2023-03-14 JC (Public)

Tue 14 March 2023, 13:30 - 16:30

Agenda

13:30 - 13:30
0 min

1. PRELIMINARY MATTERS

0.0 JC Public Agenda 14 March 2023.pdf (2 pages)

1.1. Welcome and Introductions

Verbal *Chair*

1.2. Apologies for Absence

Verbal *Chair*

1.3. Declarations of Interest

Verbal *Chair*

1.4. Minutes of the Meetings held on 10 January 2023, 17 January 2023, 13 February 2023 and Matters Arising

Attached *Chair*

1.4a Unconfirmed Extraordinary JC (Public) Minutes 10 January 2023 VFinal.pdf (6 pages)
1.4b Unconfirmed JC (Public) Minutes 17 January 2023 VFinal.pdf (13 pages)
1.4c Unconfirmed Extraordinary JC (Public) Minutes 13 February 2023 VFinal.pdf (9 pages)

1.5. Action Log

Attached *Chair*

1.5 JC Action Log 14 March 2023.pdf (3 pages)

13:30 - 13:30
0 min

2. PRESENTATION

2.1. Governance System and Process - WHSSC & HB Shared Pathway Saving Target

To Follow *Director of Planning*

13:30 - 13:30
0 min

3. ITEMS FOR CONSIDERATION AND / OR DECISION

3.1. Chair's Report

Attached *Chair*

3.1 Chair's Report.pdf (4 pages)
3.1.1 Appendix 1 - Letter WHSSC Joint Committee Chairs action Blueteq.pdf (2 pages)

3.2. Managing Director's Report

Attached *Managing Director*

3.2 Managing Director's Report.pdf (4 pages)

3.3. Delivering Thombectomy Capacity in South Wales

Attached *Director of Planning*

- 3.3 Delivering Thrombectomy Capacity in South Wales.pdf (6 pages)
- 3.3.1 Appendix 1 - Developing Regional Stroke Services v0c 160222.pdf (13 pages)
- 3.3.2 Appendix 2 - WHSSC Thrombectomy position statement - revised for March 2.._v1.pdf (7 pages)

3.4. Eating Disorder In-Patient Provision for Adults

Attached *Director of Mental Health*

- 3.4 Eating Disorder In-Patient Provision for Adults.pdf (4 pages)

3.5. Neonatal Transport ODN - Additional Funding Release

Attached *Director of Planning*

- 3.5 Neonatal Transport ODN - Additional Funding Release.pdf (4 pages)
- 3.5.1 Appendix 1 Neonatal Transport ODN Funding Release MG 22 Sept 2022.pdf (6 pages)
- 3.5.2 Appendix 2 - Summary of Funding Requests.pdf (1 pages)
- 3.5.3 Appendix 3 Funding Release for South Wales Neonatal Transport ODN MG 15.12.22.pdf (4 pages)

3.6. Neonatal Cot Configuration Project

Attached *Director of Planning*

- 3.6 Neonatal Cot Configuration Project.pdf (23 pages)
- 3.6.1 Appendix 1 - Neonatal Unit descriptors.pdf (3 pages)
- 3.6.2 Appendix 2 - Literature review neonatal cot project.pdf (2 pages)
- 3.6.3 Appendix 3 - Demand and Capacity.pdf (1 pages)
- 3.6.4 Appendix 4 - Birth rates and delivery numbers.pdf (2 pages)
- 3.6.5 Appendix 5 - Workforce BAPM.pdf (12 pages)

3.7. IPFR Engagement Update - ToR and All Wales Policy

Attached *Medical Director*

- 3.7 WHSSC IPFR Engagement Update - ToR and All Wales Policy.pdf (9 pages)
- 3.7.1 Appendix 1 Letter to WHSSC from WG IPFR ToR July 2022 FINAL.pdf (3 pages)
- 3.7.2 Appendix 2 Stakeholder Engagement Responses table WHSSC IPFR Panel.pdf (42 pages)
- 3.7.3 Appendix 3 - Proposed WHSSC IPFR Panel ToR v0.9 post consultation.pdf (7 pages)

