2022-01-18 WHSSC Joint Committee (Public)

Tue 18 January 2022, 09:30 - 11:20

Teams Meeting - Details in Calendar Invite

Agenda

09:30 - 09:35
5 min

1. PRELIMINARY MATTERS

0.0 Agenda JC 18 January 2022.pdf (2 pages)

1.1. Welcome and Introductions

Oral *Chair*

- To **open** the meeting with any new introductions.

1.2. Apologies for Absence

Oral

- To **note** and record any apologies

1.3. Declarations of Interest

Oral *Chair*

- To **note** and record any declarations of interest outside of WHSSC 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

1.4. Minutes of the Meeting held on 09 November 2021 and Matters Arising

Att. *Chair*

- To **approve** the minutes of the meeting held on 09 November 2021 and consider any matters arising

1.4 Unconfirmed JC (Public) Minutes 09 November 21.pdf (14 pages)

1.5. Action Log

Att. *Chair*

- To **review** and **update** the action log

1.5 JC Action Log for 18 Jan 2022.pdf (6 pages)

09:35 - 10:35
60 min

2. ITEMS FOR CONSIDERATION AND/OR DECISION

2.1. Chair's Report

Att. *Chair*

- To **note** the report;
- To **ratify** the action undertaken by the Chair on behalf of the Joint Committee, detailed in Appendix 1; and
- To **approve** the extension of the interim Welsh Renal Clinical Network Chair arrangement until 31 March 2022 to ensure business continuity whilst the substantive post is recruited to.

2.1.1 Chair's Report.pdf (6 pages)
2.1.2 Appendix 1 Chair's Action WRCN ToR - Ltr to JC 09 December 2021 (incl Appendices).pdf (32 pages)

2.2. Managing Director's Report

Att. *Managing Director*

- To **note** the report.

2.2 Managing Director's Report.pdf (5 pages)

2.3. Individual Patient Funding Request (IPFR) Panel Update

Att. *Managing Director*

- To **note** the issues with the current Terms of Reference of the All Wales IPFR Panel;
- To **note** the outcome of the recent Judicial Review and the implications for both the All Wales IPFR Panel and Health Board panels in Wales;
- To **note** the next steps agreed with Welsh Government regarding urgent changes to the existing All Wales IPFR Policy;
- To **note** the next steps agreed with Welsh Government regarding the authority of the Joint Committee to approve changes to the All Wales IPFR Panel Terms of Reference; and
- To **note** the suggestion from WHSSC officers regarding the need for a wider review of both the All Wales IPFR Policy and the governance arrangements for the policy

2.3.1 Individual Patient Funding Request (IPFR) Panel Update.pdf (9 pages)
2.3.2 Appendix 1 - All Wales IPFR Policy - June 2017.pdf (29 pages)
2.3.3 Appendix 2 - Wallpott v Welsh Health Judgment - Final Approved (003).pdf (34 pages)
2.3.4 Appendix 3 - IPFR QualityAssuranceGroup-ToRFeb2021.pdf (3 pages)

2.4. Audit Wales WHSSC Committee Governance Arrangements Update

Att. *Committee Secretary*

- To **note** the progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report;
- To **note** the progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and
- To **approve** the updated audit tracker for submission to Audit Wales and to HB Audit Committees for assurance in February/March 2022.

2.4.1 Audit Wales WHSSC Committee Governance Arrangements Update.pdf (5 pages)
2.4.2 Appendix 1 - Audit Wales WHSSC Governance Tracker.pdf (24 pages)

2.5. Assurance on Patients Waiting for Specialised Services

Att. *Director of Planning*

- To receive **assurance** that there are robust processes in place to gain assurance that provider organisations are managing and supporting patients waiting for specialised care and treatment;
- To **note** that the position in our NHS England specialised service providers has been generally more stable with recovery and activity across most contracts back to pre-pandemic levels. However given the rise in cases of the Omicron variant and the reports in the media that Trusts in NHS England are suspending elective care, the WHSS Team will urgently ascertain the position in our main specialised service contractors in NHS England. This will be reported to Joint Committee in the routine activity report; and
- To **note** the report.

2.5 Assurance on Patients Waiting for Specialised Services.pdf (6 pages)

2.6. WHSSC Independent Member Remuneration Update

Att. *Chair*

- To **note** the report;
- To **discuss** and **approve** the proposal to transition to a fair and open selection process for appointing WHSSC IMs through advertising the vacancies through the Health Board Chairs and the Board Secretaries, with eligibility confined to existing Health Board Independent Members;
- To **discuss** and **approve** that the existing arrangements for appointing a Cwm Taf Morgannwg Audit Lead Independent Member, can transition to advertising for an Audit/Finance Independent Member through a fair and open selection process through advertising the vacancy through the Health Board Chairs and the Board Secretaries, with eligibility confined to existing Health Board Independent Members;

- To **discuss** and **approve** the suggested proposals to remunerate WHSSC Independent Members s including the requirement for a review following the recruitment process; and
- To **discuss** and **approve** the additional annual cost of remunerating WHSSC Independent Members and approve an uplift to the Direct Running Costs (DRC) budget to enable a financial pool of resource to recurrently fund the remunerated Independent Member positions.

2.6.1 WHSSC Independent Member Remuneration.pdf (9 pages)
2.6.2 WHSSC IM Remuneration - Letter to KE from CJ confirming next steps - Jan 22.pdf (2 pages)

10:35 - 11:15
40 min

3. ROUTINE REPORTS AND ITEMS FOR INFORMATION

3.1. COVID-19 Period Activity Report Month 08 2021-22

Att. *Director of Finance*

- To **note** the information presented within the report.

3.1.1 COVID-19 Period Activity Report Month 08 2021-2022.pdf (29 pages)
3.1.2 Appendix 1 - COVID-19 Period Activity Report Month 8 2021-2022.pdf (14 pages)

3.2. Financial Performance Report Month 09 2021-22

Att. *Director of Finance*

- To **note** the current financial position and forecast year-end position.

3.2 Financial Performance Report Month 09 2021-22.pdf (12 pages)

3.3. Corporate Governance Matters Report

Att. *Committee Secretary*

- To **note** the report.

3.3.1 Corporate Governance Matters Report.pdf (5 pages)
3.3.2 Appendix 1 WHSSC JC Forward Work Programme.pdf (4 pages)

3.4. Reports from the Joint Sub-Committees

3.4.1. Audit and Risk Committee

3.4(i) CTMUHB Audit and Risk Committee Assurance Report.pdf (2 pages)

3.4.2. Management Group Briefings

Committee Secretary

3.4(ii) MG Core Briefing 25 November 2021.pdf (3 pages)
3.4(ii) MG Core Briefing 16 December 2021.pdf (2 pages)

3.4.3. Integrated Governance Committee

3.4(iii) IGC Chair's Report 12 October 2021.pdf (3 pages)

3.4.4. All Wales Individual Patient Funding Request Panel

3.4(iv) IPFR Chair's Report.pdf (3 pages)

3.4.5. Welsh Renal Clinical Network

3.4(v) WRCN Chair's Report.pdf (2 pages)

11:15 - 11:20
5 min

4. CONCLUDING BUSINESS

4.1. Any Other Business

Oral *Chair*

4.2. Date of Next Meeting (Scheduled)

Oral *Chair*

15 March 2022 at 13:30hrs

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

WHSSC Joint Committee Meeting held in public
Tuesday 18 January 2022 at 09:30 hrs

Microsoft Teams

Agenda

ITEM		LEAD	PAPER / ORAL	TIME
1.0	**PRELIMINARY MATTERS**			
1.1	Welcome and Introductions	Chair	Oral	09:30 – 09:35
1.2	Apologies for Absence	Chair	Oral	
1.3	Declarations of Interest	Chair	Oral	
1.4	Minutes of the Meeting held on 09 November 2021 and Matters Arising	Chair	Att.	
1.5	Action Log	Chair	Att.	
2.0	**ITEMS FOR CONSIDERATION AND/OR DECISION**			
2.1	Chair's Report	Chair	Att.	09:35 – 09:45
2.2	Managing Director's Report	Managing Director	Att.	09:45 – 09:55
2.3	Individual Patient Funding Request (IPFR) Panel Update	Managing Director	Att.	09:55 – 10:05
2.4	Audit Wales WHSSC Committee Governance Arrangements Update	Committee Secretary	Att.	10:05 - 10:15
2.5	Assurance on Patients Waiting for Specialised Services	Director of Planning	Att.	10:15 - 10:25
2.6	Independent Member Remuneration Update	Chair	Att.	10:25 – 10:35
3.0	**ROUTINE REPORTS AND ITEMS FOR INFORMATION**			
3.1	COVID-19 Period Activity Report Month 08 2021-22	Director of Finance	Att.	10:35 – 10:45
3.2	Financial Performance Report Month 09 2021-22	Director of Finance	Att.	10:45 – 10:55
3.3	Corporate Governance Matters Report	Committee Secretary	Att.	10:55 - 11:05

3.4	Reports from the Joint Sub-Committees i. Audit and Risk Committee Assurance Report ii. Management Group Briefings iii. Integrated Governance Committee iv. Individual Patient Funding Request Panel v. Welsh Renal Clinical Network	Joint Sub-Committee Chairs	Att.	11:05 - 11:15
4.0	**CONCLUDING BUSINESS**			
4.1	Any Other Business	Chair	Oral	
4.2	Date of Next Meeting (Scheduled) - 15 March 2022 at 13:30hrs	Chair	Oral	

Unconfirmed Minutes of the Meeting of the WHSSC Joint Committee Meeting held In Public on Tuesday 09 November 2021 via MS Teams

Members Present:

Kate Eden	(KE)	Chair
Sian Lewis	(SL)	Managing Director, WHSSC
Carole Bell	(CB)	Director of Nursing and Quality Assurance, WHSSC Director of Finance, WHSSC
Stuart Davies	(SD)	
Iolo Doull	(ID)	Medical Director, WHSSC
Mark Hackett	(MH)	Chief Executive, Swansea Bay UHB
Glyn Jones	(GJ)	Interim Chief Executive Officer, Aneurin Bevan UHB
Steve Moore	(SM)	Chief Executive Officer, Hywel Dda UHB
Ceri Phillips	(CP)	Independent Member, Cardiff & Vale UHB
Ian Phillips	(IP)	Independent Member, Powys THB
Carol Shillabeer	(CS)	Chief Executive Officer, Powys THB
Stuart Walker	(SW)	Interim Chief Executive Officer, Cardiff & Vale UHB
Ian Wells	(IW)	Independent Member, Cwm Taf Morgannwg UHB
Jo Whitehead	(JW)	Chief Executive Officer, Betsi Cadwaladr UHB

Deputies:

Linda Prosser (for Paul Mears)	(LP)	Executive Director of Strategy & Transformation, Cwm Taf Morgannwg UHB

Apologies:

Paul Mears		Chief Executive Officer, Cwm Taf Morgannwg UHB
Jason Killens		Chief Executive Officer, Welsh Ambulance Services NHS Trust (WAST)

In Attendance:

Carole Bell	(CB)	Director of Nursing, WHSSC
Jacqui Evans	(JE)	Committee Secretary & Head of Corporate Services, WHSSC
Claire Harding	(CH)	Assistant Director of Planning, WHSSC
James Leaves	(JL)	Assistant Director of Finance, WHSSC
Karen Preece	(KP)	Director of Planning, WHSSC
Helen Tyler	(HT)	Corporate Governance Manager, WHSSC

Observers

Simon Dean	(SD)	Deputy Chief Executive NHS Wales, Welsh Government (WG)
Sarah McAllister	(SMc)	Programme Manager, WHSSC

Minutes:

Debra Davies	(DD)	Executive Personal Assistant, WHSSC

The meeting opened at 13:30hrs

Min Ref	Agenda Item
JC21/061	**1.1 Welcome and Introductions** The Chair welcomed Members to the meeting in Welsh and English and reminded everyone that, due to the COVID-19 pandemic, the meeting was being held virtually via MS Teams. No objections were raised to the meeting being recorded for administrative purposes. It was noted that a quorum had been achieved. The Chair reminded Members that the purpose of the Joint Committee was to act on behalf of the seven Health Boards (HBs) to ensure equitable access to safe, effective and sustainable specialised services for the people of Wales by working collaboratively on the basis of a shared national approach, where each Member works in the wider interest.
JC21/062	**1.2 Apologies for Absence** Apologies for absence were noted as above. The Chair noted Linda Prosser (LP) was attending on behalf of Paul Mears, Chief Executive Officer, Cwm Taf Morgannwg UHB.
JC21/063	**1.3 Declarations of Interest** The Joint Committee noted the standing declarations, and there were no additional declarations of interest relating to the items for discussion on the agenda.
JC21/064	**1.4 Unconfirmed Minutes of the Meeting Held 07 September 2021** The minutes of the Joint Committee meeting held on 07 September 2021 were received and approved as a true and accurate record of the meeting.
JC21/065	**1.5 Action Log & Matters Arising:** The action log was received and members noted the following updates: • **JC21/007 – Sharing Slides** - action closed remove form action log, • **JC21/008 – Reporting and Accountability Arrangements**. The Chair (KE) gave an update and Members noted that enquiries had been made with Judith Pagett, the then CEO ABUHB and there were currently no plans to look at the reporting and accountability arrangements

	for WHSSC and/or the Emergency Ambulance Services Committee (EASC) at present, • **JC21/009 – Review of Commissioned Services Locally and Nationally** - Karen Preece (KP) gave an update and Members noted that a workshop was planned for the Management Group (MG) meeting on 25 November 2021, • **JC21/010 – Recovery Planning**- Members noted the item was on the agenda for discussion, • **JC21/011 – Recovery Planning Amalgamation of plans** - KP gave an update and Members noted that this will be discussed at the workshop with MG in November 2021, • **JC21/012 – Major Trauma** - KP gave an update and Members noted that the action was partially complete. A Major Trauma proposal has been submitted to MG for discussion in November 2021. The Joint Committee resolved to: • **Note** the updates to the action log and agree to close the completed actions.
JC21/066	**2.1 Report from the Chair** The Report from the Chair was received and the Chair gave an update on relevant matters undertaken as Chair since the previous Joint Committee meeting. The Joint Committee noted: • That no Chair's Actions had been taken since the last meeting on 07 September 2021, • Discussions with Welsh Government (WG) and Cwm Taf Morgannwg University Health Board (CTMUHB) concerning the WHSSC Independent Member (IM) Remuneration, following on from the recommendation outlined in the Audit Wales report "Committee Governance Arrangements at WHSSC were progressing. A report was presented to the NHS Wales Chairs Peer Group in October, 2021 following which the chairs agreed the way forward. A further meeting is to be held with HB and Trust Chairs. Work will continue with WG to take these proposals forward, • an update on the Integrated Governance Committee (IGC) meeting held on 12 October 2021, • an update on a series of 1:1 meetings held with HB CEOs during October and November 2021, • an update on the appointment of a new Chair for the Welsh Renal Clinical Network (WRCN), • an update on the Digital IM Network – Digital Health and Care Wales (DHCW).. The Joint Committee resolved to: • **Note** the report.

JC21/067	**2.2 Report from the Managing Director** The Report from the Managing Director was received and the Managing Director gave an update on relevant matters undertaken since the previous Joint Committee meeting. The Joint Committee received updates on: • the anticipated de-escalation of SBUHB Cardiac Surgery under the WHSSC escalation process, • the de-escalation of SBUHB Trans-catheter Aortic Valve Intervention (TAVI) Service under the WHSSC escalation process, • on 7 September 2021 the JC supported requests received from the NHS Collaborative (Collaborative) for WHSSC to commission: o Hepato-Pancreato-Biliary Services; o The Hepato-Cellular Carcinoma (HCC) MDT and; o Develop a specialist orthopaedic paediatric service specification with a view to future commissioning of the service. All HBs had approved that WHSSC formally commission these new services • the WHSSC Executive team had met with Improvement Cymru (IC) to learn more about their recently published "Achieving Quality and Safety Strategy" and to discuss and explore potential options for them to support WHSSC in developing its new specialist services strategy, and that a stakeholder engagement exercise will be undertaken in December 2021/January2022., Linda Prosser (LP) welcomed the positive progress made with services being de-escalated which demonstrated that the process was effective, and requested further details on the WHSSC de-escalation process. Sian Lewis (SL) advised that WHSSC had its own escalation policy for commissioned services, and that further information could be shared outside of the meeting to clarify the process. **ACTION:** Carole Bell (CB) to re-circulate the Escalation and De-Escalation policy to all Members for information. Mark Hackett (MH) expressed his thanks to HB colleagues who had contributed to the oversight of the cardiac surgery progress, and advised that significant points had been learnt from the escalation/de-escalation of services, which had supported the whole service to upgrade the quality management system. The Joint Committee resolved to: • **Note** the report.

JC21/068	**2.3 Integrated Commissioning Plan (ICP) 2022-25** Members received an informative presentation from Karen Preece (KP) and Stuart Davies (SD) on progress in developing the Integrated Commissioning Plan (ICP) 2022-2025 and an update on the recovery position of specialised services in Welsh providers. Members noted: • WHSSC had received recovery plans for each of the HB's, however there were some gaps in the information available, • Informal discussions had begun with NHS England to access activity where possible to meet shortfalls in capacity, • WHSSC had received a letter from the Chief Executive NHS Wales in relation to the availability of funding to aid recovery, • The summary of priorities for key commissioned services that were contained within the ICP, • That the investment required for 2022-2023 ICP was circa £28.5mreflecting an uplift of 4%. KP queried whether HBs would be content to take approval of the WHSSC ICP at the extraordinary JC meeting scheduled for 02 December 2021 or if they would prefer to wait until a meeting in January 2022. Members discussed the approval timelines for the HB Integrated Medium Term Plans (IMTPs) and the WHSSC ICP. KP confirmed that the WHSSC Planning team would draft a summary of the WHSSC plan and financial information for HBs to include in their IMPT's. This would ensure consistency throughout the plans. SD advised that the plan was not identifying further need to invest in English recovery for next year as this is dealt with by the English Recovery Fund (ERF) which will continue to be funded by Welsh Government. *[It should be noted that Welsh Government has subsequently confirmed that this will now need to be funded by Health Boards within their Recovery allocations. The ICP has been amended accordingly to include the ERF.]* Members noted that specialist services were starting to deliver pre-pandemic activity levels in NHS England. If this continues on current trajectory to the end of this financial year backlogs should be reduced. The situation was more uncertain for Welsh providers where rates of recovery have generally been slower and less consistent. MH advised that he had not been requested to contribute to the discussion on the recovery position, and suggested that his HB may be able to do more to support recovery in key areas. In addition that if we want to treat patients in Wales tertiary providers should

be asked to push their teams further to deliver more volume and support WHSSC.

Ian Phillips (IP) reflected on the conversation and suggested that time could be spent developing more radical ways of driving this agenda forward.

Jo Whitehead (JW) stated that waiting lists in excess of a year were unacceptable and reported that BCUHB had ambitious plans for two major regional treatment centres. JW queried where, following the end of funding from the Liver Disease Implementation Group (LDIG) where the future investment required for Viral Hepatitis treatment could be sourced. SL advised that the LDIG sat within the NHS Wales Health Collaborative and that further enquiries should be directed to Mark Dickinson, Director of the NHS Wales Health Collaborative.

Stuart Walker (SW) queried whether English providers could offer capacity for specialised services for Welsh patients, when they may be in the same position as Wales or worse off, and whether there was need to look at Welsh based solutions.

KP advised that the update on potential capacity from NHSE providers was based on contact made within the last week, but details regarding case mix had not been discussed. KP also advised that the capacity gap identified in Welsh provision was based on detailed recovery plans from HBs, which were discussed at Service Level Agreement (SLA meetings).

SD advised that it was good to know that there may be additional provision from Welsh providers but the he response previously from HBs had been that there was no additional.

Members discussed pre and post COVID19 activity levels and it was agreed to continue these discussions outside of the meeting. Carol Shillabeer (CS) agreed that each and every opportunity for accessing services should be considered whether this was in Wales or in England.

Members noted that the deadline for submitting IMTP's and the ICP to WG was 28 February 2022. Members discussed the timing for approving the ICP and it was agreed to re-schedule the extraordinary meeting to approve the JC until early January 2022.

ACTION: JE to reschedule the date for JC from December 2021 to early January 2022.

The Joint Committee resolved to:

- **Note** the presentation.

JC21/069	**2.4 All Wales Positron Emission Tomography (PET) Programme Update** The All Wales Positron Emission Tomography (PET) programme update was received and SL gave an update on the WHSSC Governance and Accountability Framework to support implementation of the All Wales Positron Emission Tomography (PET) Programme and briefed members on the specific areas of support requested from the JC. Attendees advised that they were all in support of the recommendations. CS commented that consideration could be given to reducing the number of people in the proposed programme board to keep discussion focused. SL agreed with CS and confirmed that the structure would be reviewed before implementation. MH welcomed the progress made and questioned why the date for implementation had been moved to 2023. SL advised that she was very keen to bring the date forward if SBUHB are able to accommodate this but there were local delays. The Joint Committee resolved to: • **Note** the content of the paper; • **Note** the mandate letter received from the Director General for Health and Social Services and the NHS Wales Chief Executive regarding the PET Programme; • **Support** the business case requesting revenue funding from Welsh Government for a Programme Management Office based at WHSSC; • **Support** the request to Welsh Government to formally appoint the Managing Director of WHSSC as the Programme SRO, and • **Approve** the changes to the top-level governance and structure of the Programme.
JC21/070	**2.5 Neonatal Transport – Update on the Development of Neonatal Transport Operational Delivery Network.** Members received an update on the development of a Neonatal Transport Operational Delivery Network and KP provided an update on progress to establish an Operational Delivery Network (ODN) for Neonatal Transport. Members noted that due to operational workforce pressures across the system, the Senior Responsible Officer (SRO) for the programme had made a written request for the Joint Committee to support an extension of the current interim 24 hour model until the from March 2022 until June 2022. MH advised that SBUHB were putting additional resource into project and agreed to bring a detailed implementation programme to the JC meeting in January 2022.

	Members supported the recommendation and noted that the Delivery Assurance Group (DAG) will be progressed, led by KP. **ACTION:** SBUHB to prepare a detailed implementation programme for presentation to the JC on 18 January 2022. **ACTION:** KP to progress the Delivery Assurance Group (DAG) and provide regular updates to the JC on progress. The Joint Committee resolved to: • **Note** the actions from the Neonatal Transport workshop; • **Note** that a letter has been issued to Neonatal Transport Colleagues from the SRO explaining the delay to the programme; • **Approve** the extension of the current interim 24 hour model until the end of June 2022; • **Support** the next steps required to establish the programme of works.
JC21/071	**2.6 Individual Patient Funding Request (IPFR) Panel Update** The Individual Patient Funding Request (IPFR) Panel Update was received and JE introduced the report and gave an update on progress in getting the terms of reference updated. Members noted: • the WHSSC IPFR panel are contained within the "All Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)", • A Report was submitted to JC on 10 November requesting to update the TOR to support efficacy and quoracy, however the proposal was not approved, • enquiries were with WG in December 2020 to confirm the governance process for reviewing the ToR, • Since then, further enquiries were made in August 2021 and an SBAR was submitted to WG outlining the issues and complexities, and the need for clarity on the governance process for approving the all Wales policy • the Joint Committee do have responsibility for approving the Terms of Reference for its sub committees, however, as the ToR sit as an appendix within an "All Wales Policy" discussions are ongoing with WG on how best to resolve this, • Given that the IPFR panel is frequently subject to challenge (including Judicial Review) this represents a considerable legal and financial risk to WHSSC. SL gave an update on the challenges faced by the sub-committee and members noted the issues concerning quoracy and future appointment of a Chair.

	Members discussed the issues and the responsibility of the JC in resolving the matter. JE advised that discussions were ongoing with WG in order to clarify governance issues. It was agreed that JE/SL should liaise with Simon Dean (SD) outside of the meeting to discuss what support could be offered to resolve the issue. **ACTION:** JE/SL to meet with SD to discuss what support Welsh Government could provide to resolve the issue of updating the WHSSC IPFR panel terms of reference which are contained within the All Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)". The Joint Committee resolved to: • **Note** the report; • **Discuss** the issues affecting the WHSSC All Wales IPFR panel and consider any action required to progress and resolve the issues.
JC21/072	**2.7 Corporate Risk Assurance Framework (CRAF)** Members received the updated Corporate Risk Assurance Framework (CRAF) which outlined the risks scoring 15 or above on the commissioning teams and directorate risk registers and noted: • following the update given to the Joint Committee back in May on the development of the CRAF and the new risk management strategy, the commissioning teams have been busy reviewing their risks through a peer review process and in addition, • a risk management workshop with the Corporate Directors Group on 16 September to review the risks, review the risk scoring in light of COVID-19 and to horizon scan for new risks, • the outcomes of the workshop included each directorate developing their own directorate specific risk register and the creation of a risk scrutiny group who meet monthly, to scrutinise directorate risks and offer a critical friend process for challenging risk narrative and scoring, • two new organisational risk had been added in relation to workforce capacity and the WHSSC IPFR panel quoracy, • one new commissioning risk had been added relating to neonatal cots, • the Integrated Governance Committee (IGC) received the updated CRAF in October and requested that further work be undertaken to benchmark the risk scoring against HB risks to monitor consistency in scoring and narrative to further strengthen the risk management process, • a further risk workshop will be held in January 2022. KP highlighted the commissioning risks added during September, 2021 in relation to Neonatal Cot Capacity at C&VUHB.

	SW advised that that the neonatal cots will start to re-open in November 2021, and suggested that the WHSSC IPFR risk may be scored too highly compared with patient facing HB risks. JE advised that the scoring would be looked at as part of the desktop audit on scoring. Due to IT access issues Ian Wells (IW) advised he was unable to ask specific questions during the meeting but had raised some queries in relation to the scores and JE confirmed she would pick these up outside of the meeting. The Joint Committee resolved to: • **Note** the updated Corporate Risk Assurance Framework (CRAF), • **Note** the amendments made to the CRAF following the risk management workshop held on 16 September 2021 to review the existing risks and identify additional corporate and organisational risks, • **Approve** the updated Corporate Risk Assurance Framework (CRAF), and • **Note** that a follow up risk management workshop will be held in January 2022 to review how the Risk management process is working, and to consider risk appetite and tolerance levels across the organisation.
JC21/073	**3.1 Activity Report Month 05 2021-22 COVID-19 period** Members received a report highlighting the scale of decrease in specialised services activity delivered for the Welsh population by providers in England, together with the two major supra-regional providers in South Wales. Members noted the key points this month: • Cardiac Surgery • Thoracic Surgery • Neurosurgery • Plastic Surgery • Paediatric Cardiac Surgery • Paediatric Surgery • English provider activity (all specialist and non-specialist SW suggested that a further discussion was required with SD in relation to Cardiac Surgery - total numbers and sub-specialities would be useful. Members discussed the data outlined within the report and members thanked SD for the detail in the report. **ACTION:** SD/SW to schedule meeting to discuss performance data further.

	The Joint Committee resolved to: • **Note** the information presented within the report.
JC21/074	**3.2 Financial Performance Report Month 06 2021-22** The Financial Performance Report Month 06 2021-22 was received and members noted: Members noted: • a favourable position at month 6 – £9.3m underspend • £2m recovery funding had been held back for possible outsourcing. Subsequently WHSSC returned the remaining £2 million, meaning that the full £4 million ICP provision has now been returned to HBs in full. CS suggested that in the interest of patients/treatments deployment of these monies should be considered. KE stated that she found the activity cards useful and requested the continued use of these. The Joint Committee resolved to: • **Note** the current financial position and forecast year-end position.
JC21/075	**3.3 Corporate Governance Matters** The Corporate Governance Matters report was received and members noted the update on corporate governance matters that had arisen since the last meeting. The Joint Committee resolved to: • **Note** the report.
JC21/076	**3.4 Reports from the Joint Sub-Committees** The Joint Sub-Committee reports were received as follows: **i. Audit and Risk Committee Assurance Report** The Joint Committee **noted** the assurance report from the CTMUHB Audit and Risk Committee (ARC) meeting held on 17 August 2021. **ii. Management Group** The Joint Committee **noted** the core briefing documents from the meetings held on 23 September 2021 and 21 October 2021. **iii. Quality & Patient Safety Committee** The Joint Committee **noted** the Chairs report from the meeting held on 12 October 2021. Ceri Phillips (CP) highlighted that a number of Mental Health providers within NHS England were currently being monitored through Assurance Boards. WHSSC has been sighted on

engagement and improvement works being undertaken and that site visits had been undertaken to review current placements and the care plans in place for individuals. It had been agreed that a deep dive into Mental Health Services would be considered at the next meeting.

The QPS Committee had specifically requested that the lack of progress in Adult Cleft Services was escalated to the Joint Committee. Further monitoring would take place through the QPS and through the SLA with the provider. Assurance was given that the patients were having regular clinical reviews and had been individually informed of the position.

iv. Integrated Governance Committee

The Joint Committee **noted** the Chairs report from the meeting held on 12 October 2021.

v. Individual Patient Funding Request Panel (IPFR)

The Joint Committee **noted** the Chairs report from the meetings held in September and October 2021.

vi. Welsh Renal Clinical Network (WRCN)

The Joint Committee **noted** the Chairs report from the meeting held on 04 October 2021.

Ian Phillips (IP), Interim Chair of the Welsh Renal Clinical Network Board briefed members on the large amount of work being undertaken and, felt that there were opportunities to improve processes and support the team.

IP highlighted the biggest risk to the network concerned a large procurement exercise in Swansea. Members noted that project support may provide assistance to deal with such a large procurement.

SD agreed to make enquiries whether the SBUHB Management team could provide support for project management

KE thanked IP for his proactive contribution and for taking over the mantle during the interim period.

ACTION: SD team to consider the WRCN procurement exercise and discuss further with IP.

The Joint Committee resolved to:

- **Note** the content of the reports from the Joint Sub-Committees.

JC21/077	**4.1 Any Other Business** LP raised one item in relation to bed management and it was agreed that SL would contact her outside of the meeting to discuss.
JC21/078	**4.2 Date and Time of Next Scheduled Meeting** The Joint Committee noted that the extraordinary meeting scheduled for 2 December 2021 to approve the ICP would be re-scheduled to early January 2022. The full JC meeting will go ahead as scheduled on 18 January 2022. There being no other business other than the above the meeting was closed at 15:40.

Chair's Signature: .....

JC21/079	**4.3 In Committee Resolution** The Joint Committee made the following resolution: "That representatives of the press and other members of the public be excluded from the remainder of the 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)".

Date: .....

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

JOINT COMMITTEE MEETING
Action Log for Joint Committee Meeting 18 January 2022

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
07.09.21	JC21/009	**JC21/045 – 2.5 WHSSC – Workforce Capacity** **ACTION:** It was agreed that WHSST would proactively engage with Management Group regarding the services currently commissioned by WHSSC, which would merit being commissioned locally at Health Board level and to review the current WHSSC portfolio of specialised services to determine if any should be removed from the specialised services commissioning list and return to Health Boards to commission.	KP	Nov 2021	Management Group Workshop took place 25 November 2021 and information added to Integrated Commissioning Plan (ICP) 2022-2025. Action to be closed with JC's approval 18.01.22.	**COMPLETED**

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
07.09.21	JC21/010	**JC21/046 – 2.6 Recovery Planning – Quality and Outcome Improvement for Patients** **ACTION:** It was agreed that a written report as to the assurances being provided by HBs to WHSSC in terms of waiting list patients would be provided to a future Joint Committee meeting.	KP	Jan 2022	On the agenda item 2.5.	**OPEN**
07.09.21	JC21/011	**JC21/046 – 2.6 Recovery Planning – Quality and Outcome Improvement for Patients** **ACTION:** Members agreed the amalgamation of recovery plans with both tertiary and secondary providers that impact how patients move though the pathway would be added to a future Management Group agenda. **UPDATED ACTION**: Workshop on recovery plans to take place on 16 December 2021.	KP	Dec 2021	Management Group Workshop on Recovery Planning took place on the 16 December 2021. Action to be closed with JC's approval on 18 January.	**COMPLETED**

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
07.09.21	JC21/012	**JC21/047 Major Trauma Priorities for in year use of Underspend and Resource Plan for 2022** **ACTION:** the proposal regarding the non-recurrent underspends, identified across the Network within this year be considered by MG and under the principle that this resource could be used across the Network.	KP	Oct 2021	The MG considered the major trauma priorities on the 25 November 2021. Action completed. Action to be closed with JC's approval 18.01.22.	**COMPLETED**
		ACTION: A report on the Major Trauma Service proposals submitted for inclusion in the ICP should be presented to Management Group and that the relative priority of the proposals compared to other proposals in the plan should be considered. The recommendations arising from the consideration should be included within the ICP for consideration by the Joint Committee.	KP	Oct 2021	The MG considered the major trauma priorities on the 25 November 2021. Action completed. Action to be closed with JC's approval 18.01.22.	**COMPLETED**

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
09.11.21	JC21/013	**JC21/067 2.2 Report from the Managing Director** **ACTION:** Carole Bell (CB) to circulate the Escalation and De-Escalation procedure to all Members for information.	CB	Dec 2021	SMH circulated the escalation procedure on behalf of CB. Action to be closed with JC's approval on 18.01.22.	**COMPLETED**
09.11.21	JC21/015	**JC21/070 2.5 Neonatal Transport – Update on the Development of Neonatal Transport Operational Delivery Network** **ACTION:** SBUHB to prepare a detailed implementation programme for presentation to the JC on 18 January 2022.	SBUHB	~~Jan 2022~~ March 2022	Operational details awaited from SBUHB. Action carried forward to March 2022	**OPEN**
		ACTION: KP to progress the Delivery Assurance Group (DAG) and provide regular updates to the JC on progress.	KP	Jan 2022	The work on the DAG has been progressed and the JC will receive regular updates. Action completed. Action to be closed with JC's approval on 18.01.22.	**COMPLETED**

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
09.11.21	JC21/016	**MG21/071 2.5 Individual Patient Funding Request (IPFR) Panel Update** **ACTION:** KE/SL to meet with SD to discuss what support Welsh Government could provide to resolve the issue of updating the WHSSC IPFR panel terms of reference which are contained within the All Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)".	KE /SL	Jan 2022	IPFR Governance update on the agenda Item 2.3.	**OPEN**
09.11.21	JC21/017	**JC21/073 3.1 Activity Report Month 5 2021-2022 COVID-19 Period** **ACTION:** SD/SW to schedule meeting to discuss performance data further.	SD	Jan 2022	SD has discussed performance data with CVUHB and confirmed that the data was correct. Action completed. Action to be closed with JC's approval on 18.01.22.	**COMPLETED**

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
09.11.21	JC21/018	**JC21/076 3.4 Report from the Welsh Renal Clinical Network** **ACTION:** WHSSC team to consider the WRCN procurement exercise and discuss further with IP.	SD	Jan 2022	**18.01.22** – SD to provide verbal update at meeting.	**OPEN**

Report Title	**Chair's Report**	**Agenda Item**	2.1
Meeting Title	**Joint Committee**	**Meeting Date**	18/01/2022
FOI Status	Public		
Author (Job title)	Chair		
Executive Lead (Job title)	-		

Purpose of the Report	The purpose of this report is to provide Joint Committee members with an update of the issues considered by the Chair since the last Joint Committee meeting.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☐	INFORM ☒

Recommendation(s)

Members are asked to:

- **Note** the report;
- **Ratify** the action undertaken by the Chair on behalf of the Joint Committee, detailed in Appendix 1; and
- **Approve** the extension of the interim WRCN Chair arrangement until 31 March 2022 to ensure business continuity whilst the substantive post is recruited to.

CHAIR'S REPORT

1.0 SITUATION

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

2.0 BACKGROUND

The Chair's report includes information on the key activities that have taken place since the last Joint Committee meeting on 09 November 2021.

3.0 ASSESSMENT

3.1 Chair's Actions

There may be circumstances where decisions which would normally be made by the Joint Committee (JC) need to be taken between scheduled meetings, and it is not practicable to call a meeting. In these circumstances the Chair, supported by the Committee Secretary as appropriate, may deal with these matters on behalf of the Joint Committee.

I wrote to Joint Committee members on 09 December 2021 confirming that, acting in conjunction with Dr Sian Lewis, Managing Director of WHSSC, and Professor Ceri Phillips, an Independent Member of WHSSC, that I have taken Chair's Action to update the Terms of Reference (ToR) for the Welsh Renal Clinical Network (WRCN) to ensure effective governance and in the interest of expediency to commence the recruitment exercise for the role of the substantive Chair to the WRCN.

A copy of the letter is attached, for information at ***Appendix 1.***

Members are asked to ratify the Chair's Action.

3.2 Extension of Interim Chair Arrangements for the Welsh Renal Clinical Network (WRCN)

Further to the interim appointment of a Chair for the Welsh Renal Clinical Network (WRCN) in July 2021 until January 2021, it is proposed that the interim arrangement for the WRCN chair position is extended until end March 2022 to ensure business continuity during the recruitment process to appoint a substantive chair.

Welsh Government (WG) have confirmed that WHSSC is responsible for recruiting to the role on behalf of the JC and has advised that the role does not need to be advertised through the formal public appointments process. The role was

therefore placed on NHS Jobs in December 2021 with a view to making an appointment by end February 2022. With JC's approval, we would therefore ask that the interim Chair appointment be extended until end March 2022 to allow for the recruitment exercise to take place and a suitable handover period. The substantive post would therefore start on 01 April 2022.

3.3 WHSSC Independent Member Remuneration

Following the recommendation for WG in the Audit Wales (AW) report, "Committee Governance Arrangements at WHSSC", concerning the remuneration of Independent Members (IMs) at WHSSC, WG presented a report to NHS Wales Chairs Group on 05 October 2021 outlining the potential options for remunerating WHSSC IMs and proposing that the existing WHSSC IMs are remunerated with a set time commitment for the role, together with the introduction of a selection process.

The NHS Wales Chairs Group suggested that further discussion was required and a meeting was held with Mark Polin, Chair of Betsi Cadwaladr UHB (BCUHB), Donna Mead, Chair of Velindre NHS Trust (VNHST), WG, the Committee Secretary of WHSSC and me on 02 November 2021 to further hear views of Chairs.

Under the Standing Orders WHSSC is required to have three IMs - two of whom are drawn from the IMs of the Health Boards (HBs), and one selected as an Audit lead from Cwm Taf Morgannwg UHB (CTMUHB). As part of the IM remuneration discussions with WG, WHSSC has also been in discussion with CTMUHB and it has been agreed that the process for selecting the Audit Lead IM role, which is currently selected from the membership of the CTMUHB Audit and Risk Committee (in accordance with the hosting agreement between WHSSC and CTMUHB), should change to broaden the pool of applicants. It is proposed that the Audit Lead vacancy is advertised through a fair and open competition alongside the other two WHSSC IM roles, with a specific requirement for a finance/audit skillset.

Following a meeting with WG it was agreed that an update report would be given to the Joint Committee on 18 January 2022 for them to discuss and agree the way forward. The update report is provided at agenda item 2.5.

3.4 Integrated Governance Committee (IGC) 13 December 2021

I chaired the WHSSC Integrated Governance Committee (IGC) on 13 December 2021 and considered the Corporate Risk and Assurance Framework (CRAF), progress on delivering the Integrated Commissioning Plan (IPC) 2020-2021, development of the ICP 2022-2025, progress made against the recommendations made in the Audit Wales "WHSSC Governance Arrangements Report" and other corporate governance matters. A further update will be provided under item 3.4 of this agenda.

3.5 Royal College of Nursing Wales – Nurse of the Year Awards 2021

The Royal College of Nursing Wales – Nurse of the Year Awards 2021 ceremony took place on 10 November 2021. WHSSC sponsored the Health Care Support Worker (HCSW) Award category and I was delighted to present the award to the winner Diane Rees on behalf of WHSSC. HCSWs play a vital role in providing excellent care to patients across all NHS care settings and the award recognised the truly remarkable achievements of health care support workers during the pandemic, who responded heroically to the unprecedented demands placed upon them.

3.6 Sub Committee Vice Chair – WHSSC IPFR Panel

I am pleased to confirm that Professor Vivienne Harpwood has appointed Dr Ruth Alcolado, Medical Director, NHS Wales Shared Services Partnership (NWSSP) as the new Vice Chair for the WHSSC IPFR Panel with effect 16 December 2021 for 2 years, in accordance with the Standing Orders.

3.7 1 to 1Meetings with Health Board CEOs

Following on from the feedback received in the annual Committee self-assessment exercise, a series of 1 to 1 meetings has been arranged between HB CEOs and me to ensure that CEOs are kept abreast of WHSSC developments. I met with Paul Mears, CEO CTMHB on 24 November and Stuart Walker, CEO CVUHB on 7 December 2021.

3.8 Key Meetings

I have attended the following meetings, in light of COVID-19, all of these have been held via MS Teams:

- Regular catch up meetings with WHSSC IMs
- Monthly meetings with Welsh Government to take forward Audit Wales' recommendation on IM Remuneration
- NHS Wales Chairs Peer Group Meeting
- Ministerial meeting with NHS Chairs and Chief Executives
- Meeting with Digital Health Care Wales (DHCW) to discuss IM Digital Network and IM 'buddying' arrangements
- Meeting with Emrys Elias, newly appointed Chair of CTMHB
- Annual HB Board attendance - attended the ABUHB Board Meeting 24 November 2021 to provide an update on the work of WHSSC

4.0 QUALITY, GOVERNANCE AND RISK

The Chairs report provides an assurance to the Joint Committee on activities undertaken since the previous meeting.

5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report
- **Ratify** the action undertaken by the Chair on behalf of the Joint Committee, detailed in Appendix 1; and
- **Approve** the extension of the interim WRCN Chair arrangement until 31 March 2022 to ensure business continuity whilst the substantive post is recruited to.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	Approval process
Health and Care Standards	Governance, Leadership and Accountability Choose an item. Choose an item.
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Choose an item. Choose an item.
Institute for HealthCare Improvement Quadruple Aim	Improving Patient Experience (including quality and Satisfaction) Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	Ensuring the Joint Committee makes fully informed decisions is dependent upon the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.
Finance/Resource Implications	Not applicable
Population Health	Not applicable
Legal Implications (including equality & diversity, socio economic duty etc)	Not applicable
Long Term Implications (incl WBFG Act 2015)	Not applicable
Report History (Meeting/Date/ Summary of Outcome	**-**
Appendices	**Appendix 1** – Letter to the Joint Committee concerning Chair's Action to update the Terms of Reference (ToR) for the Welsh Renal Clinical Network (WRCN) – 09 December 2021

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

Your ref/eich cyf:
Our ref/ein cyf: KE.JE
Date/dyddiad: 9 December 2021
Tel/ffôn: 01443 443 443 ext. 8131
Email/ebost: Jacqueline.Evans8@wales.nhs.uk

WHSSC Joint Committee Members,

Dear Colleague,

Re: Welsh Health Specialised Services Committee ("WHSSC") – Chair's Action to Update the Welsh Renal Clinical Network (WRCN) – Terms of Reference (ToR)

I am writing to you to inform you that a Chair's action has been undertaken to update the Terms of Reference (ToR) for the Welsh Renal Clinical Network (WRCN) to ensure effective governance and in the interest of expediency to commence the recruitment exercise for the role of the substantive Chair to the WRCN.

This action was taken in accordance with provisions of the WHSSC Standing Orders (SO's) , specifically section 3.1.1 in relation to Chair's action on urgent matters whereby decisions which would normally be made by the Joint Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Joint Committee.

In accordance with the section 4 of the WHSSC Standing Orders (SO's) the Joint Committee has established a Joint Committee sub Committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHB's. The WRCN is a sub committee of the JC and ensures that specialised renal services are planned and developed on an all Wales basis in an efficient, economical and integrated manner and provides a single decision-making framework with clear remit, responsibility and accountability. The terms of reference and operating arrangements for the WRCN are formally approved by the Joint Committee.

The Joint Committee agreed to appoint Ian Phillips, IM for WHSSC, as the Interim Chair of the WRCN for a 6 month period at its meeting on the 13 July 2021, to ensure business continuity and to enable the WHSSC Team time to roll out plans for recruiting a suitable candidate for appointment as the substantive WRCN Chair from early 2022. The WRCN role has historically been

Welsh Health Specialised Services Committee
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Pontypridd
CF37 5YL

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Pontypridd
CF37 5YL

remunerated, however Ian Phillips, IM, is not remunerated during his time as interim chair.

The WRCN Chair role has to date been undertaken by a senior renal clinician, however the ToR have always stated that the position is that of an Independent Chair. Given the remit of the WRCN, its increasingly strong links with third party providers, the charitable sector and Welsh Government, the person specification has therefore been updated. This now incorporates experience of working with a variety of diverse stakeholders as an essential/desirable requirement and recognises that the role should not be reserved to a senior renal clinician – the job description and person specification are presented at ***Appendix 1*** for information.

The WRCN ToR, state that remuneration is paid on a sessional basis "*Appointed on a sessional basis; 1 session a week*", however given the change to the person specification to fully reflect the role of Independent Chair we want to change this to a daily rate to ensure consistency.

In terms of approving this change

- the WRCN ToR states that "the Chair of the Welsh Renal Clinical Network will be appointed by the Chair of WHSSC",
- The SO's state that:

  *"4.0.8 The membership of any such joint sub-Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (**including remuneration** and reimbursement) - **will usually be determined by the Joint Committee**, subject to any specific requirements, regulations or directions agreed by the LHBs or the Welsh Ministers. Depending on the joint sub-Committee's defined role and remit; membership may be drawn from the Joint Committee, LHB Board or committee members, staff (subject to the conditions set in WHSSC Standing Order 4.0.9) or others."*
- the WRCN ToR state that the *"Welsh Renal Clinical Network members' terms and conditions of appointment, (including any remuneration and reimbursement) are the basis of advice from the LHB Remuneration and Terms of Service Committee."* The Committee Secretary has discussed this with the Board Secretary at CTMUHB and it is suggested that the wording is a legacy issue from when the WRCN was first established in 2009, and that as the JC has responsibility for matters relating to its sub-committees, that the ToR are updated to reflect that it is the Joint

Committee who are responsible for the terms and conditions of appointment (including remuneration) for the WRCN for completeness.

Therefore, to ensure effective governance and in the interest of expediency to commence the recruitment exercise Chair's action has been taken to update the WRCN ToR to amend the remuneration to the daily rate agreed by Welsh Government for WHSSC IMs and to reflect that the Joint Committee is responsible for matters relating to its sub-committees, specifically the terms and conditions of appointment (including remuneration) – the updated ToR are presented at ***Appendix 2*** for information.

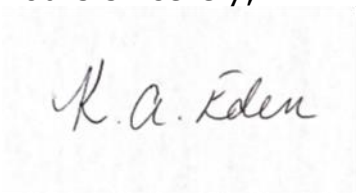
As the WRCN ToR have been updated the recruitment process to appoint a substantive Chair to the WRCN will commence in December 2021.

Chair's Action
I confirm that by this letter, acting in conjunction with Dr Sian Lewis, Managing Director of WHSSC, and Professor Ceri Phillips, an Independent Member of WHSSC, I have taken Chair's Action to amend the above mentioned elements of the WRCN ToR.

This matter will be reported on at the next Joint Committee meeting on 18 January 2022 for ratification.

If you require further information or clarification regarding this matter, please contact Jacqui Evans, Committee Secretary, Jacqueline.Evans8@wales.nhs.uk in the first instance.

Yours sincerely,



Kate Eden
Chair

Cc – Sian Lewis, Managing Director, WHSSC
Cc - Stuart Davies, Director of Finance, Executive Lead for WRCN
Cc – Ian Phillips, Interim Chair of the WRCN

Welsh Health Specialised Services Committee
Unit G1, The Willowford,
Treforest,
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Pontypridd
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Chair/Cadeirydd: *Kate Eden*
Managing Director of Specialised and Tertiary Services Commissioning/Rheolwr Gyfarwyddwr Dros Dro Comisiynu Gwasanaethau Arbenigol a Thrydyddol: *Dr Sian Lewis*

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Chair of the Welsh Renal Clinical Network (WRCN) Job Information Pack

CHAIR OF THE WELSH RENAL CLINICAL NETWORK (WRCN)

Job Information Pack – December 2021

1. Role of WHSSC

The Welsh Health Specialised Services Committee (WHSSC) is a joint committee of each Local Health Board (LHB) in Wales, established under the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35). The Joint Committee brings Local Health Boards in Wales together to plan specialised services for the population of Wales.

WHSSC is a non-statutory organisation hosted by Cwm Taf Morgannwg University Health Board (CTMUHB) and acts on behalf of the NHS Wales Health Boards, to ensure that there is equitable access to safe, effective and sustainable specialist services for the people of Wales, as close to patients' homes as possible, within available resources.

WHSSC has approximately 67 WTE staff across Wales and a commissioning budget of over £700 million.

2. Operating Model and Strategy

WHSSC is responsible, on behalf of the seven Local Health Boards, for commissioning a range of specialised services for the population of Wales. Organisationally it is split into five Directorates; Corporate, Finance, Medical, Nursing and Quality and Planning and five cross directorate commissioning teams. The commissioning teams are:

- Cancer and Blood
- Cardiac Services
- Mental Health and Vulnerable Groups
- Neurosciences and Long Term Conditions
- Women and Children's Services

WHSSC hosts the Welsh Renal Clinical Network (WRCN) and the key achievements and priorities for the WRCN priorities are also described in this plan WHSSC aims to commission high quality specialised services that deliver good patient outcomes and experiences.

4. Role and Function of the WRCN

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 £75m 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.

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, to 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 year on year growth in renal dialysis patients of 5% per annum.

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 board has a well-established structure that includes a Quality and Patient Safety (QPS) subcommittee 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.

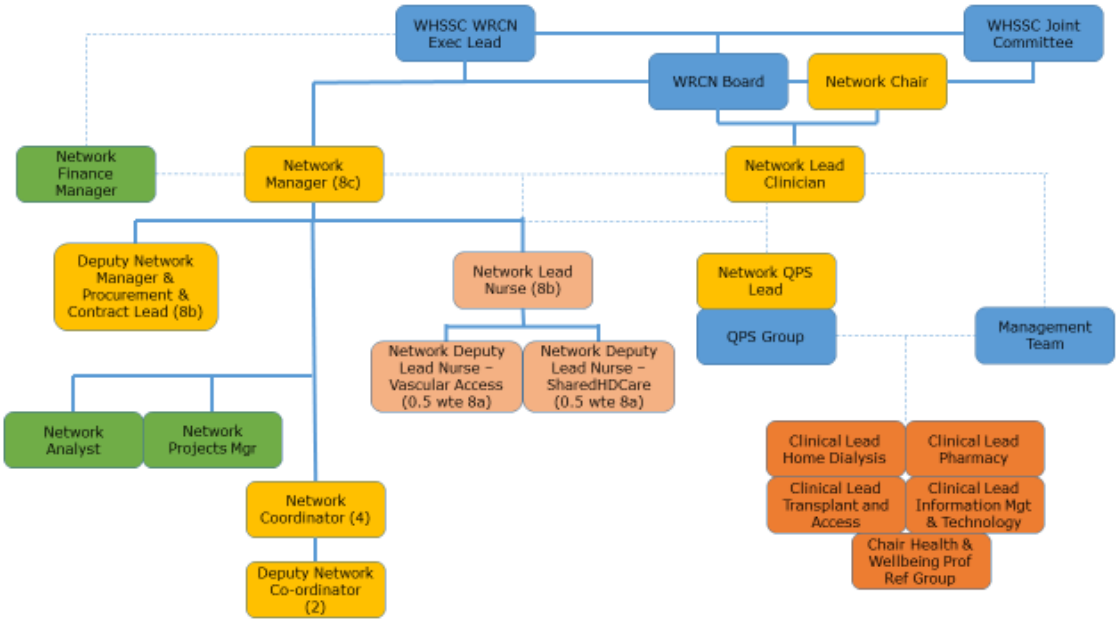
WRCN is notified of any serious incidents and the WRCN QPS lead works closely with WHSSC QPS team to ensure that all incidents are thoroughly investigated and responded to appropriately.

The main functions of the WRCN are to;

- Lead the development and implementation of renal service strategy;
- Provide evidence based and timely advice to the Welsh Government and Joint Committee to assist the LHBs in discharging their functions and meeting their responsibilities with regard to the delivery of renal policy and services across Wales;
- Undertake planning for the development and delivery of an integrated renal service on an all Wales basis on behalf of, and with the agreement of the WHSSC;
- Determine in conjunction with the WHSSC the renal services that should be procured in Wales;
- In conjunction with WHSSC, manage the centrally held, ring-fenced, renal budgets required for delivery of services;
- Performance manage, on behalf of WHSSC, the delivery units against national standards and agreed service level agreements for delivery of renal services;
- Provide timely delivery and performance reports to WHSSC and Welsh Government;
- Advise and monitor clinical governance in relation to renal services within the agreed WHSSC Quality and Safety framework;
- Lead and assist in the creation, implementation and monitoring of service specifications / care pathways / care bundles for renal services;
- Fulfil a national remit, with a sub-structure that (i) is fit for purpose and (ii) enables local interface;
- Ensure a full-time, central support function so that it can successfully undertake its delegated responsibilities;
- Lead on the strategic development and implementation of renal related IT systems, ensuring accurate and timely returns to the UK Renal Registry;
- Engage with public and patients on current and future renal service and policy developments.

WRCN Structure

The Clinical and Managerial oversight of the organisation is illustrated below.



5. Stakeholder Engagement

Of paramount importance to us are our relationships. Our relationships with the Health Boards, Trusts, Welsh Government, public, national and international commissioning partners, policymakers, and cross Government ministers. Consequently, a fundamental requirement to be successful in the role is to have the fine-tuned behaviours, interpersonal and influencing skills to create and maintain these mutual synergies and collaborative partnerships in order to galvanise collective action and enable the achievement of a healthy and sustainable Wales.

5. Role Description & Person Specification

The Role Description and person specification for the Chair is outlined at ***Appendix A.***

6. Additional Information

<u>Remuneration</u>
Band 3 of the Welsh Government Salary scale for Public Appointments - £278 per day (as at Aug 2021).

Time Requirements
2 days per month

Expenses
You will be entitled to be reimbursed, if appropriate, against receipts for travel and subsistence expenses incurred while on Trust business. Expenses must be claimed within three months of them being incurred unless there are exceptional circumstances.

Location of appointment
Whilst the post is based at our head office in Unit G1, the Willowford, Main Avenue, Treforest Industrial Estate, Pontypridd, CF37 5YL, there is significant flexibility around remote working arrangements. IT facilities will be provided to support working from home.

Tenure of office
The length of the appointment will initially be up to three (3) years. However, this is subject to the Chair remaining eligible for the role for the duration of the term. Chairs may stand for a maximum of four (4) years.

Accountability
Members are appointed by and are accountable to the Chair of the Joint Committee for carrying out their duties and for their performance.

Welsh Language
Welsh language skills are desirable for this appointment. All candidates will be expected to display empathy towards the language and demonstrate leadership to strengthen bilingual service provision within the NHS in Wales.

Assistance for Disabled Members
Where appropriate all reasonable adjustments will be made to enable members to effectively carry out their duties.

Eligibility
A person shall be disqualified from appointment if he/she:

a) has within the preceding 5 years been convicted in the UK, Channel Islands or the Isle of Man of any offence and has had passed on him/her a sentence of imprisonment (whether suspended or not) for a period of not less than 3 months;
b) has been adjudged bankrupt or has made a composition or arrangement with his creditors;
c) has been dismissed, otherwise than by reason of redundancy, or non-renewal of a fixed term contract, from any paid employment with a health service body;
d) is a person whose tenure of office as the chair, member or director of a health service body has been terminated because his/her appointment is not in the interests of the health service, for non-attendance at meetings or for non-disclosure of pecuniary interest;

It is the policy of the Welsh Government that all recent employees of HBs and NHS Trusts should serve a non-involvement break before being considered for an NHS Public Appointment.

Any other information that may materially affect your application for appointment should be declared in the application form under the Conflict of Interests section.

Applicants should be persons who conduct themselves at all times in a manner which will maintain public confidence.

In particular, applicants are required to declare whether they are aware of anything in their private or professional life that would be an embarrassment to themselves or to the Welsh Government if it became known in the event of appointment.

Candidates should also note that membership of a LHB is a disqualifying office for membership of the National Assembly for Wales under the National Assembly for Wales (Disqualification) Order 2015.

Conflicts of Interest

The nature of the work of the WCRN is that there are many interfaces with both NHS and private sector organisations and for the Chair to effectively carry out their role they must be able to clearly demonstrate their independence. This may be difficult for applicants who hold a substantive role in any current provider organisation. Applicants who hold such roles are therefore requested to discuss their application with the Committee Secretary at WHSSC prior to submission – contact Jacqui Evans at Jacqueline.Evans8@wales.nhs.uk.

In addition, applicants should particularly note the requirement to declare any private interests which may, or may be perceived to, conflict with the role and responsibilities as Chair of the WRCN including any business interests and positions of authority outside of the role in the WRCN.

If appointed, the Chair must declare these interests and seek confirmation from the Chair of WHSSC that no conflict has arisen and if it is appropriate for them to remain as the WRCN Chair.

Standards in public life

The WRCN Chair will be expected to adhere to the standards of good governance set for the NHS in Wales, which are based on the Welsh Government's Citizen Centred Governance Principles and incorporate Nolan's "Seven Principles of Public Life".

7. Interview Process

There will be a 2 stage recruitment process including a Presentation with a Stakeholder panel followed by a formal panel interview. These processes will take place on separate days, and depending on circumstances may be conducted virtually.

The ability to speak Welsh is desirable for this post; Welsh and/or English speakers are equally welcome to apply.

8. Further Information

For an Informal Discussion concerning the role please contact Debra Davies Debra.Davies5@wales.nhs.uk to arrange an informal discussion with Kate Eden, Chair of Welsh Health Specialised Services Committee (WHSSC), or Stuart Davies, Lead Executive from WHSSC for the Welsh Renal Clinical Network.

Website: Home - Welsh Health Specialised Services Committee (nhs.wales)

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

ROLE DESCRIPTION - CHAIR OF WELSH RENAL CLINICAL NETWORK (WRCN)

Accountable to: Chair of WHSSC

Appointment: Chair of WHSSC

Term of office: The Chair of the Welsh Renal Clinical Network (WRCN) will be appointed for a period of up to 3 years and will be subject to an annual review by the Chair of WHSSC. They may be re-appointed for a further period of up to 1 year but may not serve longer than 4 years in aggregate.

Time commitment: Approximately two days per month.

Remuneration: Band 3 of the Welsh Government Salary scale for Public Appointments - £278 per day (as at Aug 2021).

Liaison with: Members of the Welsh Renal Clinical Network Board (WRCN)**,** Members of the Corporate Directors Group, Officers of Welsh Health Specialised Services Committee (WHSSC), Members of the Joint Committee, Local Health Boards, Community Health Councils and key stakeholders within the community.

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1. Overall purpose

The Chair plays a crucial role in bringing an independent perspective to the WRCN, in addition to any specific knowledge and skills they may have.

The Chair has a duty to uphold the highest standards of integrity and probity and to foster good relations at the WRCN Network Board Meetings and Joint Committee meetings. They should apply similar standards of care and skill in their role as a Chair as they would in similar roles elsewhere.

The Chair is expected to participate fully as an affiliate member of the Joint Committee and Integrated Governance Committee (IGC) and will meet periodically with the Chair of WHSSC in the absence of Executive Directors to discuss issues of interest or concern.

The Chair of the WRCN Board is responsible for the effective operation of the WRCN Board:

- Chairing WRCN Board meetings;

- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all WRCN business is conducted in accordance with WHSSC Standing Orders; and
- Developing positive and professional relationships amongst the WRCN Board members.

The Chair shall ensure that key and appropriate issues are discussed by the WRCN Board in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions. This will include developing an Annual Plan of Board business that should be shared with the Board for approval.

2. The role

The Chair has a responsibility to:

- Carry out an annual performance assessment for the WRCN Board and every member of the Board;
- Attend regular meetings of the WHSSC Joint Committee as a non-voting Affiliate Member;
- Carry out an annual skills assessment to identify any gaps in knowledge or expertise. This information should be used to inform members' training requirements and be available to the Chair of WHSSC when a Board vacancy comes up for recruitment or re-appointment;
- Support Managing Director and Executive Directors in promoting the organisation's values;
- Support a positive culture throughout the organisation and NHS Wales and adopt behaviours in the boardroom and elsewhere that exemplify the corporate culture;
- Constructively challenge the proposed decisions of the Corporate Directors and ensure that appropriate challenge is made in all circumstances;
- Help develop proposals on priorities;
- Help develop proposals on risk mitigation;
- Help develop proposals on values and standards; and
- Contribute to the development of strategy.

The Chair has a duty to:

- Scrutinise the performance of the Executive management in meeting agreed goals and objectives;
- Satisfy themselves as to the integrity of financial, clinical and other information;
- Satisfy themselves that financial and clinical quality controls and systems of risk management and governance are sound and that they are used;
- Commission and use external advice as necessary;
- Ensure that they receive adequate information in the form that they specify and to monitor the reporting of performance.

Reappointments and extensions require the agreement of the Chair of WHSSC. The Chair of the WRCN should therefore ensure that any recommendations to reappoint Board members are made in sufficient time in order to allow proper consideration of such recommendations. There is no automatic presumption of reappointment; each case should be considered on its own merits, taking in to account a number of factors including, but not restricted to, the diversity of the current Board and its balance of skills and experience. This information along with a satisfactory performance appraisal for the Board member must be made available to the Chair of WHSSC.

