heart (this is cardiac surgery). A main part of a thoracic surgical team's work is on patients with lung cancer. They also operate on patients with other non-cancerous conditions such as complications from pneumonia or those who

have punctured lungs. In addition, they carry out biopsies on people with certain types of lung disease to help obtain a diagnosis.

Thoracic surgery is delivered from two centres in South Wales; Morriston Hospital, Swansea and the University Hospital of Wales, Cardiff. Each centre has two consultant thoracic surgeons delivering a service for both lung cancer patients and patients with non-cancer indications that require thoracic surgery.

The population of South Wales, South Powys and West Wales is approximately 2.2 million. The total number of patients requiring surgery (both cancer and non cancer reasons) is approximately 420 per year at Morriston Hospital, and 650 per year at the University Hospital of Wales.

1.3 Why do we want to change the way we deliver thoracic surgery in South Wales?

Improving thoracic surgery services in Wales will ensure they deliver the best care possible. There are a number of reasons we want to improve thoracic surgery services in Wales:

- We know that:
    - over the last year patients in Wales with lung cancer have waited longer than they should have for surgery
    - patients in Wales with lung cancer have some of the lowest survival rates in Europe
    - patients who require surgery but do not have lung cancer have very long waiting times. Our doctors and nurses tell us this is affecting the quality of care they can provide
    - thoracic surgery is becoming increasingly specialised and that better outcomes come from larger centres. Elsewhere in the UK and Europe services are restructuring into larger centres
    - Because thoracic surgery is now so specialised, surgeons are no longer being trained to do both cardiac and thoracic operations. This means we cannot staff our small units in the way we have done in the past

To help us decide how to do this, we asked the Royal College of Surgeons to look at thoracic surgery services in South Wales and advise us on how they can be improved. The Royal College of Surgeons have recommended that to ensure the future sustainability and quality of thoracic surgery in South Wales, there should only be one hospital delivering the service.

1.4 What are the options for delivering thoracic surgery in South Wales?

We believe there are 4 potential options:

1. Two separate centres (current model)
2. A single (larger) centre (Royal College of Surgeons recommendation)
3. Two centres working together (sharing resources e.g. surgeons and other staff)
4. A hospital Trust in England (thereby no centre in Wales)

We have considered these options and concluded that:

- Option 4 should be rejected because there are more than enough patients in South Wales to provide work for at least one centre, South Wales already has the expertise to provide high quality care and we do not want patients to travel longer distances than they already have to for treatment.
- Option 3 has also been rejected because it has been tried before and we were unable to recruit to these posts. This was because of the practical difficulties for staff working between two sites whilst trying to deliver such complicated treatment.

As a result there are therefore two potential options for the shape of the service: the current two centre mode (option 1) or a single centre model (option 2).

It is important to remember that this surgery is one very small part of a patient's treatment and all other parts, such as scans, biopsies and follow up care will happen in their local hospital. We are only considering changing the place where surgery takes place.

2. WHAT IS THE PROCESS FOR MAKING THE DECISION?

The final decision on the future shape of thoracic surgery services in Wales will be made by the ***Joint Committee*** (the Board of WHSSC as described above). That decision will be made on the basis of two separate recommendations:

- The first step will be a recommendation from the ***Thoracic Surgery Project Board*** on whether thoracic surgery should be provided from one or two centres in South Wales. We explain more about the Project Board later on in this document.

If the Project Board's recommendation is for one thoracic surgery centre there will be second step.

- The second step will involve an ***Independent Panel*** which will make a recommendation as to the preferred location of a single centre.

If the first step recommends one centre then we will move directly into the second step, we will not pause whilst the Joint Committee considers the recommendation. The reason for this is that:

1. We do not want to introduce any unnecessary delay. Our doctors and nurses tell us that our patients do not always receive the care they should and the longer we take to make a decision the more patients will be affected.

2. The Health Boards have advised us because there is strong evidence in favour of a single centre and believe the Project Board is likely to recommend a single centre, a more streamlined process is appropriate.

2.1 What is the role of the Thoracic Surgery Project Board?

The Project Board consists of people with expertise in these services, representatives from all the Health Boards in south Wales and lay members.

Below is the evidence and information that the WHSSC team has collected which they think should be considered by the Project Board to help them decide whether there should be one or two centres for thoracic surgery in South Wales.

In addition, information around travel times for patients will be provided as well as what we call an 'Equality Impact Assessment'. An 'Equality Impact Assessment' is an assessment of whether there are particular groups of people who might be disadvantaged by such a change, for example whether disabled people might find it more difficult to access treatment.

Although we have put together this evidence together we need your feedback to confirm whether or not we have missed anything out. This will help us make sure that the Project Board will make the best recommendation it can to the Joint Committee.

2.1.1. What evidence will be considered?

The report from the Royal College of Surgeons provided to WHSSC in January 2017

The Royal College of Surgeons carried out a review of the service and made a number of recommendations which were received in January 2017. These included a clear recommendation that thoracic surgery in

South Wales should be provided from a single centre. They concluded that the current two site model would not be sustainable.

The key recommendations were:

- *"It is the review team's recommendation that WHSSC adopts a single site thoracic surgery service model for South Wales."*

- *"The review team considered that this reconfiguration was in the best interests of patient care and was the most sustainable option for thoracic surgery going forward."*

- *"It was considered that changes to cardiac and thoracic surgery would mean there would not be a staffing resource that could adequately sustain a two site model in the future."*

  This is due to the new requirement to have enough thoracic surgeons to be able to provide an out of hours/emergency service while at the same time having sufficient numbers of patients for those surgeons to operate and maintain their skills.

  This is due to changes being introduced in thoracic surgery and its relationship with cardiac surgery (explained below).

  They suggested that the ideal number of surgeons for a single unit in South Wales was five. This was based on the size of the population and the number of surgeons needed to provide 24 hour emergency cover.

A summary from the Royal College of Surgeons on the planned changes to training in Thoracic Surgery in the UK

One of the reasons we asked the Royal College of Surgeons to undertake a review of thoracic surgery in Wales is because thoracic surgery has become more specialised. We wanted to see what this meant for the way we provide thoracic surgery services.

Until recently, many surgeons who carried out thoracic surgery also carried out cardiac (heart) surgery. They are known as "dual practice" cardiothoracic surgeons.

At the end of their training, surgeons now qualify as either a cardiac surgeon or a thoracic surgeon (and not as cardiothoracic surgeons). The Society for Cardiothoracic Surgery has said that from 2020 there will no longer be dual practice cardiothoracic surgeons.

This means that from 2020 all thoracic surgery, including the provision of on-call (out of normal hours) cover and emergency surgery, must be carried out by dedicated thoracic surgeons. This is an important change as currently cardiac surgeons provide much of the out of hours and emergency thoracic cover.

From 2020, we will need enough surgeons to provide a full on-call rota in each centre. The Royal College of Surgeons have advised this is not sustainable for two centres. We therefore require a single centre.

The recently agreed All Wales Service Specification which outlines the standards we would expect from a unit delivering high quality thoracic surgical services.

All centres and surgeons in the UK which provide thoracic surgery services should meet nationally recognised standards. In England they have described these in the NHS England Thoracic Surgery Service Specification. These standards are based on evidence and are designed to ensure that services are high quality, safe and give the best outcomes for patients.

We have also agreed a Thoracic Surgery Service Specification for Wales based on these standards. These were agreed through a consultation process, which took place at the beginning of 2017.

The standards include:

- *A minimum number of thoracic surgery procedures for primary lung cancer that must be carried out in the centre. There is evidence to show that there are better outcomes for patients if they receive their surgery for lung cancer at larger centres where higher numbers of operations take place each year.*

  The standard states that a **minimum** of 150 thoracic surgery procedures per year for primary lung cancer must be carried out in a centre. The table below shows the number of procedures carried out in 2015 at each of the two current thoracic surgery centres.

Thoracic Surgery Centre	Number of Primary Lung Cancer Cases Operated
Morriston, Swansea	139
UHW, Cardiff	151

We expect the numbers are now higher than this and that the number of primary lung cancer cases suitable for thoracic surgery is likely to increase further in the next 3 to 5 years. This is mainly due to the increasing number of older people within the population, a rising

incidence of lung cancer in women and more cases being diagnosed at an earlier stage and therefore suitable for surgery. However, in the longer term, this number is likely to fall due to reductions in smoking (Public Health Wales, 2017).

This implies that if we retain two centres, the minimum standard of 150 primary lung cancer procedures per year may be met in the short to medium term, but there is risk it will not be achievable in the long term. However, if there is a single centre, the minimum standard of 150 primary lung cancer procedures per year would be achieved over the long term.

- *Requirements for emergency and on-call cover. This standard helps to ensure patient safety at all times, 24 hours a day for 7 days of the week.*

  The standard specifies that a thoracic surgeon or dual practice cardiothoracic surgeon (until 2020) should provide emergency cover. Any other kind of cover is unacceptable.

  The standard also specifies that a sustainable rota must not be more frequent than one in four. This means that each thoracic surgeon should not provide on-call cover more often than once in every four days. This ensures that surgeons are properly rested and able to provide a safe service for patients.

  For South Wales, this would mean that at least four thoracic surgeons will be needed at a centre. Therefore two centres in south Wales would need at least eight surgeons. Remember that the Royal College of Surgeons recommended that five surgeons would be an appropriate number for the size of population. There is unlikely to be enough demand across south Wales to give eight surgeons enough work to be able to keep their skills up to date.

Details of the staffing numbers, physical infrastructure and support services at the two units currently providing services

Resilience means the ability of the service to cope with unpredictable changes or risks. These might include:

- Episodes of staff sickness (across the whole team)
- Vacancies in the team
- National policy changes (e.g. affecting numbers of trainee surgeons or anaesthetists)
- Impacts from temporary reductions in the number of patients who can be cared for (e.g. a technical failure; infection control)

- Fluctuations in the numbers of patients requiring treatment

In general, a larger centre has more flexibility with which to manage these risks. This is due to it having a greater number of staff and larger facilities than a smaller centre. The greater opportunities for cross cover in a larger centre will help to maintain levels of service.

A larger team will provide the opportunity for surgeons, and other staff, to develop sub-specialty expertise. This will broaden the range of service that can be offered to the local population, which will reduce the need to travel to centres further away. This also helps to attract and keep staff as it provides greater opportunity to develop their skills and career.

Summary of the Reasons for Change

Table 1 summarises the reasons for change to a single centre model based on the evidence considered in this document.

Table 1: Summary of the reasons for change:

	Issue Considered	Implications for two centre model	Implications for single centre model
External professional advice: Royal College of Surgeons	Ability to maintain staffing in light of changes in cardiac and thoracic surgery training	Advice from RCS that there would not be enough staff that could adequately maintain a two site model in the future.	Clear recommendation from RCS to adopt a single centre model to ensure sufficient staffing is maintained.
Service Specification: Quality standards	Minimum 150 lung cancer operations per annum	While it is likely we are able to achieve or nearly achieve the minimum numbers in the next 3-5 years, it is less clear we can do this in the longer term.	Minimum number of operations will be performed consistently over the long term.
	Ability to maintain an on-call rota (not less than 1 in 4)	If we employed 8 surgeons across south Wales there would not be enough work for them to do when they are not on-call. This would mean we would find recruitment difficult.	The rota will be able to be maintained.
Service Delivery	Service flexibility & benefits of scale	Smaller units mean it's more difficult to cover sickness or unexpected changes. Also we will not have enough staff for sub-specialisation.	More likely to be flexible because there will be enough staff to cover during periods of increased demand or sickness. Improved opportunity for sub-specialisation.

Are there any risks to other services if thoracic surgery is moved from one hospital and concentrated in a single hospital site?

Some health services are 'inter-dependent' with others such that if one of the services is taken away, another service will have problems functioning. However, this is not the case with thoracic surgery. If thoracic surgery was moved from the University Hospital of Wales to Morriston Hospital, or vice versa, this would not affect the ability of other services at either of these hospitals to continue as normal.

Having considered the evidence, if the Project Board recommends there should be a single centre, its preferred location will be informed by an assessment against agreed criteria. This will be conducted by an Independent Panel.

2.2 What is the role of the Independent Panel?

The Independent Panel will be made up of a range of clinical experts, service users, third sector representatives and an independent Chair. It will not include representatives from the local region because it's important that the panel is truly independent. The panel will make sure there is balance, transparency and clarity.

The panel will use the criteria which come out of this engagement process to make a recommendation on which site thoracic surgery should be situated in the future. To do this they will look at the evidence provided to them by the WHSSC team and will score the centres using their expertise and experience. There will be support for the panel in doing this by the Swansea Centre for Health Economics based at Swansea University who are experts in what we call 'group decision making'.

They will consider, if surgery is to be performed at only one centre, where that centre should be. This will then go as a recommendation to the Joint Committee. The panel will only consider Morriston Hospital, Swansea, or the University Hospital of Wales, Cardiff. The reason is that these are the only 2 centres who already have the expertise in how to delivery thoracic surgery and have cardiac surgery on site. The service specification recommends co-location with cardiac surgery:

- *Other co-located services*
  The thoracic surgery service will benefit from co-location with cardiac surgery:
  - *To share cardiothoracic trainees*
  - *Operational efficiencies from pool of support staff skilled in both thoracic and cardiac surgery.*

Thoracic surgery services must be located on a site where there is cardiac surgery but they are not dependent on any other major services. You may be aware that there is work underway to decide on the location of a major trauma centre for South Wales. It is important to understand that thoracic surgery does **not** need to be on the same site as major trauma services. This means that if we decide to have a single centre for thoracic surgery, this will not have an impact on the decision around a major trauma centre and visa versa.

2.2.1 What criteria will be used by the Independent panel to make a recommendation?

Below are the 4 criteria which we think are important:

A. **How easy will it be for patients to access care at that unit?** To measure this we will look at travel times/distance and the availability of public transport

B. **How easy will it be for the unit to meet the standards required of a high quality unit (these standards are described in the Service Specification)?** By Standards we mean whether they have the staff, equipment, space, particularly surgical theatre space etc which are necessary to deliver high quality care. To measure this we will look at the current standard of service, the gaps between the current services and the standards described in the Service Specification.

C. **How sustainable is the unit? By this we mean how likely is the unit to be able to meet our needs in the future?** We will want to know if the unit could increase their capacity (the number of patients they can treat) in the future if needed. We want to know if the unit has problems recruiting staff at the moment and if they do what are their plans for the future. Also whether there other developments planned at the site which may have an effect on the delivery of thoracic surgery.

D. **Will the unit help improve the standards of care across South Wales?** To measure this we want to know if the unit has links with universities or colleges. Does the unit have other experts (non-surgeons) or links with other experts who will help develop new services this includes services for patients who are being treated in local hospitals outside the centre.

3. WHAT DO YOU, AS STAKEHOLDERS, NEED TO DO?

Having read this document, we need you to give us feedback on the form provided at the back of the document.

We would like feedback on the following points:

1. Is there other evidence we should provide to the project Board to help them make a decision on whether there should be one or two sites?
2. Is there anything else we should do to improve this part of the process?

If the project board recommends one site then we will ask an independent panel to make a recommendation on whether this should be sited at Morriston Hospital or the University Hospital of Wales. We therefore also need your feedback on the criteria we use. We have suggested some criteria above and we need to know:

1. Whether you agree with the criteria or if you think there are other criteria which we have missed out?

2. What sort of evidence you think we should consider to measure how well the units can meet these criteria. Do you think our suggestions work or whether we could measure them differently?

People can provide feedback either as individuals or through their organisation (just let us know which one).

We would like feedback as soon as possible but the deadline is **10th November 2017**.

It is very important we get the process right in order we make the best decision we can, so the more feedback we receive the better.

Further information:

Below are links to further information which you may find helpful in understanding the situation and the planned process:

- Specialised Services Service Specification: Thoracic Surgery http://www.whssc.wales.nhs.uk/policies-and-procedures-1
- Royal College of Surgeons http://www.whssc.wales.nhs.uk/reviews-other-
- Lung Cancer Guidelines https://www.nice.org.uk/guidance/CG121
- British Thoracic Society https://www.brit-thoracic.org.uk/

- Cancer research UK http://www.cancerresearchuk.org/about-cancer/lung-cancer
- MacMillian Cancer Support http://www.macmillan.org.uk/information-and-support/lung-cancer/non-small-cell-lung-cancer/treating/surgery/surgery-explained/surgery-for-non-small-cell-lung-cancer.html -
- Roy Castle Lung Cancer Foundation https://www.roycastle.org/how-we-help/lung-cancer-information/information-about-treatments/surgery

Thoracic Surgery Services in South Wales Engagement

Stakeholder Response

Deadline for comments	Please complete and return your form by e-mail to ThoracicSurgeryReview@wales.nhs.uk by 5.00pm on 10th November 2017
Your Name	
Are you replying on behalf of an organisation?	Yes / No
If yes, name of organisation	

Declaration: Before completing this feedback form you must declare any financial or other interests in relation to any specialised services directly relevant to this engagement process. [Please refer to the WHSSC 'Standards of Behaviour' policy]
Interests to be declared:

Instructions for submitting comments

- Answer the questions overleaf
- Please note that responses will be made public. Therefore please underline and highlight any confidential information or other material that you do not wish to be made public
- Do not include medical information about yourself or another person from which you or the person could be identified
- Spell out any abbreviations you use
- For copyright reasons, comment forms must not include attachments such as research articles, letters or leaflets.

Questions for stakeholders	
1	Is there any other information you think we should consider in order to decide whether we need one or two thoracic surgery centres in South Wales? …… …… …… …… ……
2	Is there any other information you think we should include in the criteria that will be used by the Independent Panel? …… …… …… …… ……
3	Do you have comments on the process we are using to inform recommendations on the future thoracic surgery services? …… …… …… …… ……
4	Do you have any other comments on the information presented in this document? …… …… …… …… …… ……

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

Thoracic Surgery Review
Engagement Plan

1.0 Purpose

The purpose of this document is to set out the engagement plan for the conduct of the thoracic surgery review. In particular, it sets out the following:

- The principles of engagement
- Stakeholder analysis
- Plans for the engagement process which makes a recommendation on whether thoracic surgery services should be provided from one or two centres in South Wales
- Plans for the Independent Panel process which makes a recommendation on the preferred location of a single thoracic surgery centre

2.0 Background: Principles of Engagement

Services provided by the NHS should be genuinely shaped by and meet the needs of the people it serves. Patients, service users and carers need to be fully involved in decisions about their health, both at strategic level and on an individual basis. Health services need to be developed that are centred on patients, service users and carers needs, and which deliver a good experience to service users.

Organisations and services use a range of methods and approaches to:

- Engage with partners in supporting and enabling citizens to be involved in the design, planning and delivery of services;
- Seek feedback from patients, service users and carers about their experiences; and
- Demonstrate that they act on views and feedback in making changes to improve services.

WHSSC has sought advice from two sources on the requirement to consult - the Board of Community Health Councils (CHCs) and NWSSP Legal Services.

The legal advice received is that whilst full consultation is not necessary (principally because the prospective change does not constitute a 'substantial change' to the service), engagement will be required for the Thoracic Surgery Review.

Representatives from the Board of the CHCs confirmed that engagement would be required but considered that WHSSC may be required to undertake full consultation when the final decision is made.

3.0 Stakeholders

There are a number of stakeholders with whom WHSSC will need to engage. The mode of engagement will vary according to the stakeholder group. The stakeholders who have been identified are outlined below.

- **Community Health Councils (CHCs)**

Regulation 27 of "The Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010" states that it is the duty of each relevant Local Health Board and NHS Trust in Wales in respect of health services for which it is responsible, to involve a Council in the planning of the provision of those services; the development and consideration of proposals for changes in the way those services are provided; and decisions to be made by that body affecting the operation of those services.

In light of this statement, it is proposed that engagement with the CHCs is carried out via each Health Board and not directly by WHSSC. Six CHCs will need to be engaged, namely

- Abertawe Bro Morgannwg (ABM)
- Aneurin Bevan (AB)
- Cardiff & Vale (CV)
- Cwm Taf (CT)
- Hywel Dda (HD)
- Powys (P).

- **Staff**

It is proposed that engagement with staff at referring Health Boards is carried out via the lung cancer MDTs with the MDT Chair (respiratory physician) presenting the information. This is in line with advice received by the Project Board that engagement with staff on service change is best if clinically led.

The opportunity to respond to the engagement will be made available to all staff at the provider organisations through distribution of the engagement materials to Health Board Medical Directors, Nursing Directors and clinical leads.

There are eight lung cancer MDTs in the area affected:

- ABM - Princess of Wales Hospital
- ABM - Morriston & Neath Port Talbot Hospitals

- HD - Glangwili, Bronglais and Withybush Hospitals
- AB - Royal Gwent Hospital
- AB - Nevill Hall Hospital
- CV - University Hospital Llandough
- CT - Prince Charles Hospital
- CT - Royal Glamorgan Hospital

- **Third Sector Organisations**

The following Third Sector organisations have been identified:

- British Lung Cancer Foundation
- Roy Castle Lung Foundation
- National Lung Cancer Forum for Nurses
- Carers Wales

The engagement document will be sent to these organisations with an accompanying letter. The letter will also offer the option of attending one of the Health Board engagement events.

- **Patients**

The appropriate approach to citizen/public engagement will be agreed with the CHCs and Health Board engagement leads.

- **Carers**

Carers will be engaged via the organisation Carers Wales (see Third Sector Organisations above).

- **Other stakeholders**

Other stakeholders will need to be engaged, namely:

- Welsh Ambulance Service Trust (WAST)
- Velindre
- Wales Cancer Network (WCN)
- Public Health Wales

The engagement document and letter from the Chair of the Thoracic Surgery Review Project Board will be distributed to these organisations.

Stakeholder / Mode of Engagement

Stakeholder	Mode of Engagement
Community Health Councils	• Letter/email from WHSSC Medical Director and HB CEO inviting them to provide feedback and/or attend a local public engagement event

Staff	• Letter/email from WHSSC Medical Director and HB CEO inviting them to provide feedback and/or attend a local staff engagement event
	• Local Health Board engagement events:
	  • Via lung cancer MDTs
	  • MDT Chair to lead
	  • WHSSC officer to be available to support
	• Presentation at scheduled meetings

Third Sector Organisations	• Letter/email from WHSSC Medical Director and HB CEO inviting them to provide feedback and attendance at one of the public engagement events • To include plain English materials
Patients and public	• To be agreed with CHCs and Health Board engagement leads
Carers	• Carers Wales (see Third Sector Engagement)
Other • WAST • Velindre • Wales Cancer Network • Public Health Wales	• Letter/email from WHSSC Medical Director and HB CEO inviting them to provide feedback and attendance at one of the staff engagement events

3.0 Plans for the Engagement Process

3.1 The agreed timescale for stakeholder engagement is a period of six weeks, taking place 29th September to 10th November 2017.

3.2 WHSSC Medical Director and relevant Health Board CEO will write to stakeholders inviting them to attend a local engagement event.

3.3 The letter will be accompanied by an engagement document which provides stakeholders with the background to why the changes are taking place, what the change means and how the decision will be made. We are looking for your help in providing feedback on the type of information we need to consider, and the process we are using, to make this decision.

3.4 To provide a saturation effect reaching as many staff as possible the letter and supporting documentation will be cascaded through multiple sources.

3.5 Engagement events, organised by Health Board leads and led by MDT leads, will be held in each Health Board across South Wales. It is not intended that joint staff/public events will be organised.

3.6 WHSSC Officers will be available as a resource at the events working in liaison with the engagement leads.

3.7 WHSSC will also provide a presentation for each Health Board for use in discussion with their local population ensuring consistency.

3.8 Themes emerging from the events will be captured but this will not extend to detailed comments.

3.9 Should stakeholders not wish to attend an event, there is an option for comments to be provided using the response form at the end of the engagement document.

3.10 The deadline for response, 10th November 2017, along with instruction on how to complete the form has been identified.

3.11 As responses are received, responses will be collated and the comments summarised.

3.12 Present to Project Board the recommendation of whether thoracic surgery should be delivered on one or two sites for South Wales.

If the Project Board makes a recommendation on a single thoracic surgery centre for South Wales, an appraisal of options will be conducted by an Independent Panel on the preferred location.

4.0 Plans for the Independent Panel Process

4.1 An independent Chair will be appointed and membership of the Panel confirmed.

4.2 The independent panel is scheduled to meet on 27th November2017 to evaluate a set of criteria formulated following a six week period of stakeholder engagement.

4.3 A presentation detailing background information and an outline of the process will be provided.

4.4 A facilitated discussion will be held to agree weighting of each criteria.

4.5 A presentation of the evidence pack for the most highly ranked criterion for each centre (Morriston Hospital or University Hospital of Wales) will take place followed by independent electronic voting. The electronic system then provides a live visual presentation of the range of scores and facilitates further deliberative discussion and rescoring.

4.6 Each criterion is considered in turn via this process. Criteria can be revisited and rescored in the light of ongoing discussion and understanding.

4.7 The products of the process will be:

- A score for each unit for each criterion
- A weighted score calculated by the electronic software for each unit for each criterion
- A total weighted score for each unit which will be used as the basis of the recommendation to the Joint Committee
- A narrative document containing qualitative evidence collected from the panel which will underpin the recommendation from the scoring process.

4.8 The assessment process will be supported by the Swansea Centre for Health Economics and will be based on the work of EVIDEM (Evidence and Value: Impact on Decision-Making) Collaboration. This is an independent non-profit organisation run by an international Board of Directors who have developed a pragmatic decision making and priority setting framework. It is designed to:

- Consider all aspects of the decision
- Support a consistent deliberative process
- Share decisions transparently
- Rank and prioritise options based on their contextual value.

4.9 The Independent Panel will make a recommendation to the Project Board on the preferred location of a single centre to provide Thoracic Surgery services in the future.

4.10 The Joint Committee will in turn review the Project Board's recommendation on 19th December 2017.

5.0 Project Board and Independent Panel timeline

The timeline can be summarised as follows:

29 September – 10 November	Stakeholder Engagement
10 – 14 November	Analysis of Stage One Engagement Feedback Preparation of paper for Project Board

22 November	Recommendation following stakeholder engagement to Thoracic Surgery Review Project Board Meeting
27 November	Independent Panel
8 December	Recommendation following Independent Panel to Thoracic Surgery Review Project Board Meeting
19 December	Joint Committee Meeting

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

Thoracic Surgery Review

Project Board

Terms of Reference

1.0 Introduction

This document sets out the terms of reference for the Project Board for the Thoracic Surgery review.

2.0 Accountability

The Project Board will report through the WHSSC accountability structure to the Joint Committee.

3.0 Project Board Responsibilities

The Project Board will be responsible for:

- Setting the direction for the project
- Overseeing the project arrangements and ensuring that they are fit for purpose
- Approving the project plan and ensuring that the resources needed are made available to the project when required
- Delivery of the project objectives
- Ensuring that project benefits are identified
- Ensuring that risks to the project are identified and managed
- Delegating authority to the Senior Responsible Officer to lead the project on a day to day basis
- Reporting progress to the WHSSC Joint Committee.

The outcomes of the Project are to:

- Agree the Project Initiation Document: Thoracic Surgery – Development of a Commissioning Plan for Wales
- Receive and consider the advice of the Royal College of Surgeons Invited Review
- Agree the process for identifying the future service model for Thoracic Surgery
- Make recommendations to the Joint Committee on the service model for Thoracic Surgery
- If required, agree the process for making recommendations on the location of a single thoracic surgery service. This includes the membership and remit of the Independent Panel
- Agree the report to Joint Committee to recommend a commissioning plan for Thoracic Surgery
- Agree the implementation plan for the preferred model for Thoracic Surgery

- Inform and maintain a risk log
- Commissioning any sub task and finish groups to undertake specific time limited pieces of work.

4.0 Membership

The Senior Responsible Officer for the Project Board will be the Medical Director, WHSSC. Their role is to:

- design and execute the project plan
- deal with issues and manage risks that might affect progress
- manage communications with stakeholders

The membership is comprised of the following:

- Patient/third sector representatives
- Welsh Cardiothoracic Society
- Welsh Thoracic Society
- Cancer Network
- Provider representatives from ABMUHB and CVUHB
- Commissioner representatives from each Health Board
- WHSSC Medical Director (Chair)
- WHSSC Director of Planning (Vice Chair)
- WHSSC Finance Manager
- WHSSC Patient Care and Quality
- Independent Thoracic Surgeon
- Community Health Council (CHC) representative

5.0 Frequency of meetings

It is anticipated that 4 to 6 meetings will be held between September 2016 and March 2018. The precise number of meetings required to fulfil the terms of reference will be agreed by the Project Board.

6.0 Recommendations

Quorum

The Project Board will be quorate when the following are present:

- Chair or Vice Chair
- 4 Health Board commissioners
- 4 clinical representatives (excluding Chair)
- 4 others, 1 of which should be a patient representative

Agreeing Advice to Joint Committee

Recommendations from the Project Board to the Joint Committee will wherever possible be based on unanimous decision, failing which, by a majority decision consistent with the Standing Orders of the WHSSC Joint Committee. Final decisions will be made by the WHSSC Joint Committee.

Thoracic Surgery Review – South Wales

Independent Assessment Panel

Terms of Reference

1.0 Purpose

The purpose of these terms of reference is to set out the role and remit of the Independent Assessment Panel, established to advise the Welsh Health Specialised Services Joint Committee on the preferred location of a single Thoracic Surgery centre at either Morrison Hospital, Swansea or University Hospital of Wales, Cardiff. The recommendation will be advisory and will be used by the Welsh Health Specialised Services Joint Committee to make a formal recommendation on the preferred site of the centre in the region

2.0 Principles

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

- Independence
    - Panel members must have no vested interest in achieving particular outcomes.

- Group composition
    - comprehensive in the coverage of perspectives (technical and service user expertise and experience).
    - balanced (equal/similar numbers to represent the required range of expertise and experience).

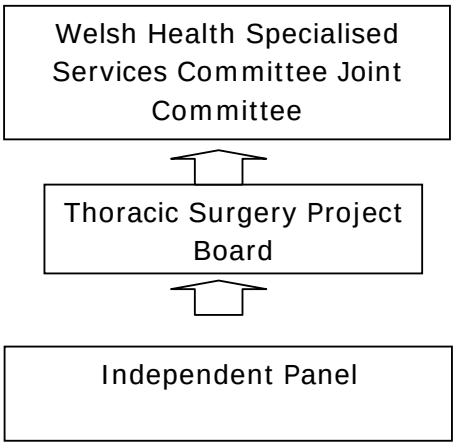
- Transparency and clarity
    - all stages of the decision process and reporting are clear and reflect the preferences of the group.
    - The group will be supported by the Swansea Centre of Health Economics based on the work of EVIDEM (Evidence and Value: Impact on Decision-Making) Collaboration. It is designed to:
        - Consider all aspects of the decision
        - Support a consistent deliberative process
        - Share decisions transparently
        - Rank and prioritise options based on their contextual value

3.0 Responsibilities

3.1 The responsibilities of the independent panel are to:

- Understand the issues in relation to Thoracic Surgery service provision across South Wales through review of information provided by the Senior Responsible Officer, Programme Board and the evidence pack provided to the group (evidence pack to be sent out in advance)
- To evaluate the existing centres against criteria formulated following the WHSSC Thoracic Surgery engagement process
- Participate in an electronic scoring system to define the weighting and scoring of criteria
- Discuss and evaluate the weighting of the criteria to provide an agreed score with other panel members
- Discuss and evaluate the score for each unit and each criterion and arrive at an agreed score with other panel members
- Review and evaluate the weighted scores as calculated via the electronic scoring system
- Agree a narrative to support the agreed scores
- Make a recommendation to the Joint Committee on which site should provide Thoracic Surgery services in the future
- The Joint Committee will in turn review this recommendation on 19th December 2017.

4.0 Accountability



5.0 Membership (to be confirmed)

5.1 The proposed membership is as follows:

Independent Chair	TBC
Medical representative	Thoracic Surgeon ?BTS
Medical representative	Respiratory Physician N Wales
Nurse representative	?Clinical Nurse Specialist N Wales
Network Manager	Cancer network lead/manager NHSE
Third Sector representative	Roy Castle Foundation (different to that individual on Project Board
Parent representative	?Patient from N Wales
Staff side representative	Royal College of Nursing (tbc)
Equality impact assessment unit	EHRC Wales
Lay person	(tbc)
Service Commissioner	NHS S West Vaughan Lewis?

6.0 Location of Meeting

The meeting of the independent panel will be on 27th November 2017 at Canolig meeting Room, NHS Wales Health Collaborative at 10.00 am and will last the whole day.

7.0 Administrative and Process Support

The Independent panel will be supported throughout the day by the Senior Responsible Officer, the Programme manager and the Swansea School of Health Economics. Administrative Support will be provided by the WHSSC officers.

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

PROJECT INITIATION DOCUMENT

Project name:	Thoracic Surgery: Development of a Commissioning Plan for Wales.
Programme:	Cancer and Blood
Product number:	M3
Release	Version 1.0 Date: 23/08/2017

Author:	Specialised Services Planner
Owner:	Acting Medical Director
Client:	Managing Director
Document Number:	

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Document History

Revision History Date of last revision:

Revision date	Previous revision date	Summary of Changes
23.08.17	17.05.17	Inclusion of Independent Panel Information Pack as a product
		Inclusion of Independent Panel as working group
		Revision of products in appendix to reflect proposed engagement process
		Revision to membership of steering group
		Update of Risk Log

Approvals This document has been approved by:

Name	Date of Issue	Version
Project Board	04.09.17	1.0

Distribution This document has been distributed to:

Name	Date of Issue	Version

Contents

Contents

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1 Purpose

This document has been produced to capture and record the basic information needed to direct and manage the project. The PID is a reiteration of the the original document which initiated the project together with revisions to apprise of direction and management of the project as it enters the engagement stage of its cycle. The PID addresses the following fundamental aspects of the project:

- The aims and objectives of the project
- The expected benefits and outcomes of the project
- The roles and responsibilities of those involved in managing the project
- The arrangements and timings to implement and manage the project

When approved by the Project Board this PID will provide the "Baseline" for the project and will become "frozen". It will be referred to whenever a major decision is taken about the project and used at the conclusion of the project to measure whether the project was managed successfully and delivered an acceptable outcome.

2 Background

2.1 General

The Joint Committee has agreed that WHSSC undertakes a review of the service model for thoracic surgery in South Wales. The current service is delivered through a 2 centre model, with surgery provided at Morriston Hospital, Swansea, for the population of Mid & West Wales, and at University Hospital of Wales, Cardiff, for the population of South East Wales. It is recognised that capacity to provide thoracic surgery in South Wales needs to increase in order to meet patient need, both for resection for cancer, where thoracic surgery offers potentially curative treatment, and for surgery to treat non cancer indications. While planned increases in commissioned activity are reflected in WHSSC's ICP to achieve improved patient outcomes in the short term, there are a number of reasons why an alternative service model might offer benefits both to patients and to the NHS:

- There is evidence that patient outcomes are better in larger surgical centres;
- A larger centre would be more robust in terms of surgical working patterns, on-call and training requirements;
- There would potentially be economies of scale and better value for money.

2.2 Planning Responsibilities

WHSSC is responsible for commissioning thoracic surgery for the population of Wales. The commissioning of earlier stages of the pathway, both for cancer and non cancer indications is the responsibility of Health Boards.

3 Project Definition

3.1 Project aim and objectives

The overarching project aim is to develop the commissioning plan for Thoracic Surgery for Wales to achieve the following goals:

- Sustainability;
- Highest quality clinical service delivering in accordance with best practice guidelines and standards;
- Delivery of timely care, treating patients within timescales required by their clinical needs, and achieving waiting times targets for both urgent and elective pathways;
- Equitable level of service across Wales;
- Providing a service that is focused on delivering the best possible patient experience;
- Service delivery and referral pathway optimally incorporate the key interdependencies and co-dependencies with other services;
- A model that provides value for money.

The project has 2 phases:

- Phase 1: to develop the commissioning plan for thoracic surgery (including the preferred service model)
- Phase 2: develop implementation plan

A further PID will be developed to take forward implementation of the recommendations from this project.

Phase 1 objectives

- To commission external expert advice, through the Royal College of Surgeons Invited Review process, to make recommendations to WHSSC to inform and shape the commissioning plan for thoracic surgery.

- On receiving the recommendations from the external advisory team, to develop service specification for thoracic surgery for the population of Wales.
- To make a recommendation to Joint Committee on whether the future service for South Wales should be delivered by one or two centres.
- If a single centre, to undertake stakeholder engagement and to agree process to make a recommendation on location to the Joint Committee
- To undertake a financial appraisal.
- To make recommendations to the Joint Committee on the commissioning plan for thoracic surgery for Wales.

Phase 2 objectives

- To work with stakeholders to develop a robust and detailed plan for implementing the agreed commissioning plan, and service model, for thoracic surgery.
- To obtain Joint Committee approval for the implementation plan.

3.2 Project scope

The scope of the project is thoracic surgery provision for all Wales. However, the main focus is on South Wales where there are alternative potential models of service delivery and where the providers are Health Boards within Wales.

In North Wales, thoracic surgery is provided at Liverpool Heart and Chest Hospital. While there are specific issues to be addressed for North Wales that fall within the overall scope of this project, it is not anticipated that there will be significant decisions required regarding the overall service model for North Wales. Similarly for residents of Powys who access thoracic surgery services in Birmingham: it is anticipated these pathways will continue to flow into Birmingham.

3.3 Project deliverables (Products)

The table below specifies the project deliverables, including completion dates, dates for submission into the WHSSC Management Group and WHSSC Joint Committee.

	Product Title	Completion Date	Project Board Date	MGM Date	JC Date	Development/Author	Quality Assurance
M1	Project Initiation Document	17th May 2016		26th May 2016		Acting DoP / Cancer & Blood Planner	CDG/Project Board
M2	Risk Log	17th May		26th May 2016		Acting DoP / Cancer & Blood Planner	CDG/Project Board
M3	Revised PID	24th August 2017	4th Sept 2017			Acting DoP / Cancer & Blood Planner	Project Steering Group
S1	Engage with RSC/SCTS. Develop terms of reference for external advisory team through the RCS Invited Review process.	31st May 2016				Acting DoP / Cancer & Blood Planner	CDG/Project Board
S2	Provide support to facilitate work of external advisory team	Jun – Dec 2016				Cancer & Blood Planner	Project Steering Group
S3	Communication and engagement action plan including materials for public engagement regarding the evidence for decision one and criteria for decision two.	Mar 2017	Sept 2017			Project Steering Group	Project Board
S4	Final report to WHSSC of external advisory	Jan 2017	Mar 2017		Mar 2017	RCS Invited Review	RCS quality assurance process

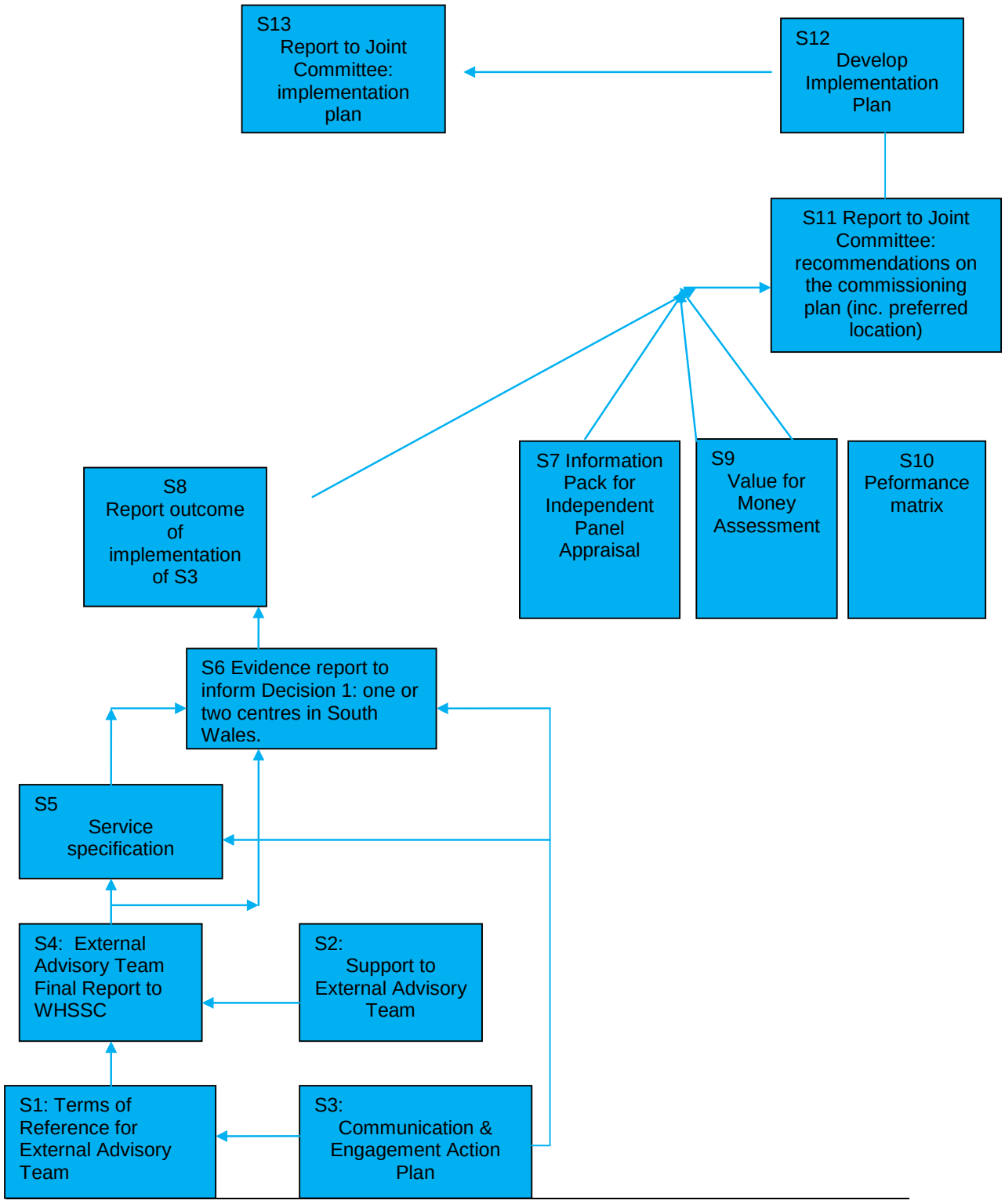
	Product Title	Completion Date	Project Board Date	MGM Date	JC Date	Development / Author	Quality Assurance
	team						
S5	Service specification	Mar 2017	Mar 2017		Mar 2017	Steering Group/ Cancer & Blood Planner	Project Board
S6	Evidence report to inform Decision one or two centres in South Wales.	Nov 2017	Nov 2017			Steering Group / Cancer & Blood Planner	Project Board
S&	Independent Panel Information Pack	Nov 2017				Cancer & Blood Planner	Steering Group
S8	Report on outcome of Independent Panel	Nov 2017	Dec 2017			Steering Group / Cancer & Blood Planner	Project Board
S9	Value for money assessment	Nov 2017	Dec 2017			Finance Task & Finish Group	Project Board
S10	Performance Matrix	Sept 2017				Steering Group / Cancer & Blood Planner	Project Board
S11	Report to Joint Committee to make recommendations regarding Decisions 1 and 2	Nov 2017	Dec 2017		Nov 2017	Steering Group / Cancer & Blood Planner	Project Board
S12	Develop implementation plan	Oct-Dec 2017	Dec 2017			Steering Group / Cancer & Blood Planner	Project Board
S13	Report to Joint Committee to recommend implementation plan	Jan 2018	Dec 2017		Jan 2018	Steering Group / Cancer & Blood Planner	Project Board

Detailed descriptions of the products are included in Appendix B.

The product breakdown structure overleaf illustrates the relationship between each of the products.

3.4 Product Breakdown Structure

The product breakdown structure shows a hierarchical structure with the end product at the top and its component parts shown at progressively higher levels of detail underneath.



3.5 Constraints

The project must be delivered within existing resources and the agreed timescales.