3. Induction and refreshing skills

It is essential that the Chair becomes conversant at the earliest opportunity with the WRCN and the Joint Committee's business activities, its strategy and the main areas of risk.

The Chair should:

- Participate in the induction programme including meeting Corporate Directors, attending briefings, meetings and reading induction materials;
- Familiarise themselves with the key challenges and areas of risk facing the WRCN and Specialised Services; and
- Take opportunities to develop and refresh their knowledge and skills and ensure that they are well informed in respect of the main areas of WHSSC activity.

4. Time commitment

Prior to taking the appointment successful candidates should confirm to the Chair that they have sufficient available time to discharge their responsibilities effectively. Once appointed the WRCN Chair should inform the Chair of WHSSC of any changes to their time commitments that are likely to impact on their ability to discharge their responsibilities effectively.

5. Person specification

Candidates should be able to demonstrate the following:

5.1 Knowledge & Experience

- Have experience of working in committees and have the ability to chair meetings or the capacity and desire to take up training to become an effective Chair;
- Have the ability to listen, reflect and challenge;
- Have a good level of understanding and interest in Specialised Services.

5.2 Personal Attributes and Skills

WHSSC has defined a set of shared core values:

To show your commitment to these values you will need to be able to demonstrate the following:

- Strong interpersonal skills with personal impact and credibility to be an effective advocate and ambassador with strong influencing and negotiating skills;
- Drive and determination, with the ability to instil vision and develop defined strategies to pursue long and short-term goals;
- Excellent communication skills, with the ability to be clear and succinct and to facilitate understanding of complex issues while demonstrating respect for the views of others;
- Sound judgement, sensitivity and political awareness;
- Capacity to be independent and resilient;
- Have the ability to think clearly and exercise sound judgment;
- Have the ability to work collaboratively utilising persuasion and influencing skills effectively in a high profile Board environment;
- Have the ability to project and promote a confident, energetic and resilient attitude at all times, providing appropriate challenge where necessary;
- Have demonstrable high level analytical skills;
- Have demonstrable high level communication skills;
- Have the ability to work positively and operate as part of a team;
- Have highly sophisticated political awareness, subtlety, tact and absolute discretion;
- Have the ability to understand complex strategic issues, analyse and resolve difficult problems;
- Have sound knowledge of corporate governance; and
- Have sufficient time and commitment to fulfil the role.

5.3 Candidates must also demonstrate:

- A clear understanding and commitment to equality issues and challenging discriminatory practices;
- A clear understanding and commitment to Nolan's 'Seven Principles of Public Life';

- That they do not have any conflicts of interest. The nature of the work of the WCRN is that there are many interfaces with both NHS and private sector organisations and for the Chair to effectively carry out their role they must be able to clearly demonstrate their independence. This may be difficult for applicants who hold a substantive role in any current provider organisation. Applicants who hold such roles are therefore requested to discuss their application with the Committee Secretary at WHSSC prior to submission – contact Jacqui Evans at Jacqueline.Evans8@wales.nhs.uk.

  In addition, applicants should particularly note the requirement to declare any private interests which may, or may be perceived to, conflict with the role and responsibilities as Chair of the WRCN including any business interests and positions of authority outside of the role in the WRCN.

  If appointed, the Chair must declare these interests and seek confirmation from the Chair of WHSSC that no conflict has arisen and if it is appropriate for them to remain WRCN Chair.

Welsh language skills are desirable. All candidates will be expected to display empathy towards the language and demonstrate leadership to strengthen bilingual service provision within the NHS in Wales.

Candidates shortlisted for interview will be required to expand on how they meet the criteria above using examples and evidence.

A person shall be disqualified from appointment if he/she:

a) has within the preceding 5 years been convicted in the UK, Channel Islands or the Isle of Man of any offence and has received a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine;
b) Is the subject of a bankruptcy restrictions order or an interim order or has made a composition or arrangement with creditors;
c) has been dismissed, other than by reason of redundancy, from paid employment with a health service body; and
d) has had his or her membership as chair, member or director of a health service body terminated, other than by reason of redundancy, voluntary resignation, reorganisation of the health service body, or expiry of the period of office for which that person was appointed.

Any other information that may materially affect your application for appointment should be declared in the application form under the 'Conflict of Interests' section.

Applicants should be persons who conduct themselves at all times in a manner which will maintain public confidence.

Applicants are required to declare whether they are aware of anything in their private or professional life that would be an embarrassment to themselves or to the Welsh Government if it became known in the event of appointment.

December 2021

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

Rhwydwaith Clinigol Arennol Cymru
Welsh Renal Clinical Network

WELSH RENAL CLINICAL NETWORK BOARD
TERMS OF REFERENCE

Document Author	**Corporate Governance Manager**
Executive Lead:	**Director of Finance & Information**
Approved By:	**Joint Committee**
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1. LEGAL FRAMEWORK

In accordance with WHSSC Standing Order 3, the Joint Committee may and, where directed by the 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 LHB Board and/or its other committees).

These may consist wholly or partly of Joint Committee members or LHB Board members or of persons who are not LHB Board 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.

On 13th August 2009 the Minister for Health and Social Services formally agreed the establishment of a single Welsh Renal Clinical Network (WRCN) to be managed by the WHSSC and to be hosted by Cwm Taf Morgannwg ~~L~~UHB (CTMUHB) and the Joint Committee shall nominate annually a committee to be known as the Welsh Renal Clinical Network (WRCN).

The ~~Welsh Renal Clinical Network~~WRCN is not a legally constituted body, but has been set up under general powers conferred on the Welsh Ministers under the National Health Service (Wales) Act 2006 (the 2006 Act). Section 1 of the of the National Health Service (Wales) Act 2006 requires the Welsh Ministers to continue the promotion of a comprehensive health service for the people of Wales. In turn, section 3 requires the Welsh Ministers to provide, to such extent as they consider necessary, "medical…and

ambulance services" and such other services or facilities or facilities as are required for the diagnosis and treatment of illness. In turn, section 2 of that Act confers on the Welsh Ministers the power to do anything which is calculated to facilitate, or is conducive or incidental to their duties under the Act. In addition, under section 16 of that Act each LHB is required to make arrangements with a view to securing they receive appropriate professional advice from health experts in order to enable them to exercise their functions effectively.

The detailed terms of reference and operating arrangements set by the Joint Committee in respect of this committee are set out below.

2. DELEGATED POWERS AND AUTHORITY

The ~~Welsh Renal Clinical Network~~WRCN is a non-statutory body and therefore obtains its authority and responsibility as delegated by the Local Health Boards (LHBs) through the Joint Committee.

This delegation will provide the autonomy within an agreed framework for the officers of the ~~Welsh Renal Clinical Network~~WRCN to carry out the duties required of them to manage and lead the planning and performance management of the renal service contracts. These roles are to be based on professional standards set by the Welsh Government (including the Renal Delivery Plan and Service Specifications) and the renal professional groups such as the Renal Association, and will ensure a consistent and equitable approach across Wales.

The ~~Welsh Renal Clinical Network~~WRCN is authorised by the Joint Committee to undertake all roles and activities within its terms of reference. In doing so, the ~~Welsh Renal Clinical Network~~WRCN shall have the right to request information relevant to renal services of the relevant LHBs. It may seek any relevant information from any employee and all employees are directed to cooperate with any reasonable request made by the Welsh Renal Clinical Network.

The ~~Welsh Renal Clinical Network~~WRCN is authorised by the Joint Committee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Joint Committee's procurement, budgetary and other requirements.

Fundamentally the ~~Welsh Renal Clinical Network~~WRCN will be able to recommend the use of ring-fenced resources that have been identified as part of the phased resource-mapping process for renal services and the wider national exercise. Initially this included transplantation, dialysis, vascular access, Erythropoietin Stimulating Agents (ESAs) and dialysis transport. Immunosuppressants for Renal Transplantation have since been added. With its central management team, the ~~Welsh Renal Clinical Network~~WRCN will manage the utilisation of ring-fenced funds on behalf of the WHSSC and in collaboration with the service providers.

The ~~Welsh Renal Clinical Network~~WRCN will also have the responsibility on behalf of the Welsh Government for overseeing the implementation of the renal standards

(principally by reference to the Service Specifications) by the LHBs for their populations. Included within this work will be to support LHBs, Clusters and practices in managing patients who may not require referral to a Nephrologist. WRCN will need to engage with other Cardiovascular Disease clinicians and clinical networks to fulfil this role.

3. PURPOSE

3.1 Strategic Intent

The Welsh ~~Assembly~~ Government published in April 2007, a National Service Framework and Policy Statement "Designed to Tackle Renal Disease in Wales". Improving the quality of the care of those people with or at risk from renal disease is the cornerstone of that policy statement and National Service Framework (NSF) which defines evidence based standards for the planning, organisation and delivery of care for those with or at risk from renal disease. Whilst the principle requirements of the NSF remain, it has been superseded by the Renal Delivery Plan and its service specifications (2016).

The ~~Welsh Renal Clinical Network~~WRCN is the vehicle through which specialised renal services can be planned and commissioned on an all Wales basis in an efficient, economical and integrated manner and will provide a single decision-making framework with clear remit, responsibility and accountability. National prioritisation and implementation will generate economies of scale and increased synergy between the network and its stakeholders.

Role of the Welsh Renal Clinical Network:

- Lead the development and implementation of renal service strategy;
- Provide evidence based and timely advice to the Welsh Government and Joint Committee to assist the LHBs in discharging their functions and meeting their responsibilities with regard to the delivery of renal policy and services across Wales;
- Undertake planning for the development and delivery of an integrated renal service on an all Wales basis on behalf of, and with the agreement of the WHSSC;
- Determine in conjunction with the WHSSC the renal services that should be procured in Wales;
- In conjunction with WHSSC, manage the centrally held, ring-fenced, renal budgets required for delivery of services;
- Performance manage, on behalf of WHSSC, the delivery units against national standards and agreed service level agreements for delivery of renal services;
- Provide timely delivery and performance reports to WHSSC and Welsh Government;
- Advise and monitor clinical governance in relation to renal services within the agreed WHSSC Quality and Safety framework;
- Lead and assist in the creation, implementation and monitoring of service specifications / care pathways / care bundles for renal services;
- Fulfil a national remit, with a sub-structure that (i) is fit for purpose and (ii) enables local interface;

- Ensure a full-time, central support function so that it can successfully undertake its delegated responsibilities;
- Lead on the strategic development and implementation of renal related IT systems, ensuring accurate and timely returns to the UK Renal Registry;
- Engage with public and patients on current and future renal service and policy developments.

4. STAFFING STRUCTURE

The following posts will be included within the Welsh Renal Clinical Network:

- Independent Chair
  Appointed for 3 years (max 4), ~~on a sessional basis; 1 session~~2 days per ~~a week~~month.
  ~~Period of three years~~
  Appointed by Chair of WHSSC

- Lead Clinician
  Appointed on a sessional basis; 2 sessions per week.
  Period of three years

- Deputy Lead Clinician
  Appointed on a sessional basis; 1 session per week.
  Period of three years

- Clinical Lead for Quality & Patient Safety
  Appointed on a sessional basis; 1 session a week.
  Period of three years

- Clinical Lead for Information Management and Technology (IM&T)
  Appointed on a sessional basis; 1 session a week.
  Period of three years

- Clinical Lead for Transplant and Vascular Access
  Appointed on a sessional basis; 1 session a week.

- Clinical Lead for Pharmacy
  Seconded 2 days a week to April 2020

- National Health & Wellbeing Professionals Reference Group Chair
  Appointed on a sessional basis; 1 session per month.
- Lead Nurse
  Permanent full time appointment into WHSSC

- Network Manager
  Permanent full time appointment into WHSSC

- Deputy Network Manager
  Permanent full time appointment into WHSSC

- Network Finance Manager
  Permanent full time appointment into WHSSC

- Network Audit and Information Analyst
  Permanent full time appointment into WHSSC

- Network Coordinator
  Permanent full time appointment into WHSSC

- Network Projects/development Manager
  Permanent full time appointment into WHSSC

~~Welsh Renal Clinical Network~~WRCN members' terms and conditions of appointment, (including any remuneration and reimbursement) are determined by the Joint Committee, in accordance with the Standing Orders, subject to any specific requirements, regulations or directions agreed by the LHBs or the Welsh Ministers.~~the basis of advice from the LHB Remuneration and Terms of Service Committee.~~ Patient and carer representatives will have reasonable travel expenses for attending Board meetings reimbursed according to LHB policy.

5. FUNCTION

As a minimum, the ~~Welsh Renal Clinical Network~~WRCN will utilise two tiers of forum:
National Board
Two sub-committees

- WRCN Management Group
- WRCN Quality & Patient Group

5.1 WRCN 'Management Group'

A sub-committee of the Welsh Renal Clinical Network Board, the Management Group will provide a forum to enable meaningful interface with the providers of renal services within Wales.

The Management Group will meet more frequently than the Network Board. A full 'terms of reference' and membership of the Management Group is appended to this document.

Membership of the Management Group:

- ~~Network Deputy Lead Clinician (~~Independent Chair~~)~~
- Network Lead Clinician
- Network Lead Nurse
- Network Manager / Deputy
- Network Finance Manager
- Network Clinical Lead for Quality & Patient Safety

- Network Clinical Information Management and Technology Lead
- Network Renal Pharmacy Advisor
- Network Lead for Renal Transplantation and Vascular Access
- National Health & Wellbeing Professionals Reference Group Chair
- Nominated Director of Welsh Health Specialised Services Team
- Renal Procurement Lead
- Provider Health Boards (~~Abertawe Bro Morgannwg~~Swansea Bay UHB, Betsi Cadwaladr UHB and Cardiff & Vale UHB):
    - Nephrology Clinical Directors
    - Nephrology Directorate Managers
    - Nephrology Lead Nurses
    - Nephrology Finance Managers

5.2 WRCN Quality & Patient Safety (QPS) Group

This will be a forum to review and analyse matters relating to Quality and Patient Safety for renal services. The ~~F~~focus will have a ~~be~~ commissioning aspect but with alignment to operational aspects so as to help ensure appropriate governance.

The Terms of Reference for the QPS Group is appended to this document and forms part of the underpinning governance arrangements of the WRCN Board.

Membership includes:

- Network Clinical Lead for Quality & Patient Safety (Chair)
- Network Lead Nurse
- Network Manager/Deputy
- Network Clinical Lead for Information Management and Technology
- Network Audit and Information Analyst
- Consultant Nephrologists (the QPS leads) from each of the five units
- Nephrology Directorate Managers

The Chair will report to the WRCN Board and the WHSSC Quality & Patient Safety Sub-committee.

6. MEMBERSHIP OF THE WELSH RENAL CLINICAL NETWORK BOARD

The Chair of the ~~Welsh Renal Clinical Network~~WRCN will be appointed by the Chair of WHSSC.

6.1 Membership of the Welsh Renal Clinical Network

Core (voting) members:

- Network Lead Clinician / Deputy Lead Clinician {single vote}

- Network Lead Nurse
- Network Clinical Lead for Quality and Patient Safety
- Network Clinical Lead for IM and T
- Network Clinical Lead for Transplant and Vascular Access
- Network Clinical Lead for Pharmacy
- Network Health & Wellbeing Professionals Group Chair
- Non-officer member LHB representative
- Patient Advocacy Groups representative*{single vote}
- Community Health Council Representative
- Clinical Director Representative – North, SW and SE Wales {single vote}

*Patient Advocacy Groups (PAG) are required to be Registered Charities with the Charities Commission and whose primary function is to support the Welsh population and/or has a dedicated focus on Wales. As at date of approving these Term of Reference patient advocacy groups in Wales that meet this criteria are:

- Kidney Wales Foundation Reg No: 700396
- Paul Popham Fund Reg No: 1160114
- Kidney Care UK Reg No: 270288

It is anticipated that as the main purpose of patient advocacy group representation on the WRCN Board is to ensure that the 'voice of the patient' is heard, the groups nominated representatives will have current or past experience of being a renal patient or carer.

All individual PAG nominations or amendments to the invited PAG as listed above, will be prior approved by the WRCN Board Chair.

In attendance:

- Nominated Director of Welsh Health Specialised Services Team;
- Network Manager / Deputy Network Manager
- Network Finance Manager
- Welsh Government – Policy Lead for Renal Services;
- WHSSC Management Group Representatives (from different health boards for planning and finance);
- Individual patient representatives from renal services and dialysis units as agreed advocates.

The following only where an agenda item requires their presence:

- Renal Hub Manager
- Network Audit and Information Analyst

- Welsh Kidney Research Unit representative
- WHSSC Medical Director
- Welsh Government – Medical Director
- Welsh Government – Chief Nursing Officer
- Welsh Association of Renal Physicians & Surgeons representative
- Members of Welsh Renal Clinical Network Project Boards

The Welsh Renal Clinical Network may also co-opt additional independent external members from outside of the organisation to provide specialist knowledge and skills.

6.2 Member Appointments

The membership of the Renal Network Board shall be determined by the Joint Committee Chair, based on the recommendation of the Chair of the Renal Network Board - 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 need to ensure appropriate geographical representation across Wales will also be required.

Appointed members shall hold office for a period of three years, during which time a member may resign or be removed by the Welsh Renal Clinical Network. An appointed member may be asked to continue their role on the Welsh Renal Clinical Network following an annual review and by the agreement of the Joint Committee Chair.

6.3 Support to Welsh Renal Clinical Network Members

The Welsh Renal Clinical Network Secretariat, on behalf of the Chair, shall:

- Arrange the provision of advice and support to members on any aspect related to the conduct of their role; and
- Co-ordinate the provision of a programme of organisational development for members.

7. BOARD MEETINGS

7.1 Quorum

At least five (voting) members must be present to ensure the quorum of the Renal Network Board one of whom should be the Committee Chair or Lead Clinician.

7.2 Decision Making Process

Decisions will normally be achieved through consensus.
In exceptional circumstances the decision may proceed to a vote. In these circumstances ~~the~~ each core member will have one vote. The vote will be a simple majority. The detail of any vote will be recorded in the minutes of the meeting and as part of any recommendation made to the Joint Committee.

7.3 Frequency of Meetings

Board meetings shall be held at a frequency to allow synchronisation with the meeting of the Joint Committee (and at least three times per annum) and otherwise as the Chair of the Committee deems necessary.

7.4 Dealing with Members' interests during Network Board 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 a 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.

The Chair, advised by the Committee Secretary, must ensure that the Network Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual board members must demonstrate, through their actions, that their contribution to the Network Board's decision making is based upon the best interests of the NHS in Wales.

Where individual members identify an interest in relation to any aspect of Network Board business set out in the Network Board's meeting agenda, that member must declare an interest at the start of the Network Board meeting. Members should seek advice from the Chair, through the Committee Secretary before the start of the meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Network Board minutes.

7.5 Withdrawal of individuals in attendance

The Network Board may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.6 Board Agenda and Papers

The Welsh Renal Clinical Network Chair will determine the agenda for each meeting, taking into account any suggestions or requests from individual members.
Members will be provided with the Agenda and supporting papers for each meeting at least five working days in advance of each meeting.
A schedule of dates for the meetings will be published for the year ahead.
Welsh Renal Clinical Network meetings will be carried out openly and transparently in a manner that encourages the active engagement of stakeholders. This will be facilitated in a number of ways including:

- active communication of forthcoming Welsh Renal Clinical Network business and activities;
- agenda published at least 5 working days in advance of each meeting; and
- the selection of accessible, appropriate meeting venues,
- An agreed record of each meeting will be published within 10 working days of the meeting;

- The Board agenda and papers /record will be published on the Welsh Renal Clinical Network website.

7.7 Conduct of Meetings

The Chair, will preside at any meeting of the Welsh Renal Clinical Network Board
The Welsh Renal Clinical Network may invite individuals or groups to address its meetings

All Board meetings will normally be held in Cardiff; however they may alternate with other suitable venues across Wales.

7.8 Values and Standards

The Welsh Renal Clinical Network will conduct all its activities in accordance with NHS Values and the Standards of Behaviour Framework set for public services in Wales. Individual members will operate within their defined standards of behaviour framework which incorporates the Seven Principles of Public Life (the Nolan Principles).

7.9 Communications

The Welsh Renal Clinical Network will agree a Communications Policy in relation to its activities.

7.10 Secretariat

The Welsh Renal Clinical Network will be supported by the Network Coordinator and the WHSSC Committee Secretary as agreed by the Renal Network Manager. Any queries should be directed to Renal Network Manager. The Secretariat will:

- provide the first point of contact for Welsh Renal Clinical Network members in relation to all routine business;
- co-ordinate the activities of the Welsh Renal Clinical Network.
- Arranging meetings and issuing invites for each meeting;
- Agreement of agendas with the Chair and preparation, collation and circulation of papers;
- ensure that all papers are distributed at least five clear working days in advance of any meeting,
- ensure that the draft minutes will be provided to the meeting Chair within ten working days following the meeting.
- 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 sub-committee.

7.11 Programme Management

The Welsh Renal Clinical Network may establish sub groups or task and finish groups to carry out on its behalf specific aspects of Welsh Renal Clinical Network business.

A number of specific standing "All Wales" project groups will be established to oversee activities linked to core renal services including:

- Quality & Patient Safety
- Vascular (Dialysis) Access
- Unit Haemodialysis
- Conservative Management & End of Life Care
- Transplantation
- Medicine Management
- Home Therapies
- Clinical Information & IT

The full range of sub groups to be established and their terms of reference will be proposed and agreed by the Network Board.

8. REPORTING AND ASSURANCE ARRANGEMENTS

The Welsh Renal Clinical Network Chair shall:

- report formally, regularly and on a timely basis to the Joint Committee on the activities of the Welsh Renal Clinical Network. This includes verbal updates on activity, the submission of Network Board minutes and written reports, as well as the presentation of an annual report;
- bring to the Joint Committee specific attention any significant matters under consideration by the Welsh Renal Clinical Network;
- ensure appropriate escalation arrangements are in place to alert the Joint Committee Chair, WHSSC Director or Chairs of other relevant WHSSC committees of any urgent/critical matters that may affect the operation and/or reputation of the WHSSC.

The Joint Committee may also require the Welsh Renal Clinical Network 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 WHSSC Committee Secretary, on behalf of the Joint Committee, shall oversee a process of regular and rigorous self assessment and evaluation of the Welsh Renal Clinical Network's performance and operation including that of any sub-groups established. In doing so, account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

9. ACCESS

The Head of Internal Audit of the host LHB shall have unrestricted and confidential access to the Chair of the Welsh Renal Clinical Network.

The Welsh Renal Clinical Network will meet with Internal Audit (and as appropriate, nominated representatives of Healthcare Inspectorate Wales) without the presence of officials on at least one occasion each year.

The Chair of the Welsh Renal Clinical Network shall have reasonable access to the Directors and other relevant senior staff within the Welsh Health Specialised Services Team.

10. RELATIONSHIP WITH THE JOINT COMMITTEE AND ITS SUB COMMITTEES/GROUPS

Although the Joint Committee WHSSC has delegated authority to the Welsh Renal Clinical Network for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens.
The Welsh Renal Clinical Network, through its Chair and members, shall work closely with the Joint Committee's other 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 Welsh Renal Clinical Network 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 Welsh Renal Clinical Network shall embed the WHSSC / LHB corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

10.1 WHSSC Management Group

The WHSSC Management Group has a number of functions delegated to it by the Joint Committee including the development of the Integrated Commissioning Plan and its interface with Health Board Integrated Medium Term Plans.

The WRCN is required to contribute to these plans as part of its commissioning and / or advisory role.

Whilst the majority of the WRCN's activities will report directly through to the Joint Committee, there will be times that this will need to go through the WHSSC Management Group first to ensure relevant and appropriate debate and contribution. This will be on an exceptional basis and will be determined in collaboration between the WRCN Management Group and WHSSC Directors.

Examples of this would include:

- Contribution to the development of the ICP / IMTPs where resources for specialist renal services are required;
- Where there is collaborative commissioning responsibility for a part of the care pathway between the WRCN and Health Boards
- Where the WRCN is providing specialist advice to Health Boards on general nephrology activities that are outside of its commissioning responsibilities e.g.

non-specialist medicine prescribing

- Where there is potential for a resource transfer between the WRCN and Health Boards akin to the previous ESA and Immunosuppression projects.

The WRCN will be represented at the WHSSC Management Group by the Network Lead Clinician and Manager (or their deputies) where such items are on the WHSSC Management Group agenda.

11. APPLICABILITY OF STANDING ORDERS TO WELSH RENAL CLINICAL NETWORK BUSINESS

The requirements for the conduct of business as set out in the WHSSC / Standing Orders are equally applicable to the operation of the Welsh Renal Clinical Network.

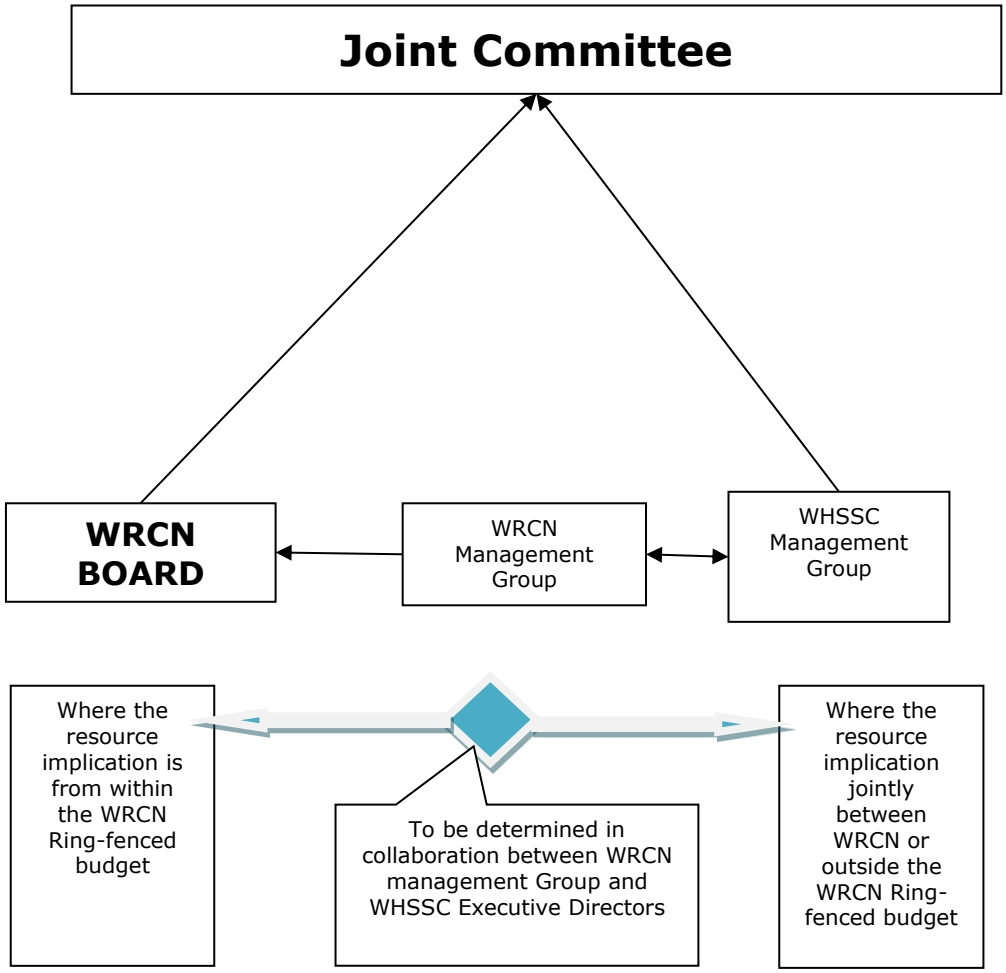
12. ACCOUNTABILITY ARRANGEMENTS FOR OFFICERS OF THE ALL WALES RENAL NETWORK

- The Welsh Renal Clinical Network Chair will be directly accountable to the Chair of the Joint Committee. The Welsh Renal Clinical Network Lead Clinician will be directly accountable to the Chair of the Joint Committee but will also provide advice to Welsh Government through the NHS Medical Director and Chief Medical Officer as required.
- The Renal Network Manager will be managerially responsible to the nominated Director of WHSST but accountable to the Network Chair / Lead Clinician for the development and delivery of the Network objectives and work plan as appropriate to this role.
- The Network Lead Nurse will be accountable to the WHSSC Director of Nursing, and managerially responsible to the Network Manager.

13. REVIEW

These Terms of Reference shall be reviewed annually by the Welsh Renal Clinical Network with reference to the Joint Committee.

Appendix 1 – Diagram of reporting of WRCN activities to the Joint Committee



Report Title	**Managing Director's Report**	**Agenda Item**	2.2
Meeting Title	Joint Committee	**Meeting Date**	18/01/2022
FOI Status	Public		
Author (Job title)	Managing Director, Specialised And Tertiary Services Commissioning, NHS Wales		
Executive Lead (Job title)	Managing Director, Specialised And Tertiary Services Commissioning		

Purpose of the Report	The purpose of this report is to provide the Joint Committee with an update on key issues that have arisen since the last meeting.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☒	INFORM ☒

Recommendation(s)

Members are asked to:

- **Note** the report.

MANAGING DIRECTOR'S REPORT

1.0 SITUATION

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

2.0 BACKGROUND

At each Joint Committee meeting, the Managing Director presents a report on key issues which have arisen since its last meeting. The purpose of the Managing Director's Report is to keep the Joint Committee up to date with important related to WHSSC. A number of issues raised within this report may also feature in more detail within the Executive Directors' reports as part of the Joint Committee's business.

3.0 ASSESSMENT

3.1 Hepato-Pancreato-Biliary (HPB) Services Workshops

The Joint Committee and the Health Boards (HBs) have agreed that WHSSC should take on responsibility for commissioning Hepato-Pancreato-Biliary (HPB) services for Wales. Two workshops were held in November/December 2021 to look at options for developing the service model in south Wales to meet the agreed service specification. The output from these workshops will be reported to the NHS Wales Collaborative Executive Group in January. Following receipt of the output of the workshops a paper will be brought for consideration by the Joint Committee that sets out the way forward.

3.2 Extension of Fast-Track Process for Military Personnel

Currently FastTrack eligibility arrangement are in place for regular service personnel (SP) which are managed through the Patient Care Team at WHSSC. WHSSC has recently received a request from Lt.Col Papworth of HQ Defence Medical Services to extend this scheme to a small numbers of Reservist SPs to maintain military, deployed capability, which is particularly important to support the NHS during winter pressures. This has been discussed with WG and the initiative is supported. As the budget impact is not material this policy change is being implemented with immediate effect.

3.3 Paediatric Inherited Metabolic Diseases (IMD)

WHSSC has been made aware that the lead clinician for the Paediatric Inherited Metabolic Diseases Service is fully retiring in February 2022. Discussions have therefore taken place with a number of providers on potential service models, which could be delivered, from this date and a decision has been made to commission the service from the Birmingham Women and Children's Foundation

Trust. The existing Cardiff team of nurses, dietitians and wider support staff will continue in their roles but with support from the Birmingham team. They will also provide outpatient clinics within Cardiff (both virtual and physical) and will offer clinical advice and support to the local team for patients that need a hospital stay.

3.4 Commissioning of Burns Treatment from SBUHB Welsh Centre for Burns

Due to workforce issues the Welsh Centre for Burns and Plastic Surgery in Swansea was temporarily closed in October 2021, and the service was escalated to level 4 of the WHSSC escalation process pending receipt of a formal action plan. The centre is the adult burns centre for the South West UK Burns Network, it covers a population of 10 million and complex burns patients can also be referred there via the National Burns Bed Bureau. Currently the issues concerning the intensive care unit rota and back up options have not been resolved.

Discussions are ongoing with SBUHB and a verbal update will be provided at the meeting.

3.5 WHSSC Specialised Services Strategy

The WHSSC Specialised Services Strategy was introduced in 2012 and is in the process of being updated to reflect the significant challenge related to the pace of development of innovative treatments, increasing costs and more recently the unprecedented and disruptive impact of the COVID-19 pandemic on NHS care.

It was previously agreed with Joint Committee that a stakeholder engagement exercise will be undertaken in January/February 2022 to gain insight on long term ambitions and to inform how we shape and design our services for the future. Given the ongoing pressures on the service due to the current wave of the pandemic this timetable is being reviewed.

Developing the strategy is a requirement of recommendation 4 of the Audit Wales report "WHSSC Committee Governance Arrangements" in relation to developing and approving a new strategy.

3.6 NCCU Surge Beds

WHSSC has been requested by the National Collaborative Commissioning Unit (NCCU) to provide support to enable them to commission mental health surge beds in response to the current omicron wave. NCCU has been asked by health boards to secure up to 80 beds of surge capacity for a limited period estimated to be up to the end of March 2022 based on their local demand assessments. The type of beds that will be sourced include Psychiatric Intensive Care (PIC), step down and low secure which are normally outside of WHSSC's direct commissioning remit. The NCCU has confirmed that the funding for the initiative will be provided directly by Welsh Government. The proposed enabling support by WHSSC will be to manage the financial allocation, financial reporting and payments associated with the scheme. WHSSC undertook similar financial support actions in 2020/21 for the previous initiative and in 2021/22 for the

payment of the COVID-19 bonus. There have been no audit issues raised to date. The NCCU undertook a similar process for earlier surge capacity needs and a contract was developed and used at that time. NCCU will be working with the NHS Wales Shared Services Partnership (NWSSP) to put in place a similar contract. WHSSC will review the contracting arrangements put in place by the NCCU to ensure an appropriate level of due diligence proportionate to the scale of timescale requirements of the initiative. The Joint Committee is asked to support that WHSSC undertakes this new activity on their behalf.

4.0 QUALITY, GOVERNANCE AND RISK

This report ensures that the Joint Committee are made aware of any the impact of any quality, governance or risk issues arising from the commissioning work of WHSSC.

5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report; and
- **Support** that WHSSC provides support to the NCCU to enable them to commission mental health surge beds in response to the current omicron wave.

Governance and Assurance	
Link to Strategic Objectives	
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	All
Institute for HealthCare Improvement Quadruple 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.
Finance/Resource Implications	There is no direct financial/resource impact from this report.
Population Health	The updates included in this report apply to all aspects of healthcare, affecting individual and population health.
Legal Implications (including equality & diversity, socio economic duty etc)	There are no specific legal implications relating within this report.
Long Term Implications (incl WBFG Act 2015)	WHSSC is committed to considering the long-term impact of its decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.
Report History (Meeting/Date/ Summary of Outcome	**-**
Appendices	-

Report Title	**All Wales Individual Patient Funding Request (IPFR) Panel Update**	**Agenda Item**	2.3
Meeting Title	Joint Committee	**Meeting Date**	18/01/2021
FOI Status	Public		
Author (Job title)	Committee Secretary & Head of Corporate Services		
Executive Lead (Job title)	Managing Director, Specialised And Tertiary Services Commissioning		

Purpose of the Report	• To provide the Joint Committee (JC) with an update regarding proposals to change the terms of reference (ToR) of the All Wales Individual Patient Funding Request (IPFR) Panel; • To provide the JC with an update regarding the recent Judicial Review of an All Wales IPFR Panel decision; and • To update the JC on the outcome of a recent meeting with Welsh Government to discuss the governance arrangements of the All Wales IPFR Panel (the 'Panel'), including the authority of JC to amend the ToR of the Panel.

	RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
Specific Action Required	☐	☐	☐	☒	☒

Recommendation(s)

Members are asked to:

- **Note** the issues with the current ToR of the All Wales IPFR Panel;
- **Note** the outcome of the recent Judicial Review and the implications for both the All Wales IPFR Panel and health board panels in Wales;
- **Note** the next steps agreed with Welsh Government regarding urgent changes to the existing All Wales IPFR Policy;
- **Note** the next steps agreed with Welsh Government regarding the authority of the Joint Committee to approve changes to the All Wales IPFR Panel ToR; and
- **Note** the suggestion from WHSSC officers regarding the need for a wider review of both the All Wales IPFR Policy and the governance arrangements for the policy.

INDIVIDUAL PATIENT FUNDING REQUEST (IPFR) UPDATE

1.0 SITUATION

The purpose of this report is to:

- Provide the Joint Committee (JC) with an update regarding proposals to change the terms of reference (ToR) of the All Wales IPFR Panel,
- Provide the JC with an update regarding the recent Judicial Review of an All Wales IPFR Panel decision,
- Update the JC on the outcome of a recent meeting with Welsh Government to discuss the governance arrangements of the All Wales IPFR Panel (the 'Panel'), including the authority of JC to amend the terms of reference (ToR) of the Panel.

2.0 BACKGROUND

The WHSSC All Wales IPFR Panel is 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 terms of reference for the panel are outlined in Appendix 2 of the "All NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)" *("the Policy")* – ***see Appendix 1.***

A report was submitted to the JC on 10 November 2020 asking members to amend the ToR of the All Wales IPFR Panel to address longstanding issues of quoracy and to address the challenges arising from the COVID-19 pandemic. The report outlined that the WHSSC - COVID-19 – Standard Operating Procedure 02, for Individual Patient funding (IPFR) decisions had been introduced and that there was a reliance on undertaking Chairs action[1] meetings to ensure effective decision making in accordance with the IPFR Policy.

The report outlined that the COVID-19 pandemic was likely to have long-term impacts on IPFR decision making and that consideration had been given to the future All Wales (WHSSC) IPFR Panel membership, and that lessons could be learned from the agile governance methods adopted during the pandemic.

The report made a recommendation to update the ToR to support efficacy and quoracy. However, the Clinical Director of the All Wales Therapeutics & Toxicology Centre (AWTTC) who chairs the IPFR Quality Assurance Group (QAG) and the

[1] *For the Chairs action to be effective the Director of Specialised and Tertiary Services together with the WHSSC Medical Director or Director of Nursing and the Chair of the WHSSC Panel (or Vice Chair) were required to be in attendance*.

IPFR Managers Group wrote to the Committee indicating that WHSSC could not update its own ToR because they believed that jurisdiction sat with the QAG. The Committee, therefore, did not approve the proposed ToR. WHSSC officers subsequently sought clarification from Welsh Government (WG) regarding the appropriate governance route for changes to the ToR.

The practical implications of not being able to update the ToR has been that the WHSSC IPFR panel is often non-quorate, or lacks a chair due to diary commitments. Given that the Panel is frequently subject to challenge (including Judicial Review) this represents a significant risk to WHSSC and is now included as a high risk on the corporate risk register.

A further report was submitted to the JC on 09 November 2021 indicating that clarification regarding the appropriate governance route for changes to the ToR had not yet been received from WG and to alert the JC of the risks related to this. The JC agreed that the Deputy Chief Executive NHS Wales would make enquiries with Welsh Government in order to progress the issue.

Following this, on 03 December 2021 a request for a judicial review in the case of Maria Rose Wallpott (MW) – v- (1) WHSSC & (2) Aneurin Bevan UHB (ABUHB) was allowed and the decision of the WHSSC IPFR panel to refuse funding for cytoreductive surgery with hyperthermic intraperitoneal chemotherapy (CRS with HIPEC) to treat MW's colorectal cancer, was quashed by the court. The judgement is presented at ***Appendix 2*** for information. The application for funding for the intervention recommended by her clinician was reconsidered "afresh" by the WHSSC IPFR panel on 16 December 2021.

An urgent meeting was held with WG officials on Friday 17 December to discuss and agree a way forward regarding the implications of the judgement on both the Policy and the need to review the ToR of the Panel.

3.0 ASSESSMENT

3.1 NHS Wales IPFR Policy

The judgment handed down is based on a significantly different interpretation of the Policy than was previously the case in Wales, which is relevant not only to the All Wales Panel but to HB panels across Wales.

Generally three criteria must be met for a panel to agree funding:

- the patient's clinical circumstances are significantly different to the general population of patients,
- the patient is likely to gain significantly more clinical benefit; and
- that the intervention offers…….value for money

It is arguable that the Judge's interpretation of the comparator group of "general population of patients" implies that any patient for whom a clinician submits an

IPFR form is "significantly different" and thus "likely to gain significantly more benefit".

Feedback to WHSSC from the legal team made clear that the Judge's interpretation of the current Policy has to prevail and that whilst the decision could be appealed, the reasons for the decision could not. Furthermore, the legal team recommended an urgent review of the Policy in light of the judgement and suggested important changes to the wording to ensure clarity such that the intended meaning of the policy could be re-instated.

The judgement handed down on 03 December 2021 focussed on three key areas:

- The All NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR),
- The definition of the comparator group,
- The record of the Panel's reasoning.

WHSSC met with WG Colleagues on 17 December and it was agreed that the Policy needs an urgent review to ensure that the intended meaning of the Policy is given effect, specifically on the definition for the comparator group and the Panels record. In addition, it was agreed they would confirm the governance route regarding these changes and write to WHSSC and HBs to confirm the arrangements. WHSSC officers agreed, in collaboration with legal advisors, to immediately start redrafting the Policy.

WG representatives also committed to writing urgently to WHSSC to confirm the authority of JC to approve changes to the ToR of the Panel.

It was emphasised to WG colleagues that the level of procedural rigour which the court is now demanding of NHS bodies will involve significantly more NHS resources being expended on IPFR processes.

3.2 Governance Structures Related to the All Wales IPFR Process

Currently there appears to be ambiguity and a potential contradiction over the governance route both for the All Wales WHSSC IPFR Panel ToR and for the All Wales IPFR Policy itself. The QAG was established following the written statement made by the then Cabinet Secretary for Health and Social Services, Vaughan Gething following the review of the IPFR process across Wales. QAG reports to medical directors and to the Welsh Government's Chief Medical Officer, the QAG ToR are presented at ***Appendix 3*** for information. It is chaired by the Clinical Director of the All Wales Therapeutics and Toxicology Centre (AWTTC), however AWTTC sits within the governance structures of Cardiff and Vale UHB (CVUHB), yet reports to the Chief Pharmacy Officer and Deputy Chief Medical Officer at WG. The expertise of AWTTC is in medicines appraisal but the vast majority of IPFR requests received by WHSSC are for non-medicines. AWTTC does not have governance expertise and the Clinical Director of AWTTC is not required to have personal experience of either Chairing or being a member of an IPFR panel.

3.3 WHSSC IPFR Panel Terms of Reference

The WHSSC IPFR Panel Terms of Reference (ToR) are outlined in the "All NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)". There is an urgent need for the WHSSC IPFR panel ToR to be updated. During the meeting with WG on 17 December 2021 WG representatives confirmed that it was their understanding that it was the authority of the Joint Committee to make decisions on the WHSSC IPFR Panel Terms of Reference (ToR), as one of its sub-committees in accordance with the WHSSC Standing Orders, however they would write to confirm this position.

Key issues needing to be addressed in the ToR include:

i. **Chair's term of office** - The current ToR states that an Independent Chair will be "from existing members of the NHS organisations Boards" – this is not clear and open to interpretation – this could mean an IM from a HB, or it could mean someone who is independent from a HB, but still from an NHS body – this needs to be clarified in advance of the forthcoming recruitment of a new Chair,

ii. **The selection process for the Chair** - the ToR are not clear on how the independent chair is appointed –to ensure that we can openness and transparency this will require clarification,

iii. **Chairs remuneration** – currently there is no reference to remuneration in the ToR and consideration will need to be given to remunerating the WHSSC IPFR sub Committee chairs role, in a similar manner to the remuneration of WHSSC IM's given the significantly increased demands of the role following the recent court judgement; and

iv. **Membership of the Panel and the use of virtual panels-** there are long standing issues regarding quoracy and these have worsened during the pandemic. In addition, the number of request has increased and implication of the recent court judgement is that more time is required for consideration and recording of each case. Finally, WHSSC recently invited an independent legal advisor to observe a Panel meeting and feedback was that the number of members made efficient running of the panel difficult.

3.4 National Review of the All Wales IPFR Policy and Process

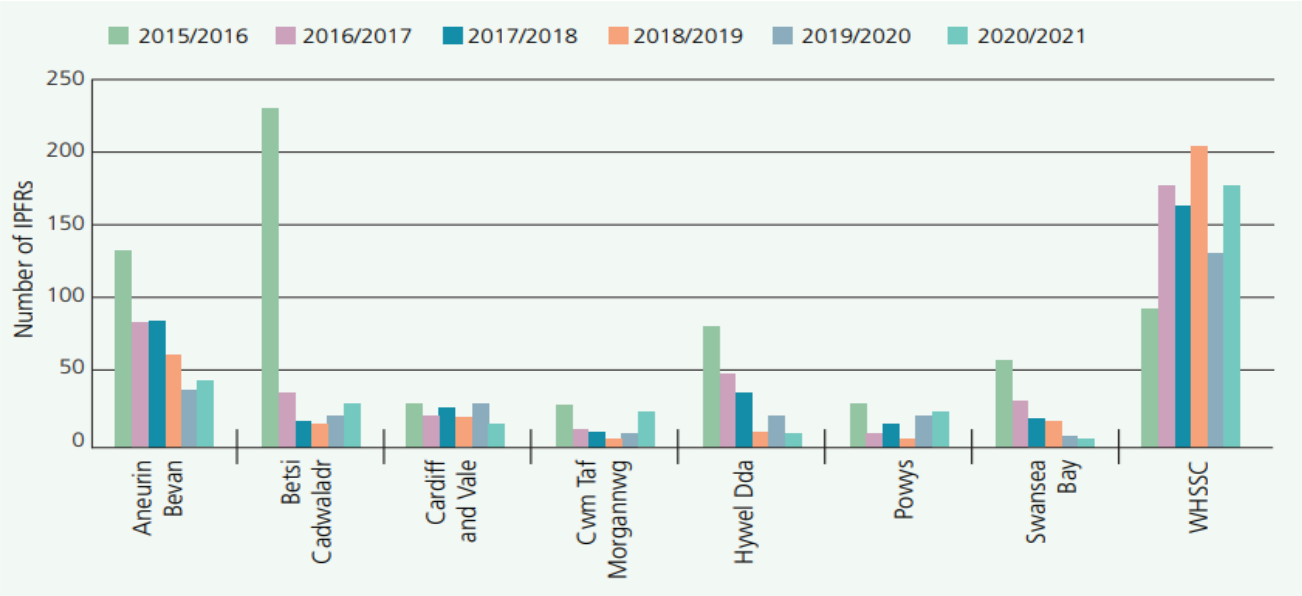
In light of the recent Judgement, the apparent ambiguity regarding the governance arrangements of the IPFR process and because the last Policy review was almost 5 years ago, WHSSC have suggested to WG that consideration is now given to undertaking a wider review of the both the Policy and governance framework of IPFR panels in Wales. This should include the current governance arrangement of the IPFR QAG and recognise the specific issues related to the All Wales IPFR Panel (see below). We have suggested this should be informed by independent legal advice as well as by governance experts from NHS Wales.

3.5 Issues Specific to the WHSSC All Wales IPFR Panel Process

It is relevant to note that there are issues specific to the work of the WHSSC All Wales IPFR Panel which require consideration in any review of the Policy. The Panel considers more requests than all the health board panels combined (Table

1). Currently the ToR requires representation from each HB and the frequent turnover of members from some HBs mean that members are unable to develop expertise. In addition, because HBs see relatively few requests, representatives may have limited experience of IPFR decision making prior to joining the Panel. This issue is compounded by the specialist nature of the requests considered by the Panel, the majority of which deal with complex non-medicine interventions.

Table 1 - Number of IPFRs within each Health Board in Wales, including WHSSC, from 2015/2016 to 2020/2021.



Source: [All Wales Therapeutics and Toxicology Centre (AWTTC) Annual Report 2020-2021]

3.6 Progress on the Actions Agreed with Welsh Government (WG)

Following on from the urgent meeting with WG officials on Friday 17 December to discuss and agree a way forward regarding the implications of the judgement on both the Policy and the need to review the ToR of the Panel, the following actions are in progress:

- WG agreed to issue a formal letter to WHSSC confirming the authority of the Joint Committee to amend the ToR of the All Wales IPFR Panel –a letter is awaited,
- WG agreed to confirm the appropriate governance route for amending the All Wales IPFR Policy and will write to HBs to confirm the position – a letter is awaited,
- Independent legal advice has been sought on updating the Policy to strengthen it to ensure it satisfies the courts requirements and the policy is being redrafted to reflect these changes, and will be shared with WG in anticipation of the updated Policy being considered and approved by HBs,
- Research is being undertaken on alternative models through benchmarking against Individual Funding Request (IFR) models in NHS England,

- HB Board Secretaries have been informed of the implications of the JR judgement handed down on HB IPFR processes and the potential need for approval of a new All Wales IPFR policy to ensure effective governance,
- The AWTTC have been made aware of the implications of the JR judgement,
- The WHSSC All Wales IPFR panel ToR are being updated and a report outlining the proposed changes and the resource implications arising from the JR will be presented to the JC meeting on 15 March 2021.

4.0 QUALITY, GOVERNANCE AND RISK

The "All NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)" has not been reviewed since 2017, and the terms of reference states that it should be reviewed annually. Recommendation 9 from the 2017 WG review stipulates that WHSSC and HB's should review all of their policies that refer to IPFRs and ensure that the policies taken together are up to date, consistent and coherent. In light of the recent court judgement the Policy needs an urgent review to ensure that the intended meaning of the Policy is given effect.

In addition, the IPFR governance risk is captured as a risk on the WHSSC Corporate Risk Assurance Framework (CRAF) and has been escalated from 16 to 20 following the handing down of the judgment.

5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the issues with the current ToR of the All Wales IPFR Panel;
- **Note** the outcome of the recent Judicial Review and the implications for both the All Wales IPFR Panel and health Board panels in Wales;
- **Note** the next steps agreed with Welsh Government regarding urgent changes to the existing All Wales IPFR Policy;
- **Note** the next steps agreed with Welsh Government regarding the authority of the Joint Committee to approve changes to the All Wales IPFR Panel ToR; and
- **Note** the suggestion from WHSSC officers regarding the need for a wider review of both the All Wales IPFR Policy and the governance arrangements for the policy.

Governance and Assurance	
Link to Strategic Objectives	
Link to Integrated Commissioning Plan	**-**
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	All
Institute for HealthCare Improvement Quadruple Aim	Improving Patient Experience (including quality and Satisfaction)
Organisational Implications	
Quality, Safety & Patient Experience	A national IPFR quality function is in place to support the IPFR panel to ensure quality and consistency. The quality function provides quality assurance around the decision-making of panels and promotes consistency across Wales.
Finance/Resource Implications	The level of procedural rigour which the court is now demanding of NHS bodies will involve significantly more NHS resources being expended on IPFR processes in future and may impact the DRC budget. A separate paper will be brought to JC regarding this matter.
Population Health	No adverse implications relating to population health have been identified.
Legal Implications (including equality & diversity, socio economic duty etc)	In accordance with the legal and regulatory framework for NHS decision making Health Boards must be able to demonstrate that their decisions are within their powers and comply with their legal obligations. In terms of the exercise of their powers, they must show that they have taken into account all relevant issues in the decision making process, giving them appropriate weight and that those decisions are rational, logical, lawful and proportionate. The level of procedural rigour which the court is now demanding of NHS bodies will involve significantly more NHS resources being expended on ensuring that there is an accurate record of the panel's discussions. No adverse implications relating to equality and diversity have been identified. The IPFR policy aims to ensure that there is a clear and open mechanism for making decisions that are fair, open and transparent.

Long Term Implications (incl WBFG Act 2015)	WHSSC is committed to considering the long-term impact of its decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.
Report History (Meeting/Date/ Summary of Outcome	**Joint Committee – 9 November 2021 –** it was agreed that the Deputy Director of NHS Wales to make enquiries with Welsh Government**.**
Appendices	**Appendix 1** - All NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR) **Appendix 2** – Judgement Maria Rose Wallpott – v – (1)WHSSC & (2)ABUHB **Appendix 3** - IPFR Quality Assurance Group (QAG) Terms of Reference (ToR)

NHS WALES POLICY
MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR)

Reference Number	Policy Reference (as per individual Health Board)	**Version Number**	FINAL June 2017
Linked Documents	Health Board Policies on Interventions Not Normally Undertaken (INNU)		

Classification of Document:	Clinical Policy
Area for Circulation:	Health Boards and Primary Care providers across Wales Public Health Wales (PHW) Welsh Health Specialised Services Committee (WHSSC) Public Domain via Internet Sites
Author:	Ann-Marie Matthews, Lead for Clinical Commissioning/IPFR, Aneurin Bevan University Health Board
Development Group:	All Wales IPFR Network
Consultation:	Legal Advice from NHS Wales Shared Services Partnership – Legal and Risk Services, May 2017 NHS Wales Medical Directors Clinical Networks Patient Groups / Patient representatives Stakeholder groups
Approved:	Health Board IPFR Panel Chairs
Date of Publication:	June 2017
Lead Health Board Contact:	Contact details as per individual Health Board
Classification	This document supersedes the previous IPFR policy document published in May 2016

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1 INTRODUCTION

1.1 Background

In 2010, the Director General, Health and Social Services, Chief Executive, NHS Wales requested that Health Boards would work together with the Welsh Health Specialised Services Committee (WHSSC) and Public Health Wales (PHW) to develop an All Wales policy and standard documentation for dealing with individual patient funding requests (IPFR) for treatment. This policy has been in place since September 2011.

1.1.1 In October 2013, The Minister for Health and Social Services announced a review of the IPFR process in Wales. An independent review group was established to explore how the current process could be strengthened.

1.1.2 In April 2014, the "Review of the IPFR process" report was published. The report concluded that the IPFR process in Wales is comprehensive and supports rational, evidence-based decision making for medicine and non-medicine technologies which are not routinely available in Wales. The review group also made a number of recommendations to strengthen the IPFR process.

1.1.3 In September 2016, following the 2014 review and implementation of its recommendations, the Cabinet Secretary for Health, Well-being and Sport agreed the time was right for a new, independent review of the IPFR process. The panel would be independent of the Welsh Government and encompass a range of expertise and knowledge.

The "Independent Review of the Individual Patient Funding Requests Process in Wales" report was published in January 2017. The recommendations made can be found at appendix 4.

1.2 Purpose of this Policy

1.2.1 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.

1.2.2 A comprehensive range of NHS healthcare services are routinely provided locally by primary care services and hospitals across Wales. In addition, the Welsh Health Specialised Services Committee (WHSSC), working on behalf of all the Health Boards in Wales, commissions a number of more specialist services at a national level. The use of the term 'Health Board' throughout this policy includes WHSSC unless specified otherwise. However, each year, requests are received for healthcare that falls outside this agreed range of services. We refer to these as Individual Patient Funding Requests (IPFR).

1.2.3 Each Health Board in Wales has a separate Policy setting out a list of healthcare treatments that are not normally available on the NHS in Wales. This is because;

- There is currently insufficient evidence of clinical and/or cost effectiveness; and/or
- The intervention has not been reviewed by the National Institute for Health and Care Excellence (NICE) or the All Wales Medicines Strategy Group (AWMSG); and/or
- The intervention is considered to be of relatively low priority for NHS resources.

1.2.4 The policy, called 'Interventions Not Normally Undertaken' (INNU) should be read together with this policy on making decisions.

1.2.5 The challenge for all Health Boards is to strike the right balance between providing services that meet the needs of the majority of the population in the geographical area for which it is then given responsibility, whilst having in place arrangements that enable it to accommodate people's individual needs. Key to this is having in place a comprehensive range of policies and schedule of services that the Health Board has decided to fund to meet local need within the resource available. To manage this aspect of the Health Board's responsibilities, there will always need to be in place a robust process for considering requests for individual patient funding within the overall priority setting framework. Demand for NHS services is always likely to exceed the resources available and, as a result, making decisions on IPFR are some of the most difficult a Health Board will have to make.

1.2.6 To ensure that we follow an open, transparent, fair, clearly understood and easily accessible process, the NHS in Wales has introduced this Policy on decision making for IPFR's. It describes both the principles underpinning how decisions are made to approve or decline individual patient requests for funding and the process for making them.

1.2.7 In line with the requirements of the Equality Act 2010 and the Welsh Government guidance 'Inclusive Policy Making' issued in May 2010, a detailed equality impact assessment has been completed to assess the relationship between this policy and the duties of the Act.

1.3 Explaining Individual Patient Funding Requests (IPFR)

1.3.1 IPFR should not be confused with requests for packages of care for patients with complex healthcare needs – these are covered by separate Continuing Healthcare arrangements. Further information can be obtained from the Health Board's Nursing Department.

1.3.2 IPFR should also not be confused with treatments that have already been provided or administered. Requests **will not** be considered for retrospective funding.

1.3.3 If the clinical circumstances for the specific individual patient have changed, an IPFR application form describing / explaining / justifying;

i. why the patient is likely to gain a significant clinical benefit from the proposed intervention; and
ii. demonstrating that the value for money of the intervention for that particular patient is likely to be reasonable,

then a case may be submitted to the Health Board for consideration for further prospective funding. For example, if a patient funds a treatment themselves and their clinician believes they can demonstrate that the patient has gained significantly more clinical benefit from the intervention than would normally be expected for that treatment, an IPFR can be submitted for consideration.

1.3.4 IPFR are defined as requests to a Health Board or WHSSC to fund NHS healthcare for individual patients who fall outside the range of services and treatments that a Health Board has arranged to routinely provide, or commission. This can include a request for any type of healthcare including a specific service, treatment, medicine, device or piece of equipment.

Such a request will normally be within one of the three following categories;

- a patient and NHS clinician have agreed together that they would like a treatment that is either new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatments (for example, a request to use a cancer drug that has yet to be approved by the Health Board for use in that particular condition);

- a patient and NHS clinician have agreed together that they would like a treatment that is provided by the Health Board in certain clinical circumstances but is not eligible in accordance with the clinical policy criteria for that treatment (for example, a request for treatment for varicose veins for cosmetic reasons alone);

- a patient has a rare or specialist condition that falls within the service remit of the WHSSC but is not eligible in accordance with the clinical policy criteria for treatment (for example, a request for plastic surgery where the indication is personal preference rather than medical need).

1.3.5 The three categories of treatment will only potentially be funded in specific clinical circumstances. It is important to note that the NHS in Wales does not operate a blanket ban for any element of NHS healthcare. We will consider each IPFR on its individual merits and in accordance with the arrangements set out in this policy. We will determine if the patient should receive funding based on the significant clinical benefit expected from the treatment and whether the cost of the treatment is in balance with the expected clinical benefits.

1.3.6 In this policy, the words "significantly different to the general population of patients" means that the patient's condition does not have

substantially the same characteristics as other members of that population. For a patient to be significantly different, their particular clinical presentation is unlikely to have been considered as being part of the population for which the policy was made.

1.3.7 In practice, it is not always practical to determine the "benefit" of an intervention in numerical terms in the same way, for example as NICE or the AWMSG. In these situations, a description of the benefit should be used to enable IPFR panels to compare the description of the incremental clinical benefit likely to be obtained. In general, the clinician should compare the benefits of the intervention being requested with what he or she considers to be the next best alternative, which may in some cases be best supportive care.

1.3.8 Whether an intervention provides "value for money" is assessed conceptually in terms of the incremental cost per incremental quality-adjusted life year (QALY) of benefit. Whilst "reasonable" value for money is to be interpreted in the same way that "cost-effective" is used in the Health Technology Appraisal (HTA) process operated by NICE and AWMSG.

1.3.9 Recognising that it can never be possible to anticipate all unusual or unexpected circumstances this policy aims to establish a clear guide to making decisions on IPFR to determine whether evidence that the patient is likely to gain a significant clinical benefit, and the value for money of the intervention for that particular patient is likely to be reasonable has been presented.

Please refer to the decision making guidance in section 6 to see how panel members determine the significant clinical benefit expected by the treatment, and whether the cost of the treatment is in balance with the expected benefits.

2 THE LEGAL CONTEXT OF THIS POLICY

2.1 In accordance with their legal obligations, Local Health Boards must:

(a) Act within the terms of the statutory functions delegated to them by the Welsh Ministers under NHS legislation, in particular the NHS (Wales) Act 2006 and the secondary legislation that flows from that statute;
(b) be accountable to the Welsh Government for the decisions they make;
(c) meet the health needs of an individual free of charge, except where the legislation and/or regulations specifically permit charges;
(d) provide these comprehensive services within the resources delegated by the Welsh Government;
(e) operate within the governance structure created by the Welsh Government;
(f) act in accordance with the requirement to implement guidance published by the National Institute for Health and Care Excellence (NICE) and All Wales Medicines Strategy Group (AWMSG) within two months of the final guidance published.

(g) act in accordance with the requirements of the principles of Administrative Law and all legislation that may be enacted from time to time and which is relevant to the activities of the Health Board; and
(h) Comply with policies issued by Welsh Government such as Welsh Health Circulars.

2.2 Health Boards must therefore be able to demonstrate that their decisions are within their powers and comply with their legal obligations. In terms of the exercise of their powers, they must show that they have taken into account all relevant issues in the decision making process, giving them appropriate weight and that those decisions are rational, logical, lawful and proportionate.

Careful consideration needs to be given in relation to all decisions; particular care may need to be given in the following circumstances:

- when evidence is not clear or conclusive;
- when the issue is controversial and may not have the support of NICE or AWMSG;
- when life or death decisions are involved;
- when limiting access to specific services or treatments;
- when setting priorities;
- When other Health Boards may have used their discretion to make a different decision on a specific topic.

2.3 It is lawful for the Health Board to have policies about which treatments will, and which will not, be routinely funded. It is lawful for the Health Board to adopt an IPFR Policy for the exercise of its discretion and to allow for exceptions to it in specific clinical circumstances.

2.4 Decisions made by Health Boards may be subject to legal challenge in the High Court. Consistency in policy and approach, together with clarity about clinical criteria for treatment and a consistent approach to dealing with IPFR requests should reduce the need for patients to have to go through a review or appeal process at any level. This should be the desirable outcome as far as it is possible.

3 UNDERSTANDING LEGAL CHALLENGE

3.1 One of the grounds which a patient might include in any application they make to the court is the allegation that there has been interference in their rights in accordance with the Articles of the Human Rights Convention set out in the Human Rights Act 1998. The Act means that the Human Rights Convention is directly applied to the UK Courts and the Courts have to take account of the Convention and the decisions of the European Court in the interpretation of any legislation.

3.2 A public body is required to give reasons for its decisions. Since it is the decision making process which the courts may scrutinise, it is imperative that the process for Health Board decisions is transparent, that the patient is able to access and understand the process and to be aware of the reasons for any decision which has been made.

3.3 In addition, the Health Board should take into account that, in the light of the Human Rights Act, the concept of "proportionality" may come into play. The concept of proportionality means even if a particular policy or action which interferes with a Convention right is aimed at pursuing a legitimate aim (for example the prevention of crime) this will not justify the interference if the means used to achieve the aim are excessive in the circumstances. This involves striking a balance between the demands of the wider community and the need to protect an individual's fundamental rights. Any interference with a Convention right should be carefully designed to meet the objective in question and must not be arbitrary or unfair. Challenge may occur where the Health Board has balanced various interests and an individual alleges that the balancing was disproportionate to their rights. In this scenario, the Health Board would be called upon to explain why it considered the challenged action was necessary and suitable to reach the desired end and why the decision did not impose an excessive burden on the applicant. If an HB is not sure whether a particular approach would be proportionate, it should seek specialist legal advice before reaching a final decision.

3.4 Individuals have the right to bring an action alleging interference with their rights where decisions made by Health Boards may be shown to have contravened the individual Articles of the Human Rights Convention. Particularly, when life and death decisions are involved, the courts will submit the decision making processes of the Health Board to rigorous scrutiny. The more substantial the potential interference with human rights, the more the court will require by way of justification before it is satisfied that the decision is reasonable.

3.5 Judicial Review is a process within administrative law which enables any individual to challenge the decision made by a public body. Greater levels of dissatisfaction may force some patients (who may be supported by a Registered Charity or Pressure Group) to seek redress for their complaints by way of Judicial Review.

3.6 The process of Judicial Review allows the Court to review decisions on the grounds that they are unlawful, irrational/unreasonable and/or procedurally unfair. The Courts will consider whether there has been an:

- error of law;
- excess exercise of powers/abuse of power;
- irrelevancy;
- irrationality;
- an unlawful limitation of discretion or fettering;
- improper delegation of decision making;
- procedural impropriety contrary to the rules of natural justice; and
- bias;
- Failure to follow its own policy.

Reviews have included decisions which unfairly discriminate between patients; 'blanket' policies not to treat particular conditions and decisions not to provide promised services.

3.7 The Court will want to consider whether the decision is beyond the range of responses open to a reasonable decision maker. They will examine the powers of the decision-maker, the requirements of the legislation and the

manner in which the decision was reached to determine if the decision-maker acted unlawfully.

3.8 In recent years, we have witnessed an increasing tendency for the Courts to use their powers to scrutinise the lawfulness of the decision making process of public bodies, including Health Boards. Previous examples include the Child B Case, challenges by transgender for the performance of cosmetic operations and a series of challenges by patients for funding for treatment with high cost cancer drugs not approved by NICE.

3.9 The Courts have shown an increased willingness to "second guess" decisions on expenditure/use of resources and substitute their own judgement for that of a public body, and even if the court does not go that far, it will scrutinise the way the decision has been reached to determine whether it is lawful. In a situation where the Courts consider that there has been a flaw in the decision making process, the Courts can declare the original decision was invalid and order a Health Board to make the decision again.

4 PRINICIPLES UNDERPINNING THIS POLICY

The principles underpinning this policy and the decision making of the Health Board are divided into five areas - the NHS Core Values, the Prudent Healthcare Principles, Evidence-based Considerations, Ethical Considerations and Economic Considerations.

4.1 NHS Core Values are set out by the Welsh Government as;

- Putting quality and safety above all else: providing high value evidence based care for our patient's at all times;
- Integrating improvement into everyday working and eliminating harm, variation and waste;
- Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales;
- Working in true partnerships with partner organisations and with our staff; and
- Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively.

4.2 Prudent Healthcare Principles

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
- Care for those with the greatest needs first, making the most effective use of all skills and resources;
- Do only what is needed, no more, no less; and do not harm;
- Reduce inappropriate variation using evidence based practices consistently and transparently.

4.3 Evidence-Based Considerations

4.3.1 Evidence-based practice is about making decisions using quality information, where possible, and recognising areas where evidence is weak. It involves a systematic approach to searching for and critically appraising that evidence.

4.3.2 The purpose of taking an evidence-based approach is to ensure that the best possible care is available to provide interventions that are sufficiently clinically effective to justify their cost and to reduce inappropriate variation using evidence-based practices consistently and transparently. NICE issue Technology Appraisals and the All Wales Medicines Strategy Group issue guidance which Health Boards are required to follow.

4.3.3 Additionally, a central repository for evidence based appraisals will be available which will provide support for clinicians making an application. This will be located on the shared database. Users will be able to upload and access the information available which will develop over time as evidence /new reports are produced.

4.3.4 It is also important to acknowledge that in decision making there is not always an automatic "right" answer that can be scientifically reached. A "reasonable" answer or decision therefore has to be reached, though there may be a range of potentially reasonable decisions. This decision is a compromise based on a balance between different value judgements and scientific (evidence-based) input. Those vested with executive authority have to be able to justify, defend and corporately "live with" such decisions.

4.4 Ethical Considerations

4.4.1 Health Boards are faced with the ethical challenge of meeting the needs of individuals within the resources available and meeting their responsibility to ensure justice in the allocation of these resources ('distributive justice'). They are expected to respect each individual as a person in his or her own right.

4.4.2 Resources available for healthcare interventions are finite, so there is a limit to what LHB's can routinely fund. That limitation is reasonable providing it is fair, and not arbitrary. It must be based on the evidence both about the effectiveness of those interventions and their cost. A cost effective intervention is one that confers a great enough benefit to justify its cost. That means policies must be based on research, but research is carried out in populations of patients, rather than individual patients. That leaves open the possibility that what is true for patients in general is not true about a specific individual patient. Fairness therefore also requires that there must be a mechanism for recognising when an individual patient will benefit from a particular intervention more than the general population of patients would. Identifying such patients is the purpose of the IPFR process.

4.4.3 Welsh Government communications set out six ethical principles for NHS organisations and these underpin this policy. They are:

- treating populations and particular people with respect;
- minimising the harm that an illness or health condition could cause;
- fairness;
- working together;
- keeping things in proportion; and
- flexibility

4.5 Economic Considerations

4.5.1 It is a matter for the Health Board to use its discretion to decide how it should best allocate its resources. Such resources are finite and difficult balancing decisions have to be made. The Health Board has to prioritise the services that can be provided whilst delivering high quality, cost effective services that actively avoid ineffective, harmful or wasteful care that is of limited benefit. The opportunity cost associated with each decision has also to be acknowledged i.e. the alternative uses to which resources could be put.

5 MAKING DECISIONS ON IPFR

5.1 In line with the principles set out earlier in this document, Welsh Government communications set out the key factors for 'good decision making'. These are:

- openness and transparency;
- inclusiveness;
- accountability;
- reasonableness;
- effectiveness and efficiency;
- exercising duty of care;
- lawful decision making; and
- the right to challenge and appeal

This policy aims to ensure that the Health Board has a clear and open mechanism for making decisions that are fair, open and transparent. It enables those responsible for decision making to demonstrate that they have followed due process, given full consideration to the above factors, and has been both rigorous and fair in arriving at their decisions. It also provides a clear process for challenge and appeal.

5.2 In accordance with Welsh Government communications, NICE definitions, and the criteria set out in this policy, the Health Board should make decisions on IPFRs based on; the evidence presented to demonstrate the expected significant clinical benefit, and the evidence presented outlining the patient's individual clinical circumstances. Decisions should be undertaken whilst taking into reasonable account the evidence base, and the economic and ethical factors below;

- **evidence-based considerations** - clinical and cost effectiveness; service and policy implications;

- **economic considerations** - opportunity cost; resources available; and
- **ethical considerations** - population and individual impact; values and principles; ethical issues.

Non-clinical factors (such as employment status) will not be considered when making decisions on IPFR.

This Policy does not cover healthcare travel costs. Information on patient eligibility for healthcare travel costs to receive NHS treatment under the care of a consultant can be found on the Welsh Government's 'healthcare costs' website.

5.3 The following guide will be used by all Health Board IPFR Panels when making IPFR decisions.

It is the responsibility of the requesting clinician to demonstrate the clinical case for the individual patient, and of the IPFR panel to consider the wider implications for the NHS, such that the criteria in **either (a) or (b)** below are satisfied:
(a) If guidelines (e.g. from NICE or AWMSG) recommend not to use the intervention/drug; I. The clinician must demonstrate that the patient's clinical circumstances are significantly different to the general population of patients for whom the recommendation is not to use the intervention, such that II. The clinician can demonstrate that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients for whom the recommendation is not to use the intervention, and III. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.
(b) If the intervention has not been appraised (e.g. in the case of medicines, by AWMSG or NICE); I. The clinician can demonstrate that the patient is likely to gain significant clinical benefit, and II. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.

6 DECISION MAKING GUIDE

IPFR Panel Decision-Making Factors	IPFR Panel Evidence for Consideration in Decision-Making
SIGNIFICANT CLINICAL BENEFIT	
Is the clinical presentation of the patient's condition significantly different in characteristics to other members of that population? ***and*** Does this presentation mean that the patient will derive a greater clinical benefit from the treatment than other patients with the same condition at the same stage?	Consider the evidence supplied in the application that describes the specific clinical circumstances of the IPFR: • What is the clinical presentation of this patient? • Is evidence supplied to explain why the clinical presentation of this patient is significantly different to that expected for this disease and this stage of the disease? • Is evidence supplied to explain why the clinical presentation means that the patient will gain a significantly greater clinical benefit from the treatment than another patient with the same disease at the same stage?
EVIDENCE BASED CONSIDERATIONS	
Does the treatment work? What is the evidence base for clinical and cost effectiveness?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What does NICE recommend or advise? • What does the AWMSG recommend or advise? • What does the Scottish Medicines Consortium recommend or advise? • What does Public Health Wales advise? • Are there peer reviewed clinical journal publications available? • What information does the locally produced evidence summary provide? • Is there evidence from clinical practice or local clinical consensus? • Has the rarity of the disease been considered in terms of the ability for there to be a comprehensive evidence base available? • Does the decision indicate a need to consider policy or service change? If so, refer to service change processes.
ECONOMIC CONSIDERATIONS	
Is it a reasonable cost? What is the cost of the **treatment** and is the cost of the treatment likely to be reasonable? i.e. Is the cost of the treatment in balance with the expected clinical benefits?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: • What is the specific cost of the treatment for this patient? • What is the cost of this treatment when compared to the alternative treatment they will receive if the IPFR is declined? • Has the concept of proportionality been considered? (Striking a balance between the rights of the individual and the impact on the wider community), in line with Prudent Healthcare Principles. • Is the treatment reasonable value for money?
ETHICAL CONSIDERATIONS	
How has the decision been reached? Is the decision a compromise based on a balance between the evidence-based input and a value judgement?	Having considered the evidence base and the costs for the treatment requested are there ethical considerations that have not been raised in the discussions? • Is the evidence base sufficient to support a decision? • Is the evidence and analysis of the cost sufficient to support a decision? • Will the decision be made on the basis of limited evidence and a value judgement? If so, have you considered the values and principles and the ethical framework set out in the policy? • Have non-clinical factors been excluded from the decision? • Has a reasonable answer been reached based on the evidence and a value judgement after considering the values and principles that underpin NHS care?

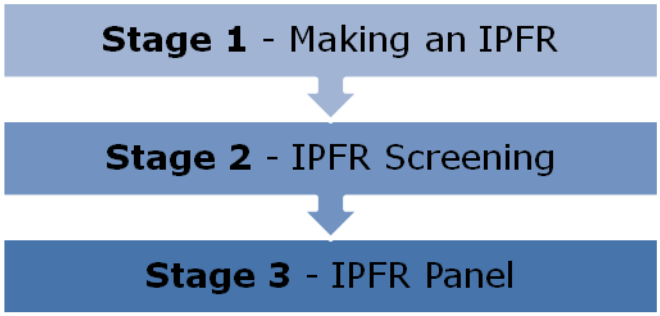
7 HOW TO MAKE A REQUEST FOR FUNDING UNDER THIS POLICY

7.1 Information on how to make an IPFR

A patient leaflet is available explaining how an individual patient funding request (IPFR) can be made. These are available from the hospital consultant, GP surgery or via the Health Board website. Further information can be obtained from the IPFR Co-ordinator.

Copies of this policy and the IPFR application forms can also be obtained via the website, or by contacting the IPFR Co-ordinator.

7.2 Summary of the IPFR Process



7.3 Stage 1 Making an IPFR

The patient and their NHS clinician (GP or local hospital consultant or out-of-area hospital consultant) agree together that a request should be made. The IPFR application form is completed by the clinician on the patient's behalf. This will ensure that adequate clinical information is provide to aid the decision making process.

The requesting clinician must sign the application form to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

Ideally, applications for specialised and tertiary services should be completed by the patient's secondary care clinician, unless extenuating circumstances dictate otherwise. This is to ensure that all pertinent information is included in the form thereby avoiding the delay that will arise from the need to request further information before the application can be processed. All IPFR applications should demonstrate support from the relevant clinical lead, head of department or multi-disciplinary team (MDT). Where relevant, advice may also be sought from the internal clinical team.

It is necessary for clinicians to provide their contact details as there may be times when additional clinical information is required during a panel meeting to aid a decision.

The application form is sent to the IPFR Co-ordinator in hard copy or electronically so that the authorised consent of the clinician is recorded.

Patients are able to access advocacy support at any stage during this process.

The IPFR application form must be completed in full to enable the IPFR Panel to reach a fully informed decision.

Should the IPFR Co-ordinator receive an application form which has not been completed sufficiently enough to determine whether or not the request can be screened out or taken to the IPFR Panel, or the incorrect form is completed, the form should be returned to the requesting clinician **within three working days**.

The requesting clinician is responsible for completing and re-submitting the application form **within ten working days**. Should this time elapse, a chaser letter will be sent providing a **further ten working days** to make a submission.

Where the information has still not been provided in the time set, the case shall be closed and the requesting clinician notified accordingly.

7.4 Stage 2 Screening of the IPFR

The IPFR application will be considered by the IPFR Senior Officer to determine whether the application needs to be screened out because:

(a) the request meets pre-agreed criteria for a service already commissioned/provided and can be automatically funded
(b) the request matches previous exceptions and precedent has been set
(c) an alternative and satisfactory clinical solution is found
(d) the request represents a service development which needs to be passed to the relevant Division or Director for their action.
(e) the request raises a policy issue where more detailed work is required

The IPFR Senior Officer should then communicate the outcome of the screening stage to the requesting clinician using a standard letter, **within five working days** of the decision being made. This letter will also include reasons for the decision and information on any further courses of action required.

7.5 Stage 3 Considerations by the IPFR Panel

Requests that are not screened out will be considered at a meeting of the IPFR Panel. The IPFR Co-ordinator will ensure that the panel has all of the information needed to make a decision and will ensure that it is anonymised before each meeting.

Panels will convene at least once per month in order to ensure that applications are dealt with in a timely manner. The volume and urgency of applications may require panels to meet more frequently as and when required.

The panel will consider each IPFR on its own merits, using the decision making criteria set out in this policy. The IPFR Co-ordinator or Senior Officer will complete a record of the panel's discussion on each IPFR, including the decision and a detailed explanation for the reason for that decision. Where possible, they should set out their assessment of the likely incremental clinical benefit and their

broad estimate of the likely incremental cost so that their judgements on value for money are clear and transparent.

A standard decision letter should be prepared to communicate the decision to the requesting clinician. Correspondence will also be sent to the patient to inform them that a decision has been made and their clinician will contact them within 5 working days to discuss. If this has not happened, patients are encouraged to contact their clinician.

These letters will be sent **within five working days** of the panel's decision and will also include information on how to request a review of the process where a decision has been made to decline the request.

7.6 Who will sit on the IPFR Panel?

The Health Board will appoint core members of the IPFR Panel which will comprise;

- Executive Public Health Director (or deputy – Public Health Consultant)
- Executive Medical Director (or deputy - Associate/Assistant Medical Director)
- Executive Director of Nursing (or deputy – Assistant Director of Nursing)
- Director of Therapies & Clinical Science (or deputy - Assistant Director of Therapies)
- Director of Pharmacy and / or Chief Pharmacist or deputy; and
- Two lay representatives.

The Chair of the Panel will be selected from the group of core members and must have a clinical background (with the exception of WHSSC – see Terms of Reference at Appendix 2).

Each organisation may also wish to appoint up to a further two Panel members at the discretion of the Chair of the Panel, for example a member of the Ethics Committee, Primary Care Director or Director of Planning.

Please refer to the Terms of Reference at Appendix 1 and 2 for details of the Health Board and WHSSC IPFR Panel.

7.7 What about clinically urgent cases?

The IPFR Policy and process allows for clinically urgent cases, as deemed by the requesting clinician, to be considered outside of the normal screening and panel processes. In these circumstances, the Chair or Vice Chair of the IPFR panel is authorised to make a decision outside of a full meeting of the panel, within their delegated financial limits. Any such decisions will be made in line with the principles of this policy, taking into account the clinical urgency of the request outlined in the application form by the clinician. Those marked urgent will be considered within 24-48 hours as per the application form.

7.8 Can patients and clinicians attend the IPFR Panel?

Patients are not permitted to attend IPFR Panels. The reasons is that it would make the process less fair, because it would draw to the attention of panel

members characteristics of the individual patient that should not influence their decision-making, such as age and gender. The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided, including the IPFR application form and other documentary evidence which is provided in support. Patients and clinicians are able to supply any written statements they feel should be considered by the Panel**. Any information provided which relates to non-clinical factors will not be considered.** Community Health Councils are able to support patients in making such statements if required.

The IPFR Panel may, at its discretion, request the attendance of any clinician to provide clarification on specific issues and/or request independent expert clinical advice for consideration by the panel at a future date. The Chair of the IPFR Panel, may also contact the referring clinician to get more clarification in respect of an individual referral.

The provision of appropriate evidence to the IPFR Panel will be entirely at the Chair of the IPFR Panels discretion.

7.9 Holding IPFR Information

The IPFR Co-ordinator will maintain a confidential electronic record of all requests. A separate, confidential hard copy file will also be maintained. This information will be held securely in compliance with Data Protection requirements and with Caldicott Guidance.

The IPFR Administration Team retains a record of the IPFR application and subsequent decision and any outcome data that is provided by the clinician. Data will be retained to help inform future planning requirements by identifying patient cohorts both at a local and national level. Data will also be used for the production of an annual report on IPFR's every year as required by the Welsh Government. This will not include any identifiable data and will use aggregated data.

In addition, a central repository for clinical evidence will be available and will develop over time as and when new evidence reports are produced / become available.

8 HOW TO REQUEST A REVIEW OF THE PROCESS

If an IPFR is declined by the panel, a patient and/or their NHS clinician has the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy, a review hearing can be requested in line with the following:

8.1 The 'review period'

There will be a period of **25 working days** from the date of the decision letter during which they may request a review by the review panel ('the review period"). The letter from the Health Board that accompanies the original decision will state the deadline for any review request. In calculating the deadline, Saturdays, Sundays and public holidays in Wales will not be counted.

8.2 Who can request a review?

A review can be requested either (a) by the original requesting clinician on the patient's behalf or (b) by the patient with the original requesting clinician's support. **The review request form must be completed by the clinician**. Both the patient and their clinician must keep each other informed of progress. This ensures the patient is kept informed at all times, that the clinician/patient relationship is maintained, and review requests are clinically supported. Patients are able to access advocacy support at any stage during this process.

8.3 What is the scope of a review?

It does not constitute a review of the merits of the original decision. It has the restricted role of hearing review requests that fall into one or more of three strictly limited grounds. A review request on any other ground will not be considered.

The 3 grounds are:

Ground One: *The Health Board has failed to act fairly and in accordance with the All Wales Policy on Making Decisions on Individual Patient Funding Requests (IPFR).*

The Health Board is committed to following a fair and equitable procedure throughout the process. A patient who believes they have not been treated fairly by the Health Board may request a review on this ground. This ground relates to the procedure followed and not directly to the decision and it should be noted that the decision with which the patient does not agree is not necessarily unfair.

Ground Two: *The Health Board has prepared a decision which is irrational in the light of the evidence submitted*

The review panel will not normally entertain a review request against the merits of the decision reached by the Health Board. However, a patient may request a review where the decision is considered to be irrational or so unreasonable that no reasonable Health Board could have reached that conclusion. A claim that a decision is irrational contends that those making the decision considered irrelevant factors, excluded relevant ones or gave unreasonable weight to particular factors.

Ground Three: *The Health Board has not exercised its powers correctly.*

The Health Board is a public body that carries out its duties in accordance with the Statutory Instruments under which it was established. A patient may request a review on the grounds that the Health Board has acted outside its remit or has acted unlawfully in any other way.

Reviews which may require a significantly disproportionate resource relative to the health needs of the local population may be rejected at the Chief Executive's discretion.

8.4 How is a review request lodged?

A review request form should be completed and logged with the IPFR Co-ordinator of the Health Board within the review period. The review request form must include the following information;

- The aspect(s) of the decision under challenge and
- The detailed ground(s) of the review request

The review request form should be sent to the IPFR Co-ordinator so that the signatures of both the patient and their clinician are recorded. A scanned version sent electronically will also be acceptable as long as signatures are present.

If the patient signature cannot be obtained in a timely manner or at all, the requesting clinician can sign to indicate that the patient is aware and agrees with the submission of the request. In doing so, the clinician is providing confirmation that the patient is fully informed of the treatment request and all its associated implications.

8.5 Initial scrutiny by the IPFR Senior Officer

The review documents lodged will be scrutinised by the IPFR Senior Officer who will look to see that they contain the necessary information. If the review request does not contain the necessary information or if the review does not appear to the IPFR Senior officer to fall under any one or more grounds of review, they will contact the referrer (patient or their clinician) to request further information or clarification.

A review will only be referred to the review panel if, after giving the patient and their clinician an opportunity to elaborate or clarify the grounds of the review the Chair of the review panel is satisfied that it falls under one or more of the grounds upon which the review panel can hear the review.

The Chair of the review panel may refuse to consider a review that does not include all of the above information.

8.6 What is the timescale for a review to be heard?

The review panel will endeavour to hear a review **within 25 working days** of the request being lodged with the Health Board. The date for hearing any review will be confirmed to the patient and their clinician in a letter.

This review process allows for clinically urgent cases, as deemed by the referring/supporting clinician, to be considered outside of the panel process by the Health Board's Chair together with a clinical member of the review panel. Any such decisions will be made in line with the principles of this policy.

8.7 Who will sit on the Review Panel?

The Health Board will appoint members of the review panel. The panel will comprise (see Terms of Reference at Appendix 6 for full details);

- Health Board Independent Board Member – Lay (Chair of the Review Panel)
- Health Board Independent Board Member (with a clinical background)
- Health Board Executive Director, or deputy (with a clinical background)
- Chief Officer of the Community Health Council, or deputy
- Chair of the Local Medical Committee, or deputy
- WHSSC Representative at Director level (where applicable)

The Health Board will intend to inform the patient and their clinician of the membership of the review panel as soon as possible after a review request has been lodged. None of the members of the review panel will have had any prior involvement in the original submission.

In appointing the members of the review panel, the Health Board will endeavour to ensure that no member has any interest that may give rise to a real danger of bias. Once appointed, the review panel will act impartially and independently.

8.8 Can new data be submitted to the review panel?

No, because should new or additional data become available then the IPFR application should be considered again by the original panel in order to maintain a patient's right to review at a later stage.

8.9 Can patients attend review panel hearings?

At the discretion of the panel, patients and/or their unpaid representative may attend review panel hearings as observers but will not be able to participate. This is because the purpose of a review hearing is to consider the process that has been followed and not to hear new or different evidence.

If new or different evidence becomes available, the case will automatically be scheduled for reconsideration by the IPFR Panel. Patients and/or their unpaid representatives are able to make their written representations to this IPFR Panel in order for their views to be taken into account.

It is important for all parties to recognise that review panel hearings may have to discuss complex, difficult and sensitive information in detail and this may be distressing for some or all of those present. Patients and/or their unpaid representatives should be aware that they will be asked to retire at the end of the review panel discussion in order for the panel to make their decision.

8.10 The decision of the review panel hearing

The IPFR Senior Officer will complete a record of the review panel's discussion including the decision and a detailed explanation for the reason for the decision. They will also prepare a standard decision letter to communicate the decisions of the panel to the patient and referring/supporting clinician.
The review panel can either;

- uphold the grounds of the review and ask the original IPFR Panel to reconsider the request; or
- not uphold the grounds of the review and allow the decision of the original IPFR Panel to stand.

There is no right to a further review unless new and relevant circumstances emerge. Should a patient be dissatisfied with the way in which the review panel carried out its functions, they are able to make a complaint to the Public Services Ombudsman for Wales.

8.11 After the review hearing

The Chair of the review panel will notify patients and their clinicians of the review panel's decision in writing. This letter should be sent **within five working days** of the panel and will also include information on how to make a complaint to the Public Services Ombudsman for Wales www.ombudsman-wales.org.uk.

8.12 How will WHSSC undertake a review?

As the WHSSC is a collaborative committee arrangement to support all Health Boards in Wales, it will not be able to constitute a review panel. WHSSC will therefore refer any requests it receives for a review of its decisions to the Health Board in which the patient resides. A WHSSC representative who was not involved in the original panel will become a member of the review panel on these occasions.

The Health Boards IPFR Senior Officer will be present at these review hearings to advise on proceedings as per their governance role. In the interests of transparency, and not to confuse the applicant, the WHSSC Senior IPFR Officer will be responsible for circulating the review documentation to review panel members, clerking the hearing and preparing the standard decision letter to communicate the decision of the review panel to the patient and clinician.

8.13 Nothing in this section shall limit or preclude an individual patient's right to bring Judicial Review proceedings if they are unhappy with a decision of the IPFR Panel.

9 REVIEW OF THIS POLICY

9.1 This Policy will be reviewed on an annual basis or as required to reflect changes in legislation or guidance.

9.2 Any of the following circumstances will trigger an immediate review of the linked INNU Policy:

- an exemption to a treatment policy criteria has been agreed;
- new scientific evidence of effectiveness is published for all patients or sub-groups;
- old scientific evidence has been re-analysed and published suggesting previous opinion on effectiveness is incorrect;
- evidence of increased cost effectiveness is produced;
- NHS treatment would be provided in all (or almost all) other parts of the UK;
- A National Service Framework recommends care.

10 MAKING A COMPLAINT

10.1 Making an IPFR does not conflict with a patient's ability to make a complaint to the Public Services Ombudsman for Wales. Further information is available on the Ombudsman's website www.ombudsman-wales.org.uk.

11 APPENDIX ONE

TERMS OF REFERENCE – IPFR PANEL (Health Board)

PURPOSE

To act as a Committee of the Health Board and hold delegated Health Board 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 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.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The IPFR Panel cannot make policy decisions for the Health Board. Any policy proposals arising from their considerations and decision will ultimately be reported to the Health Board Quality & Safety Committee for ratification. Financial authorisation is as follows: - The Panel's authorisation limit will be set at the delegated financial limit as per the individual Health Board structure. - Any decisions resulting in a financial cost in excess of this must be reported to the Health Board Chief Executive for budget authorisation.	• Executive Public Health Director or deputy • Executive Medical Director or deputy • Executive Director of Therapies and Health Science or deputy • Director of Pharmacy and/or Chief Pharmacist or deputy • Executive Director of Nursing or deputy • Two Lay Representatives A further two panel members may be appointed at the discretion of the panel Chair, for example a member of the Ethics Committee, Primary Care Director or Director of Planning. In Attendance: • IPFR Senior Officer • IPFR Co-ordinator • Finance Advisor (if required) • Senior Pharmacist (if required)

PROCEDURAL ARRANGEMENTS

Quorum: Chair or Vice Chair plus 2 panel members with a clinical background.

Meetings: At least once a month with additional meetings held as required and agreed with the Panel Chair.

Urgent Cases: It is recognised that provision must be made for occasions where decisions may need to be made urgently. In these circumstances, the Chair of the IPFR Panel is authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits.

Recording: The IPFR Co-ordinator will clerk the meetings to ensure proper record of the panel discussions and decisions are made. An electronic database of decisions will also be maintained.

12 APPENDIX TWO

TERMS OF REFERENCE – IPFR PANEL (WHSSC)

PURPOSE

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.

SCHEME OF DELEGATION REPORTING	**MEMBERSHIP AND ATTENDANCE**
The IPFR Panel has delegated authority from the Joint Committee to consider requests and make decisions, limited to the purpose set out above. The IPFR Panel cannot make policy decisions for the Health Board. Any policy proposals arising from their considerations and decisions will be reported to the Management Group and/or Joint Committee for ratification. Financial authorisation is as follows: – The panel's authorisation limit is set at £300,000 for one-off packages and £1million for lifetime packages – Any decisions resulting in a financial cost in excess of these limits must be reported to the Director of Specialised and Tertiary Services and the relevant Health Board for authorisation	• Independent Chair (who will be from existing members of the NHS organisations Boards) • Two Lay representatives • Nomination at Director level from each of the LHBs A named representative from each of the seven Health Boards who should be a Director or Deputy/Assistant Director, or named deputies of appropriate seniority and experience who can operate in the capacity of the primary representative. The intention will be to secure an appropriate balance of processional disciplines to secure an informed multi-disciplinary decision. 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. These members should come from outside the 7 Health Boards and one of which would be nominated as the Vice Chair. The Chair of the panel will review the membership as necessary. In attendance from WHSSC • Medical Director or Deputy • Director of Nursing or Deputy • IPFR Co-ordinator • Finance Advisor (if required) • Other WHSSC staff as and when required.

PROCEDURAL ARRANGEMENTS

Quorum: The Chair or Vice-Chair and representation from five of the seven Health Boards, three of which must be clinical representatives.

Meetings: At least once a month with additional meetings held as required and agreed with the Panel Chair. Video conferencing facilities will be available for all meetings.

WHSSC will be responsible for organising the WHSSC Panel and will provide members with all relevant documentation.

Urgent Cases: It is recognised that provision must be made for occasions where decisions may need to be made urgently.

Where possible, a "virtual panel" will be held to consider urgent cases. If this is not possible due to the urgency of the request, then the Director of Specialised and Tertiary Services together with the WHSSC Medical Director or Director of Nursing and the Chair of the WHSSC Panel (or Vice Chair) are authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits, on behalf of the Panel.

WHSSC will provide an update of any urgent decisions to the subsequent meeting of the Panel.

Recording: The WHSSC IPFR Co-ordinator will clerk the meetings to ensure proper records of the panel discussions and decisions are made. An electronic database of decisions will also be maintained.

13 APPENDIX THREE

TERMS OF REFERENCE – REVIEW PANEL

PURPOSE

To act as a Committee of the Health Board and hold delegated Health Board authority to review (in line with the review process outlined in this policy) the decision making processes of the Individual Patient Funding Request (IPFR) Panel.

The Review Panel may uphold the decision of the IPFR Panel or, if it identifies an issue with the decision making process, it will refer the issue back to the IPFR Panel for reconsideration.

The Review Panel will normally reach its decision on the basis of all of the written evidence which is provided to it and will not receive any new information.

SCHEME OF DELEGATION REPORTING	MEMBERSHIP AND ATTENDANCE
The Review Panel has delegated authority from the Board to undertake reviews, limited to the purpose set out above. In exceptional circumstances, the Review Panel may also wish to make a recommendation for action to the Board. The action can only be progressed following its ratification by the Board (or by its Chief Executive in urgent matters).	• Independent Board Member – Lay (Chair of the Review Panel) • Independent Board Member (usually with a clinical background) • Executive Director or deputy (with a clinical background) • Chief Officer, Community Health Council or deputy • Chairman, Local Medical Committee or deputy • WHSSC Representative at Director level (as required) In Attendance: • IPFR Senior Officer (governance advisor) • WHSSC IPFR Senior Officer (as required)

PROCEDURAL ARRANGEMENTS

Quorum: As a minimum, the Review Panel must comprise 3 members (one of whom must have a clinical background, one must be an Independent Board Member and one must be a Health Board Officer).

Meetings: As required.

Urgent Cases: It is recognised that provision must be made for occasions where reviews need to be heard urgently and before a full panel can be constituted. In these circumstances, the Health Board's Chair can undertake the review together with a clinical member of the Review Panel. This ensures both proper accountability of decision making and clinical input.

Recording: The IPFR Senior Officer will clerk the meetings to ensure a proper record of the review discussion and outcome is made. An electronic database of decisions will also be maintained.

See detail under section 8.12 on how WHSSC will undertake a review.

14 APPENDIX FOUR

INDEPENDENT REVIEW OF THE IPFR PROCESS IN WALES, January 2017 – LIST OF RECOMMENDATIONS

Recommendation 1
The 2007 ethical framework for commissioning healthcare in Wales should be updated in light of best practice, so that it is useful in making (and explaining) commissioning decisions.

Recommendation 2
Good commissioning practice should be shared between LHBs and WHSSC. A database of commissioning policies should be established, covering all interventions and used by WHSSC and LHBs to record their commissioning policies.

Recommendation 3
LHBs together with WHSSC should set up commissioning liaison meetings to coordinate their "out of area" and "out of county" services.

Recommendation 4
Ways to access interventions – commissioning and other pathways including IPFR – need to be explained more clearly to clinicians and patients. A guidebook should be developed that explains the entire process clearly and simply.

Recommendation 5
A clear and consistent national process for dealing with requests to access services outside LHBs local arrangements (including those of WHSSC) should be developed and communicated. The forms to request services that are routinely commissioned should be short and simple and consistent nationally.

Recommendation 6
The IPFR process should not be used to request services that are routinely commissioned. Different types of requests for interventions should be clearly and consistently differentiated. Information should be provided that helps clinicians to understand the distinction and the different criteria that apply.

Recommendation 7
It should be clearer to patients why they are not routinely allowed to choose their place of treatment and in which circumstances interventions are commissioned outside patients own LHB.

Recommendation 8
The services commissioned by WHSSC should be set out more clearly and accessibly. WHSSC should also explain what services it decides not to commission and why. It needs to be clear whether WHSSC is making an explicit decision that the service should not be provided or whether the LHBs have chosen not to delegate commissioning responsibility to WHSSC.

Recommendation 9
WHSSC and LHB's should review all their policies that refer to IPFRs and ensure that the policies taken together are up to date, consistent and coherent.

Recommendation 10
LHBs should set up a consistent national policy on the use of inexpensive interventions and introduce a consistent framework within which such decisions should be made, for

example, either by making them available on request by clinicians or after suitable LHB approval (e.g. by a Multi-Disciplinary Team (MDT) or head of department).

Recommendation 11
The existing decision-making criteria based on "exceptionality" should be replaced substantially and in line with the proposed decision making criteria and the explanatory notes set out in this report.

Recommendation 12
So that the best evidence is available for future decisions, where possible, clinical outcomes from the IPFR decisions should continue to be tracked and recorded so that the effectiveness of decisions can be assessed over time.

Recommendation 13
The public should be reassured that affordability is not part of the decision criteria for individual patients.

Recommendation 14
Availability of interventions should not generally be part of the decision criteria for individual patients.

Recommendation 15
IPFR panel should record in their decisions a descriptor of their broad estimate of the likely incremental clinical benefit and the broad estimate of the likely incremental cost so their judgements on value for money are clear and transparent.

Recommendation 16
We recommend that non-clinical factors continue not to be taken into account in making intervention decisions.

Recommendation 17
IPFR panels should document the reasons for their decision clearly and in sufficient detail to enable the applying clinician to understand the reasoning and to check that the panel took into account all the relevant factors.

Recommendation 18
IPFR panel should continue to consider actively whether the panel has adequate advice and expertise on which to base its decision for each patient. When considering IPFR applications for specialist conditions, IPFR panels should ensure that they have the best available evidence on which to base their decision. Where necessary, panels should seek the advice of specialists, specialist groups or networks.

Recommendation 19
A national IPFR quality function should be established to support the IPFR panels to ensure quality and consistency. This quality function will provide quality assurance around the decision-making of panels and will promote consistency across Wales. It will include facilitation, advice, training and auditing of the IPFR process, and will have an obligation to report on the quality of the processes and to highlight any concerns through the existing quality and clinical governance processes in NHS Wales.

Recommendation 20
The current configuration of panels should continue.

Recommendation 21
It is vital that all pharmaceutical companies submit their medicines to AWMSG (if they are not already on the NICE work programme) as soon as possible after licensing to

obtain a timely, fair and transparent appraisal of the medicines benefit to patients for the particular indication and to reduce the need for IPFR requests for individual patients.

Recommendation 22
Where AWMSG has issued a 'Statement of Advice' notice not endorsing the use of a medicine in NHS Wales, IPFR panels should approve requests for use of that medicine only if they are confident that there is clear evidence of likely clinical benefit to the particular patient which is sufficient to justify the cost of the medicine and associated treatment.

Recommendation 23
The IPFR quality function should create new or improved training materials (including a manual) for clinicians and separately for patients explaining in detail the IPFR process, how it is used, and what to expect.

Recommendation 24
Clinicians should enable patients to make informed decisions. Clinicians should enable their patients to understand all their treatment options and alternatives, the risks and benefits of those options and the likelihood of those risks and benefits, before seeking an IPFR on their behalf.

Recommendation 25
Clinicians should not make an IPFR application for interventions that have little or no realistic chance of clinical benefit solely in response to a patient request.

Recommendation 26
Clinicians should be supported (by training and advice) to understand the assessment process that the panel will follow for a specific request, so that the clinician can better assess the likelihood of an application's success before it is submitted.

Recommendation 27
The IPFR quality function, working with the IPFR coordinator network, should review the design of the forms in light of this report and make further improvements to streamline and simplify the process and to make it easier and quicker for clinicians to apply.

Neutral Citation Number: [2021] EWHC 3291 (Admin)

Case No: CO/3775/2021

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT FOR WALES

Cardiff Civil Justice Centre
2 Park Street, Cardiff, CF10 1ET

Date: 03/12/21

Before :

THE HONOURABLE MRS JUSTICE STEYN DBE

- -

Between :

The Queen on the application of MARIA ROSE WALLPOTT	**Claimant**
- and -	
WELSH HEALTH SPECIALISED SERVICES COMMITTEE	**First Defendant**
-and-	
ANEURIN BEVAN UNIVERSITY HEALTH BOARD	**Second Defendant**
-and-	
NHS WALES	**Interested Party**

- -
- -

Vikram Sachdeva QC and Adam Boukraa (instructed by **Irwin Mitchell LLP**) for the **Claimant**
David Lock QC and Joel Semakula (instructed by **NHS Wales Shared Services Partnership**) for the **Defendants**
The **Interested Party** did not appear and was not represented

Hearing dates: 1 and 2 December 2021

- -

Approved Judgment

Mrs Justice Steyn :

A. Introduction

1. The claimant, Maria Wallpott, is suffering from a rare form of cancer. The doctors who are treating her have recommended that she undergo cytoreductive surgery with hyperthermic intraperitoneal chemotherapy ("CRS with HIPEC"), and the claimant fervently wishes to do so. As this treatment is not routinely available in Wales to those suffering with the type of cancer that the claimant has, her treating doctors made an individual patient funding request ("IPFR"). That request was refused by the first defendant, the Welsh Health Specialised Services Committee ("WHSSC"), acting on behalf of the second defendant, on 1 July 2021, and the decision to decline funding has been maintained on review.

2. The WHSSC is a joint committee of the seven local health boards in Wales, which is hosted by Cwm Taf Morgannwg University Health Board. The second defendant, Aneurin Bevan University Health Board, is the local health board responsible for providing the claimant with NHS medical care. The decisions were made by the WHSSC on behalf of the second defendant.

3. In this claim for judicial review, the claimant seeks to challenge the defendants' decision to refuse her funding request. She raises the following five grounds of challenge:

    i) In concluding that the "information provided did not demonstrate that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients with the same condition and the same stage of disease", the defendants failed to ask the right questions and/or reached an irrational conclusion.

    ii) The defendants unlawfully failed to give reasons for rejecting the evidence before them regarding the clinical benefit of the treatment for the claimant.

    iii) The defendants erred in their construction of the relevant guidance given by the National Institute for Health and Care Excellence ("NICE").

    iv) The defendants erred in taking into account the availability of alternative treatment in the form of the use of an EGFR inhibitor, in circumstances where such treatment was not in accordance with current practice in southeast Wales for patients with the claimant's condition.

    v) The defendants failed to ask the right questions in assessing the cost effectiveness of the treatment for which the claimant sought funding.

4. This claim was filed on 2 November 2021, together with an application for urgent consideration seeking a substantive hearing by 3 December 2021. In accordance with the order of HHJ Lambert made on 5 November, the claim was listed for an expedited 'rolled up' hearing (that is, a hearing to determine both permission and the substantive claim).

5. Mr Vikram Sachdeva QC and Mr Adam Boukraa appeared on behalf of the claimant. Mr David Lock QC and Mr Joel Semakula represented the defendants. I am grateful to them for the work they have all evidently put into ensuring that this claim was ready to be heard urgently. As the claimant's medical situation is urgent, I have given judgment the day after the hearing ended. In view of the need for expedition, I have not sought to précis the parties' submissions in the way that I would have done if time had been less pressing. I have, nevertheless, given full consideration to those submissions, both written and oral.

B. The claimant's medical condition

6. The claimant is a 50 year old woman. On 28 April 2021 she was diagnosed with stage 4 metastatic appendiceal adenocarcinoma (more simply referred to as appendix cancer). The disease has spread to the claimant's omentum and peritoneum and has formed a large Krukenberg tumour. Appendix cancer is a type of colorectal cancer. As it has spread to the peritoneum, it is also a type of peritoneal carcinomatosis.

7. Peritoneal carcinomatosis is an advanced form of cancer found in the peritoneal cavity; the fluid-filled gap between the walls of the abdomen and the organs in the abdomen. This type of cancer occurs when cancers spread from their origin in, for example, the appendix, bowel, rectum or ovaries. It is associated with short survival and poor quality of life, and may lead to bowel obstruction, accumulation of fluid in the peritoneal cavity and pain.

8. The form of cancer from which the claimant suffers is described by Mr Gethin Williams, a consultant colorectal surgeon at Royal Gwent Hospital, in a letter to the claimant's GP dated 9 September 2021, as "exceedingly rare". The claimant has been advised that it affects about one to two out of every one million people.

9. The claimant's case has been considered by multi-disciplinary teams (MDTs) in Gwent, Cardiff and Basingstoke. Her treating clinicians agree that despite being stage 4, her cancer is resectable and they have advised that she be offered CRS with HIPEC.

C. Cytoreductive Surgery with Hyperthermic Intraperitoneal Chemotherapy

10. CRS with HIPEC is described in the WHSSC's policies as follows:

> "**Cytoreductive Surgery** involves removal of the maximum amount of the visible tumour through a number of surgical resections. The exact scope and extent of the surgery is dependent on the spread of the visible tumour assessed on an individual patient basis.
>
> **Hyperthermic Intraperitoneal Chemotherapy (HIPEC)** involves flushing the abdominal cavity with a heated chemotherapy agent following surgical excision."

11. The aim is to remove the macroscopic tumours using CRS and then, during the course of the operation, to treat any remaining microscopic traces of the cancer by distributing a heated chemotherapeutic drug uniformly to all surfaces within the abdominal cavity, to increase drug penetration.

12. There are two nationally designated centres in the UK where CRS with HIPEC can be provided, one of which is Basingstoke Hospital to which the claimant was referred by her treating clinicians in Gwent and Cardiff, and where it is proposed the surgery would be undertaken if funding can be obtained.

D. The policies and guidance

The context: resource allocation in the NHS

13. The context in which the policies in issue in this case have been adopted is explained by Professor Iolo Doull, the Medical Director of the WHSSC, in these terms:

> "It is a feature of all national healthcare systems across the world, whether in the public or private sector, including the NHS, that demand for healthcare is rising and exceeds the ability of healthcare providers to meet all the healthcare demands of their local populations. This is a problem in both insurance and state-run healthcare systems across the globe. The only exception to this is for wealthy individuals who have unlimited resources to buy their own healthcare, but even then there can be limitations where the resource constraint is not money as, for example, with donated organs. However, for those of us without substantial personal wealth in the rest of the world, there is a gap between demand and the ability of a healthcare system to provide medical services to meet that demand."

14. The combination of what he describes as "a massive rise in the demand for healthcare in the UK, as in all developed countries", the development of new, but expensive, effective treatments and drugs, including "new, highly expensive cancer drugs being developed and tested all the time, some of which have considerable benefits for patients suffering from life-threatening conditions", and the need to invest in health prevention means

> "that the NHS has to make some very difficult decision about how to use its limited resources to best effect. We must always consider the opportunity costs of health investment, because money allocated to one type of health provision or prevention means, necessarily, that healthcare gain elsewhere will be foregone."

15. There is, Professor Doull states, "enormous competition within the NHS for the allocation of budgets between different medical specialties". "Oncologists want more investment in oncology, those working in paediatrics want more investment in paediatrics and there is a strong demand to increase investment in public health so as to improve people's overall health by more effective preventative measures." And clinical teams working in other areas similarly, and rightly, seek more NHS investment to expand the range of treatments that they can offer to their patients.

16. Professor Doull explains:

> "For individual patients, the balance is between the potential benefits of a treatment and the potential risks. However, it is different for NHS decision makers. We have to make decisions about which treatments to fund so that we use our allocated budget to provide the most benefit to the greatest number of patients in our population. The issue for NHS decision makers is not just whether a treatment is clinically effective. In order to deliver on our obligations to the population as a whole, we need to be satisfied that the proposed treatment is cost effective. The principles of cost effectiveness have been developed by academics and are now a part of the working methods of NICE."

17. The approach to cost effectiveness taken by NICE is explained as follows:

> "If possible, NICE considers value for money by calculating the incremental cost-effectiveness ratio (ICER). This is based on an assessment of the intervention's costs and how much benefit it produces compared with the next best alternative. It is expressed as the 'cost (in £) per quality-adjusted life year (QALY) gained'. This takes into account the 'opportunity cost' of recommending one intervention instead of another, highlighting that there would have been other potential uses of the resource. It includes the needs of other people using services now or in the future who are not known and not represented. The primary consideration underpinning our guidance and standards is the overall population need. This means that sometimes we do not recommend an intervention because it does not provide enough benefit to justify its cost. It also means that we cannot apply the 'rule of rescue', which refers to the desire to help an identifiable person whose life is in danger no matter how much it costs. Sometimes NICE uses other methods if they are more suitable for the evidence available, for example when looking at interventions in public health and social care."

18. Professor Doull states that there is "no absolute measure as to what is and what is not cost effective although the NHS in Wales follows NICE in using a rough measure of up to £30,000 per ICER as being the point where a treatment is said to be no longer cost effective."

19. This context is not disputed. On behalf of the claimant, Mr Sachdeva QC acknowledged that the funding decisions that NHS Wales and the defendants have to make are complex and difficult: there is not enough money to fund every treatment that would clinically benefit patients.

The WHSSC and NHS Wales policies

20. In relation to the funding of CRS with HIPEC, WHSSC has adopted two policies. *Policy Position: Cytoreductive Surgery with Hyperthermic Intraperitoneal Chemotherapy for Peritoneal Carcinomatosis* ("PP90") is directly applicable in the claimant's case. *Specialised Services Policy: CP02 Hyperthermic Intraperitoneal Chemotherapy (HIPEC) and Cytoreductive Surgery for treatment of Pseudomyxoma*

Peritonei ("CP02") is directly applicable only in the case of patients with Pseudomyxoma Peritonei ("PMP"), which is not the type of cancer the claimant has, but CP02 is nevertheless of some relevance. In addition, a third policy, adopted by NHS Wales, is directly relevant: *NHS Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR)* ("the IPFR policy").

21. CP02 was issued in September 2015. The policy position adopted in CP02 is:

> "Funding for treatment with Cytoreductive surgery and HIPEC for adult patients with confirmed Pseudomyxoma Peritonei is supported by the Welsh Health Specialised Services Committee."

22. CP02 states that clinical evidence indicates that CRS with HIPEC is

> "effective in the treatment of patients with a low grade peritoneal mucinous tumour giving rise to Pseudomyxoma Peritonei, in which tumour cells appear low grade, are relatively scant and do not invade organs or lymph nodes and where the tumour will usually emanate from the appendix, but occasionally from the bowel or the gynaecological tract.
>
> For this group of patients evidence indicates an 86% survival at 5 years, compared to 50% for patients with a more malignant pathology."

23. CPO2 states that it should be read in conjunction with the IPFR policy and PP90. In the "access criteria" section it states:

> "**3.3 Exceptions**
>
> Funding for peritoneal carcinomatosis is not supported.
>
> If the referring clinician believes that there are exceptional grounds for treatment, an Individual Patient Funding Request (IPFR) can be made to the WHSSC under the [IPFR policy]."

24. It is common ground that the statement that funding for peritoneal carcinomatosis is not supported should be read as "not *routinely* supported". That is consistent with the reference to the IPFR policy under which an application for funding can be made for treatment that is not routinely commissioned and could not lawfully be rejected automatically. It is also consistent with paragraph 3.4 of CP02 which requires referrers and clinicians considering treatment to "inform the patient that this treatment is not routinely funded and consider alternative treatments" (emphasis added).

25. PP90 was also issued in September 2015. It was due to be reviewed in March 2021, but the review date has been extended to July 2022. Professor Doull has explained that "as with so many areas of NHS policy, the demands of the COVID-19 pandemic have led to a delay in WHSSC being able to conduct a review". PP90 is not challenged in these proceedings, and no point is taken with regard to the delayed review. PP90 expressly states that it "should be read in conjunction with" the IPFR policy and CP02.

26. The policy position adopted in PP90 is:

> "There is insufficient data on clinical and cost effectiveness to consider routine funding of HIPEC and CRS for the management of peritoneal carcinomatosis."

27. The basis for reaching this policy position is explained in PP90 in these terms:

> "The WHSSC Prioritisation Group carried out an evidence evaluation in 2013 and made a recommendation not to fund HIPEC and CRS for colorectal cancer. In response to feedback obtained via the consultation process a further evaluation was conducted in 2014. This updated evaluation was reconsidered by the Prioritisation Panel in Oct 2014.
>
> Key findings were:
>
> - The quality of evidence supporting the use of HIPEC outside the setting of Pseudomyxoma Peritonei with low grade disease is weak
> - Many of the case series suggesting benefit in patients with metastatic colorectal cancer include Pseudomyxoma Peritonei patients within their mixed cohorts which may positively skew results.
> - The morbidity arising from the usually very extensive surgery followed by intraperitoneal chemotherapy is significant with all patients requiring postoperative care in an ITU. Overall morbidity rates for grade 3 to 4 toxicity vary between 14.8 – 76% with mortality rates of 4.8 – 12%.
> - There is only one randomised control trial (*Verwaal* et al, 2003) of 103 patients which suggests possible early benefit. At 21 months 30 patients were alive in the HIPEC group compared with 20 in the standard treatment group however importantly standard treatment used lower doses of chemotherapy than is now in conventional use. Procedure related mortality was 8% and there was no difference in overall long term survival (8 years). Any benefit for HIPEC was seen in patients with more limited stage disease and complete resection with no difference in advanced disease.
> - There is no reliable data on cost effectiveness.
> - Accepting the case study data the calculated number needed to treat for HIPEC and cytoreductive surgery vs. standard chemotherapy to avoid 1 additional death at 7 months is 11.

> The conclusions of the Prioritisation Panel (31st October 2014) were that there was a lack of conclusive data for clinical and cost effectiveness and the significant harms associated with the procedure. The Prioritisation Panel ranked HIPEC and CRS for the management of peritoneal cancer as a low priority and therefore should not be routinely funded."

28. The policy position adopted in Wales by WHSSC of not routinely funding CRS with HIPEC for patients with peritoneal carcinomatosis is different to the position adopted in England, Scotland and Northern Ireland where CRS with HIPEC is routinely available to such patients. The divergence with the policy position in England is addressed in PP90 in these terms:

> "NB: This policy statement is in divergence with the current commissioning position in England. In 2013 NHS England Clinical Commissioning Board published Cytoreductive Surgery for Peritoneal Carcinomatosis and concluded that 'for colorectal cancer there is clear long term survival benefit for selected patients'. This was taken from the Bazian review (2012) which states 'with the provision [sic] it should only be provided by surgeons with the experience and expertise … it is effective and provides a significant benefit…'
>
> Importantly this policy position does not take into account:
>
> a) Consideration of the improvements in standard chemotherapy;
>
> b) A critique of the quality of the evidence (low grade evidence);
>
> c) A cost effectiveness evaluation;
>
> and did not go through relative prioritisation process."

29. Under the heading "individual patient funding requests: implications of this policy statement", PP90 states:

IPFR Decision making factors	**Decision making factors related to HIPEC**
Clinical exceptionality Is the clinical presentation of the patient unusual/rare?	▪ Most patients present with abdominal pain, swelling or weight loss or on routine scans. ▪ Evidence supporting the use in patients with limited disease is based on sub-group analysis and remains weak. ▪ This is therefore unlikely to impact decision making
Evidence based considerations Does the treatment work?	▪ See above. The evidence base is weak and many of the case controlled studies predate newer Systemic Anti-Cancer Treatments which have been shown to prolong overall survival

What is the evidence base for clinical and cost effectiveness?	▪ The procedure costs £65,000 per patient. The very limited existing data assessing cost effectiveness is flawed ▪ The WHSSC relative prioritisation process ranked this as low priority.
Ethical considerations How has the decision been reached? Is the decision a compromise based on a balance between the evidence-based input and a value judgement?	Long term follow up in the only randomised control trial suggests that for the vast majority of patients this is a palliative procedure with a significant mortality and morbidity.
Conclusion: **The lack of a sufficient evidence base, cost and palliative nature of the procedures means that this will not be commissioned via WHSSC outside the setting of a randomised controlled trial.**	

30. Although on its face the "conclusion" quoted above would appear to indicate that WHSSC is not prepared to commission CRS with HIPEC in response to any individual request for funding, only being prepared to commission it in the context of a randomised controlled trial, it is common ground that such an interpretation would not accurately reflect WHSSC's policy. The claimant submits such a policy would be unlawful and the court should strive to avoid an interpretation that would render the policy unlawful, which in this case would mean accepting the interpretation agreed by the parties. Mr Lock QC submits, and Professor Doull has given evidence, that properly understood WHSSC's policy is that it will not *routinely* fund CRS with HIPEC for patients with peritoneal carcinomatosis but it will consider individual patient funding requests in accordance with the IPFR policy. I accept that is the proper interpretation of PP90.

31. The IPFR policy was published by NHS Wales in June 2017. The purpose of the IPFR policy is explained in these terms:

> "1.2.1 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is therefore important to be open and clear about the availability of healthcare treatments on the NHS and how decisions on what should be funded by the NHS are made.
>
> 1.2.2 A comprehensive range of NHS healthcare services are routinely provided locally by primary care services and hospitals across Wales. In addition, the Welsh Health Specialised Services Committee (WHSSC), working on behalf of all the Health Boards in Wales, commissions a number of more specialist services at a national level. The use of the term 'Health Board'

> throughout this policy includes WHSSC unless specified otherwise. However, each year, requests are received for healthcare that falls outside this agreed range of services. We refer to these as Individual Patient Funding Requests (IPFR)
>
> 1.2.3 Each Health Board in Wales has a separate Policy setting out a list of healthcare treatments that are not normally available on the NHS in Wales. This is because;
>
> - There is currently insufficient evidence of clinical and/or cost effectiveness; and/or
> - The intervention has not been reviewed by the National Institute for Health and Care Excellence (NICE) or the All Wales Medicines Strategy Group (AWMSG); and/or
> - The intervention is considered to be of relatively low priority for NHS resources.
>
> 1.2.4 The policy, called 'Interventions Not Normally Undertaken' (INNU) should be read together with this policy on making decisions.
>
> 1.2.5 The challenge for all Health Boards is to strike the right balance between providing services that meet the needs of the majority of the population in the geographical area for which it is then given responsibility, whilst having in place arrangements that enable it to accommodate people's individual needs. Key to this is having in place a comprehensive range of policies and schedule of services that the Health Board has decided to fund to meet local need within the resource available. To manage this aspect of the Health Board's responsibilities, there will always need to be in place a robust process for considering requests for individual patient funding within the overall priority setting framework. Demand for NHS services is always likely to exceed the resources available and, as a result, making decisions on IPFR are some of the most difficult a Health Board will have to make."

32. If CRS with HIPEC for the treatment of peritoneal carcinomatosis were to be listed in the Interventions Not Normally Undertaken (INNU) policy, an "immediate review" of that policy would be triggered in circumstances where "NHS treatment would be provided in all (or almost all) other parts of the UK" (para 9.2 of the IPFR policy). However, that provision of the policy does not apply because it is not one of the listed treatments in the INNU policy.

33. The IPFR policy provides:

> "1.3.4 IPFR are defined as requests to a Health Board or WHSSC to fund NHS healthcare for individual patients who fall outside

> the range of services and treatments that a Health Board has arranged to routinely provide, or commission.
>
> Such a request will normally be within one of the three following categories;
>
> - …
> - a patient and NHS clinician have agreed together that they would like a treatment that is provided by the Health Board in certain clinical circumstances but is not eligible in accordance with the clinical policy criteria for that treatment (for example, a request for treatment for varicose veins for cosmetic reasons alone);
> - …
>
> 1.3.5 The three categories of treatment will only potentially be funded in specific clinical circumstances. It is important to note that the NHS in Wales does not operate a blanket ban for any element of NHS healthcare. We will consider each IPFR on its individual merits and in accordance with the arrangements set out in this policy. We will determine if the patient should receive funding based on the significant clinical benefit expected from the treatment and whether the cost of the treatment is in balance with the expected clinical benefits.
>
> 1.3.6 In this policy, the words "significantly different to the general population of patients" means that the patient's condition does not have substantially the same characteristics as other members of that population. For a patient to be significantly different, their particular clinical presentation is unlikely to have been considered as being part of the population for which the policy was made." (emphasis added)

34. At paragraph 4.3.2, the IPFR policy states:

> "The purpose of taking an evidence-based approach is to ensure that the best possible care is available to provide interventions that are sufficiently clinically effective to justify their cost and to reduce inappropriate variation using evidence-based practices consistently and transparently. …"

35. Paragraph 4.4.2 of the IPFR policy explains:

> "Resources available for healthcare interventions are finite, so there is a limit to what LHB's can routinely fund. That limitation is reasonable providing it is fair, and not arbitrary. It must be based on the evidence both about the effectiveness of those interventions and their cost. A cost effective intervention is one that confers a great enough benefit to justify its cost. That means

> policies must be based on research, but research is carried out in populations of patients, rather than individual patients. That leaves open the possibility that what is true for patients in general is not true about a specific individual patient. Fairness therefore also requires that there must be a mechanism for recognising when an individual patient will benefit from a particular intervention more than the general population of patients would. Identifying such patients is the purpose of the IPFR process."

36. Paragraph 5.3 of the IPFR policy sets out the criteria to be applied:

> "The following guide will be used by all Health Board IPFR Panels when making IPFR decisions.

It is the responsibility of the requesting clinician to demonstrate the clinical case for the individual patient, and of the IPFR panel to consider the wider implications for the NHS, such that the criteria in **either (a) or (b)** below are satisfied:
(a) If guidelines (e.g. from NICE or AWMSG) recommend not to use the intervention/drug; I. The clinician must demonstrate that the patient's clinical circumstances are significantly different to the general population of patients for whom the recommendation is not to use the intervention, such that II. The clinician can demonstrate that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients for whom the recommendation is not to use the intervention, and III. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.
(b) If the intervention has not been appraised (e.g. in the case of medicines, by AWMSG or NICE); I. The clinician can demonstrate that the patient is likely to gain significant clinical benefit, and II. The IPFR panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable."

> (emphasis added)

37. It is common ground that the claimant's case fell to be considered by reference to the three criteria in (a), although it is notable that this is not a case where there are guidelines (from NICE, AWMSG or otherwise) that "recommend not to use the intervention". As explained below, the NICE guidelines recommend that CRS with

HIPEC should only be used in the treatment of peritoneal carcinomatosis "with special arrangements", with patient selection undertaken by an experienced MDT, and in highly specialised centres. Nor does PP90 contain any recommendation not to use the intervention, albeit it will not be funded routinely (see paragraph 30 above).