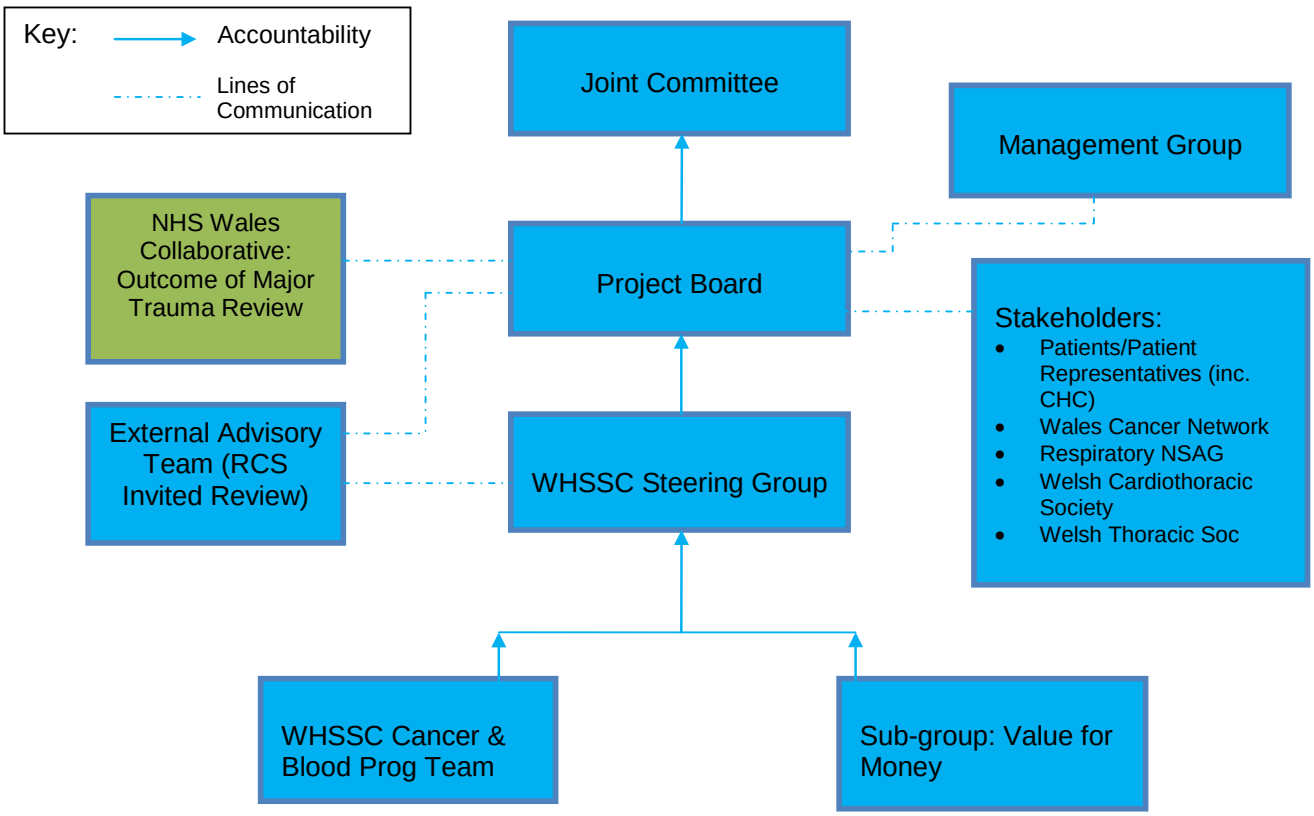
3.6 Assumptions

Assumptions made in the planning of this project are:

Recommendations on the commissioning plan and future service model will be subject to agreement from the Joint Committee.

Project Organisation structure

The project will be directed by the Acting Medical Director, WHSSC. The project manager will be the Planning Manager from NHS Wales Health Collaborative, seconded to WHSSC to assist with the review. Coordination of the project will be undertaken within the Cancer & Blood Programme Team, WHSSC. The diagram below illustrates the overall structure of the project.



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The primary roles of each of the groups are:

3.7 Joint Committee

The Joint Committee will agree and sign off recommendations from the Project Board.

3.8 Project Board

The Project Board will provide oversight of the conduct of the project and will sign-off the method of approach for delivering the products. The specific responsibilities of the Project Board include:

- Agree the Project Initiation Document: Thoracic Surgery – Development of a Commissioning Plan for Wales.
- Receive and consider the advice of the Royal College of Surgeons Invited Review.
- Agree the service specification.
- Agree the framework for the decision over the number of thoracic surgery centres in South Wales.
- Agree the framework for stakeholder engagement and the independent panel for the location of the service (if a single service is recommended).
- Agree the report to Joint Committee to recommend a commissioning plan for Thoracic Surgery in Wales.
- Agree the implementation plan for the preferred model for Thoracic Surgery in Wales.

Membership of the Project Board will include:

- Patient/third sector representatives
- Welsh Cardiothoracic Society
- Welsh Thoracic Society
- Cancer Network
- Provider representatives from ABMUHB and CVUHB
- Commissioner representatives from each Health Board
- WHSSC Medical Director (Chair)
- WHSSC Director of Planning (Vice Chair)
- WHSSC Finance Manager
- WHSSC Patient Care and Quality
- Independent Thoracic Surgeon
- Community Health Council (CHC) representative

3.9 Project Steering Group

The Project Steering Group is an internal WHSSC executive director group to oversee the delivery of the project, ensure it is on schedule, production of key project documentation including the project plan and risk register and quality assure the products. It will be chaired by the Medical Director, WHSSC. It will include WHSSC Director of Planning and Director of Finance, Corporate Secretaryand the Cancer & Blood Programme Team (Planner and Assistant Planner, Information Manager, Finance Manager).

3.10 External Advisory Team

The External Advisory Team will be commissioned via the Invited Review process of the Royal College of Surgeons to provide independent advice to WHSSC. The External Review Team will review the current service and provide advice to the Project Steering Group relating to the optimal service model for Wales. The Review team will be comprised of members of the Society for Cardiothoracic Surgery and Royal College of Surgeons, plus a lay member.

3.11 Working Groups

- WHSSC Cancer & Blood Programme Team

  The Cancer & Blood Programme Team will:
  - Support the RCS Invited Review, including developing terms of reference, collating service information, arrangements for stakeholder interview.
  - Draft key documents for the review (inc. service specification, evidence assessment to inform decision over number of centres, reports to Project Board and Joint Committee).

  The Cancer & Blood Programme Team will seek additional advice as required to address the project objectives.

- Value for Money Working Group

  The Value for Money working group will undertake assessment of the financial implications and value for money of options. It will be led by the

Financial Manager lead for thoracic surgery in WHSSC with input from external colleagues from Health Boards.

- Independent Panel

  The role of the independent panel is to:

  - Discuss and evaluate the weighting of the criteria to provide an agreed weighting with other panel members.
  - Participate in an electronic scoring system to score each element of the criteria for each provider/bidding centre.
  - Draw on their expertise and experience (as a clinical professional or as a service user/representative of service users) to make their best assessment and judgement of the evidence with regard to the criteria for each centre.
  - Discuss and evaluate the score for each element of the criteria, and each provider/bidding centre, and arrive at an agreed group score with other panel members.
  - Review and evaluate the un-weighted and weighted scores as calculated via the electronic scoring system, to reach a group decision on each of the criteria for each provider.
  - Agree a narrative to support the agreed scores.

3.12 Stakeholder Involvement

A series of groups and organisations will provide professional or patient perspective advice to the Project Board. These include:

- Patients and patient representatives
- Community Health Councils
- Wales Cancer Network
- Welsh Cardiothoracic Society
- Welsh Thoracic Society
- Respiratory NSAG

3.13 Strategic Interfaces

The project will interface with other relevant strategic initiatives including in particular the on-going work of the NHS Wales Collaborative to review major trauma provision in Wales.

4 Project tolerances

The overall project timescale is 16 months. No tolerance has been identified for this deadline.

5 Appendix A – Product Descriptions

Identifier Title	S1: External advisory team terms of reference
Purpose	To define the terms of reference for the external advisory team
Composition	Terms of reference for the external advisory team to include the aim and objectives, scope, timeline, description of final product, organisations and individuals involved, working links with WHSSC.
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	Acting Director of Planning
Quality Criteria	- Fit with overall project objectives, scope and timescales; - Achievability - Clarity
Quality check method to be used	Quality assured by Steering Group

Identifier Title	S2: Support to facilitate external advisory team.
Purpose	To identify and provide support to the external advisory team as set out in the External Review Terms of Reference.
Composition	To provide the required information and undertake actions as necessary to facilitate the work of the external advisory team.
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	Programme Team
Quality Criteria	- External advisory team have access to the information they require to deliver their report in line with the Terms of Reference.
Quality check method to be used	Quality assured by Steering Group

Identifier Title	S3: Communication and engagement action plan
Purpose	To set out the principles, approach and action plan for communication and stakeholder engagement. Includes evidence for single centre, criteria for determining location of a single centre.
Composition	The principles and specific approach to integrating communication and engagement with all stakeholders (service providers, commissioners, patients, public) within the conduct of the project.
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	Programme Team
Quality Criteria	Best practice principles for engagement in relation to service change and development.
Quality check method to be used	Quality assured by Steering Group

Identifier Title	S4: External advisory team final report to WHSSC.
Purpose	To provide WHSSC with the advice and recommendations of the external advisory Team to address the objectives and questions set in the Terms of Reference.
Composition	Determined by the External Review Terms of Reference.
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	External advisory team.
Quality Criteria	- To be set by Terms of Reference.
Quality check method to be used	Quality assured by Steering Group

Identifier Title	S5: Thoracic Surgery Service Specification
Purpose	To set out the service specification for thoracic surgery for the population of Wales.
Composition	To be based on advice from RCS Invited Review and other key sources, in particular the NHS England thoracic surgery specification.
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	Programme Team
Quality Criteria	The specification will be agreed by Project Board and issued for stakeholder consultation.
Quality check method to be used	Quality assured by Steering Group Approval by Project Board

Identifier Title	S6: Evidence report: one or two centres in South Wales
Purpose	To provide the evidence on the basis of which the Project Board will make a recommendation to the Joint Committee on the optimum number of centres (one or two) for South Wales.
Composition	To be developed by the Steering Group and agreed by the Project Board.
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	Programme Team.
Quality Criteria	The framework of which evidence to include will be agreed by the Project Board.
Quality check method to be used	Quality assured by Steering Group. Agreed by Project Board.

8

Identifier Title	S7: Independent Panel Information Pack
Purpose	To provide the evidence and criteria to form the basis of which the Independent Panel will appraise the options for the service. .
Composition	To be developed by the Steering Group and agreed by the Project Board.
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	Programme Team.
Quality Criteria	The criteria will be determined through an engagement exercise with stakeholders.
Quality check method to be used	Quality assured by Steering Group. Agreed by Project Board.

Identifier Title	S08: Project report on the outcome of the independent panel
Purpose	To provide a report for the Project Board on the outcome of the independent panel together with the methodology and criteria used by the panel
Composition	To be developed by the Programme Team and Steering Group.
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	Programme Team.
Quality Criteria	To be set by Terms of Reference.
Quality check method to be used	Quality assured by Steering Group. Agreed by Project Board.

8

Identifier Title	S09: Value for money assessment
Purpose	To undertake financial assessment of the options considered in the options appraisal.
Composition	Assessment of implications for capital infrastructure and revenue costs of the options considered by the options appraisal.
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	Value for money working group
Quality Criteria	To be agreed by finance group.
Quality check method to be used	Quality assured by Steering Group.

Identifier Title	S10: Performance Matrix
Purpose	To complement the service specification (S5) and to give granularity to commissioning.
Composition	
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	Cancer & Blood Planner/Steering Group
Quality Criteria	To be agreed
Quality check method to be used	Quality assured by Project Board.

Identifier Title	S11: Report to Joint Committee to make recommendations on the commissioning plan (inc. preferred service location)
Purpose	To make a recommendation to Joint Committee for the commissioning plan for thoracic surgery in Wales.
Composition	To include outcome of engagement and appraisal process, and assessment of financial implications.
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	Cancer and Blood Specialised Services Planner
Quality Criteria	Determined by S8.
Quality check method to be used	Quality assured by Steering Group. Agreed by Project Board.

Identifier Title	S12: Implementation Plan
Purpose	To set out key milestones and framework for the implementation of the agreed commissioning plan.
Composition	To include: range of issues that need to be addressed and working groups required, proposed lead organisation and project structure, key milestones and expected timescales.
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	Review Core Working Group
Quality Criteria	To be agreed
Quality check method to be used	Quality assured by Steering Group. Agreed by Project Board.

Identifier Title	S13: Report to Joint Committee to recommend implementation plan.
Purpose	To recommend the implementation plan (S11) to the Joint Committee.
Composition	See S11.
Format and Presentation	Microsoft Word report supported by Microsoft Excel documents.
Allocated to	Cancer and Blood Specialised Services Planner
Quality Criteria	Implementation plan will be agreed by the Project Board.
Quality check method to be used	Quality assured by Steering Group. Agreed by Project Board.

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6 Appendix B - Initial Risk Log (M2)

Ref:	Description	Impact (1-10)	Probability (1-10)	Risk I x P	Counter-measures	Owner	Author	Date Identified
R1	WHSSC staff capacity to sustain project (e.g. sickness in Cancer Prog Team)	8	2	16	Flexible cross portfolio working within the organisation.	CDG	Cancer planner	May 2016
R2	External Review timescale: if any factor leads to a delay in the report from the External Review team, the whole project will be delayed.	10	2	20	Full 6 months allowance in project plan leaves some potential for delay (aim to complete in less than 6/12)	Steering Group	Cancer Planner	May 2016
R3	Public engagement: complexity of conducuting regional engagement when current structures are designed for local engagement. Risk to timeline for project to obtain agreement and sign-up to the process across Health Boards.	6	8	48	Dialogue with Chief officers of the Board of CHCs / dialogue with Health Board engagement leads.	Steering Group	Cancer Planner	March 2017
R4	Public engagement: expertise and capacity within WHSSC to undertake a public engagement exercise	5	8	40	Seek external support (e.g. Health Board engagement leads, South Wales Collaborative)	Steering Group	Cancer Planner	June 2017

Ref:	Description	Impact (1-10)	Probability (1-10)	Risk I x P	Counter-measures	Owner	Author	Date Identified
R5	Project Board: ensuring quoracy.	5	8	40	Action taken to escalate requirement for attendance; utilisation of alternative approaches to approve products where possible and appropriate; review quoracy requirements to ensure reasonable and appropriate.	Steering Group	Cancer Planner	March 2017

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Alternative timeline for the Thoracic Surgery Review

Event	Date
Final HB meetings	28th September 2017
Amendments to document	29th September – 13th October
Engagement period	18th October – 29th November
Project Board	11th December
Independent Panel	5th January 2018
Project Board	15th January
Distribution of JC Papers	23rd January
Joint Committee	30th January

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

		Agenda Item	9
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	PET scan policy development		
Author (Job title)	Managing Director		
Executive Lead (Job title)	Managing Director	Public / In Committee	Public

Purpose	To present a business case which mitigates the financial risk associated with proposed changes to the PET policy as recommended by the All Wales PET Advisory Group (AWPET)			
RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☐	INFORM ☐

Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: ● **Approve** the proposal to fund the PET policy expansion out of the current PET provision in the WHSSC ICP 2017-20 ● **Note** the information within this report and the current risk to patients, providers and commissioning Health Boards; ● **Note** the support from Management Group to fund the PET policy expansion out of the current PET provision in the WHSSC ICP 2017-20, subject to assurances from Welsh Government.		

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 ✓

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1.0 Situation

1.1 The WHSSC 2017/18 Integrated Commissioning Plan (ICP) did not include any new interventions or service developments. This reflected the financial pressures and competing priorities within the NHS in Wales.

1.2 In response to this WHSSC developed a risk management framework. The framework identified significant risk around the lack of investment in extending the number of indications for PET scanning in Wales. The scheme to increase PET indications also received the third highest score from the Clinical Impact Assessment Group (CIAG) when assessed against all other high risk schemes being considered for inclusion in the 2017/18 ICP.

1.3 In June 2017 the Joint Committee in response to this risk assessment asked WHSSC officers to look at a specific business case development which would allow an expansion to the current list of indications.

1.4 In addition, the NHS Wales Chief Executive wrote to all Health Board Chief Executives in June 2017 asking them why the decision was taken not to fund these new indications given the strong underpinning evidence base and impact on patient outcome.

1.5 A draft paper outlining a business case which mitigates the financial risk associated with expanding the PET indications was presented to Management Group on the 27 July. In response Management Group members supported the proposal to recommend the business case to Joint Committee as an in-year development. However this was subject to (i) WHSSC writing to Welsh Government informing them of this proposal and requesting their assurance that any financial risk to WHSSC would be underwritten by Welsh Government and; (ii) the latest activity and demand predictions for PET across Wales being included in the business case presented to Joint Committee.

1.6 The letter from WHSSC to Dr Andrew Goodall (NHS Wales Chief Executive) was sent from the Managing Director on Monday 11 September and a copy circulated to Management Group members for information.

2.0 Background

2.1 The All Wales PET Advisory Group (AWPET) was established in September 2016 to review the evidence base for PET and advise WHSSC on the introduction of new indications within the existing policy (CP50: Positron Emission Tomography). Welsh Government is represented by the Chief Scientific Officer (Health) and the Group works in close collaboration with COSC.

2.2 At their first meeting members presented a 'Gap Analysis' which compared PET activity and commissioned indications across the four UK home nations. This concluded that NHS Wales scans 50% fewer patients (PET scans per million population per year) compared to NHS England. This discrepancy is mainly due to the greater number of indications available to patients in England (*Evidence based indications for the use of PET-CT in the United Kingdom (2016), Royal College of Radiologists / Royal College of Physicians*)

2.3 In December 2016 the Group engaged widely with the clinical community in Wales and reviewed the submitted evidence for a range of new indications. This resulted in a series of recommendations to WHSSC to increase the range of indications for PET scans.

2.4 The underlying case for this policy change is the relatively consistent finding that PET scans will identify previously undetected disease and will change management in around 40% of patients. This is because PET offers a higher level of sensitivity compared to other diagnostic techniques. Typically it will avoid unnecessary complex surgery in cancer patients with more advanced disease.

2.5 Based on estimates provided by multidisciplinary teams (MDTs) across Wales and by members of AWPET, the likely impact of these new indications would be to increase the number of scans needed per year by 461.

2.6 The cost of providing these additional scans for a full year is estimated to be £461,000 based on an estimate of 301 FDG scans costing £850 and 160 choline scans for prostate cancer costing £1,285.

2.7 The part year 2017/18 impact is estimated to be £154k, assuming the new PET policy is issued on the 1 December 2017.

2.8 Historically WHSSC has predicted as increase in annual activity based on the existing policy indications of around 13-14% per year.

3.0 Assessment

3.1 During discussion with Management Group members in June, a number of suggestions for cost saving or cost avoidance were identified for further investigation. These were:

A. A review of current projections of activity in the light of recent demand reduction;
B. Any potential offset costs against increasing IPFR requests;
C. The provision of scans for patients from North Powys to Wrexham rather than Cardiff where the unit cost is lower;
D. The option for renegotiation of the contracted position with PETIC which delivers scans in Cardiff for the population of South Wales;
E. The options for a change in the commercial arrangements around isotope production by PETIC to create a lower unit cost.

At the following Management Group meeting in July members supported the proposal to recommend a business case to Joint Committee as an in-year development. However this was subject to WHSSC writing to Welsh Government informing them of this proposal and requesting their assurance that any financial risk to WHSSC would be underwritten by Welsh Government.

A] Current activity projections:

Based on data submitted for the first 5 months of 2017/18 there appears to be a trend for slowing of growth in activity for existing PET indications across Wales (Table 1 and Table 2).

In South Wales growth has slowed to 7% over 2015/16 outturn and is predicted to decrease by 1.2% compared to 2016/17.

In North Wales activity has also reduced with a 1% fall in 2016-17 compared with 2015-16. Activity in the first 4 months of 2017-18 suggests a further 9% reduction in scans compared 2016-17. However as the activity rate is anticipated to return to the 2016-17 level for the remainder of the year, a prudent rolling average forecast of 760 has been assumed for the basis of the calculations in this paper. In addition BCU will refer an additional 30 scans to the Christie that are not clinically appropriate to be undertaken by the mobile scanner at Wrexham.

If this trend continues the total requirement for Wales in 2017/18 will be **3012** scans.

Table 1 – South Wales Activity (PETIC) 2010/11 to 2017/18

Period	PET scans performed	Growth (compared to previous year)
2010-11	675	
2011-12	1285	90%
2012-13	1417	10%
2013-14	1619	14%
2014-15	1920	19%
2015-16	2119	10%
2016-17	2263	7%
2017-18	2222 (predicted)	-1.2%

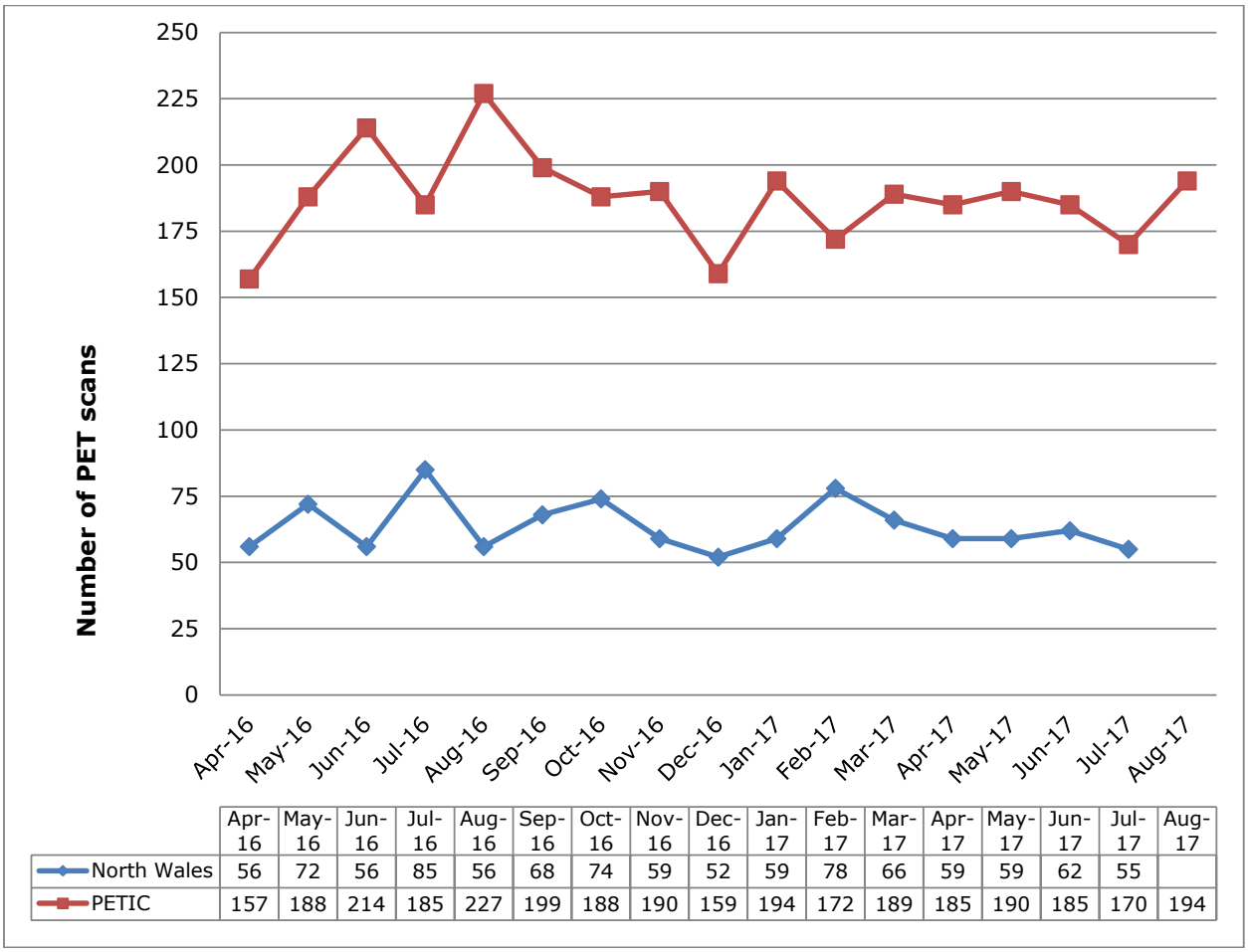
Table 2 – North Wales Activity 2015/16 to 2017/18

Period	PET scans performed	Growth (compared to previous year)
2015-16	794	
2016-17	784	-1%
2017-18	790* (predicted)	0%

*BCU rolling 12 month forecast include 30 scans at Christie

Figure 1 shows the monthly demand in both North and South Wales. It confirms a relatively stable demand over the last 9 months.

Figure 1 PET activity (April 2016 to August 2017)



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
North Wales	56	72	56	85	56	68	74	59	52	59	78	66	59	59	62	55	
PETIC	157	188	214	185	227	199	188	190	159	194	172	189	185	190	185	170	194

B] Baseline provision within the 2017/18 ICP

PETIC

Through the 2017/18 ICP, South and Mid Wales commissioners approved a £384k growth investment in PETIC which effectively increased the baseline from 2,067 scans to 2,492. This was in recognition of the 2016/17 performance and anticipated growth. No provision for new indications was made on affordability grounds.

The most recent PETIC activity forecast for 2017/18 is 2,222 scans (Table 1), therefore there is an over provision of 270 scans funded within the plan.

BCU

Through the 2017/18 ICP, BCU approved additional funding for growth of £214k, which included a £50k specific provision for new indications. However it is

recognised that in 2016/17 the block BCU PET contract baseline was based on repatriation from the Christie at the 2014/15 baseline level of 620 scans. Therefore at the 2016/17 outturn of 784 scans BCU provider would effectively have been reimbursed by BCU commissioner at an inferred rate of £629 per scan.

The BCU growth investment of £164k effectively increases the cost per scan to a more equitable £850 at the forecast 790 scan outturn. This is before utilising the £50k new indication provision.

C] IPFR demand for PET scans which would offset the cost of new indications

IPFR requests for PET scans have increased significantly during 2017 with approximately 10 requests per month. Of the approved requests approximately 25-30% would be approved within the new indications in the proposed PET policy. This means the cost of approximately 40 scans per year could be diverted from the IPFR budget. This includes some choline PET scans which have a higher unit price. WHSSC estimates this cost to be approximately £40k.

D] Provision of scans for patients from North Powys in Wrexham

We are unable to separate North Powys patients from the general Powys population however on a population basis we predict approximately 60 patients per year could be diverted from Cardiff to Wrexham. Although this would improve patient experience there is unlikely to be any significant savings.

E] PETIC contract and North Wales block contract

The current PETIC baseline is 2150 FDG scans at a unit cost of £925. The marginal cost for scans above the baseline is a unit cost of £850 per scan. In 2016/17 a total of 2263 scans were carried which equates to an average cost per scan of £921. The current contracting arrangement was agreed in January 2016 and will be reviewed as part of the 2018/19 ICP development.

Benchmarking data suggests that there are limited options for renegotiation:

- Christie NHS Trust: £908 per FDG scan
- Birmingham NHS Trust: £1,350 per FDG scan

Before utilising the £50k additional provision for new indications, at the forecast outturn of 790 scans, the 2017/18 inferred cost per scan for BCU commissioner to reimburse its provider arm is £850 per scan.

E] Isotope production

This option only relates to the establishment of a second scanner and the requirement for a step up in isotope production. PETIC could easily meet this increased requirement at minimal cost. However Alliance Medical currently have marketing authorisation for FDG across the UK and are unlikely to allow PETIC to

supply another NHS centre. PETIC currently have a 'special license' to manufacture isotope for their own use. This issue only becomes relevant if we build a second fixed scanner however it does mean than establishing a second centre not linked to PETIC would require an additional £150 per scan for isotope alone.

4.0 Summary

4.1 Following discussions at the July and August WHSSC Management Group, members supported a proposal to fund the PET policy expansion out of the current PET provision in the WHSSC ICP 2017-20.

4.2 Before the policy expansion business case is submitted to Joint Committee for approval, Management Group members requested that WHSSC ask Welsh Government to underwrite the financial risk of an overspend arising against the current ICP PET provision, in the event of actual activity growth exceeding the revised forecast levels in year. A letter was sent from the WHSSC Managing Director to Dr Andrew Goodall on the 11 September and we are now awaiting a response.

4.3 A commitment by Welsh Government to underwrite any potential overspend in PET activity would provide additional assurance to Joint Committee. This is particularly relevant in the context of the inherent financial risks that commissioning Health Boards are exposed to in delivering a balanced financial plan in the WHSSC ICP, for example the liability of the uplift in English provider specialist PbR tariff rates.

4.4 The demand for PET scans within the current WHSSC PET policy position has stabilised and appears to have reduced over the last 12 months.

4.5 There is likely to be an overprovision in the PETIC baseline for 2017/18 to cover unavoidable growth for additional PET scans across mid and South Wales equating to a financial provision of £230k. If the new indications are funded in 2017/18 the forecast cost is £119k

4.6 In the BCU contract there is a specific provision to fund new indications of £50k. The 2017/18 forecast of funding the new indications is £35k.

4.7 There is a degree of cost mitigation available due to a likely reduction in IPFR requests of approximately £40k (40 scans).

4.8 The year 2 provision of the 2017-20 ICP included an additional PET unavoidable growth provision of £150k for PETIC and £186k for BCU which includes a further £50k for new indications. This is above the 2017/18 provisions of £364k

4.9 Therefore the recurrent additional provision in 2018/19 of £700k will cover the anticipated full year policy expansion costs of £461k with headroom for existing indication growth.

5.0 Recommendations

5.1 Given the strong evidence base, clinical impact and evidence of opportunities to mitigate the financial risk the new indications recommended by AWPET should be considered for approval by the Joint Committee as an in year service development.

5.2 In addition to this case of affordability there are both clinical and cost benefits within Health Boards for patients who are appropriately managed following a successful PET scan.

5.3 Members are asked to:

- **Approve** the proposal to fund the PET policy expansion out of the current PET provision in the WHSSC ICP 2017-20
- **Note** the information within this report and the current risk to patients, providers and commissioning Health Boards;
- **Note** the support from Management Group to fund the PET policy expansion out of the current PET provision in the WHSSC ICP 2017-20, subject to assurances from Welsh Government.

Link to Healthcare Objectives	
Strategic Objective(s)	Implementation of the Plan Governance and Assurance
Link to Integrated Commissioning Plan	The proposal to commission new indications within a revised PET policy was put forward as a scheme for inclusion in the 2017/18 ICP
Health and Care Standards	Effective Care
Principles of Prudent Healthcare	Reduce inappropriate variation Only do what is needed
Institute for HealthCare Improvement Triple Aim	Not applicable
Organisational Implications	
Quality, Safety & Patient Experience	None
Resources Implications	These are clearly outlined in the paper
Risk and Assurance	Possible risk of patient and clinician complaints if equity of access to PET continues to be restricted compared to other UK devolved nations.
Evidence Base	An evidence evaluation for all new indications under this proposal has been carried out jointly by WHSSC and AWPET.
Equality and Diversity	All policy propositions will be subject to a full EIA.
Population Health	There are no additional implications for population health in this report.
Legal Implications	There are no legal implications associated with this report.

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

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

		Agenda Item	10
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	Risk Management Framework – Alternative Augmentative Communication Service		
Author (Job title)	Acting Assistant Director of Planning		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	In Committee

Purpose	This paper provides a summary of the current position of the All Wales Alternative Augmentative Communication service, describing the risk to patients, Cardiff and Vale UHB as the provider and WHSSC as the current Commissioner of the service as outlined on the Risk Management Framework. It also describes the work to mitigate the risks identified.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☒

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	21/08/2017
	Management Group	Meeting Date	31/08/2017
Recommendation(s)	Members are asked to: • **Note** the current risks to the All Wales Alternative Augmentative Communication service as outlined in the Risk Management Framework and the mitigation that has been identified to date. • **Agree** the option to progress in order to mitigate the identified risks.		

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Considerations within the report (tick as appropriate)

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

1.0 Situation

This paper outlines the risk scores identified in the Risk Management Framework (RMF) of not funding the proposal from the All Wales Alternative, Augmentative Communication Service for additional non pay for AAC equipment. There is a time critical element to the risks, as the service has identified that the funding that they were provided with by Welsh Government for equipment runs out in Autumn 2017.

The Risk scores for the service have been completed in collaboration with Health Boards. The patient risk has been scored by Management Group on behalf of their resident Health Board population, provider risk scored by Cardiff and Vale University Health Board who host the service on behalf of all Health Boards in NHS Wales and the Commissioner risk scored by WHSSC.

2.0 Background

The establishment of an All-Wales specialist service for complex aids for Augmentative and Alternative Communication (AAC) was announced by the Minister for Health and Social Care in June 2016, to be developed from the existing Electronic Assistive Technology Service (EATS) at Rookwood Hospital.

Prior to the establishment of this service there was no coherent or consistent provision to meet these needs. Patients obtained AAC equipment from a variety of funding sources – Education, Health, Social Care and privately funded. The variable service due to the range of local and national budgets made available for AAC meant that inequity in provision was inherent. Reviews commissioned by the Welsh Government reported that the lack of consistent recording made it impossible to quantify what little support was being offered.

The Social Services and Wellbeing (Wales) Act 2014 has as one of its main principles stronger partnership working to ensure that resources are available and effectively utilised. This was re-iterated in the Wellbeing Future Generations Act (Wales) 2015 which established Public Services Boards to strengthen joint working across public services in Wales. The tripartite model of Health, Social Care and Education within the Boards, ideally places these organisations as key to resolving where funding for the AAC service should originate from. However, with 19 such Boards there is still opportunity for inequity.

The service is a central national hub with most communication difficulties continuing to be addressed locally and patients only referred to this service when their needs cannot be met locally and they meet the set eligibility criteria.

The Welsh Government supported the development with recurrent ring-fenced funding for five posts to do the necessary work in assessment and provision and 2 years non-recurrent money for the purchase of communication equipment for long term loans to patients. The Welsh Government undertook to consider further funding for the high cost, low volume equipment in the light of an evaluation of the first two years operation.

The service commissioning was undertaken by WHSSC and a Service Specification and Commissioning Policy were agreed by the Joint Committee in March 2017. The time needed to develop the Commissioning Policy and Service Specification and then for the service to recruit, led to the delays in the service being established. Non pay funding was carried over in both 2016/17 and 2017/18 and the evaluation planned presentation to Joint Committee in September 2017 following the availability of a year's dataset.

In September 2016, Joint Committee supported the extension of the evaluation period for the specialist AAC service until 2017/18 when a full year of service data would be available and approved the carrying forward of any under spend on non recurrent budget which is primarily used for the AAC equipment.

2.1 Evaluation

Arrangements have been put in place with the Cardiff School of Health Sciences in Cardiff Metropolitan University to undertake an evaluation of the AAC service since it has been formally commissioned in 2017. An evaluation framework is in place with the service covering activity, outcome measures and user and stakeholder feedback.

The evaluation is due for presentation at Joint Committee in November 2017.

The experience of AAC hubs commissioned in England in April 2015 has shown that their referral patterns have not stabilised after 18 months. This supported the case for delaying the initially planned evaluation period to Autumn 2017/18, allowing the service to embed and ensure that there is

sufficient data available for analysis. This will allow the evaluation to contribute to more effective modelling of future demand and costs.

2.1.1 Informal assessment of the AAC service

An informal assessment of the service was completed by the Clinical Lead for the AAC Service and the WHSSC Project Manager who was employed for a fixed term basis to support the establishment of the service. This assessment provided assurance that the service was developing as specified and was addressing the service gaps and patient need as envisaged. However, it noted that there was limited time to generate activity data to inform likely realistic demand in the future.

3.0 Assessment

The AAC service has indicated that non pay funding for AAC equipment will run out in October 2017. If ongoing funding is not identified, there will be unmet need with patients being assessed for equipment but not provided with it. This will lead to a return to the inequitable service that this funding was brought in to eliminate.

The reported budget of the AAC service at month 4 is outlined below. The non pay, non recurrent expenditure includes stock equipment of £244k.

Table 1: 2017/18 Budget and spend of the AAC service

	2017/18 Budget (£000)	2017/18 Mth 4 Budget (£000)	2017/18 Mth 4 Actual (£000)	2017/18 Mth 4 Variance (£000)
WG funding via WHSSC	293	98	98	-
Direct pay expenditure	288	96	50	(46)
Direct non-pay expenditure		-	155	155
Staff related non-pay expenditure	5	2	-	(2)
ALAS Directorate Net expenditure	**293**	**98**	**205**	**107**

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3.1 Patient Risk

The inability to provide patients with AAC equipment unless further funding is identified in Autumn 2018 has scored as one of the highest risks on the Risk Management Framework.

The risk from a patient perspective of not being able to provide equipment has been described by the service as denying some patients the opportunity to retain their ability to communicate as there are optimal times to start using such equipment during the progression of diseases such as Motor Neurone Disease (MND). Other patients will not be able to have a voice at all and be 'Condemned to Silence' which was the title of an All Party Parliamentary Group enquiry into access to communication support for people with MND published in 2015.

The Motor Neurone Disease Association has written to both WHSSC and Welsh Government to raise concerns around the waiting times currently experienced by the people accessing the AAC service. They highlight that if additional funding for equipment is not provided, that people with MND could wait even longer to wait for additional stock to become available or be provided with a device that does not meet their needs. They are concerned that even within a 6 month period, the impact of MND can escalate dramatically and people living with MND may find themselves without a means to communicate affecting their ability to remain in employment and having a negative impact on their quality of life.

In the recent WHSSC Posture and Mobility Audit Day at which all providers of Artificial Limb and Appliance services presented, including the Clinical Lead for the AAC service, the AAC service was prioritised as the service at highest risk to patients if not invested in. Whilst the AAC equipment is not life saving, it has a huge impact on a patient's quality of life.

3.1.1 Patient Risk scores by Health Board

When the risk to patients of not implementing the AAC scheme was assessed by Management Group representatives on behalf of their resident populations, the following scores were given –

Health Board	Patient Risk Score
Aneurin Bevan	20
Abertawe Bro Morgannwg	15
Betsi Cadwaladr	20
Cardiff and Vale	20

Cwm Taf	16
Hywel Dda	16
Powys	16

These scores show the lack of investment in the AAC service to be the second highest risk of the WHSSC schemes from a patient perspective.

The scores which show the perceived risk to patients as extreme for three Health Boards and high for a further three Health Boards, do lead to the issue being escalated to Management Group in the first instance and if mitigation cannot be identified, the risk escalated to Joint Committee to resolution.

We are not currently aware of any mitigation in place in Health Boards which would help to explain the variance in score between Health Boards that all access the specialist AAC support via the national service.

3.2 Provider Risk

The risk has been described by C&VUHB as the provider of the AAC service for Wales as –

Reputational/Standards of Care – pilot funding coming to an end and money for equipment expected to run out before year end; high risk patients at the end stage of their disease would be left unable to communicate without provision of appropriate equipment. Scored as 3 x 4 = 12 (Moderate risk). The mitigation is described as –

- Clinical Service prioritising patients on basis of clinical urgency and need;
- Once funding runs out, a case for approval will be sent to WHSSC; and
- Option for slippage.

WHSSC has never funded AAC equipment previously so there is no provision for this in WHSSC funding. This paper pre-empts the case briefly described as a mitigating action from C&VUHB.

3.3 Commissioner Risk

WHSSC have scored the Commissioner risk of the service as 20 based on the consequence of not funding the service as Major loss of service to patients (4) and the Likelihood of the risk occurring as Almost Certain (5).

3.4 Mitigation

The options for mitigation are as follows:

1. **Do nothing and wait for the outcome of the service evaluation**

   Cardiff Metropolitan University have agreed to undertake the service evaluation and we are in the process of providing them with the requisite information. This is due to be presented at the November Joint Committee meeting.

   The risk ratings scores in the Referral Management Framework would not be reduced if this option was taken.

2. **Funding non recurrently for the remainder of 2017/18**

   With the impending end of the non pay funding for AAC equipment and the yet to be completed service evaluation, it needs to be considered if the service could be provided with funding until the end of 2017/18 by which time the evaluation would be complete and an informed decision could be made on the continuation of the service. Based on approximate spend of £40k per month, this would reduce funding of £240k based on the funding running out in October.

   This action would reduce the risk ratings scores to a minor or moderate risk but due to the time limited nature of the funding and the lack of alternative service to refer to would not eliminate the risk.

3. **Fund on a recurrent basis**

   When the AAC proposal was presented to Management Group for consideration of inclusion in the 2017/18 Integrated Commissioning Plan, it was not supported for funding on a recurrent basis. This was primarily due to the fact that funding within the NHS was limited and as the funding for the service had previously come from a variety of sources and the formalising of the service had come from Welsh Government, it was felt that the responsibility should not site solely with the NHS.

   This action would eliminate the patient risk but only reduce rather than eliminate the provider and commissioner risks as there would still be risks around sustainability of a developing service.

4. Collectively Escalate to Welsh Government

As the funding for the centralised service originated from Welsh Government, in some part as a consolidation of the funding from NHS, Social Care and Education sources that originally funded the AAC equipment, collectively escalate the issue as one that needs to be resolved by Welsh Government, potentially through the mechanism of Public Services Board.

Welsh Government is aware that the funding for equipment is shortly to run out but we could formally write to them as a Joint Committee to formally highlight the risks and request additional funding.

This action could potentially reduce the risk but is reliant on a swift and positive outcome from Welsh Government with regards to funding.

4.0 Recommendations

Members are asked to:

Note: the current risks to the All Wales Alternative Augmentative Communication service as outlined in the Risk Management Framework and the mitigations that have been identified to date.
Agree: the option to progress in order to mitigate the identified risks within the AAC service.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Implementation of the Plan
Link to Integrated Commissioning Plan	ICP17-087
Health and Care Standards	Dignified Care Effective Care Timely Care
Principles of Prudent Healthcare	Care for Those with the greatest health need first Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction)
Organisational Implications	
Quality, Safety & Patient Experience	This report describes the risks to the quality, safety and patient experience of the AAC service and its non recurrent budget issues.
Resources Implications	This flags the potential resource implications for mitigating the current risks with the AAC service.
Risk and Assurance	The ICP Risk Management Framework is an assurance mechanism for managing the risks.
Evidence Base	Evidence has been used from NHS England's experience of introducing and evaluating central AAC services.
Equality and Diversity	Equality issues have been highlighted for certain disease groups within this report.
Population Health	The implications for Population Health are outlined in this report.
Legal Implications	There are no known legal implications with the content of this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	21/08/2017	Approved for Management Group
Management Group	31/08/2017	Approved for Joint Committee with additional reference to the relevant legislation.

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

		Agenda Item	11
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	Adult Cystic Fibrosis service at C&VUHB: Update		
Author (Job title)	Planning Manager Women and Children		
Executive Lead (Job title)	Director of Planning	Public / In Committee	Public

Purpose	This paper provides a summary of the current position with regards adult Cystic Fibrosis services for Mid and South Wales, the risks to the sustainability of this service and the potential for a commissioning decision regarding the revenue requirements to address these

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☒

Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the ongoing risks to patient care associated with the adult CF service at C&V UHB, as discussed at the September Management Group workshop • **Note** that the service will soon reach capacity and be unable to accommodate new referrals, meaning new patients referred to centres in England • **Support** the case for change in order to mitigate the current risks within the service.		

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Considerations within the report (tick as appropriate)

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

1. Situation

1.1 Services for adult patients with Cystic Fibrosis from Mid and South Wales are delivered by C&V UHB from a dedicated CF unit at the University Hospital Llandough, offering a full multi disciplinary service.

1.2 Due to population growth and improvements in treatment, the service has seen a significant increase in patient numbers over recent years, such that it will soon be unable to accommodate any new referrals without investment in additional inpatient facilities and supporting MDT, meaning that patients would need to be referred to a centre in England for their care.

1.3 This position is supported by a peer review undertaken by the CF Trust in 2015, which identified the unit as having one of the lowest bed base per patient in the UK. This report also identified that UHL has the only unit in the UK to have shared bathroom facilities, posing a significant infection risk to patients.

1.4 C&V are currently developing a capital business case for increased inpatient beds at the CF unit and to provide en-suite accommodation for all. In parallel, a proposal was submitted for consideration as part of the 2017/18 WHSSC ICP prioritisation process for the revenue required to staff the additional beds and to expand the MDT, however this was not funded.

1.5 The Cabinet Secretary is actively monitoring this and officials from WG have met with representatives from WHSSC and C&V in August 2017 to discuss progress. Arising from this meeting, C&V have confirmed that they will submit their capital business case within 6 weeks and WHSSC have agreed to progress discussions with Health Boards around the risks associated with this service and the potential commissioning decisions around revenue requirements.

1.6 The risks and case for change were presented to the WHSSC Management Group workshop in September 2017 and group members acknowledged the risks of the current position and provided feedback as to the points that they felt will require focus within the business case from C&V.

2. Background

2.1 Cystic Fibrosis (CF) is a complex, multisystem, progressive, and ultimately fatal genetic condition affecting more than 10,800 people in the UK. Patients are born with cystic fibrosis and cannot catch it later in life, but 1 in 25 people carry the faulty gene that causes it, usually without even knowing.

2.2 The gene affected by CF controls the movement of salt and water in and out of cells. People with CF experience a build-up of thick sticky mucus in the lungs, digestive system and other organs, causing a wide range of challenging symptoms affecting the entire body. The build-up of mucus in the lungs causes chronic infections, meaning that people with CF struggle with reduced lung function and have to spend hours doing physiotherapy and taking nebulised treatments each day. As the pancreas becomes blocked with mucus, enzymes required for digesting food cannot reach the stomach. Exacerbations, often owing to infection, can lead to frequent hospitalisation for weeks at a time, interfering with work and home life.

2.3 Only a small proportion of GPs will have experience of CF during training and only approximately 25% will have patients with CF within their practice. As a result, most of the primary care support, as well as tertiary specialised care, is managed through the specialist CF centres. In Mid and South Wales, the adult CF service is delivered by the All Wales Adult Cystic Fibrosis Centre (AWACFC), from a dedicated unit at the University Hospital Llandough (UHL). The unit provides dedicated inpatient and outpatient facilities and the service delivers a multi-disciplinary approach, given the range of clinical skills essential in delivering effective outcomes to patients.

2.4 CF patients are commonly categorised into five 'bandings'. These are reflective of disease progression, acuity and resource requirement in managing a patient's care, with band 1 being the least severe and band 5 being the most severe. Anecdotally, the number of patients in the higher bands of disease severity is likely to rise accordingly as patients continue to live longer, with additional complications, coupled with a greater number of pre and post lung transplant patients.

Growth

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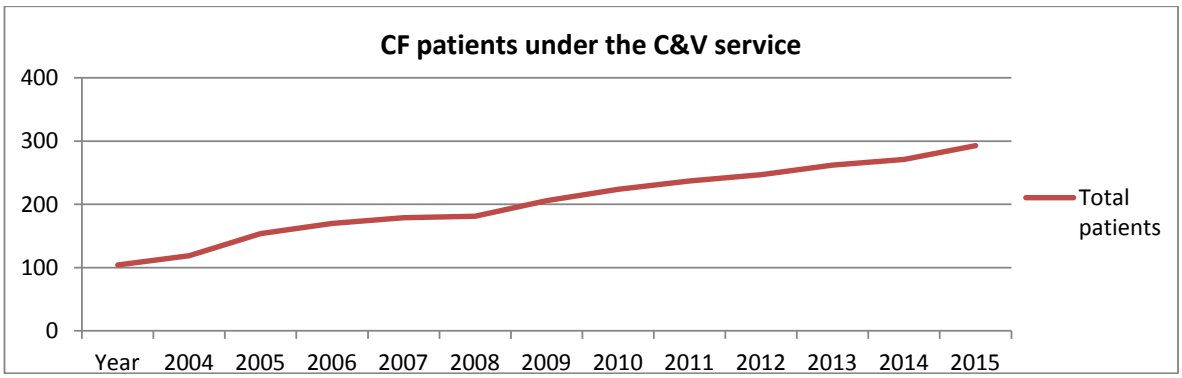
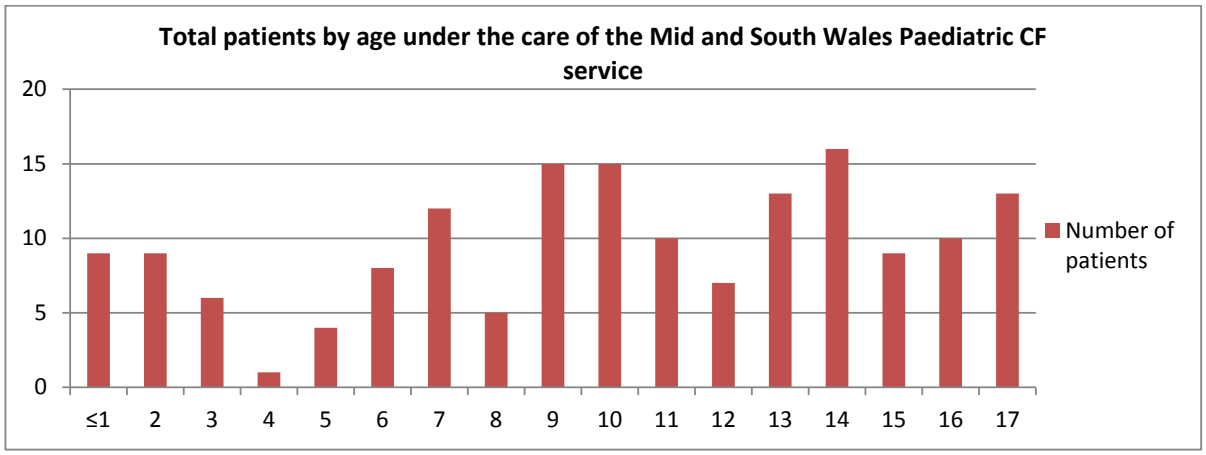
2.5 Since 2004, the service has expanded from 104 patients to a level of 293 patients at the end of 2016-



2.6 This level of growth is anticipated to continue and this is due to the fact that the rate of detection remains constant, however the life expectancy of patients with CF continues to increase.

2.7 The following demonstrates the number of patients under the paediatric service that will be entering the adult service in future years-



2.8 The graph represents 113 transfers in the next 10 years based on those patients turning 17 years old, including a transfer within 2017-18 of 13 patients as a minimum. There are also patients from England that are referred to the service e.g. students attending university and people moving to Wales.

2.9 As described, due to developments in CF specialist care, including new therapies and lung transplantation, survival in CF continues to increase and, therefore, life expectancy is also a factor in the growth in number of patients. Mortality within the C&V service in 2016 was 4/292 patients (1.4%) compared to 8/154 (5.2%) in 2006. It is anticipated that future care will no longer be for young adults but will support an ageing CF patient population, addressing not only the current associated complications linked to CF, but also those of ageing.

2.10 Patient care is already compromised by the number of patients that the service is managing within the limited capacity, meaning that there is a constant waiting list of patients waiting to be admitted, estimated at 3-12 patients at any given time waiting up to 2 weeks. Due to the nature of the condition and the risk of acquiring infection, it is not appropriate for patients to be admitted to general wards, meaning that patients have no choice but to wait. Where emergency admission is required, if this is not directly to a bed in the CF Unit due to capacity constraints, then patients are exposed to the infection risk related to being on a general ward and potentially using shared facilities.

2.11 The service estimates that it can manage a total patient cohort of no more than 300 patients within the current infrastructure and that beyond this any new referrals will need to be sent to CF centres in England. Given the current rate of patient growth, it is anticipated that the service will be at capacity by the end of 2017/18. CF services across the UK are under pressure therefore it is not clear which would be able to accommodate patients from Wales. Given that some patients require frequent appointments for review and treatment and potentially repeat admissions, the requirement to travel to a service in England would significantly impact on their lives and their care. Such patients would be in poor health, with this exacerbated by the additional travel required.

Standards

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

2.13 Currently, the CF Unit in UHL is constrained by a dedicated bed base of 7 (only 1 en-suite) and 1 cubicle on an outlying ward. The CF Trust has stated that this results in one of the lowest beds per patient ratio for any centre in the UK and is well below expected standards. As described above, this results in patients waiting to be admitted to the unit and potentially facing infection risks should more urgent admission be required to a non dedicated CF ward area.

2.14 In addition, the CF Trust has confirmed that UHL is the only adult CF Unit in the UK where patients have shared bathroom facilities. Due to the nature of the condition, patients with CF are at high risk of cross infection, therefore this arrangement significantly increase this risk. As a result, the service attempts to manage the very highest risk patients within the 1 en-suite room available, however this is clearly extremely challenging and means that all other patients are put at risk through sharing bathroom facilities.

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

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

This should be immediate and is absolutely pivotal for continued service development and growth.

2.16 The Peer review also provided areas for further consideration:

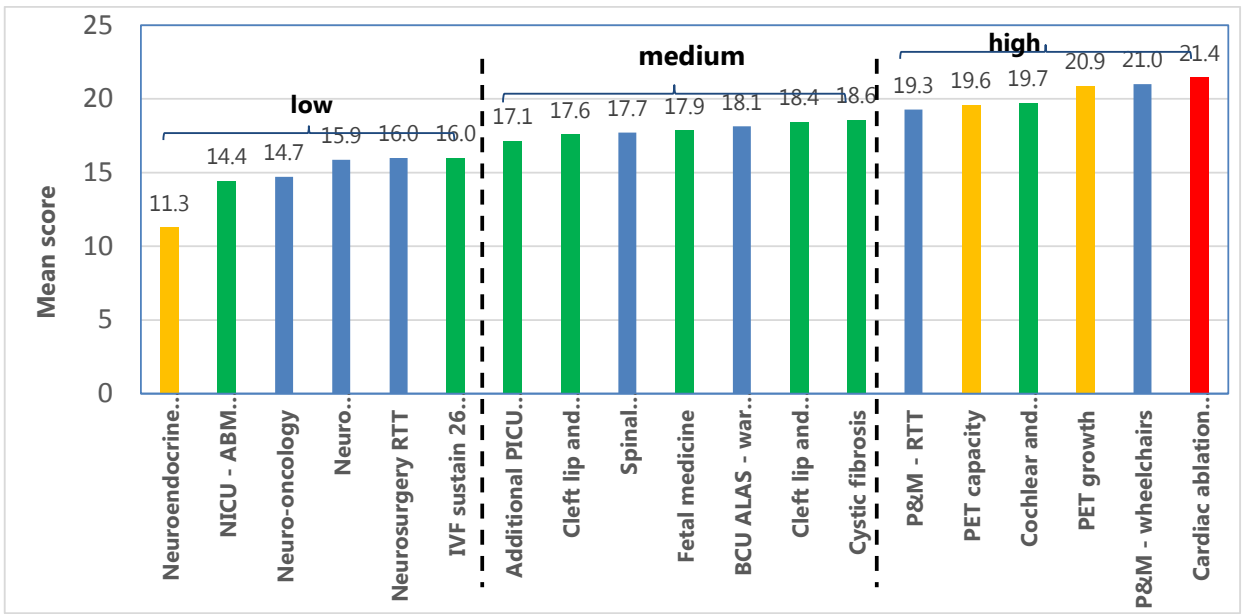
- Development of a comprehensive home intravenous (IV) antibiotic service with delivery of pre-prepared antibiotics to patients in their homes would help in modernising the delivery of care.
- Consideration of the feasibility of expanding on the out-reach clinic, with more of the specialist team travelling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

2.17 In order to begin to address these recommendations, investment was made by WHSSC during 2015/16 to recruit a Middle Grade doctor post and to increase pharmacy support to 1 WTE.

2.18 A further proposal was submitted for consideration as part of the 2017/18 WHSSC ICP prioritisation process for the following-

- Funding to staff for additional inpatient beds
- Funding for staff to increase the provision of outreach clinics
- Funding to fully implement and safely deliver a home care service
- Funding to develop specialist liver, diabetes and palliative care services

2.19 This was scored highly by the Clinical Impact Assessment Group, receiving the highest score of the 'medium' risk schemes as below, however funding was not approved-



2.20 As the above demonstrates, the CF proposal was on the borderline of being within the group of proposals assessed as representing the highest risk by the Clinical Impact Assessment Group and should, therefore, be seen as a significant risk to patients and to commissioners.

Benchmarking with other Adult CF Centres

2.21 As part of their previous revenue case, C&V have provided the following benchmarking information demonstrating the low number of inpatient beds per patient at UHL when compared to other units-

Centre	Patients	Inpatient beds	Beds per patient	% more/(less) than UHL
UHL	*294*	*8*	*0.03*	*NA*
Manchester	450	22	0.05	80%
Birmingham	388	20	0.05	89%
Brompton	600	25	0.04	53%
Sheffield	210	16	0.08	180%

2.22 Due to the low bed base at UHL, the service has a constant list of patients waiting to be admitted, estimated as 3-12 patients waiting up to 2 weeks at any given time. As such, patient care is compromised by a delay in accessing the treatment that they require. Where emergency admission is required and there is no capacity in the CF Unit, patients are exposed to infection risk through admission to general wards. The lack of inpatient beds at UHL is, therefore, a significant risk for patients.

Risk

2.23 The risks currently facing the service, should there be no additional capital and revenue investment, are as follows-

- Closure of service to new patients (including those transferring from the Cardiff paediatric service). Adult patients with CF from Wales will need to receive specialist care in English centres.
- The current position of patients waiting for admission to inpatient beds at UHL will continue to rise, increasing risk further (currently 3-12 patients at any given time waiting up to 2 weeks)
- The CF Trust Peer Review report recommendations will not be addressed
- The major cross-infection risk will remain with shared bathroom facilities
- The national all-Wales service at UHL will remain unsustainable for current patient requirements
- Specific risks in some staffing groups will present an inability to provide virtual and satellite clinics and further development of specialised services leading to poorer patient outcomes
- On-going reliance on hospital setting if homecare provider for IV not implemented putting further pressure on inpatient beds

2.24 This translates into significant risk to patients as follows-

- The service is currently unable to accommodate all patients that require admission, meaning patients waiting to be admitted, estimated at 3-12 patients at any given time waiting up to 2 weeks. Where emergency admission is required and patients cannot be accommodated within the CF Unit, patients are exposed to infection risk when admitted to non-CF wards.
- Should the service reach capacity, this would mean that any new patients requiring adult CF services, including those currently under the care of the Paediatric service, would need to be referred to a centre in England that has the capacity to accommodate. Given the nature of the condition and the potential requirement for frequent appointments and admissions, the additional distance required to travel would impact significantly on patients, particularly considering that those requiring this level of input will likely be in very poor health.
- Patients with CF are at a high risk of cross infection and this is increased by the current shared bathroom facilities. Failure to invest in the service will mean that this risk will not be addressed.

2.25 This service has been considered under the WHSSC Risk Management Framework with the following risk scores provided-

Patient risk:

2.26 The risk to patients has been described above under 2.23. The following patient risk scores have been provided by the Health Boards for their resident population-

	ABHB	ABMU	C&V	CT	HD	Po
Risk score	9	9	16		9	9

2.27 As the above demonstrates, all Health Boards have scored this patient risk as either high or extreme. C&V have reported a higher patient risk score than other Health Boards and since it is not known that there is any additional mitigation in other areas, this would appear to be due to different interpretation of this risk.

Provider risk:

2.28 The provider risks are described under 2.22. As such, C&V have provided a provider risk score of 20 (extreme risk) related to these issues.

Commissioner risk:

2.29 WHSSC have provided a commissioner risk score of 16 (extreme risk), related to all of the above risks, particularly the risk of not commissioning in line with standards (e.g. not responding to the concerns from the CF

Trust) and the risk of not commissioning sufficient capacity and the risk to patients that this creates.

Mitigation:

2.30 The service continues to manage the patient cohort within the existing resource and facilities, managing capacity by risk assessing patients etc. There will soon come a point, however, where it will no longer be possible to accommodate any additional patients, at which the risk will be managed by referring new patients to centres in England.

3. Assessment-

3.1 As described above, there are significant risks to patients under the care of by this service related to the limited inpatient facilities, delay in admission and risk of infection due to shared bathroom facilities.

3.2 There is a further significant risk to new patients referred to the service, including those currently under the paediatric service, due to the ongoing growth in patient numbers and the very limited capacity for the service to accommodate any additional demand. As such, without additional investment very soon any new patients will require referral to centres in England for their treatment. Given the nature of the condition and potential requirement for frequent appointments and repeat admissions as well as the poor health that such patients would be experiencing, the extended travel time and lack of quick access to services would offer a very poor service for patients.

3.3 This position is supported by peer review from the CF Trust as well as by benchmarking against other adult CF centres. This is also politically sensitive due to the interest of the CF Trust as well as Welsh Government.

3.4 The above risks and case for change was presented to the WHSSC Management Group workshop on 7th September 2017 and the group acknowledged the risks with the current position, requesting that the business case from C&V addresses the following points-

- Clarity around the existing service model and the proposed service model, particularly how the service will provide greater outreach outside Cardiff to bring care closer to patients
- Clarity around which patients could and could not use a properly resourced home IV service and data around the impact that this would have on bed requirements
- It was suggested that any investment may need to be phased, so this will need to be built into the business case with clear phasing and prioritisation of investment

- Need to emphasize that the 'do nothing' option is not cost neutral - the alternative will likely be patients referred to a centre in England at higher cost than investing in the UHL service

3.5 It will be vital, therefore, to work with C&V to ensure that an appropriate revenue case is developed that will ensure the ongoing sustainability of the service in order to address the risks identified above and to support the capital business case that will be submitted to Welsh Government.

4. Recommendation

4.1 Members are asked to:

- **Note** the ongoing risks to patient care associated with the adult CF service at C&V UHB, as discussed at the September Management Group workshop
- **Note** that the service will soon reach capacity and be unable to accommodate new referrals, meaning new patients referred to centres in England
- **Support** the case for change in order to mitigate the current risks within the service.

Link to Healthcare Objectives	
Strategic Objective(s)	Development of the Plan
Link to Integrated Commissioning Plan	ICP 17/154
Health and Care Standards	Safe Care Timely Care Staff and Resourcing
Principles of Prudent Healthcare	Care for Those with the greatest health need first Reduce inappropriate variation Only do what is needed
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	Should the service reach capacity and new patients have to be referred to England, this will significantly impact on patient experience.
Resources Implications	This proposal will require revenue investment
Risk and Assurance	The risks associated with the current are articulated above, both in terms of infection risks from the current inpatient facilities as well as service sustainability risks due to growing patient numbers
Evidence Base	CF Trust peer review 2015
Equality and Diversity	NA
Population Health	NA
Legal Implications	None

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

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

		Agenda Item	12
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	Risk Sharing Update		
Author (Job title)	Director of Finance		
Executive Lead (Job title)	Director of Finance	Public / In Committee	Public

Purpose	This paper provides an update of the impact of implementing proposals to move to the neutralisation date from the end of 2011/12 to 2013/14. The report sets out the latest modelling together with the issues and questions raised by the standing Finance Sub Group.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☐

Sub Group /Committee	Joint Committee	Meeting Date	30/05/2017
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the impact assessment and the nature of the queries raised by the Finance Group. • **Consider** options for the next steps. • **Receive assuranc**e that the technical queries raised are being worked through and will be reported to the next Finance Group.		

Considerations within the report (tick as appropriate)

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

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1.0 Situation

1.1 The May Joint Committee agreed in principle that the changes proposed to risk sharing arrangements be phased in over a three year period and subject to a maximum additional year on year contribution of £0.75m, in order not to destabilise any one Health Board. In addition it was agreed that historic movements be neutralised up to the end of 2013/14. The recommendation to extend the neutralisation period was a compromise position aimed at reducing the scale of backlog variation to bring utilisation and income into alignment. The impact assessment has been a complex process that has taken longer than expected owing to difficulties in getting full information from provider organisations and the need for a number of technical adjustments.

2.0 Background

2.1 The Finance Sub Group has met on multiple occasions since May in order to agree the methodology required to implement the intentions of the Joint Committee. The key points included:

- The proposed risk sharing framework would be applied to the 2013/14 outturn activity position to derive the baselines liabilities of Health Boards. These would be compared to income contributions at that point in order to derive a neutralisation position at that point in time. These derived positions could then form the basis of one off baseline adjustments between Health Boards.
- In addition, in order to ensure that approved collective agreements were honoured in full it was agreed to neutralise for the rebasing a number of Welsh LTAs and take account of transfer of services.
- Adjustments were made to correct for a number of non recurrent income flows, including VERS and WAST flows routed via Cwm Taf UHB, that could have otherwise produced errors.

3.0 Assessment

3.1 The results are summarised below together with the key comments from the Finance Sub Group.

3.2 The baseline assessment of the 2013/14 position is detailed in the table below:

Table 1

2013-14	Actual to Date £'000	Cardiff and Vale £'000	ABM £'000	Cwm Taf £'000	Aneurin Bevan £'000	Hywel Dda £'000	Powys £'000	Betsi Cadwaladr £'000
Total Contriubution 13/14	**601,810**	**104,977**	**99,604**	**56,134**	**109,334**	**67,689**	**28,825**	**135,247**
Expenditure								
Welsh Local Health Boards								
Cardiff & Vale University Health Board	171,091	52,955	21,464	23,026	42,791	14,034	4,572	12,251
Abertawe Bro Morgannwg University Health Board	82,264	7,659	29,837	5,493	10,209	18,049	3,026	7,991
Cwm Taf University Health Board	4,548	1,322	327	934	858	464	270	372
Aneurin Bevan Health Board	2,999	17	8	13	2,895	5	59	3
Hywel Dda Health Board	33	2	3	1	3	20	1	3
Betsi Cadwaladr University Health Board Provider	33,243	4,076	4,603	2,381	4,938	2,855	1,154	13,235
Velindre NHS Trust	29,734	6,586	5,377	4,260	8,560	3,555	1,394	-
Welsh Ambulance Service NHS Trust	121,012	14,786	16,510	11,210	20,616	16,937	9,198	31,755
	-							
Non Welsh SLAs	96,887	7,518	6,880	4,534	8,727	6,050	7,213	55,966
IPM & NCA	46,057	8,322	7,804	4,105	8,390	3,893	2,609	10,934
Renal	7,956	1,190	1,325	770	1,496	1,006	354	1,815
Unallocated Development and Savings targets	2,541	175	33	1,701	273	73	32	255
Direct Running Costs	3,447	601	570	321	626	388	165	775
Phasing adjustment - budget only	-	-	-	-	-	-	-	-
Total Expenditure	**601,811**	**105,210**	**94,740**	**58,750**	**110,382**	**67,328**	**30,046**	**135,356**
Neutralisation		**234**	**(4,864)**	**2,616**	**1,048**	**(361)**	**1,220**	**109**

3.3 This table shows the neutralisation required to align impact of applying the new framework to 2013/14 outturn activity positions compared to income contributions made by Health Boards.

3.4 This approach clears all historic legacy issues but it recognised that it is based on a specific point in time rather than performance over a period.

3.5 The position then calculates the impact of bringing the framework up to date to the end of 2016/17 and the IMTP income contributions in Table 2.

3.6 Table 3 shows the total impact which is the total of the results from Table 2 adjusted by the neutralisation of the 2013/14 baseline.

Table 2

	16/17 Utilisation & Pooling							
	Total Opening	C&V £'000	ABM £'000	CT £'000	AB £'000	HD £'000	Po £'000	BC £'000
2017/18 Opening Plan Contributi	557,039	98,646	97,700	50,836	106,172	60,221	22,032	121,432
Ivorcaftor	-1	-231	-199	78	300	298	103	-350
2017/18 WAST contributions	140,251	17,016	19,870	13,357	23,693	19,389	10,538	36,389
2017/18 Total Contribution	**697,289**	**115,431**	**117,371**	**64,271**	**130,164**	**79,908**	**32,673**	**157,471**
Expenditure								
Cardiff & Vale University Health B	187,596	52,935	27,113	25,343	46,131	17,248	4,640	14,185
Abertawe Bro Morgannwg Univers	96,362	8,792	35,814	6,162	10,304	21,605	2,983	10,703
Cwm Taf University Health Board	7,453	1,424	1,157	2,876	950	629	313	103
Aneurin Bevan Health Board	8,833	166	32	282	8,027	68	258	-
Hywel Dda Health Board	1,486	2	13	3	3	1,460	1	4
Betsi Cadwaladr University Health	38,137	4,183	4,912	2,438	4,783	3,243	1,119	17,460
Velindre NHS Trust	38,027	8,570	5,694	5,194	10,345	3,676	1,513	3,035
Welsh Ambulance Service NHS T	140,235	17,086	20,010	12,920	23,721	19,428	10,591	36,479
Non Welsh SLAs	108,177	8,401	9,780	4,397	10,820	6,881	8,407	59,491
IPM & NCA	53,413	9,257	9,373	4,330	8,869	4,979	2,154	14,451
Renal	5,261	787	876	509	989	665	234	1,201
Developments	8,831	1,904	1,466	994	1,612	976	327	1,552
Direct Running Costs	3,465	602	579	311	630	391	167	784
Utilisation Sub Total	**697,276**	**114,107**	**116,819**	**65,759**	**127,185**	**81,251**	**32,706**	**159,446**
Utilisation movement		(1,324)	(552)	1,489	(2,980)	1,343	33	1,975

Table 3

	Total £'000	C&V £'000	ABM £'000	CT £'000	AB £'000	HD £'000	Po £'000	BC £'000
Utilisation movement	(16)	(1,324)	(552)	1,489	(2,980)	1,343	33	1,975
Neutralisation 2013-14	2	234	(4,864)	2,616	1,048	(361)	1,220	109
Aggregate	(18)	(1,558)	4,311	(1,128)	(4,028)	1,704	(1,187)	1,867

3.7 The results indicate the following:

- Moving the neutralisation point to 2013/14 has changed the impact assessment materially indicating that the calculations are highly sensitive to points in time.
- There is a different impact by Health Board with HDHB now in an adverse position and ABMUHB in materially adverse position.
- The three year transition would not be achieved by a cap set at £0.75m.
- The degree of volatility in terms of impact on individual HBs is greater than expected against the proposed framework – which added to the backlog impact creates a challenge regarding transition.

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3.8 The Finance Group met on the 20th September to consider the draft figures and set out a range of areas that need to be followed through to check for impact and accuracy. These include:

- A further review of the impact of income flows.
- The impact of volatility in medium secure services and the consistency of the models in place in North and South Wales for in area capacity and out of area referrals.
- The impact of FACTS services and consistency of calculation.
- The impact of BCUHB internal contracts.
- The introduction of the new contracting framework for NIC/SCBU.
- The impact of transfer of service out of and into specialised services in the period.
- Assurance that renal budgets are fully shared.
- A review of whether the method used for ALAS reflects the All Wales nature of the service.
- Understanding the volatility regarding the utilisation of ICU/HDU services in the CVUHB provider contract.
- Ensuring that the method correctly reflects the agreed CAMHS investment in community intensive services from the Tier 4 and out of area resource.
- Understanding whether the trends in utilisation make sense and can be justified and verified by base data.

4 Recommendations

4.1 Members are asked to consider the impact assessment and the direction of travel.

4.2 Members are asked to:

- **Note** the impact assessment and the nature of the queries raised by the Finance Group.
- **Consider** options for the next steps.
- **Receive assurance** that the technical queries raised are being worked through and will be reported to the next Finance Group.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance
Link to Integrated Commissioning Plan	
Health and Care Standards	Governance, Leadership and Accountability Staff and Resourcing
Principles of Prudent Healthcare	Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	
Organisational Implications	
Quality, Safety & Patient Experience	Not applicable
Resources Implications	No increased cost overall but significant impact on cost to individual health boards.
Risk and Assurance	Resolution of the risk sharing framework will enable a clearer focus on core commissioning issues.
Evidence Base	Contracting datasets and activity information held at provider and commissioner levels.
Equality and Diversity	Not applicable
Population Health	The proposed framework increases the focus on Health Boards understanding their respective utilisation of specialised services, the pathways to these services and alternatives.
Legal Implications	Not applicable

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Joint Committee	30 May 2017	Recommended method and baseline year

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

		Agenda Item	13
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	Cardiac Magnetic Resonance Imaging (CMRI) – future planning responsibilities		
Author (Job title)	Planning Manager, Cardiac		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	To provide members with an update on the collective commissioning work that has been completed by WHSSC in respect of Cardiac MRI and to consider the ongoing provision of commissioner support for this service.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☐	☐	☒

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	21/08/2017
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the collective commissioning work completed by WHSSC; • **Approve** the adoption of the CMRI Service Specification by Health Boards; and • **Approve** the recommendation to confirm that WHSSC has completed its role in collective commissioning for this service and to transfer the responsibility for further planning and implementation to Health Boards/ Regional Planning Boards, supported the All Wales Cardiac 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	✓		Institute for HealthCare Improvement Triple Aim	✓		Quality, Safety & Patient Experience	✓	
Resources Implications	✓		Risk and Assurance	✓		Evidence Base	✓	
Equality and Diversity		✓	Population Health	✓		Legal Implications		✓

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1.0 Situation

1.1 In March 2015 WHSSC Joint Committee agreed commissioning intentions for Cardiac Magnetic Resonance Imaging (CMRI) in line with the collective commissioning framework. As CMRI is not a specialised service it was agreed that implementation of the intentions would be taken forward via Health Board IMTPs.

1.2 The commissioning intentions sought to increase access to CMRI from historically low to clinically appropriate levels for each Health Board over a five year period. It was agreed that in addition to monitoring implementation of the CMRI plans WHSSC would continue to facilitate the provision of commissioning support and advice in line with the collective commissioning framework.

1.3 Action completed to date:

- Advice to Joint Committee on the link between CMRI commissioning and risks to the future of cardiology training in Wales
- Finalisation of the Commissioning Policy for approval and distribution through Health Board's governance processes;
- Drafting and consultation on a Service Specification for CMRI services,
- Baseline assessment of plans, undertaken by the All Wales Cardiac Network and reported to the Heart Disease Delivery Implementation Group (HDDIG) in December 2016.

1.4 Outstanding action:

- Approval and distribution of the service specification through Health Board governance processes;
- Agreement that WHSSC has completed its functions with regards CMRI and that responsibility for further planning and implementation will transfer to Health Boards and Regional Planning Boards, to be supported by the all Wales Cardiac Network.

2.0 Background

2.1 Cardiac MRI is not a specialised service and is not, therefore commissioned by WHSSC. It was agreed, however, that WHSSC would facilitate the provision of commissioning support and advice in line with the collective commissioning framework in order to progress all-Wales discussions around capacity requirements. This work has ultimately led to 5 year plans, developed through Health Board IMTPs, to increase access to Cardiac MRI across Wales to appropriate levels.

2.2 In order to provide a framework for this service, WHSSC has developed a clinical access policy that has been adopted by the Health Boards and a

service specification that has been consulted on and approved internally but not yet adopted by the Health Boards.

2.3 Although Health Board representatives at the all Wales CMRI meetings continue to support the recommended commissioning intentions it is recognised that there are a number of factors that have and will continue to limit Health Boards' ability to implement these intentions. These include-

- A national shortage of appropriately trained clinicians
- The capital investment required to expand capacity in some areas
- The need to align with individual Health Board plans for imaging services;
- The requirement for co-ordinated regional level planning to ensure that CMRI activity is appropriately directed between tertiary and DGH providers to maintain service sustainability.

2.4 At the HDDIG meeting (now Heart Conditions Implementation Group - HCIG) meeting in September 2016 Health Boards indicated that they would value input from the All Wales Cardiac Network to facilitate local discussions regarding Health Boards implementation plans and to strengthen arrangements for regional planning. The Network has commenced this work and to date has facilitated meetings in South East and South West Wales.

2.5 An update paper was presented to Management Group on 30th March 2017, at which point it was approved that WHSSC had completed its role in collective commissioning for this service and that discussions should be held to transfer ongoing responsibility for implementation and delivery to the Cardiac Network. The Network has confirmed that they can support and facilitate regional discussion as required, but cannot take on full responsibility for this.

3.0 Assessment

3.1 WHSSC has been asked to provide CMRI commissioning support and advice to Health Boards under the collective commissioning framework. Whilst some progress has been made, namely the production of a commissioning policy and service specification, WHSSC is not well placed to oversee the co-ordinated regional level planning required to implement additional CMRI capacity.

3.2 WHSSC has taken forward the national aspects of collective commissioning required to underpin the development of CMRI services. Once the CMRI service specification and policy have been finalised and adopted by Health Boards attention will need to focus on the development of regional plans to implement delivery of CMRI services for the population of Wales. It is proposed that the development of regional plans would be best served by a collaborative regional rather than national approach which will be able to address the unique set of factors influencing the development of CMRI

services in each region of Wales.

3.3 The all Wales Cardiac Network has already demonstrated the value it can support discussions at a regional level and it is therefore proposed that responsibility for the ongoing planning and implementation of CMRI is progressed by the Health Boards and through the Regional Planning Boards, supported by the Cardiac Network as required.

4.0 Recommendations

4.1 Members are asked to:

- **Note** the collective commissioning work completed by WHSSC;
- **Approve** the adoption of the CMRI Service Specification by Health Boards; and
- **Approve** the recommendation to confirm that WHSSC has completed its role in collective commissioning for this service and to transfer the responsibility for further planning and implementation to Health Boards/ Regional Planning Boards, supported the All Wales Cardiac Network.

5.0 Appendices / Annexes

5.1 Cardiac MRI Service Specification

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance
Link to Integrated Commissioning Plan	Collective Commissioning scheme
Health and Care Standards	Effective Care Staff and Resourcing Timely Care
Principles of Prudent Healthcare	Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Improving Patient Experience (including quality and Satisfaction)
Organisational Implications	
Quality, Safety & Patient Experience	CMRI is not a specialised service. Implementation of commissioning intentions by Health Boards will improve quality, safety and patient experience.
Resources Implications	There are resource implications for WHSSC to continue to support the planning of this service
Risk and Assurance	Collective commissioning in line with WHSSC risk and assurance processes.
Evidence Base	Commissioning intentions are evidence based.
Equality and Diversity	N/A
Population Health	Commissioning intentions seek to improve population health.
Legal Implications	N/A

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	21/08/2017	Supported subject to minor amendments

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

Appendix 1:

Specialised Services Service Specification:
Adult Cardiovascular magnetic resonance Imaging (CMRI)

Document Author:	*Agreed by the Wales MRI Commissioning Group and approved by the WHSSC Policy Group. Drafting supported by: Specialised Planning Manager for Cardiac Programme, WHSSC.*
Executive Lead:	*Acting Director of Planning*
Approved by:	
Issue Date:	*May 2017*
Review Date:	*May 2020*
Document No:	*To be obtained from Corporate Services Manager or Corporate Governance Manager*

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Document History

Revision History			
Version No.	Revision date	Summary of Changes	Updated to version no.:
0.2	**April 2017**	**See paper to WHSSC policy group May 2017 meeting**	**0.3**
Date of next revision			

Consultation		
Name	Date of Issue	Version Number
MRI Commissioning Group	23rd September 2016	0.1
Cardiac Network	2nd November 2016	0.2
WHSSC Policy Group	May 2017	0.3

Approvals		
Name	Date of Issue	Version No.
WHSSC Policy Group		**1.0**

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

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1. Aim

1.1 Introduction

The Health Boards in Wales have agreed a 5 year phased plan to significantly increase provision of CMRI for their adult resident populations from the current low level of access to the recommended rate of 2275 scans per million population per annum. The transformation in the level of CMRI provision, particularly in years 3, 4 and 5 of the plan, will require investment in facilities, equipment and staff. At the current time, the CMRI service is largely a tertiary centre delivered service. However, it is anticipated that as the 5 year plan is implemented and capacity increases, the delivery model will also transform towards a more locally delivered, secondary care, service, linked with and supported by the tertiary centres.

The document has been developed as the service specification for the provision of *Cardiac Magnetic Resonance Imaging (CMRI)* for adult patients, age 18 years old or above, ordinarily resident in Wales.

The purpose of this document is to:

- Detail the specification (quality standards) for the *CMRI* service for adult patients, age 18 years or above, who are resident in Wales;
- Outline the relevant national quality standards and indicators;
- Set out audit requirements to ensure standards are maintained;
- Ensure that patients, families and carers are at the forefront of services.

1.2 Relationship with other Policies and Service Specifications

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

- *Commissioning Intentions*
- *Commissioning policy for Cardiac MRI*
- *Service specification for congenital heart disease (in development)*

2. Quality and Patient Safety

2.1 Quality and Patient Safety

The providers must work to the written quality standards as stated in 2.2 of this document.

Each Health Board needs to ensure that they provide effective and robust monitoring arrangements to ensure performance, quality and efficiency of all services are delivered on their behalf.

2.2 Quality Standards

The Quality Standards for CMRI in Wales are taken from the British Society for Cardiovascular Magnetic Resonance (BSCMR)/British Society for Cardiovascular Imaging (BSCI) guidelines. These standards cover the following:

a) Core Standards
b) Minimum requirements for CMRI centres
c) Care Team
d) Service Delivery
e) Individual training, accreditation and CPD
f) Equipment
g) Quality control
h) Exposure limits
i) Emergency procedures

The specific standards for categories a) to e) are itemised below. Standards f) to i) are included in the appendix. All standards should be achieved by centres commissioned to provide CMRI for Wales.

2.2.1 Core Standards

Standard	Description	Timescale
A nominated Clinical Lead	A nominated Clinical Lead with appropriate training accreditation and continuing medical education(CME)/Continuing Professional Development (CPD)	Immediately
At least 2 members of staff present during scanning	Both of whom will be trained in magnet safety, and at least one of whom will be appropriately trained in CMR scanning. For stress imaging, there should be access to appropriately trained staff in the event of an emergency.	Immediately
A specified Magnetic Resonance (MR) responsible clinician	Each unit will have a specified MR responsible clinician (who is in charge of MR safety)	Immediately
MRI scanner with cardiac capability	A fully maintained, shared or dedicated MRI scanner with appropriate cardiac capability.	Immediately
Sufficient magnet access	Sufficient magnet access to achieve minimum annual unit numbers of at least 300 scans and more than 500 cases per annum for training centres	Within 3 years
Written Procedures in place	Written Procedures in place to ensure a safe environment and quality	Immediately

2.2.2 Minimum Requirements for a CMRI service (including mobile units)

Standard	Description	Timescale
Minimum number of scans for a CMR centre: CMR requires a high degree of operator input and expertise during scanning. The diverse nature of clinical indications and findings in clinical context means that CMR reporting benefits from minimum numbers to maintain quality and competency, even in trained staff.	The BSCMR/BSCI guidelines recommend that Institutional CMR numbers are: • *minimum of 300 cases per annum* • *If a newly established centre there should be a minimum of 300 cases within 3 years* • *300 cases per annum minimum for training centres.*	Within 3 years
Should a centre not be performing 300 cases per year:	• A review of the centre should be undertaken to establish the reason why the centre is not meeting the minimum requirements. • The unit will have a formal link-up with a high volume centre to ensure consistent quality until such time as 300 scans per annum are being performed. This will include access to joint reporting facilities, participating in CMR audit and governance meetings and may include scanning/reporting sessions at the high volume centre. • If 300 cases per year cannot be achieved, the centre should review the	

	CMR scanning and consider the transfer of activity to a high volume centre. • Less than 300 cases per year is acceptable for a site where an established CMR team do outreach lists, in which case this activity should be considered as part of the main site's activity.	
Training	In centres performing under 500 cases per year, Society of Cardiovascular Magnetic Resonance (SCMR) Level 1 core CMR training can be performed, as can some advanced modules/sub-specialty training – but the advanced module/sub-speciality trainee will require additional experience at an accredited training centre for at least one year (half of their advanced modules/sub-specialty training).	

2.2.3 The Care Team

The service should encompass the following staff members who are trained in MRI:

A nominated Clinical Lead	With appropriate training, accreditation and CME/CPD, who is on the UK Specialist Register for Cardiology, Radiology, Nuclear Medicine or who is subspecialty accredited in CMR	Immediately
A nominated MR Superintendent	With appropriate training, responsible for (or delegating) equipment management and maintenance	Immediately
Medical and technical staff	Appropriately trained medical and technical staff to deliver the service	Immediately
A medical physics expert	Arrangements for scientific and technical input from a medical physics expert appropriately trained in CMR methods.	Immediately
Staff Development	Arrangements for appropriate staff development, (education, training, accreditation, CPD, revalidation)	Immediately
Individual Accreditation	Current or planned total activity sufficient to maintain individual accreditation	Immediately

2.2.4 Service delivery standards

Scanning	• Patient confidentiality will be maintained at all times. • Units will base their scan protocols on nationally agreed scanning protocols. • At least 2 members of staff will be present during scanning, both of whom will be trained in magnet safety, and at least one of whom will be appropriately trained in CMR scanning. For stress imaging, at least one available member of staff will be medically trained and up-to-date to deal with potential complications (including a valid Advanced Life Support or Immediate Life Support qualification).	Immediately

Reporting	• All clinical CMR scans will have a report generated. • Responsibility for CMR reports always lies with a consultant, no reports will be signed off without it being clear who this is. • CMR reporting will be clinically integrated with scan result availability at multidisciplinary review at least fortnightly. • Should only one SCMR level 3 accredited physician be present in a unit, that unit will have a formal link-up with a separate centre or reporting physician at least six times a year. • CMR reports will conform to appropriate national standards and/or adjust international reporting standards to local UK needs. • When reporting, all areas of all images will be reviewed – including scout images and any extra-cardiac areas cropped out by some viewing software. This includes situations when the aim of imaging is designed for import into other systems (e.g. atrial angiograms for electrophysiology procedures, stent design). • Where a cardiologist/nuclear physician is reporting alone, radiology advice will be available to discuss extra-cardiac pathology; similarly expert cardiology advice will be available for discussion of findings in radiology based services.	Immediately

2.2.5 Individual training, accreditation and CPD

Initial Staff Training	• At least 6 months of full-time experience in MR (At a centre performing >300 CMR cases/year) **OR** at least 12 months of training in MR (At a facility performing between 50-300 CMR exams per year) • 30 hours of CMR-related coursework. Coursework must be completed at the university level, accredited CME/CEU programs, or accredited CMR training programs. Recognized registered MRI Technologists maybe exempt from these requirements upon successful documentation of previous work	Immediately
Individual Physician Accreditation/ Certification	The Clinical Lead for the CMR lab: • Must hold one of: SCMR Level 3 accreditation i.e. completed advanced modules in CMR and/or subspecialty degree in cardiac radiology or equivalent. **AND** • Be a consultant with CCT in cardiology or radiology, who is on the UK Specialist Register.	Immediately
Revalidation and CPD	The CMR physician will be required to maintain competence including revalidation. For level 2 and 3 accreditation, the SCMR requirements are currently: • Level II: Twenty hours of coursework and primary interpretation of 100 cases every two years. • Level III: Forty hours of coursework and primary interpretation of 200 cases every two years.	Immediately

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3. Putting Things Right: Raising a Concern

Each Health Board (HB) is committed to the health, safety and welfare of its patients, users, staff, visitors and contractors across the health community by being proactive in its approach to managing Concerns and reducing risks.

The Health Board's Concerns Team aims to support all staff and patients in the management of patient Concerns (complaints, patient safety incidents and claims), in line with the Welsh Government's Putting Things Right guidance, with the aim of ensuring that learning's are identified when something goes wrong. So that the Health Board can continually improve.

The NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 came into force on the 1st April 2011 and apply to Welsh NHS bodies, Primary Care Providers in Wales and Independent Providers in Wales providing NHS funded care. These arrangements represent a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

4. Performance Monitoring and Information Requirements

4.1 Performance Monitoring

For the services defined in this document the following approach will be adopted:

- Service providers to evidence quality and performance controls
- Service providers to evidence compliance with standards of care

Performance and quality reviews will be conducted on an annual basis.

Patient experience
Feedback from patients regarding their experience must be gained in a structured manner at least annually. This feedback may also be used to make service change where required.

Co-production
The centre must enable the patient's, carer's and advocate's informed participation and to be able to demonstrate this. Provision should be made for patients with communication difficulties. Patients should be provided with a range of communication and information aids.

Audit and Risk Assessment
The centre will undergo regular audit as part of the clinical governance of the service. Although at this stage, national and international guidelines and audit standards are poorly developed, specific areas for attention will include those where interpretation may be particularly complex, for example perfusion CMR, arrhythmogenic right ventricular cardiomyopathy (ARVC), dobutamine stress and congenital heart disease. The BSCMR also recommends regular patients' view audit, as recommended in the Royal College of Radiologists audit live website.

A reporting discrepancy occurs when a retrospective review, or subsequent information about patient outcome, leads to an opinion different from that expressed in the original report. Not all reporting discrepancies are errors.

The BSCMR recommends discrepancy meetings ~4 times a year, either separately, as part of 'hits and misses' meeting or as part of multimodality imaging meetings or audit meetings. The purpose of these is to facilitate collective learning thereby improving patient safety. They do require sensitive handling and specific, detailed guidance exists from the Royal College of Radiologists on them. Such meetings form an important part of the audit process and the structure of these meetings must ensure a blame-free learning orientated environment.

4.2 Key Performance Indicators

It is the provider's responsibility to notify the commissioner should there be any breaches of the waiting times. Where there are any breaches any consequences will be deemed as being the provider's responsibility. In addition to the waiting

times, the provider must not compromise patient choice and should be able to offer the patient a choice of appointment times and for diagnostic/ treatment options.

The providers will be expected to monitor against the following target outcomes:

- CMRI Waiting Times
- Monthly referral to Treatment waiting times
- National and local KPI's

MINIMUM REQUIREMENTS

Appendix 1: Technical Standards

The following technical and procedural standards for a CMRI service are taken from the BSCMR/BSCI guidelines. They cover:

- Equipment
- Quality control
- Exposure limits
- Emergency procedures

A1.1 Equipment and Technical Standards

MRI scanner: A fully maintained, shared or dedicated MRI scanner (minimum 1.5 Tesla) with cardiac capability.