38. The IPFR policy then sets out a "decision making guide":

IPFR Panel Decision-Making Factors	**IPFR Panel Evidence for Consideration in Decision-Making**
SIGNIFICANT CLINICAL BENEFIT	
Is the clinical presentation of the patient's condition significantly different in characteristics to other members of that population? **and** Does this presentation mean that the patient will derive a greater clinical benefit from the treatment than other patients with the same condition at the same stage?	Consider the evidence supplied in the application that describes the specific clinical circumstances of the IPFR: ▪ What is the clinical presentation of this patient? ▪ Is evidence supplied to explain why the clinical presentation of this patient is significantly different to that expected for this disease and this stage of the disease? ▪ Is evidence supplied to explain why the clinical presentation means that the patient will gain a significantly greater clinical benefit from the treatment than another patient with the same disease at the same stage?
EVIDENCE BASED CONSIDERATIONS	
Does the treatment work? What is the evidence base for clinical and cost effectiveness?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: ▪ What does NICE recommend or advise? ▪ What does the AWMSG recommend or advise? ▪ What does the Scottish Medicines Consortium recommend or advise? ▪ What does Public Health Wales advise? ▪ Are there peer reviewed clinical journal publications available? ▪ What information does the locally produced evidence summary provide? ▪ Is there evidence from clinical practice or local clinical consensus? ▪ Has the rarity of the disease been considered in terms of the ability for there to be a comprehensive evidence base available? ▪ Does the decision indicate a need to consider policy or service change? If so, refer to service change processes.

ECONOMIC CONSIDERATIONS	
Is it a reasonable cost? What is the cost of the treatment and is the cost of the treatment likely to be reasonable? i.e. Is the cost of the treatment in balance with the expected clinical benefits?	Consider the evidence supplied in the application, and supplementary evidence (where applicable) supplied by professional advisors to the Panel: ▪ What is the specific cost of the treatment for this patient? ▪ What is the cost of this treatment when compared to the alternative treatment they will receive if the IPFR is declined? ▪ Has the concept of proportionality been considered? (Striking a balance between the rights of the individual and the impact on the wider community), in line with Prudent Healthcare Principles. ▪ Is the treatment reasonable value for money?
ETHICAL CONSIDERATIONS	
How has the decision been reached? Is the decision a compromise based on a balance between the evidence-based input and a value judgement?	Having considered the evidence base and the costs for the treatment requested are there ethical considerations that have not been raised in the discussions? ▪ Is the evidence base sufficient to support a decision? ▪ Is the evidence and analysis of the cost sufficient to support a decision? ▪ Will the decision be made on the basis of limited evidence and a value judgement? If so, have you considered the values and principles and the ethical framework set out in the policy? ▪ Have non-clinical factors been excluded from the decision? ▪ Has a reasonable answer been reached based on the evidence and a value judgement after considering the values and principles that underpin NHS care?

39. Paragraph 7.5 describes the process where requests are referred to the panel for consideration. It states:

> "The panel will consider each IPFR on its own merits, using the decision making criteria set out in this policy. The IPFR Co-ordinator or Senior Officer will complete a record of the panel's discussion on each IPFR, including the decision and a detailed explanation for the reason for that decision. Where possible, they should set out their assessment of the likely incremental clinical benefit and their broad estimate of the likely incremental cost so that their judgements on value for money are clear and transparent.

> A standard decision letter should be prepared to communicate the decision to the requesting clinician. …"

40. Paragraph 8 of the IPFR policy provides a right to request a review hearing. Such a review "does not constitute a review of the merits of the original decision. It has the restricted role of hearing review requests that fall into one or more of three strictly limited grounds", namely, failure to act fairly and in accordance with the IPFR policy, irrationality and failure to exercise powers correctly.

41. Paragraph 8.10 provides, in respect of review panel hearings:

> "The IPFR Senior Officer will complete a record of the review panel's discussion including the decision and a detailed explanation for the reason for the decision. They will also prepare a standard decision letter to communicate the decisions of the panel to the patient and referring/supporting clinician. "

The NICE guidance

42. NICE (in its original form as the National Institute for Clinical Excellence) was first established in 1999 as a special health authority, serving England and Wales. Its legal relationship with England and Wales now differs. In relation to England, the general duties of NICE are set out in section 233 of the Health and Social Care Act 20122012 Act. By section 237, the Secretary of State for Health may issue regulations authorising NICE to give "advice or guidance". The resulting regulations are the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 (SI 2013/259). By regulation 7, NICE may publish a "technology appraisal recommendation" for the use of a particular medicine or treatment. By regulation 7(6), "a relevant health body must comply with a technology appraisal recommendation". In relation to Wales, the obligation to follow a technology appraisal ("TA") appears to stem from a funding direction issued by the Welsh Government.

43. NICE has not published a TA in respect of the use of CRS with HIPEC for the treatment of peritoneal carcinomatosis. NICE has published "interventional procedures guidance" ("IPG"). Unlike a TA, which (the parties agreed) the defendants would be bound to apply, an IPG does not provide binding guidance. It is, nonetheless, common ground that the WHSSC was bound to have regard to the IPG issued by NICE in determining the claimant's IPFR. The purpose of an IPG is to assess the safety and efficacy of the procedure that is the subject of the IPG.

44. NICE published *Cytoreduction surgery with hyperthermic intraoperative peritoneal chemotherapy for peritoneal carcinomatosis* ("IPG 688") on 3 March 2021. IPG 688 provides:

> "This guidance represents the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take this guidance fully into account. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the

> individual patient, in consultation with the patient and/or guardian or carer.
>
> Commissioners and/or providers have a responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. …
>
> **1 Recommendations**
>
> 1.1 Evidence on the safety of cytoreduction surgery with hyperthermic intraoperative peritoneal chemotherapy for peritoneal carcinomatosis shows frequent and serious but well-recognised complications. Evidence on its efficacy is limited in quality. Therefore, this procedure should only be used with special arrangements for clinical governance, consent, and audit or research. Find out what special arrangements mean on the NICE website."

45. Paragraphs 1.2 and 1.3 set out certain steps that clinicians wishing to perform CRS with HIPEC for peritoneal carcinomatosis should take, and that should be taken by healthcare organisations. IPG 668 continues:

> "1.4 Patient selection should be done by an experienced multidisciplinary team.
>
> 1.5 The procedure should only be done in highly specialised centres by clinicians with specialist expertise and specific training in cytoreduction surgery and hyperthermic intraoperative peritoneal chemotherapy."

46. Under the heading "Committee considerations", IPG 668 provides:

> "**The evidence**
>
> 3.1 NICE did a rapid review of the published literature on the efficacy and safety of this procedure. This comprised a comprehensive literature search and detailed review of the evidence from 10 sources, which was discussed by the committee. The evidence included 6 meta-analyses, 3 systematic reviews and 1 randomised controlled trial. It is presented in the summary of key evidence section in the interventional procedures overview. Other relevant literature is in the appendix of the overview.
>
> 3.2 The professional experts and the committee considered the key efficacy outcomes to be: progression-free survival, disease-free survival, recurrence-free survival, overall survival and improvement in quality of life (physical and emotional).

> 3.3 The professional experts and the committee considered the key safety outcomes to be: postoperative haemorrhage, perioperative mortality, anastomotic leaks, sepsis, pain, stoma rate, readmission to an intensive care unit and the need for further surgery.
>
> 3.4 Two commentaries from patients who have had this procedure were discussed by the committee.
>
> **Committee comments**
>
> 3.5 This procedure is unlikely to be curative and may be offered to patients for whom cure is not the intention. Therefore, it is important that patients are clearly informed that the procedure is associated with significant periprocedural morbidity including prolonged treatment in an intensive care unit and long-term postoperative recovery.
>
> 3.6 The resectability of the tumours is important in determining the outcome, but criteria for this have not been clearly established.
>
> 3.7 Hyperthermic intraoperative peritoneal chemotherapy has no standardised protocol, and protocols are continuing to evolve. Variations in the drug regimens include temperature, dose, duration of infusion time, and whether a drug is used on its own or in combination with other drugs.
>
> 3.8 There have been large improvements in survival and quality of life for patients with metastatic cancer in recent years because of advances in systemic chemotherapy. This made it difficult to assess the benefits of hyperthermic intraoperative peritoneal chemotherapy.
>
> 3.9 The outcomes are different depending on the type of tumour being treated." (emphasis added)

47. The five page guidance from which the quotations above are drawn is accompanied by a 94 page overview. The efficacy summary in respect of colorectal cancer states:

> "A systematic review and meta-analysis of 1,036 patients (in 76 studies including 15 controlled and 16 non-controlled studies) who had treatments for peritoneal carcinomatosis from colorectal cancer reported that the mean overall survival for CRS plus HIPEC was 29.2 (±11.3) months. Meta-analysis of 15 controlled studies (including 3,179 patients) reported that the mean overall survival for the CRS plus HIPEC treatment group was 34.3 (±14.8) months and the traditional therapy group was 18.8 (±8.8) months. The summarised hazard ratio for overall survival was 2.67 (95% CI 2.21 to 3.23, I^2=0%, p<0.00001).

…

5-year survival

The systematic review and meta-analysis of 10,036 patients who had treatments for peritoneal carcinomatosis from colorectal cancer reported that the 5-year survival rate was 27.5% (±14.1). Meta-analysis of 15 controlled studies (with 3,179 patients) reported that 5-year survival for the CRS plus HIPEC group 40% (±11.5) compared with 18% (±14.1) for the traditional therapy group.

…

Summary of findings from the evidence review for this policy

Clinical effectiveness

- When delivered by a surgeon and units with the experience and expertise in achieving high rates of complete cytoreduction provides a significant survival benefit in peritoneal carcinomatosis secondary to colorectal and ovarian carcinoma.

…

The evidence suggests that the completeness of cytoreduction is an important determinant of effectiveness, and therefore this parameter should be monitored where the procedure is done.

…

Issues for consideration by IPAC

- …

- NICE Colorectal cancer guideline published in January 2020 supports the use of CRS and HIPEC for people with metastatic colorectal cancer in the peritoneum … 'Although evidence on the effectiveness was mixed, the committee decided that it was important to recommend referral to a nationally commissioned specialist centre after discussion within a multidisciplinary team for consideration of CRS and HIPEC so that more patients can have potentially curative treatment. This advice is in line with NICE IPG 331." (emphasis added)

48. IPG 668 replaced IPG 331 which was published on 1 February 2010. IPG 331 provided, as does IPG 668, that CRS with HIPEC should only be used with special arrangements for clinical governance, consent and audit or research, and patient selection should be carried out in the context of a MDT, including oncologists and surgeons with experience in this operation. Paragraph 1.1 of IPG 331 stated:

> "Current evidence on the efficacy of cytoreduction surgery (CRS) followed by hyperthermic intraoperative peritoneal chemotherapy (HIPEC) for peritoneal carcinomatosis shows some improvement in survival for selected patients with colorectal metastases, but evidence is limited for other types of cancer. The evidence on safety shows significant risks of morbidity and mortality which need to be balanced against the perceived benefit for each patient. Therefore, this procedure should only be used with special arrangements for clinical governance, consent and audit or research."

The Cedar review

49. Professor Doull states in his witness statement:

> "In 2018 WHSSC commissioned Cedar (a combined NHS-academic healthcare technology research centre, part of both Cardiff and Vale University Health Board and Cardiff University) to carry out a rapid evidence review of 'Cytoreductive Surgery with Hyperthermic Intraperitoneal Chemotherapy for Peritoneal Carcinomatosis'. The final version was submitted to WHSSC in July 2018.
>
> Subsequently CRS with HIPEC was presented to the WHSSC Prioritisation Panel on 16 October 2018, and the Cedar review was considered in the supporting evidence. The procedure was assessed and prioritised against ten other topics by the prioritisation panel, using agreed WHSSC methodology.
>
> The WHSSC Prioritisation Panel concluded that there was a "lack of conclusive data for clinical and cost effectiveness and significant harms associated with the procedure." The Prioritisation Panel ranked CRS with HIPEC as a low priority and consequently the WHSSC policy (PP90) and its recommendations remained unchanged."

E. The IPFR application, decision and review

50. Following the diagnosis on 28 April 2021 (see paragraph 6 above), on 24 May 2021, the Royal Gwent Hospital Colorectal Cancer MDT considered the claimant's case. She was referred by Mr Gethin Williams to Mr Brendan Moran, a consultant general and colorectal surgeon at the Peritoneal Malignancy Centre at Basingstoke Hospital, where her case was initially discussed on 1 June 2021, and to Lt Col Leigh Davies, a consultant colorectal surgeon at the University Hospital of Wales. The claimant's case was considered by the Cardiff MDT on 16 June 2021 and discussed with Mr Moran.

51. On 17 June 2021 Lt Col Davies submitted an IPFR. He asked for the application to be considered urgently (within 24-28 hours), noting:

> "The patient has cancer and needs a rapid decision to facilitate urgent and early treatment. There has been delay previously. Patient and relatives highly anxious".

52. The reference to previous delay is to the fact the claimant had a CT scan following trauma in June 2020. That scan has since been described by Mr Moran as showing some evidence of an abnormality near the caecum at that point in time at the site of the appendix. That scan was initially reported as being unable to exclude malignancy of the caecum but it appears that nothing was done to investigate the position. Lt Col Davies has described that as a missed opportunity to prevent advanced disease.

53. This is not a clinical negligence claim. The defendants take no position in these proceedings on whether there was negligence on the part of the treating physician in June 2020. Professor Doull has explained in his evidence that when considering the IPFR the panel considered that the possibility that the claimant had been treated negligently earlier in the process was not a relevant consideration. He explains:

> "Patients in the NHS in Wales do not get additional priority because of errors made earlier in a treatment process. We allocate funding based on a patient's presenting medical condition alone, not on the circumstances which led to that presenting condition. Hence, to use an example, two drivers in a road traffic crash get the same level of treatment regardless as to which driver caused the crash. A victim of violence gets the same treatment regardless as to whether he was a wholly innocent victim of an assault or whether he had been the perpetrator of a fight in which he came off worse. I can understand why Mr Davies thought that this was a key feature of the case, but the NHS does not differentiate between the treatments available as NHS funded care for patients with identical presenting conditions depending on what led to the patient being in that condition."

The claimant does not take issue with this aspect of the defendants' approach.

54. In the IPFR application form, Lt Col Davies stated that the diagnosis was peritoneal malignancy secondary to appendix carcinoma. It was stage 4. He described Ms Wallpott as "otherwise fit and well". He stated:

> "The patient has already been discussed in Basingstoke MDT and has been assessed as resectable. This is confirmed with the opinion of the Cardiff Colorectal MDT in the presence of the Lead Malignancy Clinician.
>
> …
>
> This is a NICE approved therapy and is potentially lifesaving. Current survival rates in patients who undergo CRS and HIPEC are up to 40% over 5 years the equivalent of liver resection for metastatic disease."

55. I note that the figures cited by Lt Col Davies reflect the 5 year survival rate referred to by NICE in the IPG 668 overview (see paragraph 47 above).

56. The IPFR application continued:

Has the patient been through all NICE / AWMSG approved regimes?	Yes – The proposed treatment is NICE approved.
What is the usual treatment pathway and why is the patient not following the usual treatment pathway?	Peritoneal disease has limited potential for successful treatment with systemic chemotherapy with the vast majority succumbing to disease progression within a year on chemotherapy alone with little effect on median survival on this modality The only reasonable life-saving option is the proposed treatment. The usual treatment pathway if this patient was resident in the rest of the UK would be for them to undergo CRS & HIPEC as per NICE guidance.
What is the alternative treatment intervention?	Systemic chemotherapy – poor success rate in peritoneal malignancy due to poor peritoneal penetration. Recent advances in life expectancy from systemic chemotherapy with other sites of metastatic disease have not been demonstrated in peritoneal disease. Median life expectancy with peritoneal disease and systemic chemotherapy remains poor at approximately 9 months.
What are the reasons for not using an alternative intervention strategy?	They are largely unhelpful in improving survival quality of life nor life expectancy.

(emphasis added)

57. In the section of the form headed "evidence of clinical effectiveness", in response to the request for details of key studies supporting the use of this intervention for this condition, Lt Col Davies referred to two Dutch trials (one a randomised controlled trial), a review article written by the Basingstoke team in association with Paul Sugarbaker, who he described as the world's leading authority on CRS and HIPEC, and the NICE guidance which he attached. He provided a full reference list of 19 articles.

58. In the economic assessment section, Lt Col Davies stated the cost of CRS with HIPEC as £65,000 compared to the cost of chemotherapy of £16,285. He put the net cost of the procedure as "£65,000-£16,000 = £49,000", stating:

> "If this intervention is approved then there is a lesser requirement for full ongoing chemotherapy as above".

59. In the section of the application form headed "statement in support of application", Lt Col Davies stated:

> "This patient has been assessed by multiple MDTs including a specific Peritoneal Malignancy MDT in Basingstoke and the conclusions of these MDTs is that this patient has resectable disease with the intent of cure.
>
> She is a young patient with a missed opportunity to treat her disease at an earlier stage of only 1 year previously but the lesion was not identified on her scan at that time. As such there is considerable anxiety surrounding this patient's ongoing management from both the patient and her Sister
>
> The treatment has been appraised by NICE and is an approved treatment for the management of peritoneal malignancy secondary to appendix metastases. Appendix disease has a better outcome for colorectal metastases as it often behave[s] biologically more like PMP.
>
> This is an increasing frequent finding at the colorectal MDT. The patient is an exceptional [case] because although the patient's disease is advanced by standard criteria it remains at this time resectable by the surgical techniques described above. Given the potential gains to the patient, I feel that this intervention should be undertaken in this case.
>
> The benefits in this otherwise fit patient would greatly outweigh the potential benefits that this intervention would offer a typical cancer patient in a similar position.
>
> This application is submitted as this patient will not be helped by systemic chemotherapy which is almost universally unhelpful in these patients – systemic treatment is no better than best supportive care and they will have a median survival of between 8 and 12 months. They have been assessed as potentially resectable by a number of clinicians with experience in cytoreductive surgery and HIPEC and deemed suitable for surgery. With CRS and HIPEC they have a good chance of long term (>5 years) survival and similar outcomes to Liver and lung resection for colorectal metastases.
>
> …" (emphasis added)

60. On 1 July 2021, the WHSSC panel considered the IPFR and decided not to approve the request for funding. The decision letter, addressed to Lt Col Davies, dated 6 July 2021 states:

> "**Reason for Decision:**

> The information provided did not demonstrate that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients with the same condition and the same stage of disease.
>
> Discussion was held around the efficacy of CRS with HIPEC, and the NICE published efficacy summary was referenced. The Panel also acknowledged that the proposed procedure is radical with significant risk of morbidity and mortality.
>
> NICE IPG688 states that:
>
> *"Evidence on the safety of cytoreduction surgery with hyperthermic intraoperative peritoneal chemotherapy for peritoneal carcinomatosis shows frequent and serious but well-recognised complications. Evidence on its efficacy is limited in quality. Therefore, this procedure should only be used with special arrangements for clinical governance, consent, and audit or research".*
>
> It was also questioned by the Panel if Genetic testing had been carried out on the tumour, as no information had been provided on this. It was suggested that all future requests for this intervention includes results of genetic testing of the tumour and referring clinicians need to clarify whether or not they have undertaken high microsatellite instability (MSI-H)/DNA mismatch repair (dMMR) assessments."

61. The Panel Record Sheet of the meeting on 1 July 2021 records:

Evidence of Significant Clinical Benefit (…)	The extant WHSSC policy for CRS and HIPEC states that this treatment should not be routinely available. The panel noted that the IPFR form suggests that the proposed treatment is NICE approved for this indication and quotes that Peritoneal carcinomatosis secondary to appendix carcinoma is a current indication for periotonectomy and HIPEC treatment should the disease be assessed as resectable (NICE IPG688 – 2021). The form also quotes NICE IPG331 but the Panel clarified that the quoted guidance has now been replaced with NICE IPG688 (March 2021) which states that: [*The same quotation as is included in the letter was set out.*] The information provided did not demonstrate any clinical features which would suggest that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients with the same condition and the same stage of disease.
Evidence-Based	The Panel noted that the IPFR form stated that CRS with HIPEC is a NICE approved therapy. It was clarified that

Considerations (…)	NICE has only published an IPG not a Technology Appraisal supporting its use. The IPFR states that "This is a NICE approved therapy and is potentially lifesaving". The NICE IPG however states "This procedure is unlikely to be curative and may be offered to patients for whom cure is not the intention. Therefore, it is important that patients are clearly informed that the procedure is associated with significant periprocedural morbidity including prolonged treatment in an intensive care unit and long-term postoperative recovery". Discussion was held around the efficacy of CRS with HIPEC, and the NICE published efficacy summary was referenced. The Panel also acknowledged that the proposed procedure is radical with a significant risk of morbidity and mortality. The panel discussed other improvements in cancer care including the benefit of genetic testing and new drugs and that HIPEC had not be [sic] compared with current treatment options.
Economic Considerations (…)	£73,000 approx for package of treatment …The Panel were not satisfied that the value for money of the intervention for this particular patient is likely to be reasonable. There is lack of information to demonstrate that the treatment is cost-effective in comparison to the expected clinical benefits.
Ethical Considerations (…)	The information provided did not demonstrate that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients with the same condition and the same stage of disease. Current clinical evidence does not suggest the treatment is curative. <u>Current clinical evidence does not support the use of CRS with HIPEC as being clinically effective.</u> It was also questioned by the Panel if Genetic testing has been carried out on the tumour, as no information had been provided on this. It was suggested that all future requests for this intervention includes results of future genetic testing of the tumour and referring clinicians need to clarify whether or not they have… undertaken high microsatellite (MSI-H)/DNA mismatch repair (dMMR) assessments."
Rationale for Decision	[*This was set out in the same terms as appear in the letter quoted above.*]

(emphasis added)

62. A review of the decision of 1 July 2021 was sought on 14 July 2021. Lt Col Davies stated:

> "The panel of non-experts in CRS and HIPEC have reviewed the IPFR application and decided that this patient is not resectable despite her being considered for the same by 3 separate MDTs of specialists in colorectal malignancy and 2 of these are specialist MDTs in CRS and HIPEC."

He stated that the claimant's disease was exceptional because it was resectable.

63. A second panel considered the IPFR on 5 August 2021 and decided that the decision not to approve funding should stand. The decision letter sent to Lt Col Davies on 9 August 2021 states:

> "The additional information provided did not demonstrate that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients with the same condition and the same stage of disease.
>
> The Panel noted the additional information submitted highlighting the MSI status of the patient confirmed that the patient has other forms of treatment available to them i.e. Monoclonal Antibody therapy/chemotherapy which can be less toxic and improve the patient[']s quality of life.
>
> There was no new or additional information provided to the Panel to justify changing the initial funding decision."

64. On 17 September 2021 a further review application was submitted by Dr Hilary Williams. The grounds were, first, that there was no clear definition of exceptionality or why the claimant had not been found to be exceptional, secondly, that the policy was outdated and failed to distinguish between appendix and colorectal cancer, thirdly, the finding that alternative treatment was available was wrong as current practice in southeast Wales is not to use EGFR inhibitors in right sided tumours (including appendiceal cancer) in view of the compelling evidence that right and left sided cancers have different responses to chemotherapy and biological therapies, and the inefficacy of such alternative treatment.

65. The further review request was rejected on 30 September 2021 on the basis that grounds for review had not been clearly stated in line with the policy.

F. Ground 1: Tameside/Irrationality

66. There are two aspects to ground 1. First, the claimant submits that the panel failed to ask the right questions to ascertain clinical benefit, in breach of the *Tameside* duty. In particular, the claimant contends that the panel was required to ask the following two questions as set out in the decision making guide (see paragraph 38 above):

    i) "Is the clinical presentation of the patient's condition significantly different in characteristics to other members of that population?" and

ii) "Does this presentation mean that the patient will derive a greater clinical benefit from the treatment than other patients with the same condition at the same stage?"

67. I consider that the claimant's *Tameside* point essentially boils down to the question whether the WHSSC's interpretation of the comparator to be adopted in applying criterion II of the IPFR policy was erroneous. Professor Doull has given evidence that the panels (at the initial and review stages) interpreted the IPFR policy as involving "a comparison between Ms Wallpott and other patients with advanced cancer who would be recommended for the treatment but were not offered it because of the policy which said it would not be routinely funded". There was no hint of this reasoning in the contemporaneous decision letters or panel records.

68. In support of the defendants' interpretation, Mr Lock QC relies on *R (Condliff) v North Staffordshire Primary Care NHS Trust* [2011] EWCA Civ 910, [2012] PTSR 460, in which Toulson LJ referred at [19] *et seq* to a paper entitled *Priority Setting: Managing Individual Funding Requests*, published in 2008 by the NHS Confederation. At [21] Toulson LJ notes:

> "Under the heading 'What approach should PCTs take to individual funding requests?' the author suggests:
>
> > "Exceptionality is essentially an equity issue that is best expressed by the question: 'On what grounds can the PCT justify funding this patient when others from the same group are not being funded?'"

69. Mr Lock QC submits that it is only an equity issue if the comparator is the pool of patients who, but for the decision not to fund the treatment for them, *would* receive the treatment. If their clinician would not recommend it for them, they would be unaffected by the policy and so no lack of equity arises.

70. It is well established and common ground that interpretation of policy is a matter for the court. In my judgement, the defendants' interpretation is inconsistent with the terms of the policy. First, paragraph 1.3.6 states that in the IPFR policy, the words "significantly different to the general population of patients" mean that the patient's condition does not have substantially the same characteristics as other members of that population i.e. the general population of patients. There is nothing in paragraphs 1.3.5 or 1.3.6 to support the defendants' interpretation. Paragraph 1.3.6 refers to the "population for which the policy was made". In this case, PP90 was made for the whole population of patients with peritoneal carcinomatosis: it applies to all such patients.

71. Secondly, the decision making guide in the IPFR policy expressly specifies (see paragraph 38 above) that the comparison is with the clinical presentation "expected for this disease and this stage of the disease". Panels are not directed in the decision making guide to further reduce the comparator population of patients to those with the same condition, at the same stage and for whom the treating clinician has recommended the treatment. On the contrary, each of the questions decision-makers are directed to answer in the box headed "significant clinical benefit" directs them to compare the patient to "other patients with the same condition at the same stage".

72. Thirdly, Criterion II in paragraph 5.3 of the IPFR policy compares the patient's position with that of "patients for whom the recommendation is not to use the intervention" (emphasis added). It is clear from the opening sentence at (a) - "*If guidelines (e.g. from NICE or AWMSG) recommend not to use the intervention/drug*" - that the "recommendation" referred to is one contained in guidelines, such as from NICE. In circumstances where there are guidelines recommending that an intervention should not be used, the purpose of the comparison is to consider what (if anything) distinguishes the individual patient, whose treating clinician is seeking funding for the intervention, from others with the same condition at the same stage to whom that recommendation applies, so as to justify a departure from the recommendation not to use the intervention in the individual patient's case.

73. IPG 668 does not make a recommendation not to use CRS with HIPEC for patients with peritoneal carcinomatosis. It is, as Mr Lock QC submitted, permissive. It requires the procedure to be used with special arrangements, and for the procedure to be done in highly specialised centres, following patient selection by experienced MDTs. Insofar as it could be said that there are any patients with peritoneal carcinomatosis for whom the NICE recommendation is not to use CRS with HIPEC, it is those who are not selected by an experienced MDT for the procedure to be done by a highly specialised centre. (Nor is PP90 a recommendation not to use the intervention (see paragraphs 30 and 37 above); and, in any event, if it could be construed in such a way, any such recommendation in PP90 would apply to all patients with peritoneal carcinomatosis.)

74. This is flatly inconsistent with the defendants' submission that the comparator population excludes those whose clinicians do not recommend the treatment for them. The IPFR policy expressly posits comparison with those patients who will not be recommended for the treatment by their clinicians because it would be contrary to guidance.

75. In my judgement, *Condliff* does not assist on this point. The court was not interpreting the policy that is before me, and the IPFR policy does not direct panels to address equity by asking the question posed in the paper to which Toulson LJ referred.

76. I also accept the claimant's contention that the defendants' interpretation would appear to introduce a test of uniqueness: *cf R (Ross) v West Sussex Primary Care Trust* [2008] EWHC 2252 (Admin). Mr Lock QC referred in his submissions (on instructions, albeit the matter is not in evidence) to one case in which funding has been granted for CRS with HIPEC for treatment of peritoneal carcinomatosis, but the basis for that decision appears to have been that the clinical presentation was so close to PMP that the patient should be treated, in effect, as if they fell within CP02.

77. The claimant's alternative submission under this ground is that the panel was required to come to a decision which was rational on the evidence, that is within the range of reasonable decisions taken by a panel: *Basma v Manchester University Hospitals NHS Foundation Trust* [2021] EWCA Civ 278 at [73]-[83].

78. I consider that it is unnecessary and would be inappropriate to address this alternative submission. The WHSSC has not reached a conclusion as to whether the criterion that the claimant would be likely to gain significantly more clinical benefit than the general population of patients with stage 4 peritoneal carcinomatosis is met because of the misinterpretation of the policy to which I have referred.

79. Accordingly, I find that this ground succeeds on the basis that in making the decision the defendants misinterpreted the IPFR policy.

G. Ground 2: Reasons

80. It is not disputed that there was a duty to give reasons. The policy expressly required a "detailed explanation" to be given of the reasons for the decision. Even if that were not the case, fairness required reasons to be given in this case. That is so, first, because of the vital importance of the decision to the claimant. In the IPFR application submitted in June 2021, the claimant's treating clinician described the "median survival" (i.e. her life expectancy) with the only other available treatment, systemic chemotherapy, as between 8 and 12 months. Whereas the treatment for which he sought funding gave a "good chance of long term (>5 years) survival", that "good chance" being expressed elsewhere in the form as "up to 40%". He also described the proposed treatment as "potentially lifesaving", albeit IPG688 advised that the procedure is "unlikely to be curative". In this context, fairness necessarily imposed a requirement to give proper reasons for any decision to refuse to fund the treatment. Secondly, the claimant had a right to seek review of the decision on limited grounds, in accordance with the terms of the policy. If the claimant was not provided with an adequate explanation of the reasons for refusal of the request, she would be unable to exercise that review right effectively.

81. Both parties rely on the opinion of Lord Brown, with which all members of the Judicial Committee of the House of Lords agreed, given in *South Bucks District Council v Porter (No2)* [2004] 1 WLR 1953 at [35]-[36], addressing the extent of the duty to give reasons in the context of a planning inspector's decision. In particular, Lord Brown observed at [36]:

> "The reasons for a decision must be intelligible and they must be adequate. They must enable the reader to understand why the matter was decided as it was and what conclusions were reached on the "principal important controversial issues", disclosing how any issue of law or fact was resolved. Reasons can be briefly stated, the degree of particularity required depending entirely on the nature of the issues falling for decision. The reasoning must not give rise to a substantial doubt as to whether the decision-maker erred in law, for example by misunderstanding some relevant policy or some other important matter or by failing to reach a rational decision on relevant grounds. But such adverse inference will not readily be drawn. The reasons need refer only to the main issues in the dispute, not to every material consideration. They should enable disappointed developers to assess their prospects of obtaining some alternative development permission, or, as the case may be, their unsuccessful opponents to understand how the policy or approach underlying the grant of permission may impact upon future such applications. Decision letters must be read in a straightforward manner, recognising that they are addressed to parties well aware of the issues involved and the arguments advanced. A reasons challenge will only succeed if the party aggrieved can satisfy the court that he has genuinely been substantially prejudiced by the failure to provide an adequately reasoned decision."

82. As Chamberlain J observed in *Inclusion Housing Community Interest Company v Regulator of Social Housing* [2020] EWHC 346 (Admin) at [77], that passage has been applied generally in public law cases, both in and outside the planning and environmental field.

83. The contentious issue is whether the reasons given satisfied the requirements described by Lord Brown. In making that assessment, a further question arises as to whether, insofar as Professor Doull gives evidence as to the panel's reasons (endorsed in the statement given by Professor Vivienne Harpwood, the Chair of the WHSSC IPFR Panel), his evidence is inadmissible in accordance with the *Ermakov* line of authority (drawn from *R v Westminster City Council, ex p Ermakov* [1996] 2 All ER 302).

84. Professor Doull gives evidence regarding the panel's deliberations at paragraphs 54 to 78 of his statement. At paragraph 60 he refers to the alleged negligence at an earlier stage of the claimant's treatment (see paragraph 53 above). There is no live issue between the parties and so I consider that evidence is admissible background evidence. Paragraphs 54-59 of Professor Doull's statement address the interpretation of the NICE guidance, the admissibility of which I address in the context of ground 3. Paragraphs 74 to 77 address the issue of alternative treatments that I consider when addressing ground 4. Paragraphs 71 to 72 address the issue of cost effectiveness, the admissibility of which I have considered in the context of ground 5 below.

85. At paragraph 61, Professor Doull refers to the fact that the procedure is routinely commissioned by NHS England and asserts that if that is correct it was not a relevant matter for the panel to consider. The claimant acknowledges that it was open to the defendants to adopt a different policy to each of the other countries of the UK and, as I have said, she does not challenge PP90. Although Mr Sachdeva referred in his oral submissions to paragraph 9.2 of the IPFR as showing that the approach taken to NHS treatment across the rest of the UK is a mandatory consideration in certain circumstances, there is no pleaded claim alleging a failure to take into account the approach in the rest of the UK when determining this IPFR. Accordingly, this paragraph does not go to a live issue and I consider it admissible background evidence.

86. In paragraphs 62 to 70 of his statement, Professor Doull addresses in detail the panel's approach to the question of clinical benefit and in particular the comparison to be drawn in addressing the second criterion. It is unnecessary to address the *Ermakov* principles in detail in this judgment. In short, as Chamberlain J put it in the *Inclusion* case at [78]:

> "So far as *ex post facto* reasons are concerned, the authorities draw a distinction between evidence elucidating those originally given and evidence contradicting the reasons originally given or providing wholly new reasons: *Ermakov*, pp. 325-6. Evidence of the former kind may be admissible; evidence of the latter kind is generally not. Furthermore, reasons proffered after the commencement of proceedings must be treated especially carefully, because there is a natural tendency to seek to defend and bolster a decision that is under challenge: *Nash*, [34(e)]."

87. In my view, it is plain that Professor Doull's evidence in paragraphs 62 to 70 goes well beyond elucidating the reasons given contemporaneously. His witness statement provides new reasons and it does so after the commencement of proceedings. Insofar

as he has explained the interpretation of the IPFR policy adopted by the panel, I have taken this part of his evidence into account on the basis that the interpretation error to which I have referred is identified. Save to that extent, I consider that this section of Professor Doull's evidence is clearly inadmissible *ex post facto* reasoning.

88. In considering the reasons given contemporaneously by the WHSSC for each decision, as Mr Sachdeva QC accepts, it is necessary to look at both the decision letters and the records of the panel meetings. The primary reason given in both decision letters is that the information provided did not show that criterion II of paragraph 5.3(a) of the IPFR policy (see paragraph 36 above) was met. This was no more than an incantation of the criterion and a bare statement that it was not met.

89. Mr Lock QC submits that all that was required was a very brief statement because that reflected the treating clinician's failure to put forward evidence that this criterion was met. He contends that the information put forward amounted to no more than bare assertions.

90. Lt Col Davies had put forward the following factors in support of his contention that criterion II was met:

i) The claimant's cancer was assessed by the MDTs as resectable. This was exceptional for a patient with her condition at stage 4. It was a potentially vital factor because most patients with the same condition, at the same stage, would not be resectable. (And for patients with the same condition who were resectable, but at an earlier stage of the disease, and so potentially having a greater life expectancy and quality of life than the claimant, the overall assessment of benefit – having regard to the risks - would potentially differ.)

ii) Appendix cancer often behaves biologically more like PMP (for which CRS with HIPEC is routinely funded by NHS Wales) and has a better outcome than other colorectal cancers. This was an increasingly frequent finding made at the colorectal MDT. This information that appendix cancer has a better outcome than other colorectal cancers fell to be considered in the context of the NICE guidance which referred to "a significant survival benefit" in peritoneal carcinomatosis where it was secondary to two types of carcinoma, namely, colorectal and ovarian (see paragraph 47 above).

iii) Compared to the cohort of patients with this disease, and at this stage of the disease, the claimant is young and otherwise fit and well, with a WHO performance status of zero (i.e. the best level).

iv) The *only* alternative treatment available was systemic chemotherapy which was "largely"/"almost universally" unhelpful in treating peritoneal disease due to poor penetration of the peritoneum. So the "large improvements in survival and quality of life … because of advances in systemic chemotherapy" - which made it difficult for NICE to assess the benefits of HIPEC - referred to in IPG688 (see paragraph 46 above), were said to be inapplicable in this case.

91. Neither the decision letters nor the panel records addressed any of these reasons. It is evident that Lt Col Davies understood the first decision to mean that the panel had rejected the assessment made by the MDTs that the claimant's cancer is resectable and

so he took that reasoning to be the target of his application for review. While I accept the defendants' witness evidence that the assessment that the claimant's cancer was resectable, and that it was possible (albeit unlikely) that the procedure would be curative for the claimant, was accepted by the WHSSC, given the WHSSC's failure to address any of those four key factors, it is unsurprising that Lt Col Davies misunderstood the basis for the refusal of funding. It is equally unsurprising that Dr Heather Williams was still asking in her second review request why the panel considered the claimant did not fit what she referred to as the exceptionality criterion. The reasoning was also insufficient to enable the claimant to identify during the review process any error made by the WHSSC in interpreting the IPFR policy (see ground 1 above).

92. In my judgement, it is clear that the reasons given in this case failed to address the principal controversial important issues and they were insufficient to enable the claimant to have a fair opportunity to exercise the right to review.

H. Ground 3: Construction of the NICE guidance

93. The first decision states that, "Current clinical evidence does not support the use of CRS with HIPEC as being clinically effective". The claimant submits that this finding shows that the panel has erroneously construed IPG668 as meaning that the treatment is not clinically effective at all, and there are no patient sub-groups in whom it is clinically effective. That is, the claimant submits, a plain misreading of the NICE guidance.

94. In their detailed grounds of resistance, the defendants asserted that the panel "never came to a finding that the treatment was not clinically effective at all". Mr Lock QC submits that IPP668 is permissive. Paragraphs 54-59 of Professor Doull's statement address the interpretation of the NICE guidance. That is evidence that goes far beyond elucidation of the reasons given in the contemporaneous reasons and I do not consider it admissible.

95. In my judgement, it is unclear how the panel in their decisions construed the NICE guidance. I would accept that Mr Lock's description of IPG668 as permissive is apt. It is not prescriptive, save to the extent of imposing requirements in relation to matters such as who can select patients and undertake the procedure. But it is clear that it is permissive because NICE has assessed that it is a clinically effective treatment for some patients with peritoneal carcinomatosis, albeit careful selection is required and treatment at specialised centres.

96. The statement that "Current clinical evidence does not support the use of CRS with HIPEC as being clinically effective" is concerning. It appears to reflect the interpretation of PP90 that the defendants acknowledge cannot be correct i.e. that this treatment should only be funded in randomised controlled trials. The defendants have acknowledged that PP90 should not be interpreted in that way. Funding for it can be sought pursuant to the IPFR policy. That must be on the basis that it is acknowledged to be clinically effective for some patients with peritoneal carcinomatosis, otherwise every IPFR application for this treatment would be automatically rejected. That would be unlawful.

97. While I am not persuaded that this has been made out as a separate ground, the lack of clarity as to how the NICE guidance was interpreted provides further support for the conclusion that the reasons given were inadequate. And the concern to which I have

referred in the paragraph above is a matter to be taken into account in considering whether this is an appropriate case for the application of s.31(2A) of the Senior Courts Act 1981.

I. Ground 4: Mistake of fact/Irrelevant Consideration re alternative treatment

98. In the review decision the WHSSC expressly took into account its view that the claimant "has other forms of treatment available to them", referring specifically to EGFR inhibitors. There was no evidence before the panel to suggest that such treatment was available to the claimant and as soon as this point was made in the decision letter the claimant's treating clinician clarified that, in fact, this treatment is not available to the claimant because her cancer is on the right side of the abdomen and it is not current practice in southeast Wales to use EGFR inhibitors in right-sided tumours.

99. The defendants' initial position, reflected in the evidence of Professor Doull, was that this treatment was "available", that term being a statement of NHS commissioning policy, even though it was not treatment that her clinician would make use of in her case. However, in his oral submissions, Mr Lock QC acknowledged that whether treatment is available has to be determined by whether it is available to the patient.

100. That is plainly right. The decision letter referred to alternative treatment "available to them" (i.e. to the claimant). That reflects the IPFR policy: the decision making guide refers to "alternative treatment they will receive if the IPFR is declined" (emphasis added). The use of EGFR inhibitors was not recommended by the claimant's clinicians as an appropriate treatment for her. The conclusion that it was a treatment that was available to her was a factual error.

101. The leading case on mistake of fact as a ground of challenge in judicial review proceedings is *E v Secretary of State for the Home Department* [2004] QB 1044 at [66]. To establish unfairness stemming from a mistake of fact it is generally necessary to meet the following requirements:

> "First, there must have been a mistake as to an existing fact, including a mistake as to the availability of evidence on a particular matter. Secondly, the fact or evidence must have been "established", in the sense that it was uncontentious and objectively verifiable. Thirdly, the appellant (or his advisers) must not have been responsible for the mistake. Fourthly, the mistake must have played a material (not necessarily decisive) part in the tribunal's reasoning."

102. In my judgement, these requirements are met. The fact that the use of EGFR inhibitors was not a treatment available to the claimant was an existing fact at the time of the challenged decision. It is uncontentious. The claimant and her advisers cannot be held responsible for the mistake. Her treating clinicians addressed the question as to what alternative treatment was available and made no suggestion that use of EGFR inhibitors was a possible treatment available to the claimant. Nor were they asked if it was an available treatment.

103. The only criterion that Mr Lock QC submits is not met is the fourth: materiality. He contends that the IPFR was refused essentially on the grounds that evidence to

demonstrate that the claimant was likely to gain significantly more clinical benefit from the intervention than would normally be expected for patients in the relevant population was lacking. The reference to alternative treatment was, he submits, no more than an ancillary point. The decision would have been the same even if the error had not been made.

104. I do not accept that the error was immaterial. A significant aspect of the assessment of clinical benefit for the claimant of CRS with HIPEC involved assessing the degree of benefit of that treatment compared to any alternative treatments available to her. So for example, the net benefit of CRS with HIPEC would be reduced if, as the panel suggested in the context of their first decision, there were (relevant) "improvements in cancer care including the benefit of genetic testing and new drugs". Whereas there could be no such reduction of the assessed benefit by reference to a treatment (EGFR inhibitors) that was unavailable to the claimant. The removal of this suggested alternative from the equation was material because it had the effect that the only alternative treatment available (systemic chemotherapy) was one which the panel were informed was almost universally unhelpful to patients in the claimant's position.

J. Ground 5: Economic considerations

105. The panel found that the cost of the treatment was £73,000. Although Lt Col Davies had stated the figure for the treatment was £65,000, the claimant does not suggest that difference gives rise to any public law error. The aspect of the decision that the claimant takes issue with is the failure to deduct the sum of £16,000 (or thereabouts) in respect of chemotherapy. Lt Col Davies addressed the question in the application whether there were any offset costs. He stated that there were because in the intervention was approved there would be a lesser requirement for full ongoing chemotherapy. He stated that £16,000 should be offset from the cost of CRS with HIPEC.

106. In the decision, the WHSSC recorded that the cost was £73,000 and they did not offset any cost in respect of the lesser requirement for chemotherapy. Nor did they give any explanation for not doing so.

107. Mr Lock QC submitted that as CRS with HIPEC was unlikely to be curative, it was likely that the need for systemic chemotherapy would only be postponed and so there would be not offset. The difficulties with this submission are, first, that there is nothing in the contemporaneous records of the decisions, or even in the evidence produced during the course of these proceedings, to support the submission that that is the view the WHSSC took. There is no evidence to support the submission that treatment with systemic chemotherapy would be used after CRS with HIPEC; a submission which is contrary to the information provided by the consultant colorectal surgeon. And if his view that there would be a lesser requirement for chemotherapy if the funding was approved was rejected, no reason for doing so was given.

108. Mr Lock QC submits that cost effectiveness was not a major part of the decision because the panel had concluded the request should be refused applying earlier criteria. I accept that is the case, but it is nevertheless apparent on the face of the decision that some consideration was given to economic considerations and so the question whether the panel reached an unlawful conclusion does arise.

109. Mr Lock QC also submitted that even if there should have been an offset, it is immaterial because there was no way this treatment was ever going to be found to be cost effective. In this regard he relied on PP90 itself and the statement that there is "no reliable data on cost effectiveness". In my judgement, if the defendants were to take the approach of concluding in response to an IPFR in respect of CRS with HIPEC that it automatically fails the cost effectiveness test because of the findings in PP90, that would amount to fettering their discretion and failing to apply the IPFR policy on the individual merits of each case. I do not suggest that is what they have done here, but that would be the effect if the line taken by Mr Lock QC in his submissions was taken.

110. For the reasons I have given, I consider that the panel failed to have regard to a material consideration in failing to offset the chemotherapy cost or, if they rejected Lt Col Davies statement that it fell to be offset, then they failed to state their conclusion or give any reasons for it.

111. Professor Doull has provided evidence at paragraphs 71 to 72 of his statement regarding cost effectiveness. In my judgement, that part of his evidence clearly falls foul of the *Ermakov* principles. It is true that the reasons given are not *contradictory* of the contemporaneous reasons, but that will often be the case where contemporaneous reasons do little more than recite the test and assert it is not met. In this case, the extensive reasons for the decisions given in evidence do not provide mere clarification or elucidation. They constitute new reasons given for the first time after the commencement of proceedings; and in addition the reasons are given by one panel member supported by one other, in the context of decisions taken by panels with many more members. Such evidence is not admissible. Accordingly, I also reject the contention that the error was immaterial.

K. Section 31(2A) of the Senior Courts Act 1981

112. The defendants submit that this is a case in which I should apply s.31(2A) of the Senior Courts Act 1981 and refuse relief on the grounds that it is highly likely that the outcome for the applicant would not have been substantially different but for the errors that I have identified.

113. In my judgement, this is very far indeed from an appropriate case in which to refuse relief under that section. It is not for me to put myself in the shoes of the decision-makers. It is plain that the "highly likely" threshold is nowhere close to being met in this case given, in particular, the misinterpretation of the policy and the failure to give any adequate reasons for rejecting the factors the claimant's treating clinician relied on as demonstrating the criteria were met in her case.

L. Conclusion

114. Accordingly, I grant permission and allow this application for judicial review. I will hear the parties on the precise form of the order.

THE INDIVIDUAL PATIENT FUNDING REQUEST PROCESS

QUALITY ASSURANCE ADVISORY GROUP

Terms of reference

1. OBJECTIVES OF THE GROUP

To monitor and support all Individual Patient Funding Request (IPFR) panels to ensure quality in decision-making and consistency across Wales.

2. TERMS OF REFERENCE

2.1 The Group will scrutinise the workload and efficiency of the IPFR processes in the health boards and The Welsh Health Specialised Services Committee.

2.2 The Group will receive and comment upon quarterly reports of anonymised random sample IPFR reports in relation to their completeness, timeliness and efficiency of communication.

2.3 The Group will report (via the Chair) to the Deputy Chief Medical Officer for Wales on the quality of the processes and highlight any concerns through the existing quality and clinical governance processes in NHS Wales.

2.4 The Group will normally meet on a quarterly basis, conducting its business online.

2.5 The Group will contribute to simulation exercises conducted with all panels at the annual IPFR training day and comment on the feedback from this exercise.

2.6 The Group will comment on aspects of quality assurance of the IPFR process raised by stakeholders as appropriate and required.

2.7 The Group will obtain professional and administrative support from the All Wales Therapeutic and Toxicology Centre (AWTTC).

2.8 The group will forward on any relevant topics of interest identified through the QA process that may be appropriate for consideration by Health Technology Wales.

3. MEMBERSHIP

3.1 Members will be appointed by AWTTC.

3.2 The Group will consist of the following members:

- One Chair - Clinical Director of AWTTC
- One deputy Chair – NHS Wales Public Health Consultant following nomination by the Director of Public Health Wales
- Lead IPFR co-ordinator
- Two lay representatives following nomination by Community Health Councils, patient organisations or self-nomination
- One non-medicine technologies group representative following nomination by Health Technology Wales.

4. DEPUTIES

With the exception of the Chair, in the event of a member being unable to attend a meeting of the Group, a named deputy, who has been nominated by the appropriate nominating body may attend in their place. Appointed deputies for all members of the Group, except for the Chair, may be elevated to the appropriate vacancy should a vacancy occur.

5. TERM OF OFFICE

The members' terms of office shall be 3 years. Appointees may serve 2 terms but the total period of appointment must not exceed 6 years. Reappointment is subject to a satisfactory attendance and performance appraisal which will be undertaken by the Chair.

6. MEETINGS

6.1 The Terms of Reference and roles and responsibilities of the Group should be readily available to any relevant party on request.

6.2 Secretariat service will be provided by AWTTC.

7. FINANCIAL OR PERSONAL INTERESTS

Members should declare, in advance, financial or personal interests, whether pecuniary or otherwise, in any related matter that is the subject of consideration. All declarations of interest made as a result of this provision, any action taken, should be noted in the minutes of the meeting.

8. CONFIDENTIALITY

To ensure confidentiality in all matters relating to patients and staff and to information obtained during the course of serving on the group.

All members will be expected to sign a declaration of confidentiality.

9. QUORUM

The quorum for meetings of the Group will be 3 members, comprising of one Lay Member and 2 non-lay representatives.

10. VALIDITY OF PROCEEDINGS

The validity of the proceedings of the Group is not affected by any vacancy among the members or any defect in the appointment of a member or a deputy.

11. VACANCIES IN MEMBERSHIP

Membership of the Group shall end if members:

- resign by giving notice in writing to the Chair
- are absent from three consecutive meetings, unless the Group is satisfied that the absence is due to a reasonable cause

- term of office expires
- death of member occurs.

12. TERMS OF REFERENCE REVIEW

The terms of reference will be reviewed by AWTTC at regular intervals and at least on an annual basis and amended as necessary to reflect policy and structural changes within the NHS in Wales.

December 2017

Last updated: February 2021

Report Title	**Audit Wales WHSSC Committee Governance Arrangements Update**	**Agenda Item**	2.4
Meeting Title	Joint Committee	**Meeting Date**	18/01/2022
FOI Status	Public		
Author (Job title)	Committee Secretary & Head of Corporate Services		
Executive Lead (Job title)	Committee Secretary & Head of Corporate Services		

Purpose of the Report	The purpose of this report is to provide an update on progress against the recommendations outlined in the Audit Wales WHSSC Committee Governance Arrangements report.				
Specific Action Required	RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☒	INFORM ☒

Recommendation(s)

Members are asked to:

- **Note** the progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report;
- **Note** the progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and
- **Approve** the updated audit tracker for submission to Audit Wales and to HB Audit Committees for assurance in February/March 2022.

AUDIT WALES WHSSC COMMITTEE GOVERNANCE ARRANGEMENTS UPDATE

1.0 SITUATION

The purpose of this report is to provide an update on progress against the recommendations outlined in the Audit Wales WHSSC Committee Governance Arrangements report.

2.0 BACKGROUND

In 2015, the Good Governance Institute (GGI) and Healthcare Inspectorate Wales (HIW) undertook two separate governance reviews for WHSSC which highlighted issues with WHSSC's governance arrangements. The GGI highlighted concerns relating to decision making and conflicts of interest, and identified the need to improve senior level clinical input as well as the need to create a more independent organisation that is free to make strong and sometimes unpopular (to some) decisions in the best interest of the people of Wales. HIW) conducted a review of clinical governance and found that WHSSC was beginning to strengthen its clinical governance arrangements but needed to strengthen its approach for monitoring service quality and also improve clinical engagement.

Since then, considering the increasing service and financial pressures, and the potentially changing landscape of national collaborative commissioning and NHS Executive as set out in Welsh Government's "A Healthier Wales", the Auditor General for Wales felt it was timely to undertake a review WHSSC's governance arrangements.

The Audit Wales review into Committee Governance arrangements at WHSSC was undertaken between March and June 2020, however as a result of the COVID-19 pandemic, aspects of the review were paused, and re-commenced in July. A survey was issued to all Health Boards and the fieldwork was concluded in October 2020.

The scope of the work included interviews with officers and independent members at WHSSC, observations from attending Joint Committee and sub-committee meetings, feedback from questionnaires issued to Health Board Chief Executive and Chairs and a review of corporate documents.

The findings were published in May 2021 in the Audit Wales Committee Governance Arrangements at WHSSC report.

The report outlined 4 recommendations for WHSSC and the 3 recommendations for Welsh Government.

3.0 ASSESSMENT

3.1 WHSSC Management Response

The report outlined 4 recommendations for WHSSC and progress against the actions outlined within the management response have been monitored through the Integrated Governance Committee (IGC).

The IGC received updates on progress on 12 October and 13 December 2021 and noted the positive progress made and endorsed the tracker for submission to the JC.

The updated tracker document is presented at ***Appendix 1*** for approval.

The majority of actions have been completed and there are only three areas of partial compliance on:

- **R3b page 12** – relating to the appointment of an AMD for Public Health – despite proactive efforts to recruit, we have been unable to fill the position,
- **R4a page 14 and R4b page 18** – stakeholder engagement exercise to develop a new specialised services strategy – The timetable for this is being revised in response to the system pressures related to the current wave of the pandemic and the letter from the CEO of NHS Wales regarding use of the Options Framework and the necessity to step down non-essential activities.

3.2 Welsh Government Management Response

The report outlined 3 recommendations for Welsh Government (WG) and progress against the WG management responses is monitored through discussions between the Chair, the WHSSC Managing Director and the Director General Health & Social Services/ NHS Wales Chief executive.

An update was received from Welsh Government on the 15 December 2021 advising that the advice on the NHS Executive is still being considered by the Minister, and that the Public Accounts and Public Administration Committee had written to the Director General/Chief Executive NHS Wales following her recent appearance before them to ask for an update on the WHSSC Audit Wales Reports recommendations 5, 6 and 7 and a response will be issued in due course. The Chair of WHSSC and the Committee Secretary met with Welsh Government officials on the 21 December 2021 and a further update is awaited on progress in early January 2022.

4.0 QUALITY, GOVERNANCE AND RISK

Audit Wales undertake an annual programme of independent external audits on NHS services, and NHS bodies are required to present a formal management response to the recommendations through a public report.

Once the updated tracker has been considered and approved by the Joint Committee on the 18 January 2022 the tracking report will be shared with the NHS Wales Board Secretaries in HBs for inclusion on HB Audit Committee agendas in February/March 2022 to ensure that all NHS bodies are able to maintain a line of sight on the progress being made, noting WHSSC's status as a Joint Committee of each HB in Wales.

Risk management is a key element of developing WHSSC's services and risk assessments are undertaken as required.

5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report;
- **Note** the progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and
- **Approve** the updated audit tracker for submission to Audit Wales and to HB Audit Committees for assurance in February/March 2022.

Governance and Assurance	
Link to Strategic Objectives	
Link to Integrated Commissioning Plan	**-**
Health and Care Standards	Governance, Leadership and Accountability Safe Care Effective Care
Principles of Prudent Healthcare	Only do what is needed Reduce Inappropriate Variation
Institute for HealthCare Improvement Quadruple Aim	Improving Patient Experience (including quality and Satisfaction)
Organisational Implications	
Quality, Safety & Patient Experience	The Management responses outline activities to strengthen and develop WHSSC's impact on quality, safety and patient experience.
Finance/Resource Implications	Some improvement actions may require the application of additional resources.
Population Health	There are no specific population health implications related to the activity outlined in this report.
Legal Implications (including equality & diversity, socio economic duty etc)	There are no specific legal implications related to the activity outlined in this report. There are no adverse impacts concerning equality and diversity or the socio economic duty.
Long Term Implications (incl WBFG Act 2015)	The WHSSC management responses take into consideration the long-term impact of decisions, to support better working with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.
Report History (Meeting/Date/ Summary of Outcome	Integrated Governance Committee 13 December 2021 - Supported
Appendices	**Appendix 1** - WHSSC Audit Wales Governance Report Tracker – Jan 2022

Recommendations from the Audit Wales Report
Welsh Health Specialised Services Committee Governance Arrangements

Audit Tracker– Update January 2022

In May 2021, Audit Wales published the "Welsh Health Specialised Services Committee Governance Arrangements"[1] which found that the governance, management and planning arrangements at WHSSC have improved, however the impact of COVID-19 will require a clear strategy to recover key services and that the Welsh Government's long-term model for health and social care 'A Healthier Wales', and the references made to WHSSC should be re-visited.

Audit Wales made a number of recommendations for both WHSSC and Welsh Government and the management response was presented to the Joint Committee on the 13 July 2021. Progress against actions to address the recommendations will be monitored through the Integrated Governance Committee (IGC).