- Written procedures in place to ensure a safe environment and quality

ECG gating, patient monitoring (including BP, oxygen saturation)
For a new CMR installation, BSCMR recommendations are:
• RF receiver: should comprise 16 or more RF channels (torso/body/cardiac receiver array with multiple elements).
• Gradient specifications: 30mT/m, 150mT/m/msec
• Artefact resistant electrocardiogram (ECG) hardware/software (e.g. vector cardiogram)

Specific cardiac sequences
The minimum is:
• Steady State Free Precision (SSFP) cine imaging (bFFE, FIESTA or TrueFISP)
• Black blood prepared T1/T2W turbo spin echo (TSE) sequences with/without fat saturation
• Single shot black blood prepared TSE sequences (e.g. half-fourier acquisition single shot (HASTE))
• Phase contrast Flow/velocity sequences with quantification
• Large vessel angiography
• Late Gadolinium Enhancement imaging
Recommended is
• Real-time cine sequence
• Perfusion sequences
• Alternative late enhancement sequences (3D, phase sensitive inversion recovery (PSIR), inversion recovery prepared SSFP (IR_SSFP))
• 3D whole heart other sequences (Short Tau Inversion Recovery (STIR), tagging, coronary sequence, cardiac iron)

Specialist software for analysis
The minimum is:
• Volumetric quantification of left ventricle(LV)/right ventricle(RV) volumes and mass
• Quantification of velocity and flow

Additional software may include:
• complex 3D angiographic reconstruction, perfusion
• quantification, late enhancement quantification, LV analysis with long axis function, tagging analysis.

Other equipment
• Resuscitation facilities (including defibrillation/oxygen/suction)
• An emergency trolley with specific drugs to deal with potential reactions to IV contrast media and stressors.
• Magnetic resonance (MR safe wheelchair & trolley)
• MR compatible monitoring equipment such as: non-invasive
blood pressure and saturation of peripheral oxygen (SpO2) monitoring equipment
• MR compatible power injectors and infusion pumps

A1.2 Quality control

- The quality assurance programme will be defined in a written policy with regular audit of all policies and procedures. Radiographers/technologists and medical physics staff will be fully involved in this process with appropriate analysis and monitoring of the data obtained. Guidance relating the quality control measures has been provided by the Institute of Physics and Engineering in Medicine (IPEM).

- A written policy will be in place for CMR equipment image quality testing. Signal and geometric parameters should be monitored. Information will be provided by the MR safety advisor or medical physics expert in MRI.

- The unit will have an effective framework for the safe use of the MR equipment which will comply with the detailed guidance available in the Medicines and Healthcare products Regulatory Agency (MHRA) Device Bulletin, DB2007, Dec 2007: Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use. These guidelines cover all aspects of safety including unit design and maintenance.

- Each unit will have a specified MR responsible clinician (in most cases the Clinical Lead or the superintendent radiographer of the unit) who is in charge of MR safety. The MR responsible clinician will work closely with a MR safety advisor, a clinical scientist with MR physics expertise, who will advise on necessary engineering, scientific and administrative aspects of the safe use of MR.

A1.3 Exposure limits

- RF exposure for most routine clinical scans will fall within an uncontrolled or upper level scanning mode. All scans incurring an experimental mode of exposure (i.e. controlled mode scanning) must have ethical approval from the local institutional ethics committee. Scanning pregnant patients will be considered on a risk/benefit basis.

- Detailed information is available from the MHRA guidelines DB2007. Exposure limits are similar for all clinical MRI units.

A1.4 Emergency Procedures

Emergency procedures will be reviewed and audited at regular intervals (at least annually)

- Cardiac arrest
- Fire
- Magnet quench
- Decreased oxygen level
- Power loss / loss of lighting

The service will comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidelines DB2007 (3) which are applicable to all clinical MRI units.

Appendix 2: CMRI Reference Centres

It is expected that CMRI centres in Wales will become reference centres.

The BSCMR recommends centres aim to become 'reference centres', This is a voluntary process but represents a standard that the NHS has adopted for commissioning purposes. The title of 'reference centre' is attached to a named unit and Director and is recommended within 3 years of an institution commencing scanning. This service is provided by BSCMR as part of their society objectives and is free of charge provided the applicant (unit director) is a society member. It is not meant to be arduous, bureaucratic or restrictive and consists of the following 3 types of information:

1. Written confirmation of appropriate equipment and trained staff.
2. Central (BSCMR/BSCI subcommittee) review of the images of any ten cases submitted from the unit, the cases representing at least five pathologies out of the 14 referenced in SMCR standard
protocols.
3. Central (BSCMR/BSCI subcommittee) review of the reports of the above cases.

It is expected that such centres will have, in addition:

- access to educational material
- journal clubs
- interesting case reviews and
- research opportunities for trainees – although these are not formally assessed as part of accreditation.

Each reference centre will submit an annual return to BSCMR. This return will relate to unit activity, growth, numbers of trainees etc. allowing BSCMR to provide activity statistics to help Department of Health planning and CMR service delivery/commissioning.

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

		Agenda Item	14
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	Development of WHSSC Integrated Commissioning Plan 2018-21		
Author (Job title)	Acting Assistant Director of Planning		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	This paper outlines the Commissioning Intentions that have been drafted to inform the development of the WHSSC three year Integrated Commissioning Plan for Specialised Services 2018-21.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☒

Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Approve** the WHSSC Commissioning Intentions to inform the development of the WHSSC Integrated Commissioning Plan 2018-21.		

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		✓

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

1.0 Situation

The Commissioning Intentions have been drafted to inform the development of the Welsh Health Specialised Services Committee's (WHSSC) three year Integrated Commissioning Plan for Specialised Services 2018-2021. They are intended to be shared with Health Boards and NHS Trusts in Wales in order inform the development of NHS organisation Integrated Plans with regard to the commissioning and delivery of specialised services. It is hoped that through such co-production, the benefits of working in collaboration across the Health community can be fully realised.

2.0 Background

The WHSSC Commissioning Intentions are largely unchanged from previous years.

The significance difference is that the Integrated Risk Management Framework which has been developed to assess, monitor and mitigate the risks identified for each of the schemes, identified within the WHSSC 2017-20 Integrated Commissioning Plan will be used to consider any proposals for inclusion in the 2018-21 Plan. This includes schemes that have been highlighted by Welsh Government as Ministerial priorities.

3.0 Assessment

The Commissioning Intentions have been structured in line with the strategic aim of WHSSC which is:

"on behalf of the seven Health Boards; to ensure equitable access to safe, sustainable and effective specialist services for the people of Wales, as close to patients' home as possible, within available resources".

Safe

- **Quality and Outcomes Framework** - WHSSC will implement the Quality and Outcomes Framework for Specialised Services agreed by Joint Committee supported by the Quality Team which is in the process of being recruited to.

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- **Patient Experience** - Patient experience will be captured using a variety of methods – Audit Days, Patient experience surveys, Stakeholder meetings. This will require close working with Health Boards and Trusts and development of relations with Third Sector and other patient focused organisations.

- **Clinical Risk -** WHSSC will work with Health Boards to review their corporate risk registers in order to develop plans to address any clinical risks that have been identified, both within the services that they provide, or that their resident population access from another provider.

Sustainable

- **Responsive to Government legislation and new developments in Healthcare –** WHSSC will be responsive to legislation such as The Social Services and Wellbeing (Wales) Act 2014 and the Wellbeing Future Generations Act (Wales) 2015 by working with all stakeholders to ensure that each of the five sustainable development principles – long term thinking, prevention, involvement, collaboration and integration, are reflected in all of the services that it commissions on behalf of Health Boards.

  WHSSC will need to be aware and take account of the impact that new developments in the way Healthcare is delivered such as through the introduction of Major Trauma Centres, Units and Networks will have on existing specialised services.

- **Demand and Capacity -** WHSSC will expect Health Boards and Trusts to have appropriate referral pathways in place including primary and secondary care provision, in order to ensure that all referrals into specialised services are managed in accordance with the agreed pathways of care. This will include effective repatriation of non specialist activity to secondary and primary care facilities and working with providers to reduce unnecessary referrals to specialised services through providing pre referral advice and where appropriate, non medical interventions such as physiotherapy as a pre-requisite for listing for surgery.

  Where clinically appropriate and cost effective, WHSSC will work closely with Welsh providers to identify and develop plans for activity that can be repatriated back into Welsh services.

- **Service Risk –** WHSSC will work with Health Boards to develop plans to address risks identified by Health Boards relating to the sustainability of specialized services.

Effective

- **Evidence Based Commissioning -** WHSSC will consider all proposals for new developments on the basis of the available evidence for clinical and cost-effectiveness.

- **Clinical Innovation** - WHSSC will work closely with Welsh and NHS England providers to review the potential for implementing clinical innovation where it is evidence-based and cost-effective.

- **Delivery of Tier 1 Targets –** Most notably in regard to the Referral to Treatment and Cancer Delivery targets, WHSSC will work with providers on plans to meet and sustain the agreed Delivery Measures and National Priorities. This will include implementation of the recently developed Performance Escalation process which has a series of steps to address specialties which are failing to achieve Tier 1 targets whilst underperforming against the contracted baseline.

- **Managing within Resources -** WHSSC has a duty on behalf of NHS Wales to utilise its allocated resources effectively and efficiently and to manage specialised services within the resources agreed by NHS Wales.

  Providers will be expected to ensure that any local cost improvement plans for specialised services are clearly identified, and confirm that plans will have no adverse impact on the quality or performance of the service.

- **Referral Management system –** Implementation of the WHSSC referral system which clearly sets out the WHSSC commissioned services and IPFR/Gate-keeping arrangements for access to treatments which fall outside of the Referral Management system.

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

3.1 Next Steps

If approved at Joint Committee, we will write out to Directors of Planning and Finance to outline our commissioning intentions for 2018-21in order to inform assumptions around Specialised Services for the next three years and set out the specific actions required from Health Boards and Trusts to support the WHSSC team in the development of the Plan.

4.0 Recommendations

Members are asked to:

Approve: the WHSSC Commissioning Intentions to inform the development of the WHSSC Integrated Commissioning Plan 2018-21.

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Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Implementation of the Plan
Link to Integrated Commissioning Plan	These commissioning intentions will inform the development of the Integrated Commissioning Plan for Specialised Services 2018-21.
Health and Care Standards	Dignified Care Effective Care Timely Care
Principles of Prudent Healthcare	Care for Those with the greatest health need first Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Improving Health of Populations Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	This report describes the commissioning intentions which include Quality, Safety and Patient Experience as key intentions.
Resources Implications	There are no known resource implications within the content of this report.
Risk and Assurance	The ICP Risk Management Framework which underpins the commissioning intentions is an assurance mechanism for managing risks.
Evidence Base	Evidence base is a key commissioning intention referenced within this report.
Equality and Diversity	Equality issues will be addressed through the commissioning intentions of providing safe and equitable services.
Population Health	The implications for Population Health are outlined in this report.
Legal Implications	There are no known legal implications within the content of this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Management Group Workshop	07/09/2017	Proceed to Joint Committee

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

		Agenda Item	15
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	Restructuring of staffing models within the Welsh Health Specialised Services Team (WHSST)		
Author (Job title)	Managing Director WHSSC		
Executive Lead (Job title)	Managing Director WHSSC	Public / In Committee	Public

Purpose	The purpose of this paper is to: • inform the Joint Committee of a planned staffing restructure which addresses the recommendations of the Good Governance Institute and Healthcare Inspectorate Wales Reviews through the cost neutral establishment of a Quality Team; • seek approval for future cost neutral staff restructuring within the WHSST.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☒	☐	☐

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	15/08/2016
	Quality and Patient Safety Committee	Meeting Date	30/08/2016
Recommendation(s)	**Members** are asked to: • **Support** the proposed staff restructuring which addresses the recommendations of the Good Governance Institute and Healthcare Inspectorate Wales Reviews through the cost neutral establishment of a Quality Team within the directorate of nursing; • **Approve** future cost neutral staff restructuring without the need to seek approval for specific changes.		

Considerations within the report (tick as appropriate)

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

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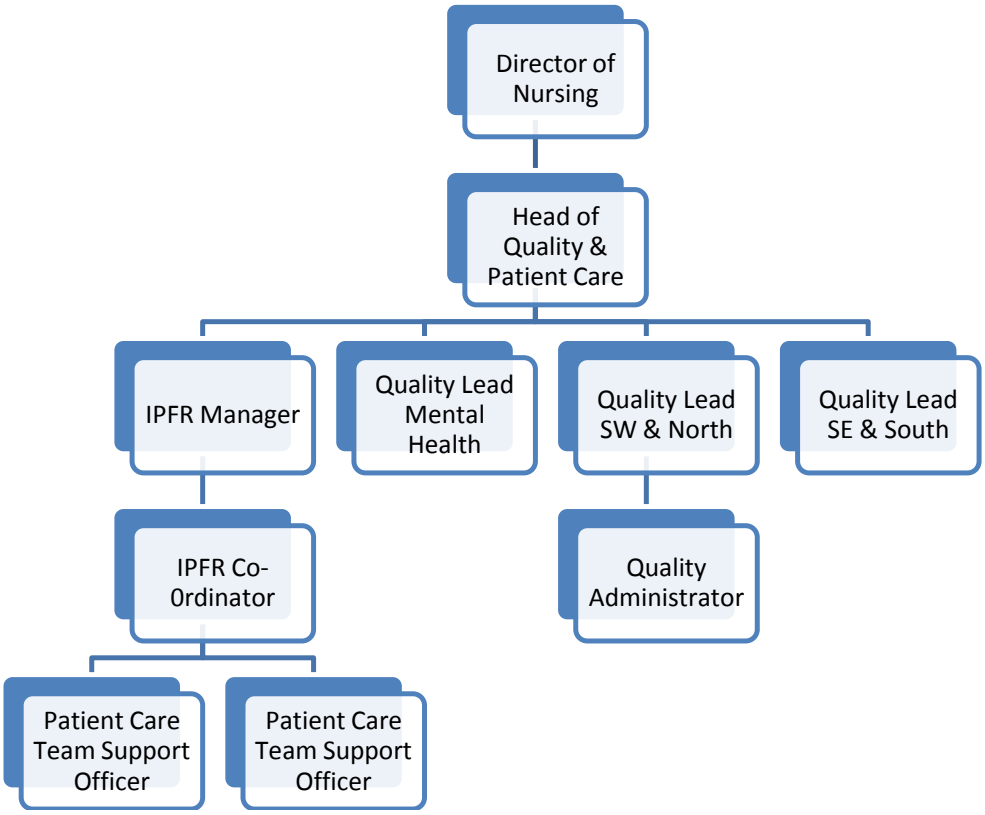
1.0 Situation

1.1 WHSSC Directors, the WHSSC Integrated Governance Committee (IGC) Quality Patient Safety Committee (QPS) and Management Group have approved a new organisational structure to support the WHSSC quality function which will sit in the nursing directorate. The structure requires 3 additional full time band 7 posts as well as informatics support. To date however no funding stream has been identified for this structure. The agreed streamlined quality structure is as follows:



2.0 Background

2.1 The Good Governance Institute Review and Health Inspectorate Wales reviews of WHSSC identified the need to strengthen a, quality team which sits within the nursing directorate of WHSSC. This has been identified in the WHSSC ICPs for the last 2 years however no scheme or alternative funding model has been put forward.

3.0 Assessment

3.1 On- going review of the staffing models within the WHSSC directorates has identified a number of opportunities for restructuring which will either release funds or support quality activities through existing posts.

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3.2 Informatics support:

3.3 The job description of the currently vacant Informatics Manager post (Band 8B) will be redrafted to include a quality function

It is anticipated that the existing Informatics officer posts (Band 4 and Band 5) will have increased capacity when the new finance software is fully implemented. This could be aligned to the quality function

3.4 Quality Manager posts:

A structure which will include 3 new posts at band 7 has been supported by WHSSC IGC and QPS. The following opportunities have been identified for restructuring which will release funding:

1. The appointment of a part time Medical Director and a part time Deputy Medical Director will provide a cost saving compared to the previous salary structure for a single full time Medical Director.

2. The previous arrangement of an SLA with Public Health Wales has been terminated and an appointment process is underway for a part-time associate medical director. This will provide a cost saving.

3. The finance directorate have identified an opportunity to establish an apprenticeship post to replace an existing assistant finance post. This will release funding.

4. The Corporate Directorate and Planning Directorate have both identified opportunities to release administrative posts because of the capacity created by the quality functions of the new team.

5. The organisation has consistently reported an 8% vacancy factor which has been identified as being available for short term funding for new posts.

The spread sheet summarising these cost savings and the cost requirements for the new structure are summarised in appendix A.

4.0 Recommendations

The recommendations made by both the Good Governance Institute (GGI) WHSSC Governance Review (October 2015) and Health Inspectorate Wales (HIW) Clinical Governance Review (December 2015) recommend a strengthened quality structure within the nursing directorate. They emphasise the importance of robust processes and structures to deliver the

quality assurance framework providing assurance of the quality of commissioned services for both the organisation and the Joint Committee.

These reports highlight the relationship of the quality function with effective commissioning and will also increase organisational resilience within the nursing directorate and enhance clinical input at provider level.

This restructuring represents an example of how the existing staffing model within the WHSST can effectively be redesigned in a cost neutral way to deliver the new and evolving priorities of the organisation. It is likely further, similar, opportunities are present within the organisation and the organisation would benefit from the autonomy to pursue these opportunities as needed.

5.0 Members are asked to:

- **Support** the proposed staff restructuring which addresses the recommendations of the Good Governance Institute and Healthcare Inspectorate Wales Reviews through the cost neutral establishment of a Quality Team within the directorate of nursing;

- **Approve** future cost neutral staff restructuring without the need to seek approval for specific changes

6.0 Appendices / Annexes

The spread sheet summarising the cost savings and the cost requirements for the new structure are summarised in appendix A.

Appendix A

DRC resources for Quality team:

	£'000	Equivalent in Band 7 posts (mid point)
Resources released:		
Restructuring of Medical Director's Office	51	
PHW SLA - budget from IPFR as SLA now cancelled	50	
Assistant Medical Director - 2 sessions Public Health consultant	(24)	
Finance - Band 6 Planning Assistant	38	
Finance - less Band 3 cover of Planning Assistant post	(24)	
Corporate - Band 4	26	
Planning - Band 4	26	
Sub-total – Recurrent Funding Released	**143**	
Total - 17/18 Resource for Quality team	**143**	**3.0**

Notes:

Midscale gross costs 1.0wte Band 7 - £47k (Payscale range £39k - £52k)

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance
Link to Integrated Commissioning Plan	Relates directly to recommendations of the Good Governance Institute and Healthcare Inspectorate Wales Reviews and also Section 6 Quality Improvement and Section 8 Finance of the IMTP
Health and Care Standards	Staff and Resourcing Governance, Leadership and Accountability Safe Care
Principles of Prudent Healthcare	Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction)
Organisational Implications	
Quality, Safety & Patient Experience	WHSSC recognises that providing high quality patient centred care is central to the aims of the organisation. Implementation of the framework will strengthen and enhance the patient experience by ensuring that there is a robust process in place for monitoring and improving the quality of the service commissioned.
Resources Implications	Two previous papers submitted to the Joint Committee on 16th November 2015 & 11 January 2016 both highlighted that there would be a resource implication associated with the infrastructure required to deliver the quality agenda. Currently there is no dedicated team within the nursing directorate to support this function.
Risk and Assurance	The quality framework is key to ensuring that safe commissioned services are in place. It strengthens the current systems and hence reduces the risk for both providers and commissioners alike. Its success is however dependant on a quality team to both implement and deliver the components and report its findings into the organisation for assurance purposes.
Evidence Base	WHSSC Quality Assurance Framework Integrated Plan for Commissioning Specialist Services for Wales 2015 – 2018 Good Governance Institute (GGI) WHSSC Governance Review (October 2015) Health Inspectorate Wales (HIW) Clinical Governance Review (December 2015)
Equality and Diversity	The monitoring of agreed standards and the application of a consistent approach will provide equitable access to high

	standards of health care and consistency of agreed reporting for providers
Population Health	Implementation of the Quality Framework will undoubtedly ensure that the aim of WHSSC in providing on behalf of the seven Health Boards equitable access to safe, effective, and sustainable specialist services for the people of Wales.
Legal Implications	There are no legal implications associated with this paper.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	15/08/2016	Supported
Quality Patient Safety Committee	30/08/2016	Supported

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

		Agenda Item	16
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	Governance for Clinical Networks		
Author (Job title)	Committee Secretary		
Executive Lead (Job title)	Committee Secretary	Public / In Committee	Public

Purpose	The recommendations in this paper set out to facilitate regularisation of the governance and accountability arrangements for the two clinical networks that have historically been governed by WHSSC but transferred to the NHS Wales Health Collaborative, hosted by Public Health Wales, on 1 October 2016 and to formalise the ongoing relationship between five clinical networks and WHSSC.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☐	☐	☒

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	18/04/2017
	Integrated Governance Committee	Meeting Date	15/08/2017
Recommendation(s)	Members are asked to: • **Note** the information presented within the report; and • **Approve** the recommendations.		

Considerations within the report (tick as appropriate)

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

1.0 Situation

1.1 Five clinical networks transferred to the NHS Wales Health Collaborative ('the Collaborative'), hosted by Public Health Wales, on 1 October 2016 as part of the implementation of the Review of Clinical Networks ('the Review') previously undertaken by Adam Cairns. No changes were made to the governance arrangements for the clinical networks prior to their transfer. The recomendations in this paper set out to facilitate regularisation of the governance and accountability arrangements for the two clinical networks that have historically been governed by WHSSC but transferred to the Collaborative and to formalise the ongoing relationship between all five clinical networks now managed by the Collaborative and WHSSC.

2.0 Background

2.1 In September 2015, in the spirit of all Wales collaboration, the Public Health Wales Board agreed to act in support of the NHS Wales Chief Executives' recommendation that, in accordance with the findings of the Review, the Collaborative would manage clinical networks (excluding the Welsh Renal Clinical Network) in the future; facilitated by Public Health Wales acting as host and employer of any employees of the Collaborative and the clinical networks.

2.2 The five clinical networks that transferred on 1 October 2016 were:

- Cancer
- CAMHS/ ED
- Cardiac
- Critical Care & Trauma
- Neonatal

2.3 WHSSC established the steering groups for the CAMHS/ ED and Neonatal networks and historically had therefore been responsible for their governance and accountability. Whilst WHSSC had historically received advice from the other three clinical networks listed above it had not been responsible for their governance or accountability arrangements.

2.4 The Collaborative is now 'de facto' managing the five clinical networks.

2.5 WHSSC continues to have an interest in receiving advice and/or services from all five clinical networks.

2.6 Representatives of the Collaborative and WHSSC have informally agreed a way forward, which has been considered by the WHSSC corporate Directors Group and the Integrated Governance Committee and recommended for approval by the Joint Committee.

2.7 The attached Appendices show the current (or inherited) and proposed lines of governance and accountability.

3.0 Assessment

3.1 The Collaborative proposes to approve its own governance and accountability arrangements for the CAMHS/ ED and Neonatal networks steering groups with effect from a date to be determined.

3.2 In recognition of the Collaborative's proposal, it is recommended that the Joint Committee revokes the Terms of Reference for the CAMHS/ ED and Neonatal networks steering groups simultaneous with the Collaborative's action referred to at 3.1 above.

3.3 To protect the interests of WHSSC in receiving advice and/or services from the five clinical networks, it is recommended that a Memorandum of Understanding is agreed between WHSSC and the Collaborative simultaneous with the actions referred to in 3.1 and 3.2 above, setting out the nature of the relationship between WHSSC and the clinical networks that will record the basis on which the clinical networks will continue to provide advice and/or services to WHSSC.

4.0 Recommendations

4.1 Members are asked to:

- **Note** the information presented within the report; and
- **Approve** the recommendations.

5.0 Appendices / Annexes

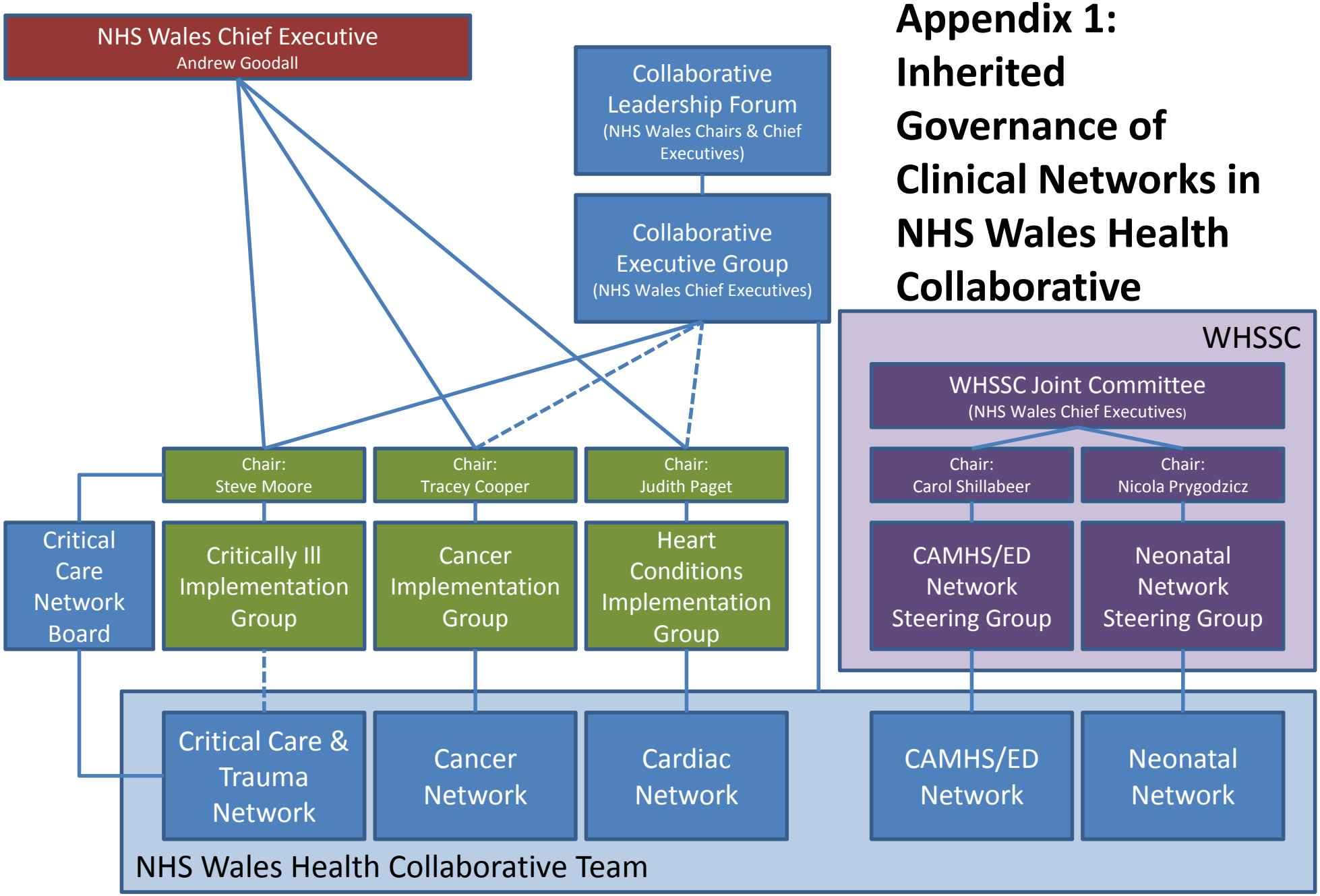
5.1 Appendix 1 – Inherited Governance of Clinical Networks in NHS Wales Health Collaborative.

5.2 Appendix 2 – Proposed Governance of Clinical Networks in NHS Wales Health Collaborative.

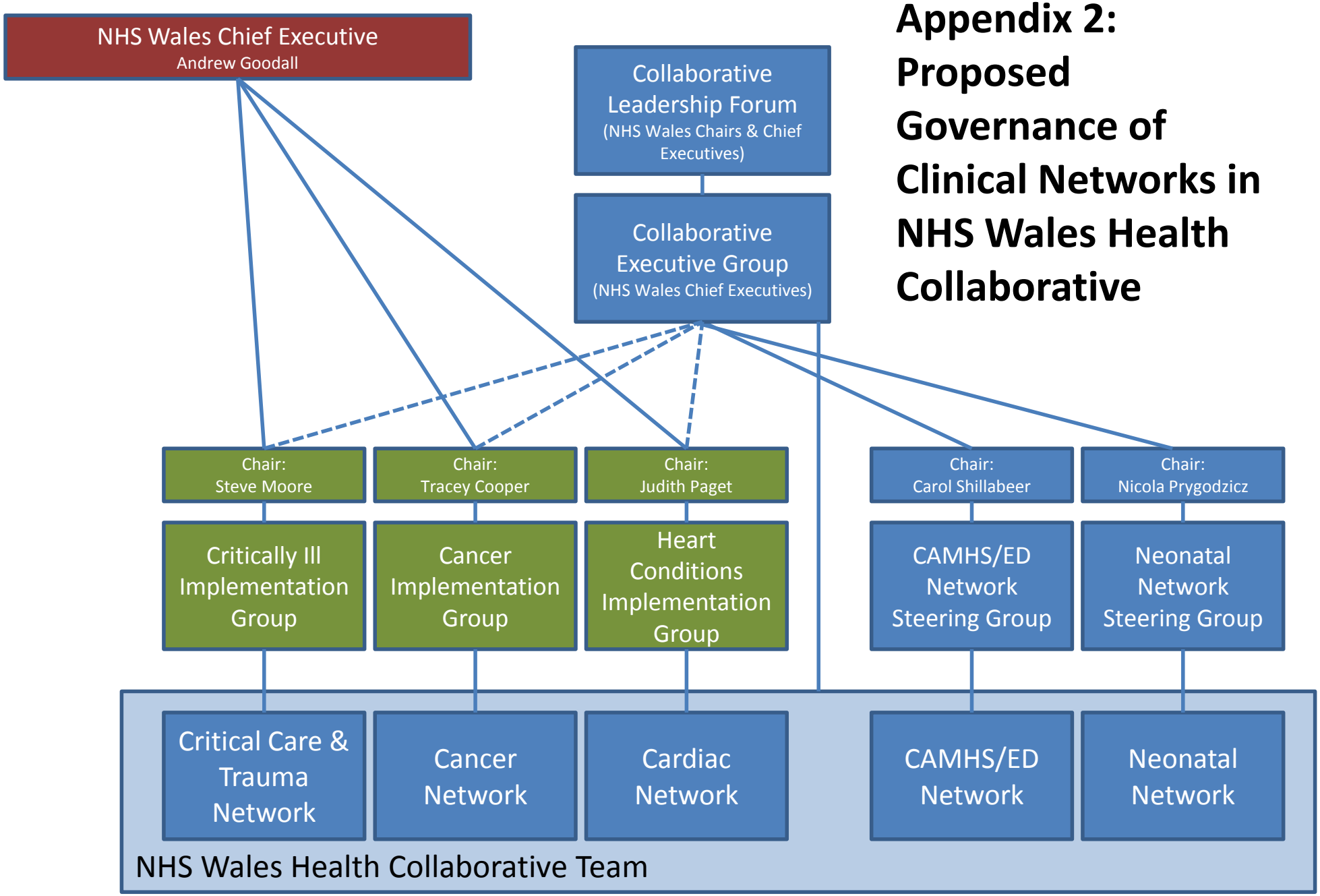
Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance
Link to Integrated Commissioning Plan	Reflecting the transfer of clinical networks to the NHS Wales Health Collaborative
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	Not applicable
Institute for HealthCare Improvement Triple Aim	Not applicable
Organisational Implications	
Quality, Safety & Patient Experience	None
Resources Implications	None
Risk and Assurance	None
Evidence Base	None
Equality and Diversity	None
Population Health	None
Legal Implications	None

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	18/04/2017	Noted and supported
Integrated Governance Committee	15/08/2017	Noted and supported

Appendix 1: Inherited Governance of Clinical Networks in NHS Wales Health Collaborative



Appendix 2: Proposed Governance of Clinical Networks in NHS Wales Health Collaborative



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

		Agenda Item	17
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	ICP Risk Management Framework		
Author (Job title)	Assistant Planning Manager (ADoP Team)		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	The purpose of this report is to: • provide an update on the implementation of the ICP Risk Management Framework; and • to highlight the schemes that require further review, risk mitigation and escalation in line with the requirements of the ICP Risk Management Framework.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☐	☐	☒

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	21/08/2017
	Management Group	Meeting Date	31/08/2017
Recommendation(s)	**Members are asked to:** • **Note** both the 'Extreme' and 'High' risk rated schemes requiring further review, risk mitigation and escalation.		

Considerations within the report (tick as appropriate)

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

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

1.0 Situation

The purpose of this report is to:

- provide an update on the implementation of the ICP Risk Management Framework; and
- to highlight the schemes that require further review, risk mitigation and escalation i.e. schemes with extreme risks scoring 20 or above and those considered high risk because they have scored 16 or above in the risk domains for 'Patient', 'Provider' or 'Commissioner'.

2.0 Background

The ICP Risk Management Framework is a new document for both WHSSC and Management Group. Each of the ICP schemes included in the Risk Management Framework have been considered by Management Group as part of the 2017-20 ICP development process, and through Management Group meetings and workshops.

The Joint Committee approved ICP 2017-20 and Technical Plan have both described the 'ICP Risk Management Framework', with positive feedback being received.

This is the third report submitted to Management Group providing information and progress on the implementation of the ICP Risk Management Framework.

3.0 Assessment

3.1 ICP Risk Management Framework

The ICP Risk Management Framework has been developed to assess, monitor and mitigate risks for schemes within the ICP 2017-20. All schemes that were not approved for inclusion in the ICP 2017-20 have been considered and reviewed using the ICP Risk Management Framework process for schemes in the following categories:

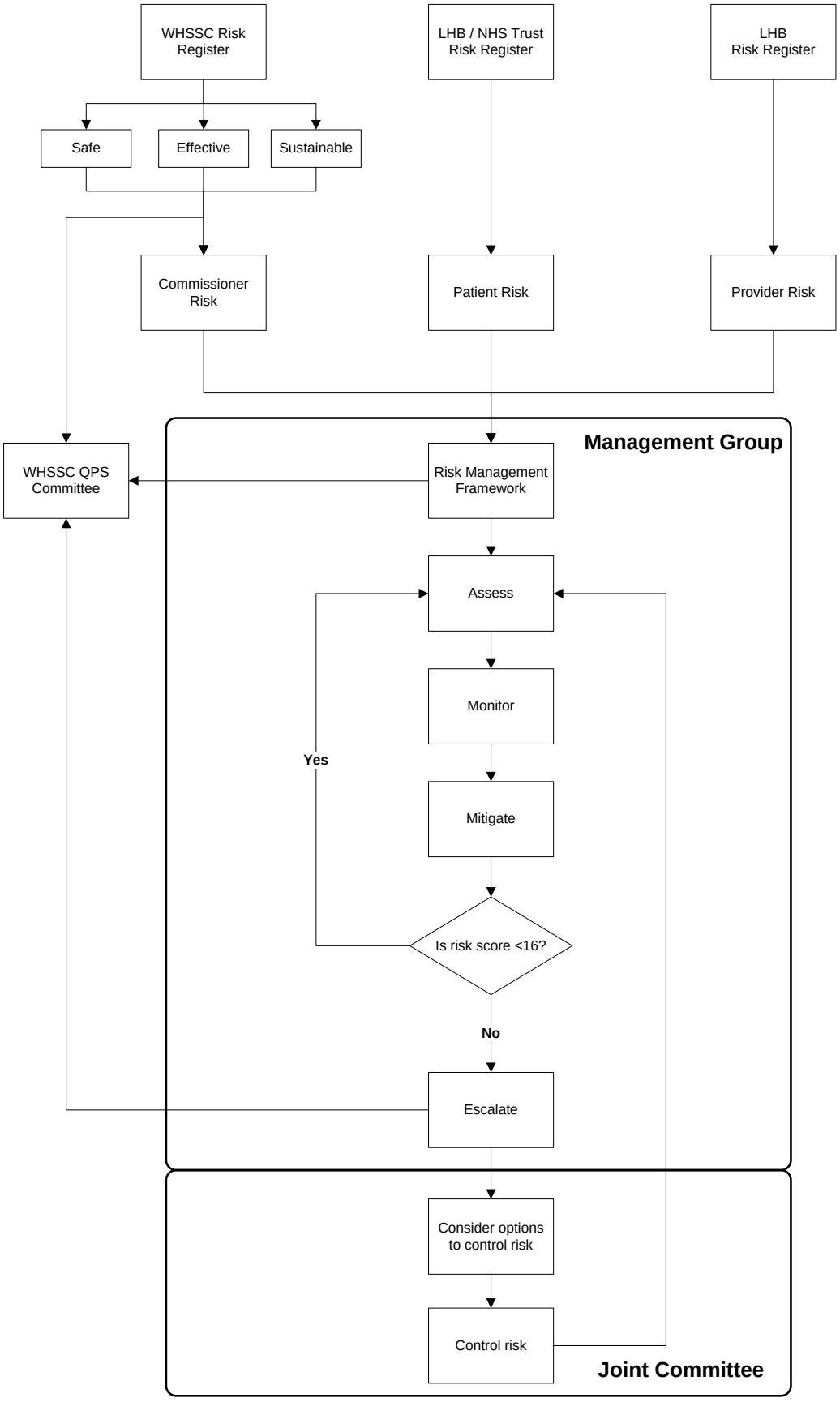
- unfunded schemes;
- schemes within Strategic Reviews; and
- highlighted schemes from the workplan.

The aim of the ICP Risk Management Framework is to utilise existing risk management processes and key sources of information including:

- scheme proposals and business cases;
- information from the Health Board risk registers and risk scores; and
- scheme information reviewed and considered by the WHSSC Clinical Impact Assessment Group (CIAG);

This data, where available to WHSSC, has informed the development of the ICP Risk Management Framework and has been included in the 'Risk Assessment Dashboard' for the three areas of risk assessment domains 'Patient', 'Provider' and 'Commissioner'. The patient, provider and Commissioner risks link respectively with the three domains of the WHSSC aim – Safe, Sustainable and Effective.

Risks for the domains have been scored using a standard impact x likelihood risk assessment methodology, using a 5x5 matrix. Risks scoring 15 or higher will be reviewed by the Management Group on a monthly basis and those scoring less than 15 will be reviewed on a quarterly basis. Where necessary, Management Group will escalate extreme (those scoring 20 and above) and high (those scoring 15-19) risks, which do not respond to mitigation, to the Joint Committee for resolution. The escalation process for managing this risk is outlined in the below diagram.


WHSSC Risk Register
LHB / NHS Trust Risk Register
LHB Risk Register
Safe
Effective
Sustainable
Commissioner Risk
Patient Risk
Provider Risk
Management Group
WHSSC QPS Committee
Risk Management Framework
Assess
Monitor
Yes
Mitigate
Is risk score <16?
No
Escalate
Consider options to control risk
Control risk
Joint Committee

3.2 Risk Assessment Summary

The following schemes scored highly across all of the three domains of risk 'Patient', 'Provider' and 'Commissioner':

ICP Ref	Scheme	Patient	Provider(s)	Commissioner
ICP17-031*	Cardiac Ablation	3 scores of 20	16	20
ICP17-199	Cleft Lip and Palate	1 score of 20	16	20

3.2.1 Cardiac Ablation

Patient risk:
Three of the Health Boards scored the Patient risk as 20 based on the limited access to cardiac ablation services, increased waiting times for patients and poor quality of life whilst waiting for treatment (4) and the Likelihood of the risk occurring as Almost Certain (5).

Provider risk:
One of the Health Board's has scored the risk to the Provider as 16 based on the consequence of not meeting the waiting times targets for patient treatment (4) and the Likelihood of the risk occurring as will probably happen/recur (4).

Commissioner risk:
WHSSC have scored the Commissioner risk of the service as 20 based on the consequence of not funding the service as a Major loss of service to patients (4) and the Likelihood of the risk occurring as Almost Certain (5).

3.2.2 Cleft Lip and Palate

Patient risk:
One of the Health Board's has scored the Patient risk as 20 based on the extremely long waiting list with little prospect of patients having surgery, lack of adult operating time and the lack of available adult beds (4) and the Likelihood of the risk occurring as Almost Certain (5) as the number of years wait for Surgery is clearly evident.

Provider risk:
One of the Health Board's scored the risk to the Provider as 16 based on the consequence of not meeting the waiting times guidance (4) and the Likelihood of the risk occurring as will probably happen/recur (4).

Commissioner risk:
WHSSC have scored the Commissioner risk of the service as 20 based on the consequence of not funding the service as Major loss of service to patients (4) and the Likelihood of the risk occurring as Almost Certain (5).

Overall the total number of schemes that risk scored 20+ (Extreme) and 15+ (High) for each risk domain are as follows:

1. **Patient:**
    - 6 schemes are risk rated as 'Extreme' risk and requiring urgent action;
    - 7 schemes are risk rated as 'High' risk requiring action as soon as possible.
2. **Provider:**
    - 6 schemes are risk rated as 'Extreme' risk and requiring urgent action;
    - 5 schemes risk rated as 'High' risk requiring actions as soon as possible.
3. **Commissioner**:
    - 11 schemes risk rated as 'Extreme' risk requiring urgent action;
    - 4 schemes risk rated as 'High' risk requiring action as soon as possible.

The full details of the risks rating as 'Extreme' and 'High' are outlined in the following Annexes. **Annex 1** includes the ICP Risk Management schedule for 'Patient' risk, **Annex 2** includes the schedule for 'Commissioner' risk, and **Annex 3** includes the schedule for 'Provider' risk.

Further review of the risk rated schemes may be required:

- to ensure that there has not been an over estimate of the potential 'Extreme' risk impact for 'Commissioner' rated schemes because of the increased number of schemes risked rated higher than that for both 'Patient' and 'Provider' risk;

Reports will be drafted for the schemes that scored 15+, and a schedule of these will be produced including a timeline for submission to Management Group meetings for consideration and further escalation to Joint Committee as appropriate.

For the September meetings of Management Group and Joint Committee, Risk Management Framework reports on the Alternative, Augmentative Communication (AAC) Service and the provision of Cardiac Ablation in South Wales have been scheduled for discussion.

3.3 Outcomes of the July Management Group meeting

Information was presented to Management Group members in the workshop in July for the following schemes:

- Minimally invasive mitral valve surgery (for first time surgery);
- Rituximab for immunoglobulin G4 related disease (IgG4-RD).

Members asked for further information on both schemes to be brought to a future meeting to enable them to provide an informed assessment on whether the commissioning of these schemes should be considered and taken forward. However, members advised that were in a position to score the risks to patients based on the information provided, and both were below the risk threshold for further escalation.

4.0 Recommendations

Members are asked to:

- **Note** both the 'Extreme' and 'High' risk rated schemes requiring further review, risk mitigation and escalation.

Summary of the Top 'Patient', 'Provider' and 'Commissioner' Risks

Schemes presented in Table 1 have been ranked in the order of those scoring the highest total for 'Patient' risk for each Health Board (schemes that have scored 16 and above and meet the threshold for reporting and escalation).

Table 1 – Patient Risk for each Health Board

ICP Ref	Scheme	'Patient' Risk Rating Across all Provider Health Boards	Risk(s) Description	Mitigating Action
ICP17-260	Graft versus Host Disease (GvHD) following Haematopoietic Stem Cell Transplantation	5 scores of 20	This treatment is delivered in transplant centres and patients are therefore required to travel. Adding these indications would not alter the current clinical pathway. WHSSC already commissions treatment of chronic GvHD and has developed a policy position to follow the British Society for Blood and Marrow Transplantation (BSBMT) guideline.	Patients will continue to be referred via IPFR. Approximately 6 patients were referred to the WHSSC panel last year. Regardless of whether this scheme is funded in its entirety, the Prioritisation Panel strongly recommended that WHSSC should update CP91 to add liver and pulmonary to the list of sites for treating chronic GvHD with ECP. Further review of this scheme is required and Provider risk assessment information to be submitted to assess the risk fully across the three domains and overall mitigating action to be confirmed.
ICP17-087	Alternative Augmentative Communication (AAC)	4 scores of 20, 2 scores of 16, 1 score of 15 gfgf4 scores of 4 df	• Service users will experience a delay between assessment and issue of equipment. • Cost pressure to Health Boards for both new and maintenance/replacement of equipment.	This issue has been flagged with Welsh Government and a proposal was submitted for inclusion in the 2017-20 ICP. This was not supported by Management Group who felt that this was not an issue for WHSSC. Further review is required and Provider risk assessment information to be submitted to assess the risk fully across the three domains and overall mitigating action to be confirmed.
ICP17-031*	Cardiac Ablation (ABMUHB)	3 scores of 20	Very limited access to ablation services in ABMUHB.	Options for mitigation are limited. WHSSC will continue to keep access rates under review and will report on

				associated risks in line with the framework. Funding is required to address and/or mitigate this risk.
ICP17-032	Cardiac Ablation (C&VUHB)	2 scores of 20, and 2 scores of 16	Very limited access to ablation services in C&VUHB.	Options for mitigation are limited. WHSSC will continue to keep access rates under review and will report on associated risks in line with the framework. Funding is required to address and/or mitigate this risk.
ICP17-	TAVI (Policy)	1 score of 25 and 1 score of 20	Pts in Wales have limited action to TAVI as a treatment option.	Mitigation action would be to update the WHSSC TAVI Policy in line with NICE guidance.
ICP17-199	Cleft Lip and Palate	1 score of 20	Patients who are prioritised as non-urgent will wait in excess of the waiting times guidance.	If this is not funded, the mitigating actions will be for the service to ensure that all patients are appropriately risk assessed and treated accordingly to clinical urgency as well as time waited. Ultimately, however patients will continue to experience very long waiting times for treatment. All patients waiting over 52 weeks are being clinically reviewed by the Clinical Director and to date WHSSC have been informed that the long waits have not had a detrimental effect on any patients.
ICP17-147	Neurosurgery RTT	1 score of 20	Commissioning is inequitable for Neurosurgery services for the population of Wales with far longer waits than the recommended guidance. Some patients waiting in excess of 100 weeks for surgery.	Enhanced performance management of the service is already in place with fortnightly meetings with the service and monthly meetings taking place with the Specialist Services Clinical Board. However, patients continue to experience long waiting times for treatment.
ICP17-180	PET New Indications	4 scores of 16	• Risk of unnecessary procedure or procedure of limited benefit; • Risk of not receiving the most appropriate treatment; • Poorer patient outcomes.	If timely access to PET cannot be provided locally, the site specific MDTs will determine best management on the diagnostic and imaging information available. Further review of this scheme is required and Provider risk assessment information to be submitted to assess the risk fully across the three domains and overall mitigating action to be confirmed.

ICP17-165	Paediatric Critical Care	4 scores of 16	There is a risk to patients of receiving care in an inappropriate environment when PICU do not have capacity to admit. There is also risk associated with the travel requirements when transfer outside Wales is necessary. This also places additional pressure on the retrieval teams reducing their capacity to support other calls.	The retrieval teams are now responsible for identifying an available PICU bed when called to support a transfer, reducing the impact on PICU staff trying to manage this whilst delivering clinical care. Proposal developed for 2017-20 ICP for additional commissioned PICU bed. Further review of this scheme is required and Provider risk assessment information to be submitted to assess the risk fully across the three domains and overall mitigating action to be confirmed.
ICP17-193	Spinal Rehabilitation	3 scores of 16	With one Spinal Rehabilitation Consultant against the recommendation of three Consultants for the size of the Unit, as well as shortfalls in many of the other staffing groups of the MDT, the service is unable to comply with the BSRM standards and has sustainability concerns.	A proposal to address the immediate staffing concerns was submitted for inclusion in the 2017-20 ICP. Similarly to the majority of proposals submitted, funding was not allocated to this proposal and the risk remains. Further review of this scheme is required and Provider risk assessment information to be submitted to assess the risk fully across the three domains and overall mitigating action to be confirmed.
ICP17-148	Neuro-oncology	2 scores of 16	Lack of sustainable Radiological support for diagnosis or staging could result in sub optimum treatment and longer waits for treatment. Lack of post-operative scans which are present in all other Neurosurgical centres could result in patients receiving inadequate surgery and inadequate post operative treatment plans due to the failure to assess surgical effectiveness.	Currently members of the service are carrying out preparation for the MDT outside of their job plan through goodwill. Regular monitoring of cancer waiting times are reported and the Tertiary Centre in Cardiff is undertaking patient surveys so that more qualitative information is available. A proposal to address the staffing shortfalls was submitted for inclusion in the 2017-20 ICP. Similarly to the majority of proposals submitted, funding was not allocated to this proposal and the risk remains. Further review of this scheme is required and Provider risk assessment information to be submitted to assess

				the risk fully across the three domains and overall mitigating action to be confirmed.
ICP17-194	Replacement Wheelchairs Programme	1 score of 16	Patients already with a chair will no longer be able to have it repaired and will have to wait in a basic chair whilst a new chair is modified to their specification. This could lead to patients being socially isolated and at higher risk of pressure sores and hospitalisation.	Proposal to replace the discontinued chairs as part of a three year replacement programme was submitted as part of the 2017-20 ICP and was one of the top priorities of the CIAG. Further review of this scheme is required and Provider risk assessment information to be submitted to assess the risk fully across the three domains and overall mitigating action to be confirmed.
ICP17-191	ALAS – capacity to accommodate War Veterans (BCUHB)	1 score of 16	• The service is unable to meet the key performance indicators due to the impact of the war veteran demands on the existing civilian service. • Inequitable service across Wales.	Staff working overtime in order to cover the shortfalls, this has resulted in a significant overspend. Further review of this scheme is required and Provider risk assessment information to be submitted to assess the risk fully across the three domains and overall mitigating action to be confirmed.
ICP17-132	PET Capacity	1 score of 16	• Risk of delay to treatment leading to poorer patient outcomes (including disease progression affecting treatment choice and outcome; poorer survival); • Failure to achieve PET-CT waiting times target; • Failure to achieve cancer waiting times targets.	If timely access to PET cannot be provided locally, the site specific MDTs will determine best management on the diagnostic and imaging information available. Further review of this scheme is required and Provider risk assessment information to be submitted to assess the risk fully across the three domains and overall mitigating action to be confirmed.

Schemes presented in Table 2 (below) have been ranked in the order of those scoring the highest total for 'Commissioner' risk (schemes that have scored 16 and above and meet the threshold for reporting and escalation). The rationale for including the same schemes as in Table 1 (above) is that the information included for 'Commissioner' risk varies and/or is different to that included in the 'Patient' risk sections.

Table 2 – Provider Risk

ICP Ref	Scheme	Total 'Provider' Risk Rating	Risk(s) Description	Mitigating Action
ICP17-036	Transcatheter aortic valve implantation	1 score of 20 and 1 score of 16	Increased waiting times for patients. Increased number of 36 week breach patients. Potential for reputational damage – increased concerns, possible negative publicity. Increased working times/length of stay for inpatients if procedure is restricted and/or IPFR process reintroduced. Mortality rate @ 50% when patient is waiting 2years+	Funding is required to address and/or mitigate this risk.
ICP17-147	Neurosurgery	20	PERFORMANCE – Failure to deliver tier 1 targets (referral to treatment time). REPUTATIONAL / PATIENT EXPERIENCE – Increase in patient complaints and anxiety as a consequence of not being able to confirm treatment dates for surgery. FINANCIAL – lost income due to non-delivery of contracted activity.	Work with WHSSC to apply the repatriation policy. Proposal on beds to be submitted to WHSSC. Patients admitted for surgery clinically prioritised by consultants. Seeking alternatives to inpatient beds for certain procedures. Maximise use of available theatre lists.
ICP17-193	Spinal Injury Rehabilitation	20	STANDARDS OF CARE - Patients may receive sub-optimal care due to shortfalls against BSRM standards WORKFORCE - single-handed consultant service, one of only 12 centres in the UK. During periods of leave there is no cross-cover in place. Any prolonged absences may require the service to close.	Registrar grade cover is in place. 2 Neuro-rehab consultants provide some medical support.
ICP17-154	Cystic Fibrosis	20	REPUTATIONAL / STANDARDS OF CARE • If there is not expansion of the service to allow for new patients (including transfers from paediatrics service, 15-20 per annum) the service will need to close and new Adult Welsh CF patients will need to receive Specialist CF Care in English CF Centres; • Current waiting list (3-12 patients at any given time waiting up to 2 weeks) for admission will continue to rise, increasing risk further; • CF Trust Peer Review report recommendations not addressed; • Major cross-infection risk remains with shared bathroom	The unit will close to new patients.

			facilities; • National All-Wales Service at UHL is unsustainable for current patient requirements; • Specific risks in MDT staffing groups will present an inability to provide virtual and satellite clinics and further development of specialised services leading to poorer patient outcomes; • On-going reliance on hospital setting if homecare provider for IV administration not implemented putting further pressure on inpatient beds.	
ICP17-165	Paediatric Critical	20	REPUTATION / STANDARDS OF CARE - Clinical risk associated with children transferring out of Wales, associated poor experience for families and children. Currently non compliant with PICU society standards of nurse staffing for PICU beds. FINANCIAL - Cost of Welsh children being admitted to English centres, increased cost of agency nurse cover to create temporary capacity, lost income through LTAs PERFORMANCE - Disruption and cancellations of elective surgical activity and consequences to RTT.	New contract. Ad hoc staffing arrangements in place to enable additional capacity to be opened up as needed. Flexibility to move between HDU and ITU beds is maximised.
ICP17-210	Neonatal Intensive Care	20	REPUTATIONAL / STANDARDS OF CARE - lack of cot capacity results in mothers being transferred out of Cardiff/Wales to deliver with associated clinical, financial and reputational risks; WORKFORCE - the capacity issues have adverse effects on staff with increased level of stress and sickness, impacting ability to recruit Neonatologists.	Full cost per case contract in place. Limit capacity to 28 cots, as per contract, unless case approved through BCAG +/- WHSSC. Request service specification from WHSSC.
ICP17-266	Paediatric Congenital Heart Disease	16	Failure to commission services in line with standards (although not yet adopted in Wales), failure to commission sufficient capacity to meet demand.	Undertake a review of South Wales services and provide resources as appropriate.
ICP17-031*	Cardiac Ablation (ABMUHB)	16	Very limited access to ablation services in ABMUHB. Increased waiting times for patients. Increased number of 36 week breach patients. Potential for reputational damage – increased concerns, possible negative publicity. Poor patient experience and quality of life whilst waiting for treatment i.e. inability to drive, work, obtain holiday insurance etc.	Funding is required to address and/or mitigate this risk.
ICP17-066*	Cleft Lip and Palate	16	Cleft Nurse Specialist Service provision is inadequate. The administrative service is insufficient in supporting the	ABMUHB have confirmed that the only option available to control the risks of this shortfall

			existing service and will be unable to manage growing demands on the service in future.	is dependent on the goodwill of current part-time Cleft Nursing staff to increase hours where they are able to during sickness. However, this does not breach the sickness gap, and does not address the substantive shortfall.
ICP17-199	Cleft Lip and Palate	16	Long waiting adult patients of the Cleft Service – These patients require cleft revisional surgery, e.g. revision of cleft lip, palate, nose including cleft rhinoplasty. As of April 2017, there are currently 67 patients on the above reported waiting list. Every week, patients are being added to this waiting list with little prospect of having surgery. The principal reasons that they are not being treated is the need for surgery in babies, lack of adult operating time and lack of available adult beds.	Monthly list implemented at Singleton Hospital for long waiting patients, currently commissioned by the health board at risk.

Table 3 – Commissioner Risk

ICP Ref	Scheme	Total 'Commissioner' Risk Rating	Risk(s) Description	Mitigating Action
ICP17-031*	Cardiac Ablation (ABMUHB)	20	Very limited access to ablation services in ABMUHB.	Funding is required to address and/or mitigate this risk.
ICP17-032	Cardiac Ablation (C&VUHB)	20	Very limited access to ablation services in C&VUHB.	Funding is required to address and/or mitigate this risk.
ICP17-087	Alternative Augmentative Communication (AAC)	20	Only being able to advise patients on equipment that they may benefit from rather than supply it goes against the policy established for delivering AAC.	Escalated to Welsh Government to advise of non pay funding shortfall.
ICP17-147	Neurosurgery	20	Commissioning inequitable Neurosurgery services for the population of Wales with far longer waits than recommended guidance.	Monthly performance meetings are taking place with C&VUHB to discuss the waiting list position, efficiencies such as theatre utilisation and recovery plans. As one of the main reasons for underperformance is cancellation of elective surgery due to bed unavailability due to lack of flow across the whole Neurosciences pathway, we have changed our rehabilitation policy, to highlight when patients have received their specialised rehabilitation and require repatriation to their LHB.
ICP17-191	Prosthetics	20	The service is unable to meet the key performance indicators due to the impact of the war veteran demands on the existing civilian service. We are commissioning an inequitable service across Wales as Cardiff received funding in 2016/17 to resolve the demands of the war veterans on the civilian service.	A proposal to address the staffing and non pay shortfalls was submitted for inclusion in the 2017-20 ICP. Similarly to the majority of proposals submitted, funding was not allocated to this proposal and the risk remains. Further review of this scheme is required and Provider risk assessment information to be submitted to assess the risk fully across the three domains and overall mitigating action to be confirmed.

ICP17-193	Spinal Injury Rehabilitation	20	The service is unable to comply with the BSRM standards and has sustainability concerns.	A proposal to address the immediate staffing concerns was submitted for inclusion in the 2017-20 ICP. Similarly to the majority of proposals submitted, funding was not allocated to this proposal and the risk remains. Further review of this scheme is required and Provider risk assessment information to be submitted to assess the risk fully across the three domains and overall mitigating action to be confirmed.
ICP17-156	Genetics	20	Not commissioning sufficient testing capacity to meet demand leading to delays	Funding required for sufficient capacity to meet demand. Further review of this scheme is required and Provider risk assessment information to be submitted to assess the risk fully across the three domains and overall mitigating action to be confirmed.
ICP17-199	Cleft Lip and Palate	20	Extremely long waiting times for adult revisional surgery as resources not sufficient to meet demand for new patients and adults requiring revisional surgery.	Provide additional resources for increased operating capacity.
ICP17-202	IVF (deliver and sustain waiting time standards)	20	Not commissioning sufficient capacity to deliver services in line with waiting time standards.	Provide funding for the additional capacity required to sustainably meet waiting time standards.
Review	Paediatric Rheumatology	20	Failure to commission services in line with national standards.	Provide resources to deliver a sustainable South Wales service in line with national standards.
ICP17-001a	Thoracic Surgery	16	High risk in that the commissioned service does not achieve expected levels of access for patients with non cancer conditions; and does not achieve equity in access for non cancer patients across Wales.	The release of funding for the thoracic surgery ICP schemes to increase capacity was confirmed at Management Group in June 2016. ABMUHB and C&VUHB are currently implementing their delivery plans to increase capacity. Bimonthly performance meetings with both south Wales providers have been implemented.

ICP17-154	Cystic Fibrosis	16	Not commissioning sufficient capacity to meet patient need or to deliver services in line with standards.	Resources required to support enhancement of the service as well as additional inpatient beds.
ICP17-165	Paediatric Critical	16	Not commissioning sufficient PICU capacity to meet patient need.	Provide resources for additional PICU capacity. Further review of this scheme is required and Provider risk assessment information to be submitted to assess the risk fully across the three domains and overall mitigating action to be confirmed.
ICP17-266	Paediatric Congenital Heart Disease	16	Failure to commission services in line with standards (although not yet adopted in Wales), failure to commission sufficient capacity to meet demand.	Undertake a review of South Wales services and provide resources as appropriate.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Implementation of the Plan Development of the Plan
Link to Integrated Commissioning Plan	This paper outlines progress made to implement the Risk Framework outlined in the 2017-20 Integrated Commissioning Plan and Technical Plan.
Health and Care Standards	Safe Care Effective Care Governance, Leadership and Accountability
Principles of Prudent Healthcare	Reduce inappropriate variation Care for Those with the greatest health need first Only do what is needed
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	The report outlines how it will address the risks to Patient, Safety and Patient Experience through implementation of the Risk Management Framework.
Resources Implications	There are no resource implications associated with this report.
Risk and Assurance	The ICP Risk Management Framework is an assurance mechanism for managing the risks.
Evidence Base	The paper references the use of Risk Registers from both WHSSC and Health Boards to inform the Risk Framework.
Equality and Diversity	There are no equality and diversity implications associated with this report.
Population Health	There are no additional implications for population health associated with this report.
Legal Implications	There are no legal implications associated with this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	21/08/17	Proceed to Management Group
Management Group	31/08/17	Proceed to Joint Committee

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

		Agenda Item	18
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	Integrated Performance Report – June 2017		
Author (Job title)	Performance Analyst / Assistant Planning Manager		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	The attached report provides members with a summary of the performance of services commissioned by WHSSC for June 2017 and details the action being undertaken to address areas of non-compliance.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☐	☐	☒

Sub Group /Committee	Management Group	Meeting Date	31/08/2017
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** current performance and the action being undertaken to address areas of non-compliance.		

Considerations within the report (tick as appropriate)

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

WHSSC Integrated Performance Report

June 2017

WHSSC

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JUNE 2017 WHSSC PERFORMANCE REPORT

1.0 Situation

The purpose of this report is to provide an overview on the performance of providers for services commissioned by WHSSC for the period June 2017.

2.0 Structure of report

PROVIDER PERFORMANCE

Section 1 Provider Dashboard

The report includes an integrated provider dashboard which provides an assessment of the overall progress trend across each of the four domains, and the areas in which there has been either an improvement in performance, sustained performance or a decline in performance.

The dashboard has the following domains:

- Indicator Reference
- Provider – In section 2 aggregate data is used from all providers, in sections 4 onwards, is the exception report providing further detail on services that are not meeting target
- Measure – the performance measure that the organisation is being assessed against
- Target – the performance target that the organisation must achieve
- Tolerance levels – These range from Red to Green, depending on whether the performance is being achieved, and if not the level of variance between the actual and target performance
- Month Trend Data – this includes an indicator light (in line with the tolerance levels) and the numeric level
- Latest Movement – this shows movement from the previous month

Section 2 Individual Service Sheets

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

3.0 PROVIDER PERFORMANCE

3.1. Section 1 Service Dashboard

Commissioning Team	Specialty	WHSSC Indicator Ref	Measure		Tolerance Levels			Provider	Apr-17	May-17	Jun-17	Latest Status	Latest Trend
					Red	Amber	Green						
Quality	**Serious Incidents**	S01	Qrtly	Number of new Serious Incidents reported to WHSSC by provider within 48hours	<50%	50-99%	100%				30%		
Cardiac	**Cardiac Surgery**	E01	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	96%	94%	94%		
Cancer & Blood	**Thoracic Surgery**	E02	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	96%	96%	99%		
	Lung Cancer	*E02D*	Mthly	Urgent Lung resection < 62 days	<90% within 62 days	90-95% within 62 days	=,>95% within 62 days	All	-	-	-		
		E02E	Mthly	Non-Urgent Lung resection < 31 days	<90% within 31 days	90-95% within 31 days	=,>95% within 31 days	All	-	-	-		
	Bariatric Surgery	E03	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	73%	83%	88%		
	Cancer patients - PET scans	E04	Mthly	Cancer patients to receive a PET scan < 10 days from referral	<90% within 10 days	90-95% within 10 days	=,>95% within 10 days	All	98%	99%	99%		
	Plastic Surgery	E05	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	97%	97%	97%		
Neuro	**Neurosurgery**	E06	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	88%	87%	83%		
	Adult Posture & Mobility	E07	Mthly	RTT < 26 weeks	<85% within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	All	83%	85%	85%		
	Paediatric Posture & Mobility	E08	Mthly	RTT < 26 weeks	<85% within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	All	96%	96%	98%		
Mental Health	**CAMHS**	E09	Mthly	OOA placements	>16	>14, <16	=,<14	All	13	16	17		
		E09i	Mthly	NHS Beddays	<85%,>105%	< 90%, >100%	90% - 100%	All	88%	79%	79%		
		E09ii	Mthly	NHS Home Leave	<20%, >40%	<25%, >35%	25%-35%	All	35%	34%	30%		
	Adult Medium Secure	E10	Mthly	NHS Beddays	<90%, >110%	< 95%, >105%	95% - 105%	All	87%	88%	88%		
Women & Children	**Paediatric Surgery**	E11	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	91%	91%	93%		
	IVF	*E12*	Mthly	IVF patients waiting for OPA	<95% within 26 weeks	95%-99% within 26 weeks	100% within 26 weeks	All	100%	99%	100%		
		E12i	Mthly	IVF patients waiting to commence treatment	<95% within 10 weeks	95%-99% within 10 weeks	100% within 10 weeks	All	40%	39%	41%		
		E12ii	Mthly	IVF patients accepted for 2nd cycle waiting to commence treatment	<95% within 10 weeks	95%-99% within 10 weeks	100% within 10 weeks	All	60%	54%	49%		

3.2 Provider Performance Summary

The trend for performance for all provider services has largely remained unchanged across the first quarter of 2017/2018. Of the 19 service targets that were monitored 12 (71%) remain in breach at quarter end. The most significant movement was seen in the CAMHS Out of Area placements service due to reduced capacity in the Ty Llewellyn unit in North Wales. WHSSC has placed this service, in addition to the Neurosurgery and Paediatric Surgery services, into Level 3 of the escalation process. A review of the service at Ty Llewellyn with BCUHB has now been arranged and Commissioning Quality Visits will take place shortly at CVUHB for review of their Neurosurgery and Paediatric Surgery services.

3.3 Key Issues for June 2017

Cardiac
There continues to be breaches of the 36 weeks maximum waiting times target for cardiac surgery patients at CVUHB, ABMUHB and Liverpool.

Cancer & Blood
Thoracic surgery: Additional capacity is being commissioned from University Hospital North Midlands for thoracic surgery for patients in West Wales to achieve cancer waiting times targets. After a period of delay, the pathway is expected to commence shortly following resolution of I.T. technical difficulties.

Plastic Surgery
Patients continue to breach maximum waiting times for hand and breast surgery at ABMUHB. Pathway workshops are currently in progress with further workshops continuing in September and a summit in November 2017.

Bariatric surgery:
The service specification for bariatric surgery is currently out for consultation. This specification will form the basis of the tender process for the future bariatric surgery service for South Wales.

Neurological & Chronic Conditions

- Neurosurgery: The position in CVUHB continues to deteriorate. Level 3 of the escalation process has been triggered and a Commissioning Quality Visit is in the process of being set up.

- Neuro-Radiology: Due to the continued shortfalls in the Interventional Neuro-Radiology service in CVUHB, emergency patients are being treated on an individual patient basis by specialist centres in NHS England. Elective activity has been sourced from the Walton Centre to help with managing the long waits.

- Posture & Mobility – Adult: Staff shortages continue to impact on waiting times in both CVUHB and BCUHB. A further plan to manage the ongoing

difficulties in recruitment is being discussed at the ALAS Technical Group meeting.

CAMHS
CAMHS Out of Area (OoA) performance has declined significantly over the last 3 months with month on month increase in number of OoA placements. The increase in OoA placements is linked directly to reduced capacity in the North Wales unit due to severe staff shortages.

The issue has been raised with BCUHB and a meeting is being arranged as part of the Level 3 escalation process.

Women & Children
Paediatric Surgery: CVUHB has been advised that due to the continued deteriorating performance in Paediatric Surgery, Level 3 of the escalation process has been triggered and a Commissioning Quality Visit will need to take place.

IVF: A proposal regarding tolerances for the monitoring of IVF waiting times within the performance report was approved by CDG in July 2017. However, when attempting to report against these tolerances it was found that there was no practical way to report against them within the reporting framework. The report requires one fixed waiting time standard, against which a percentage tolerance can be applied for red, amber and green, whereas the original proposal had variable waiting time standards for red, amber and green. A small adjustment has therefore been made to accommodate this and the revised tolerances can be seen in the updated performance report.

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

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Management Group	31/08/2017	Noted

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

19

		Agenda Item	19
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	Financial Performance Report – Month 5 2017/18		
Author (Job title)	Finance Manager – MH, DRC, IPFR & MM		
Executive Lead (Job title)	Director of Finance	Public / In Committee	Public

Purpose	The purpose of this report is to set out the estimated financial position for WHSSC for the 5th month of 2017/18. There is no corrective action required at this point. The financial position is reported against the 2017/18 baselines following provisional approval of the 2017/18 Technical Plan by the Joint Committee in March 2017.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the current financial position and forecast year-end position.		

Considerations within the report (tick as appropriate)

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

1.0 Situation

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

2.0 Background

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

3.0 Assessment

3.1 The financial position reported at Month 5 for WHSSC is an underspend to year-end of £2,082k.

The year-end improvement of £2,284k relates primarily to the initial £2,000k release of Balance Sheet reserves for 2016/17.

3.2 Appendix A contains a full report of the Income and Expenditure values which make up this total, with further detail and explanations.

4.0 Recommendations

4.1 Members of the appropriate Group/Committee are requested to:

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

5.0 Appendices / Annex

5.1 Appendix A – full report of the details behind the reported financial position. This includes:
  - WHSSC Expected Expenditure breakdown across LHB's/budget headings. This reconciles to the total reported to WG.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Development of the Plan
Link to Integrated Commissioning Plan	This document reports on the ongoing financial performance against the agreed IMTP
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	Only do what is needed
Institute for HealthCare Improvement Triple Aim	Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	Not applicable
Resources Implications	This document reports on the ongoing financial performance against the agreed IMTP
Risk and Assurance	This document reports on the ongoing financial performance against the agreed IMTP
Evidence Base	Not applicable
Equality and Diversity	Not applicable
Population Health	Not applicable
Legal Implications	Not applicable

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

19

Finance Performance Report – Month 5

1. Situation / Purpose of Report

The purpose of this report is to set out the estimated financial position for WHSSC for the 5th month of 2017/18 together with any corrective action required.

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

Table 1 - WHSSC / EASC split

	Annual Budget	Budgeted to Date	Actual to Date	Variance to Date	Movement in Var to date	Current EOYF	Movement in EOYF position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
WHSSC	557,321	232,217	233,326	1,109	(412)	(2,082)	(2,284)
Sub-total WHSSC	**557,321**	**232,217**	**233,326**	**1,109**	**(412)**	**(2,082)**	**(2,284)**
WAST	138,962	57,901	57,901	0	0	0	0
EASC team costs	350	146	168	22	19	43	29
QAT team costs	672	280	302	22	19	43	29
Sub-total WAST / EASC / QAT	139,984	58,327	58,371	44	38	85	57
Total as per Risk-share tables	697,304	290,543	291,696	1,153	(374)	(1,997)	(2,227)

Please note that as LHB's cover any WHSSC variances, any over/under spends are adjusted back out to LHB's. Therefore, although this document reports on the effective position to date, this value is actually reported through the LHB monthly positions, and the WHSSC position as reported to WG is a nil variance.

2. Background / Introduction

The financial position is reported against the 2017/18 baselines following provisional approval of the 2017/18 Technical Plan by the Joint Committee in March 2017. The remit of WHSSC is to deliver a plan for Health Boards within an overall financially balanced position. However, the composite individual positions are important and are dealt with in this financial report together with consideration of corrective actions as the need arises.

The overall financial position at Month 5 is an overspend of £1,109k to date, with a forecast year-end underspend of £2,082k.

The majority of NHS England is reported in line with the previous month's activity returns (Month 4). WHSSC continues to commission in line with the contract intentions agreed as part of the IMTP and 2016/17 Pbr rules, and declines payment for activity that is not compliant with the business rules related to out of time activity. WHSSC does not pay CQUIN payments for the majority of the English activity.

The inherent increased demand led-financial risk exposure from contracting with the English system remains but it is planned that this will have been partially mitigated in 2017/18 as financial baselines have been uplifted based on historic activity. Reported variances are currently in line with this intention.

3. Governance & Contracting

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

Distribution of the reported position has been shown using the 2016/17 risk shares based on 2015/16 outturn utilisation, and work is ongoing to move these to the 2016/17 outturn utilisation for Month 4. The Finance Working Group has worked on validating prospective changes to the risk-sharing process, and ongoing updates are be shared with Management Group and Joint Committee regularly. Until there is formal agreement between Health Boards to progress with the new risk sharing process the current system remains in operation.

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

Table 2 - Expenditure variance analysis

Financial Summary (see Risk-sharing tables for further details)	Annual Budget £'000	Budgeted to Date £'000	Actual to Date £'000	Variance to Date £'000	Previous month Var to date £'000	Current EOYF Variance £'000	Previous month EOYF Var £'000
NHS Wales							
Cardiff & Vale University Health Board	187,484	78,118	78,041	(77)	(60)	(480)	(629)
Abertawe Bro Morgannwg University Health Board	95,761	39,901	40,305	405	214	385	312
Cwm Taf University Health Board	7,452	3,105	3,158	53	63	37	49
Aneurin Bevan Health Board	8,833	3,681	3,697	16	4	16	4
Hywel Dda Health Board	1,486	619	781	161	129	161	129
Betsi Cadwaladr University Health Board Provider	38,137	15,891	15,897	7	(11)	18	(22)
Velindre NHS Trust	38,421	16,009	15,924	(85)	(68)	(203)	(203)
Sub-total NHS Wales	**377,575**	**157,323**	**157,803**	**480**	**271**	**(65)**	**(360)**
Non Welsh SLAs	95,774	39,906	43,393	3,487	1,729	1,419	831
IPFR	28,673	11,947	12,040	93	53	772	843
IVF	4,375	1,823	1,990	167	131	(0)	(0)
Mental Health	32,718	13,632	13,061	(571)	(240)	(1,820)	(975)
Renal	5,227	2,178	2,059	(119)	(98)	142	211
Prior Year developments	6,035	2,515	2,659	145	195	275	512
2016/17 Plan Developments	3,395	1,415	1,040	(375)	(361)	(821)	(941)
Direct Running Costs	3,549	1,479	1,281	(198)	(159)	15	79
Reserves Releases 2016/17	0	0	(2,000)	(2,000)	0	(2,000)	0
Total Expenditure	**557,321**	**232,217**	**233,326**	**1,109**	**1,521**	**(2,083)**	**200**

The reported position is based on the following:

- NHS Wales activity – based on Month 4 data or Annual Plan values if deemed to vary from the 2016/17 outturn.
- NHS England activity – Month 4 data in most cases. Most final 2016/17 returns have now been received, and work is ongoing to analyse the final performances against the 2016/17 Balance Sheet Reserves.
- IVF – one NHS Wales contract, with some NHS England activity and IPFR approvals. Except for the NHS Wales contract, the other budget lines have been reported as break-even for year-end pending more activity data.
- IPFR – based on approved Funding Requests; reporting dates based on usual lead times for the various treatments, with unclaimed funding being released after 36 weeks.
- Renal – a variety of bases; please refer to the risk-sharing tab for Renal for more details on the various budgets and providers.
- Mental Health – live patient data as at the end of the month, plus current funding approvals. This excludes High Secure, where the 2 contracts are calculated using previous years occupancy.
- Developments – variety of bases, including agreed phasing of funding. Financial impacts of approved funding releases are currently accounted for in the forecasts.
  ** Please note that Income is collected from LHB's in equal 12ths, therefore there is usually an excess budget in Months 1-11 which relates to Developments funding in future months. To keep the Income and Expenditure position equal, the phasing adjustment is shown on a separate line for transparency and is accrued to date to avoid a technical underspend.

5. Financial position detail - Providers

5.1 NHS Wales – Cardiff & Vale contract:

Various over and underspends from the Month 4 data have been extrapolated to a total Month 5 position of £77k underspent, with a year-end forecast of £480k underspent. These figures include the net effect of the development and savings funding available to the LHB. The position includes the following areas:

- Cardiology – activity remains buoyant in this area (particularly with PCI and ICD procedures) but the overperformance has slowed in month 4 with the overspend now standing at £131k across all 5 sub-headings. This overperformance is a continuing trend (as it was last year) and looks to have reached a sustained level. WHSSC is working with the programme team and the network to assess this area. Please note that budget for 16/17 planned recurrent overperformance has been moved to the Developments area whilst the policy is reviewed. The growth in activity for 17/18 is currently above these levels and the year end forecast is consistent with 16/17 outturn.

- Cardiac Surgery – low activity means the trend of underperformance remains in this area with the YTD underspend across the 3 sub headings

increasing to £188k. Theatre team availability is still an issue and the year end forecast will worsen as AMBU referrals to Cardiff & Vale stopped at month 3. The year end forecast remains constant at £777k underspent.

- TAVI – an underspend of £10k exists for this service. This is a minor movement from last month. We have based our year end forecast on the same patient numbers as were outturned last year and this remains constant at £155k underspent.

- Thoracic Surgery – the YTD position has moved by £40k compared to last months reported position and thus stands at £38k overspent. This is due to data issues meaning that EBVR procedures were incorrectly reported at month 4.

- Neurosurgery – the area has moved to an overperformance of £29k YTD which is a £41k movement compared to last month. This is driven by emergency cases more than offsetting the underperformance in elective cases and the inclusion of an estimate of interventional neuroradiology outsourcing at contract rates. The forecast is based upon the YTD variance.

- Hospital Renal Dialysis – overperformance in this area continues and the YTD figure now stands at £224k. This is due to unfunded cost pressure from 16/17 manifesting itself in this financial year. The result is a current year end forecast of £800k overspent. This will be offset by the planned funding HBs provided for through the IMTP.

- Renal Transplants – WHSSC has looked at the rebasing the activity to 100 procedures per year and this results in a YTD underspend standing at £281k with a year end forecast of £437k underspent. These assumptions will be verified with both the service and the LHB in the coming months.

- Haemophillia – the reported YTD position has moved to an overspend of £157k with the year end forecast matching this figure. The figures in the previous month were an estimate as no data was received from the service and thus the reason for the large monthly swing.

- BMT & Clinical Immunology – these areas are both currently underspent YTD by £172k and £62k respectively. There have been issues in previous months with data being received from the service but assurance has been given that this will be rectified for next months reporting.

- AICU – the YTD overperformance has grown further in this area to £315k as a result of an increase in long stay patients and the inclusion of an estimate of interventional neuroradiology outsourcing at contract rates This has also been reflected in the year end forecast increase to £194k overperformance.

- UK GTN Send Out Tests – overperformance has increased to £41k YTD and due to this continued trend of overperformance, we have felt it prudent to extrapolate this to a year end forecast overspend of £98k.

- Cystic Fibrosis – the YTD position has moved by £27k and the overperformance now stands at £64k. Activity is rising above baseline and the cost of new therapies are also growing so we have taken the prudent view and increased the year end forecast to £155k overspent.

5.2 NHS Wales – ABM contract:
Various over and underspends from the Month 4 data have been extrapolated to a month 5 position of £405k overspent, with a year-end forecast of £385k overspent. These figures include the net effect of the development and savings funding available to the LHB. The position includes:

- Renal – a YTD position of £101k overspent exists in this area which is driven by overperformance in hospital renal dialysis which will continue throughout the year giving rise to a forecast year end overspend of £277k.

- Cardiac Surgery – the YTD underspend has increased to £310k driven by scrub nurse availability which will remain an issue though the first half of this year but as ABMU are no longer referring patients to Cardiff & Vale, WHSSC expects activity to increase throughout the remainder of the year.

- TAVI – activity increase in month has resulted in the YTD overperformance increasing to £52k. The LHB has reduced the TAVI procedure forecast this month due to the mandate on prior approval for the procedure. This now stands at 50 procedures for the year.

- Cardiology – the position remains largely static with a year end forecast remaining at £155k over budget and is in line with 16/17 outturn. Please note consistent with other providers the recurrent 16/17 overperformance budget for Cardiology is now reported through the Developments area whilst the policy is reviewed. The current position remains excess of these provisions and has grown in month due to an increase in ICD implants in July.

- Plastics – the overperformance in this area has not dropped as expected and currently stands at £118k YTD and thus we have taken the prudent position of moving the year end forecast back to baseline.

- Burns – the YTD position has increased by £116k to an overspend of £212k which is driven by the discharge of 1 long stay patient (177 days). Year end forecast has been increased to £100k as a result of this.

- Sarcoma – the YTD underspend has increased to £98k which is as expected mostly as a result of the Cardiff and Vale service closure. Due to this increased underperformance, the year end forecast has been moved to £150k underspent but will need to be monitored as we may also see some activity come via UH Birmingham.

5.3 NHS Wales – BCU contract:
Very little movement in the BCU position at month 5. All extrapolations were based on month 3 data. The new high cost haemophilia patient has now made a full recovery and has ceased treatment and thus the full year forecast of £150k seems prudent. WHSSC are awaiting final cost details.

5.4 NHS Wales – Cwm Taf contract:
The YTD position for Cwm Taf stands at £53k overspent, a slight decrease from last month. The main drivers for this are £25k in CAMHS as a result of additional admissions above the stated baseline and £22k for NICU based on month 4 data extrapolated for month 5.

5.5 NHS Wales – Aneurin Bevan contract:
No material variances to report at this point in the year.

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

5.7 NHS Wales – Velindre contract:
The Velindre contract is forecasting £203k under performance, this is based on early year forecast that Melanoma drugs expenditure will be significantly lower than Plan provision. However this offset by forecast over spend on non melanoma drugs and the main LTA performance.

5.8 NHS England contracts:
Total £3,487k overspend to month 5, which is a deterioration of £1,759k from Month 4. The English position has been reported using Month 4 monitoring returns in most cases. The activity included in the monitoring returns received from English providers is costed using the new HRG4+ prices which will be included in the to date position.

The year-end forecast position this month includes a partial adjustment for HRG 4+ as a result of some positive conversations with NHS Improvements. Whilst the full impact of this is unknown and details need to be finalised, WHSSC has been

able to estimate the full potential price increase Welsh Commissioners would be exposed to. In effect, where contracts in England are subject to a price impact and the contract is over-performing, the forecast has been reduced by 5/12ths of the impact reducing the over-performing contract to activity based positions. Where a contract is underperforming, no adjustments have been made of price increases so the position remains partially prudent.

Final 16/17 positions will be reconciled within the Balance Sheet in 17/18.

The larger variances include:

- Alder Hey Children's:
  Core contract – overspend of £534k to date is only partly due to tariff; majority of cost is driven by two high cost Respiratory ECMO's including associated costs of £135k, a paediatric Nephrology patient of £128k, and long stay PICU/NICU/Critical care bed days for a small cohort of patients.

- Birmingham Childrens – overspend of £265k across various smaller costs.

- Imperial – overspend to date of £324k is mainly due to a few high-cost patients, not overall tariff costs.

- Liverpool Heart & Chest – overspend to date of £837k. Overperformance is a combination of mainly HRG 4+ tariff, but with increased activity in Month 4.

- Royal Brompton - the reported over performance of 436k to date solely relates to Non PBR activity. We have currently spent £1.2 million on non Pbr activity to date compared to £681k in 2016/17. (Difference 519k). 2017/18 has saw 3 heart transplants and 5 lung transplants in the first 4 months compared to 0 in 2016/17. The procedure cost total 251k on its own with Critical care costs a further 102k higher in 2017/18.

  The transplant waiting list currently shows 14 patients on the list for Harefield which may or may not happen this year. This could cause further financial pressures on this contract.

  The PBR element of this contract is lower in 17/18 than in 16/17 with less than 200k spent to date compared to £285k in 16/17. This is due to no cardiac surgery happening as yet in 17/18. This is an area of concern as there may be a backlog, and a significant amount of procedures maybe undertaken over the next couple of months. (Further information to be requested from provider) With the higher tariffs around cardiac surgery it would increase the over performance on the contract further.

- University Hospital Bristol - the reported over performance of 610k to date relates to an increase in PBR activity and an increase in the level of the tariff price.

The PBR element of the contract was 1.25 million in 16/17 to month 4 compared to 1.95Million in 2017/18, an increase in performance of £700k year to year. The main area seems to be around congenital heart surgery. In 16/17 expenditure was around 565k compared to £1.56m in 17/18. The overspend to date is split between an increase in price approx 300k and increase in activity 300k price. (Further information from provider to be requested around the planned procedures to see if activity tails off)

- Walton Centre – overspend to date of £758k. Activity to M4 includes 3 new patients on MS drug –Alemtuzumab at £110k. The remaining overperformance appears to be tariff driven.

Detailed explanations and trends on all the English providers are noted on the appropriate tab of the financial Risk-sharing tables sent to all LHB's on the 3rd working day; please see them for any further details. Triangulation of alternative methods of forecasting informs the degree of risk at any time and are reviewed each month.

5.9 IPFR:
Various budgets totalling an overspend to year-end of £772k. The improvement of £71k relates to all the various budgets with no material movements. Please note that all forecasts are extrapolated from the to-date positions except the VAD and ECMO lines, where the underspend to date has been lower compared to 2016/17. As lower activity in the first few weeks of the year does not indicate this will continue for this small patient cohort, the assumption is that future months will mirror last year.

5.10 IVF:
An overspend of £167k has been reported against English and private providers, but break-even for year-end as activity is expected to the planned level for the year.

There is no variance against the IVF element of the ABM contract.

5.11 Mental Health:
Various budgets totalling an underspend to date of £571k and a year-end forecast underspend of £1,820k. The year-end forecast improved by £845k this month, mainly in relation to reduction in Medium Secure OOA patients by the end of August with several discharges. This is a positive effect of the £500k invested in the two Case Management team, and illustrates effective investment for both financial and quality reasons.

The MH budgets include:

- The High Secure contract with Ashworth has been finalised for 2017/18 as £10,656k, against the Annual Plan budget of £10,767k, leading to a small

underspend for the year. The current Rampton proposals are also creating a forecast underspend against the budget; this may increase depending on discussions regarding one DSPD patient.

- Medium Secure has an underspend reported of £552k to date, based on current and expected patients. This area received growth funding in the Annual Plan and is currently expected to have a year-end underspend of £1,686k due to several discharges so far this year.

  The new Case Management teams funded in 2016/17 are now progressing through their recruitment, and it was expected that the increased clinical support in this area would reduce patient numbers going forward as staff come into post. The investment of £500k has been more than saved in Medium Secure costs, with the added positive factor of patients receiving appropriate care.

- South Wales CAMHS and All-Wales FACTS inpatient budgets have continued low activity and currently have a combined underspend of £204k to date and £458k year-end.

- BCU CAMHS inpatient budget has an unexpected overspend of £440k to Month 5 due to high occupancy since April, but the additional patients over previous levels has now reduced back down to 3. The current year-end position of £706k overspent no longer contains any assumptions of further discharges, unlike previous months, and is now based on all the actual patients in placements.

5.12 Renal:

Regarding the devolved renal funding held by the WRCN, cross border services provided by NHS England continue to be lower than expected. Renal transplant services provided by the Royal Liverpool and Broadgreen Trust have not continued at the same high levels that they achieved in 16/17. This is a factor of availability of suitable organs and donor matching. At the moment, they have a clear service delivery plan in place and continue to predict activity increases for the latter half of the year. As previously reported, 3 renal transplants have been undertaken by University Hospitals Birmingham for Welsh residents, this is an unprecedented level for this provider at this stage in the financial year and should not be expected to continue at that pace. Meanwhile, cross border dialysis services are broadly balancing out across providers.

The WRCN is taking on board activity and cost pressures experienced by ABMU relating to the West Wales dialysis units. Activity for the first quarter of the financial year continues to increase and ABMU have been asked to undertake further validation of their activity data to ensure the accuracy of the reported position. Dialysis activity in the Cardiff and Vale units remains within expected levels, however, as with the Liverpool service, the number of transplants undertaken by the Cardiff transplant team since April is lower than predicted.

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

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

No release has been made from accruals relating to NHS England at this point, as some final payments are yet to be made and the current year position regarding HRG 4+ is volatile. Further work will be concluded regarding these accruals shortly.

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

There is an improvement in the forecast due to decreased radio labelled therapy activity and cost in the Royal Free for Neuroendocrine Tumour patients. The £347k forecast overspend is an extrapolation of number of cycles undertaken in the first quarter and is under review.

The assumptions in the performance provision have been maintained in the month 5 position, with planned performance spend offsetting LTA reported expenditure.

Of the new 2017/18 developments work is currently ongoing to correlate planned genetics scheme spend with funding from the genomic strategy. The £800k provision for dialysis growth has been reported as a full underspend offsetting the growth reported within the provider LTA lines.

5.15 Direct Running Costs (Staffing and non-pay):
The running cost budget is currently £198k underspent. This is due to the significant staffing vacancies the organisation is currently running with; some should be appointed to shortly and there is some minimal Agency spend in the meantime.

Non-pay overspends include the Cwm Taf hosting fee. Netting off the non-pay forecast overspend with the staffing forecast underspend gives a current year-end forecast of £15k overspent.

Please note that the lease on the current Caerphilly office expires in March 2018, and new premises are being sourced. A provision for Dilapidations was entered in the 2016/17 Annual Accounts for £96k.

6. Financial position detail – by Commissioners

The financial arrangements for WHSSC do not allow WHSSC to either over or underspend, and thus any variance is distributed to LHB's based on a clearly defined risk sharing mechanism. The following table provides details of how the current variance is allocated and how the movements from last month impact on LHB's.

Table 3 – Year to Date position by LHB

	Allocation of Variance							
	Total	Cardiff and Vale	ABM	Cwm Taf	Aneurin Bevan	Hywel Dda	Powys	Betsi Cadwaladr
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Variance M5	1,109	(57)	20	111	(789)	124	130	1,570
Variance M4	1,521	(5)	59	157	(67)	109	(78)	1,347
Movement	(411)	(52)	(38)	(46)	(722)	16	208	223

Table 4 – End of Year Forecast by LHB

	Allocation of Variance							
	Total	Cardiff and Vale	ABM	Cwm Taf	Aneurin Bevan	Hywel Dda	Powys	Betsi Cadwaladr
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
EOY forecast M5	(2,082)	(503)	(591)	(172)	(1,166)	12	15	322
EOY forecast M4	200	(250)	(314)	6	(244)	150	(41)	892
EOY movement	(2,282)	(253)	(278)	(177)	(922)	(138)	56	(570)

Please note that as the risk-sharing is still based on last year-end shares, some of these positions may move once that is updated for the new year. Any movements will be reconciled.

Material reporting positions or movements include:

6.1 Cardiff & Vale LHB:

- IPFR - £42k year-end deterioration, mainly due to ALAS (War vets) spend in Month 5.
- NHS England - £216k to date and £128k year-end forecast overspends across various providers, mainly Royal Brompton and University Hospitals Birmingham.
- Mental Health - £54k to date and £144k year-end forecast underspends, primarily due to reduction in Medium Secure patient through Case Management.