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
Quality governance and management				
R1 Increase the focus on quality at the Joint Committee. This should ensure effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients.				
a) We will include in our routine reports to Joint Committee (JC) on quality, performance and finance a section highlighting key areas of concern to promote effective focus and discussion.	Sept 2021	Director of Finance Director of Nursing & Quality Director of Planning	As a consequence of the COVID-19 pandemic the routine reports on activity, quality and financial performance presented to each Joint Committee (JC) meeting have evolved to include additional detailed analysis of the position and any key points to promote effective focus and discussion. For 2021 the position is very stable with an improving underspend position.	Completed

[1] Welsh Health Specialised Services Committee Governance Arrangements (audit.wales)

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			In addition, to ensure effective governance we have reviewed the structure of the committee report template for routine reports (including for quality, performance and finance) and have updated it to include a section on governance, quality and risk which specifically captures key areas of concern to promote effective focus and discussion. This ensures effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients. This will be used from January 2022 onwards. The new template was considered by the Corporate Directors Group Board (CDGB) in September and in November 2021, and was considered by the Integrated Governance Committee (IGC) on the 12 October and will approved by them on the 13 December 2021. The JC received a detailed presentation on "Recovery" at its meeting on the 7 September 2021 which focussed on quality, performance and finance and which highlighted key areas of risk and	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			concern. The presentation was also given to the Management Group (MG) sub committee on the 23 September 2021 for assurance.	
b) We will develop a revised suite of routine reports for JC that will include elements of the activity reporting, that we introduced during the pandemic, and will take into account the quality and outcome reporting that is currently being developed by Welsh Government (WG).	Mar 2022	Director of Finance Director of Nursing & Quality Director of Planning	As a consequence of the COVID-19 pandemic the routine reports on activity, quality and financial performance presented to each JC were reset to include more explicit, measurable intentions to measure achievement against. This includes detailed analysis of the position and any key points to promote effective focus and discussion. Detailed activity performance reports are prepared on a monthly basis and provide qualitative information and quantitive data to the JC and MG. The reports detail delivery by provider and specialty against historic performance and waiting times. Prospectively activity reports will also include performance compared to provider agreed recovery plans and waiting list profiles. A presentation dashboard format of the waiting times position has been agreed and details variation from agreed activity delivery, referral rates and overall waiting lists whenever possible.	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			The activity dashboard will evolve and align to the quality and outcome reporting that is currently being developed by Welsh Government (WG). The WHSSC Commissioning Assurance Framework (CAF) was considered by the JC in May 2021 and approved in September 2021. Assurance against the CAF is achieved through service specifications, Service Level Agreement (SLA) and performance monitoring through the Quality and Patient Safety Committee (QPS) and the Integrated Governance Committee (IGC).	
c) We will encourage members of the JC to engage in consideration and discussion of key areas of concern that are highlighted.	Sept 2021	Chair of WHSSC	The Joint Committee received a detailed presentation on "Recovery" at its meeting on the 7 September 2021 which focussed on quality, performance and finance and which highlighted key areas of risk and concern. The Recovery presentation encouraged wide-ranging discussion and it was agreed that structured highlight reports will be presented to the JC from November 2021 onwards. Following on from the recovery discussion WHSSC have requested further detailed plans from providers as	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			additional detail was required from HBs in some areas. As part of WHSSC's commitment to improving the effectiveness and efficiency of the Joint Committee and WHSSC we have embarked on a development programme, which included the JC participating in an equity workshop in May 2021, and there are plans for further development sessions to review the Integrated Commissioning Plan (ICP) and to revisit equity going forward.	
d) We will include routinely at JC an invitation for an oral report to be delivered by, or on behalf of, the Chair of the WHSSC Quality & Patient Safety Committee (Q&PSC) based on the written report from the Chair of Q&PSC.	Sep 2021	Chair of WHSSC/ Committee Secretary	Each JC meeting receives a Chairs assurance report from each of the sub-committees which provides an update on the business discussions of each sub-committee meeting. Each relevant chair is asked to present the Chairs report and to outline any salient points during the JC meeting. The Chair of WHSSC invites the Chair of the Quality & Patient Safety Committee (QPSC)/and or the Director of Nursing and Quality as Executive lead to provide a verbal update based on the written report at each JC meeting.	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
Programme Management				
R2 Implement clear programme management arrangements for the introduction of new commissioned services. This should include clear and explicit milestones which are set from concept through to completion (i.e. early in the development through to post implementation benefits analysis). Progress reporting against those milestones should then form part of reporting into the Joint Committee.				
a) Building Programme Management competency/capacity A number of new staff have recently joined WHSSC in senior positions in the planning team who bring with them strong programme and project management skills. There are 'lunch and learn' sessions planned to share this approach, and the use of common templates is embedding, it is anticipated that this approach will grow programme management competency and capacity within the organisation. The approach is already starting to embed in the way the planning team operates, with programme management approaches already applied to the two strategic pieces committed to through the 2021 ICP (namely paediatrics and mental health) and to the management of the CIAG prioritisation process. Common templates apply to highlight and exception reporting, risk logs and timelines/milestones.	Nov 2021	Director of Planning	We have built programme management capacity and competency and implemented programme management arrangements for the introduction of new commissioned services including: • undertaking a recruitment exercise to appoint 3 dedicated Project Manager roles (2 generic PM roles and one to specifically support Traumatic Stress Wales (TSW)), The posts work as part of the PMO hosted within the planning directorate to share learning, skill and competencies, as well as integrating a project management approach across WHSSC, • the PM roles will review our existing programme management methodology, and introduce new specific templates for project initiation, project highlight reports, risk assessments and project closure reports,	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			• develop a project management training package, • provide project highlight updates to JC. Programme Management arrangements are now in place for all new programmes of strategic work (e.g. Paediatrics and Mental Health).	
b) Programme management on WHSSC commissioned services. Programme arrangements have previously been used for strategic service reviews and the development of the PET (positron Emission Therapy) business case. We will further develop this approach as outlined above, i.e. through a common approach to programme management across the organisation and to and the use of common templates. These will become the basis of reporting through programme structures and as necessary to Joint Committee.	Nov 2021	Director of Planning	We have built programme management capacity and competency and implemented programme management arrangements for the introduction of new commissioned services including: • the programme management arrangements for the All Wales Positron Emission Tomography (PET) Programme demonstrate how WHSSC has developed and strengthened its approach to programme management and the Programme Business Case (PBC) for the project was approved by HBs and endorsed by Welsh Government (WG) Ministers on the 25 August 2021. The All Wales PET Programme Board will utilise its governance structure and reporting arrangements to provide ongoing assurance on	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			progress and it is proposed that it reports into the JC going forward, • we have appointed 3 dedicated Project Manager roles. The posts work as part of the PMO hosted within the planning Directorate to share learning, skill and competencies, as well as integrating a project management approach across WHSSC, • the PM roles will review our existing programme management methodology, and introducing specific templates for project initiation, project highlight reports, risk assessments and project closure reports, • developing a project management training package, • providing project highlight updates to JC. With increased project and programme management capacity and competency, this structured approach will be adopted consistently for all future major projects.	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
c) HB Commissioned Services – when services are not the sole responsibility of WHSSC, and where the senior responsible officer is outside of WHSSC, we will contribute to the programme arrangements, offering clarity about the role of WHSSC and the scope of the responsibilities it has within the programme. We will seek to deliver against any key milestones set, and report progress, risk and exception accordingly.	Oct 2021	Director of Planning	We have built programme management capacity and competency and implemented programme management arrangements for the introduction of projects for new commissioned services. Each project has its own specific terms of reference outlining the purpose and scope of the project, and including the membership and roles and responsibilities. Where services are not the sole responsibility of WHSSC we ensure that the membership includes representatives from Health Boards (HBs), professional groups etc and that the project plan includes measurable milestones with regular reports on progress being presented to the reporting sponsor, for example the JC.	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
Recovery Planning				
R3 In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on: a. the backlog of waits for specialised services, how these will be managed whilst reducing patient harm. b. potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening. c. the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.				
a) Managing backlog of waits whilst reducing harm i. Introduction of real-time monitoring and reporting of waiting times to Management Group and Joint Committee ii. Review of recovery plans with Welsh provider Health Boards, iii. Regular Reset and Recovery meetings with services to monitor performance against plans. Significant variance from plans will be managed through the WHSSC escalation process iv. Introduction of the WHSSC Commissioner Assurance Framework (CAF), v. Workshop with Joint Committee members on how to deliver 'equity' in specialised services. Report shared with HBs and WG.	Sep 2021 Jul 2021 From Apr 2021 In Place	Director of Finance Director of Nursing & Quality Director of Planning	i. Real time monthly monitoring and reporting of waiting times are presented to the MG on a monthly basis and to each JC meeting through regular performance reports, which include trend analysis and information on comparisons to support effective performance management, ii. WHSSC have discussed recovery plans with Welsh providers through Service Level Agreement (SLA) meetings and received recovery positions from each of the welsh providers of tertiary services. There was an initial delay in receiving the recovery plans, and some detail is still awaited, iii. WHSSC hold regular Reset and Recovery meetings with services	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			to monitor performance against plans. A joint Executive to Executive meeting has been agreed between WHSSC, CVUHB, SBUHB and BCUHB, in order to discuss the welsh position across the plans and where necessary identify alternate pathways or welsh patients. Any Significant variance from plans will be managed through the WHSSC escalation process, discussed with the relevant provider and reported to the QPS Committee and the JC, iv. The final Commissioning Assurance Framework (CAF) was formally approved by the JC on the 7 September 2021 and is supported by a Performance Assurance Framework, Risk Management Strategy, Escalation Process and a Patient Engagement & Experience Framework, v. Following on from a discussion at JC in February 2021, as part of WHSSC's commitment to improving the effectiveness and efficiency of the Joint Committee and WHSSC we have embarked	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			on a development programme, which included the JC participating in an equity workshop in May 2021. The findings of the workshop were shared with HBs and Welsh Government.	
b) Potential impact and cost of managing hidden demand. i. Introduction of demand monitoring compared to historical levels for high volume specialties, findings to be reported to the WG Planned Care Board and HBs to inform non- WHSSC commissioned pathway development. ii. Appointment of an Associate Medical Director for Public Health to work with Health Board Directors of Public Health to assess impact.	In place Q3/Q4 2021-22	Director of Finance Director of Nursing & Quality Director of Planning Medical Director	i. The introduction of demand monitoring comparing historical levels for high volume specialities is routinely undertaken and the findings are reported to the WG Planned Care Board and HBs to inform non- WHSSC commissioned pathway Development. Demand monitoring continuously features as part of the ICP process, board presentations to HBs and through strategic reviews highlighting variations in access using data systems, ii. Despite proactive efforts WHSSC have not been able to appoint an Associate Medical Director for Public Health and alternative models are being explored.	Partially Completed
c)Financial consequences of services that were commissioned and under-delivered as a result of COVID-19	In Place	Director of Finance	Information pertaining to the financial consequences of services that were commissioned and under delivered as a consequence of COVID-19 are	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
i. This information is already captured through our contract monitoring process and compared against the national block contract framework implemented to maintain income stability through COVID-19. This will inform future planned baselines and contract negotiation, where the negotiation is within our control. WHSSC is working with contracted providers across Wales and England to establish their specialised recovery trajectories and where appropriate will secure recovery funding from WG to direct to providers for recovery performance if above established contracted baseline levels.			monitored through block contracts which remain in place during 2021-22 with the position reviewed for 2022-23. The planned position for 2022-23 will be return to cost and volume contracting to ensure full incentives to deliver commissioned volumes. WHSSC are fully participating in the English recovery incentive process with additional funding secured from Welsh Government.	
d) Reporting Analysis We will review and analyse the business intelligence gathered from the actions outlined in points a, b and c above and use the real-time and historical data to inform our decision making on managing existing, and developing new specialised commissioned services. We will report our analysis and outcomes to the Joint Committee, Welsh Government and the Management Group as appropriate.	Sept 2021	Director of Finance Director of Nursing & Quality Director of Planning	We have reviewed and analysed the business intelligence gathered from real-time monitoring and reporting of waiting times, demand monitoring compared to historical levels for high volume specialties and contract monitoring and developed a full information reporting system which provides monthly updates on delivery against historic activity levels, delivery against recovery plans, referral levels against plan and waiting list positions.	Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			We report our analysis and outcomes to the JC, Welsh Government and the MG as appropriate.	
Specialised Services Strategy				
R4 The current specialised services strategy was approved in 2012. WHSSC should develop and approve a new strategy during 2021. This should: a. embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post pandemic recovery. b. be informed by a review of the extent of the wider services already commissioned by WHSSC, by developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning. The review should assess services: • which do not demonstrate clinical efficacy or patient • outcome (stop); • which should no longer be considered specialised and therefore could transfer to become core services of health boards (transfer); • where alternative interventions provide better outcome for the investment (change); currently commissioned, which should continue.				
a. Embrace New Innovations i. We will continue to utilise our well-established horizon scanning process to identify new therapeutic and technological innovations, drive value and benchmark services against other commissioning models to support , short, medium, and long-term approach for post pandemic recovery, ii. We will continue to develop our relationship with NICE, AWMSG and	Jul 2021 Q3	Managing Director Director of Finance Director of Nursing & Quality	i. The dual processes of horizon scanning and prioritisation is firmly embedded in WHSSC's commissioning practice and has been applied successfully since 2016. The process helps ensure the NHS in Wales effectively commissions' new and innovative treatments that are both clinically and cost effective, and are made available in a timely manner.	Partially Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
HTW in relation to the evaluation of new drugs and interventions, iii. We will engage with developments for digital and Artificial intelligence (AI), iv. We will continue our regular dialogue and knowledge sharing with the four nations' specialised services commissioners, v. We will continue to build upon our existing relationships with the Royal Colleges, vi. We will continue to develop our work on value-based commissioning, vii. We will develop a communication and engagement plan to support and inform the strategy. viii. As previously agreed with Joint Committee a stakeholder engagement exercise will be undertaken to gain insight on long-term ambitions and to inform how we shape and design our services for the future. This will inform the Specialised Services Strategy and the supporting the 3 year integrated commissioning plan.	2021-22 In Place Dec 2021 Dec 2021	Director of Planning	Horizon scanning identifies new interventions which may be suitable for funding, and prioritisation allows them to be ranked according to a set of pre-determined criteria, including clinical and cost effectiveness. This information when combined with information around demands from existing services and interventions will underpin and feed into the development of the WHSSC Integrated Commissioning Plan (ICP). A horizon scanning exercise was undertaken by the Medical Directorate between January and May 2021, which informed the new Interventions Prioritisation Panel on the 20 July 2021, and the Clinical Impact Advisory Group (CIAG) prioritisation day on the 3 August 2021, ii. WHSSC continues to develop its relationships including: a. Three members of the WHSS team are current members of NICE appraisal committees (AC – TA committee A; ID – TA committee D; SD – HST committee). AC is also Chair of the NICE Welsh Health Network,	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			b. WHSSC has a built a strong working relationship with HTW. A MoU was signed in 2018 (currently being updated) and WHSSC is represented on their Assessment Group, Appraisal Group and Stakeholder Forum. A joint proposal to support all Wales policy development of HTW guidance was supported by MG in June and the HTW Executive Board in July 2021. Funding for two posts (Project Manager and Admin) to support this work is now being sought from WG c. WHSSC also has a close working relationship with AWMSG, focused mainly on medicines management and horizon scanning. A MoU is now being developed between WHSSC and AWMSG to formalise these links and to share knowledge and expertise. The appointment of a WHSSC Medicines Management Pharmacist (due to start January 2022) will	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			further strengthen this partnership. iii. We continue to engage with developments for digital and Artificial intelligence (AI) iv. We continue to attend the four nations' specialised services commissioners meetings, v. We continue to build upon our existing relationships with the Royal Colleges, vi. We continue to develop our work on value-based commissioning, vii. We have developed a communication and engagement plan to support and inform the strategy which will be presented to the CDGB in January 2022, viii. It was previously agreed with Joint Committee that a stakeholder engagement exercise would be undertaken in December 2021/January 2022 to gain insight on long term ambitions and to inform how we shape and design our services for the future. This would inform the Specialised Services Strategy which would be presented to the JC in January/March 2022. The timetable for this is however being revised in response to the	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			system pressures related to the current wave of the pandemic and the letter from Judith Paget CEO of NHS Wales regarding use of the Options Framework and the necessity to step down non-essential activities.	
b. Approach to Review of Services will be considered in strategy engagement **i.** The draft strategy will consider our approach to the review of the existing portfolio of commissioned services and undertake a value based services assessment to assess if existing services are still categorised as specialised, ii. We will continue to undertake our annual prioritisation panel with HB's to assess new specialised services that could be commissioned, iii. We will continue to undertake a process of continuous horizon scanning to identify potential new and emerging services and drugs, and to focus on existing and new hyper-specialised services, iv. WHSSC will investigate opportunities for strengthening its information function through internal re-organisation and investment. This will include the	Sept 2021 March 2022	Director of Finance Director of Nursing & Quality Director of Planning	i. The draft new specialised services strategy: a. It was previously agreed with Joint Committee a stakeholder engagement exercise would be undertaken in December 2021/January 2022 to gain insight on long term ambitions and to inform how we shape and design our services for the future. This would inform the Specialised Services Strategy which would be presented to the JC in January/March 2022. The timetable for this is however being revised in response to the system pressures related to the	Partially Completed

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
development of an outcome manager post to support both the WHSSC strategic approach to outcome measurement as well as a feasibility analysis of currently available tools. We will pursue our planned investment to utilise the SAIL database with a view to assessing the population impact of services in a number of pilot areas. As previously agreed with the Joint Committee a stakeholder engagement exercise will be undertaken to gain insight from our stakeholders on long term ambitions and to inform how we shape and design our services for the future. This will inform transferring commissioned services into and out of the WHSSC portfolio to meet stakeholder and patient demand.			current wave of the pandemic and the letter from Judith Paget, CEO of NHS Wales regarding use of the Options Framework and the necessity to step down non-essential activities. b. On the 28 September 2021 the WHSSC executive team met with Improvement Cymru (IC) to discuss and explore potential options for them to support WHSSC in developing its new specialist services strategy and WHSSC agreed to hold a Quality Improvement workshop facilitated by IC in January 2022 and to develop improvement and audit days with nursing teams with a view to undertaking our own internal competency assessment to drive improvement, and considered predictive modelling for interventions, and international collaborative networks,	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			c. WHSSC are required to agree annually those services that should be planned on a national basis and those that should be planned locally (section 1.1.4 WHSSC SO's), to support this, following a discussion at the JC 7 September 2021 a workshop was held with the MG on the 25 November 2021 to evaluate the commissioning of services. MG members were requested to submit expressions of interest to evaluate specific commissioned services in order to evaluate the merits of the service being commissioned locally at HB level or through WHSSC. d. A recovery workshop was held with the MG on the 16 December 2021 to discuss recovery Planning and Quality and Outcome Improvement for Patients. ii. The annual prioritisation panel with HB's to assess new specialised services that could be commissioned was held on the 20 July 2021,	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
			iii. The process of continuous horizon scanning to identify potential new and emerging services and drugs, and to focus on existing and new hyper-specialised services was undertaken between January and May 2021 and informed the prioritisation panel on the 20 July 2021, iv. We have investigated opportunities for strengthening our information function through internal re-organisation and investment and have strengthened the staffing model of the information function to enable more timely information. The WHSSC staffing structure has been reviewed to include a senior outcomes commissioner to design outcome systems and monitor and report outcomes.	
Welsh Government Recommendation - Independent member recruitment				
R5 Review the options to recruit and retain WHSSC independent members. This should include considering measures to expand the range of NHS bodies that WHSSC members can be drawn from, and remuneration for undertaking the role				
Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated: I am aware there have been challenges in securing nominations from health boards			<u>WG update received 15/12/21</u> WHSSC are in discussions with WG on the IM remuneration and time commitment issues and a report was	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
to undertake the independent member role at WHSSC. My officials have been looking at options in relation to recruitment, remuneration and retention of independent members and I am currently considering their advice before the matter is raised with the Minister. There are a number of options, some of which could be achieved relatively simply and others which would require changes to the legislation. I will write to you again when we have a clear way forward.			presented to the Chairs group in October 2021 requesting their views. The Chair of WHSSC and the Committee Secretary meet with WG officials on a monthly basis to progress the IM remuneration discussions. A progress report will be presented to the Joint Committee on the 18 January 2021.	
Welsh Government Recommendation - Sub-regional and regional programme management				
R6 This is linked to Recommendation 2 made to WHSSC in this report. When new regional or sub-regional specialised services are planned which are not the sole responsibility of WHSSC, ensure that effective multi- partner programme management arrangements are in place from concept through to completion (i.e. early in the development through to post-implementation benefits analysis).				
Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated: As you have highlighted, whilst some key service areas like major trauma have been developed successfully and with good collaboration across organisations, the timelines around such changes have been slow and often hampered by a lack of clarity on who is driving the process. I agree with your view that end-to-end programme management of such schemes, which are not within the sole remit of WHSSC, should be strengthened.			<u>WG update received 15/12/21</u> This is linked to R2 and an update will be received in due course.	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
The National Clinical Framework which we published on 22 March, sets out a vision for a health system that is co-ordinated centrally and delivered locally or through regional collaborations. Implementation will be taken forward through NHS planning and quality improvement approaches and our accountability arrangements with NHS bodies.				
Welsh Government Recommendation - Future governance and accountability arrangements for specialised services				
R7 A Healthier Wales included a commitment to review the WHSSC arrangements along with other national hosted and specialist advisory functions. COVID-19 has contributed to delays in taking forward that action. It is recommended that the Welsh Government set a revised timescale for the action and use the findings of this report to inform any further work looking at governance and accountability arrangements for commissioning specialised services as part of a wider consolidation of current national activity.				
Letter from Dr Andrew Goodall to Adrian Crompton, 2 June 2021 stated: A Healthier Wales committed to reviewing the WHSSC arrangements alongside other hosted national and specialised functions, in the context of the development of the NHS Executive function. The position of WHSSC within this landscape needs to be carefully considered. On the one hand, there are strengths in the current system whereby health boards, through the joint committee, retain overall responsibility for the commissioning of specialised services. This requires collaboration and mature discussion from both the commissioner			<u>WG update received 15/12/21</u> Welsh Government have advised that the advice on the NHS Executive is still being considered by the Minister. The Public Accounts and Public Administration Committee has written to the Director General/Chief Executive NHS Wales following her recent appearance before them to ask for an update on the WHSSC Audit Wales Reports recommendations 5, 6 and 7 and a	

Response/ Action	Target Date	Exec Lead	Progress/Comments January 2022	RAG
and provider standpoint. However, I recognise the inherent risk of conflict of interest in this arrangement and note the reference made in your report to the Good Governance Institute's report of 2015 which suggested a more national model may be appropriate. In my letter to health boards of 14 August 2019, I indicated that, as recommended by the Parliamentary Review, the governance and hosting arrangements for the existing Joint Committees would be streamlined and standardised. I also said that it was intended the NHS Executive would be become a member of the Joint Committees' Boards in order to ensure there is a stronger national focus to decision making. However, the thinking at the time was that the joint committee functions would not be subsumed into the NHS Executive function. We will continue to look at this as the NHS Executive function develops further and I will update you should there be any change to the direction of travel I indicated in 2019.			response will be issued in due course.	

Report Title	Assurance on Patients Waiting for Specialised Services	**Agenda Item**	2.5
Meeting Title	**Joint Committee**	**Meeting Date**	18/01/2022
FOI Status	Open/Public		
Author (Job title)	Director of Planning		
Executive Lead (Job title)	Director of Planning		

Purpose of the Report	The Joint Committee regularly receives information on the numbers of patients waiting for and being treated within specialised services. Given the growing waiting lists, Joint Committee asked for assurance that patients are being supported adequately whilst waiting to be seen. This report provides detail on the processes being used within WHSSC to seek assurance around how patients are being managed whilst on a waiting list.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☒	INFORM ☐

Recommendation(s)

Members are asked to:

- Receive **assurance** that there are robust processes in place to gain assurance that provider organisations are managing and supporting patients waiting for specialised care and treatment;
- **Note** that the position in our NHS England specialised service providers has been generally more stable with recovery and activity across most contracts back to pre-pandemic levels. However given the rise in cases of the Omicron variant and the reports in the media that Trusts in NHS England are suspending elective care, the WHSS Team will urgently ascertain the position in our main specialised service contractors in NHS England. This will be reported to Joint Committee in the routine activity report; and
- **Note** the report.

ASSURANCE ON PATIENTS WAITING FOR SPECIALISED SERVICES

1.0 SITUATION

The Joint Committee (JC) regularly receives information on the numbers of patients waiting for and being treated within specialised services. Given the growing waiting lists, Joint Committee asked for assurance that patients are being supported adequately whilst waiting to be seen. This report provides detail on the processes being used within WHSSC to seek assurance around how patients are being managed whilst on a waiting list.

2.0 BACKGROUND

Activity reports are presented to the JC at their bi-monthly meetings. Since the onset of the pandemic, waiting lists across all of the WHSSC commissioned specialties in Welsh provider organisations have generally grown. The position in our NHS England specialised service providers has been generally more stable with recovery and activity across most contracts back to pre-pandemic levels.

However, due to the increasing waiting times, the JC has expressed concern and sought assurance that patients receiving treatment though WHSSC commissioned services are being treated according to their clinical priority and that they are being adequately supported and managed whilst waiting for treatment.

The WHSS Team have sought assurances via a number of mechanisms about how patients are being prioritised for treatment and supported whilst waiting and these are described below.

This report focuses on the Welsh Health Boards (HBs) as this is where the main issues regarding waiting times are seen.

However given the rise of cases of the Omicron variant and the situation being reported in the media with regard to Trusts in NHS England suspending elective services, the WHSS Team will urgently seek a position update from our main contractors in NHS England. This position will be reported to the JC through the routine activity report.

3.0 ASSESSMENT

There are a number of ways that the WHSS Team engage with services in NHS Wales to gain assurance.

Each commissioning team have Risk, Recovery and Assurance meetings at a service level. At each of these meetings activity and waiting times are discussed and plans for increasing activity, trajectories for year end and how the service plans to recover are also considered. For each service area, how the patients are prioritised and what contact is made with patients waiting is ascertained and followed up at each meeting to ensure that the processes are current.

There are Executive led Service Level Agreement (SLA) meetings with each of our Welsh providers. Again activity and waiting times across all of the portfolios are discussed along with recovery trajectories and how patients are prioritised and supported.

The Quality Team meet with members of the quality and safety departments at each provider HB and discuss outcomes within WHSSC commissioned services, look at incidents and complaints within services and monitor action plans to address the incidents.

Assurances from each of the services include:

- HBs are clinically prioritising referrals, using the Royal College of Surgeons (RCS) classification P1-P4 to guide their decision making. The prioritisation assigned to patients is from clinical discussion,
- Most HBs have clinically led groups for theatre utilisation decisions assigning theatre sessions according to identified priorities,
- Paediatric surgery is dealt with differently recognising that the RCS definitions do not relate well to children who need surgery often according to their age rather than clinical presentation,
- All HBs have processes whereby they keep the patients waiting informed and have provided patients with details of how to contact services if conditions deteriorate,
- These discussions with services are continuous and happen each time the Commissioning Team meet with the service and at SLA meetings.

Routine contracting meetings are held with specialist service providers in NHS England. Similarly at these meetings there is a discussion regarding activity, waiting times and how patients are being managed whilst waiting. As reported here and in the routine activity report, the position in our NHS England specialised service providers has been generally more stable with recovery and activity across most contracts back to pre-pandemic levels.

However given the rise of cases of the Omicron variant and the situation being reported in the media with regard to Trusts in NHS England suspending elective services, the WHSS Team will urgently seek a position update from our main

contractors in NHS England. This position will be reported to the JC through the routine activity report

4.0 RECOMMENDATIONS

Members are asked to:

- Receive **assurance** that there are robust processes in place to gain assurance that provider organisations are managing and supporting patients waiting for specialised care and treatment;
- **Note** that the position in our NHS England specialised service providers has been generally more stable with recovery and activity across most contracts back to pre-pandemic levels. However given the rise in cases of the Omicron variant and the reports in the media that Trusts in NHS England are suspending elective care, the WHSS Team will urgently ascertain the position in our main specialised service contractors in NHS England. This will be reported to Joint Committee in the routine activity report; and
- **Note** the report.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	Activity reports are presented to the JC at their bi-monthly meetings. Since the onset of the pandemic, waiting lists across all of the WHSSC commissioned specialties in Welsh provider organisations have generally grown
Health and Care Standards	Safe Care Effective Care Timely Care
Principles of Prudent Healthcare	Care for Those with the greatest health need first Reduce inappropriate variation Choose an item.
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	Ensuring that patients are supported whilst waiting and treated according to clinical priority is key to a high quality and safe service.
Finance/Resource Implications	None identified in the report
Population Health	Patients treated according to clinical priority
Legal Implications (including equality & diversity, socio economic duty etc)	Patients treated according to clinical priority
Long Term Implications (incl WBFG Act 2015)	
Report History (Meeting/Date/ Summary of Outcome	
Appendices	None

Report Title	**WHSSC Independent Member (IM) Remuneration**	**Agenda Item**	2.6
Meeting Title	Joint Committee	**Meeting Date**	18/01/2022
FOI Status	Public		
Author (Job title)	Committee Secretary & Head of Corporate Services		
Executive Lead (Job title)	Committee Secretary & Head of Corporate Services		

Purpose of the Report	The purpose of this report is to provide the Joint Committee (JC) with an update on discussions with Welsh Government to review the options to recruit and retain WHSSC Independent members (IMs) in response to the recommendation outlined in the Audit Wales report "WHSSC Committee Governance Arrangements".				
Specific Action Required	RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☒	INFORM ☒

Recommendation(s)
Members are asked to:

- **Note** the report,
- **Discuss** and **approve** the proposal to transition to a fair and open selection process for appointing WHSSC IMs through advertising the vacancies through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs,
- **Discuss** and **approve** that the existing arrangements for appointing a CTM audit lead IM, can transition to advertising for an Audit/Finance IM through a fair and open selection process through advertising the vacancy through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs,
- **Discuss** and **approve** the suggested proposals to remunerate WHSSC IMs including the requirement for a review following the recruitment process,
- **Discuss** and **approve** the additional annual cost of remunerating WHSSC IMs and **approve** an uplift to the Direct Running Costs (DRC) budget to enable a financial pool of resource to recurrently fund the remunerated IM positions.

WHSSC INDEPENDENT MEMBER (IM) REMUNERATION

1.0 SITUATION

The purpose of this report is to provide the Joint Committee (JC) with an update on discussions with Welsh Government to review the options to recruit and retain WHSSC Independent members (IMs) in response to the recommendation outlined in the Audit Wales report "WHSSC Committee Governance Arrangements".

2.0 BACKGROUND

In 2015, two separate reviews highlighted issues with WHSSC's governance arrangements. The Good Governance Institute highlighted concerns relating to decision making and conflicts of interest, and identified the need to improve senior level clinical input as well as the need to create a more independent organisation that is free to make strong and sometimes unpopular (to some) decisions in the best interest of the people of Wales. In the same year, Healthcare Inspectorate Wales (HIW) conducted a review of clinical governance at WHSSC. That review found that WHSSC was beginning to strengthen its clinical governance arrangements but needed to strengthen its approach for monitoring service quality.

In 2020 the Auditor General for Wales felt it was timely to undertake a review of WHSSC's governance arrangements

The Audit Wales review into *Committee Governance arrangements at WHSSC* was undertaken between March and July 2020; a survey was issued to all HBs and the fieldwork concluded in October 2020. The scope of the work included interviews with officers and IMs at WHSSC, observations from attending JC and sub-committee meetings, feedback from questionnaires issued to HB Chief Executives and Chairs and a review of corporate documents. The findings were published in May 2021[1].

The report outlined four recommendations for WHSSC and three recommendations for Welsh Government (WG).

One of the recommendations for WG stated that they should:

> *[Recommendation 5] – 'Review the options to recruit and retain WHSSC independent members. This should include considering measures to expand the range of NHS bodies that WHSSC members can be drawn from, and remuneration for undertaking the role'.*

[1] https://audit.wales/sites/default/files/publications/WHSSC-Eng.pdf

The arrangements for remunerating IMs is the responsibility of WG, therefore this report provides an update on discussions between WHSSC, WG and the NHS Wales Chairs group to explore the potential options for remunerating WHSSC IMs and proposes that the existing WHSSC IMs are remunerated with a set time commitment for the role, together with the introduction of a selection process.

3.0 ASSESSMENT

3.1 WHSSC Independent Members (IMs)

WHSSC is a Joint Committee (JC) of the seven HBs, set up to plan and commission a full range of specialised services for the Welsh population. The JC is hosted by Cwm Taf Morgannwg University Health Board (CTMUHB) on behalf of each of the seven Health Boards (HBs) in Wales. The Joint Committee (JC) is comprised of:

- A remunerated chair appointed by the Minister for Health and Social Services;
- **Three IMs -** (a vice chair and two non-officer members) two of whom are drawn from the IMs of the HBs, and one selected as an Audit lead from CTMUHB, (in accordance with the hosting agreement between WHSSC and CTMUHB);
- the Chief Executive of each HB;
- various executive officers of WHSSC employed by the host HB, and
- The Chief Executives of the three Welsh NHS Trusts, who are Associate Members.

Historically, the additional time commitment required of HB IM members to perform the WHSSC IM roles has not been recognised and no additional remuneration has been provided. Whilst there has been a role profile, the specific skills required for a WHSSC IM, as opposed to a HB IM, have not been fully explored or described. There have been longstanding issues in recruiting IMs to sit on the WHSSC JC and the meeting was frequently at risk of being non-quorate.

Feedback from both prospective IMs and former IMs has suggested that the complexity of the role is not manageable alongside a HB IM role. In particular, time is not compensated for within the HB time commitment and the IMs who have been nominated have effectively been using their own personal time, unpaid, to undertake the role. Due to the difficulty of finding replacements, IMs have also been unable to step down from their tenure on WHSSC in a timely fashion. These concerns were raised with the previous Minister for Health and Social Services by the WHSSC Chair and were also brought to the attention of the NHS Wales Chairs Group.

In light of the recommendations in the Audit Wales report, recognition that the role of IM at WHSSC is a complex one, that there is a pressure on the time commitment required of IMs of HBs, and the ongoing risk of the JC being non-

quorate, WG officials have been in discussion with WHSSC and the NHS Wales Chairs group.

3.2 Consultation with NHS Chair's Group

On 05 October, a paper was presented to the NHS Wales Chairs' meeting, which sought to address the recommendation from Audit Wales that IMs of WHSSC should be remunerated and/or drawn from a wider pool. Chairs raised a number of issues which officials undertook to explore with representatives of the Chairs Peer Group. A meeting was held on 2 November between those representatives and representatives of WG. At the meeting the following was agreed:

- Whilst the immediate risk of non-quoracy of WHSSC had been averted by the appointment of two new members, there was still a need to achieve resilience going forward,
- The Chairs were content to put in place measures to remunerate WHSSC IMs, so long as a review period was built in. It was suggested 6 months after the IMs were in post, however, it was agreed this was likely to be too soon and 12 months would be more appropriate,
- Looking ahead, a clear signal should be given that legislative amendment may be required in order to widen the pool from which IMs members can be drawn, if remuneration does not prove to be the solution to the issue,
- Officials need to be mindful of perceptions of inequity in the remuneration rates across NHS bodies in Wales and that this may need to be subject to further consideration as part of a wider piece of work,
- That changing the arrangements between the host and WHSSC in relation to the audit committee representative would not require other hosting organisations to review their own arrangements. It was for each organisation that hosts other bodies to consider the most appropriate governance arrangements in conjunction with those hosted bodies.

WG officials confirmed they would continue to work alongside WHSSC and the hosting body as appropriate to implement this change, and that WHSSC should proceed with agreeing the arrangements for appointment of the IMs via the JC governance arrangements.

3.3 WHSSC Independent Member Appointment

In accordance with para 1.4.3 of the WHSSC Model Standing Orders, the JC must agree the appointment process for IMs with the approval of each of the HBs. WG have advised that it is a matter for WHSSC to recruit, and that the roles do not need to be advertised through the WG public appointments process. Therefore, the JC are asked to approve the suggested approach.

3.3.1 Recruitment process

The current recruitment process for appointing WHSSC IMs is one of nomination by HBs to the non-remunerated IM positions. Traditionally, the HB Chairs would canvass interest amongst HB IM's and then put the names of nominated HB IM forward to the Chair of WHSSC, who would then

formally accept the HB IM as an unremunerated member of WHSSC for an initial 2 year period.

Once the WHSSC IM roles are remunerated, we will need to transition to a fair and open selection process and it is proposed that the IMs are recruited through advertising the vacancies through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs. WG officials have taken advice from the Public Appointments Unit and agreed that a 'light touch' selection process will be appropriate for the WHSSC IM roles as they are non-regulated appointments. This recognises that HB IMs have already been subject to a public appointments process and demonstrated their suitability for that role.

To support the recruitment exercise a concise 'Information for Candidates' pack will be developed setting out several key criteria which the candidate would be expected to evidence in an 'expression of interest' format. These expressions of interest would be sought via the individual HB Chairs and the Board Secretaries, (with eligibility confined to existing HB IMs) and be submitted to the WHSSC Chair for consideration. There would then need to be a selection panel comprised appropriately, which will assess the suitability of the candidates for the role against the specific criteria. WG officials will work with the WHSSC Committee Secretary and the HB Board Secretaries to develop a documented procedure to support the proposal.

The JC are asked to **approve** the proposal to transition to a fair and open selection process for appointing WHSSC IMs through advertising the vacancies through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs.

3.3.2 Audit Lead Independent Member

If remuneration is to be introduced for WHSSC IMs, as indicated above this will require a fair selection process. The current hosting agreement between WHSSC and CTMUHB requires that one of the three IMs to WHSSC will be the CTMUHB IM who sits on the CTMUHB Audit & Risk Committee (ARC) (which also oversees WHSSC). If this arrangement were kept in place, this would mean that one of the remunerated WHSSC IMs will have been selected via a different process and will secure remuneration for a role they have not competed for and for which they have not been required to demonstrate the skills and attributes. This does not seem equitable and could be challenged by others who might want to have the experience of being on WHSSC and who might feel they have the skills to do so, including audit and finance skills.

Following discussions WG, WHSSC and the host body, CTMUHB it has been agreed that the current arrangements for appointing a CTMUHB audit lead are no-longer required, and that the audit lead role can be recruited through a fair and open recruitment process. This will enable the

appointment arrangements to be consistent with the other two HB IM roles, with an emphasis on the skills required to participate in the ARC. The hosting agreement between the host HB and the seven HBs will be amended accordingly. The audit lead IM will be required to attend the CTMUHB part 2 Audit and Risk Committee which WHSSC attends to discharge its audit and accountability requirements.

The JC are requested to **approve** that the existing arrangements for appointing a CTM audit lead IM, can transition to advertising for an Audit/Finance IM through a fair and open selection process through advertising the vacancy through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs.

3.3.3 Transition Phase for Remunerating Independent Members

Consideration needs to be given to how to transition from an unpaid to a remunerated system, and how this will affect the existing IMs of WHSSC, all of whom were appointed/re-appointed for 2 years periods in 2021, specifically:

- Powys IM - Re-appointed for a consecutive 2 year period on the 1 April 2021 – term of office ends 31 March 2023,
- Cardiff & Vale UHB (CVUHB) IM - 1 June 2021 for 2 years - term of office ends 31 May 2023,
- CTMUHB Audit lead - 1 May 2021 for 2 years - term of office ends 30 Apr 2023.

In order to ensure a smooth transition, based on the arrangement, being considered for appointing substantive Vice Chairs at the three NHS Wales Trusts, it is suggested that WHSSC continue with the current WHSSC IMs tenures and introduce remuneration with effect from 1 April 2022. The alternative approach would be to step down existing members and then embark on the new recruitment process, however, this would have business continuity implications for the Committee, exacerbated by operational pressures within HBs as a consequence of the COVID-19 pandemic.

Following the discussions with WG and WHSSC to confirm the terms of remuneration, time commitment and the recruitment process WHSSC have requested a formal letter to confirm the agreement which will be shared with the JC when received.

It is proposed that:

i. the existing WHSSC IMs are remunerated from 1 April 2022 until 31 March 2023 for a time commitment of 2 days per month at Band 3 of the WG IM remuneration scale,
ii. the transition to a fair and open selection process for appointing the Audit/Finance WHSSC IM commences in June 2022, through advertising the vacancies through the HB Chairs and the Board Secretaries, with

eligibility confined to existing HB IMs. The intention is to appoint a new Audit/Finance lead in autumn 2022. This also allows for the three IMs to have staggered start/end tenure dates. The hosting agreement between CTMUHB and WHSSC will be updated to reflect this change,

iii. the transition to a fair and open selection process for appointing the two remaining HB WHSSC IMs to commence in early 2023 through advertising the vacancies through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs, with a view to appointing two substantive new IM's for a 2 year period from 1 April 2023 onwards.

It is proposed that the new recruitment round is undertaken in advance of April 2023 to align with the tenure of existing IMs. As requested by the NHS Wales Chairs Group a review into the principle of remunerating IM positions to elicit a wider pool of candidates will be undertaken following the completion of the recruitment rounds for the three IMs and the feedback will be fed back to the Chairs group.

The JC are requested to **approve** the suggested proposals to remunerate WHSSC IMs including the requirement for a review following the recruitment process.

Should any of the existing WHSSC IMs wish to stand down earlier than their current tenure, the appointment process for the remunerated position would be brought forward.

3.4 Funding of the Remuneration Package

Following discussions with former and current WHSSC IMs and WG officials the required time commitment of an IM of WHSSC has been estimated to be two days per month. Basing the remuneration on that of the WHSSC Chair which is broadly comparable to Band 3 HB Chair level of the WG IM remuneration table, this equates to an estimated total annual cost of around £21,000. This comprises of a daily rate of £278 for an IM and £306 for the Vice Chair.

It is proposed that the remuneration is aligned to the Chair's role within WHSSC and not on the IMs' substantive roles at their home HB. The separate rate recognises the specific requirements of the WHSSC IM role and provides equity for all members. These costs would need to be met from WHSSCs Direct Running Cost (DRC) budget and an uplift will be required to fund this.

The JC are requested to **approve** the additional annual cost of remunerating WHSSC IMs and approve an uplift to the DRC budget to enable a financial pool of resource to recurrently fund the remunerated IM positions. If approved the additional cost will be added to the approved Integrated Commissioning Plan (ICP) for completeness.

4.0 QUALITY, GOVERNANCE AND RISK

The current HB and WHSSC model Standing Orders make clear that the Vice Chair and IMs for WHSSC should be appointed from existing non-officer members of the HBs. It is unlikely that the Standing Orders will need to be revised to reflect the change that these positions will be remunerated and have an additional time commitment, as they are already drafted widely enough to accommodate this change. However, as detailed, the procedure to support the proposal will be developed in collaboration with the WHSSC Committee Secretary and the HB Board Secretaries. Consideration will also be given to the administrative arrangements for ensuring the additional remuneration at, what may be a different rate to that of their host HB.

If approved, the hosting agreement between CTMUHB and the seven HBs will be amended to reflect the change concerning the recruitment of the Audit Lead IM.

In terms of risks the longstanding risks to the JC of being non-quorate will not be addressed without addressing the issue of IM recruitment.

5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report;
- **Discuss** and **approve** the proposal to transition to a fair and open selection process for appointing WHSSC IMs through advertising the vacancies through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs;
- **Discuss** and **approve** that the existing arrangements for appointing a CTM audit lead IM, can transition to advertising for an Audit/Finance IM through a fair and open selection process through advertising the vacancy through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs;
- **Discuss** and **approve** the suggested proposals to remunerate WHSSC IMs including the requirement for a review following the recruitment process; and
- **Discuss** and **approve** the additional annual cost of remunerating WHSSC IMs and **approve** an uplift to the Direct Running Costs (DRC) budget to enable a financial pool of resource to recurrently fund the remunerated IM positions.

Governance and Assurance	
Link to Strategic Objectives	
Link to Integrated Commissioning Plan	This report will have an impact on the future financial resourcing element of the ICP.
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	All
Institute for HealthCare Improvement Quadruple Aim	Improving Provider Satisfaction
Organisational Implications	
Quality, Safety & Patient Experience	WG have advised that it is a matter for WHSSC to recruit, and that the roles do not need to be advertised through the WG public appointments process. WHSSC will ensure that the recruitment process follows the quality standards set by WG.
Finance/Resource Implications	Financial Resource implications are considered within the report.
Population Health	No adverse implications relating to population health have been identified.
Legal Implications (including equality & diversity, socio economic duty etc)	No adverse implications relating to equality and diversity or Welsh language have been identified. The recruitment process will ensure a fair and transparent process and welcome applicants from underrepresented groups, including female applicants and those from an ethnic minority. WHSSC acknowledges the importance of developing and growing bilingual capabilities in public appointments in Wales, and welcome applications from candidates who demonstrate their capability to work in both English and Welsh.
Long Term Implications (incl WBFG Act 2015)	WHSSC is committed to considering the long-term impact of its decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.
Report History (Meeting/Date/ Summary of Outcome	**-**
Appendices	**-**

Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Llywodraeth Cymru
Welsh Government

Kate Eden
Chair
Welsh Health Specialised Services Committee

Kate.Eden2@wales.nhs.uk

12 January 2022

Dear Kate,

REMUNERATION OF WHSSC INDEPENDENT MEMBERS

I would like to thank you and the WHSSC team for working with Welsh Government officials to take forward the recommendation of Audit Wales that, in order to attract and retain independent members of WHSSC, they should be remunerated. This is something the Minister agreed should be explored and it seems that progress is being made. I am very grateful to you for presenting the paper prepared in association with Welsh Government officials at the NHS Wales Chairs meeting in October last year. This allowed Chairs to provide their comments and observations which have been considered. I am also grateful to Jacqui Evans for discussing the proposals with the Board Secretaries' Group.

I now confirm that Welsh Government has asked WHSSC to develop an appropriate appointments process for selecting independent members from within the cadre of health board independent members. This reflects the provisions of paragraph 1.4.3 of the WHSSC Model Standing Orders. There is no requirement to involve the Public Bodies Unit in this process as these are not regulated appointments; however, our officials are of course happy to continue to work alongside you as this process is developed and to provide any advice you may require.

WHSSC will also agree with the health boards a suitable package of remuneration which recognises the additional time commitment required by health board independent members when fulfilling the role of a WHSSC independent member. It is expected that the time commitment of a WHSSC independent member will be two days per month and the remuneration of a member will be £278 per day and the vice chair £306 per day, making the total annual costs around £21,000 per annum. This is based on Band 3 of the current remuneration rates for NHS Wales Chairs and non-executive board members and is commensurate with the current rates payable in respect of the WHSSC Chair's role.

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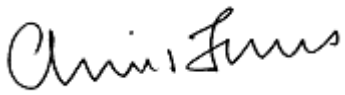
It has also been agreed with the NHS Wales Chairs that this arrangement will be reviewed after 12 months' operation.

Yours sincerely,



PROFESSOR CHRIS JONES

Report Title	**COVID-19 Period Activity Report Month 08 2021-2022**	**Agenda Item**	3.1
Meeting Title	**Joint Committee**	**Meeting Date**	18/01/2022
FOI Status	Open/Public		
Author (Job title)	Head of Information		
Executive Lead (Job title)	Director of Finance		

Purpose of the Report	The purpose of this report is to highlight the scale of the decrease in activity levels during the peak COVID-19 period, and whether there are any signs of recovery in specialised services activity. These activity decreases are shown in the context of the potential risk re patient harms and of the loss of value from nationally agreed financial block contract arrangements.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☐	INFORM ☒

Recommendation(s)

Members are asked to:

- **Note** the report

COVID-19 PERIOD ACTIVITY REPORT
MONTH 08 2021-2022

1.0 SITUATION

This report sets out the scale of decrease in specialised services activity delivered for the Welsh population by providers in England, together with the two major supra-regional providers in South Wales. The context for this report is to illustrate the decrease during the peak COVID-19 periods, and to inform the level of potential harms to specialised services patients. It also illustrates the loss of financial value from the necessary national block contracting arrangements introduced to provide overall system stability, but this is covered in greater detail in the separate monthly Finance report. Recovery rates, access comparisons across Health Boards and waiting lists are also considered.

2.0 BACKGROUND

The impact of COVID-19 on the level of provision of healthcare has been felt across all levels of service, including specialised services which have traditionally been assumed to be essential services. WHSSC has used the national data sources from DHCW (previously known as NWIS) together with monthly contract monitoring information to inform this report. Members are asked to note that the DHCW data for Admitted Patient Care and Patients Waiting includes all Welsh activity at providers with a WHSSC contract, and also includes some non-specialist activity that may be included in local Health Board contracts.

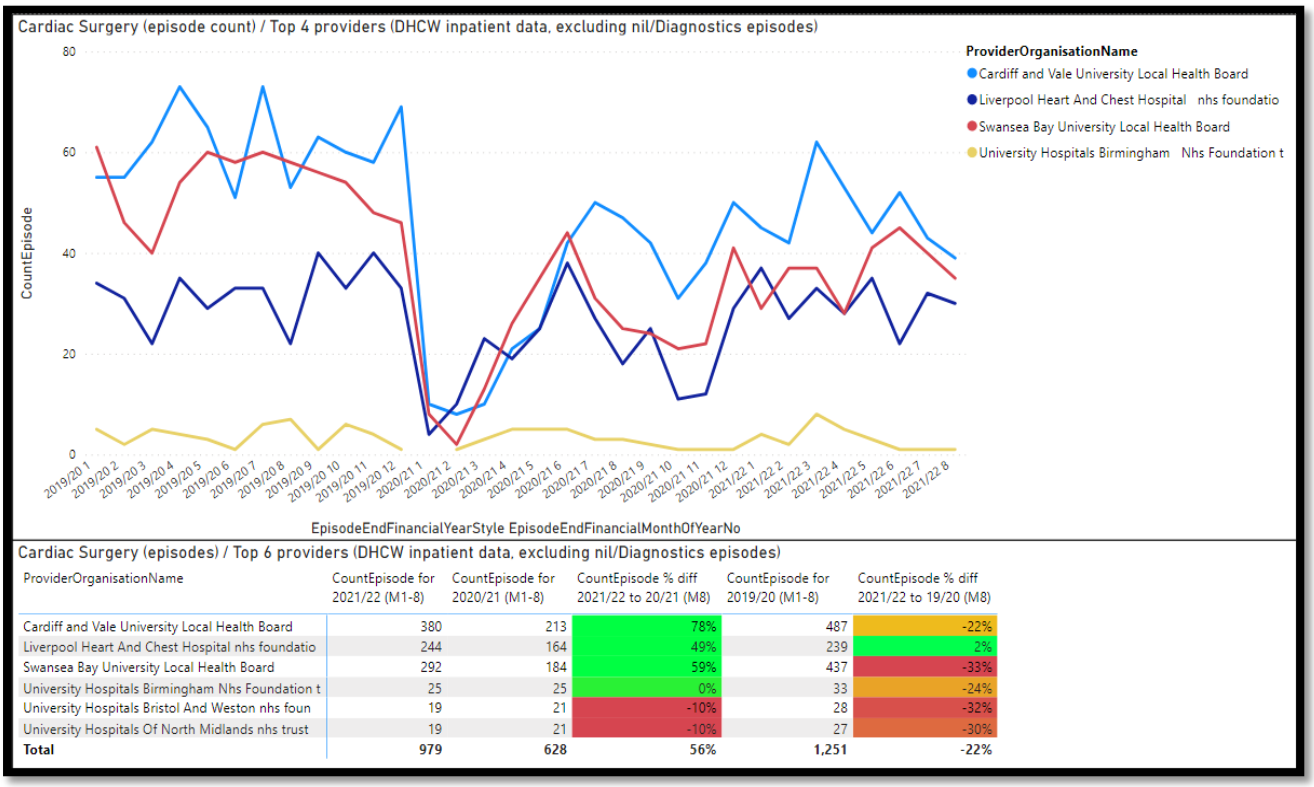
3.0 ASSESSMENT

This report has been rearranged from the version used in 2020/21 to deal with Specialties/areas on an all-Wales basis. Specialties/areas covered in this report include:

- Cardiac Surgery
- Thoracic Surgery
- Neurosurgery
- Plastic Surgery
- Paediatric Cardiac Surgery
- Paediatric Surgery
- English provider activity (all specialist and non-specialist
- Annex A and B – summary of Cardiff & Vale and Swansea Bay contracts
- Appendix A – charts of DHCW data showing inpatient activity at NHS England Trusts with a WHSSC contract (specialist and non-specialist)

3.1 Cardiac Surgery

3.1.1 Cardiac Surgery – Activity and Access Rate Summary



Cardiac Surgery (episodes) / Top 6 providers (DHCW inpatient data, excluding nil/Diagnostics episodes)

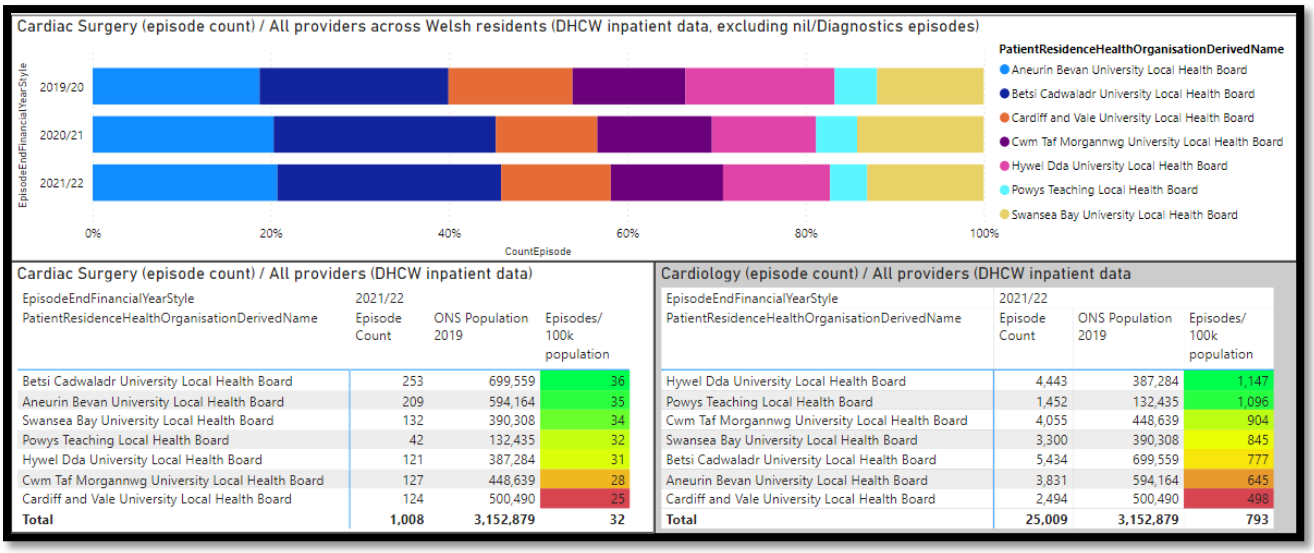
ProviderOrganisationName	CountEpisode for 2021/22 (M1-8)	CountEpisode for 2020/21 (M1-8)	CountEpisode % diff 2021/22 to 20/21 (M8)	CountEpisode for 2019/20 (M1-8)	CountEpisode % diff 2021/22 to 19/20 (M8)
Cardiff and Vale University Local Health Board	380	213	78%	487	-22%
Liverpool Heart And Chest Hospital nhs foundatio	244	164	49%	239	2%
Swansea Bay University Local Health Board	292	184	59%	437	-33%
University Hospitals Birmingham Nhs Foundation t	25	25	0%	33	-24%
University Hospitals Bristol And Weston nhs foun	19	21	-10%	28	-32%
University Hospitals Of North Midlands nhs trust	19	21	-10%	27	-30%
Total	**979**	**628**	**56%**	**1,251**	**-22%**

Data source: DHCW central data warehouse; **Note: inpatient activity excl. non-procedure/diagnostic episodes**

The above table highlights the variance in Cardiac Surgery inpatient recovery across the main specialist providers, with Liverpool Heart & Chest showing the highest and quickest recovery. The main 3 providers show the expected inverse relationship to the COVID-19 waves across the UK, with activity increasing again.

There was a concerning drop in the volume of Cardiac inpatient activity reported during the COVID-19 period, which is recovering but stood at 48% less activity overall in 2020/21 compared to 2019/20. Using activity to date this year 2021/22 (Month 8), activity is already 56% more than last year, but is still 22% lower than to the same month in 2019/20. Historically, Cardiac surgery is seen as an urgent elective specialty with high levels of emergency and inter hospital referrals and lower levels of elective referrals. The decrease is therefore of concern and indicative of a significant risk of harm during the highest COVID-19 periods. The risk of COVID infection in cardiac patients was a real risk identified at the outset of the period and outcomes for positive patients were poor.

There has been some proactive switching into TAVI for selected sub groups of patients but numbers are not material.



EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2021/22 Episode Count	ONS Population 2019	Episodes/ 100k population
Betsi Cadwaladr University Local Health Board	253	699,559	36
Aneurin Bevan University Local Health Board	209	594,164	35
Swansea Bay University Local Health Board	132	390,308	34
Powys Teaching Local Health Board	42	132,435	32
Hywel Dda University Local Health Board	121	387,284	31
Cwm Taf Morgannwg University Local Health Board	127	448,639	28
Cardiff and Vale University Local Health Board	124	500,490	25
Total	**1,008**	**3,152,879**	**32**

EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2021/22 Episode Count	ONS Population 2019	Episodes/ 100k population
Hywel Dda University Local Health Board	4,443	387,284	1,147
Powys Teaching Local Health Board	1,452	132,435	1,096
Cwm Taf Morgannwg University Local Health Board	4,055	448,639	904
Swansea Bay University Local Health Board	3,300	390,308	845
Betsi Cadwaladr University Local Health Board	5,434	699,559	777
Aneurin Bevan University Local Health Board	3,831	594,164	645
Cardiff and Vale University Local Health Board	2,494	500,490	498
Total	**25,009**	**3,152,879**	**793**

Data source: DHCW central data warehouse; **Note: inpatient activity excl. non-procedure/diagnostic episodes**

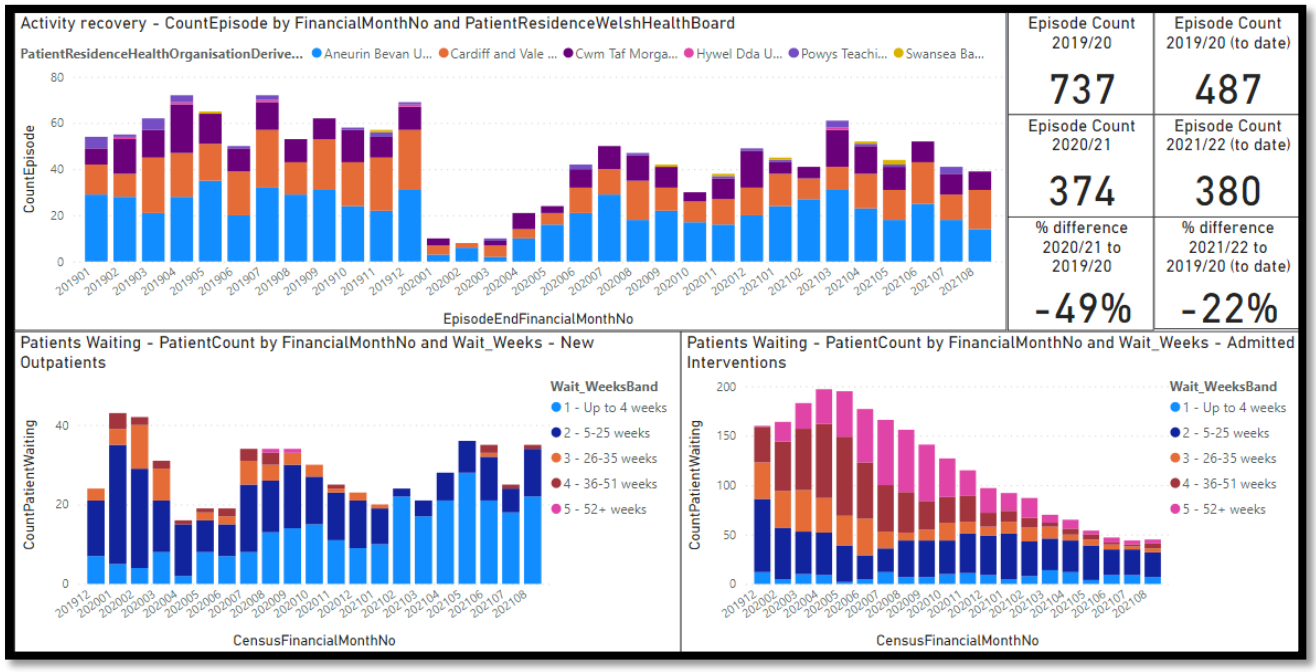
Access rates across the Health Boards varied the most during the initial COVID-19 wave, but have stabilised in recent months to almost the same split of the available activity as 2019/20. However, Betsi Cadwaladr is reflecting an increased share of the activity, due to the good recovery at Liverpool Heart & Chest.

Inpatient episodes per 100k population varies significantly overall across the Health Board areas, from 25 to 36 so far in 2021/22 as per the small table above to the left.

Interestingly, the access rates vary to those of Cardiology (mostly non-specialist), which is shown in the small table above to the right. This data is shown for information only, as this is not WHSSC-commissioned, except for some specific devices/interventions.

3.1.2 Cardiac Surgery – Recovery and Waiting Lists

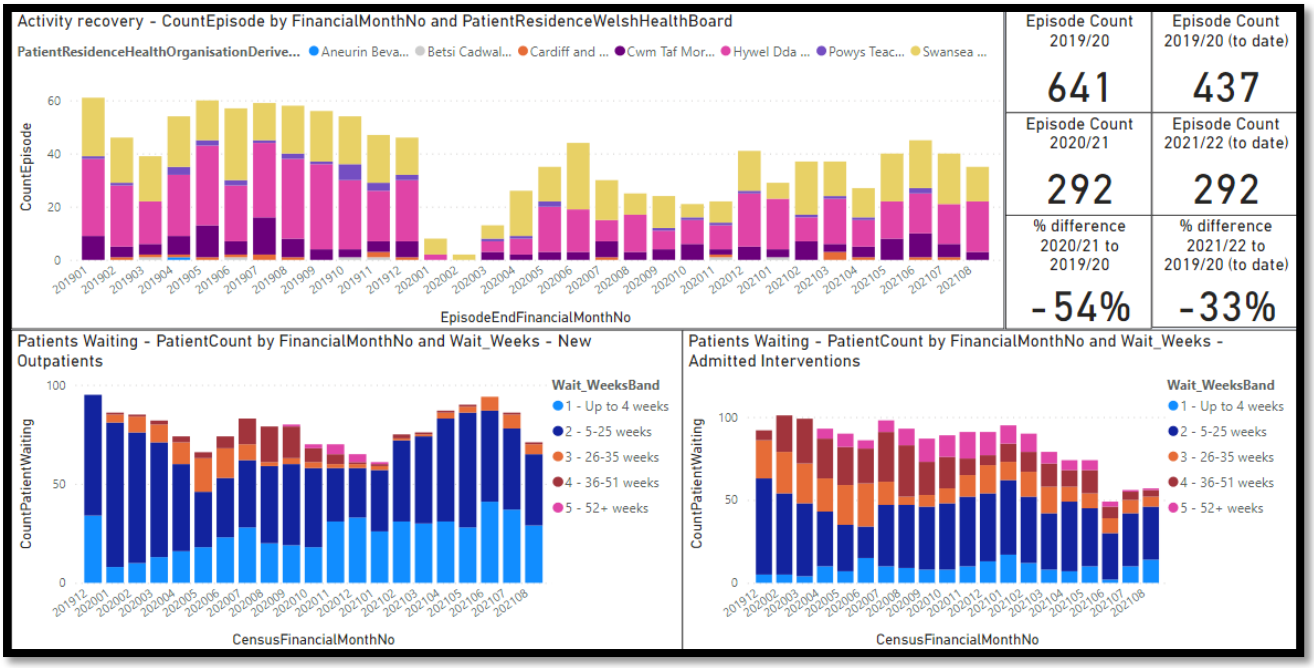
Cardiff & Vale UHB



Data source: DHCW central data warehouse; **Note: inpatient activity excl. non-procedure/diagnostic episodes**

The tables above show a summary of the position at Cardiff & Vale in relation to Cardiac Surgery. Whilst the chart showing New Outpatients shows a growing increase in new referrals (those between 0-4 weeks) again, elective activity has kept pace to the point that the waiting list for admissions has reduced to almost a third of pre-COVID-19 demand, with very few patients now waiting over 26 weeks.

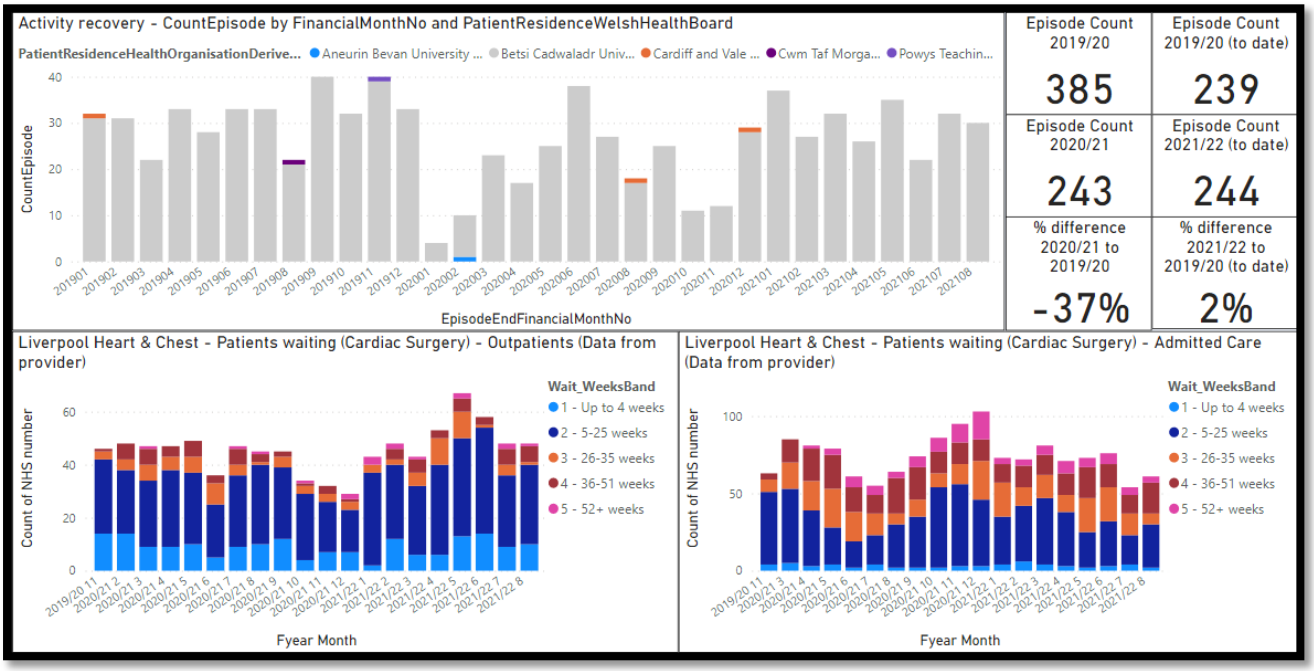
Swansea Bay UHB



Data source: DHCW central data warehouse; **Note: inpatient activity excl. non-procedure/diagnostic episodes**

The tables above show a summary of the position at Swansea Bay in relation to Cardiac Surgery. Whilst the chart showing New Outpatients shows a growing increase in new referrals (those between 0-4 weeks) again to Pre-COVID-19 levels, elective activity has kept pace to the point that the waiting list for admissions has reduced to about half of Pre-COVID-19 demand, with about 25% now waiting over 26 weeks.

Liverpool Heart & Chest Hospital



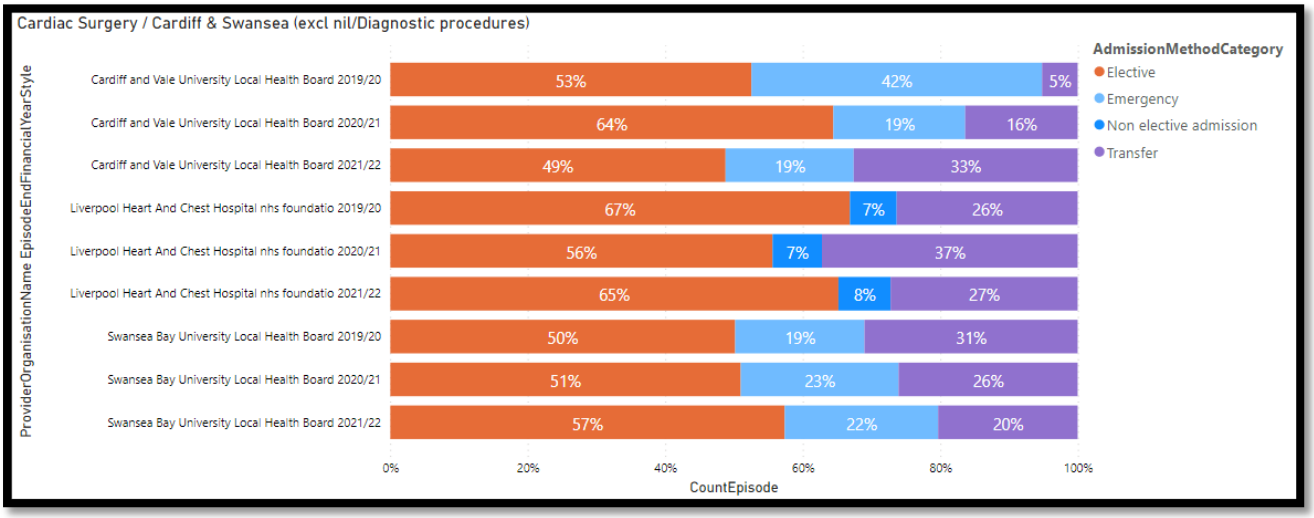
Data source: DHCW central data warehouse; **Note: inpatient activity excl. non-procedure/diagnostic episodes**

The tables above show a summary of the position at Liverpool Heart & Chest in relation to Cardiac Surgery. Whilst the chart showing New Outpatients shows a similar pattern in new referrals (those between 0-4 weeks) again to Pre-COVID-19 levels, elective activity is also back to the same Pre-COVID-19 levels. The waiting list for admissions is also roughly the same again, but with just over half now waiting over 26 weeks.

Overall notes

An additional note is that the reported pattern of activity is historically different between Wales and England, with England reporting typically higher proportions of elective/transferred expected overnight stay activity. Welsh centres have reported that the pressure from transfers squeezes capacity available for elective cases with a resulting adverse impact on the waiting list.

The below chart shows the elective/emergency percentages of the overall inpatient activity. Whilst Liverpool Heart & Chest appears to be back to 2019/20 splits, Cardiff has seen a marked increase in Transferred activity, while Swansea has seen a decrease.



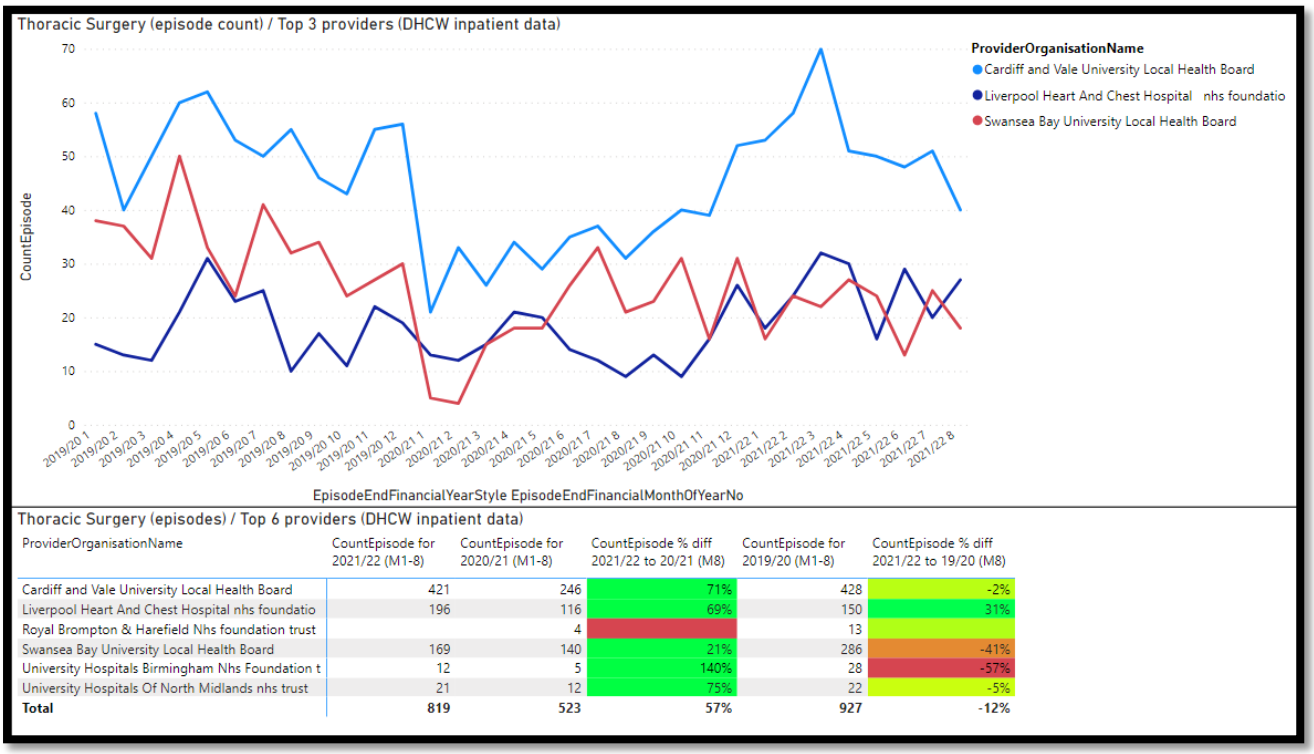
Data source: DHCW central data warehouse; all inpatient activity excl. non-procedure/diagnostic episodes

Specialised Planner comments:

Both South Wales centres continue to drive forward the improvement work based on the recommendations from the GIRFT review. It is important to note that whilst referrals to cardiac surgery are increasing and the number of long waiting patients are relatively low compared to pre–COVID-19 there is a risk that as local health boards manage the recovery of cardiology waits that there could be a significant increase in numbers and time waiting for cardiac surgery over the forthcoming months.

3.2 Thoracic Surgery

3.2.1 Thoracic Surgery – Activity and Access Rate Summary



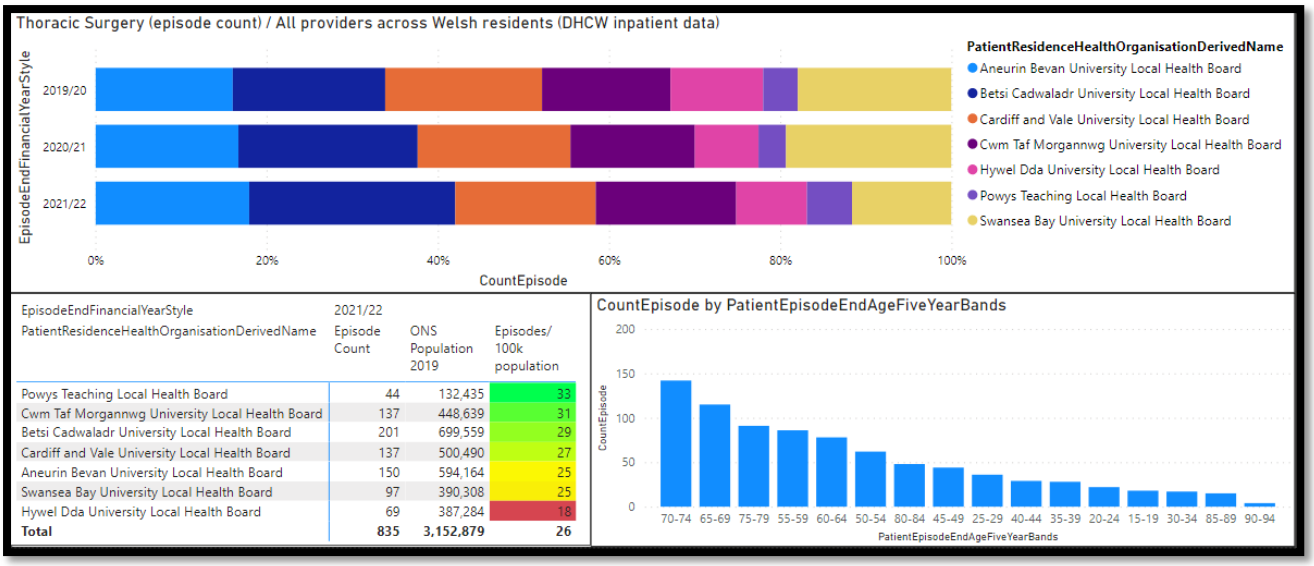
Thoracic Surgery (episodes) / Top 6 providers (DHCW inpatient data)

ProviderOrganisationName	CountEpisode for 2021/22 (M1-8)	CountEpisode for 2020/21 (M1-8)	CountEpisode % diff 2021/22 to 20/21 (M8)	CountEpisode for 2019/20 (M1-8)	CountEpisode % diff 2021/22 to 19/20 (M8)
Cardiff and Vale University Local Health Board	421	246	71%	428	-2%
Liverpool Heart And Chest Hospital nhs foundatio	196	116	69%	150	31%
Royal Brompton & Harefield Nhs foundation trust		4		13	
Swansea Bay University Local Health Board	169	140	21%	286	-41%
University Hospitals Birmingham Nhs Foundation t	12	5	140%	28	-57%
University Hospitals Of North Midlands nhs trust	21	12	75%	22	-5%
Total	**819**	**523**	**57%**	**927**	**-12%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Thoracic Surgery inpatient recovery across the main specialist providers, with Liverpool Heart & Chest showing the highest and quickest recovery to activity. Liverpool actually has performed inpatient episodes 31% higher to date than 2019/20. Cardiff & Vale is showing similar activity to 2019/20 to the same month. However, Swansea Bay is showing a 41% drop in activity to date compared to 2019/20, although this is still 21% more than they had performed to this point in 2020/21.

The drop in the volume of Thoracic inpatient activity reported over the COVID-19 period stood at 35% less activity overall in 2020/21 compared to 2019/20. Using activity to date this year 2021/22 (Month 8), activity is 12% less than 2019/20, but is 57% higher in total than to the same month last year.



EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2021/22 Episode Count	ONS Population 2019	Episodes/ 100k population
Powys Teaching Local Health Board	44	132,435	33
Cwm Taf Morgannwg University Local Health Board	137	448,639	31
Betsi Cadwaladr University Local Health Board	201	699,559	29
Cardiff and Vale University Local Health Board	137	500,490	27
Aneurin Bevan University Local Health Board	150	594,164	25
Swansea Bay University Local Health Board	97	390,308	25
Hywel Dda University Local Health Board	69	387,284	18
Total	**835**	**3,152,879**	**26**

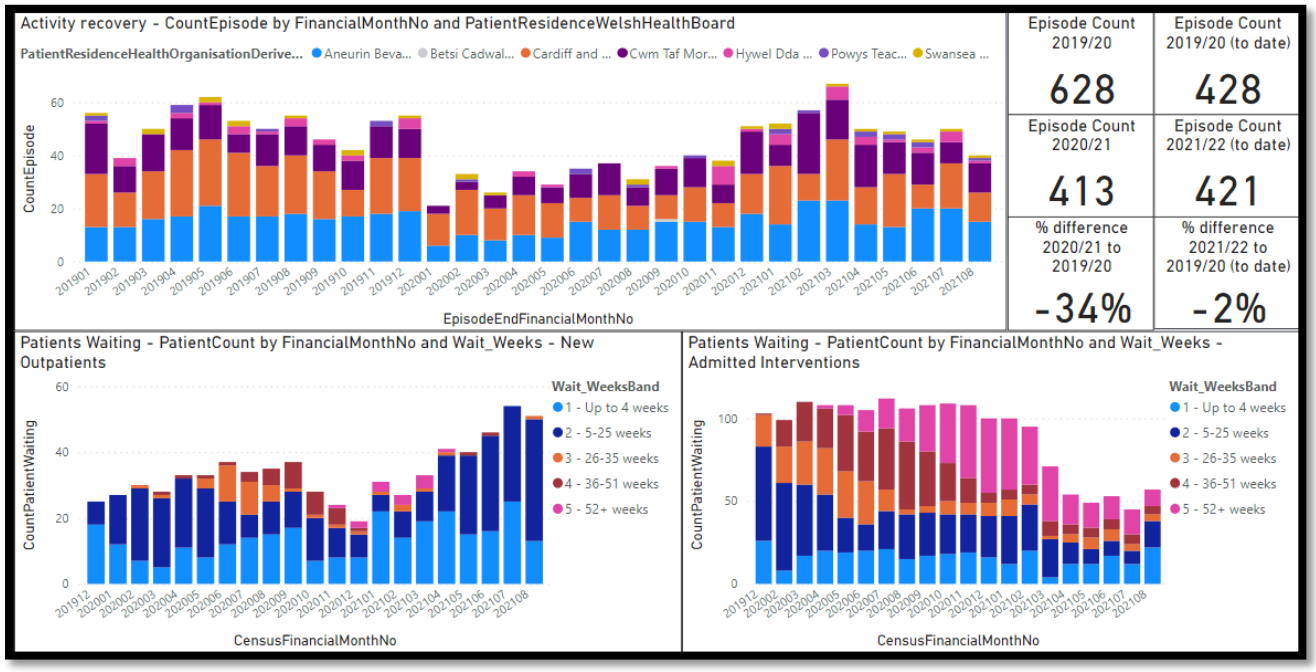
Data source: DHCW central data warehouse; all inpatient activity

Access rates across the Health Boards varied across the past two years, which is to be expected given the relatively low activity numbers (about 73/month), but should still be monitored.

Inpatient episodes per 100k population varies significantly overall across the Health Board areas, from 18 to 33 as per the small table above for 2021/22. Given Swansea's slower recovery, it is unsurprising to see lower access rates for Hywel Dda and Swansea residents. A breakdown of the total activity across 5-year age bands shows a higher access by ages 60-79, which should be taken into account.

3.2. Thoracic Surgery – Recovery and Waiting Lists

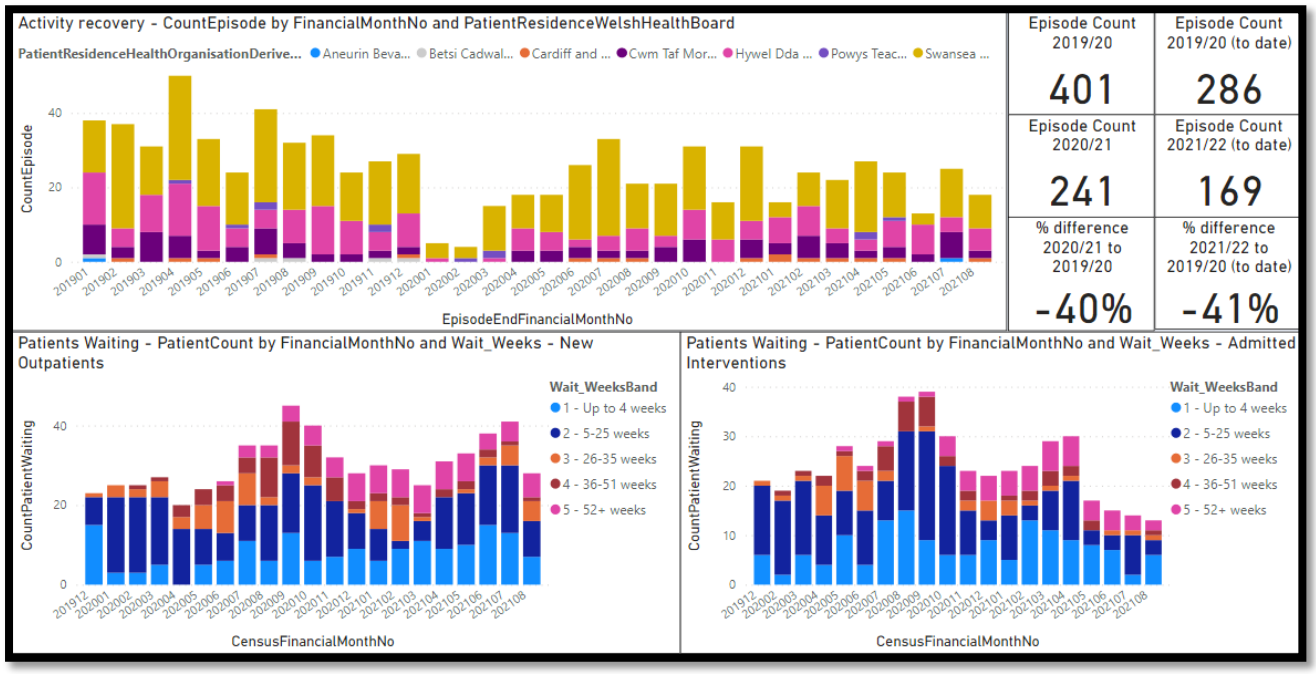
Cardiff and Vale UHB



Data source: DHCW central data warehouse; all patients waiting with an open pathway

The tables above show a summary of the position at Cardiff & Vale in relation to Thoracic Surgery. Whilst the chart showing New Outpatients shows a growing increase in new referrals (those between 0-4 weeks) again, elective activity has recovered to the same episode counts as 2019/20. The waiting list for admissions has reduced to around half of Pre-COVID-19 demand.

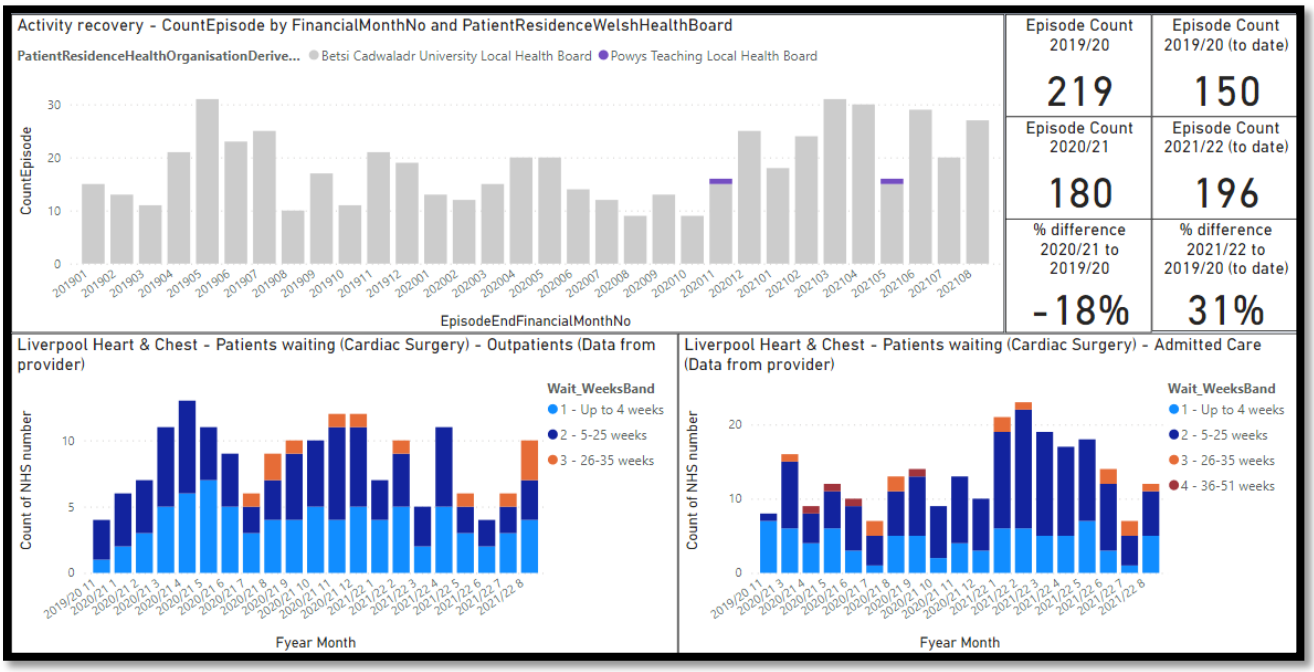
Swansea Bay UHB



Data source: DHCW central data warehouse; all patients waiting with an open pathwa

The tables above show a summary of the position at Swansea Bay in relation to Thoracic Surgery. Whilst the chart showing New Outpatients shows a growing increase in new referrals (those between 0-4 weeks) again, elective activity is still 41% lower than 2019/20, a similar recovery level as to this point in 2020/21. However, the overall waiting list for admissions has reduced slightly.

Liverpool Heart & Chest Hospital



Data source: DHCW central data warehouse; Waiting list data from provider directly

The tables above show a summary of the position at Liverpool Heart & Chest in relation to Thoracic Surgery. Whilst the chart showing New Outpatients shows a quick increase in new referrals (those between 0-4 weeks) after the pandemic started, inpatient activity has increased by 31% compared to 2019/20. Despite this, the patients waiting for admission has still almost doubled, although these are not material numbers and are easily skewed month-on-month.

Specialised Planner omments:

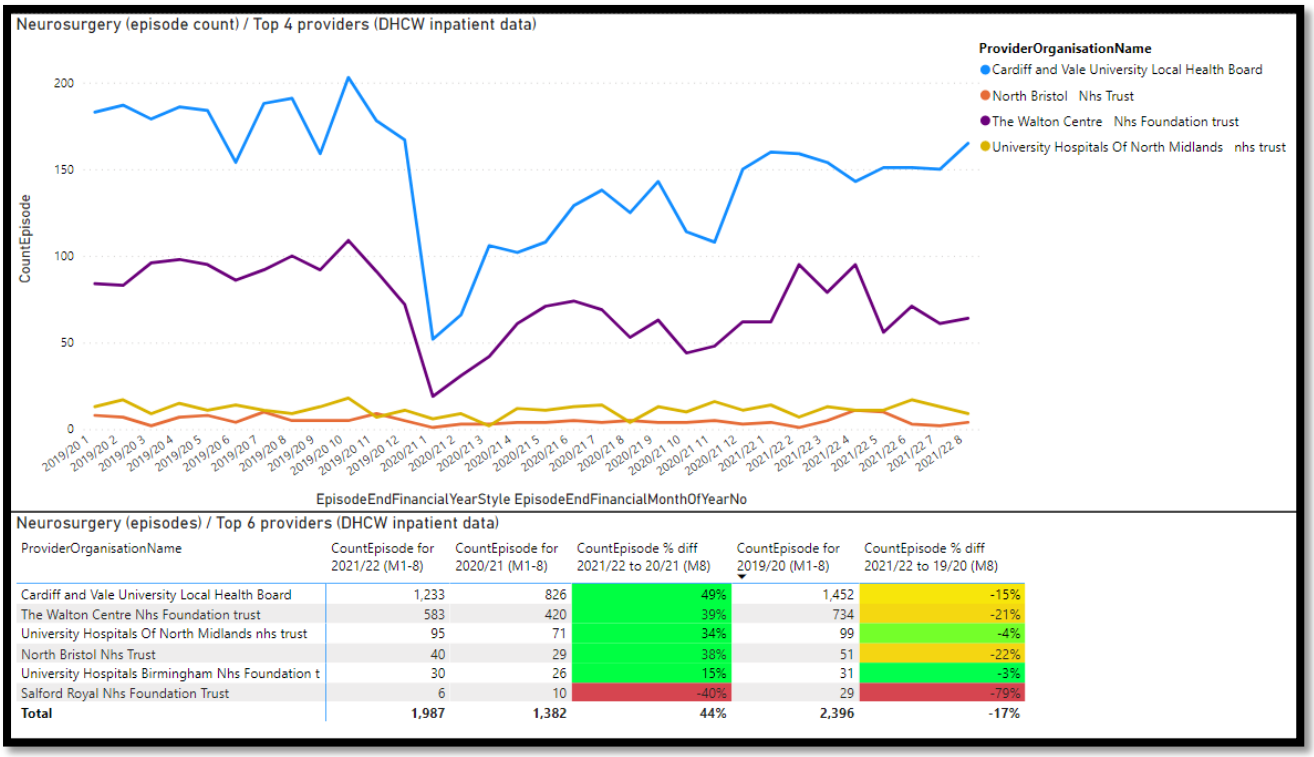
In interpreting the data above, it is important to note that over the last 12 months, collaborative arrangements have been in place between the two South Wales thoracic surgery services to use the joint capacity across the 2 services to ensure equitable access. This ensures that if their usual centre is capacity constrained due to the impact of the pandemic (or potentially other factors) and there is available capacity at the other south Wales service, patients can be cross referred and access treatment on the basis of clinical need. This means that activity at a particular centre does not directly translate into access for residents of health boards for which it is the usual provider.

It is important also to be aware that the lung cancer MDT in Hywel Dda UHB has reported that many patients referred to the MDT over the last few months have presented late in their disease which has led directly to lower referrals to surgery

since patients with advanced disease are less likely to be suitable for surgical treatment. This is the likely explanation for the particularly low rate of utilisation for Hywel Dda residents observed to month 7. This also at least partly explains the lower level of activity at Swansea in comparison to 2019/20. Discussions at the bi-weekly joint thoracic surgical meeting between Cardiff and Swansea have indicated that late presentation has not to date been a significant factor affecting surgical referrals in other parts of the region.

3.3 Neurosurgery

3.3.1 Neurosurgery – Activity and Access Rate Summary



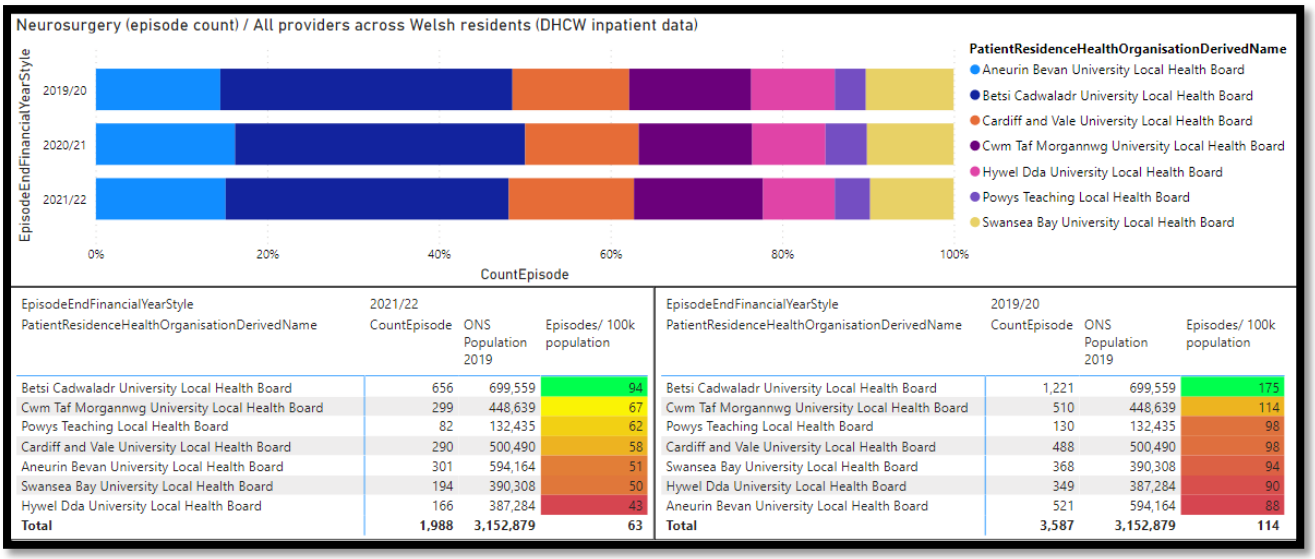
Neurosurgery (episodes) / Top 6 providers (DHCW inpatient data)

ProviderOrganisationName	CountEpisode for 2021/22 (M1-8)	CountEpisode for 2020/21 (M1-8)	CountEpisode % diff 2021/22 to 20/21 (M8)	CountEpisode for 2019/20 (M1-8)	CountEpisode % diff 2021/22 to 19/20 (M8)
Cardiff and Vale University Local Health Board	1,233	826	49%	1,452	-15%
The Walton Centre Nhs Foundation trust	583	420	39%	734	-21%
University Hospitals Of North Midlands nhs trust	95	71	34%	99	-4%
North Bristol Nhs Trust	40	29	38%	51	-22%
University Hospitals Birmingham Nhs Foundation t	30	26	15%	31	-3%
Salford Royal Nhs Foundation Trust	6	10	-40%	29	-79%
Total	**1,987**	**1,382**	**44%**	**2,396**	**-17%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Neurosurgery inpatient recovery across the main specialist providers, with Cardiff and the Walton showing similar recoveries with reductions of 15% and 21% this year compared to the same point in 2019/20. Overall activity was 39% less in 2020/21 than in 2019/20, with the equivalent figure being 17% less so far in 2021/22.

Please note the UH North Midlands activity above primarily relates to North Wales residents, which is paid for through a local contract and not WHSSC.



EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2021/22 CountEpisode	ONS Population 2019	Episodes/ 100k population
Betsi Cadwaladr University Local Health Board	656	699,559	94
Cwm Taf Morgannwg University Local Health Board	299	448,639	67
Powys Teaching Local Health Board	82	132,435	62
Cardiff and Vale University Local Health Board	290	500,490	58
Aneurin Bevan University Local Health Board	301	594,164	51
Swansea Bay University Local Health Board	194	390,308	50
Hywel Dda University Local Health Board	166	387,284	43
Total	**1,988**	**3,152,879**	**63**

EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2019/20 CountEpisode	ONS Population 2019	Episodes/ 100k population
Betsi Cadwaladr University Local Health Board	1,221	699,559	175
Cwm Taf Morgannwg University Local Health Board	510	448,639	114
Powys Teaching Local Health Board	130	132,435	98
Cardiff and Vale University Local Health Board	488	500,490	98
Swansea Bay University Local Health Board	368	390,308	94
Hywel Dda University Local Health Board	349	387,284	90
Aneurin Bevan University Local Health Board	521	594,164	88
Total	**3,587**	**3,152,879**	**114**

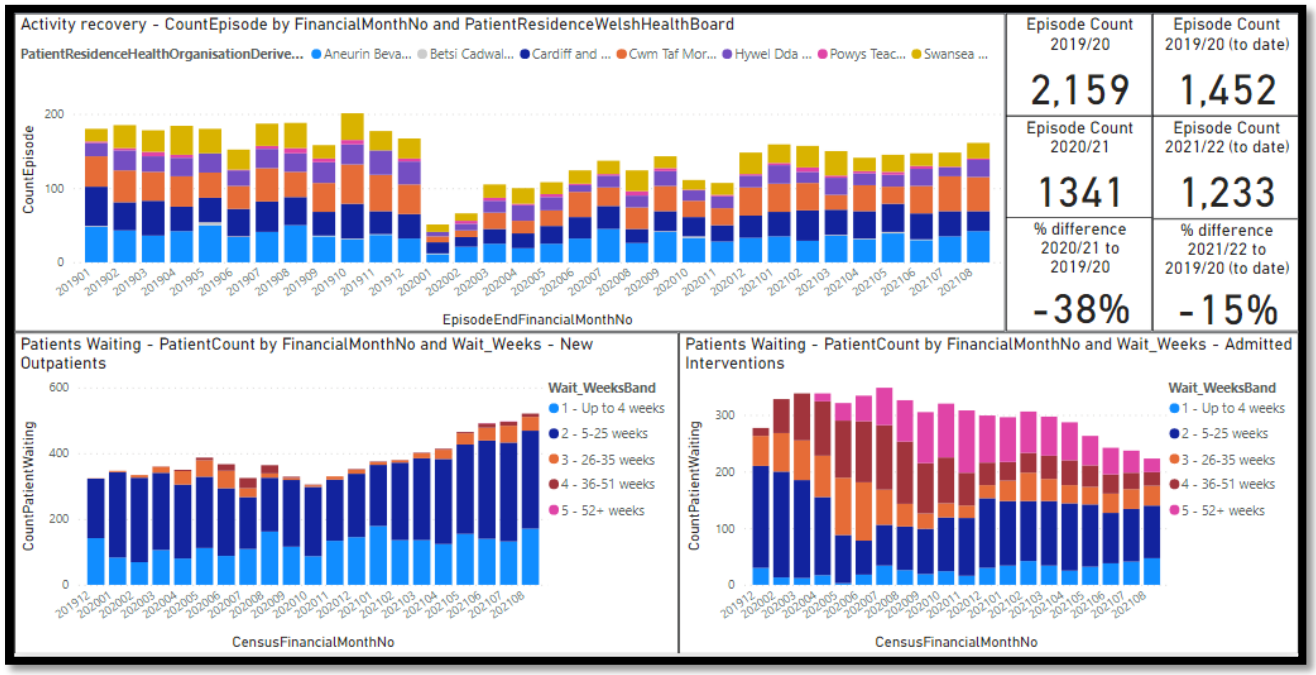
Data source: DHCW central data warehouse; all inpatient activity

Access rates across the Health Boards have not varied much across the past three years, as shown in the charts above. Inpatient episodes per 100k population in 2021/22 so far vary from 43 to 94 across Health Boards in the bottom left chart, but it is noteworthy that the order of access rates was also a similar pattern in the 2019/20 list on the bottom right chart, although North Wales resident access remains the highest both years.

This may be related to the way activity is reported between the two main centres as being in different NHS countries. There is certainly a variance between elective/emergency activity, as shown in the next section.

3.3.2 Neurosurgery – Recovery and Waiting Lists

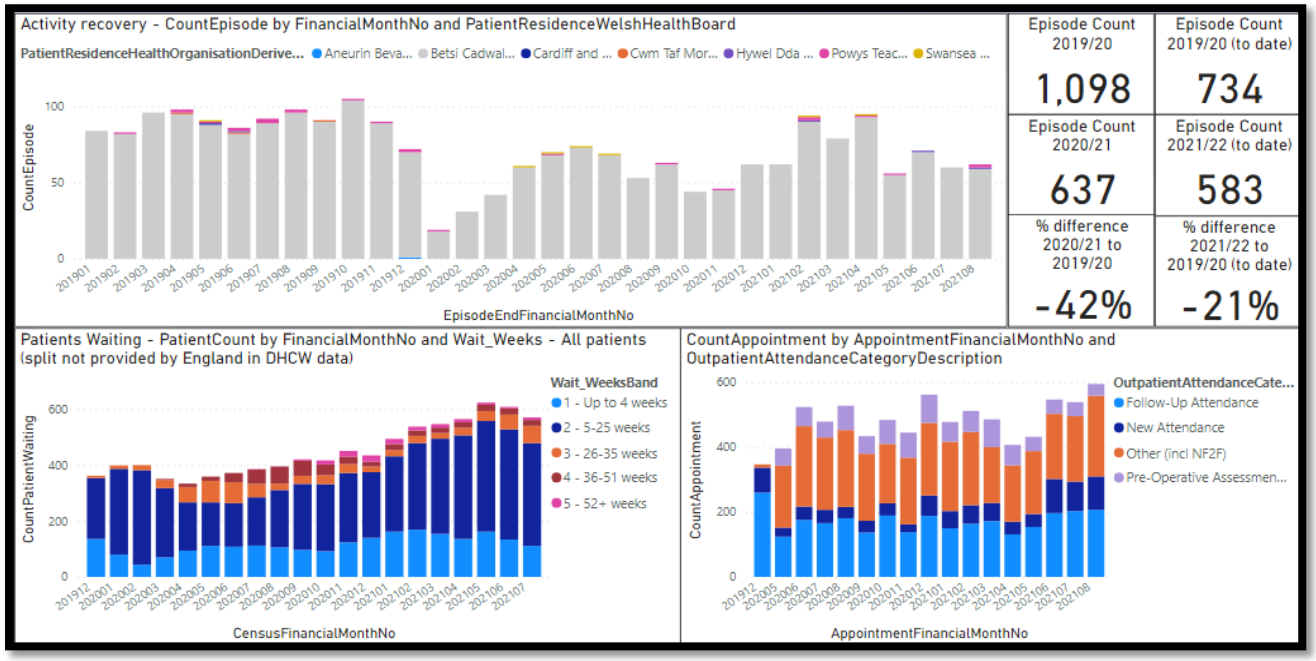
Cardiff & Vale UHB



Data source: DHCW central data warehouse; all patients waiting with an open pathway

The tables above show a summary of the position at Cardiff & Vale in relation to Neurosurgery. Whilst the chart showing New Outpatients shows a comparable rate in new referrals (those between 0-4 weeks), the total is now growing. While elective activity increased from the initial reduction, it has stayed static for a few months, but the total waiting list for admissions has been steadily reducing.

The Walton Centre



Data source: DHCW central data warehouse; all patients waiting with an open pathway

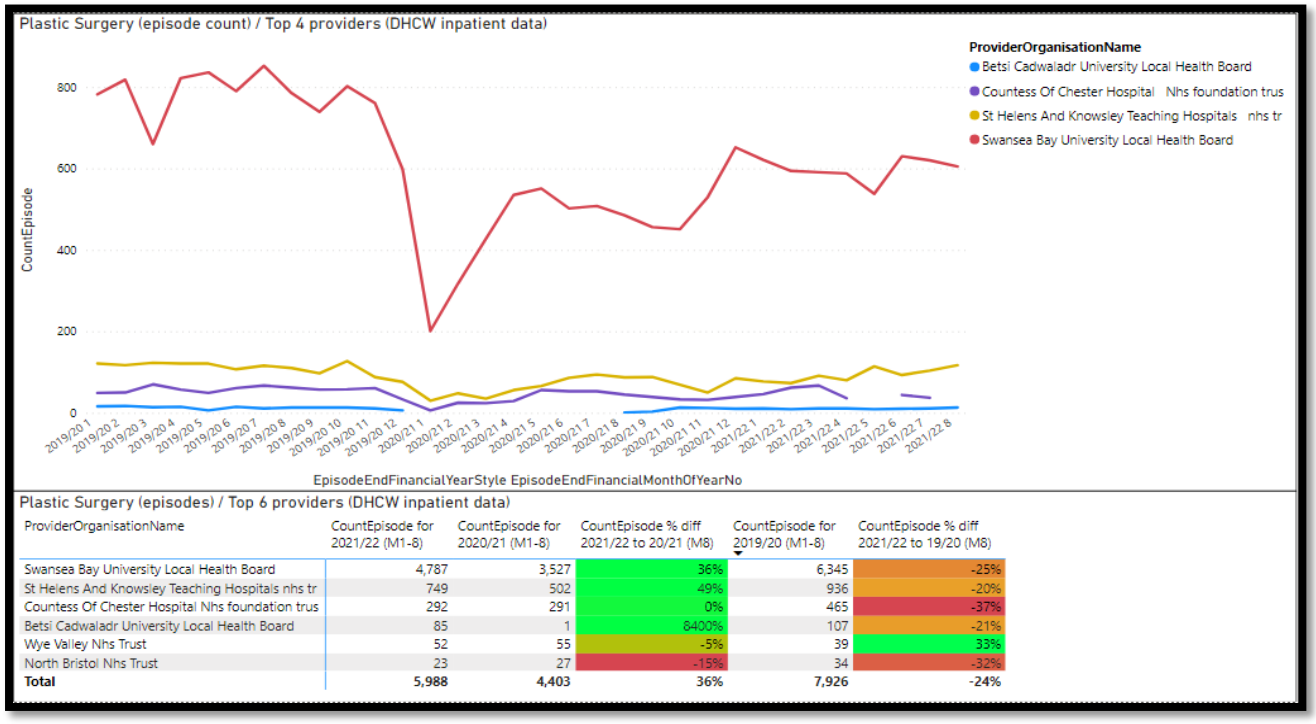
The tables above show a summary of the position at the Walton in relation to Neurosurgery. Whilst activity is now 21% less this year than 2019/20, the total patients waiting had been steadily increasing to almost 50% more than what it was as COVID-19 struck, and some patients have now been waiting more than a year. However, the past couple of months are showing an improvement in the waiting list numbers, and this will hopefully continue.

One point to note is the bottom right chart, which shows the movement across types of Outpatient appointment since March 2020, new attendances in person are starting to increase, and it is notable that non face-to-face appointments have been well-utilised during the COVID-19 period.

Specialised Planner comments:
The number of patients waiting >36 weeks at Cardiff and Vale is reducing but at a slower rate than planned. These levels are significantly higher than pre-COVID-19 levels, as the service had managed to achieve no breaches >36 weeks. One of the main contributing factors for the current waiting list position is that not all the pre-COVID-19 theatre capacity has been made available to the service. The plan is for the service to treat all patients waiting >52 weeks by the end of March 2022. The position will continued to be monitored with the service at the bi monthly risk and assurance meetings.

3.4 Plastic Surgery (excl. Burns)

3.4.1 Plastic Surgery (excl. Burns) – Activity and Access rate summary



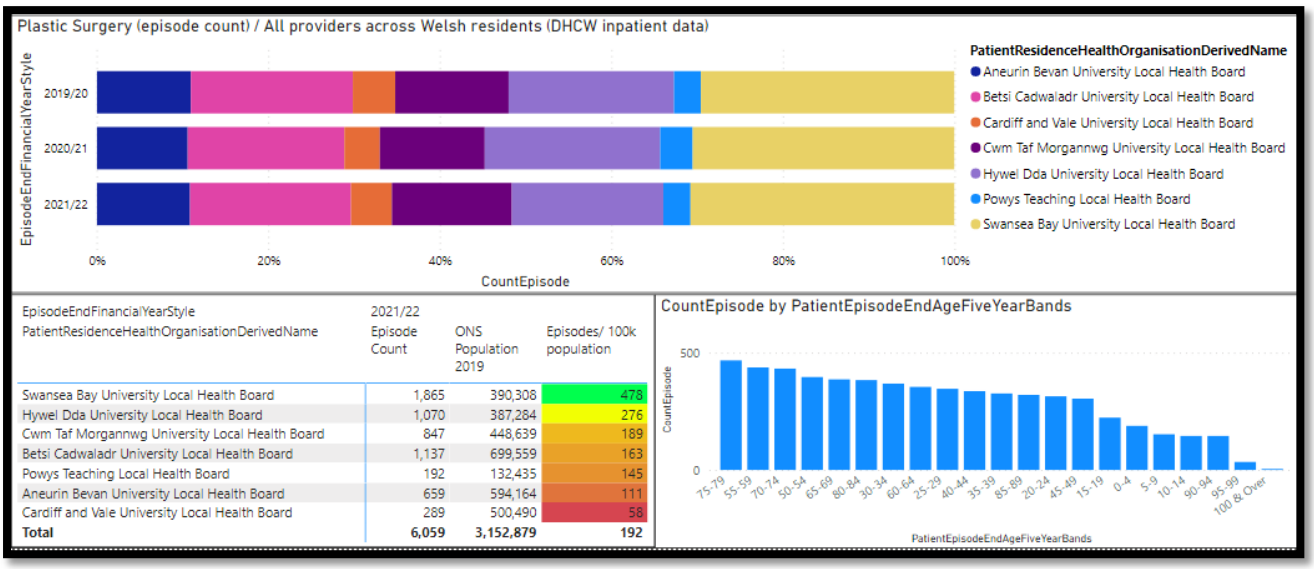
Plastic Surgery (episodes) / Top 6 providers (DHCW inpatient data)

ProviderOrganisationName	CountEpisode for 2021/22 (M1-8)	CountEpisode for 2020/21 (M1-8)	CountEpisode % diff 2021/22 to 20/21 (M8)	CountEpisode for 2019/20 (M1-8)	CountEpisode % diff 2021/22 to 19/20 (M8)
Swansea Bay University Local Health Board	4,787	3,527	36%	6,345	-25%
St Helens And Knowsley Teaching Hospitals nhs tr	749	502	49%	936	-20%
Countess Of Chester Hospital Nhs foundation trus	292	291	0%	465	-37%
Betsi Cadwaladr University Local Health Board	85	1	8400%	107	-21%
Wye Valley Nhs Trust	52	55	-5%	39	33%
North Bristol Nhs Trust	23	27	-15%	34	-32%
Total	**5,988**	**4,403**	**36%**	**7,926**	**-24%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Plastic Surgery inpatient recovery across the main specialist providers, with an overall reduction of 24% so far this year compared to 2019/20. The total reduction was 39% across the full year of 2020/21. They all show the expected inverse relationship to the COVID-19 waves across the UK, with activity steadily increasing again after the first few months.

Please note the Countess of Chester activity above primarily relates to North Wales residents, which is paid for through a local contract and not WHSSC. Wye Valley patients are primarily Powys residents through the WHSSC contract.



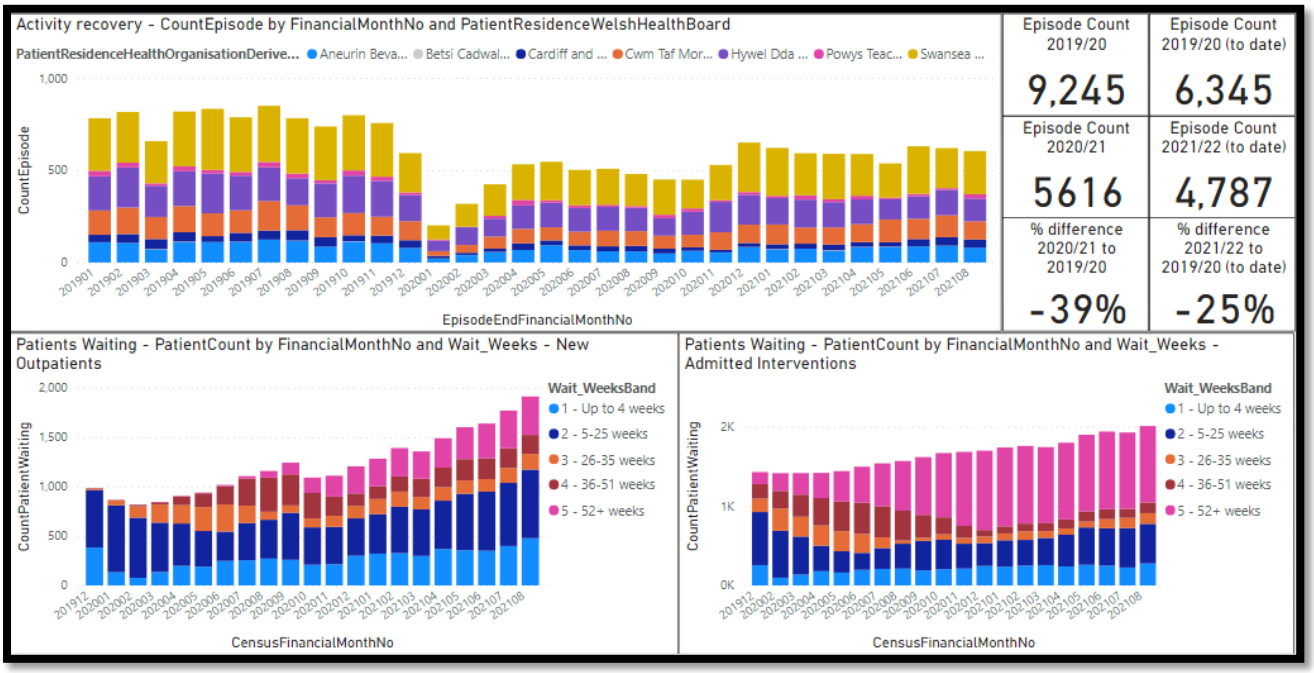
Data source: DHCW central data warehouse; all inpatient activity

Access rates across the Health Boards do not appear to have varied much across the past 2 years, as shown in the charts above.

However, there is a big variation across episodes/100k population, with inpatient episodes per 100k population in 2020/21 varying from 58 to 552 across Health Boards, and between 58 and 478 in 2021/22 in the bottom left chart. This is related to the current contract that Swansea Bay hold as the lead South Wales centre, which includes significant non-specialist activity for both Swansea Bay and Hywel Dda residents, and is being discussed internally. Non-specialist activity for other Health Boards is reported under non-WHSSC areas/specialties, and reporting is also linked to the specialty/grade of the treating medic (eg. Dermatology/Plastic Surgery).

3.4.2 Plastic Surgery (excl. Burns) – Recovery & waiting lists

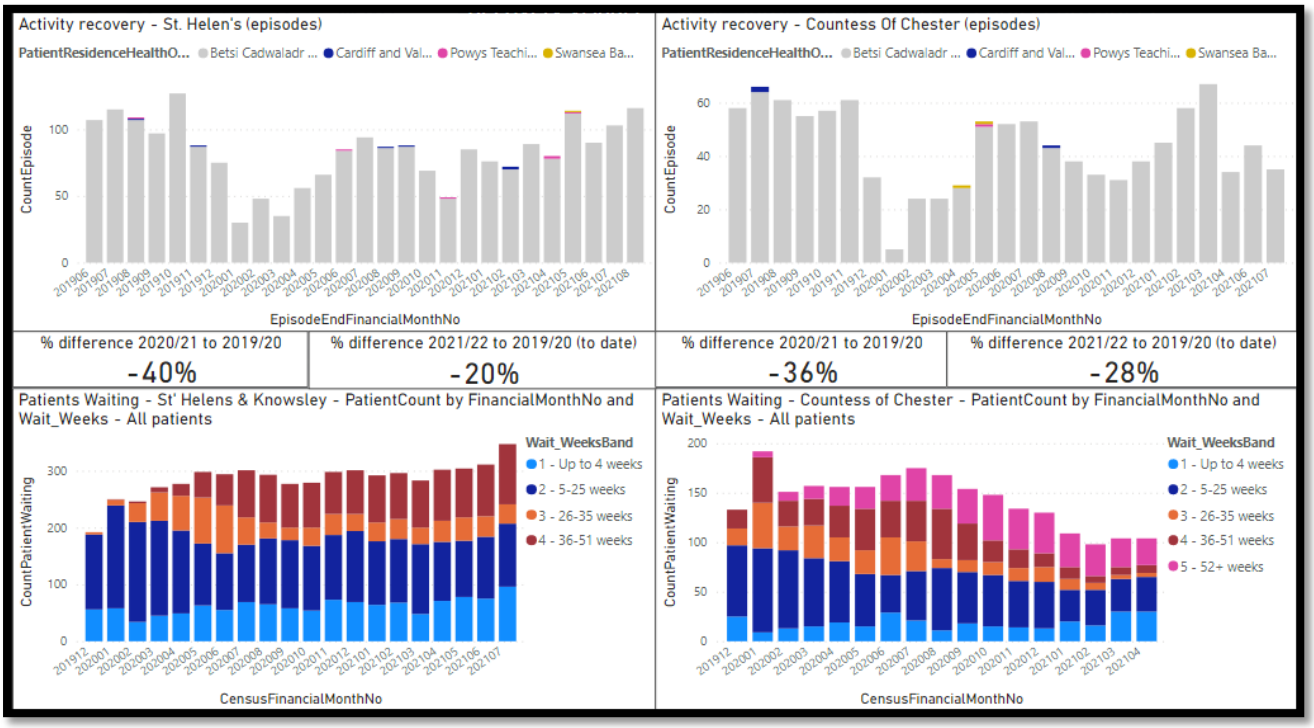
Swansea Bay UHB



Data source: DHCW central data warehouse; all patients waiting with an open pathway

The tables above show a summary of the position at Swansea Bay in relation to Plastic Surgery. Whilst activity is now 25% less this year than 2019/20, which is better than the 39% drop to this point in 2020/21, the total patients waiting has been steadily increasing to almost double what it was as COVID-19 struck, and a significant number of patients have now been waiting more than a year. Within the total of patients waiting, those waiting for new outpatient appointments have nearly doubled since February 2020, and those waiting for admissions have increased by around 35%.

English providers – St. Helen's & Knowsley Teaching Hospitals NHS Trust, Countess of Chester Hospital



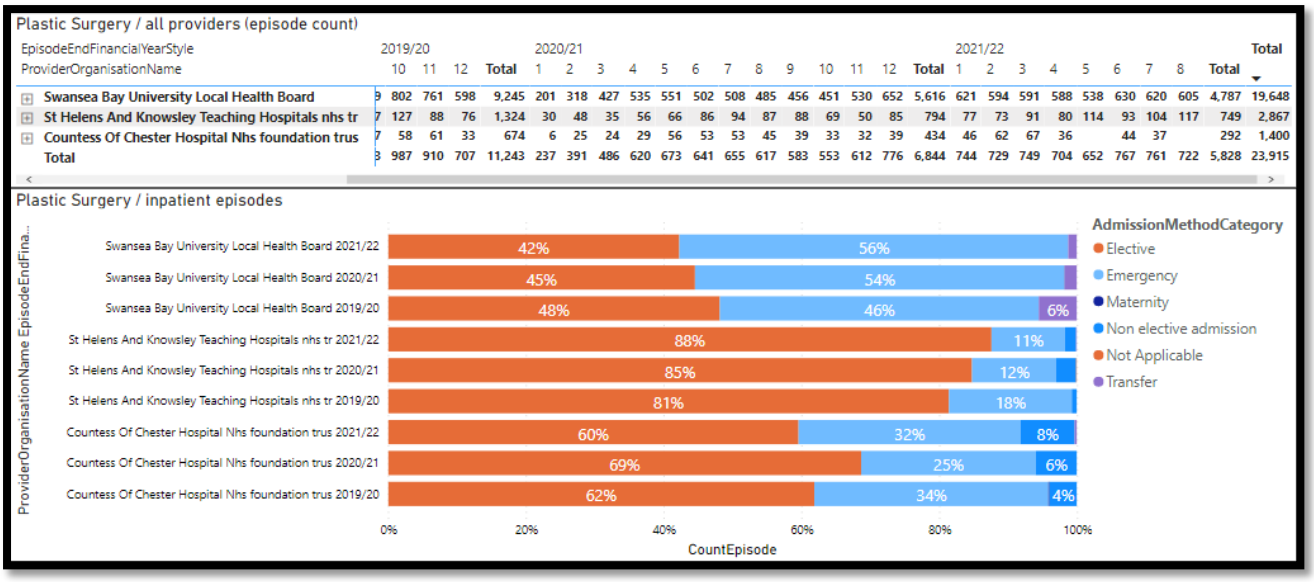
Data source: DHCW central data warehouse; all patients waiting with an open pathway

Whilst English providers also reflect the trend of patients in general waiting longer than before the pandemic, the percentage of patients waiting over a year is much lower. Total waiting patients have increased at St Helen's, although no one has been waiting over a year. The total initially increased but since decreased to Pre-COVID-19 levels at Countess of Chester (local BCU contract), although about a third of the patients have been waiting for over a year.

Other notes

Interestingly, data on the inpatient episodes shows an inverse of the elective/non-elective split for Swansea and the English providers, with Swansea having a higher proportion of emergency activity. Please see the below chart for the movements across the past 3 years. The episode counts have been included to give some perspective on the numbers, as Swansea treats a far higher volume of Welsh patients.

Given the expected prioritisation weighted towards cancer work, it is likely that there will be a legacy of non-cancer elective waiting list cases, although the available data does not give the cancer breakdown.



Data source: DHCW central data warehouse; all inpatient activity

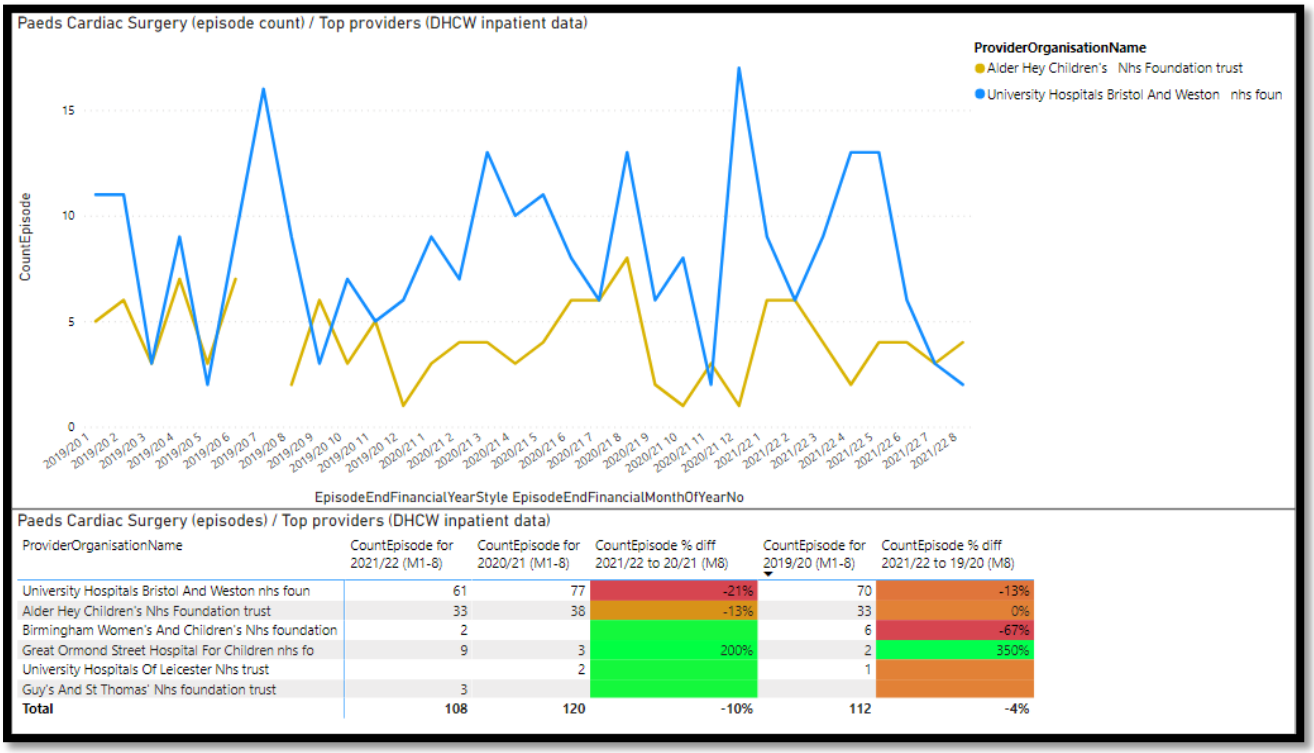
Specialised Planner comments:

As noted in the comments above, variation across heath boards in utilisation of plastic surgery does not necessarily reflect variation in access to appropriate treatment since many procedures (the majority of activity) provided by plastic surgery are also provided by other specialties. Whether a particular patient is treated by a plastic surgeon or a surgeon from another specialty largely depends on the local services available in the patient's health board (unless it is a specialised procedure only offered by plastics).

WHSSC will be working with SBUHB to support the recovery plan for plastic surgery to address the significant backlog of patients with long waiting times for treatment.