- Release of 2016/17 Balance Sheet accruals of £257k.

6.2 ABM LHB:

- NHS England - £158k to date and £43k year-end forecast overspends across various providers, mainly Royal Brompton and University Hospitals Bristol.
- Mental Health - £75k to date and £174k year-end forecast underspends, primarily due to reduction in Medium Secure patient through Case Management.
- Release of 2016/17 Balance Sheet accruals of £193k.

6.3 Cwm Taf LHB:

- NHS England - £121k to date and £62k year-end forecast overspends across various providers, mainly Royal Brompton and University Hospitals Bristol.
- Mental Health - £41k to date and £80k year-end forecast underspends, primarily due to reduction in Medium Secure patient through Case Management.
- Release of 2016/17 Balance Sheet accruals of £92k.

6.4 Aneurin Bevan LHB:

- Cardiff & Vale contract – total deterioration of £47k to date and £85k year-end across various headings.
- NHS England - £139k to date and £12k year-end forecast overspends across various providers, mainly Royal Brompton and University Hospitals Birmingham and Bristol.
- Mental Health - £52k to date and £108k year-end forecast underspends, primarily due to reduction in Medium Secure patient through Case Management.
- Release of 2016/17 Balance Sheet accruals of £872k.

6.5 Hywel Dda LHB:

- ABM contract – various areas totalling overspends of £76k to date and £32k year-end.
- NHS England - £111k to date and £59k year-end forecast overspends across various providers, mainly Royal Brompton and University Hospitals Birmingham and Bristol.
- Mental Health - £56k to date and £107k year-end forecast underspends, primarily due to reduction in CAMHS and MH Deaf patient levels.
- Release of 2016/17 Balance Sheet accruals of £115k.

6.6 Powys LHB:

- NHS England - £300k to date and £180k year-end forecast overspends across various providers, mainly University Hospitals Birmingham and North Staffordshire.
- Release of 2016/17 Balance Sheet accruals of £80k.

6.7 BCU LHB:

- NHS England - £715k deterioration to date and £103k year-end deterioration across various providers. The largest movements include:
  - Alderhey - £54k to date and £60k year-end overspends
  - Liverpool Heart & Chest - £522k to date overspend
  - Walton - £202k to date and £125k year-end overspends
    Please refer to the risk-share tables to see further details of the NHS England position to Month 5.
- Mental Health - £40k to date and £199k year-end forecast underspends, primarily due to reduction in Medium Secure patient through Case Management.
- Release of 2016/17 Balance Sheet accruals of £392k.

7. Income / Expenditure Assumptions

7.1 Income from LHB's

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

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

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

	2017/18 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	Other sundry Income (invoiced) £'000	EOY total expected income £'000
ABM	117,532	48,972	48,972	0	0	48,972	(574)	0	116,958
Aneurin Bevan	129,819	54,091	54,110	0	(19)	54,091	(1,152)	0	128,666
Betsi Cadwaladr	158,031	65,846	65,847	0	0	65,847	339	0	158,370
Cardiff and Vale	115,629	48,179	48,179	0	0	48,179	(488)	0	115,141
Cwm Taf	64,171	26,738	26,738	0	0	26,738	(163)	19	64,028
Hywel Dda	79,572	33,155	33,155	0	0	33,155	20	0	79,592
Powys	32,550	13,562	13,562	0	0	13,562	22	0	32,571
Public Health Wales						0			0
Velindre						0			0
WAST						0			0
Total	**697,304**	**290,543**	**290,562**	**0**	**(19)**	**290,543**	**(1,997)**	**19**	**695,326**

An additional column relating to Other Sundry Income has been shown to reconcile the total anticipated Income as per the I&E expectations submitted to WG as part of the monthly Monitoring Returns Ie. Both risk-shared Commissioner Income plus sundry non-recurring income through invoices. This should help reconciliation between WHSSC and other organisations' I&E tables, and expedite clarifying any differences, as per WG requests. Please note that secondment income is netted against the payroll spend and is therefore included in our Expenditure figures.

Sundry invoices raised:
Cwm Taf - £19,152 relating to EASC Chair WG Allocation 17/18
Please note that Mental Health DTOC invoices for 17/18 to date will be processed shortly

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

7.2 Expenditure with LHB's

A full breakdown of the expected expenditure across LHB's and budget headings is included as Annex A. These figures are also reported in the I&E expectations submitted to WG as part of the monthly Monitoring Returns. This Annex should help reconciliation between WHSSC and other organisations' I&E tables, and expedite clarifying any differences, as per WG requests.

8. Overview of Key Risks / Opportunities

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

- Phasing of Development funding as projects start; possible slippage in start dates may lead to non-recurrent in-year savings.
- Growth in all activity above that projected in the IMTP.
- Lack of investment in unfunded schemes which may incur costs anyway (figures quoted are extracted from Plan document tables 9d-f):
  Prioritisation New Technology interventions - £250k
  Cardiac ablation for AF and VT - £556k
  Posture & Mobility – replacement of wheelchairs - £400k
  PET policy – new indications growth & target access rates - £486k
  Cochlear & BAHA's - £405k
  Implement Thoracic Commissioning Plans - £353k
  Renal Replacement Therapy Demand provision - £370k
  BCU ALAS – Capacity for war veterans - £72k
  Additional PICU capacity - £275k
  Neurosurgery RTT clear backlog - £375k
  IVF sustain RTT - £300k

Neuro-oncology - £240k
Remaining schemes not included as classified as Amber schemes; above schemes are classified as Red schemes.

The additional risks and opportunities highlighted are:

- HRG4+ - as reported in the IMTP the most significant financial risk is the net additional risk of the prices increases associated with HRG4+. The cost has been calculated as high as £5.695m as detailed in the attached Appendix A. This also shows the translation of that risk into Health Boards. This remains an estimated liability as not all English Trusts have provided the requested price comparison and it not yet possible to replicate English pricing systems to enable local calculation. In partnership with Health Boards and Welsh Government, WHSSC is in discussion with NHS England, NHS Improvement and NHS Trusts to resolve the issue of this unfunded change in the pricing system. It remains the formal Welsh position that the move to paying HRG4+ will not be agreed unless and until there is an appropriate allocation transfer to Wales to enable payment. There has been some initial progress in these discussion with NHS Improvement but a next meeting of all parties is still awaited. The impact of HRG4+ is not currently reported in the outturn forecast as agreed in the July Joint Committee pending further consideration at the September Joint Committee. It is difficult to allocate in year performance variances between real terms volume movements and price movements but WHSSC has attempted to do this based on estimates of pricing impacts compared to overall performance in order to provide for volume. WHSSC has been sharing with Health Boards these additional calculations as part of the monthly financial information set. Outside of specialised services the impact on health boards is reported as broadly neutral with the exception of Powys (estimated up to circa £0.75m) where there is an adverse impact owing to the scale of its cross border activities.
- Wales OPCS codes to be regrouped; there is the risk of costs being grouped into higher levels than previously.
- Reserves releases – there may be opportunities to write back additional NHS England accruals from 2016/17

All these headings have been entered in Table G of the MMR tables, but with nil "Most Likely" values given that this is the early part of the year, and most contract monitoring has only been received to the Month 3 level at this point.

9. Public Sector Payment Compliance

The WHSSC payment compliance target is consolidated and reported through the Cwm Taf monitoring process.

10. Responses to Action Notes from WG MMR responses

Action Point 4.1 – The I&E variances with Cardiff & Vale have been discussed and reconciled

Action Point 4.2 – No action necessary as the invoice was paid as reported in the M4 MMR returns

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

Stuart Davies,
Acting Managing, WHSSC

Stacey Taylor,
Deputy Director of Finance, WHSSC

Annex A - 2017/18 Expected Expenditure

	2017/18 Baseline contract	2017/18 Contract EOYF variance	IPFR	IVF	Mental Health	Renal	Develo-pments & Reserves	WHSSC/ EASC/QAT Running Costs (includes Secondment income)	2017/18 Sub-Total Other Spend	2017/18 Total expected spend
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ABM	95,761	385	1,327	2,940	333	676	601	2	6,264	102,025
Aneurin Bevan	8,833	16	21			142		(131)	48	8,881
Betsi Cadwaladr	38,137	18	1,381		168	681	0	(55)	2,192	40,330
Cardiff and Vale	187,484	(480)	7,593			1,407	5,187	55	13,761	201,245
Cwm Taf	7,452	37	0			0		484	521	7,973
Hywel Dda	1,486	161	30			555		0	747	2,232
Powys			0			0		0	0	0
Public Health			0			0		(77)	(77)	(77)
Velindre	38,421	(203)	195			105	714	(103)	707	39,127
WAST (managed by EASC)	139,480	0	0			60		0	60	139,540
Total	**517,054**	**(65)**	**10,542**	**2,940**	**500**	**3,625**	**6,501**	**179**	**24,222**	**541,276**

APPENDIX A – HRG4+ IMPACT ASSESSMENT FULL YEAR ESTIMATE

PROVIDER	Difference	Difference % based on Total Available to Agree (Column K)	Risk-sharing % as per July 2017 reports								Difference shared out using July 2017 risk-sharing £k							
			C&V	ABM	CT	AB	HD	Po	BC	Total	C&V	ABM	CT	AB	HD	Po	BC	Total
Alder Hey Children's NHS Foundation Trust	-69.469	-1%	0.18%	0.00%	0.00%	0.01%	0.17%	2.20%	97.43%	100%	-0.126	-0.003	-	-0.008	-0.117	-1.530	-67.685	-69.469
Birmingham Children's Hospital NHS Foundation Trust	56.000	3%	18.76%	4.16%	1.61%	21.94%	2.44%	43.63%	7.46%	100%	10.505	2.330	0.900	12.286	1.368	24.432	4.179	56
Birmingham Women's NHS Foundation Trust	-	#DIV/0!	6.35%	0.88%	1.98%	7.43%	2.69%	65.70%	14.99%	100%	-	-	-	-	-	-	-	0
Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's)	-20.416	-2%	30.28%	13.39%	1.63%	3.35%	8.99%	11.57%	30.79%	100%	-6.182	-2.734	-0.334	-0.684	-1.835	-2.361	-6.287	-20.416
Central Manchester University Hospitals NHS Foundation Trust	-20.845	-1%	0.92%	5.11%	0.11%	1.62%	2.44%	2.31%	87.50%	100%	-0.193	-1.066	-0.022	-0.337	-0.508	-0.481	-18.239	-20.845
(The) Christie NHS Foundation Trust	144.000	4%	0.04%	0.27%	0.13%	0.04%	1.11%	2.33%	96.09%	100%	0.056	0.394	0.181	0.052	1.592	3.362	138.364	144
DDRC	-	0%	30.06%	11.77%	29.18%	28.98%	0.00%	0.00%	0.00%	100%	-	-	-	-	-	-	-	0
Great Ormond Street Hospital for Children NHS Foundation Trust	-17.000	-1%	17.81%	21.82%	5.53%	11.82%	9.69%	1.75%	31.58%	100%	-3.028	-3.710	-0.940	-2.010	-1.648	-0.297	-5.368	-17
Guy's and St Thomas' NHS Foundation Trust	97.291	9%	21.73%	12.65%	20.04%	9.21%	12.39%	5.05%	18.93%	100%	21.146	12.308	19.494	8.963	12.053	4.914	18.414	97.291
Heart of England NHS Foundation Trust	-12.710	-4%	4.60%	6.38%	0.73%	3.30%	7.90%	63.39%	13.70%	100%	-0.584	-0.811	-0.093	-0.419	-1.004	-8.057	-1.741	-12.71
Imperial College Healthcare NHS Trust	25.102	1%	27.50%	26.14%	11.32%	8.94%	16.85%	4.57%	4.68%	100%	6.904	6.561	2.841	2.244	4.229	1.148	1.175	25.102
King's College Hospital NHS Foundation Trust	-5.157	-1%	21.98%	19.33%	7.36%	5.91%	19.88%	8.60%	16.93%	100%	-1.134	-0.997	-0.380	-0.305	-1.025	-0.444	-0.873	-5.157
Leeds Teaching Hospitals NHS Trust	22.921	12%	7.51%	10.40%	2.02%	5.32%	6.70%	3.20%	64.84%	100%	1.722	2.385	0.463	1.220	1.535	0.734	14.862	22.921
Liverpool Heart and Chest Hospital NHS Foundation Trust	2,318.337	15%	0.00%	0.03%	0.00%	0.00%	0.12%	0.30%	99.55%	100%	0.027	0.730	-	0.022	2.887	6.860	2,307.811	2318.337
(The) Newcastle Upon Tyne Hospitals NHS Foundation Trust	-	0%	27.03%	24.32%	8.11%	2.70%	5.41%	5.41%	27.03%	100%	-	-	-	-	-	-	-	0
Papworth Hospital NHS Foundation Trust	20.017	3%	16.14%	15.95%	5.13%	21.74%	17.94%	0.42%	22.67%	100%	3.231	3.193	1.027	4.352	3.592	0.084	4.538	20.017
(The) Robert Jones and Agnus Hunt Orthopaedic Hospital NHS Foundation Trust	-	0%	0.00%	0.22%	0.00%	0.05%	7.08%	8.68%	83.97%	100%	-	-	-	-	-	-	-	0
Royal Brompton & Harefield NHS Foundation Trust	265.758	9%	22.52%	22.41%	17.97%	18.68%	14.81%	1.44%	2.16%	100%	59.861	59.565	47.749	49.650	39.362	3.821	5.750	265.758
Royal Free London NHS Foundation Trust (Hampstead)	51.976	3%	4.64%	25.91%	14.79%	10.16%	5.16%	2.17%	37.17%	100%	2.414	13.465	7.689	5.280	2.680	1.127	19.322	51.976
(The) Royal Liverpool and Broadgreen University Hospitals NHS Trust	32.584	2%	0.00%	0.10%	0.02%	0.00%	0.00%	1.37%	98.52%	100%	-	0.032	0.006	-	-	0.445	32.101	32.584
(The) Royal Marsden NHS Foundation Trust	12.620	11%	11.97%	37.29%	0.97%	18.18%	6.10%	1.25%	24.24%	100%	1.511	4.705	0.122	2.295	0.769	0.158	3.059	12.62
(The) Royal Orthopaedic Hospital NHS Foundation Trust	-148.371	-15%	11.18%	14.65%	19.10%	16.75%	26.68%	7.10%	4.54%	100%	-16.584	-21.730	-28.335	-24.857	-39.592	-10.541	-6.732	-148.371
Salford Royal NHS Foundation Trust	56.497	4%	0.07%	0.45%	0.00%	0.34%	2.65%	4.74%	91.75%	100%	0.041	0.252	-	0.191	1.497	2.679	51.836	56.497
Sheffield Teaching Hospitals NHS Foundation Trust	71.497	14%	5.86%	10.93%	0.62%	12.79%	1.22%	5.86%	62.72%	100%	4.188	7.817	0.443	9.142	0.873	4.190	44.844	71.497
St Helens and Knowsley Teaching Hospitals NHS Trust	49.281	2%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100%	-	-	-	-	-	-	49.281	49.281
University College London Hospitals NHS Foundation Trust	68.449	4%	10.62%	20.43%	5.90%	14.74%	13.80%	6.38%	28.13%	100%	7.271	13.985	4.037	10.089	9.443	4.367	19.257	68.449
University Hospital of South Manchester NHS Foundation Trust	-32.476	-2%	3.66%	2.05%	0.00%	6.23%	3.17%	1.23%	83.66%	100%	-1.188	-0.666	-	-2.024	-1.029	-0.398	-27.170	-32.476
University Hospitals Birmingham NHS Foundation Trust	400.856	5%	8.35%	5.23%	6.79%	13.21%	10.40%	45.16%	10.85%	100%	33.460	20.983	27.214	52.956	41.705	181.028	43.511	400.856
University Hospitals Bristol NHS Foundation Trust	1,318.484	14%	17.98%	26.26%	12.39%	27.70%	9.77%	2.29%	3.63%	100%	237.004	346.180	163.316	365.195	128.786	30.159	47.843	1318.484
University Hospitals of North Midlands NHS Trust	97.000	5%	0.48%	3.15%	0.17%	1.60%	1.55%	93.05%	0.00%	100%	0.462	3.054	0.169	1.547	1.504	90.263	-	97
(The) Walton Centre NHS Foundation Trust	935.939	6%	0.02%	0.01%	0.01%	0.10%	0.02%	0.67%	99.17%	100%	0.195	0.140	0.049	0.902	0.210	6.247	928.196	935.939
Wye Valley NHS Trust (Hereford)	-23.102	-15%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	100%	-	-	-	-	-	-23.102	-	-23.102
PETIC																		
NHS Blood & Transplant - National Organ Donation																		
HCS Activity Project																		
TOTAL NON WELSH SLA's (EXCL Mental Health)	5,695.063	6%									360.979	466.364	245.595	495.743	207.327	318.806	3,600.248	5,695.063
								COMMISSIONER >40%			COMMISSIONER ADV IMPACT>£100K PER CONTRACT OR SIGNIFICANT OVERALL						-	0.00

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

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		Agenda Item	20
Meeting Title	**Joint Committee**	Meeting Date	26/09/2017
Report Title	WHSSC Joint Committee Self-Assessment 2016-17		
Author (Job title)	Corporate Governance Officer		
Executive Lead (Job title)	Committee Secretary	Public / In Committee	Public

Purpose	The purpose of this paper is to provide members with information relating to the outcome of the Joint Committee's annual self-assessment.			
RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☐	INFORM ☒

Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the information presented within the report; and • **Support** consideration by the Chair and Committee Secretary of a 'development day' and/or induction programme.		

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 ✓

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

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1.0 Situation

1.1 The purpose of this paper is to provide members with information relating to the outcome of the Joint Committee's annual self-assessment.

2.0 Background

2.1 Section 8.3 of the Standing Orders for WHSSC provides guidance in relation to reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups. In which it states that:

> "The Joint Committee shall introduce a process of regular and rigorous self assessment and evaluation of its own operations and performance and that of its joint sub-Committees, expert panels and any other Advisory Groups. Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated."

2.2 To support this and to ensure good governance practice Members of the Joint Committee were asked to complete an anonymous self-assessment questionnaire to understand the Committee's effectiveness and highlight any areas for improvement.

2.3 The questionnaire was split into four areas: Composition, Establishment and Duties; Effectiveness; Compliance with the Law and Regulations Governing the NHS; and Individual Effectiveness. There was also an opportunity for members and deputies to provide free text comment in relation to anything that worked well or required improvement/clarity.

3.0 Assessment

3.1 The initial questionnaire was circulated on 1 August 2017 with responses requested by 11 August 2017.

3.2 **Response Rate**

The survey was distributed to all Members and Associate members of the Joint Committee during 2016-17. Also included were those regularly 'In Attendance'. This was a total of 20 individuals; a total of 9 responses were received. This represents an **overall response rate of 45%**; lower than previous years.

3.3 **Composition, Establishment and Duties**

This section of the assessment related to the structural framework of the Joint Committee. There was some uncertainly amongst responders in relation to the strategic plan for WHSSC, which was supported by the 'free text' comments provided. Also, the appropriate induction and training for members undertaking their role on the Joint Committee was noted as an area for improvement. This appears to be an ongoing theme highlighted in previous self-assessments.

The responses to all other statements the were mostly positive including operating within and familiarity of the guidelines set out in the Governance and Accountability Framework, the adequate distribution of Joint Committee assignments.

3.4 **Effectiveness**

This section of the assessment related to the work carried out by the Joint Committee. The majority of responses were positive with the main areas of disagreement or uncertainty focussing around an annual plan of work, provision of clear direction to Joint Sub-Committees and the process for managing/monitoring areas for development to ensure the Joint Committee's effectiveness. With one responder suggesting that:

> *"I think there would be value in having some scheduled Committee development days/sessions. We tend to do our business in formal meetings and using a broader approach might be helpful moving forward."*

3.5 **Compliance with the Law and Regulations Governing the NHS**

In this section respondents were asked about the wider elements of the Joint Committee's role, how it integrates with the wider WHSSC governance structure and the assurances it receives from its sub-committees.

Although there appeared to be a high level of agreement in responses across the statements, 44% of respondents felt that there had not been/or were unsure that any formal consideration had been given as to the way in which it integrates within the NHS in Wales. 66% were unsure of or disagreed that the Committee had undertake a review of the robustness of data behind reports and assurances it receives, again this reflective of previous years.

3.6 **Individual Effectiveness**

This section of the assessment sought to identify the individuals' views in regard to their own knowledge and skills relating to identification of issues and ability to challenge executives and management on critical and sensitive matters.

All respondents were confident in their ability to challenge Executive team members and Joint Committee colleagues. The majority of respondents also agreed that they had an understanding of WHSSC to identify issues appropriately.

It was interesting to note a slight shift in the number of people disagreeing or feeling unsure around the opportunities for development to support their effectiveness as a member. This correlated with the earlier statement around potential development sessions for the Joint Committee as a whole.

3.7 **Considerations for Members of the Joint Committee**

Overall, responses to the self assessment questions were positive; with 78% of all responses agreed with the statements. However, the responses where individuals noted that they were unsure or disagreed remained relatively similar to that from previous years.

Members may wish to consider those areas which have regularly appeared over the past few years as areas of uncertainty or disagreement. These being:

- The approach to induction and training for new members
- Opportunities to hold development session for the Joint Committee as a whole
- Consideration of the way in which the WHSSC Joint Committee integrates with the NHS in Wales
- Individual/Group development opportunities to strengthen individual member effectiveness.

Members may also wish to consider the mechanism through which the self-assessment is carried out. Given that the results have been similar over several years, and a suggestion of development sessions be considered, Members are asked to support the consideration of a facilitated self-assessment process for 2017-18.

4.0 Recommendations

4.1 Members are asked to:

- **Note** the information presented within the report; and
- **Support** consideration by the Chair and Committee Secretary of a 'development day' and/or induction programme.

5.0 Appendices / Annexes

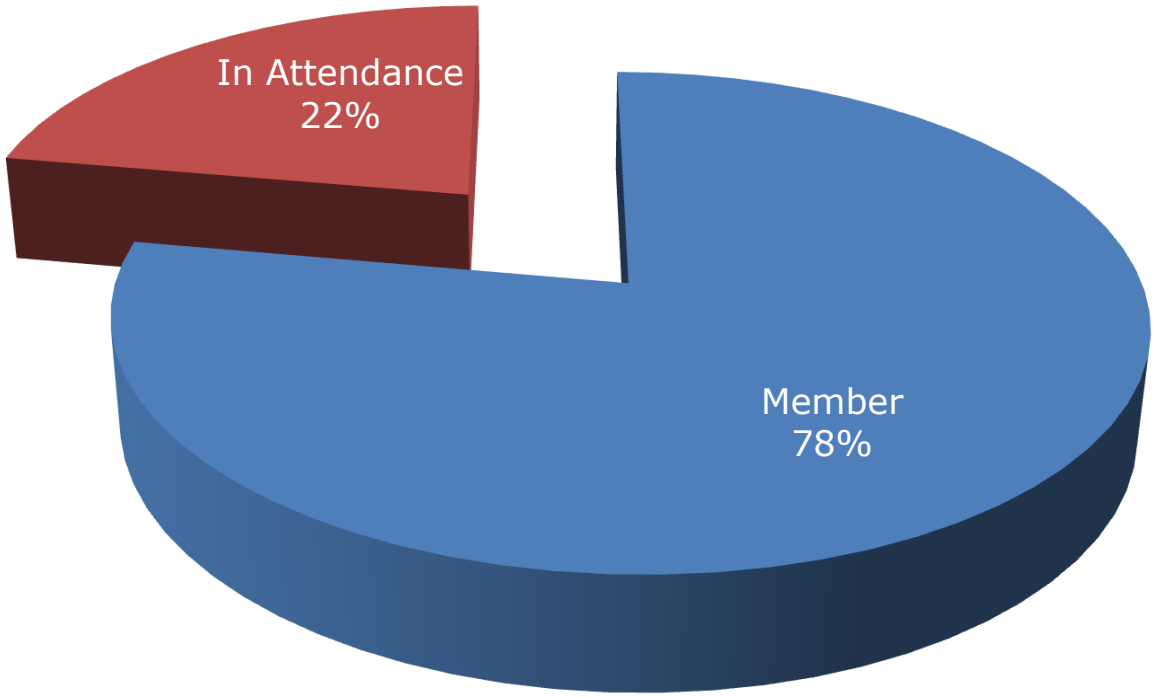
5.1 Appendix 1 – WHSSC Joint Committee Self-Assessment 2016-17

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Organisation Development
Link to Integrated Commissioning Plan	Not applicable
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	Strong governance mechanisms will indirectly improve quality of service and patient safety and experience.
Resources Implications	Not applicable
Risk and Assurance	In order for the Committee to carry out its duties in relation to scrutiny of potential risks which impact on services provided, it needs to consider its own effectiveness and ability to do this.
Evidence Base	Appendix 1 – WHSSC Joint Committee Self –assessment 2016-17
Equality and Diversity	Not applicable
Population Health	Not applicable
Legal Implications	Not applicable

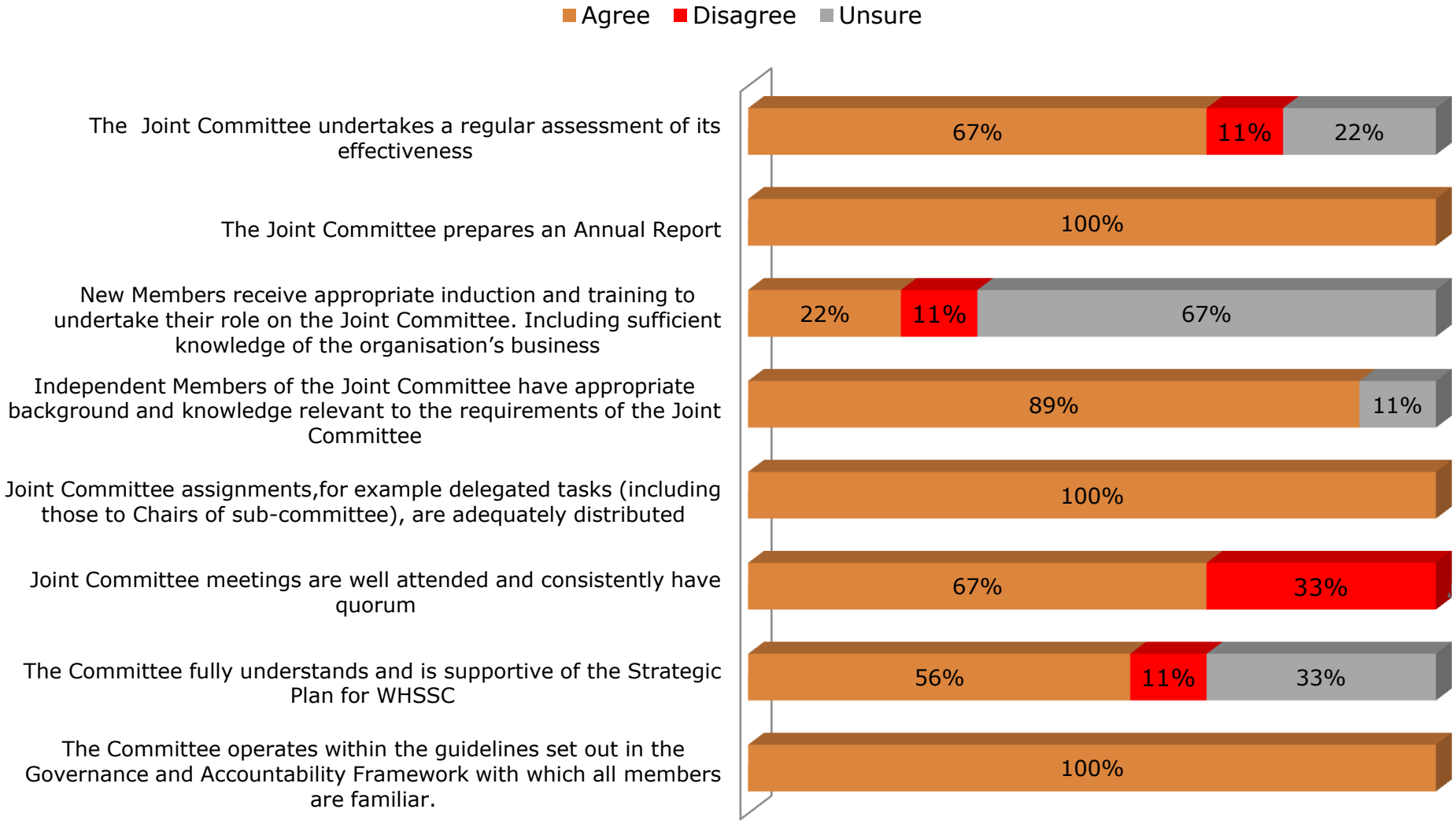
Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Not applicable		

WHSSC Joint Committee
Annual Self-assessment 2016-17
Results

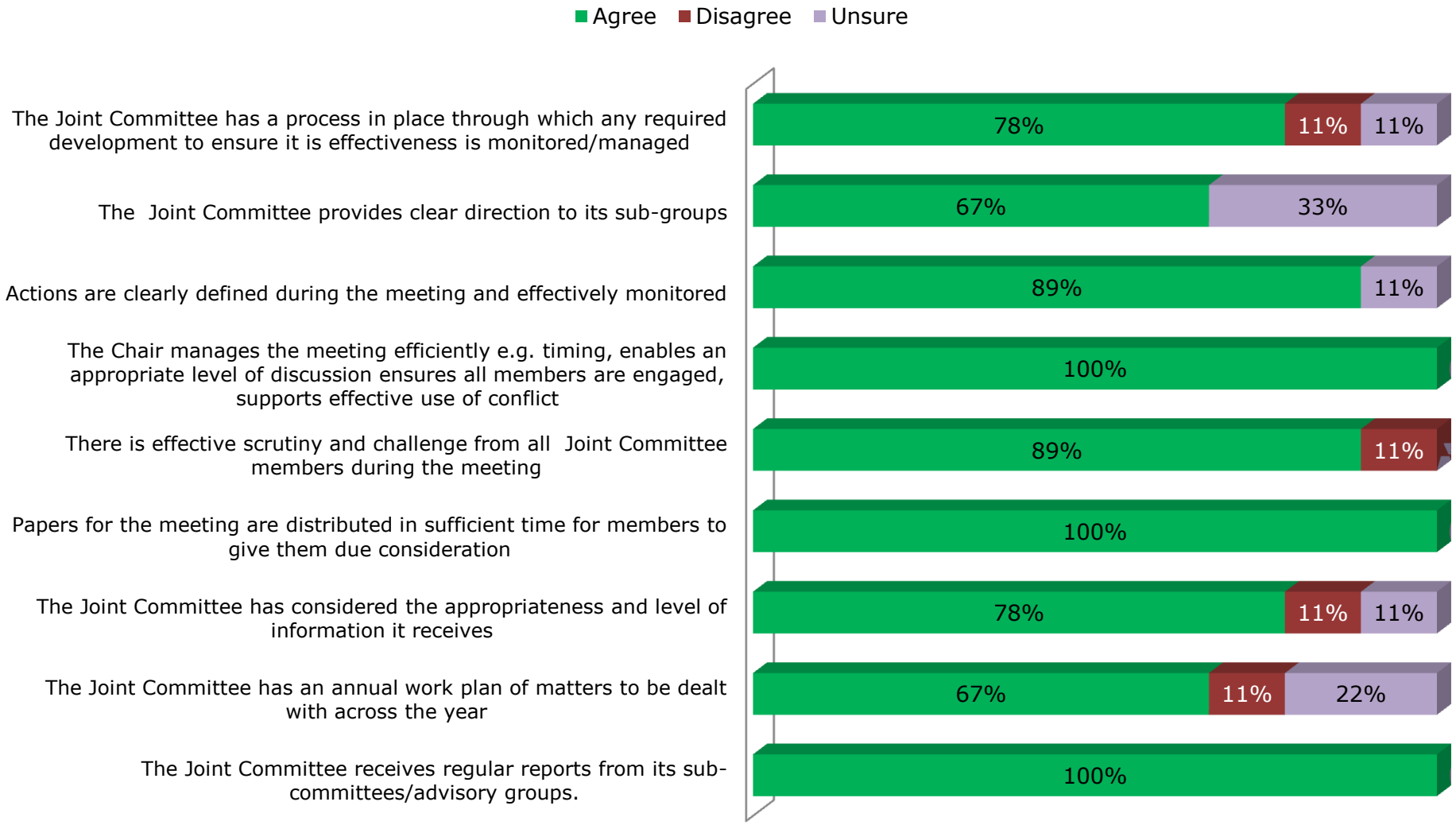
Responder by Type



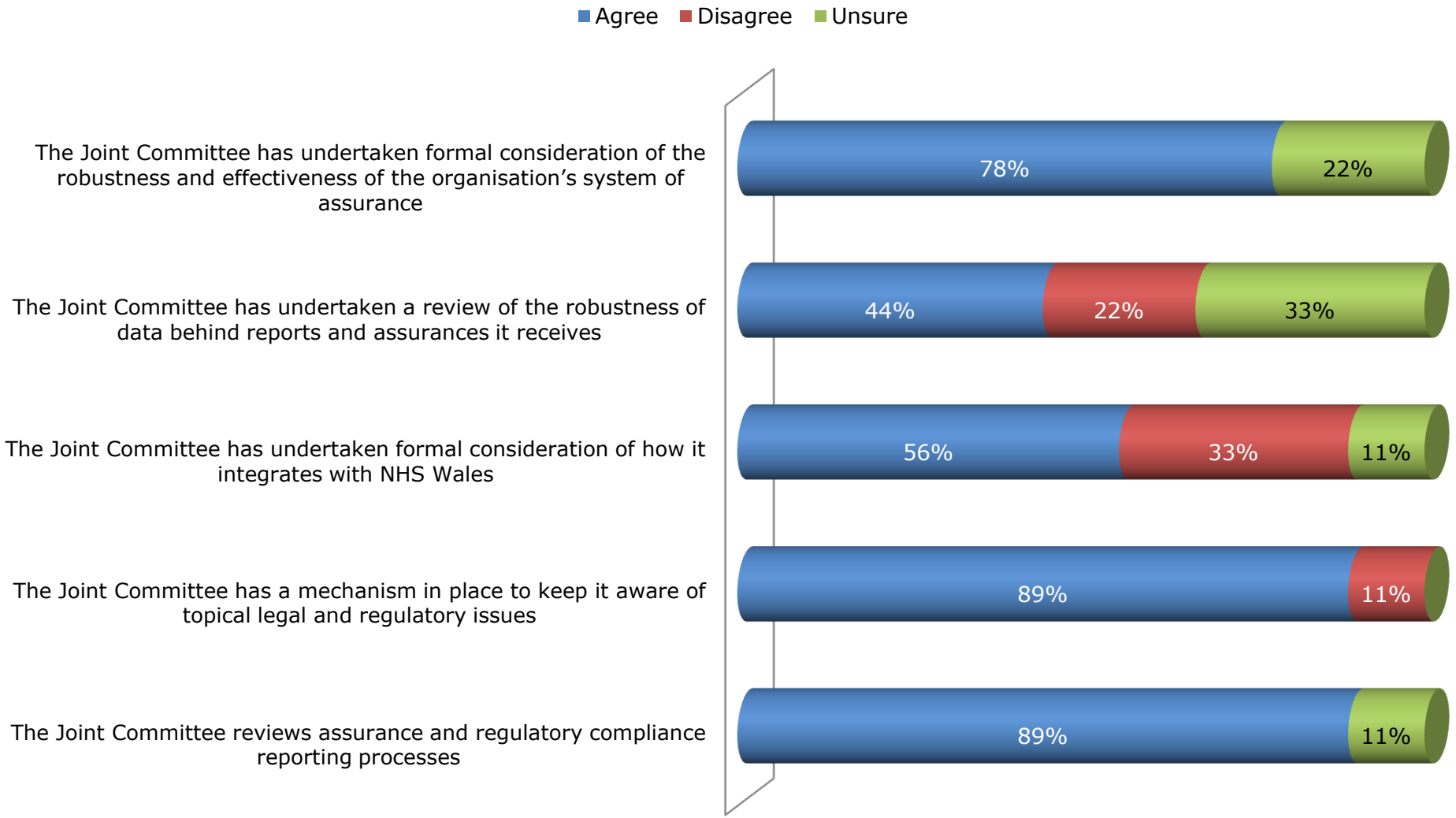
Composition, Establishment and Duties

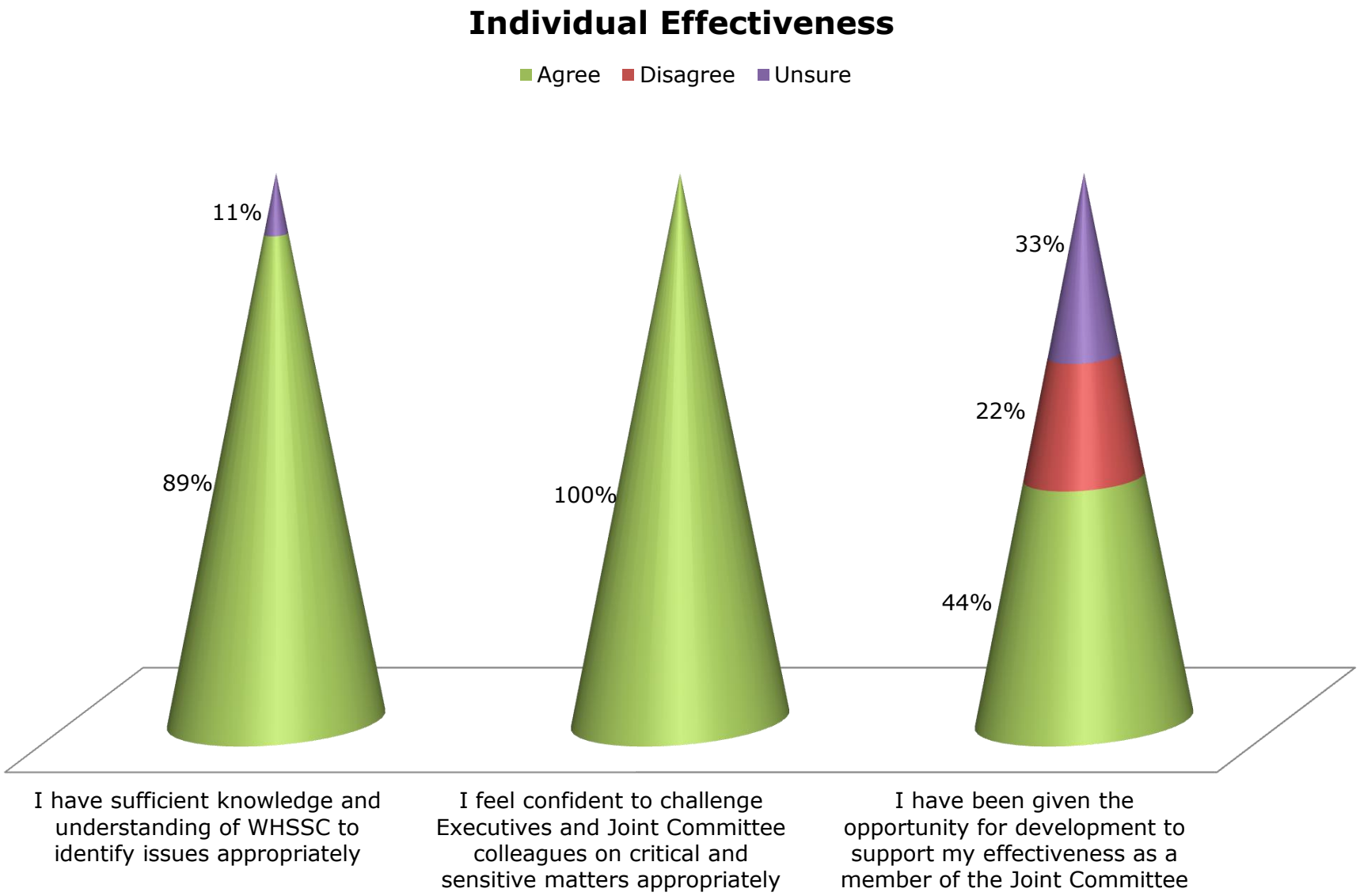


Effectiveness



Compliance with Law and Regulation




Individual Effectiveness
Agree
Disagree
Unsure
11%
89%
100%
33%
22%
44%
I have sufficient knowledge and understanding of WHSSC to identify issues appropriately
I feel confident to challenge Executives and Joint Committee colleagues on critical and sensitive matters appropriately
I have been given the opportunity for development to support my effectiveness as a member of the Joint Committee

Comments

Composition, Establishment and Duties					
The Committee operates within the guidelines set out in the Governance and Accountability Framework with which all members are familiar.	However, the work currently underway to clarify what business is done in Management Group versus JC will be helpful to strengthen this				
The Committee fully understands and is supportive of the Strategic Plan for WHSSC	if this question refers to the IMTP I would say that the committee understand and are supportive	I am reasonably clear but I am not sure if I can speak for all Cttee members in this respect. I do think there is sometimes confusion about what is approved in principle (subject to business cases that hav e not yet been developed) versus what is approved	The strategic plan in the current context is the Commissioning Plan. There is work to do on the Strategy for Specialised Services which has been delayed. It will be important that this work can be progressed to enable a clear strategy to inform future commissioning plans.	However the Strategy is overdue for review but the Committee does understand and support the Integrated Commissioning Plan.	What is the strategic plan for WHSSC? How can I find it?
Joint Committee meetings are well attended and consistently have quorum	mostly the meetings are well attended and quorate. one recent meeting where this was not the case.				
Joint Committee assignments,for example delegated tasks (including those to Chairs of sub-committee), are adequately distributed	I believe this to be the case	See comment re: Management Group above			
Independent Members of the Joint Committee have appropriate background and knowledge relevant to the requirements of the Joint Committee	Training for new Independent members would be useful as not all will have the relevant background knowledge of specialised services or WHSSC.	Further induction/ background briefings would be helpful			
New Members receive appropriate induction and training to undertake their role on the Joint Committee. Including sufficient knowledge of the organisation's business	Training for new members should be considered	sorry - I cannot answer this as I am not sure what the induction and training process is for new members	Learnt as the committees progressed	Sorry - I am not familiar with what is done for new members	I have been a member for over 2 years. The induction was insufficient at that time (relying on 'on the job' learning), however it may have improved and the newer members comments will assist here.
The Joint Committee prepares an Annual Report	This is form recollection only - I haven't seen this years??				
The Joint Committee undertakes a regular assessment of its effectiveness	difficult to answer as we might all have a different view on what 'regular' is. Surveys such as this are helpful and could be used more frequently	Im not aware that this is done formally	annually		

Comments

Effectiveness			
The Joint Committee receives regular reports from its sub-committees/advisory groups.	although it may be useful that we have a timetable of the committees/advisory groups so that we can consider them in more detail (frequency vs detail)	Some committees and advisory groups are better at routinely reporting than others.	
The Joint Committee has an annual work plan of matters to be dealt with across the year	It has an annual plan but not sure about a work-plan	If there is one it is more informal - and strengthening this could support the work of the committee	
The Joint Committee has considered the appropriateness and level of information it receives	Not formally - particularly problematic when it comes to business cases for investment	In part - with the performance report and the quality reporting. This will require revisiting at certain points.	Implicitly, rather than expressly.
There is effective scrutiny and challenge from all Joint Committee members during the meeting	Overall scrutiny = yes but variable from members		
Actions are clearly defined during the meeting and effectively monitored	There have been occasions where the members have different views of what was agreed. However this is rare		
The Joint Committee provides clear direction to its sub-groups	This relates to earlier comment. There is a tendency to 'receive' report from sub groups and improved scheduling/planning of agenda items may allow for more discussion and clearer direction to be given from the committee.	Where applicable.	
The Joint Committee has a process in place through which any required development to ensure it is effectiveness is monitored/managed	I think there would be value in having some scheduled Committee development days/sessions. We tend to do our business in formal meetings and using a broader approach might be helpful moving forward.	Where applicable.	

Comments

Compliance with Law and Regulation		
The Joint Committee reviews assurance and regulatory compliance reporting processes	Not sure I understand this question	although there is room for strengthening this
The Joint Committee has undertaken formal consideration of the robustness and effectiveness of the organisation's system of assurance	Governance Review	It would be a uuseful consideration to have assurance reports (such as those developed by internal Audit) to come through the Committee as well as going through the Cwm Taf HB Audit Committee

Individual Effectiveness			
I have sufficient knowledge and understanding of WHSSC to identify issues appropriately	Still developing my level of understanding. But I have made significant progress		
I have been given the opportunity for development to support my effectiveness as a member of the Joint Committee	I have received support on issues as they have arisen	Not specifically but I am sure if I had asked for it I would have been supported	I clearly have development for my overarching role. On the specifics of the Joint Committee - there is value in development days/sessions where dialogue and development of effectiveness as well as key topics could bring additional benefit.