3.5 Paediatric Cardiac Surgery (English providers using this specialty code)

3.5.1 Paediatric Cardiac Surgery – Activity and Access rate summary



Paeds Cardiac Surgery (episodes) / Top providers (DHCW inpatient data)

ProviderOrganisationName	CountEpisode for 2021/22 (M1-8)	CountEpisode for 2020/21 (M1-8)	CountEpisode % diff 2021/22 to 20/21 (M8)	CountEpisode for 2019/20 (M1-8)	CountEpisode % diff 2021/22 to 19/20 (M8)
University Hospitals Bristol And Weston nhs foun	61	77	-21%	70	-13%
Alder Hey Children's Nhs Foundation trust	33	38	-13%	33	0%
Birmingham Women's And Children's Nhs foundation	2			6	-67%
Great Ormond Street Hospital For Children nhs fo	9	3	200%	2	350%
University Hospitals Of Leicester Nhs trust		2		1	
Guy's And St Thomas' Nhs foundation trust	3				
Total	**108**	**120**	**-10%**	**112**	**-4%**

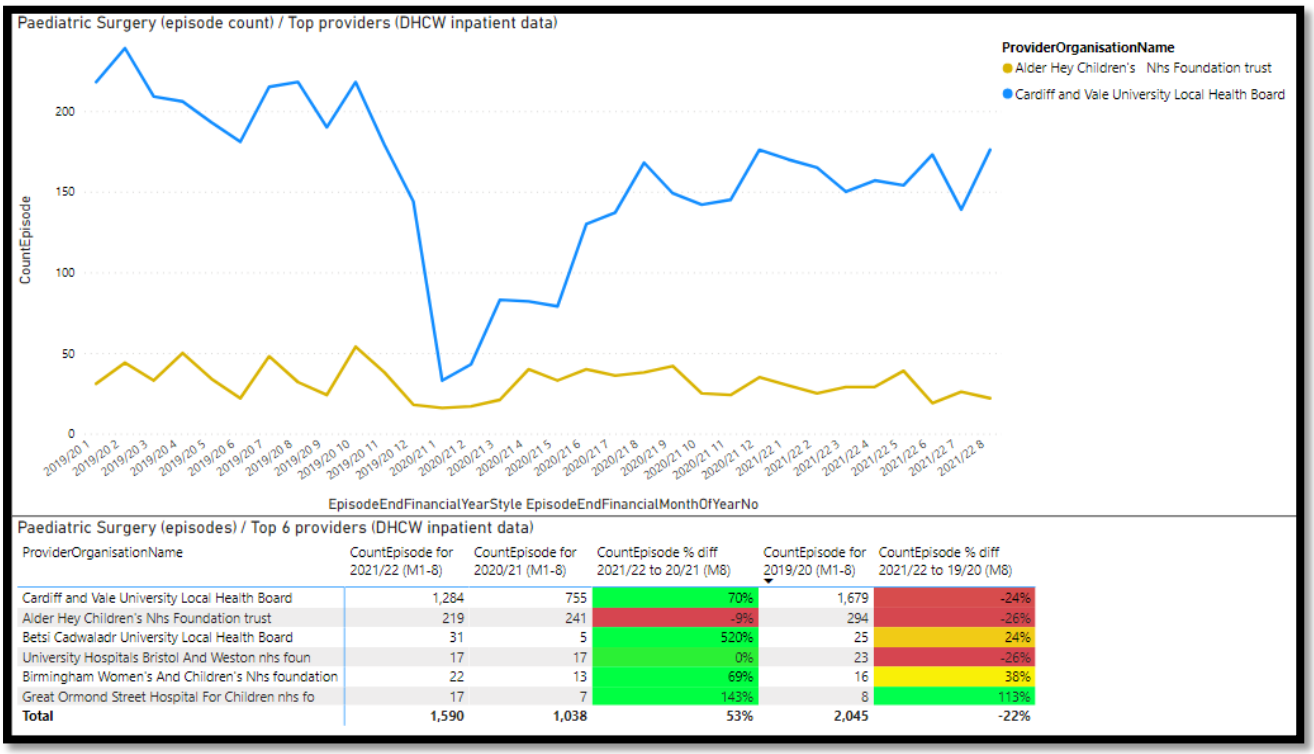
Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Paeds Cardiac Surgery inpatient recovery across the main specialist providers.

Case volumes are traditionally small but with high importance in terms of outcomes. Encouragingly, figures to date for this year show a 1% deterioration compared to 2019/20, and a 4% deterioration compared to 2020/21.

3.6 Paediatric Surgery

3.6.1 Paediatric Surgery – Activity and Access rate summary



Paediatric Surgery (episodes) / Top 6 providers (DHCW inpatient data)

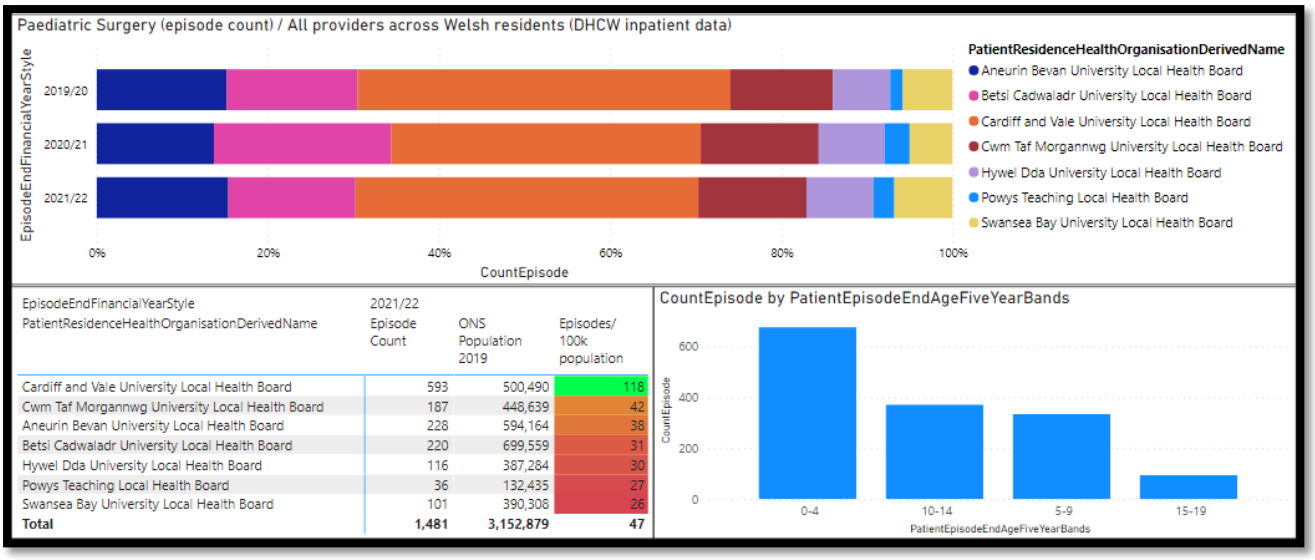
ProviderOrganisationName	CountEpisode for 2021/22 (M1-8)	CountEpisode for 2020/21 (M1-8)	CountEpisode % diff 2021/22 to 20/21 (M8)	CountEpisode for 2019/20 (M1-8)	CountEpisode % diff 2021/22 to 19/20 (M8)
Cardiff and Vale University Local Health Board	1,284	755	70%	1,679	-24%
Alder Hey Children's Nhs Foundation trust	219	241	-9%	294	-26%
Betsi Cadwaladr University Local Health Board	31	5	520%	25	24%
University Hospitals Bristol And Weston nhs foun	17	17	0%	23	-26%
Birmingham Women's And Children's Nhs foundation	22	13	69%	16	38%
Great Ormond Street Hospital For Children nhs fo	17	7	143%	8	113%
Total	**1,590**	**1,038**	**53%**	**2,045**	**-22%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Paediatric Surgery inpatient recovery across the main specialist providers, with Alder Hey initially showing the highest and quicker recovery, although the main providers (Alder Hey and Cardiff) are now both around the same percentage decrease in 2021/22. The main 2 providers show the expected inverse relationship to the COVID-19 waves across the UK, with activity increasing again.

There was a drop in the volume of Paediatric Surgery inpatient activity reported during the period, which is recovering but was 38% less activity overall in 2020/21 compared to 2019/20.

Activity so far in 2021/22 shows a 53% increase compared to last year at this point, but 22% less than 2019/20, with the 2 main providers being roughly the same.



EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2021/22 Episode Count	ONS Population 2019	Episodes/ 100k population
Cardiff and Vale University Local Health Board	593	500,490	118
Cwm Taf Morgannwg University Local Health Board	187	448,639	42
Aneurin Bevan University Local Health Board	228	594,164	38
Betsi Cadwaladr University Local Health Board	220	699,559	31
Hywel Dda University Local Health Board	116	387,284	30
Powys Teaching Local Health Board	36	132,435	27
Swansea Bay University Local Health Board	101	390,308	26
Total	**1,481**	**3,152,879**	**47**

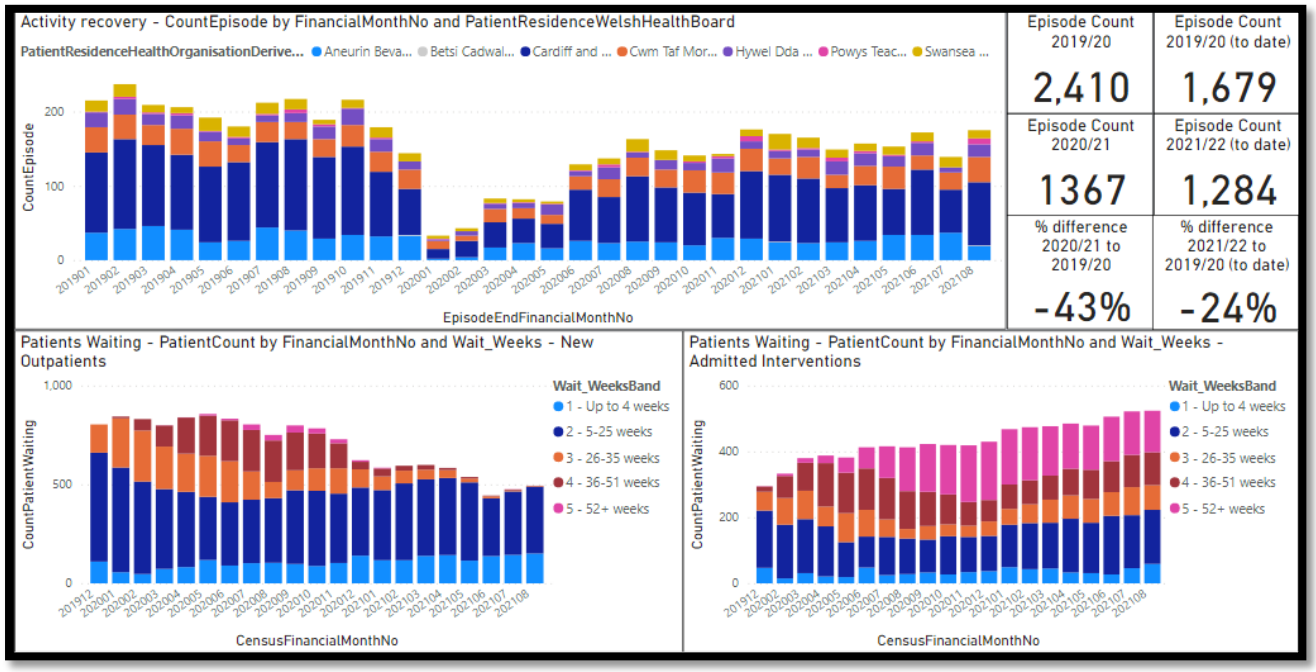
Data source: DHCW central data warehouse; all inpatient activity

Access rates across the Health Boards varied as the pandemic initially hit, but have now stabilised to roughly the same split as last year. The highest age group having inpatient episodes are by far the 0-4 age group.

However, inpatient episodes per 100k population varies significantly overall across the Health Board areas, from 26 to 118 as per the small table above, with Cardiff being by far the highest. This may be linked to Cardiff being the contracted provider of this service, with all activity passing through the WHSSC contract, and is being considered internally.

3.6.2 Paediatric Surgery – Recovery & waiting lists

Cardiff & Vale UHB

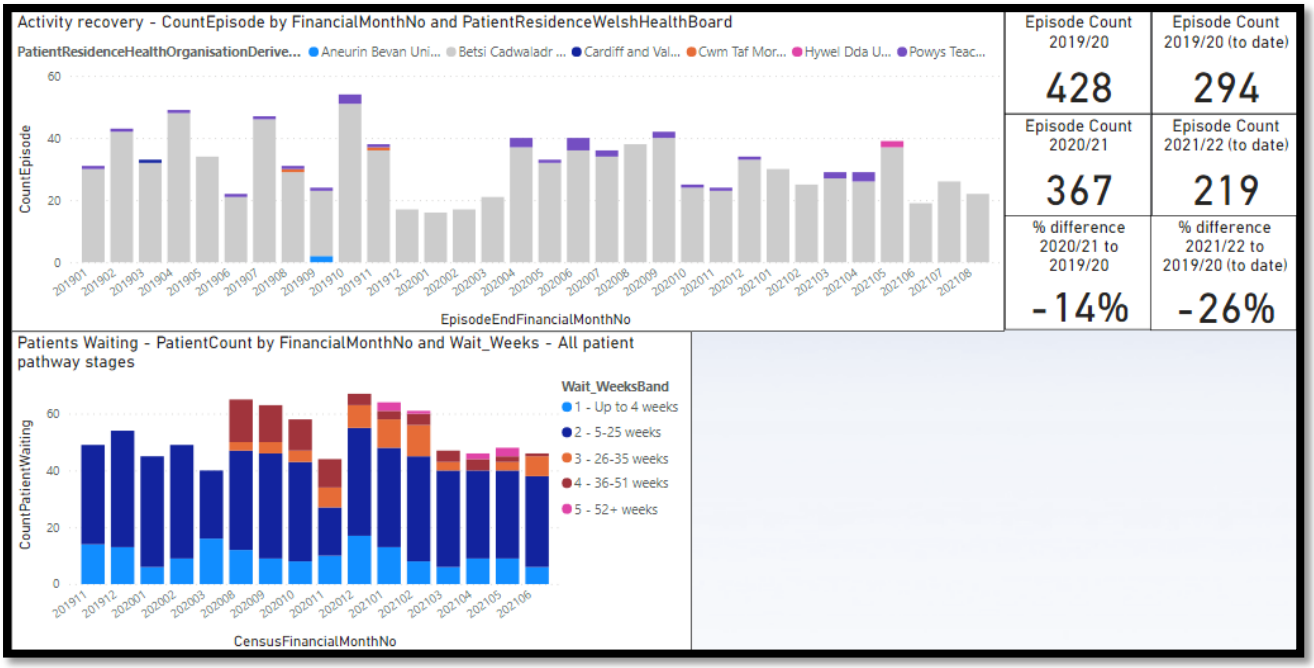


Data source: DHCW central data warehouse; all patients waiting with an open pathway

The tables above show the progression of patients waiting for Paediatric Surgery services at Cardiff & Vale. As the main provider, Cardiff shows mixed results – while patients waiting for outpatient appointments have reduced, particularly for follow-ups, patients waiting for admitted interventions have increased, with almost 30% now having waited for over a year. Given that the highest age band of this specialty is in the 0-4 age band, this is particularly significant. Whilst tackling the New Outpatient waiting list is to be commended, it appears to then adversely affect the waiting list for admissions.

Previous experience emphasizes the importance of maintaining elective waiting lists delivered on a timely basis, given the qualitative impact on the development of children. It will be important to see a more rapid increase in activity if waiting times for children are to be kept to tolerable levels. Meanwhile it will be essential for the provider to have in place appropriate systems to monitor the risk of these patients waiting for surgery.

Alder Hey Hospital



Data source: DHCW central data warehouse; all inpatient activity

The tables above show a summary of the position at Alder Hey in relation to Paediatric Surgery. Whilst the recovery position to the current month is actually less than last year (14% less in 2020/21 compared to 2019/20 in total, and 26% less to date this year compared to 2019/20), the total waiting list has reduced to Pre-COVID-19 levels.

Specialised Planner comments:

Alder Hey had previously reported to WHSSC through their recovery plans that activity was currently higher than Pre-COVID-19 levels and a robust plan is in place to manage the small number of patients waiting over 52 weeks. The provider has confirmed that all patients waiting over 52 weeks will be treated before the end of March 2022, and indeed by the end of September 2021 the single longest waiting patient was between 36-51 weeks.

Cardiff and Vale are reporting a significant number of patients waiting over 52 weeks. In dialogue with the provider, there are a number of contributing factors to the waiting list including nurse capacity, bed capacity and theatre availability. The Health Board are refining the recovery plan for paediatrics to detail the trajectory for managing the patient cohort. WHSSC have sought assurance on the clinical review and communication with patients on the waiting list. There are 50 newly qualified nurses due to start within the Children's hospital over the coming months, which will work towards alleviating the nursing and bed pressures.

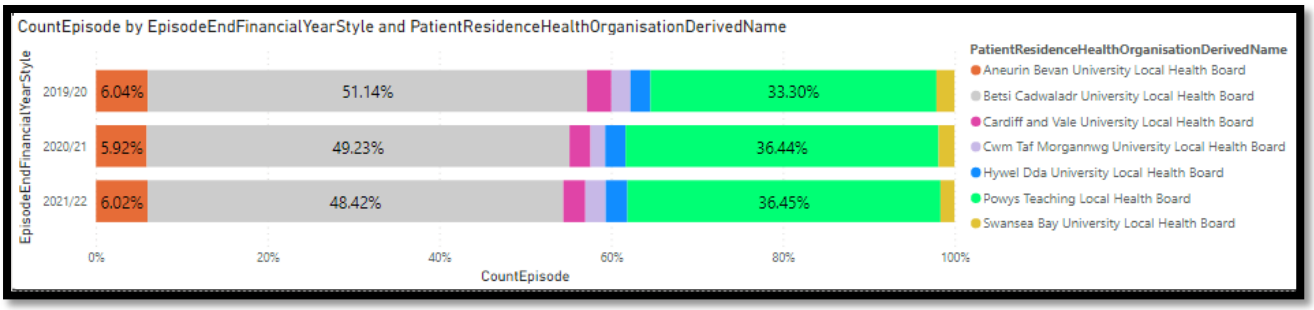
3.7 NHS England Providers – Organisations with WHSSC Contracts

The key summaries and analysis relating to English providers are set out in Appendix A.

3.7.1 Analysis summary

Tables 1 to 3 of Appendix A detail the trend in admitted patient care activity levels since the 2019/20 financial year. Table 2 analyses the activity by resident Health Board, and Table 3 analyses the activity by Specialty. In summary, 2020/21 English provider activity (using providers with WHSSC contracts) dropped by 34% in comparison to 2019/20, and in the inverse pattern to the COVID-19 waves, as expected. November 2021 activity shows a continued increase in performance and is expected to continue into 2021/22, and indeed activity this year to date has improved to just 15% less than to this point in 2019/20.

It is worth noting that the overall split across resident Health Boards is relatively unchanged, with inpatient access rates close to the same percentages as before COVID-19, with the exception of Powys, whose share has increased slightly. The following chart shows the shares since April 2019. The actual episode counts can be found in Appendix A, Table 2, and there are pages per Health Board as Table 4.x



Data source: NWIS central data warehouse; all inpatient activity at English Trusts with WHSSC contracts

4.0 SUMMARY

In summary of the data and detail in the report, the main points can be condensed to the following:

Cardiac Surgery (pages 3-7) – Whilst overall inpatient activity has decreased by 22% to date this financial year, compared to 2019/20, this has not translated into higher waiting lists due to lower demand for inpatient admissions. Cardiff's waiting list for admissions has actually reduced to about a third of Pre-COVID-19 levels (about 50 patients), and Swansea's has reduced to about half (about 60 patients), although Liverpool's list has increased slightly (about 60 patients).

However, referrals for New outpatient appointments is now growing again after an initial lull as COVID-19 hit Wales, and the Welsh centres historically have a

much higher percentage than Liverpool of emergency admissions compared to elective admissions. Therefore the good progress must be maintained, especially considering the link to Cardiology and that patients may move to Cardiac Surgery lists at short notice.

Thoracic Surgery (pages 8-12) – Whilst inpatient activity overall has decreased by 12% to date this financial year, compared to 2019/20, this varies across the 3 main providers. Cardiff have actually performed the same episode volume as in 2019/20, and have halved their waiting list for admissions (about 50 patients). Liverpool have increased their inpatient activity by 31%, but their waiting list for admissions has increased a little to about 10 patients. Swansea's activity is 41% lower than 2019/20 so far this year, but their waiting list has also decreased to about 15 patients.

Similar to Cardiac Surgery, New Outpatient referrals appear to be now increasing again though, so the good work needs to be maintained.

Neurosurgery (pages 12-15) – Inpatient activity has decreased by 17% to date this financial year compared to 2019/20, with both Cardiff and the Walton showing similar recovery rates. However, Cardiff's waiting list for admissions has reduced a little (about 210 patients), although a fifth of those have been waiting for over a year, while the Walton's waiting list for admissions has been steadily increasing from about 350 patients in March 2020 to almost 600 in November 2021.

New outpatient referrals appear to be consistent, but both centres now have a growing waiting list for new appointments, which could translate into pressure on the waiting list for admissions.

Plastic Surgery (pages 15-19) – Inpatient activity is still 24% less so far this financial year compared to 2019/20, although this is higher than 2020/21. Both of the centres commissioned by WHSSC (Swansea and St. Helen's and Knowsley) are now showing large waiting lists for admissions, with large numbers having waited over a year. Swansea's inpatient waiting list has grown from about 1,450 in March 2020 to about 2,000 in November 2021, with roughly half having waited over a year. St. Helen's and Knowsley's total waiting list for all pathway points has grown from just under 200 in March 2020 to well over 300 in November 2021, although none have waited over a year. WHSSC will be working with SBUHB to support the recovery plan for plastic surgery to address the significant backlog of patients with long waiting times for treatment.

It is noteworthy that Swansea shows a far higher percentage of emergency activity (56% to date in 2021/22) than St Helen's (12% to date in 2021/22), although this was also the case Pre-COVID-19.

Paediatric Surgery (pages 21-24) - Inpatient activity overall has decreased by 22% to date this financial year, compared to 2019/20, but this is still

significantly more than in 2020/21. Whilst Cardiff has clearly worked to reduce the New Outpatient waiting list (which has seen steadily growing referrals again since April 2020), the waiting list for admissions has been progressively growing from about 300 patients in March 2020 to about 500 in November 2021, with about 30% having now waited over a year (very few had waited over 36 weeks Pre-COVID-19). This is concerning, given that children aged 0-4 are the highest age band of admitted patients. However, WHSSC have been in discussions with the Health Board around their recovery plan, and 50 newly qualified nurses are due to start within the Children's hospital over the coming months, which will work towards alleviating the nursing and bed pressures.

Alder Hey's waiting list has remained fairly static since Pre-COVID-19, with about 45 patients waiting across all pathway points. The Trust had confirmed that all patients waiting over 52 weeks will be treated before the end of March 2022, and achieved that by November 2021.

NHS England providers (page 25, Appendix 1) – Overall, the English Trusts that WHSSC commission have performed by 15% less inpatient episodes so far this year compared to 2019/20. It can be noted that part of this reduction is due to the lower volumes of emergency admissions from Welsh residents (probably due to less travelling over the COVID-19 period), and that the specialist activity has reduced by less than this. For example, Trauma & Orthopaedics, which accounts for about 15% of the total inpatient activity has reduced by 22% in total, and A&E by 19%. The Appendix lists all the specialties in order, and also shows the position by Health Board.

5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Implementation of the Plan Choose an item. Choose an item.
Link to Integrated Commissioning Plan	This report provides assurance on delivery of the ICP.
Health and Care Standards	Choose an item. Choose an item. Choose an item.
Principles of Prudent Healthcare	Choose an item. Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Choose an item. Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	
Finance/Resource Implications	
Population Health	
Legal Implications (including equality & diversity, socio economic duty etc)	
Long Term Implications (incl WBFG Act 2015)	
Report History (Meeting/Date/ Summary of Outcome	
Appendices	**Annex A** – contract monitoring return activity CVUHB **Annex B** – contract monitoring return activity SBUHB **Appendix 1** • Table 1 – activity by provider • Table 2 – activity by specialty • Table 3 – activity by specialty graphs for all Wales • Table 4 – activity by specialty graphs for each resident Health Board

APPENDIX 1

Admitted Patient Care Data for WHSSC English contract providers (DHCW data warehouse – all reported episodes Spec+NonSpc)

Table 1 – Analysis by NHS England Provider by Month

Episodes by provider - 2019/20 and 2020/21 full year, 2021/22 to previous full month - DHCW data for Welsh/border resident

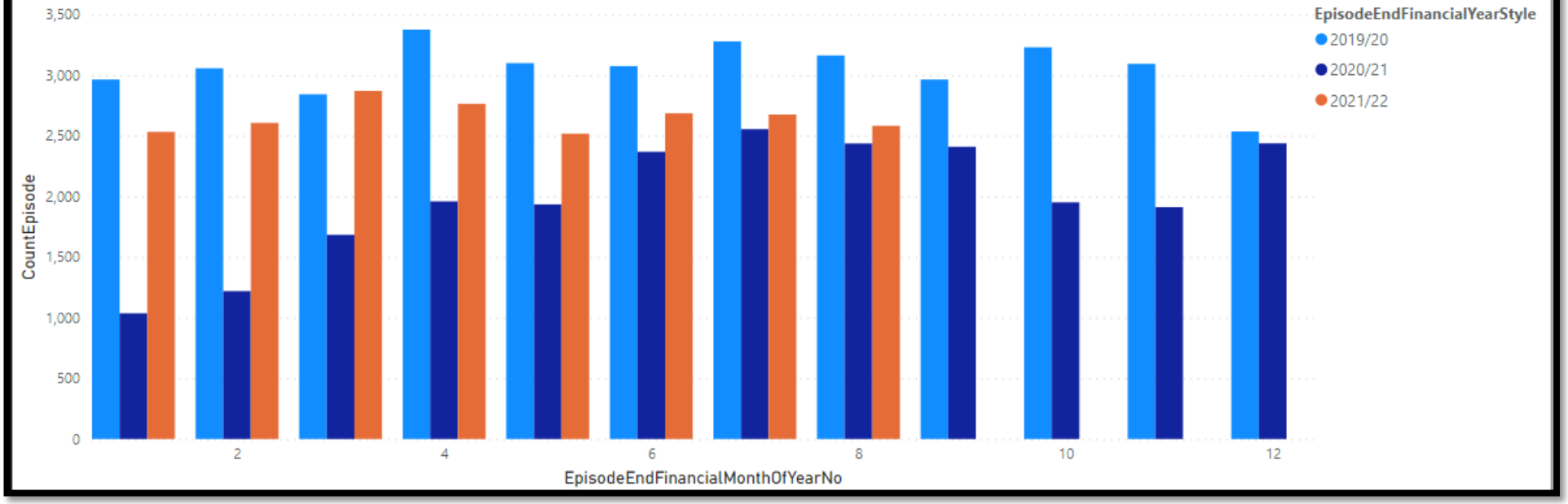
Main HB	2019/20	2020/21	2021/22	Total	CountEpisode for 2021/22 (M1-8)	CountEpisode for 2020/21 (M1-8)	CountEpisode % diff 2021/22 to 20/21 (M8)	CountEpisode for 2019/20 (M1-8)	CountEpisode % diff 2021/22 to 19/20 (M8)
	4,213	**2,529**	**2,364**	**9,106**	**2,364**	**1,684**	**40%**	**2,957**	**-20%**
Cambridge University Hospitals Nhs Foundation tr	80	27	29	**136**	29	23	26%	57	-49%
Great Ormond Street Hospital For Children nhs fo	326	193	266	**785**	266	141	89%	234	14%
Guy's And St Thomas' Nhs foundation trust	446	182	197	**825**	197	115	71%	329	-40%
Imperial College Healthcare Nhs Trust	302	131	165	**598**	165	78	112%	234	-29%
King's College Hospital Nhs Foundation trust	130	61	66	**257**	66	45	47%	89	-26%
Leeds Teaching Hospitals Nhs Trust	80	24	35	**139**	35	22	59%	57	-39%
Royal Free London Nhs Foundation trust	193	121	108	**422**	108	86	26%	135	-20%
Royal Papworth Hospital Nhs Foundation trust	105	32	42	**179**	42	25	68%	73	-42%
The Newcastle Upon Tyne Hospitals nhs foundation	132	103	36	**271**	36	65	-45%	87	-59%
The Royal Marsden Nhs Foundation trust	52	54	42	**148**	42	36	17%	32	31%
The Royal Orthopaedic Hospital Nhs foundation tr	159	98	96	**353**	96	55	75%	107	-10%
University College London Hospitals Nhs foundati	357	216	221	**794**	221	157	41%	246	-10%
University Hospitals Bristol And Weston nhs foun	1,851	1,287	1,061	**4,199**	1,061	836	27%	1,277	-17%
Major North Wales provider	**14,810**	**9,779**	**8,261**	**32,850**	**8,261**	**6,242**	**32%**	**9,982**	**-17%**
Alder Hey Children's Nhs Foundation trust	3,669	2,812	2,055	**8,536**	2,055	1,818	13%	2,531	-19%
Liverpool Heart And Chest Hospital nhs foundatio	1,400	1,129	1,050	**3,579**	1,050	697	51%	913	15%
Liverpool University Hospitals Nhs Foundation tr	2,572	1,454	1,314	**5,340**	1,314	928	42%	1,746	-25%
Manchester University Nhs Foundation Trust	1,106	571	636	**2,313**	636	359	77%	726	-12%
Salford Royal Nhs Foundation Trust	301	109	105	**515**	105	71	48%	191	-45%
Sheffield Teaching Hospitals Nhs Foundation trus	221	155	138	**514**	138	109	27%	150	-8%
St Helens And Knowsley Teaching Hospitals nhs tr	1,655	1,010	905	**3,570**	905	646	40%	1,112	-19%
The Christie Nhs Foundation Trust	620	542	297	**1,459**	297	337	-12%	391	-24%
The Clatterbridge Cancer Centre Nhs foundation t	351	212	195	**758**	195	133	47%	282	-31%
The Walton Centre Nhs Foundation trust	1,895	1,170	1,101	**4,166**	1,101	713	54%	1,271	-13%
Wirral University Teaching Hospital Nhs foundati	1,020	615	465	**2,100**	465	431	8%	669	-30%
Major Powys provider	**17,649**	**11,591**	**10,604**	**39,844**	**10,604**	**7,264**	**46%**	**11,912**	**-11%**
Birmingham Women's And Children's Nhs foundation	413	313	261	**987**	261	192	36%	283	-8%
The Robert Jones And Agnes Hunt Orthopaedic hospit	5,188	2,193	2,733	**10,114**	2,733	1,261	117%	3,473	-21%
University Hospitals Birmingham Nhs Foundation t	1,154	702	550	**2,406**	550	497	11%	761	-28%
University Hospitals Of North Midlands nhs trust	903	738	571	**2,212**	571	477	20%	623	-8%
Wye Valley Nhs Trust	9,991	7,645	6,489	**24,125**	6,489	4,837	34%	6,772	-4%
Total	**36,672**	**23,899**	**21,229**	**81,800**	**21,229**	**15,190**	**40%**	**24,851**	**-15%**

Admitted Patient Care Data for WHSSC English contract providers (DHCW data warehouse – all reported episodes Spec+NonSpc)
Table 2 – High level summary by LHB of residence (Note. Variance to the previous table relates to border/unknown residents)

Episode total to current month (DHCW data warehouse)

EpisodeEndFinancialYearStyle	2020/21										2021/22									Total
PatientResidenceHealthOrganisationDerivedName		5	6	7	8	9	10	11	12	Total	1	2	3	4	5	6	7	8	Total	
Aneurin Bevan University Local Health Board	12	114	153	177	121	136	98	96	126	1,344	124	179	167	141	138	169	171	151	1,240	2,584
Betsi Cadwaladr University Local Health Board	927	938	1,119	1,154	1,138	1,178	921	867	1,141	11,169	1,138	1,242	1,349	1,214	1,167	1,212	1,256	1,235	9,813	20,982
Cardiff and Vale University Local Health Board	52	51	53	65	70	53	29	46	46	556	51	53	53	70	75	80	79	72	533	1,089
Cwm Taf Morgannwg University Local Health Board	37	35	49	43	46	24	30	18	33	388	60	40	65	79	60	70	56	54	484	872
Hywel Dda University Local Health Board	50	40	65	66	70	59	44	34	54	538	68	48	80	64	48	66	76	45	495	1,033
Powys Teaching Local Health Board	639	593	755	870	845	818	724	727	878	8,268	920	871	1,002	1,017	863	908	877	874	7,332	15,600
Swansea Bay University Local Health Board	31	61	51	50	43	37	23	30	40	431	42	33	38	49	52	41	50	37	342	773
Total	**748**	**1,832**	**2,245**	**2,425**	**2,333**	**2,305**	**1,869**	**1,818**	**2,318**	**22,694**	**2,403**	**2,466**	**2,754**	**2,634**	**2,403**	**2,546**	**2,565**	**2,468**	**20,239**	**42,933**

Episode total to current month (NWIS data warehouse) - NB. Includes non-HB residents so reflects marginally higher activity than the above table



Admitted Patient Care Data for WHSSC English contract providers (DHCW data warehouse – all reported episodes Spec+NonSpc)
Table 3 (4 pages) – Analysis by Specialty – Comparison of episodes to current month in 2021/22 to 2019/20 and 2020/21

Episodes by provider - 2019/20 and 2020/21 full year, 2021/22 to previous full month - DHCW data for Welsh/border residents

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	Total
Accident & Emergency	384	194	206	**784**
Adult Cystic Fibrosis Service	69	34	11	**114**
Adult Mental Illness	2			**2**
Allergy Service	91	54	76	**221**
Anaesthetics	20	15	98	**133**
Blood And Marrow Transplantation	137	83	94	**314**
Breast Surgery	89	61	50	**200**
Burns Care	95	77	55	**227**
Cardiac Surgery	602	376	380	**1,358**
Cardiology	1,865	1,330	1,205	**4,200**
Cardiothoracic Surgery	72	52	42	**166**
Cardiothoracic Transplantation	71	29	33	**133**
Chemical Pathology	3	2		**5**
Child & Adolescent Psychiatry				
Clinical Genetics	1		1	**2**
Clinical Haematology	1,055	926	661	**2,642**
Clinical Immunology	22	6		**28**
Clinical Immunology And	17	15	32	**64**
Clinical Microbiology		2		**2**
Clinical Neurophysiology	4		2	**6**
Clinical Oncology (previously Radiotherapy)	491	406	258	**1,155**
Clinical Pharmacology	7	23	12	**42**
Colorectal Surgery	270	204	177	**651**
Community Paediatrics				
Congenital Heart Disease	29	28	18	**75**
Critical Care Medicine	201	116	100	**417**
Dental Medicine Specialties		1	2	**3**
Dermatology	503	404	266	**1,173**
Diabetic Medicine	29	20	11	**60**
Diagnostic Imaging	190	186	146	**521**
Total	**36,672**	**23,899**	**21,229**	**81,800**

TreatmentSpecialtyDescription	CountEpisode for 2021/22 (M1-8)	CountEpisode for 2020/21 (M1-8)	CountEpisode % diff 2021/22 to 20/21 (M8)	CountEpisode for 2019/20 (M1-8)	CountEpisode % diff 2021/22 to 19/20 (M8)
Accident & Emergency	206	135	53%	276	-25%
Adult Cystic Fibrosis Service	11	25	-56%	48	-77%
Adult Mental Illness				1	
Allergy Service	76	23	230%	51	49%
Anaesthetics	98	5	1860%	17	476%
Blood And Marrow Transplantation	94	63	49%	85	11%
Breast Surgery	50	34	47%	57	-12%
Burns Care	55	52	6%	56	-2%
Cardiac Surgery	380	267	42%	377	1%
Cardiology	1,205	813	48%	1,115	8%
Cardiothoracic Surgery	42	37	14%	55	-24%
Cardiothoracic Transplantation	33	18	83%	59	-44%
Chemical Pathology		1		3	
Child & Adolescent Psychiatry					
Clinical Genetics	1			1	0%
Clinical Haematology	661	603	10%	687	-4%
Clinical Immunology		3		12	
Clinical Immunology And	32	3	967%	11	191%
Clinical Microbiology		2			
Clinical Neurophysiology	2			3	-33%
Clinical Oncology (previously Radiotherapy)	258	260	-1%	363	-29%
Clinical Pharmacology	12	12	0%	6	100%
Colorectal Surgery	177	109	62%	179	-1%
Community Paediatrics					
Congenital Heart Disease	18	14	29%	14	29%
Critical Care Medicine	100	75	33%	129	-22%
Dental Medicine Specialties	2	1	100%		
Dermatology	266	254	5%	293	-9%
Diabetic Medicine	11	11	0%	21	-48%
Total	**21,229**	**15,190**	**40%**	**24,851**	**-15%**

Episodes by provider - 2019/20 and 2020/21 full year, 2021/22 to previous full month - DHCW data for Welsh/border residents

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	Total
Diagnostic Imaging	199	186	146	**531**
Endocrinology	91	72	66	**229**
ENT	322	127	153	**602**
Gastroenterology	1,695	1,343	1,173	**4,211**
General Medicine	3,018	2,431	1,741	**7,190**
General Surgery	1,799	1,101	937	**3,837**
Geriatric Medicine	376	367	262	**1,005**
Gynaecological Oncology	9	17	7	**33**
Gynaecology	448	238	258	**944**
Haemophilia Service		3	2	**5**
Hepatobiliary & Pancreatic Surgery	297	188	145	**630**
Hepatology	216	194	143	**553**
Infectious Diseases	38	17	24	**79**
Intermediate Care			2	**2**
Interventional Radiology	138	103	96	**337**
Maxillo-Facial Surgery	110	29	20	**159**
Medical Oncology	474	266	248	**988**
Midwifery Service	15	10	5	**30**
Neonatology	77	74	54	**205**
Nephrology	425	303	227	**955**
Neurology	962	652	618	**2,232**
Neurosurgery	1,376	830	743	**2,949**
Nuclear Medicine	9	6	6	**21**
Obstetrics Hospital Bed	343	366	273	**982**
Ophthalmology	1,530	689	759	**2,978**
Oral Surgery	198	101	78	**377**
Orthoptics	1			**1**
Orthotics			1	**1**
Paediatric Audiological		1		**1**
Paediatric Burns Care	58	53	31	**142**
Total	**36,672**	**23,899**	**21,229**	**81,800**

TreatmentSpecialtyDescription	CountEpisode for 2021/22 (M1-8)	CountEpisode for 2020/21 (M1-8)	CountEpisode % diff 2021/22 to 20/21 (M8)	CountEpisode for 2019/20 (M1-8)	CountEpisode % diff 2021/22 to 19/20 (M8)
Diagnostic Imaging	146	117	25%	139	5%
Endocrinology	66	43	53%	60	10%
ENT	153	100	53%	226	-32%
Gastroenterology	1,173	800	47%	1,141	3%
General Medicine	1,741	1,514	15%	2,068	-16%
General Surgery	937	734	28%	1,269	-26%
Geriatric Medicine	262	243	8%	265	-1%
Gynaecological Oncology	7	12	-42%	7	0%
Gynaecology	258	165	56%	314	-18%
Haemophilia Service	2	2	0%		
Hepatobiliary & Pancreatic Surgery	145	114	27%	199	-27%
Hepatology	143	123	16%	150	-5%
Infectious Diseases	24	9	167%	23	4%
Intermediate Care	2				
Interventional Radiology	96	61	57%	89	8%
Maxillo-Facial Surgery	20	23	-13%	73	-73%
Medical Oncology	248	179	39%	345	-28%
Midwifery Service	5	6	-17%	12	-58%
Neonatology	54	45	20%	52	4%
Nephrology	227	254	-11%	300	-24%
Neurology	618	409	51%	639	-3%
Neurosurgery	743	546	36%	923	-20%
Nuclear Medicine	6	4	50%	9	-33%
Obstetrics Hospital Bed	273	241	13%	233	17%
Ophthalmology	759	461	65%	934	-19%
Oral Surgery	78	69	13%	147	-47%
Orthoptics					
Orthotics	1				
Paediatric Audiological		1			
Paediatric Burns Care	31	40	-23%	39	-21%
Total	**21,229**	**15,190**	**40%**	**24,851**	**-15%**

Episodes by provider - 2019/20 and 2020/21 full year, 2021/22 to previous full month - DHCW data for Welsh/border residents

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	Total
Paediatric Cardiac Surgery	153	159	108	**420**
Paediatric Cardiology	355	267	206	**828**
Paediatric Clinical Haematology	354	162	154	**670**
Paediatric Clinical Immunology And Allergy Service	47	18	14	**79**
Paediatric Dentistry	52	28	25	**105**
Paediatric Dermatology	31	18	27	**76**
Paediatric Diabetic Medicine		3		**3**
Paediatric Ear Nose and Throat	205	107	105	**417**
Paediatric Endocrinology	122	78	73	**273**
Paediatric Epilepsy	24	11	11	**46**
Paediatric Gastroenterology	221	217	202	**640**
Paediatric Infectious Diseases	1			**1**
Paediatric Intensive Care	158	132	117	**407**
Paediatric Interventional Radiology	26	12	13	**51**
Paediatric Maxillo-Facial	2	1	5	**8**
Paediatric Medical Oncology	679	553	245	**1,477**
Paediatric Metabolic Disease	17	17	15	**49**
Paediatric Nephrology	367	267	222	**856**
Paediatric Neuro-Disability		2	1	**3**
Paediatric Neurology	151	99	81	**331**
Paediatric Neurosurgery	193	141	115	**449**
Paediatric Ophthalmology	95	94	78	**267**
Paediatric Pain Management			1	**1**
Paediatric Plastic Surgery	187	139	112	**438**
Paediatric Respiratory Medicine	158	100	85	**343**
Paediatric Rheumatology	103	95	64	**262**
Paediatric Surgery	513	440	279	**1,232**
Paediatric Thoracic Surgery	6	2	3	**11**
Paediatric Transplantation	10	2	5	**17**
Total	**36,672**	**23,899**	**21,229**	**81,800**

TreatmentSpecialtyDescription	CountEpisode for 2021/22 (M1-8)	CountEpisode for 2020/21 (M1-8)	CountEpisode % diff 2021/22 to 20/21 (M8)	CountEpisode for 2019/20 (M1-8)	CountEpisode % diff 2021/22 to 19/20 (M8)
Paediatric Cardiac Surgery	108	118	-8%	111	-3%
Paediatric Cardiology	206	190	8%	261	-21%
Paediatric Clinical Haematology	154	92	67%	222	-31%
Paediatric Clinical Immunology And Allergy Service	14	8	75%	32	-56%
Paediatric Dentistry	25	23	9%	40	-38%
Paediatric Dermatology	27	13	108%	23	17%
Paediatric Diabetic Medicine		1			
Paediatric Ear Nose and Throat	105	65	62%	144	-27%
Paediatric Endocrinology	73	45	62%	84	-13%
Paediatric Epilepsy	11	9	22%	17	-35%
Paediatric Gastroenterology	202	137	47%	156	29%
Paediatric Infectious Diseases				1	
Paediatric Intensive Care	117	107	9%	106	10%
Paediatric Interventional Radiology	13	7	86%	21	-38%
Paediatric Maxillo-Facial Surgery	5	1	400%	2	150%
Paediatric Medical Oncology	245	384	-36%	433	-43%
Paediatric Metabolic Disease	15	10	50%	9	67%
Paediatric Nephrology	222	163	36%	282	-21%
Paediatric Neuro-Disability	1	2	-50%		
Paediatric Neurology	81	66	23%	112	-28%
Paediatric Neurosurgery	115	96	20%	135	-15%
Paediatric Ophthalmology	78	58	34%	61	28%
Paediatric Pain Management	1				
Paediatric Plastic Surgery	112	87	29%	126	-11%
Paediatric Respiratory Medicine	85	62	37%	101	-16%
Paediatric Rheumatology	64	50	28%	70	-9%
Paediatric Surgery	279	287	-3%	345	-19%
Paediatric Thoracic Surgery	3			6	-50%
Paediatric Transplantation	5	1	400%	5	0%
Total	**21,229**	**15,190**	**40%**	**24,851**	**-15%**

Episodes by provider - 2019/20 and 2020/21 full year, 2021/22 to previous full month - DHCW data for Welsh/border residents

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	Total
Paediatric Respiratory Medicine	158	100	85	343
Paediatric Rheumatology	103	95	64	262
Paediatric Surgery	513	440	279	1,232
Paediatric Thoracic Surgery	6	2	3	11
Paediatric Transplantation Surgery	10	2	5	17
Paediatric Trauma and Orthopaedics	143	95	91	329
Paediatric Urology	331	235	242	808
Paediatrics	708	361	286	1,355
Pain Management	126	75	34	235
Palliative Medicine	1	5	3	9
Physiotherapy				
Plastic Surgery	1,490	939	852	3,281
Podiatric Surgery	109	22	53	184
Rehabilitation Service	46	37	15	98
Respiratory Medicine	875	510	435	1,820
Respiratory Physiology	4	3	1	8
Restorative Dentistry	2	3	1	6
Rheumatology	728	550	617	1,895
Spinal Injuries	235	84	71	390
Spinal Surgery Service	27	39	23	89
Stroke Medicine	157	171	122	450
Thoracic Surgery	309	210	235	754
Transient Ischaemic Attack				
Transplantation Surgery	242	158	98	498
Trauma & Orthopaedics	5,429	2,171	2,818	10,418
Tropical Medicine	2			2
Upper Gastrointestinal Surgery	87	46	46	179
Urology	1,103	718	748	2,569
Vascular Surgery	113	64	47	224
Well Babies	22	14	17	53
Total	**36,672**	**23,899**	**21,229**	**81,800**

TreatmentSpecialtyDescription	CountEpisode for 2021/22 (M1-8)	CountEpisode for 2020/21 (M1-8)	CountEpisode % diff 2021/22 to 20/21 (M8)	CountEpisode for 2019/20 (M1-8)	CountEpisode % diff 2021/22 to 19/20 (M8)
Paediatric Rheumatology	64	50	28%	70	-9%
Paediatric Surgery	279	287	-3%	345	-19%
Paediatric Thoracic Surgery	3			6	-50%
Paediatric Transplantation Surgery	5	1	400%	5	0%
Paediatric Trauma and Orthopaedics	91	56	63%	105	-13%
Paediatric Urology	242	136	78%	225	8%
Paediatrics	286	222	29%	432	-34%
Pain Management	34	22	55%	93	-63%
Palliative Medicine	3	2	50%	1	200%
Physiotherapy					
Plastic Surgery	852	605	41%	1,050	-19%
Podiatric Surgery	53	14	279%	87	-39%
Rehabilitation Service	15	23	-35%	26	-42%
Respiratory Medicine	435	302	44%	606	-28%
Respiratory Physiology	1	3	-67%	4	-75%
Restorative Dentistry	1	3	-67%	1	0%
Rheumatology	617	318	94%	508	21%
Spinal Injuries	71	58	22%	173	-59%
Spinal Surgery Service	23	22	5%	15	53%
Stroke Medicine	122	105	16%	122	0%
Thoracic Surgery	235	138	70%	221	6%
Transient Ischaemic Attack					
Transplantation Surgery	98	111	-12%	147	-33%
Trauma & Orthopaedics	2,818	1,330	112%	3,622	-22%
Tropical Medicine				2	
Upper Gastrointestinal Surgery	46	34	35%	56	-18%
Urology	748	420	78%	789	-5%
Vascular Surgery	47	43	9%	73	-36%
Well Babies	17	6	183%	13	31%
Total	**21,229**	**15,190**	**40%**	**24,851**	**-15%**

Admitted Patient Care Data for WHSSC English contract providers (DHCW data warehouse – all reported episodes Spec+NonSpc)
Table 4 (8 pages) – Analysis by Specialty – Comparison of episodes to current month between 2019/20, 2020/21 and 2021/22 (All-Wales and each Health Board of residence)

4.1 All-Wales:

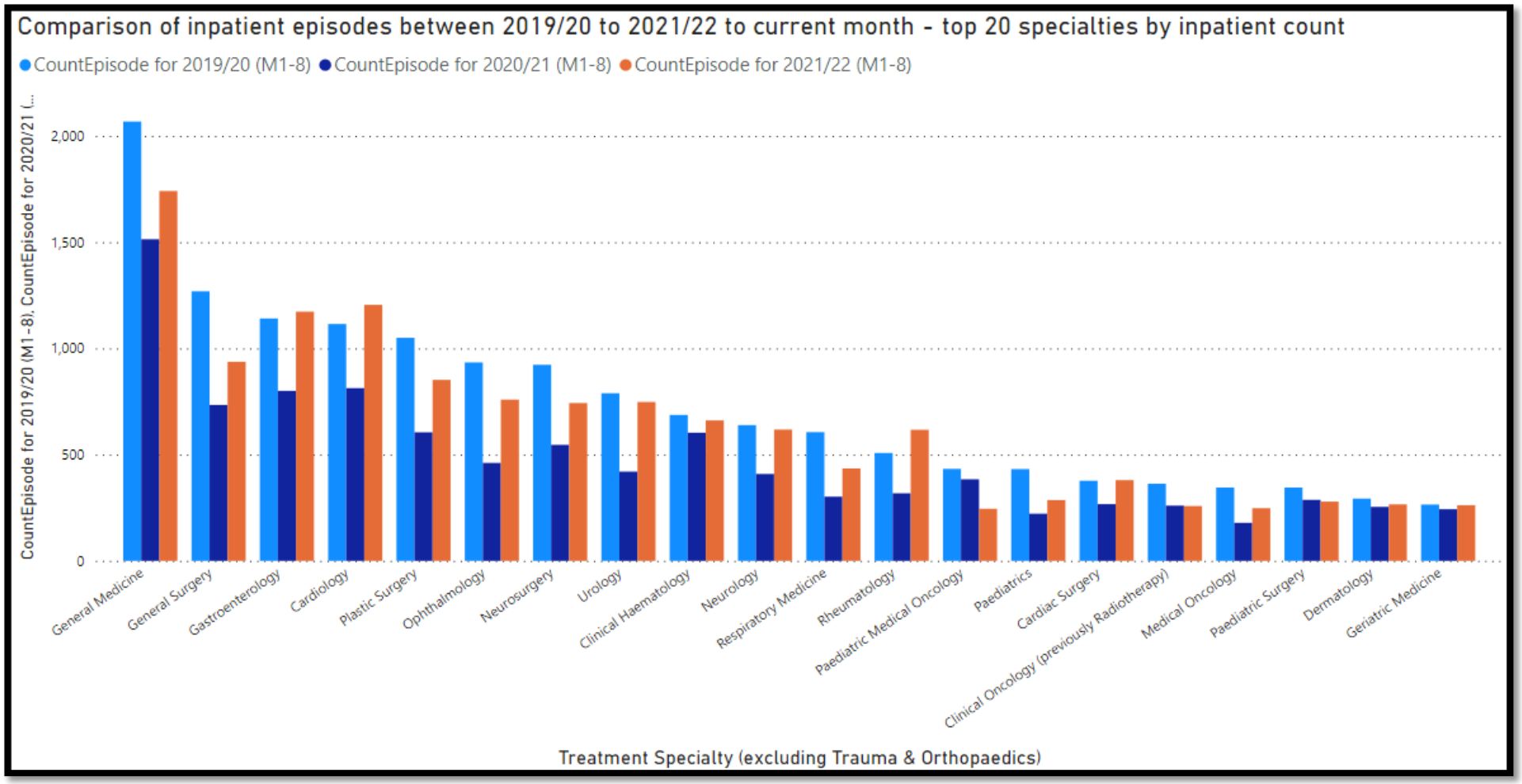


Table 4.2 – Aneurin Bevan UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20, 2020/21 and 2021/22

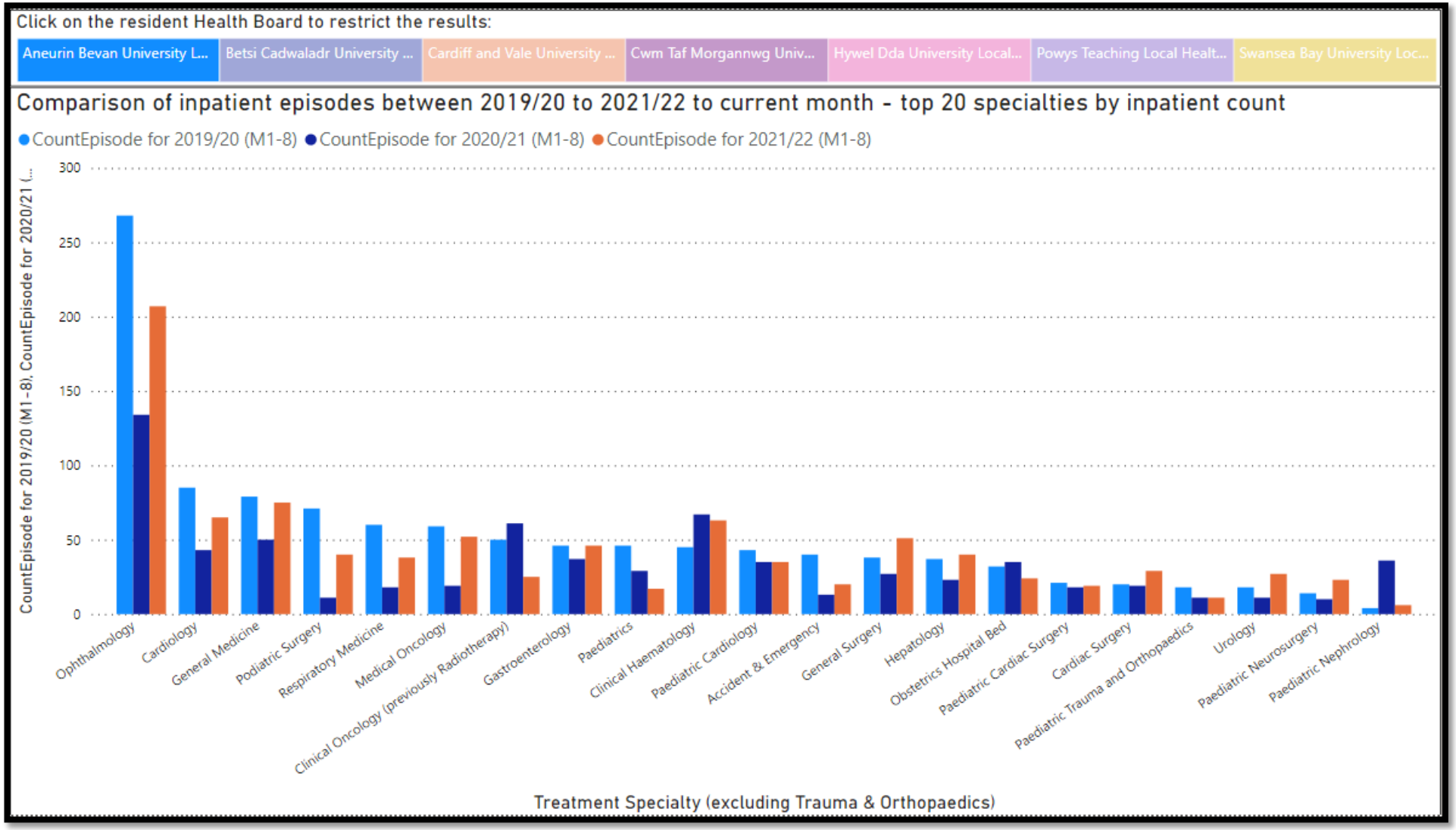


Table 4.3 – Betsi Cadwaladr UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20, 2020/21 and 2021/22

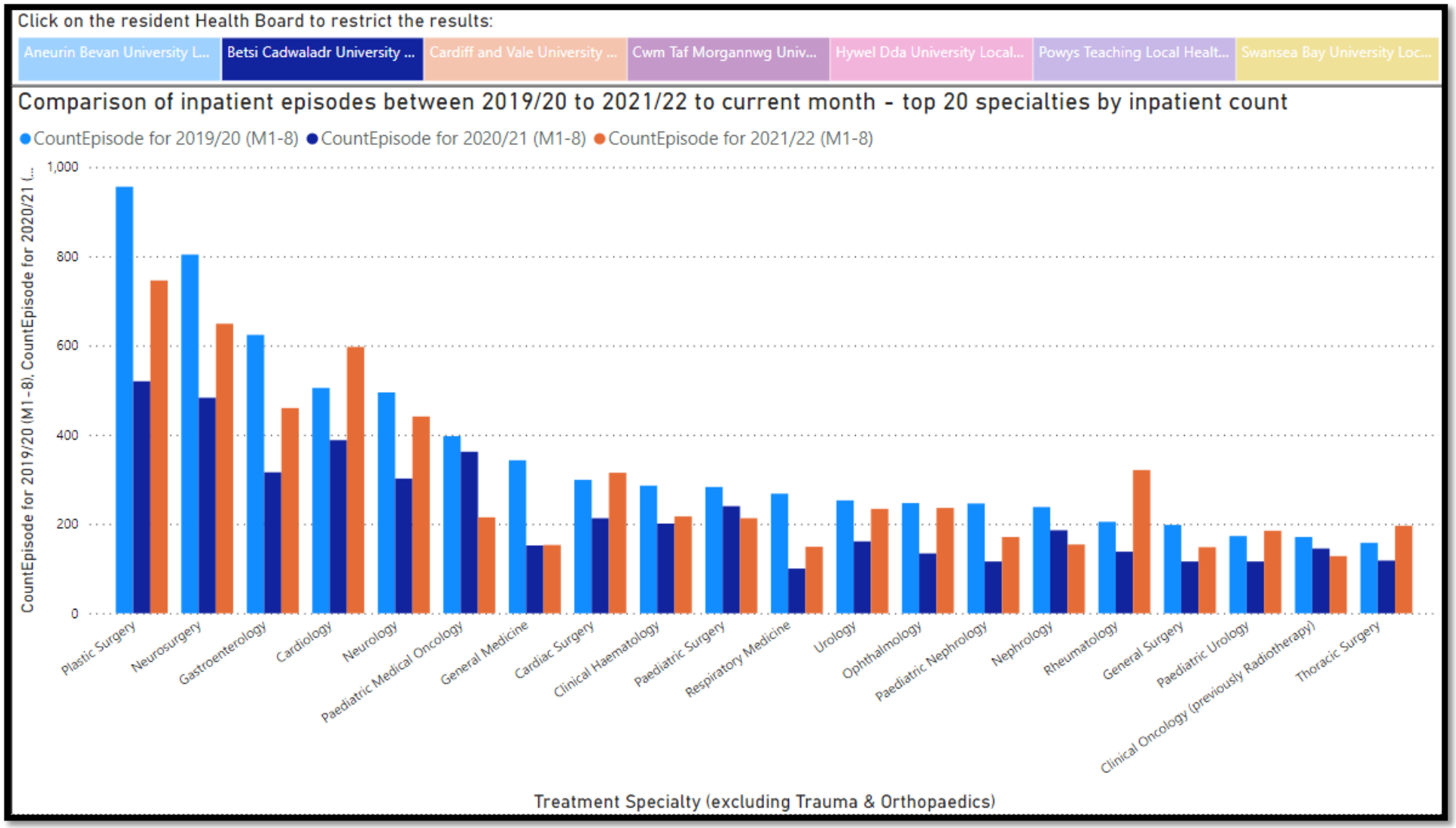


Table 4.4 – Cardiff & Vale UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20, 2020/21 and 2021/22

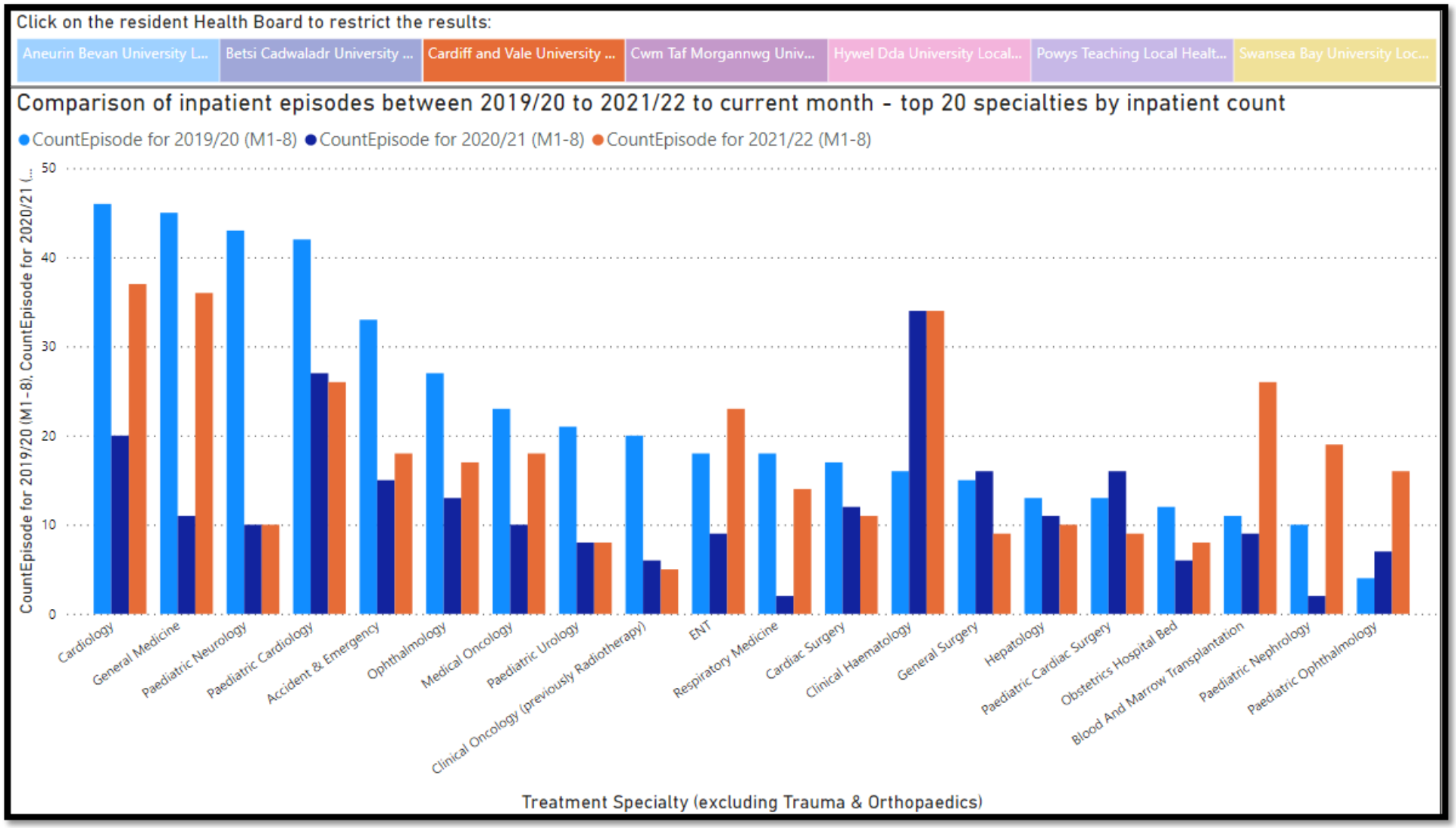


Table 4.5 – Cwm Taf Morgannwg UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20, 2020/21 and 2021/22