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

Agenda Item 21.1
WHSSC Joint Committee
26 September 2017

Reporting Committee	**Cwm Taf UHB Audit Committee**
Chaired by	**Cwm Taf UHB Audit Committee Chair**
Lead Executive	**Committee Secretary**
Date of last meeting	**11 September 2017**

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

Members of the Committee received and reviewed a progress report on the implementation of recommendations for WHSSC internal audits undertaken during 2015-16 and 2016-17. It was noted that a number of actions were overdue but it was suggested that this reflected a timing issue between the early production of the report and subsequent closure of actions. A more complete version of the report was anticipated for the next meeting.

A report providing an overview of the revised WHSSC risk management framework and an update on the WHSSC Corporate Risk and Assurance Framework, as at 7 August 2017, was received and considered. It was noted that this reflected 'work in progress' and that feedback had been received from the Cwm Taf Quality, Safety and Risk Committee, which had considered the same report the previous week. Members acknowledged the amount of work that had been done to develop the framework and identify key risks, and encouraged the WHSSC Team to continue with this work, taking into account the need for clear narratives, consistency of colour coding, greater clarity on mitigation and control measures, and the need for time bound actions.

Members received assurance from a report on the processes for the monitoring and collation of Corporate Registers in accordance with the WHSSC Standards of Behaviour Policy.

Members of the Committee received the Internal Audit Report on WHSSC's prioritisation process for the planning and commissioning of specialised services in relation to the WHSSC 2017-18 Integrated Commissioning Plan, which reported 'Reasonable Assurance'. Two recommendations were noted, both of which were medium level and one of which was already reported as closed in the Report.

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

- None

Matters requiring Joint Committee level consideration and / or approval

- None

Matters referred to other Committees

- None

Date of next meeting	13 November 2017

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

Agenda Item 21.2
WHSSC Joint Committee
26 September 2017

Reporting Committee	**All Wales Individual Patient Funding Request (IPFR) Panel**
Chaired by	**Acting Chair – Dr Stuart Linton**
Lead Executive Director	**Director of Nursing & Quality Assurance**
Date of last meeting	**30 August 2017**

21.2

Summary of key matters

The Panel meeting was quorate in relation to Health Board representation and clinical representation at both the July and August meetings.

18 IPFR were considered by the Panel in July 2017:

- 10 requests were considered at the meeting
- 2 via virtual email Panel
- 6 Chair actions (PET)

11 IPFR considered by the Panel in August 2017:

- 9 requests were considered at meeting
- 2 via virtual email Panel

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

Replacement Panel Chair

As Professor Vivienne Harpwood has been appointed as WHSSC Chair she is no longer able to continue as the All Wales IPFR Chair.

The Panel Chair must be an independent member of an existing Health Board. The replacement Chair is yet to be identified.

Interim arrangements had to be made for the August meeting as the Vice Chair on leave. A member of the Panel acted as Chair but did not participate in discussions or represent their respective Health Board

Interim process for considering PET IPFR

There are a significant number of requests being received by WHSSC for PET Scanning which are outside the indications within the current PET policy.

To ensure openness and transparency in decision making, it was agreed that the process to manage PETS should reflect the guidance in the All Wales IPFR policy which is utilised for considering urgent funding requests. Decisions would therefore be a made as a "Chair action".

The more complex PET requests are still to be presented to a full Panel.

PET requests considered as a Chair action are reported on a monthly basis

to the Panel.

The outcomes/ benefits of approved PET scans are also being routinely requested and reported.

Report on Independent Review Panel

An independent review of the process followed by the All Wales Panel on 25 January 2017 was considered by the Abertawe Bro Morgannwg University Health Board on 4 July 2017.

Summary of lessons learnt:

- The IPFR Application forms to been screened more carefully on receipt and further information requested before submission to the All Wales IPFR Panel.
- The IPFR Panel should have considered clinical exceptionality.
- The IPFR Panel should have questioned the veracity of the clinical evidence presented to it and possibly sought more up to date clinical evidence.
- The IPFR Panel minutes should have been more comprehensive and fully documented discussions and the detailed rationale for the Panel's decision.
- On receipt of new data to support the application the review process should have been suspended or abandoned.

Actions:

- NWIS developing on-line application form where all mandatory fields must be completed or the form cannot be submitted.
- Training packages to support both clinicians and patients around IPFR are being developed by AWTTC and the IPFR Network.
- IPFR network to share minute taking best-practice

NHS Wales Policy – Making Decisions on Individual Patient Funding Requests -June 2017

The Policy will be formally adopted across NHS Wales from 18 September 2017.

The All Wales Panel will therefore apply the amended decision making criteria at their next meeting scheduled for 27 September 2017.

Matters requiring Committee level consideration and/or approval

- None

Matters referred to other Committees

- Integrated Governance Committee have been informed of the interim PET IPFR decision process and agreed the implementation of the revised All Wales IPFR policy.

Date of next meeting	**27 September 2017**

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

21.2

INDIVIDUAL PATIENT FUNDING REQUEST (IPFR) PANEL

Annual Report 2016/17

Sub-Committee/Group Chair:	**All Wales Individual Patient Funding Request (IPFR) Panel**
Report Approved by Sub-Committee:	

Individual Patient Funding Request (IPFR) Panel
ANNUAL REPORT

1. BACKGROUND / INTRODUCTION

The All Wales IPFR Panel are constituted to act as a Sub Committee of the Welsh Health Specialised Services Committee (the Joint Committee) and hold delegated Joint Committee authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

The Panel will act at all times in accordance with the all Wales IPFR Policy taking into account the appropriate funding policies agreed by WHSSC.

The Panel will normally reach its decision on the basis of all of the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support.

The Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

2. MEMBERSHIP

The membership of the Committee comprises of 10 members, enabling the Committee to operate independently of the management decision-making processes. Membership during 2016-17 was as follows:

- Independent Chair
- Two Lay representatives
- Nomination at Director level from each of the 7 LHBs

A further two panel members may be appointed at the discretion of the Chair of the panel, for example a member of the Ethics Committee or a Senior Pharmacist.

3. MEETINGS

The All Wales Individual Patient Funding Panel met in person on 12 occasions. During the period 2016/17 12 meetings were quorate (The Chair or Vice-Chair and representation from five of the seven Health Boards, three of which must be clinical representatives).

In the same period, 26 virtual (email) Panel decisions and 20 urgent Chair actions were made.

Were virtual Panel responses were not quorate a Chair action decision was made.

In addition to the members, the following also attended the committee meetings during the year:

- WHSSC Medical Director or Deputy
- WHSSC Director of Nursing or Deputy
- WHSSC IPFR Co-ordinator
- WHSSC IPFR Manager

4. MAIN AREAS OF COMMITTEE ACTIVITY

The agenda for each meeting follows a standard format which is broken down into:

Preliminary matters

This section of the meeting covers off standard issues such as apologies, welcome, declarations of interest, minutes of the last meeting, reports on clinical outcomes received , reports on virtual Panels held in previous month, action log updates and matters arising.

Items for discussion and consideration

This section covers IPFR Requests for discussion.

The requests are anonymised. The Panel consider on average 8 requests per meeting.

The IPFR Panel cannot make policy decisions. Any policy proposals arising from their considerations and decisions are reported to the WHSSC programme teams.

The Panel have financial authorisation to agree funding up to a set limit of £300,000 for one-off packages and £1million for lifetime packages

Authorisation for any decisions resulting in a financial cost in excess of this limit must be obtained from the relevant Health Board and reported to the Managing Director of Specialised and Tertiary Services.

Any Other Business

5. LINKS WITH OTHER COMMITTEES

The WHSSC Director of Nursing and Quality Assurance and Acting Medical Director have provided a connection with other committees such as the Quality and Patient Safety Committee, Integrated Governance Committee, Clinical Networks and WHSSC Performance and Risk Group.

6. WORK PROGRAMME

In order to monitor progress and any necessary follow up action the Committee was supported by the WHSSC IPFR Coordinator in developing a work log that captured all agreed actions. This provided an essential element of assurance both to the Committee and from the Committee to the Integrated Governance Committee and the Joint Committee.

7. ASSESSMENT OF GOVERNANCE AND RISK ISSUES

IPFR decisions are at risk of judicial review if not made in line with All Wales policy and procedure. Therefore, the All Wales IPFR Panel provided an essential element of the overall governance framework for the organisation and has operated within its Terms of Reference and in accordance with the Governance and Accountability Framework.

The Panel undertakes a self-assessment and this has been compiled and any actions will be picked up as part of the work plan for 2017/18. A copy of the assessment is attached at Annex A.

8. ASSURANCE TO THE BOARD

The All Wales IPFR Panel wishes to assure the Board that on the basis of the work completed by the Committee during 2016/17, there are effective measures in place and there are no outstanding issues that the Committee wishes to bring to the attention of the Joint Committee.

9. CONCLUSION AND LOOK FORWARD

The Committee is committed to continuing to develop its function and effectiveness and intends seeking further assurance in 2017/18 in respect of implementing:

- The recommendations of the Independent Review of Individual Patient Funding Request Process Report (January 2017)
- The revised All Wales IPFR Policy (June 2017) and decision making criteria.
- Appointing a replacement Chair and Vice Chair

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

Agenda Item 21.3
WHSSC Joint Committee
26 September 2017

Reporting Committee	**Integrated Governance Committee**
Chaired by	**WHSSC Chair**
Lead Executive	**Committee Secretary**
Date of last meeting	**15 August 2017**

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

21.3

Members received an oral update on QAIT/NCCU that confirmed assurance that the governance arrangements for QAIT/NCCU now sat with CTUHB, via S Harrhy, and that QAIT/NCCU was now seeking additional funding to continue its activities in relation to the framework for secure mental health services and related quality assurance. Members agreed that the WHSSC Team should develop a proposal to be presented to the Management Group for scrutiny, and brought forward to the Joint Committee, regarding the services provided by QAIT/NCCU to WHHSC and related matters.

Members received a presentation on the governance arrangements for the Child & Adolescent Mental Health Service and Eating Disorders Network and the Neonatal Network following their transfer to the NHS Wales Health Collaborative. It was noted that Memoranda of Understanding would be put in place between WHSSC and the Collaborative for each of the clinical networks managed by the Collaborative that would record any ongoing requirements of WHSSC in relation to each network. This would not apply to the Welsh Clinical Renal Network as it was a commissioning network and, as such, would continue to be governed and managed by WHSSC. Members confirmed that they were content for the proposed arrangements to be recommended to the Joint Committee in conjunction with continuing discussions on the detail with the Collaborative and appraisal of the LHB Chairs.

Following a significant increase in IPFR requests for PET scans, members received assurance regarding an interim process introduced by WHSSC to consider requests for PET scans which do not meet the indications within the extant PET policy. The interim process reflected the 'Chair's action' process set out in the All Wales IPFR policy.

Members received and reviewed the Corporate Risk and Assurance Framework and noted the continuing developmental work that had been done since the last review. It was noted that further work was proposed to consider the relative weightings around the three domains: Safe/ Sustainable/ Effective. Consideration would also be given by the WHSSC Team to the potential risks associated with the General Data Protection Regulation, which would become effective in May 2018, QAIT/NCCU and transfer of the clinical networks. It was

suggested that the WHSSC Team re-visit and review the corporate risk appetite and compare it to the current risk appetite statement. Members of the Committee received and reviewed the results of the Committee's 2016-17 Self Assessment and its Annual Report to the Joint Committee. Members suggested that an induction programme and/or 'development day' might be very useful for members of the Committee.
Key risks and issues/matters of concern and any mitigating actions
As recorded above.
Matters requiring Joint Committee level consideration and/or approval
As recorded above.
Matters referred to other Committees
None
Confirmed Minutes for the all meetings held are available on request

Date of next meeting	17 October 2017

21.3

Integrated Governance Committee

Annual Report
2016/17

Sub-Committee/Group Chair: Professor V Harpwood

Report Approved by Sub-Committee: 15 August 2017

Integrated Governance Committee
Annual Report

1. BACKGROUND / INTRODUCTION

The purpose of the *Integrated Governance Committee* "the Committee" is to scrutinise evidence and information brought before it in relation to activities and potential risks which impact on the services provided and provide assurance to the Joint Committee that effective governance and scrutiny arrangements are in place across the organisation.

The Committee will, in respect of its provision of advice to the Joint Committee, ensure that it: -

- maintains an oversight of the work of the Quality & Patient Safety Committee, the Cwm Taf UHB Audit Committee and the All Wales Individual Patient Funding Request (IPFR) Panel. The Committee will ensure integration of the governance work, addressing issues which fall outside or between the work of the these committees, ensuring no duplication and coordinating those issues which need the attention of more than one of the sub-committees;

- ensures that appropriate mechanisms are in place to manage risk issues, identifying and reviewing the highest level of WHSSC risks and ensuring that plans are in place to manage those risks;

- oversees the Joint Committee's major policy objectives such as the Integrated Commissioning Plan for Specialised Services, identifying issues which need Joint Committee action or involvement, and scrutinising the delivery and performance in those areas.

- maintains an oversight of the work of the Welsh Renal Clinical Network Board (WRCN) addressing issues which fall outside the work of the Network Board.

During 2016-17 the Committee also maintained oversight of the work of the CAMHS & ED and Neonatal Networks. The management of these networks transferred to the NHS Wales Health Collaborative with effect from October 2016.

2. MEMBERSHIP

The membership enables the Committee to operate independently of the management decision-making processes. Membership during 2016-17 was as follows:

- WHSSC Chair
- WHSSC Vice Chair
- Acting Managing Director of Specialised and Tertiary Services
- Audit Committee Lead - Independent Member

- Chair Quality & Patient Safety Committee
- Chair Welsh Renal Clinical Network

During 2016-17 the following were members; however, as described above the management of the Networks (excluding the WRCN) transferred to the NHS Wales Health Collaborative.

- Chair, Mental Health Mental Health and Learning Disability Collaborative Commissioning Group
- Chair, Welsh Neonatal Network Steering Group
- Chair, Children and Adolescent Mental Health Service and Eating Disorder (CAMHS & ED) Steering Group.

The Chair of the All Wales IPFR Panel is invited to attend all meetings.

Corporate Directors are invited to attend all meetings.

3. MEETINGS

The *Integrated Governance Committee* met on five occasions during 2016-17 only four of which meetings were quorate.

4. MAIN AREAS OF COMMITTEE ACTIVITY

The agenda for each meeting follows a standard format, broken down into four main parts:-

Preliminary Matters

This section of the meeting covers off standard issues such as apologies, welcome, declarations of interest, minutes of the last meeting and matters arising.

Items for Decision and Consideration

The Integrated Governance Committee considered a number of items of WHSSC business during 2016-17, an example of which is provided below:

WHSSC Governance Action Plan

During 2015/16 the Health Care Inspectorate Wales Clinical Governance Review and the Good Governance Institute Governance Review were approved. An action plan was development to ensure the implementation of the recommendations.

Throughout 2016-17 the Integrated Governance Committee continued to undertaken an overarching scrutiny and assurance role on behalf of the WHSSC Joint Committee. An annual review of the WHSSC Governance Action Plan was undertaken in March 2017. The Integrated Governance Committee approved a recommendation that the outstanding actions from

the Governance Action Plan be consolidated managed through 'business as usual' processes.

Routine Reports
During 2016-17, the Integrated Governance Committee received a number of routine reports on an annual or quarterly basis, with a number provided at each meeting. These being Corporate Risk and Assurance Framework, Standards for Health and Care, WHSSC Governance Action Plan, Standards of Behaviour, and the Annual Governance Statement.

Items for Information
The Integrated Governance Committee received a number of items for information which are used to ensure that Members remain up to date with any matters pertinent to their role and responsibilities, but which do not require a decision or consideration directly.

5. LINKS WITH OTHER COMMITTEES

Directors on the Sub-committee provide linkage with other committees such as the Quality & Patient Safety Committee, Audit Committee, All Wales IPFR Panel, and Welsh Renal Clinical Network. Members of the Integrated Governance Committee report progress at each meeting and also provide an update on their relevant sub-committee/sub group/network to the Joint Committee. Any patient specific risks are directed to the Quality & Patient Safety Committee and the link for this is the Medical Director in the absence of the Director of Nursing.

6. WORK PROGRAMME

In order to monitor progress and any necessary follow up action, the Sub-committee has developed an Action Log that captures all agreed actions. This has provided an essential element of assurance both to the Sub-committee and from the Sub-committee to the *Integrated Governance Committee* and to the WHSSC Joint Committee.

7. ASSESSMENT OF GOVERNANCE AND RISK ISSUES

The Integrated Governance Committee provides an essential element of the overall governance framework for the organisation and has operated within its Terms of Reference and in accordance with the Governance and Accountability Framework.

8. ASSURANCE TO THE JOINT COMMITTEE

The Integrated Governance Committee wishes assure the WHSSC Joint Committee that on the basis of the work completed by the Committee during 2016-17, there are effective measures in place and there are no outstanding issues that the

Committee wishes to bring to the attention of the WHSSC Joint Committee.

9. CONCLUSION AND LOOK FORWARD

The Committee is committed to continuing to develop its function and effectiveness and intends seeking further assurance in 2017-18 in respect of the:

- Completion of the self assessment for the Committee;
- Review of the Terms of Reference and Membership of the Integrated Governance Committee; and
- Further development of the corporate risk and assurance mechanisms.

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

Agenda Item 21.4
WHSSC Joint Committee
26 September 2017

Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Chris Koehli**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**26 September, 2017**

21.4

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

Serious Concerns Report
Members received an overview of the current position. It was reported that there were a large number of closure forms from Cardiff and Vale UHB; it was suggested that the higher reporting levels being with the provider were due to the close working relationship and regular meetings in place to oversee the process. Further work was being undertaken to develop similar links with all the providers and to set a threshold for the reporting of incidents.

Concerns Overview report
Members received the report and requested that a section on cases referred to the Ombudsman be included in future reports. Assurance was given that reporting of such events was part of the contractual process.

Escalation Process
Members received an update and were supportive of the work being undertaken to develop the escalation framework.

Corporate Risk and Assurance Framework
Members received a report outlining the key developments linked in to the risk framework around patients, providers and commissioners. Further work was required to ensure it was linked to the escalation process. A workshop and dedicated time at the next meeting was planned for this to be undertaken.

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme from 2017/18
Members received the programme and requested that the Commissioning teams work with the Welsh providers on the reporting of the audits in the areas relevant to commissioned services. The findings would be reported by exception back to the committee.

Terms of Reference
As part of the discussions around the self assessment it was noted that the revised Terms of Reference of the Committee needed to go to Joint Committee for approval.

Report from WHSSC Performance Group
Members received the WHSSC Performance Report. They were advised that a significant amount of work had been undertaken to revise the format of the report to ensure that both quality and outcomes were integrated into the report. The appointment of the quality team would help strengthen the quality, patient outcome and patient experience elements within the report.

Report from the WHSSC Policy Group
Members received a report from the group which showed good progress in the review and development of policies. In addition the appointment of a Project manager who was due to start in September would also strengthen and speed up any outstanding work.

Updates from the Commissioning Teams and Renal network
Updates were received from each of the above and issues highlighted in the next section of the report.

Quality and Safety Committee Briefing to Joint Committee
Members received the briefing for information.

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

Cancer & Blood

Caner target breaches were noted. Close monitoring was required for the treatment of lung cancer to ensure no further deterioration of the position.

It was pleasing to announce that BCUHB North Wales had received confirmation that they have achieved JACIE accreditation. The Committee were satisfied that the risk could be removed from the risk register.

Mental Health

CAMHS out of area placements have risen significantly in North Wales. North Wales adolescent service (NWAS) have been escalated to level 3 and appropriate monitoring is in place.

Neurosciences

Interventional Neuroradiology is no longer available in CVUHB. WHSSC is working with NHS England in securing alternate arrangements.

Women & Children

Paediatric Surgery has been escalated to level three and appropriate monitoring is in place.

Renal

Concern was raised that the Renal Services do not receive adequate up to date core morbidity data from NHS England providers. This is problematic as it is difficult therefore to benchmark against comparable data. Further work was being undertaken in this area.

Matters requiring Committee level consideration and/or approval

Approval of the Terms of Reference

Note the services escalated at level 3 or above	
Matters referred to other Committees	
None	
Confirmed Minutes for the meeting held 16th August 2017 are available from http://www.whssc.wales.nhs.uk/quality-and-patient-safety-committee-con	
Date of next meeting	October 17th 2017

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

21.4

Quality and Patient Safety Committee

Terms of Reference

Document Author:	Corporate Governance Manager
Executive Lead:	Director of Nursing and Quality Assurance
Approved by:	Joint Committee
Issue Date:	
Review Date:	

1.0 Constitution and Purpose

1.1 In accordance with WHSSC Standing Order 3, the Joint Committee may and, where directed by the Local Health Boards (LHBs) jointly or the Welsh Government must, appoint joint sub-committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each Local Health Board (LHB) and/or its other committees).

These may consist wholly or partly of Joint Committee members or LHB members or of persons who are not LHB members or Board members of other health service bodies.

The Joint Committee shall establish a joint sub-committee structure that meets its own advisory and assurance needs and in doing so the needs of the LHBs jointly. As a minimum, it shall establish a joint sub-committee whose purpose is to provide advice and assurance on all matters of quality and patient safety relevant to the work of the Joint Committee. This sub-committee will be known as the **Quality and Patient Safety Committee.**

1.1. Purpose

The purpose of the Welsh Health Specialised Services Committee (Joint Committee) 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 LHB Quality and Patient Safety Committees are informed of any issues relating to their population recognising that concerns of specialised service may impact on primary and secondary and vice versa (whole pathway).

1.2. Relationships and accountabilities

Although the Joint Committee has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, the LHBs retain overall responsibility and accountability for ensuring the quality and safety of care to their citizens.

The Sub-Committee is directly accountable to the Joint Committee for its performance in exercising the functions set out in these terms of reference.

The Sub-Committee through its Chair and Members shall work closely with Joint Committee's other joint sub-committees and groups to provide advice and assurance to the Joint Committee through the:

- Joint planning and co-ordination of the Joint Committee and Sub-Committee business; and

- Sharing of information.

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Joint Committee's overall risk and assurance framework.

The Sub-Committee through its Chair and Members shall work closely with LHB Quality and Safety Committees to ensure that LHB Boards are informed of any issues relating to their population recognising that concerns of specialised service may impact on primary and secondary and vice versa (whole pathway).

The Sub-Committee shall embed the Joint Committee's standards, priorities and requirements e.g. equality and human rights, through the conduct of its business.

2.0 Delegated Powers and Authority

2.1 The Quality and Patient Safety Sub-Committee (the Sub-Committee) will, in respect of its provision of advice to the Joint Committee:

- Oversee the development of a quality assurance framework for the commissioning of safe, effective and sustainable specialised for the people of Wales;
- Monitor and support the implementation of the quality assurance framework ensuring that there is continuous improvement in the commissioning of safe, effective and sustainable specialised for the people of Wales;
- Oversee the development of a patient engagement framework for the commissioning of safe, effective and sustainable specialised for the people of Wales;
- Monitor and support the implementation of the patient engagement framework ensuring that there is continuous improvement in the commissioning of specialised for the people of Wales;
- Consider the quality and patient safety implications arising from the development of commissioning strategies, including developments included in the Integrated Commissioning Plan;
- Ensure that all programmes and programme teams, through regular reporting to the committee consider quality and safety as part of service commissioning;
- Receive from the programmes and programme teams, when required, items for urgent consideration and escalation;
- Receive regular updates on the development of commissioning policies and any implications for the quality and safety of commissioned services;
- Oversee the development and implementation of the risk management systems for WHSSC, ensuring that quality and safety of services are priority for the organisation;
- Monitor and scrutinise risk management and assurance arrangements from the perspective of clinical and patient safety risks;

- Monitor and scrutinise concerns management arrangements ensuring that patient safety and safeguarding is paramount within WHSSC; and
- Ensure that lessons are learnt from patient safety incidents, complaints and claims (within specialised services) and that all such lessons are disseminated to all providers of services commissioned by the Joint Committee.

2.2 **Authority**

The Quality and Patient Safety Sub-Committee is authorised by the Joint Committee to investigate, or have investigated, any activity within its terms of reference.

The Sub-Committee is authorised by the Joint Committee to obtain outside legal or other independent professional and clinical advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with WHSSC's procurement, budgetary and other requirements.

The Sub-Committee will ensure that it is aware of and receives relevant reports on the activities and reports of external independent regulators and agencies, such as Health Inspectorate Wales, Care Quality Commission, National Audit Office and Wales Audit Office, that relate to the commissioning and delivery of specialised services.

2.3 **Access**

The Head of Internal Audit of the host LHB shall have unrestricted and confidential access to the Chair of the Quality and Patient Safety Sub-Committee.

The Sub-Committee will meet with Internal Audit without the presence of WHSSC officials on at least one occasion each year.

The Chair will also meet with nominated representatives of Healthcare Inspectorate Wales without the presence of officials on at least one occasion each year.

The Chair of the Quality and Patient Safety Sub-Committee shall have reasonable access to the Directors and other relevant senior staff within the Welsh Health Specialised Services Team.

3.0 Sub-groups

The Sub-Committee may, subject to the approval of Committee, establish sub-groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business.

4.0 Membership

The membership of the Sub-Committee shall be determined by the Joint Committee, based on the recommendation of the Chair of WHSSC, taking account of the balance of skills and expertise necessary to deliver the Sub-Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

The Quality and Patient Safety Committee shall select, from nominations from the Local Health Boards and Welsh NHS Trusts by the Chair of the Joint Committee and the Chair of the Sub-Committee. This selection will provide as wide a representation across Wales as possible.

The Sub-Committee shall consist of not less than five Independent Members drawn from Health Boards. The Chair and Vice Chair will be appointed from the Independent Members or will be an Independent External Advisor (as appropriate).

The Sub-Committee may also co-opt further additional independent members from outside of the organisation to provide specialist knowledge and skills.

The committee will be supported by the following:

- WHSSC Medical Director
- WHSSC Director of Nursing and Quality; and
- Committee Secretariat.

A representative of the Community Health Council (Wales) and a representative from Healthcare Inspectorate Wales will be invited to attend as an observer.

The Sub-Committee Chair may extend invitations to attend Sub-Committee meetings as appropriate.

5.0 Quorum

At least two members must be present to ensure the quorum of the Sub-Committee, one of whom should be the Committee Chair or Vice Chair.

6.0 Frequency and Attendance

The Sub-Committee will hold a minimum of five meetings per year.

Additional meetings may be called as appropriate with agreement of all members.

Additional meetings may be held with the Chairs of the LHB's Quality and Safety Committees where there is urgent business for escalation. The Chairs of the LHB will also be invited to attend the Sub-Committee when it considers the draft Annual Quality Statement.

Members will be required to attend a minimum of 75% of all meetings.

7.0 Dealing with Members' interest during meetings

Declarations of Interest will be a standing agenda item for all meetings**.**

Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for the meeting.

Interests declared at the start of, or during a meeting will be managed in accordance with section 7.3 of the WHSSC Standing Orders.

8.0 Decision Process

Decisions can only be made in line within the parameter of the Committee's functions and the delegated powers and authority of the group as set out in section 2.0.

This committee is an assurance committee and therefore where a decision is required the matter will be referred to the Joint Committee.

9.0 Administrative Support

The Committee will be supported by WHSSC Corporate Secretariat, whose duties and responsibilities include:

- Arranging meetings and issuing invites for each meeting;
- Agreement of agendas with the Chair and preparation, collation and circulation of papers;
- Taking the minutes notes;
- Ensuring that there is a register of actions agreed at meetings and seeking timely updates from members with regards to their specific action points;
- Maintaining records of members' appointments and renewal dates; and
- Maintaining the register of interests for the committee/group.

10.0 Support to Committee Members

The Committee Secretary, on behalf of the Chair of WHSSC, shall:

- Arrange the provision of advice and support to the Sub-Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of organisational development for Sub-Committee members as part of the overall OD programme developed by the Joint Committee.

11.0 Circulation of papers

The Committee Secretariat will ensure that all papers are distributed at least five clear working days in advance of the meeting.

Items for information will not be considered by the Committee in accordance with the Business Framework 4.1.7. These items may be circulated outside of the meeting.

12.0 Circulation of minutes

The Committee Secretariat will ensure that the draft minutes will be provided to the meeting Chair within ten working days following the meeting.

The Committee Secretariat will ensure that a Chair's brief is shared with Members, where practicable, within five working days following the meeting.

13.0 Reporting and Assurance Arrangements

The Sub-Committee Chair will:

- Report formally, regularly and on a timely basis to the Joint Committee on the Sub-Committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports as well as the presentation of an annual report;
- Bring to Joint Committee's attention any significant matters under consideration by the Sub-Committee;
- Ensure appropriate escalation arrangements are in place to alert the Chair, Director or Chairs of other relevant committees of any urgent or critical matters that may compromise patient care and affect the operation or reputation of the Joint Committee;

The Joint Committee may also require the Sub-Committee Chair to report upon the committee's activities at public meetings or to partners and other stakeholders including NHS Wales Health Boards where this is considered appropriate;

The Committee Secretariat will, on behalf of the Sub-Committee Chair, submit the committee minutes and written reports to the LHB Board Secretary for consideration the LHB Quality and Safety Committees.

14.0 Training, Development and Performance

The Committee Secretary, on behalf of the Joint Committee, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any task and finish groups established.

An induction process will be established for new members and any training and development sessions will be managed by the Chair and Committee Secretary.

15.0 Review

The Sub-Committee Membership will be reviewed every two years.

Members of the Sub-Committee will be appointed for a period of two years but should serve no more than four consecutive years. During this time a member may resign or be removed by WHSSC.

These terms of reference shall be reviewed annually by the Sub-Committee with reference to the Joint Committee.

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

Agenda Item 21.5
WHSSC Joint Committee
26 September 2017

Reporting Committee	**Welsh Renal Clinical Network**
Chaired by	**Chair, Welsh Renal Clinical Network**
Lead Executive Director	**Director of Finance**
Date of last meeting	**7 August 2017**

21.5

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

- The implementation of the SE Wales dialysis contract is complete with the remaining unit in North Gwent having opened on 11th July. The unit was officially opened by the Cabinet Secretary on 14 Sept 2017
- A North East Wales dialysis tender process underway with an initial options appraisal held on 31st July 2017.
- Plans for the refurbishment of the main dialysis unit in Cardiff are progressing although a business case has not yet been submitted to Welsh Government
- An expansion to the dialysis unit at Llandrindod Wells is planned to increase the number of stations from four to six. A business case submission to Welsh Government is anticipated next month

- The WRCN board received a presentation from the Renal youth worker. The youth worker post was initially funded as a two year pilot scheme. Since in post the youth worker has engaged with over 100 young patients and has positively impacted on compliance to treatment, access to education and employment and the preservation of kidney transplants in young adults.
- A presentation was received from Dr Kieron Donovan on Patient Reported Outcome Measures and value based health care. Dr Donovan reported that data is being collated in Wales that will help informed and evidence based decision making on renal patient care. This will enable patients to make informed choices about treatment options and offer commissioners of the service assurances around value for money and prudent application of resources
- A presentation was received from Roy Thomas from Kidney Wales Foundation that detailed a proposal by the charity to build a wellness centre for renal patients in Wales that would facilitate holiday dialysis/respite care for renal patients and their families. The proposal is in the early stages with Kidney Wales Foundation seeking support in principle before further work is undertaken to ascertain feasibility and a detailed business case.

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

- ABMU transport has presented a cost pressure during 16/17 and will continue to be a risk 17/18 until the transport tender can be resolved
- A review of the renal element of the Cardiff LTA has been undertaken and WRCN board have approved non recurrent changes to activity baselines to

reflect the current use of the ongoing under spend in transplant activity. The transplant has baseline is to be revised downwards from 160 transplants to a 100. The Cardiff dialysis baseline is to be revised upwards by £525K to account for the ongoing over performance. This leaves a forecast net under spend position of £390K which will be used to off set the growth requirements submitted to the WHSSC ICP
Matters requiring Committee level consideration and/or approval
•
Matters referred to other Committees
Annexes: Annual Report from the Chair of the WRCN

Date of next meeting	**9th October 2017**

21.5

Rhwydwaith Clinigol Arennol Cymru
Welsh Renal Clinical Network

Annual Report

2016-2017

1. Background

The WRCN was established in 2009 by Welsh Assembly Government, with specialist commissioning and advisory responsibility for adult renal services in Wales. It was adopted as a subcommittee of WHSSC in 2011. The WRCN is funded by the LHB's via WHSSC and manages a ring fenced commissioning budget of circa £70m on behalf of WHSSC. Renal services are the only specialist service to be clinically led by a national network of clinicians working collaboratively in Wales to provide clinical leadership, strategy and guidance.

One of the key strengths of the WRCN has been effective patient representation and participation at both a board level and on specific work groups enabling the co production of renal services that are patient focused and fit for purpose.

The WRCN management team is a subcommittee of the WRCN board and acts as an interface between the WRCN as a commissioning group and the LHB renal directorate teams. This provides an effective process of engagement to progress key issues, collectively consider business cases for service change put forward by the individual renal teams across Wales, ensure consistency of services across the regions and make recommendations to WRCN board. The collaborative work of the management team has enabled prudent use of resources, reinvestment of ring fenced renal savings and the avoidance of any net financial investment from WHSSC being needed until 2017 despite a continued growth in renal patients of 3% per annum.

Membership of both the Board and Management Team is noted in appendix 1.

2. UK Context

According to the most recent published data, Wales remains as the home nation with the highest incidence of adults requiring renal replacement therapy (RRT) and having the highest prevalence RRT (all), Peritoneal Dialysis (home dialysis) and Transplantation.

Incidence/Prevalence of Home Nations for Renal Replacement Therapy and Renal Transplant

Persons per million of Population (PMP)	**Wales**	**England**	**Scotland**	**Northern Ireland**	**UK**
Incidence	119	117	101	93	115
Renal Replacement Therapy prevalence	919	918	874	874	913
Haemodialysis	361	379	346	344	374
Peritoneal Dialysis	62	58	40	34	56
Transplantation	496	481	488	496	482

Source: UK Renal Registry 18th Annual Report

3. Key Achievements in 2016-17

3.1 Safety and Sustainability

3.1.1 **Opening of new dialysis units in Gwent at Mamhilad (Pontypool) and Cleppa Park (Newport) as part of the successful re tendering of SE Wales Contract**

Service improvements realised as a result include:

- Increased capacity closer to patient homes
- Better facilities to improve patient experience
- Improved nurse to patient ratios for closer clinical supervision and acceptance of more dependent patients
- World class facilities and space that is future proofed for at least 5-10 years of anticipated growth

3.1.2 **Home Dialysis – Refresh of national commissioning framework**

- The national framework for home therapies has been operational for twelve months and a contract refresh process is underway to identify areas that can be amended in response to service feedback and to look for opportunities to increase the overall value for money.
- The expansion of home therapies remains a key work area for WRCN and a national programme for nurse education and engagement will support this over the next twelve months under the strategic leadership of the newly appointed WRCN Lead Nurse.

3.1.3 **Vascular Access**

The All Wales Vascular Access Network facilitates regular audit and peer review of vascular access services in Wales. Over 2016-2017 the combined Welsh units have achieved the standards set by the UK Renal Association. This is currently achieved by few UK renal units. The major challenges to the service relate to sustainability. The funding of elements of the service still requires clarity.

3.1.4 **Renal Transplantation**

Since 2015 and the implementation of the Transplantation (Wales) Act, the renal transplant service in Wales has been under particular scrutiny. As yet it is difficult to determine the impact that the Act has had on kidney transplants in Wales. However, data that is available for Wales shows us to be in a very favorable position in comparison with the rest of the UK, with shorter waiting lists, shorter waiting times and higher proportions of pre-emptive live donor transplantation.

	Wales	UK
Waiting list (pmp)	57	81
Incident transplants (pmp)	42	51
Prevalent transplants (pmp)	532	482
Median waiting time to deceased donor transplant (days)	588	905
Proportion patients transplanted first year after activation*	52%	25%
Live Donor Transplants (pmp)	17	15
LD transplants proportion of total	41%	30%
LD transplants proportion of waiting list	30%	19%
Pre-emptive LD transplants	54%	37%

3.2 Quality

3.2.1 **Value Based HealthCare- Implementation of prospective collection of patient reported data about outcomes, expectation and experience.**

- Traditionally the quality of renal services has been judged on data submitted to the Renal registry. This is now supported by analysis of the patient experience and determines whether the treatment offered matches the expected outcome.

3.2.2 **Appointment of Lead Nurse (April 2017)**

3.2.3 **Appointment of Lead Renal Pharmacist**

- This role has helped coordinated prescribing, developed protocols for high cost drugs, facilitated integration of prescribing within the National IT systems and provided advice the WRCN Board about issues and developments including horizon scanning for new (and potentially expensive) products.

3.2.4 **Service Specifications**

- Published in April 2016 (available on WRCN website)
- These set out the minimum requirements of a service, measures of good practice and the national audit requirements and are central to delivering high quality renal services in Wales.
- Produced in collaboration with service users and clinicians, the Welsh Renal Clinical Network led the development of a range of service specifications covering the care pathway across Chronic Kidney Disease, from pre-dialysis care through to end of life care.
- Each regional service will complete an annual self assessment against the service specifications that will assist WRCN in assessing both service quality and service equity across Wales. The speciications relate to:

1	Chronic Kidney Disease (CKD)
2	Vascular Access
3	Peritoneal Dialysis

4	Home Haemodialysis
5	Unit Haemodialysis
6	Conservative Management & End of Life
7	Transplantation
8	AKI (Acute Kidney Injury)
9	Unit Haemodialysis Transport

3.2.5 **Appointment of Youth support worker for young people with renal disease**

- To enable improvements in support and well being of younger patients with renal failure.
- Initial results indicate a reduced number of kidney transplants lost due to non engagement with Tx services in young persons

3.2.6 **Information Technology**

- The development of Renal IT systems to facilitate automated reporting to support all Wales Audit, returns to National registries and to assist more effective day to day clinical management of patients

3.2.7 **Transport**

- There has been significant improvement in the safety issues over the last year. Fewer patients have reduced dialysis treatments as a result of transport delays (70 per month reduced to 20 per month) with no patients during 2016-17 experiencing a reduced treatment more than three times within a four week period.
- What remains a problem for patients, is the uncertainty and timeliness of the return journeys following their dialysis treatment.

3.2.8 **Clinical Audit Event**

- The WRCN audit has been running for the last seven years and is the only specialist service audit in Wales inclusive of all multi disciplinary health professionals and patients. Since inception, the involvement of different members of the renal multidisciplinary team has been crucial in, evaluating compliance with Renal Service Specifications and implementing the principles of Prudent Healthcare. Patients' representatives are always invited to attend this meeting and participate in presentation, discussions and planning for future meetings/ presentations.

Examples of some of the presentation for this year's audit (22/9)

1. High cost immunosuppressant drugs utilisation and expenditure in the treatment of renal transplant recipients.

2. Frailty Index, patient choice and Quality of Life for patients offered renal replacement therapy.

3. Temporal trend of diagnosis, management and outcome of Acute Kidney injury in Wales.

4. Integrating Social Care Issues with Renal Service and Health Research.
5. Learning lessons from critical incidents/ external reviews.

3.2.9 **Financial Management**

The WRCN holds the responsibility for an annual budget of £67.7m which is specifically ring fenced for renal dialysis and transplant services across Wales.

For the financial year 2016/2017, the WRCN made the following additional investments

Dialysis Services	£2.119m
Transplant Services	£2.966m
Dialysis Transport	£0.329m
Clinical Staff Posts	£0.175m

Within this £0.117m was invested into the Health Vision Swansea development to fund the refurbishment and expansion of the main Swansea dialysis unit and a further £0.146m to fund the refurbishment and expansion of the Bangor and Alltwen units in North Wales.

£0.343m was provided to increase access to dialysis services within the SE Wales region including the newly opened Newport and Cardiff South units, while £0.570m supported dialysis services in West Wales. £0.410m was specifically made available to fund services for Mid Wales patients who do not normally have access to locally based specialist services, and a further £0.405m funded home dialysis services in N Wales, as well as specific dialysis services for Flintshire residents.

Further investment was provided to Transplant services across Wales including an additional £1.333m for anti rejection drugs, an additional £1.128m to fund transplant services to the N Wales population and £0.505 to fund the Wales Blood Service donor matching laboratories.

4.0 Work Plan for 2017-2018

4.1 **Development of business case for N Wales dialysis expansion and redevelopment**

- Maximising opportunity to develop a single North Wales approach to HD facilities in order to replicate the success of the developments already realised in the SE and SW of Wales

4.2 **Development of a business case for dialysis expansion in Powys**

- Increasing the existing capacity in Llandrindod Wells Dialysis Unit by two stations via WG Capital programme.

4.3 **Supervision of design and changing function of the main dialysis unit in UHW**

- Design and function agreed with Directorate to help improve patient experience and quality of treatment
- Business case in process of being submitted to WG by Cardiff and Vale

University Health Board (CVUHB)

4.4 **Provision of advice for the development of improved dialysis facilities in Pelican Ward for children on dialysis**

- Continuing to providing expert advice through a close relationship between WRCN, CVUHB Children's Renal service, UHW Estates and Board and Kidney Wales Foundation Charity. This should enable more space for dialysis adjacent to the Children's kidney ward and also allow the old dialysis facilities to be used for an improved outpatient environment.

4.5 **Renal Nurse Development**

- Re-establish a Degree/Masters level Renal Course in the Swansea University for the South of Wales. The course will mirror a similar course in North Wales. This will encourage structured Renal learning for nursing staff, career progression and recruitment and retention in Renal service. It will commence early2018.

4.6 **Quality Assurance Programme**

- National Service Improvement /Inspectorate programme will be established by the Lead Nurse to help evaluate, discuss, improve and harmonise the quality of dialysis units across Wales. This will start in 2018.

5. Governance and Reporting Structure

The WRCN board has a well established structure that includes a QPS sub committee and work groups assigned to the various areas of responsibility. Patient representation and engagement is embedded throughout all work streams and patients are encouraged to participate wherever they feel they can contribute.

The QPS subcommittee works closely with the WHSSC QPS committee and the QPS teams work closely together to respond to risks and incidents identified. The renal QPS lead provides a standing update to the WHSSC QPS agenda at each QPS meeting.

The WRCN through its QPS sub-committee provides national leadership of renal clinical governance and works closely with the LHBs to monitor risk and respond to issues promptly. The WRCN QPS committee, as a standing agenda item to its quarterly meetings, reviews the individual directorate risk registers and holds a discrete WRCN risk register that encompasses all risks to service safety, sustainability and effectiveness. This is shared as a standing agenda item for WHSSC QPS committee.

WRCN is notified of any serious incidents and the WRCN QPS lead works closely with WHSSC QPS team to ensure that all incidents are thoroughly investigated and responded to appropriately.

The WRCN board has met on 5 occasions during 2016-17. Copies of the minutes of these meetings can be found on http://www.wales.nhs.uk/sites3/page.cfm?orgid=773&pid=50046
The WRCN management team has met on 5 occasions.

The WRCN QPS committee has met on 5 occasions and has contributed to the WHSSC QPS board meetings as a standing agenda item as required.

6 ASSURANCE TO THE JOINT COMMITTEE

The WRCN Chair:

- Reports formally to the Joint Committee and to the Integrated Governance Committee on the activities of the WRCN Board. This includes updates on activity, the submission of WRCN Board minutes and written reports as well as the presentation of an annual report.
- Brings to Joint Committee's attention any significant matters under consideration by the WRCN Board.

The WRCN QPS Lead:

- Reports regularly to WHSSC QPS board and ensures the escalation of any critical matters that may impact on patient care and service sustainability
- The WRCN lead clinician and network manager advise the WHSSC Management committee regarding relevant aspects of their function that have impact outwith the ring fenced envelope of the WRCN

Appendix 1

Remit and Scope of the Welsh Renal Clinical Network

The WRCN has the following discrete areas of responsibility:

- Chronic Haemodialysis including Home Haemodialysis
- Peritoneal Dialysis
- Renal Transplantation
- Transport to and from dialysis
- Vascular Access for dialysis

Other areas where the Welsh Renal Clinical Network supports NHS Wales with advice and planning guidance include:

- Acute Kidney Injury and acute dialysis
- Conservative Management
- Renal Pharmacy
- Renal Workforce
- Service User Engagement
- General Nephrology and Chronic Kidney Disease
- Transport to and from dialysis
- High cost drugs

The WRCN Board has the following membership:

Core (voting) members:

- Network Lead Clinician
- Network Lead Nurse
- Network Clinical Lead for Quality and Patient Safety
- Regional (North, South West and South East Wales) Renal Services Clinical Directors
- WHSSC Management Group representatives (from different health boards for planning and finance);
- Non-officer member LHB representative
- Patient group representative*
- Community Health Council Representative

*Patient Groups will include:

- Kidney Wales Foundation

- National Kidney Federation
- Welsh Kidney Patients Association

In attendance:

- Nominated Director of Welsh Health Specialised Services Team;
- Network Manager
- Network Finance Manager
- Deputy Network Manager
- Welsh Government – Policy Lead for Renal Services;
- Individual patient representatives from renal services and dialysis units as agreed advocates.

The membership of the management team is as follows:

Membership of the Management Group:

- Network Lead Clinician / deputy (Chair)
- Network Lead Nurse
- Network Manager / deputy
- Network Finance Manager
- Network Clinical Lead for Quality & Patient Safety
- Network Clinical Information Lead
- Nominated Director of Welsh Health Specialised Services Team
- Provider Health Boards (Abertawe Bro Morgannwg, Betsi Cadwaladr and Cardiff & Vale):
    - Nephrology Clinical Directors
    - Nephrology Directorate Managers
    - Nephrology Lead Nurses
    - Nephrology Finance Managers
- National Renal Pharmacist
- National Lead for Renal Transplantation

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

Agenda Item 21.6
WHSSC Joint Committee
26 September 2017

Reporting Committee	**Management Group**
Chaired by	**Acting Managing Director, WHSSC**
Lead Executive Director	**Committee Secretary**
Date of last meeting	**31 August 2017**

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

21.6

Interventional Neuroradiology
Members received the paper which presented an update on the current Interventional Neuro-Radiology service in CVUHB.

Members noted that the service 'went down' on 25 August 2017 and is unlikely to resume before October 2017. An interim solution was provided over the bank holiday weekend, with support from North Bristol NHS Trust. It was noted that discussions had been held with the Medical Director at CVUHB around the risks to patients and that North Bristol NHS Trust would be approached to establish formal contracting arrangements.

Members were informed that a meeting had been scheduled with North Bristol NHS Trust, following which arrangements for an interim solution would be shared with members.

A discussion was held around the level of investment made into the service, an opportunity to review a wider network model for service delivery and undertake lessons to be learned exercise.

Members noted that a review of service management had been commissioned; a report on which would be presented to CVUHB Board in September 2017.

Members also discussed issues relating to payment for emergency thrombectomy cases and requested support from HBs around the authorisation process. A paper is to be submitted to the Joint Committee in September 2017.

ICP Risk Management Framework: Update
Members received the report which provided an update on the implementation of the ICP Risk Management Framework; and highlighted the schemes that required further review, risk mitigation and escalation in line with the requirements of the ICP Risk Management Framework.

Members were presented with an overview of the report, noting that schemes scoring 15 or more would automatically be included in the ICP process for 2018-19.

ICP Risk Management Framework: Cardiac Ablation
Members received a paper which provided a summary of the current position of cardiac ablation provision in South Wales, the risk to patients and the recommendations as to the actions required to mitigate this risk and manage it going forward. It was noted that current access rates for south Wales were significantly lower than the British Heart Rhythm Society standard.

The risk scores provided at both commissioner and provider level highlighted a high service risk. It was noted that Cardiac Ablation had previously been recognised as a potential economic benefit scheme for the 2016-17 ICP, however was note progressed due to lack of evidence to identify off set cost/benefit.

It was agreed that in relation to the access issues, plans would be requested from both CVUHB and ABMU to deliver a rate of 100 AF ablations and 20 VT ablations per million population with a view to developing capital and revenue business cases as required. Parallel to this, a needs assessment would be undertaken and presented at a future Management Group meeting. The paper would be updated to include provision in west Midlands and north Midlands.

ICP Risk Management Framework: Alternative Augmentative Communication (AAC)
Members received the paper which provided a summary of the current position of the All Wales AAC service.

Members were reminded that in 2015 the Welsh Government had supported the development of the service with the provision of recurrent funding for staffing but a two-year non-recurrent for equipment. It was noted that the non-recurrent funding was anticipated to expire Autumn 2017 and options for mitigation of the risk of not having the equipment element funded were presented at section 3.5 of the report.

Members were informed that an evaluation of the first two years was being undertaken by Cardiff Metropolitan University which was due to be presented to the WHSSC Joint Committee in September 2017. It was suggested that consideration of the impacts of the new legal framework; including the Well-being of Future Generations (Wales) Act 2015 be taken during the evaluation process.

It was agreed that option 4 - Collectively Escalate to Welsh Government be strengthen around the request for the Welsh Government to consider the provision of funding under the tripartite arranges that originally funded the AAC equipment. Highlighting the current risks and requesting joined up discussion between policy leads across education, social services and health.

Financial Performance Report
Members received the report which set out the estimated financial position for WHSSC for the fourth month of 2017/18.

A year-end financial position of £200k overspend was reported at Month 4, there had been a year end deterioration of c.£400k attributed to Individual Patient Funding Requests expenditure and NHS England performance.

Members received an update on HRG4+ noting a £5.5m pressure for WHSSC and it was noted that SD had met with Welsh Government in relation to concerns and a meeting had been arranged between Welsh Government and NHS England to discuss further.

Integrated Performance Report
Members received a report which provided a summary of the performance of services commissioned by WHSSC for June 2017; Thoracic Surgery, Plastic Surgery, Bariatric Surgery, Neuro Surgery, and Posture & Mobility were highlighted as key areas to note.

A discussion was held around the recent announcement of £50m Welsh Government resource to support the reduction and achievement of RTT targets. The WHSSC Team sought views from members on where waiting list initiatives could add value for specialised services and requested that these be fed back to the team.

Key risks and issues/matters of concern and any mitigating actions
• None
Matters requiring Committee level consideration and/or approval
• None
Matters referred to other Committees
• None
Confirmed Minutes for the meeting held 25 July 2017 are available on request.

Date of next meeting	**21 September 2017**

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

Agenda Item 21.7
WHSSC Joint Committee
26 September 2017

Reporting Committee	**NHS Wales Gender Identity Partnership Group**
Chaired by	**Tracy Myhill**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**21 August 2017**

21.7

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

Pride Cymru NHS Stand
Members discussed the draft banner and flyer for use at the NHS Stand at Pride Cymru.

All Wales Gender Variance Pathway: Update on interim model and next steps
Members were provided with an overview of the phased approach to the pathway development and the elements of the interim pathway model. Members discussed the revised interim pathway model. It was confirmed that the lifespan service would be the focus of phase two and onwards and that the first phase was an interim pathway model for adults.

It was reported that as part of the first phase, a Welsh Gender Identity Team would be established that would be the expert team able to answer questions from and provide advice to local services so that the local teams would be empowered to provide the care for the person who is transgender.

It was noted that the intention for the interim model was to have a network of designated GPs with a special interest. It was confirmed that is was envisaged that there would be a minimum of one GP with a special interest in everylocal health board area.

Early referral to Mental Health Services was discussed and it was agreed that this referral should only be made when there was a clinical need for input from this service. It was also agreed that psychiatry or psychology should become part of the Welsh Gender Identity Team as soon as possible. It was recommended that secondary care services such as voice therapy be included in the future phases of the pathway work.

It was also noted that the Cabinet Secretary for Health and Social Services was proposing to issue a statement regarding a Welsh Gender Identity Team.

Gender identity services consultation - NHS England
It was reported that a consultation exercise was being held by NHS England reviewing the Gender Identity Services. It was noted that this consultation that

as Welsh service users receive services from within NHS England that this consultation was relevant and therefore should be publicized. It was also noted that NHS England had agreed to hold a consultation event within Wales during October 2017.

Stakeholder nominations: update
Members received an update with regards to the appointment of new stakeholders. It was reported that 13 nominations had been received and 13 appointments made. It was also reported that some stakeholders were able to commit more time than other and that some stakeholders had request further information regarding the work to be undertaken.

Canadian Professional Association for Transgender Health (CPATH) Conference
Members supported the attendance of a stakeholder and a clinician at this conference. It was noted that the service model within Canada was a model which could benefit NHS Wales. Therefore it was agreed that the learning from the conference would be use to inform the pathway remodelling work.

Items for Information
Members received the following items for information:

- NHS Wales CEHR update
- Welsh Government update
- Royal College of Psychiatrists QNCC Annual Forum on 8 November 2017 – call for posters
- NHS England's Survey – Improving Trans Awareness in the NHS

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

All Wales Gender Variance Pathway: interim model and next steps
Engagement and support from the LHBs and LMCs is crucial to the successful implementation of the interim model and development of the future service model.

Matters requiring Committee level consideration and/or approval

None

Matters referred to other Committees
No matter have been referred to other committees

Confirmed Minutes for the meeting held 16 May 2017 are available from http://www.whssc.wales.nhs.uk/all-wales-gender-dysphoria-partnership-b

Date of next meeting	To be confirmed

All Wales Interim Gender Pathway

Background

- Welsh Government (March 2016) Action Plan to advance equality for transgender people
- A Gender Variance clinical pathway task and finish group a sub group of the All Wales Gender Dysphoria Partnership Board was set up in April 2016 to support work to consider an All Wales Gender Identity Service for Wales. It was jointly chaired by Voirrey Manson Interim Director, NHS Centre for Equality and Human Rights and Jenny- Anne Bishop Lay representative (Unique Transgender Network).
- The outcome of that work was the presentation of a Non- Financial Outcome appraisal for Gender Identity Services Care Pathway in Wales to the Joint Committee on the 22nd November 2016 who accepted a set of recommendations.
- On November 3rd, 2016 the Health, Social Care and Sport Committee announced £1m funding towards the establishment of eating disorders and gender identity provision in Wales as a result of the Budget Agreement with Plaid Cymru.
- In order to support the work additional funding from Welsh Government was requested and a further uplift of £65,000 non recurrent funding to the mental health allocation was agreed on the 7th April, 2017. A project lead is in the process of being appointed to lead the work.

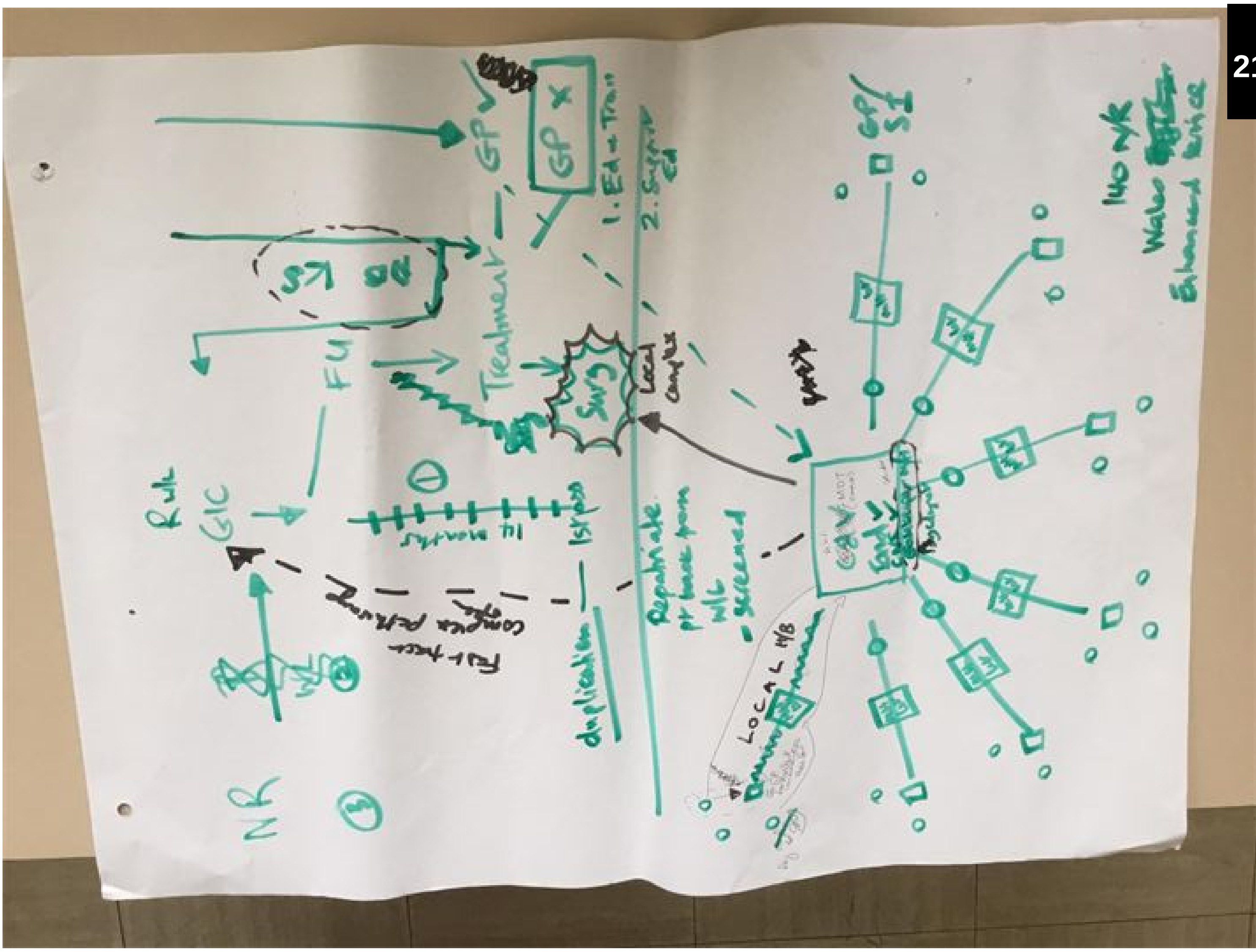
Task & Finish Recommendations

- Interim model to address prescribing issues
- Long term sustainable model

Surgical pathways

- Education & Training
- Shared care protocols / service specifications
- Communication plan

21.7


NR
Rule
GIC
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Treatment
GP
GP
1. Ed + Train
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Surg
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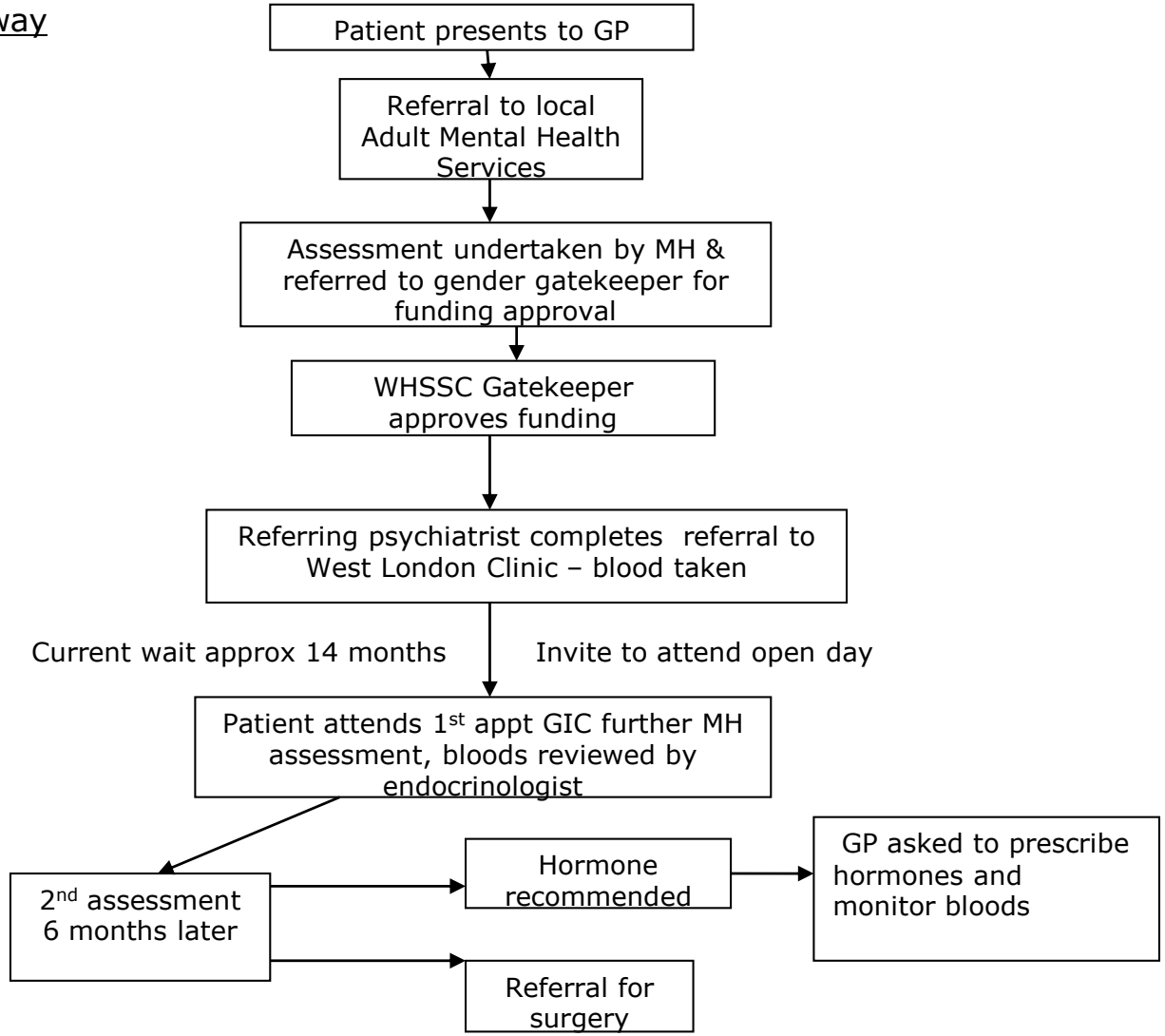
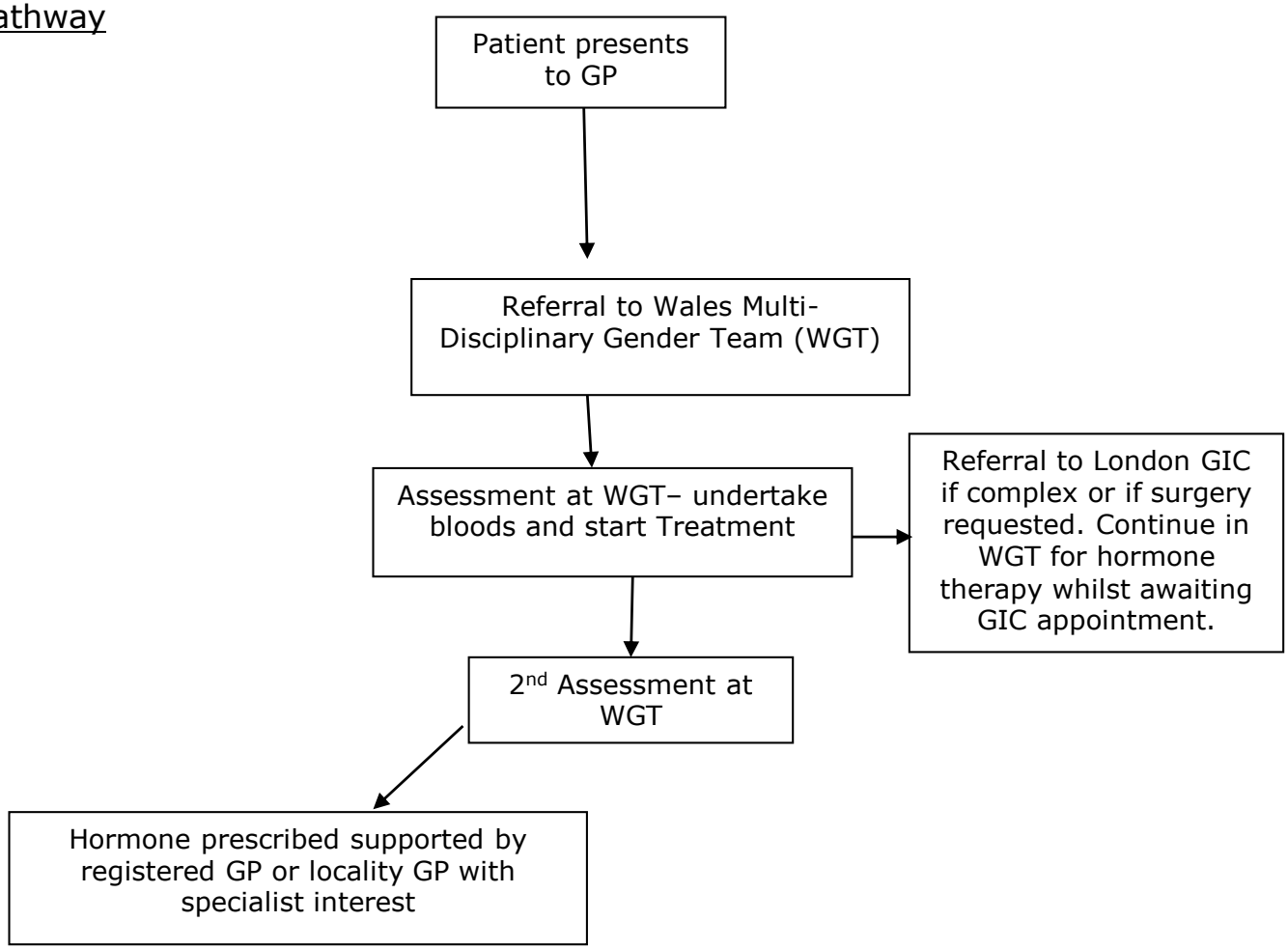
- screened
LOCAL H/B
GP/SI
140 n/k
Wales
Enhanced Service

Current Pathway

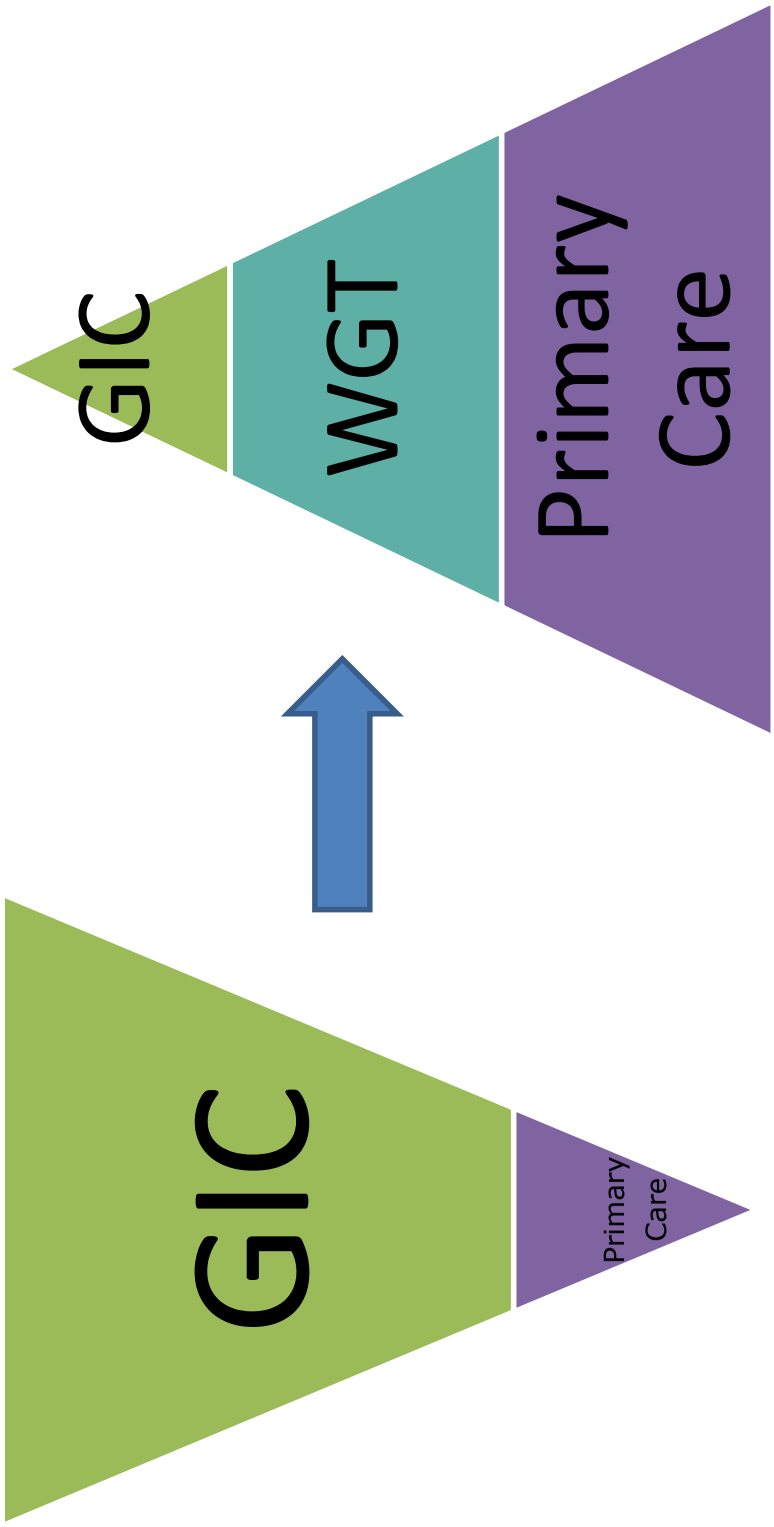


West London Gender Identity Clinic (Tavistock & Portman)
Also Known as Charring Cross

Proposed Interim Pathway



All Wales Multi-disciplinary Gender Team (WGT), Endocrinologist, Clinical Nurse Specialist, Psychiatrist, Psychologist/Counsellor,

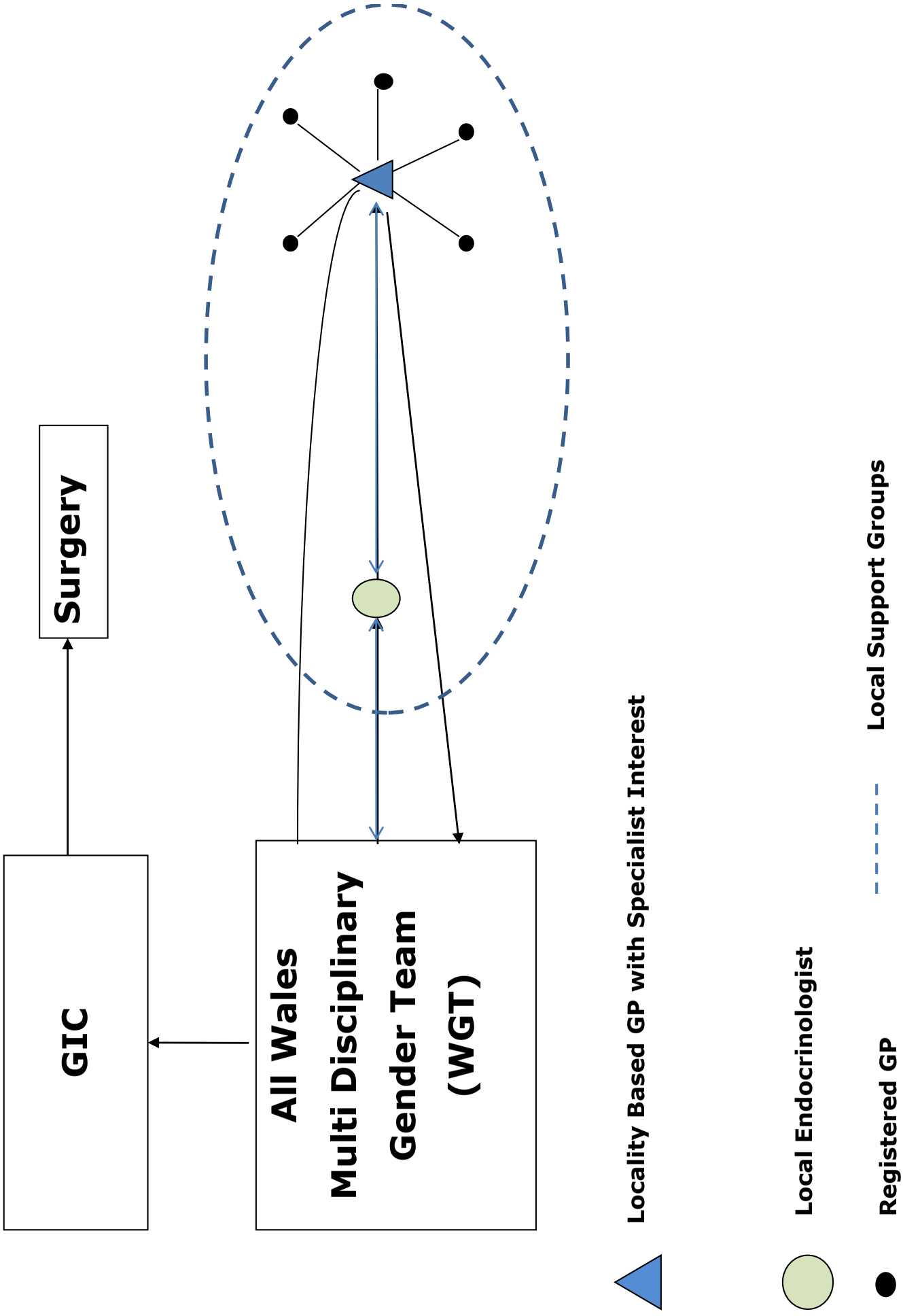

GIC
WGT
Primary Care
GIC
Primary Care

Proposed Timescales

- Phase 1 Address prescribing problems and WGT to work with GIC - Early Autumn 2017

- Phase 2 Repatriation of waiting list from GIC – End March 2018

- Estimated waiting list to WGT within Welsh RTT (26 weeks)


Surgery
GIC
All Wales
Multi Disciplinary
Gender Team
(WGT)
Locality Based GP with Specialist Interest
Local Endocrinologist
Registered GP
Local Support Groups

Proposed Initial Next Steps

- Implement and Evaluate Phase 1
- Increase network of GP's with specialist interest
- Start work with London GIC to repatriate waiting list and future referrals recognised as follow ups (fast track) rather than new patients.
- Review surgical pathways and providers with the aim of direct referral.

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

Agenda Item 21.8
WHSSC Joint Committee
26 September 2017

Reporting Committee	**Wales CAMHS/ED Network**
Chaired by	**Carol Shillabeer**
Lead Executive Director	**Mark Dickinson**
Date of last meeting	**1 September 2017**

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

- It was agreed by all Health Boards that as part of the NHS Collaborative Peer Review programme, the Network would review Primary Mental Health work across all Health Board areas.
- At the request of Professor Dame Sue Bailey the Network will carry out a review of Assertive Outreach Teams, current models and effective evidence based practice being used. A timetable for the fieldwork is being drawn up and will include staff from WHSSC.
- The Network will undertake a review of the current provision of Low Secure services provided for young people in Wales. This is making good progress and an optional appraisal will be available by December 2017 to inform the best way forward.
- The work plan for the Wales CAMHS/ED Network was formally agreed by Network members.
- The Network continues to support the work carried out by the "Together for Children and Young People" programme and is supporting the programme to gather evidence and data for the Welsh Government inquiry.
- The Wales CAMHS/ED Network is in the process of organising the annual Audit Day, due to take place on the 26th January 2018. The day will include the transformational work carried out by Dr R Colgate and will introduce the "UK Mental Health Triage Scale" to Specialist CAMHS services.

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

- The appointed Chair has been unavailable to attend meetings for the last four consecutive meetings.

Matters requiring Committee level consideration and/or approval

- None

Matters referred to other Committees

- None

Confirmed Minutes for the meeting held 1st September 2017 are available on request.

Date of next meeting	**7th December 2017**

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

21.8

Wales Child and Adolescent Mental Health Services and Eating Disorder Network

Annual Report 2016 /17

Sub-Committee/Group Chair: **Carol Shillabeer**

Report Approved by Sub-Committee: **23-JUNE-2017**

Wales Child and Adolescent Mental Health Services and Eating Disorder Network Annual Report

1. BACKGROUND / INTRODUCTION

The Network brings together NHS Wales professionals and key multi-agency partners. These jointly design and plan services in order to improve access, effectiveness and the quality of services from a patient perspective in Child and Adolescent Mental Health Services, emotional health and well-being.
In line with the review of clinical Networks by Chief Executives, a defined set of all Wales clinical Networks, including the CAMHS/ED Network, transferred to the NHS Wales Health Collaborative in October 2016. The NHS Wales Health Collaborative works to support NHS Wales Chief Executives and Health Board Chairs to collectively help shape, plan and make recommendations on the future of NHS services across Wales, and is hosted by Public Health Wales.
The Network recognises the importance of involving appropriate clinical advice and leadership in developing their plans and from each health board in Wales to ensure full geographical service representation. Key Network responsibilities are shown below:

Strategic Planning and Delivery

- ***Produces plans*** for ongoing delivery of services in response to national policy and strategy;
- ***Develops a national vision and a service delivery model*** for CAMHS/ED services that addresses interconnectivities across the services and is based upon a philosophy of early intervention, prevention and recovery;
- ***Co-ordinates national planning and submission of funding proposals*** to funding bodies as appropriate;
- ***Acts as a source of expertise***, to influence policy and strategic service development;
- ***Upholds Royal College of Psychiatry (RCP) standards*** in service development through its membership of the RCP CAMHs advisory council

Operational Planning and Delivery, unconstrained by organisational boundaries

- ***Develops a common performance monitoring framework*** to monitor service delivery against agreed plans;
- ***Builds on local interagency planning mechanisms*** to ensure best practise is shared nationally;
- ***Develops plans*** to ensure equitable access to high quality sustainable services within financial resource limits;
- ***Promotes communication across local planning structures***, providers of service and WG policy leads

- ***Works closely with other clinical Networks*** in the Collaborative, promoting improved cross working, innovation, effectiveness and new synergies building on joint and shared skill sets.

2. MEMBERSHIP

The membership of the Committee comprises of twenty eight, enabling the Committee to operate independently of the management decision-making processes. Membership during 2014-15 was as follows:

Membership CAMHS/ED Network Board

Role	Name and Job title	Organisation/ Health Board
Carol Shillabeer **(CHAIR)**	Chief Executive Powys Teaching Health Board	Powys THB
Mark Dickinson	Director Business Unit NHS collaborative	NHS Wales Health Collaborative
Dr Dave Williams	Divisional Director of Family and Therapies Aneurin Bevan Health Board and Professional Adviser CAMH to CMO and Welsh Government	Aneurin Bevan UHB and Welsh Government
Angela Lodwick	Head of Specialist CAMHS and Psychological Therapies services	Hywel Dda UHB
Carl Shortland	CAMHS Planning Lead	WHSSC
Caroline Winstone	CAMHS Network Manager	NHS Wales Health Collaborative
Claire Lines	Assistant Director	Powys HB
Dr Samantha Sharpe	Clinical Lead, Specialist Eating Disorder Services (Adult) Tier 3	BCUHB
Paul Davies	Assistant Director of Operations (Mental Health)	Cwm Taf UHB
Dr Peter Gore-Rees	Consultant Child Psychiatrist	BCUHB
Dr Mark Griffiths	Consultant Child Psychiatrist	Aneurin Bevan UHB
Dr Robin Glaze	Clinical Director	BCUHB
Gerrard McCullagh	Clinical Lead, Specialist Eating Disorder Services (Adult) Tier 3	Aneurin Bevan HB and Powys HB
Glyn Jones	Manager Specialist	NHS Wales

	CAMHS Network	Health Collaborative
Helen Matthews	Consultant Psychiatrist	Hywel Dda UHB
Jayne Lawrence	Head of Primary Care	Cwm Taf UHB
Jason Pollard	Policy Lead	Welsh Government
Jenni Richards	CAMHS Case Manager	WHSSC
Joanne Davis	Chief Executives Department	ABMU
Joanna Williams	Directorate Manager	Cwm Taf UHB
Julie Withecombe	All Wales Forensic Adolescent and Consultation Treatment Services	Cwm Taf UHB
Lindsay Lowe	Paediatrics	Cardiff and Vale UHB
Rose Whittle	Head of Operations and Delivery Community Child Health Directorate	C&V UHB
Shane Mills	NHS Wales Quality Assurance Team	WHSSC
Sian Harrop-Griffiths	Director of Strategy	ABMU
Siân Stewart	Programme Director T4CYP	Welsh Government
Warren Lloyd	Consultant Child Psychiatrist, Clinical Lead S-CAMHS, Associate Medical Director; Mental Health & Learning Disabilities	Hywel Dda UHB
Wendy Bell	Clinical Lead Specialist Eating Disorders Services (Adult) Tier 3	Hywel Dda & ABMU HB
Wendy Clarke	Senior Nurse & Specialist Lead for Eating Disorders CAMHS	Aneurin Bevan UHB
Leslie Rudd	Head of Wales Centre for Mental Health	Public Health Wales

Service user involvement

The CAMHS/ED network and its sub groups have service users as members who are supported prior to and after meetings. The network therefore places service users at the very heart of its business and functioning.

3. MEETINGS

The Wales CAMHS/ED Network met on four occasions. During the period 2016/17 all meetings were quorate.

In addition to the members, the following also attended Committee meetings during the year:

4. MAIN AREAS OF COMMITTEE ACTIVITY

Network managers manage a core team and wider Network activity and to illustrate their role over the past year, they have delivered on the following actions:

- ✓ Participated in the consultation of the review of clinical Networks which concluded that all Networks will be hosted by Public Health Wales from 1st October 2016.
- ✓ Continued to support and assist with the retrospective audit of Tier 4 adult eating disorder in patient units, in England, towards improved contractual aarrangements and outcomes for patients.
- ✓ Continued to facilitate the training of CAMHS staff across Wales delivered by the South London and Maudsley NHS Foundation Trust in evidence based therapies for eating disorders.
- ✓ Recruited a data and information analyst to develop a performance dashboard and outcome measures framework, the role will also develop systems to record waiting times and to work collaboratively with other clinical Networks.
- ✓ Designed and held on January 20th 2017 the first CAMHS audit and best or innovative practice day with just over 100 delegates, the starting point in the establishment of an annual audit cycle.
- ✓ Collaboratively assisted the T4CYP Programme in several work streams; development of the 'Caremore' Data set; ongoing monitoring of the neurodevelopmental bids submitted to Welsh Government from Health Boards; CITT data set development; core members of the workforce work stream; core members of the early years and resilience work stream; supported Transition work stream consultation event in Wrexham on 5th May 2016.
- ✓ Continued the historical connection with the Office of the Children's Commissioner in Wales. The Commissioner has acknowledged the purpose of the single all Wales CAMHS Network as a key driver for change in the planning and delivery of CAMHS in Wales. The Office of the Children's Commissioner is directly linked to the work of the CAMHS/ED Network via membership.

- ✓ Designed and commissioned from the Tavistock and Portman NHS Trust refugee and asylum seeking children training for CAMHs staff at all health boards in Wales ensuring equity of access across Wales.

Key Network Activities in Support of Patient Care

Research has shown that clinical Networks across the UK provide a valuable contribution to quality improvement. The CAMHS/ED Network is no different in this respect, and this section illustrates many of the value added activities undertaken by it to support the improvement of services, care and quality. Each of these has, ultimately, a real and practical impact on patient care and outcomes.

The improvement of patient outcomes

Development of standard clinical pathways and protocols to support patient care

- ✓ Support for standardised operational hours and out of hours equitable Community Intensive Therapy Team CITT/Outreach teams across Health Boards which has continued to be undertaken by the Network

- ✓ It has also developed a protocol/guidance for transition of young people who have an eating disorder, between CAMHS and adult mental health services.

- ✓ Enhanced delivery of Community intensive support services with enhanced access, times of working and engagement with Emergency departments

Supporting Delivery Plans which aim to implement improved outcomes over Wales

- ✓ Developing a *sCAMHS Framework for Improvement* in collaboration with Together for Children and Young People Programme (T4CYP)

- ✓ Developed with the eating disorder sub group a battery of outcome measures for those with an eating disorder in CAMHS

Providing strong independent and consistent expert clinical advice to Health Boards, NHS Trusts and WHSSC

- ✓ The Network has advised WHSSC on clinical issues, the Mental Health Act, the Children Act, Looked after Children and Safeguarding Children and Young People.

- ✓ It also provides clinical input and advice to T4CYP and supports the NHS Wales Quality Assurance & Improvement (QAIT) Team around

CAMHS issues; quality assurance for the Out of Area Framework and the sharing of good practice across Health Boards.

- ✓ It has assisted Public Health Wales 1000 Lives perinatal service development as the key link to securing access to and implementation of the Royal College of Psychiatry Perinatal Standards Network for all health boards in Wales.

Service planning, including supporting development and implementation of delivery and plans by Health Boards

- ✓ The Network has worked alongside Health Boards to operationalise the agreed proposals for £7.65 million investment into CAMHS services

- ✓ As members of the cross party group on eating disorders the Network has provided input regarding the additional investment of 500,000k in Eating Disorders across the full age range announced in January 2017 and will provide governance of the allocation

- ✓ In alignment with Health Boards and the 1000 Lives Programme, the Network has worked on the interface of perinatal service development as it relates to CAMHS/ED provision. The Network has the ability to provide an audit of the recurrent and ongoing £1.6 million new investment for community based perinatal services at Health Boards in Wales

- ✓ Contributing to continued improvement against new waiting times targets

- ✓ Supporting the enhanced neurodevelopmental assessment and treatment provision with child health and therapy colleagues; expansion of early onset psychosis services; psychological therapies available to children and young people and local primary mental health care services for children

Providing advice on service standards.

- ✓ The Network continues to be heavily involved in service planning and workforce development, for example the scrutiny and development of health board proposals for the £7.65 million investment to CAMHS services before submission to the Welsh Government and subsequent implementation of these proposals.

Development of service specifications for commissioning and collaborative planning

- ✓ The CAMHS Network developed the Business Case and Service Specification for the *Enhanced Eating Disorder Service* for South East,

Mid and West Wales in relation to Welsh Government additional funding (£250K) to improve existing services.

- ✓ It also developed a *service specification on behalf of WHSSC* for the CAMHS inpatient units in Bridgend and Abergele to standardise the delivery of care and length of stay and support more equitable service delivery across Wales.

Influencing commissioning and collaborative service planning

- ✓ The development of business cases, service specifications, protocols, guidance and input to the framework for improvement by the CAMHS Network has been able to strongly influence service delivery, with the responsibility remaining with the Health Boards and WHSSC.

Reviewing provider compliance with standards

- ✓ The Network does not currently use Peer Review, but has been involved in the scoping up of future work in this area. It has identified Early intervention and prevention as delivered by the primary care workforce as its area of focus to undertake peer review in. Some teams in Wales are members of the Royal College of Psychiatry (RCP) quality Network of community CAMHs (QNCC) – this provides a mechanism of self review, peer review and teams can work towards accreditation – Network manager is a member of the RCP advisory council and undertakes reviews of other CAMHs in UK to share best practice.

- ✓ Secured for all Health Boards in Wales the use of the Royal College Psychiatry Perinatal Standards

Reviewing service outcomes, and developing and monitoring other outcomes measures

- ✓ The CAMHS Network has commenced the undertaking of the development of performance indicators for CAMHS Community Intensive Therapy Teams (CITT) and Outreach Teams.

- ✓ It continues to review service outcomes, and previously enhanced the delivery of care by providing funding (via Welsh Government) for "Waiting Time initiatives", workforce development and infrastructure.

- ✓ Full participation in the NHS CAMHS Benchmarking exercise 2016

Developing models of care and pathways

- ✓ In conjunction with the T4CYP programme, the Network has developed the *Framework for Improvement* in the Specialist CAMHS Work Stream, including comprehensive evidence based models of care and care pathways.
- ✓ Work to date on the *enhanced CAMHS eating disorder specification*

and the *CAMHS Inpatient specification* are based on the most up to date evidence based practice.

- ✓ Assisted with the proposal for the service model for the enhancement of mental health services for young people in Wales in the Youth Justice system
- ✓ Continued collaborate development and support with Public Health Wales Perinatal Network assuring robust governance arrangements across the Perinatal pathway both community and the tier 4 pathway development work.

Supporting Health Boards in taking forward the integration agenda

- ✓ Health Boards and WHSSC are fully supported by the Network to achieve the best outcomes for children, young people and their families. The Network encourages equitable services across Wales and highlights good inter-professional practice

- ✓ Secured information resources and displays for the second all Wales Community of Perinatal Practice held in December 2016

5. LINKS WITH OTHER COMMITTEES

The Wales CAMHS/ED Network supports the Specialist CAMHS work stream for the "Together for Children and Young People Programme"

6. WORK PROGRAMME

In order to monitor progress and any necessary follow up action the Committee was supported by the Business Director, NHS Collaborative in developing a work log that captured all agreed actions. This provided an essential element of assurance both to the Committee and from the Committee to the Integrated Governance Committee and the Joint Committee.

7. ASSESSMENT OF GOVERNANCE AND RISK ISSUES

The Wales CAMHS/ED network provides an essential element of the overall governance framework for the organisation and has operated within its Terms of Reference and in accordance with the Governance and Accountability Framework. The Committee undertakes a self assessment and this is in the process of being compiled and any actions will be picked up as part of the work plan for 2017/18.

8. ASSURANCE TO THE BOARD

The Wales CAMHS/ED Network wishes assure the Board that on the basis of the work completed by the Committee during 2016/17, there are effective measures in place and there are no outstanding issues that the Committee wishes to bring to the attention of the Joint Committee.

9. CONCLUSION AND LOOK FORWARD

The Committee is committed to continuing to develop its function and effectiveness and intends seeking further assurance in 2017/18 in respect of the comprehensive transformational workplan.