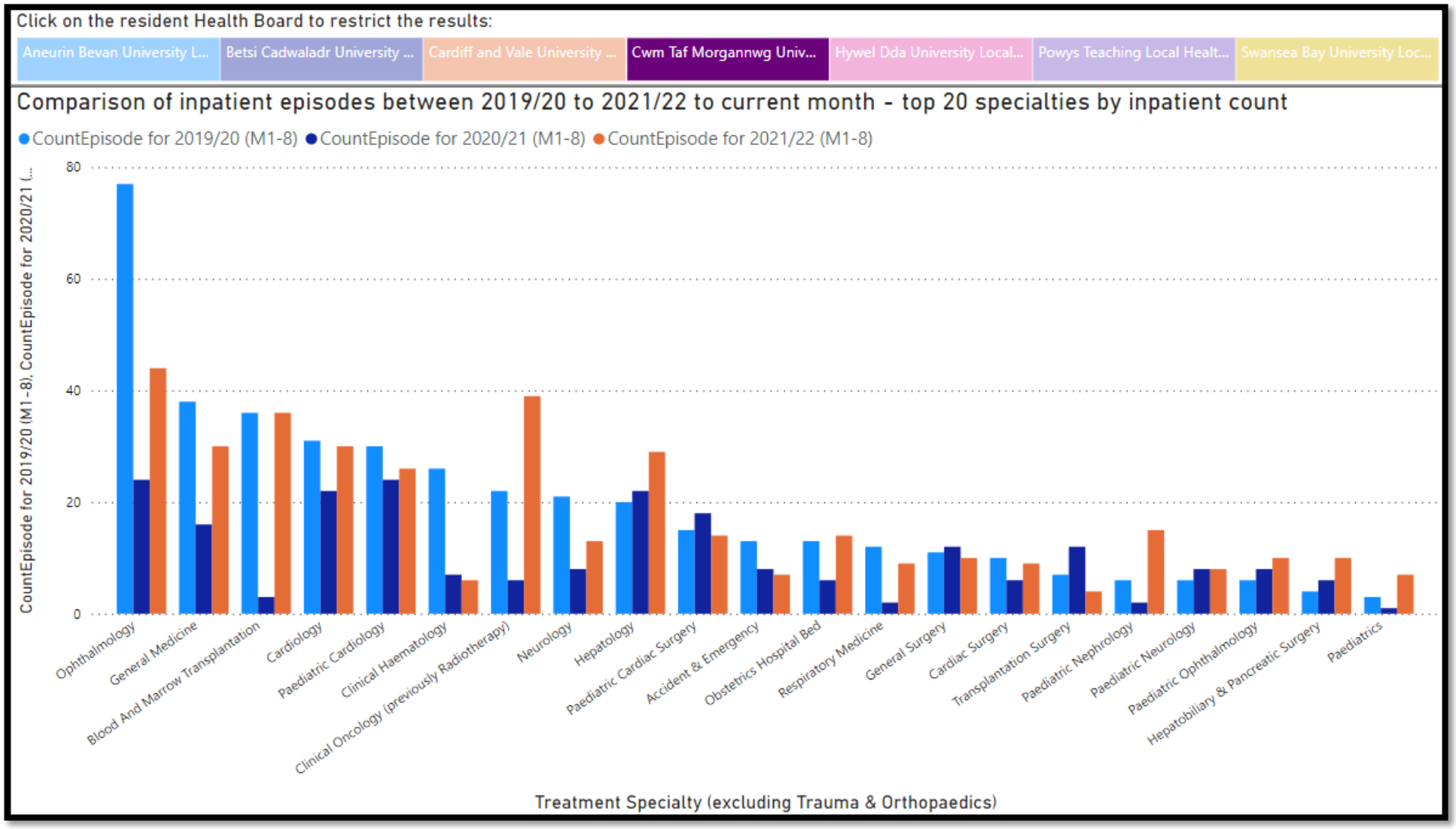


Table 4.6 – Hywel Dda HB - Analysis by Specialty – Comparison of episodes to current month between 2019/20, 2020/21 and 2021/22

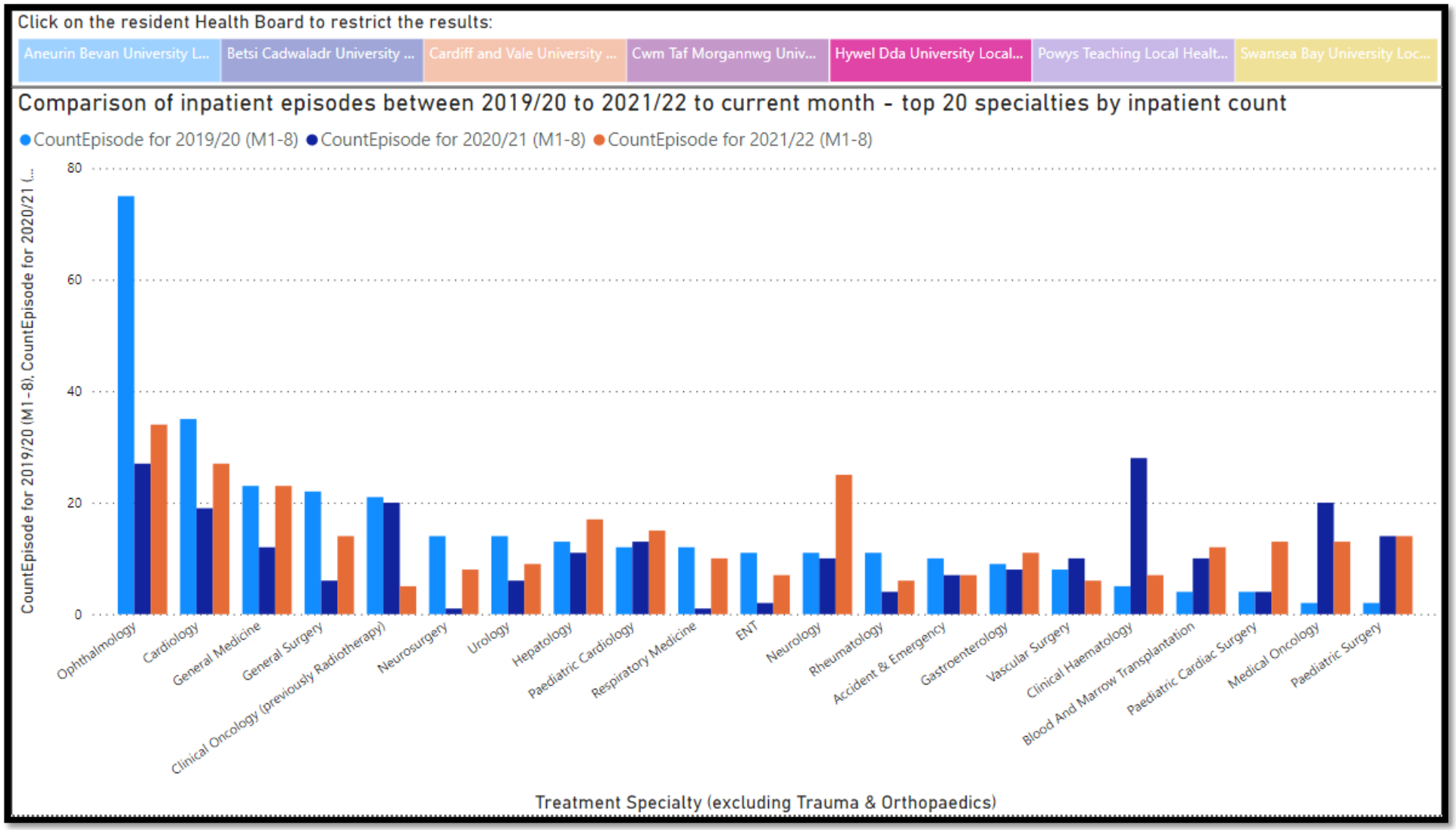


Table 4.7 – Powys THB - Analysis by Specialty – Comparison of episodes to current month between 2019/20, 2020/21 and 2021/22

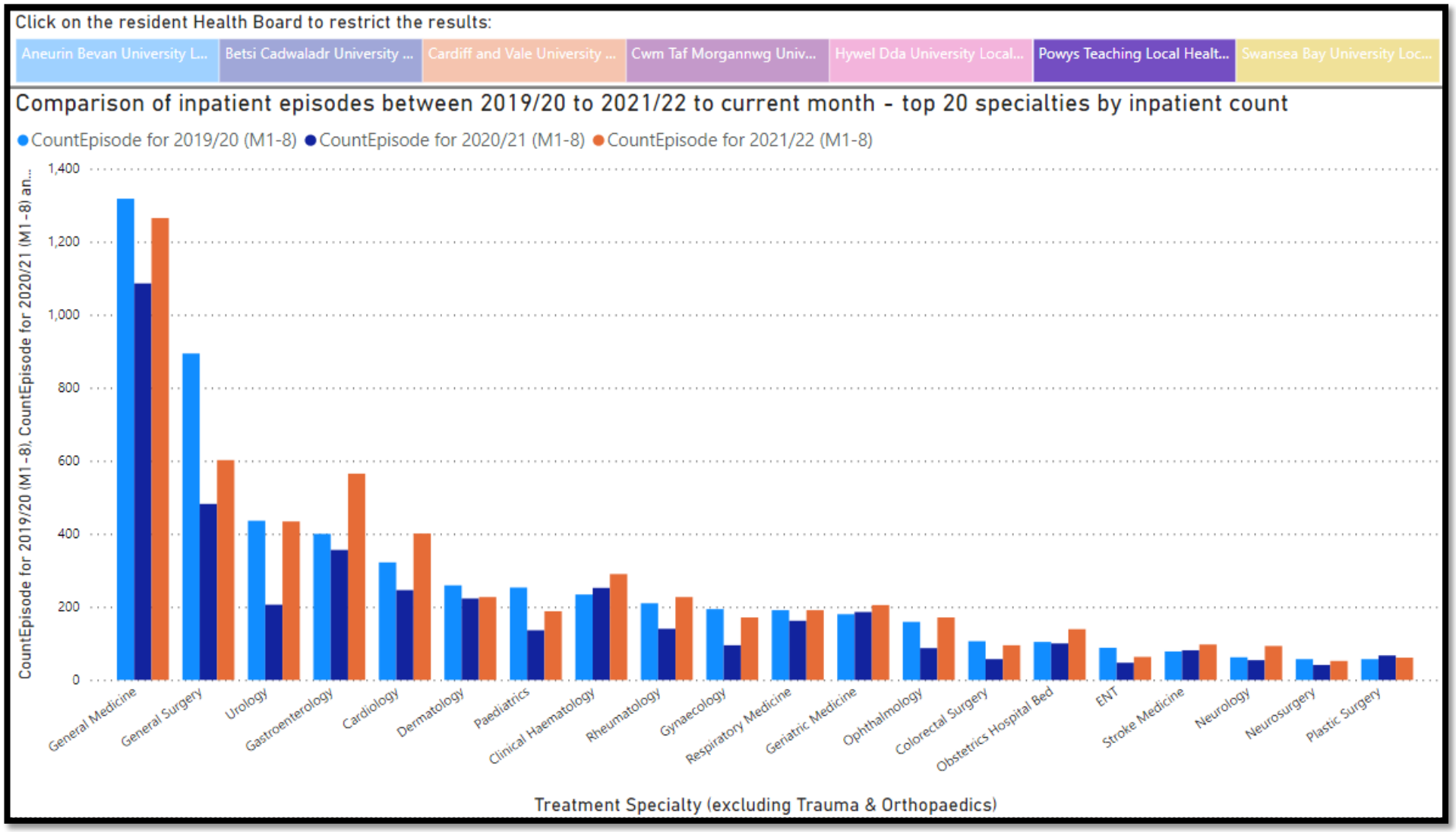
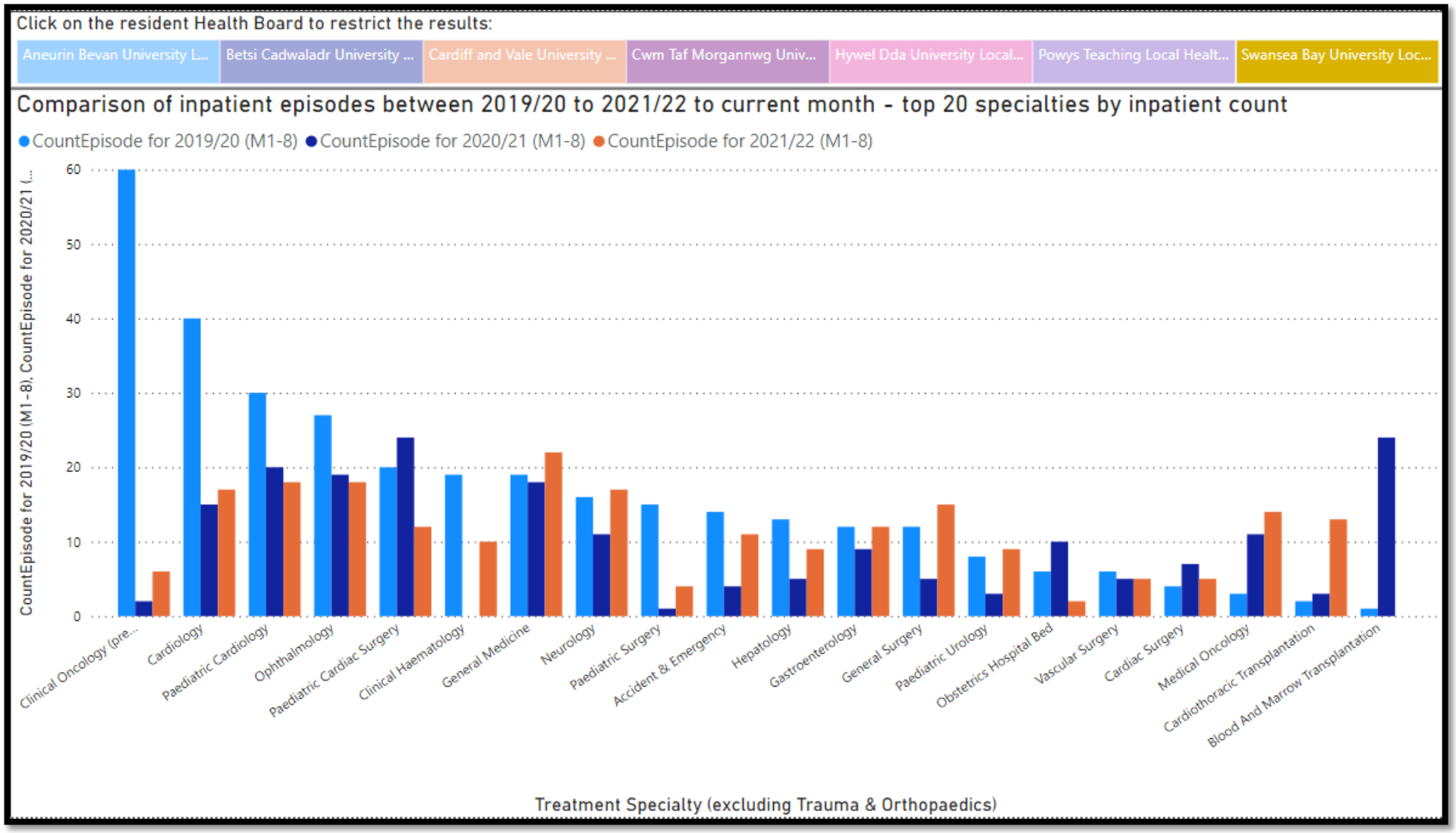


Table 4.8 – Swansea Bay UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20, 2020/21 and 2021/22



Report Title	**Financial Performance Report Month 09 2021-22**	**Agenda Item**	3.2
Meeting Title	**Joint Committee**	**Meeting Date**	18/01/2022
FOI Status	Open/Public		
Author (Job title)	Finance Manager - Contracting		
Executive Lead (Job title)	Director of Finance		

Purpose of the Report	The purpose of this report is to set out the financial position for WHSSC for the 9th month of 2021-22. The financial position is reported against the 2021-22 baselines following approval of the 2021-22 WHSSC Integrated Commissioning Plan by the Joint Committee in January 2021.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☐	INFORM ☐

Recommendation(s)

Members are asked to:

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

FINANCIAL PERFORMANCE REPORT
MONTH 09 2021-22

1.0 SITUATION

The purpose of this report is to provide the current financial position of WHSSC together with outturn forecasts for the 2021-22 financial year.

This report will be shared with WHSSC Joint Committee on 18 January and Management Group on 20 January.

2.0 BACKGROUND

The financial position is reported against the 2021-22 baselines following approval of the 2021-22 WHSSC Integrated Commissioning Plan the Joint Committee in January 2021.

3.0 ASSESSMENT

The financial position reported at Month 9 for WHSSC is a year-end outturn forecast under spend of £13,261k.

The under spend predominantly relates to the slippage of planned developments, declared slippage of prior year developments by Cardiff & Vale, release of renal growth provisions above 2021-22 forecast requirement and releasable reserves from 2020-21 provisions. There is a partial cost pressure offset with the over spend in IPFR, inclusion of inflation in English provider positions for the second half of the year, provisional assumption that the centrally funded genetics test directory year 3 business case uplift is not claimed from WG in 2021-22 and Mental Health due to high CAMHS out of area activity and complex LD patient placements.

4.0 RECOMMENDATIONS

Members are asked to:

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

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Development of the Plan Choose an item.
Link to Integrated Commissioning Plan	This document reports on the ongoing financial performance against the agreed IMTP
Health and Care Standards	Governance, Leadership and Accountability Choose an item. Choose an item.
Principles of Prudent Healthcare	Only do what is needed Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Reducing the per capita cost of health care Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	
Finance/Resource Implications	This document reports on the ongoing financial performance against the agreed IMTP
Population Health	
Legal Implications (including equality & diversity, socio economic duty etc)	
Long Term Implications (incl WBFG Act 2015)	
Report History (Meeting/Date/ Summary of Outcome	
Appendices	

FINANCE PERFORMANCE REPORT – MONTH 9 2021-22

1.0 SITUATION / PURPOSE OF REPORT

The purpose of this report is to set out the estimated financial position for WHSSC for the 9th month of 2021-22 together with any corrective action required.

Table 1 - WHSSC / EASC split

	Annual Budget	Budgeted to Date	Actual to Date	Variance to Date	Movement in Var to date	Current EOYF	Movement in EOYF position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
WHSSC	727,258	545,443	532,248	(13,196)	(939)	(13,261)	(914)
EASC (WAST, EMRTS, NCCU)	193,816	145,362	145,362	0	0	0	0
Total as per Risk-share tables	921,074	690,806	677,610	(13,196)	(938)	(13,261)	(914)

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

Please note that as LHB's cover any WHSSC variances, any over/under spends are adjusted back out to LHB's. Therefore, although this document reports on the effective position to date, this value is actually reported through the LHB monthly positions, and the WHSSC position as reported to WG is a nil variance.

2.0 BACKGROUND / INTRODUCTION

The financial position is reported against the 2021-22 baselines following approval of the 2021-22 ICP by the Joint Committee in January 2021. 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 financial position at Month 9 is a year to date underspend of £13,196k and a forecast outturn underspend of £13,261k.

NHS England is reported in line with the current IMTP. WHSSC continues to commission in line with the contract intentions agreed as part of the IMTP and historic standard PBR principles, and declines payment for activity that is not compliant with the business rules related to out of time activity.

3.0 GOVERNANCE & CONTRACTING

All budgets have been updated to reflect the 2021-22 ICP, including the full year effects of 2020/21 Developments. Inflation framework agreements have been allocated within this position. The agreed ICP sets the baseline for all the 2020/21 contract values which have been transposed into the 2021-22 contract documents.

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

4.0 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	248,240	186,180	184,845	(1,335)	(796)	(1,980)	(1,382)
Swansea Bay University Health Board	109,075	81,806	82,289	483	407	741	559
Cwm Taf Morgannwg University Health Board	10,146	7,610	7,610	0	0	0	0
Aneurin Bevan Health Board	8,934	6,701	6,701	0	0	0	0
Hywel Dda Health Board	1,662	1,246	1,246	0	0	0	0
Betsi Cadwaladr Univ Health Board Provider	44,239	33,179	32,836	(343)	(315)	(417)	(315)
Velindre NHS Trust	49,566	37,175	37,175	0	0	(133)	(133)
Sub-total NHS Wales	**471,862**	**353,897**	**352,701**	**(1,196)**	**(704)**	**(1,790)**	**(1,271)**
Non Welsh SLAs	119,250	89,437	89,402	(36)	(609)	233	(322)
IPFR	45,756	34,317	40,672	6,355	4,547	7,954	6,980
IVF	4,906	3,680	3,438	(242)	(214)	27	29
Mental Health	35,013	26,260	27,187	927	(175)	1,491	1,358
Renal	4,834	3,626	3,406	(220)	(249)	(115)	(116)
Prior Year developments	1,928	1,446	2,537	1,091	883	2,326	2,326
2020/21 Plan Developments	39,436	29,577	17,508	(12,069)	(8,808)	(13,119)	(11,131)
Direct Running Costs	4,272	3,204	3,065	(139)	(114)	(45)	24
Reserves Releases 2019/20	0	0	(7,667)	(7,667)	(6,815)	(10,223)	(10,223)
Phasing adjustment for Developments not yet implemented ** see below	0	0	0	0	0	0	0
Total Expenditure	**727,258**	**545,443**	**532,248**	**(13,196)**	**(12,258)**	**(13,261)**	**(12,347)**

The reported position is based on the following:

- Developments – variety of bases, including agreed phasing of funding.
- Mental Health – live patient data as at the end of the month, plus current funding approvals.
- NHS England activity – block basis for months 1-9 of this financial year.
- All other areas are reported as 1/12th of IMTP.

** 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.

5.0 FINANCIAL POSITION DETAIL - PROVIDERS

Provider positions can be summarised as follows for month 9:

5.1 NHS Wales Providers

YTD M9 position (£1,196k), Forecast YE position (£1,790k).

Month 9 reporting is based on the COVID-19 block funding flow agreements for 21/22, with pass through elements paid on pass through.

Both underspending positions relate to significant non recurrent slippage of prior year developments in the Cardiff & Vale provider position due to recruitment lag. These developments include Cystic Fibrosis, Inherited Bleeding Disorders, Adult Congenital Heart Disease and the Hereditary Anaemia service. There is also non-recurrent slippage on full year allocations for WG funded developments such as the MTC and critical care Long Term Ventilation. This month has also seen a continued underspend in Immunology products and ALAS wheelchairs reported in both YTD and forecast positions. There are also underspends in Haemophilia blood products in BCU and melanoma drugs in Velindre that are partially offset by over spends in SB NICE drugs and Haemophilia blood products.

5.2 NHS England Providers

YTD M9 position (£36k), Forecast YE position £233k.

The movement in both YTD and forecast positions is mainly a result of an increase in drugs and devices charged outside the block agreements across several providers but particularly in the north west.

Additional activity payments to NHSE providers under the 'elective recovery fund' terms are estimated to be £6,000k for 2021-22, this is reported in the COVID recovery section of the tables as directly funded through Welsh Government.

5.3 Individual Patient Commissioning & Non Contract Activity

YTD M9 position £6,355k, Forecast YE position £7,954k.

The year-end forecast has increased at month 9 by £974k. This reflects an increase in approvals for Home Parenteral Nutrition patients. There continues to be growth in high cost drug approvals and the position contains the expected costs of the remaining long term critical care patient at GOSH awaiting a heart transplant. One patient received a transplant in October and was discharged in November.

5.4 Specialised Mental Health

YTD M9 position £927k, Forecast YE position £1,491k.

There continues to be pressure on the CAMHS OOA position due to capacity constraints in Welsh contracted provider units. The medium secure a provision to

block buy a number of female beds to accommodate placements currently being held in a low secure setting is not expected to commence until the end of January and the forecast is adjusted accordingly. There is also continued provision for a complex MH patient currently held in a low secure setting. Month 9 has seen an increase in NHSE Gender assessment activity.

5.5 Renal

YTD M9 position (£220k), Forecast YE position (£115k).

Renal forecast is under budget mainly due to lower than planned activity in Royal Liverpool & Broadgreen.

5.6 WHSSC Developments and Strategic Priorities

YTD M9 position (£10,978k), Forecast YE position (£10,793k)

The position reflects significant slippage released in developments against in year funding releases, prioritisation schemes and collective commissioning provisions where spend is unlikely to now materialise in 21/22. This equates to a forecast reduction of £1,988k at month 9.

The genetics test directory position assumes a number of non-recurrent recovery schemes are supported to reduce waiting times and backlogs across the wider portfolio of laboratory and clinical genetics, this results in a forecast variance of £1,661k over the current allocated baseline for the test directory. There is central WG funding available to cover the year 3 uplift of the test directory, but in the context of the wider WHSSC underspend it is proposed that this is not drawn down in 21/22 to not further impact the commissioner underspend positions. Month 8 has seen the position reflect further slippage against plan in Thrombectomy activity and against WG allocation funding for Micro Processor Knees.

5.7 WHSSC Running Costs

YTD M9 position (£139k), Forecast YE position (£45k).

The underspend to date reflects vacancies for first 9 months of the year and this is profiled for the remainder of the year to arrive at the forecast year end underspend position. This position includes the incurred legal fees for an IPFR judicial review.

5.8 Reserves

YTD M9 position (£7,667k), Forecast YE position (£10,223k)

No additional reserves have been released in the month 9 position.

6.0 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	SB	Cwm Taf Morgannwg	Aneurin Bevan	Hywel Dda	Powys	Betsi Cadwaladr
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Variance M9	(13,196)	(2,417)	(1,139)	(1,978)	(2,448)	(1,647)	(733)	(2,834)
Variance M8	(12,258)	(2,047)	(1,138)	(1,690)	(2,444)	(1,424)	(835)	(2,679)
Movement	(939)	(370)	(0)	(288)	(4)	(223)	102	(156)

Table 4 – End of Year Forecast by LHB

	Allocation of Variance							
	Total	Cardiff and Vale	SB	Cwm Taf Morgannwg	Aneurin Bevan	Hywel Dda	Powys	Betsi Cadwaladr
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
EOY forecast M9	(13,261)	(2,481)	(1,071)	(1,966)	(2,498)	(1,656)	(792)	(2,797)
EOY forecast M8	(12,347)	(2,173)	(912)	(1,736)	(2,256)	(1,490)	(776)	(3,003)
EOY movement	(914)	(308)	(159)	(230)	(241)	(165)	(17)	206

7.0 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.

These figures reflect the rebased risksharing financial framework and a cost neutral allocation adjustment is anticipated to realign commissioner funding with the WHSSC income expectations.

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

Table 5 – 2020/21 Commissioner Income Expected and Received to Date

	2020/21 Planned Commissioner Income £'000	Income Expected to Date £'000	Actual Income Received to Date £'000	Accrued Income - WHSSC £'000	Accrued Income - EASC £'000	Total Income Accounted to Date £'000	EOY Comm'er Position £'000
SB	111,682	83,762	83,632	129	0	83,762	(1,071)
Aneurin Bevan	175,338	131,504	129,782	1,722	0	131,504	(2,498)
Betsi Cadwaladr	200,069	150,052	149,199	846	7	150,052	(2,797)
Cardiff and Vale	148,427	111,320	111,320	0	0	111,320	(2,481)
Cwm Taf Morgannwg	132,650	99,488	97,495	1,574	419	99,488	(1,966)
Hywel Dda	108,673	81,505	81,645	(116)	(24)	81,505	(1,656)
Powys	44,234	33,176	33,044	132	0	33,176	(792)
Public Health Wales						0	
Velindre						0	
WAST						0	
Total	**921,074**	**690,806**	**686,117**	**4,288**	**401**	**690,806**	**(13,261)**

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

None

8.0 OVERVIEW OF KEY RISKS / OPPORTUNITIES

- NHS England – 21/22 recovery over performance payments to English providers is estimated at £4.1m at month 9 based on months 1-8 contract monitoring. Whilst the thresholds for over performance are anticipated to remain at 95% in H2 there is a risk that sustained elective performance increases and the associated costs of drugs and devices outside of the ERF will be chargeable by English providers.

  The current forecast for ERF payments is £6m for 21/22.

  An analysis showing the 'actual' Recovery Costs incurred to date by English Providers are provided below. These costs are those in the month 9 reported position.

- Alder Hey £521,500 (Paediatrics)
- Liverpool Heart and Chest £2,409,876 (Cardiac/Cardiology)
- The Walton £413,844 (Neuro)
- St Helens and Knowsley £31,463 (Plastics)
- North Midlands £278,747 (Cardiac/Cardiology)
- Liverpool Womens £84,523 (IVF)

- Birmingham Women & Children's £84,592 (Paediatrics)
- Uni Birmingham £134,347 (multiple specialties)
- GOSH £136,699(Paediatrics)

Total estimated at M9 = £4,095,591

9.0 PUBLIC SECTOR PAYMENT COMPLIANCE

As at month 6 WHSSC has achieved 100% compliance for NHS invoices paid within 30 days by value and 99.8% by number.

For non NHS invoices WHSSC has achieved 99.3% in value for invoices paid within 30 days and 97.2% by number.

This data is updated on a quarterly basis.

WHSSC has undertaken a self-audit of our PSPP results as provided by NHS WSSP and are content that they are accurate. Therefore we have updated our forecast end of year position.

10.0 RESPONSES TO ACTION NOTES FROM WG MMR RESPONSES

No actions raised in M8

11.0 SLA 21/22 STATUS UPDATE

All Welsh SLAs have been signed.

12.0 CONFIRMATION OF POSITION REPORT BY THE MD AND DOF

Sian Lewis,
Managing Director, WHSSC

Stuart Davies,
Director of Finance, WHSSC

Report Title	**Corporate Governance Matters Report**	**Agenda Item**	3.3
Meeting Title	Joint Committee	**Meeting Date**	18/01/2022
FOI Status	Public		
Author (Job title)	Committee Secretary & Head of Corporate Services		
Executive Lead (Job title)	Committee Secretary & Head of Corporate Services		

Purpose of the Report	The purpose of this report is to provide an update on corporate governance matters that have arisen since the previous meeting.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☒	INFORM ☒

Recommendation(s)

Members are asked to:

- **Note** the report.

CORPORATE GOVERNANCE MATTERS

1.0 SITUATION

The purpose of this report is to provide an update on corporate governance matters that have arisen since the previous meeting.

2.0 BACKGROUND

There are a number of corporate governance matters which need to be reported as a regular item in-line with the governance and accountability framework for WHSSC. This report encompasses all such issues as one agenda item.

3.0 ASSESSMENT

3.1 Sub-Committee Terms of Reference (ToR)

To ensure effective governance the Terms of Reference (ToR) for the sub-committees are traditionally reviewed on an annual basis in tandem with the publication of the sub-committee annual reports. In readiness for the end of year annual reporting period, work has begun to review the sub-committee ToR as follows:

3.1.1 Welsh Renal Clinical Network (WRCN)

A Chairs Action has been approved to amend the Terms of Reference (ToR) for the Welsh Renal Clinical Network (WRCN) to ensure effective governance and to enable WHSSC to formally advertise the WRCN Chair role.

The WRCN ToR amended the remuneration of the Chair to a daily rate and to reflect that the Joint Committee is responsible for matters relating to its sub-committees, specifically the terms and conditions of appointment (including remuneration)

3.1.2 Management Group, Integrated Governance Committee & the Quality & Patient Safety Committee

The ToR for the Management Group**,** the Integrated Governance Committee (IGC) & the Quality & Patient Safety (Q&PS) Committee will be reviewed in January 2021 and will be presented to the JC for consideration and approval in March 2021.

3.1.3 WHSSC Individual Patient Funding Request (IPFR) Panel

Further to the update given to members at the IGC meeting on 13 December 2021, WHSSC met with Welsh Government regarding updating the ToR for the WHSSC IPFR panel which are contained within the "All NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)" on 17 December 2021, and it was confirmed that the Joint Committee has authority to make decisions on the WHSSC IPFR Panel Terms of Reference (ToR), as one of its sub-committees in accordance with the WHSSC Standing Orders. Consequently, the ToR will be reviewed and updated and be presented to the JC for consideration and approval in March 2021.

3.2 Welsh Health Circular's (WHC's)

Welsh Government (WG) issues Welsh Health Circular's (WHCs) around specific topics. The following WHCs have been received since the last meeting and are available via the WG website, where further details as to the risks and governance issues are available:

- WHC (2021) 026 Overseas Visitors' Eligibility to receive free primary care,
- WHC (2021) 027 NHS Wales Blood Health Plan
- WHC (2021) 031 NHS Wales Planning Framework 2022 to 2025
- WHC (2021) 032 Role and Provision of Dental Public Health in Wales
- WHC (2021) 033 Role and Provision of Oral Surgery in Wales

3.3 Committee Report Template

To ensure effective governance the report template for Committee reports has been reviewed and updated to reflect:

- feedback received in the Audit Wales report "Committee Governance Arrangements at WHSSC" to increase the focus on quality at the Joint Committee;
- an increased focus on quality following the publication of the WG's NHS Quality & Safety Framework [1]on 17 September 2021, including the provisions of the Health and Social Care (Quality and Engagement) (Wales) Act, in relation to the new duty of quality and duty of candour;
- to consider the impact of decisions in light of the Well-being of Future Generations Act 2015, the new Socio-economic Inequalities (Wales) Regulations 2021 and the NHS Wales Decarbonisation Strategic Delivery Plan 2021-2023[2]; and
- a focus on the quality, governance and risk implications of the report.

The template was approved by the Corporate Directors Group Board (CDGB) on 29 November 2021, and endorsed by the IGC 13 December 2021. The new template will be used from January 2022 onwards.

[1] NHS Quality and Safety Framework | GOV.WALES
[2] NHS Wales Decarbonisation Strategic Delivery Plan (gov.wales)

3.4 Forward Work Plan

In accordance with the SO's the Annual plan of Committee business was agreed at the Joint Committee on 09 March 2021. Going forward, each Joint Committee meeting will receive a copy of its business cycle which outlines the business planned for each meeting for assurance. The forward work plan is presented at ***Appendix 1*** for information.

3.5 Committee Arrangements during COVID-19

As the WHSSC continues to manage and support its response to the recovery phase of COVID-19, the Joint Committee arrangements will continue to be held virtually, with focussed agendas and shorter meetings.

4.0 QUALITY, GOVERNANCE AND RISK

The Corporate Risk Assurance Framework (CRAF) was considered and approved by the Joint Committee on November 2021. The IGC, the Q&PS and the Audit & Risk Committee monitor the CRAF at each meeting. The CRAF will next be presented to the JC for review and approval on 15 March/10 May 2022.

5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report.

Governance and Assurance	
Link to Strategic Objectives	
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	All
Quadruple Aim	Not applicable
Organisational Implications	
Quality, Safety & Patient Experience	Welsh Health Circulars (WHCs) provide advice, guidance and information relating to changes in process or services which work to enhance services
Finance/Resource Implications	There are no financial/resource implications associated with this report.
Population Health	The updates included in this report apply to all aspects of healthcare, affecting individual and population health.
Legal Implications (including equality & diversity, socio economic duty etc)	This report demonstrates compliance with the Model Standing Orders, Reservations and Delegation of Powers (SO's) which were last issued by WG in September 2019 for Local Health Boards, Trusts, the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC).
Long Term Implications (incl WBFG Act 2015)	WHSSC is committed to considering the long-term impact of its decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.
Report History (Meeting/Date/ Summary of Outcome	**-**
Appendices	**Appendix 1** – Forward Work Plan

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

WHSSC JOINT COMMITTEE
FORWARD WORK PROGRAMME – JANUARY 2022

MEETING	STANDING ITEMS	FOR APPROVAL / ACTION	ROUTINE REPORTS	INFORMATION
18 January 2022	Declarations of Interest Minutes Action Log Forward Work Programme	Chair's Report Managing Director's Report Audit Wales WHSSC Committee Governance Arrangements Update IPFR Panel Update Assurance on Patients Waiting for Specialised Services Independent Member Remuneration	COVID-19 Period Activity Report Financial Performance Report Month Report from the Chair of the CTMUHB Audit & Risk Committee Reports from the Joint Sub-Committees - Management Group Briefings - Integrated Governance Committee - Individual Patient Funding Request Panel - WRCN	

MEETING	STANDING ITEMS	FOR APPROVAL / ACTION	ROUTINE REPORTS	INFORMATION
15 March 2022	Declarations of Interest Minutes Action Log Forward Work Programme	Chair's Report Managing Director's Report Annual Review of Committee Effectiveness 2022 All Wales IPFR Terms of Reference (ToR) Learning Disability Advisory Group – disestablishment	COVID-19 Period Activity Report Financial Performance Report Report from the Chair of the CTMUHB Audit & Risk Committee Reports from the Joint Sub-Committees - Management Group Briefings - Quality & Patient Safety Committee - Integrated Governance Committee - Individual Patient Funding Request Panel - WRCN	JC Annual Cycle of Business 2022-23

MEETING	STANDING ITEMS	FOR APPROVAL / ACTION	ROUTINE REPORTS	INFORMATION
10 May 2022	Declarations of Interest Minutes Action Log Forward Work Programme	Report from the Chair Report from the Managing Director Corporate Risk Assurance Framework WHSSC Specialised Services Strategy Sub Committee annual reports and ToR	COVID-19 Period Activity Report Financial Performance Report Annual Governance Statement Report from the Chair of the CTMUHB Audit & Risk Committee	Strategy for Specialised Services
12 July 2022	Declarations of Interest Minutes Action Log Forward Work Programme	Report from the Chair Report from the Managing Director Sub-Committee Annual Reports Annual Committee Self-Assessment 2022 Risk Management Strategy	COVID-19 Period Activity Report Financial Performance Report Report from the Chair of the CTMUHB Audit & Risk Committee WHSSC Annual Report	
6 September 2022	Declarations of Interest	Report from the Chair	WHSSC Standing Orders	

	Minutes Action Log Forward Work Programme	Report from the Managing Director WHSSC Standing Orders		
8 November 2022	Declarations of Interest Minutes Action Log Forward Work Programme	Report from the Chair Report from the Managing Director	COVID-19 Period Activity Report Financial Performance Report Report from the Chair of the CTMUHB Audit & Risk Committee	

CTMUHB Audit and Risk Committee – Part 2 Assurance Report

Reporting Committee	**CTMUHB Audit and Risk Committee – Part 2**
Chaired by	**Ian Wells, Vice Chair of CTMUHB Audit and Risk Committee**
In attendance for WHSSC	**Ian Wells, WHSSC IM – Audit Lead** **Stuart Davies, Director of Finance & Information** **Jacqui Evans, Committee Secretary**
Date of Meeting	**07 December 2021**
Report Author	**Committee Secretary**

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

The CTMUHB Audit & Risk Committee (ARC) provide assurance to the Joint Committee of the effectiveness of its arrangements for handling reservations and delegations. The Memorandum of Agreement states that the Audit Lead will provide reports to the Joint Committee following the Host Audit & Risk Committee meetings. This assurance report sets out the key areas of discussion and decision.

1.0 WHSSC Corporate Risk Assurance Framework (CRAF)

Jacqui Evans (JE), WHSSC Committee Secretary presented the updated Corporate Risk Assurance Framework (CRAF) which had been approved by the Joint Committee on 09 November 2021. Members noted that:

- a risk management workshop was held with the Corporate Directors Group on 16 September 2021, which reviewed the existing risks, reviewed the scoring and identified potential additional corporate and operational risks though discussion with each individual directorate,
- each directorate had developed their own directorate specific risk register,
- a risk scrutiny group (RSG) had been introduced which met monthly, to scrutinise directorate risks and offer a critical friend process for challenging risk narrative and scoring and to consider those risks scoring 15 and above which should be escalated to the CRAF in accordance with the risk strategy,
- As at October 2021 there were a total of 29 risks scoring 15 and above, 27 commissioning risks and 2 organisational risks.
- a further risk management workshop was planned for February 2022 to review how the RSG process is working, to consider risk appetite and tolerance levels and to discuss developing a Joint Assurance Framework (JAF).

The Committee **noted** the report.

2.0 WHSSC Internal Audit Recommendations Tracker

Stuart Davies (SD), Director of Finance & Information gave a progress report on the implementation of internal audit recommendations and members noted that since 2018 8 reports have been issued, 21 recommendations have been made, 20 recommendations have been achieved and 1 recommendation was outstanding, which had not yet reached its due date.

Members noted the progress made against the seven external audit recommendations outlined in the Audit Wales report "WHSSC Committee Governance Arrangements".

The Committee **noted** the report.

3.0 EASC Risk Register

SH gave an update on the EASC risk register and advised that it had been extensively reviewed and updated by the EASC Team in October 2021 and approved by the EAS Joint Committee on the 9 November 2021. Members noted there were 2 risks which scored 15 and above.

The Committee **noted** the report.

4.0 Hosting Assurance Framework

Georgina Galletly presented the Hosting Assurance Framework and members noted that it had been developed to summarise and deliberately distinguish between the accountabilities for operational delivery and for governance. The Framework details the arrangements and requirements for organisations hosted by CTMUHB to support effective governance and provide clarity of roles of individuals and in particular, of the CTMUHB Audit and Risk Committee.

The Committee **noted** the report.

Matters referred to other Committees	
None	
Date of next scheduled meeting	24 February 2022

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

CORE BRIEF TO MANAGEMENT GROUP MEMBERS

MEETING HELD ON 25 NOVEMBER 2021

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

1. Welcome and Introductions

The Chair welcomed members to the meeting noting that, due to the COVID-19 pandemic, the meeting was being held via MS Teams. It was noted that a quorum had been achieved.

Written questions from members and answers had been published in advance of the meeting and had been embedded within the meeting papers.

2. Action Log

Members received an update on progress against the action log and **noted** the updates.

3. Managing Director's Report

Members received the Managing Director's Report and **noted** updates on:

- The SBUHB Welsh Centre for Burns,
- The Integrated Commissioning Plan (ICP) 2022-2025,
- SitRep for Paediatrics and Neonatal Service, and
- Perinatal Mental Health.

4. Paediatric Radiology - Funding Release for Implementation of 2021-22 ICP scheme

Members received a report requesting support for the release of funding to enable the implementation of the 2021/22 Integrated Commissioning Plan (ICP) scheme to commission a 24 hour paediatric radiology service for the south and west Wales population.

Members (1) **Supported** the release of funding to enable the implementation of the 2021-22 ICP scheme for a 24 hour paediatric radiology service for the population of south and west Wales, and (2) **Noted** that the requested funding was within the provision made for paediatric radiology within the ICP 2021-24.

5. A combined South Wales Service for Paediatric Gastroenterology - Funding Release for Implementation of 2021-22 ICP scheme.

Members received a report requesting support for the release of funding to enable the implementation of the 2021/22 ICP scheme to commission a combined south Wales service for paediatric gastroenterology.

Members (1) **supported** the release of funding to enable the implementation of the 2021-22 ICP scheme for a combined south Wales service for paediatric gastroenterology, and (2) **noted** that the requested funding was within the provision made for paediatric gastroenterology within the ICP 2021-24.

6. ICP 2021-24 Funding Release - Neuro-Oncology Surgery; NICE and Peer Review Compliance for South, Mid and West Wales

Members received a report requesting support for the release of funding to enable the implementation of the 2021-24 ICP scheme for an improved Neuro-oncology Surgery Service for South, Mid and West Wales.

Members (1) **approved** the release of funding for the Neuro-oncology ICP Scheme, (2) **noted** that the requested funding was within the provision made for the Neuro-oncology ICP Scheme 2021-24, and (3) **noted** that the investment in the additional staffing will enable the Neuro-oncology Surgery service to deliver to standards and addresses the remaining concerns identified in the 2016 Peer Review.

7. ICP 2021-24 Funding Release- Relocation of Rehabilitation services from Rookwood Hospital to University Hospital Llandough

Members received a report requesting support for the release of funding to enable the implementation of the 2021-24 ICP scheme for the relocation of rehabilitation services from the Rookwood Hospital to the University Hospital Llandough.

Members (1) **approved** the release of funding for the relocation of rehabilitation services from Rookwood Hospital to University Hospital Llandough; (2) **noted** that the requested funding was within the scheme provision, and (3) **noted** that the WHSSC team will work with the provider to agree the full range of quality metrics.

8. Major Trauma Priorities for Inclusion in the ICP 2022

Members received a report seeking support for the priorities identified by the Major Trauma Network to be included in the ICP for 2022.

Members (1) **discussed** the issues in the report, **(2) noted** that the Joint Committee has requested that the Management Group undertake further work regarding priorities for major trauma they wished to see included in the ICP, and the relative priority of those areas compared to other proposals in the plan, (3) **discussed** and **agreed** the areas that they wished to support for inclusion in the draft Integrated Commissioning Plan (ICP) for 2022 to be considered by MG in December prior to consideration by the Joint Committee in January 2022.

9. COVID-19 Activity Report for Month 6 2021-2022
Members received a report highlighting the scale of the decrease in activity delivered for the Welsh population by providers in England, together with the two major supra-regional providers in South Wales.

Members noted the decrease in activity during the peak COVID-19 periods, which informed the level of potential harms to specialised services patients and the loss of financial value from the necessary national block contracting arrangements introduced to provide overall system stability. The report also gave an update on recovery rates, access comparisons across HBs and waiting lists.

Members **noted** the report.

10. Financial Performance Report - Month 7 2021-22
Members received the Financial Performance Report for Month 7 which provided the current financial position of WHSSC together with the outturn forecast for the financial year. The financial position reported at Month 7 for WHSSC is a year-end outturn forecast under spend of £12,342k.

Members **noted** the current financial position and forecast year-end position.

11. WHSSC Policy Group Report
Members received a report providing an update on the work of the WHSSC Policy Group.

Members **noted** the report.

12. Forward Work Plan
Members **noted** the forward work plan.

13. AOB

i. **Neonatal Transport**

Members received a verbal update on Neonatal transport and noted that the progress made to establish an operational delivery network (ODN) for neonatal transport, and that due to operational workforce pressures across the system, the Joint Committee meeting on the 9 November had agreed to extend the current interim 24 hour model until the end of June 2022.

ii. **Paediatric Inherited Metabolic Disease**

Members received a report to consider and approve a preferred model for the new Paediatric Inherited Metabolic Disease service for the population of south and west Wales, in light of the cessation of the service at Cardiff and Vale UHB from 1 February 2022.

Members **noted** the updates.

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

CORE BRIEF TO MANAGEMENT GROUP MEMBERS

MEETING HELD ON 16 DECEMBER 2021

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

1. Welcome and Introductions

The Chair welcomed members to the meeting noting that, due to the COVID-19 pandemic, the meeting was being held via MS Teams. It was noted that a quorum had been achieved.

Written questions from members and answers had been published in advance of the meeting and had been embedded within the meeting papers.

2. Action Log

Members received an update on progress against the action log and **noted** the updates.

3. Managing Director's Report

Members received the Managing Director's Report and **noted** updates on:

- Hepato-Pancreato-Biliary (HPB) Services Workshops,
- An Extension of Fastrack Process for Military Personnel,
- The Mental Health Secure Services Review Report, and
- Paediatric Inherited Metabolic Diseases (IMD).

4. Integrated Commissioning Plan 2022-2025

Members received a report introducing the Integrated Commissioning Plan 2022-2025 (ICP) which has been developed to respond to the Welsh Government requirement set out in the NHS Annual Planning Framework Guidance 2021-2022. Members noted that the ICP presented a cohesive plan for the commissioning of Specialised Services for the people of Wales.

Members (1) **Considered** the content and structure of the Integrated Commissioning Plan 2022-2025; and (2) **Endorsed** the Integrated Commissioning Plan 2022-2025 for submission to the Joint Committee.

5. SABR for Lung Cancer – Designation Assessment of Swansea Bay UHB

Members received a report making recommendations in relation to the designation of Swansea Bay UHB as a commissioned provider of Stereotactic

ablative body radiotherapy (SABR) to treat lung cancer for patients in south-west and mid Wales. Members noted that WHSSC had undertaken an assessment of SBUHB's ability to become a designated provider of SABR for treating patients with lung cancer and the process and outcomes of the assessment were considered by the group.

Members (1) **Noted** the information in the report; (2) **Noted** the Cancer & Blood commissioning team's recommendation that SBUHB's proposal would provide a safe, high quality and sustainable service that improves equity of access for the population of south-west and parts of mid Wales; (3) **Noted** the value for money assessment that commissioning SABR at SBUHB will provide additional benefits to patients from improved accessibility, at an additional cost per patient at the volumes that will be delivered in the first few years of the service; (4) **Noted** that the development of a SABR service at SBUHB is affordable within the ICP provision for SABR; and (5) **Supported** the strategic intent for the designation of SBUHB as a commissioned provider of SABR for lung cancer and agreed to re-consider an updated report to include additional information on costs and service resilience in early 2022.

9. COVID-19 Activity Report for Month 7 2021-2022
Members received a report highlighting the scale of the decrease in activity delivered for the Welsh population by providers in England, together with the two major supra-regional providers in South Wales.

Members noted the decrease in activity during the peak COVID-19 periods, which informed the level of potential harms to specialised services patients and the loss of financial value from the necessary national block contracting arrangements introduced to provide overall system stability. The report also gave an update on recovery rates, access comparisons across HBs and waiting lists.

Members **noted** the report.

10. Financial Performance Report - Month 8 2021-22
Members received the Financial Performance Report for Month 8 which provided the current financial position of WHSSC together with the outturn forecast for the financial year. The financial position reported at Month 8 for WHSSC is a year-end outturn forecast under spend of £12,347k.

Members **noted** the current financial position and forecast year-end position.

12. Forward Work Plan
Members **noted** the forward work plan.

Reporting Committee	**Integrated Governance Committee**
Chaired by	**WHSSC Chair**
Lead Executive Director	**Committee Secretary**
Date of last meeting	**13 December 2021**

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

13 December 2021
Due to the COVID-19 pandemic, the meeting was held via MS Teams.

The main focus of the meeting included a comprehensive update on the implementation of the Integrated Commissioning Plan 2021-2022, Corporate Risk Assurance Framework and an update on Progress against the Audit Wales Governance Review.

Implementation of the Integrated Commissioning Plan 2021-2022 Quarter 2 Progress Report
The progress report on the implementation of the Integrated Commissioning Plan 2021-2022 Quarter 2 was received. KP presented the half yearly progress report and members noted that the report would be submitted to Welsh Government for information.

KP explained that she had set out all of the actions that were planned for delivery up to quarter 2 and had provided comments on whether the target date had been achieved. Members noted that some actions spanned the entire year so no specific target date could be provided and KP explained that she had provided updates on progress to date but further updates would also be provided as and when required against these on-going actions. The actions marked as red contained a detailed explanation for any delay.

Members commented that overall the rate of progress was pleasing especially when we continue to operate with the challenges of a pandemic. It was noted that the majority of delayed actions were because WHSSC was waiting and was dependant on other organisations. KP explained that this was not unusual and advised that WHSSC was aware of the service pressures facing Cardiff & Vale UHB (CVUHB) and that their business case was delayed. Members agreed it was important to provide a measured approach as some services were struggling with capacity.

Corporate Risk Assurance Framework (CRAF)
The Corporate Risk Assurance Framework (CRAF) was received. JE advised that KP would provide members with an update on commissioning risks, HT would

provide an update on the work of the Risk Scrutiny Group and JE would provide an overall summary.

KP provided members with an overview of the 2 new commissioning risks as highlighted in the CRAF Cover Report concerning CB04 – Major Burns ITU and CB05 – HCC South Wales.

KP explained that risk CB04 was scored as a 16 as they were assured that progress was being made against the Health Board action plan in place to help mitigate the risk. An agreement was in place through the South Wales and West Burns Network. In addition to appearing as a new risk the service had also been escalated to level 4 of the WHSSC escalation process.

The HCC risk CB05 was being addressed and a business case to address the problems would shortly be presented to the Management Group. A financial provision had been provided in the WHSSC ICP 2021/22 for patients with hepatology conditions.

JE advised that whilst the risk has been mitigated and the score had been reduced, it remained a "live" risk as the recruitment of the identified staff resource may take several months, and that WHSSC staff would remain under considerable pressure due to increased workloads, until the new staff were appointed and were in post.

Members discussed the risk relating to mental health, the political imperative and the need for all secure services to have a single commissioner. Members noted that a new group had been formed to look at mental health placements and that CVUHB were heavily invested in getting traction on this issues. KP advised that there was a gatekeeping policy in place.

JE concluded the item and provided members with an overall summary:

- there were currently 22 risks appearing on the CRAF down from 28,
- 2 new risks had been escalated as referenced by KP,
- an internal audit on WHSSC risk management processes would be undertaken in in January 2022.

Update on Progress Against the Audit Wales Governance Review

Members received the update on progress against the Audit Wales Governance review and considered the progress made against the recommendations following the Audit Wales report on "Committee Governance arrangements at WHSSC."

JE gave an update on progress and members noted:

- the findings of the Audit Wales report on "Committee Governance arrangements at WHSSC" were presented to the JC in July and it was agreed that the IGC would monitor progress against the recommendations and a report would be presented back to JC in January 2022,

• the report outlined 4 recommendations for WHSSC and the CDGB have reviewed the progress made against each management response and the tracker document had been updated, • the tracker document had been updated to include further updates, • the 3 recommendations assigned to WG were being monitored through discussions between the Chair of WHSSC, the WHSSC Managing Director and Dr Andrew Goodall. CP advised that the report provided a comprehensive update and comprehensive narrative. Members expressed concern that despite the comprehensive updates provided by WHSSC, no recent updates had been received for the recommendations relating to Welsh Government (WG). JE advised that the responses to the WG recommendations had been discussed at the part 2 Cwm Taf Morgannwg (CTMUHB) Audit & Risk committee held on the 7 December 2022 and that Dave Thomas from Audit Wales (AW) had also confirmed that he had requested an update from WG on progress. **Corporate Governance Update** The Corporate Governance update report was received and JE explained that the report would also be presented to JC on 18 January 2022.
Key risks and issues/matters of concern and any mitigating actions
As recorded above
Matters requiring Joint Committee level consideration and/or approval
None
Matters referred to other Committees
None
Confirmed Minutes for IGC meetings are available on request

Date of next meeting	30 March 2022

Reporting Committee	**All Wales Individual Patient Funding Request (IPFR) Panel**
Chaired by	**Professor Vivienne Harpwood**
Lead Executive Director	**Director of Nursing and Quality Assurance**
Date of last meeting	**Twice Monthly Virtual – 16/12/21**

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

The All Wales IPFR Panel has met 3 times between the 04 November and the 30 December 2021. During the same period, the Chairs Action Panel has also met on 3 separate occasions.

The following table demonstrates the number of requests considered by both the AW IPFR Panel and the Chairs Action Panel during this period.

Dr Ruth Alcolado, Medical Director of NWSSP has been appointed as Vice-Chair of the Panel and has attended both IPFR Panel meetings held since her appointment.

	Number of Requests discussed by IPFR Panel	Number of Requests discussed as Chairs Action	Number of Requests APPROVED
November	10	7	9
December	12	9	9

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

All Wales IPFR Panel Quoracy

There are long standing issues in achieving quoracy for the All Wales IPFR meetings. This was particularly challenging at the last meeting on 16 December 2021. It is recognised that this is likely to be due to the increasing service pressures related to the current wave of the pandemic.

Previously, during the pandemic, when we were asked to step down the Panel we used the Chairs action arrangement outlined in the terms of reference (ToR) and strengthened it by including 2 WHSSC Clinical Directors and a lay member.

Therefore, given the increased service pressures on the NHS due to COVID-19, the recent letter from Mrs Judith Paget CEO of NHS Wales suggesting NHS bodies step down any non-essential meetings, and the challenges in maintaining quoracy at virtual panel meetings, to ensure business continuity WHSSC intend to use the strengthened Chairs Action option for Panel decisions during January 2022 instead of the full Panel.

WHSSC will provide an update of any decisions to the subsequent meeting of the Panel. We will review the situation on a monthly basis thereafter.

Vice Panel Chair
Dr Ruth Alcolado, Medical Director, NHS Wales Shared Services Partnership, has been appointed as Vice Chair with effect from 16 December 2021 for 2 years until December 2023.

Judicial Review
On 03 December 2021 a request for a judicial review in the case of Maria Rose Wallpott (MW) – v- (1) WHSSC & (2) Aneurin Bevan UHB (ABUHB) was allowed and the decision of the WHSSC IPFR panel to refuse funding for cytoreductive surgery with hyperthermic intraperitoneal chemotherapy (CRS with HIPEC) to treat MW's colorectal cancer, was quashed by the court. Further details regarding this are included in agenda item 2.3. The application for funding for the intervention recommended by her clinician was reconsidered "afresh" by the WHSSC IPFR panel on the 16 December 2021

Request for Independent Review by Health Board
WHSSC has received a request for an Independent Review by Cardiff and Vale University Health Board (CVUHB) of the process followed by the All Wales Panel. A provisional date has been agreed for 19 January 2022. The outcome of the Review will be reported to the Joint Committee.

AWTTC 2021 IPFR Workshop
A virtual IPFR workshop was held on Monday 29 November 2021 between 9:15-12:15. Attendance was via Zoom and Chaired by Dr James Coulson, Interim Clinical Director, AWTTC.

Delegates had the opportunity to access sessions including application completion, ethics, law and the role of Panel members.

MOD Fast-Track Process Recognition
"On behalf of our Officer Commanding Major Frank Short and all the Regional Rehab Team at St Athan to extend our grateful thanks for all the hard work you did looking after our patients through 2021.

The Covid Pandemic has been a real challenge however, the team at WHSSC have gone the extra yard to assisting our Service Patients to access Secondary Care services and to return to duty".

Matters requiring Committee level consideration and/or approval

- None

Matters referred to other Committees	
• None	
Confirmed Minutes for each of the meetings are available on request.	
Date of next meeting	**06 January 2022**

Reporting Committee	**Welsh Renal Clinical Network (WRCN)**
Chaired by	**(Interim) Chair, Welsh Renal Clinical Network**
Lead Executive Director	**Director of Finance**
Date of last meeting	**10 November 2021**

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

- **Interim Chair arrangements and Recruitment of Permanent Chair**

From July 2021, Mr Ian Phillips, Vice Chair, WHSSC is acting as interim Chair for the Network for a period of 6 months. The application process to appoint to substantive post is being overseen by WHSSC.

- **Function of the WRCN Board**

Early discussions have been initiated by the Interim Chair to consider how the Board could achieve an efficient balance between strategic focus and quality performance requirements. This builds on the outcomes from the Healthy Board Workshops completed in 2021.

- **Prioritisation of requests to fund service developments**

The clinical prioritisation of all service development requests was concluded and a report of outcomes submitted to the WRCN Board. Whilst Board members were new to the process it was recognised that this approach was both transparent and fair. Further discussion noted the need for additional clarity in relation to how service growth should be dealt with under the prioritisation process. This will be reflected in the next iteration of the process following discussion with WRCN Executive Lead and Health Board representatives. Business cases for all this years prioritised schemes will be submitted for internal quality assurance and for onward submission to the WHSSC ICP approval process.

- **Peer Review – Home Dialysis**

The peer review of current home dialysis services in Wales was completed in July 2021. Reports highlighting best practice and recommendations for service improvement issued to Health Board Chief Executives on 13 August 2021. There is one outstanding response from BCUHB.

- **COVID-19 Recovery**

Growth in demand for dialysis was flattened during the first 18 months of the pandemic, but there are signs of recovery. A financial strategy paper is to be brought to the next Board meeting forecasting for the next three years the potential impact on resources.

Key risks and issues/matters of concern and any mitigating actions	
• **Procurement Programme, SBUHB** The procurement programme approved by Welsh Government in October 2020 to re-tender existing dialysis units, re-provide in-hospital dialysis machines and provide for two new expansion units is progressing with the final invitation to tender anticipated to be issued in late January 2022. The efforts to maintain progress on this complex project have been significant particularly in the context of ongoing service pressures experienced by both the Health Board, Procurement colleagues and the WRCN core team. In recognition that the current level of work to progress and implement the procurement process and resultant contract is unstainable, the project team require urgent support to ensure the project remains on track. As a consequence monies to provide additional project management support have been agreed by the WRCN and are being progressed by the SBUHB Renal Directorate. • **Vascular Access** Issues relating to capacity to enable timely formation of vascular access for haemodialysis (HD) patients remains on the WRCN risk register. All areas saw a fall in definitive access for patients prior to commencement of HD during 2020 and corresponding falls in prevalent patients. A peer review of services is being planned for late summer 2022 to enable focused recommendations and sharing of best practice. Health Boards were reminded that WHSSC would fund vascular access waiting list initiatives if these were considered an appropriate response to clear any back-log of procedures.	
Matters requiring Committee level consideration and/or approval	
• None	
Matters referred to other Committees	
• None	
Annexes:	
Date of next meeting	