3.8. WHSSC Governance & Accountability Framework - SOs and SFIs

Attached *Committee Secretary*

- 3.8 WHSSC Governance and Accountability Framework.pdf (10 pages)
- 3.8.1 Appendix 1 - Updated Standing Orders Feb 2023.pdf (57 pages)
- 3.8.2 Appendix 2 - WHSSC MoA Feb 2023 with Annex 1-5.pdf (66 pages)
- 3.8.3 Appendix 3 WHSSCS SFIs July 2021.pdf (33 pages)
- 3.8.4 Appendix 3a - Scheme of Delegation New Proposed.pdf (8 pages)
- 3.8.5 Appendix 3b - Copy of Authorisation Matrix.pdf (1 pages)

13:30 - 13:30
0 min

4. ROUTINE REPORTS AND ITEMS FOR INFORMATION

4.1. Performance & Activity Report Month 9 2022-2023

Attached *Director of Finance*

- 4.1 Performance & Activity Report Month 9 2022-2023.pdf (36 pages)
- 4.1.1 Performance & Activity Report Month 9 2022-2023 - Appendix 1 English data.pdf (14 pages)
- 4.1.2 Performance & Activity Report Month 9 2022-2023 - Appendix 2 WG measures.pdf (10 pages)

4.2. Financial Performance Report Month 10 2022-2023

Attached *Director of Finance*

4.2 Financial Performance Report Month 10 22-23.pdf (11 pages)

4.3. Neonatal Delivery Assurance Group (DAG) Update

Attached *Director of Planning*

4.3 Neonatal Delivery Assurance Group (DAG) Report.pdf (4 pages)

4.4. Corporate Governance Matters Report

Attached *Committee Secretary*

4.4 Corporate Governance Report.pdf (5 pages)
4.4.1 Appendix 1 WHSSC Joint Committee 12 Month Forward Work Plan 2023-2024.pdf (8 pages)

4.5. Reports from the Joint Sub-Committees

Attached *Joint Sub-Committee Chairs*

4.5.1. Audit and Risk Committee (ARC) Assurance Report

4.5.1 Audit and Risk Committee Assurance Report - February 2023 - HT.pdf (4 pages)

4.5.2. Management Group Briefings

4.5.2a 2023-02-23 MG Core Brief v2.1.pdf (6 pages)
4.5.2b 2023-01-26 MG Core Brief.pdf (3 pages)

4.5.3. Individual Patient Funding Request (IPFR) Panel

4.5.3 IPFR Chair Report 2023 v3.pdf (3 pages)

4.5.4. Integrated Governance Committee (IGC)

4.5.4 IGC Chair's Report.pdf (5 pages)

4.5.5. Quality and Patient Safety Committee (QPSC)

4.5.5 QPSC Chairs report v0.3.pdf (10 pages)

4.5.6. Welsh Kidney Network (WKN)

4.5.6 WKN Chairs Report.pdf (5 pages)

13:30 - 13:30
0 min

5. CONCLUDING BUSINESS

5.1. Any Other Business

Verbal *Chair*

5.2. Date of Next Meeting (Scheduled)

Verbal *Chair*

16 May 2023 at 09.30hrs

5.3. In Committee Resolution

The Joint Committee is recommended to make the following resolution: “That representatives of the press and other members

of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960)".

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

WHSSC Joint Committee Meeting held in public
Tuesday 14 March 2023
at 13:30 hrs

Microsoft Teams

AGENDA

ITEM		LEAD	PAPER / ORAL	TIME
1.0	**PRELIMINARY MATTERS**			
1.1	Welcome and Introductions	Chair	Oral	13:30 - 13:35
1.2	Apologies for Absence	Chair	Oral	
1.3	Declarations of Interest	Chair	Oral	
1.4	Minutes of the Meetings held on 10 January 2023, 17 January 2023, 13 February 2023 and Matters Arising	Chair	Att.	
1.5	Action Log	Chair	Att.	
2.0	**PRESENTATION**			
2.1	Governance System and Process – WHSSC & HB Shared Pathway Saving Target	Director of Planning	To Follow	13:35 – 13:50
3.0	**ITEMS FOR CONSIDERATION AND/OR DECISION**			
3.1	Chair's Report	Chair	Att.	13:50 – 13:55
3.2	Managing Director's Report	Managing Director	Att.	13:55 - 14:00
3.3	Delivering Thrombectomy Capacity in South Wales	Director of Planning	Att.	14:00 - 14:05
3.4	Eating Disorder In-Patient Provision for Adults	Director of Mental Health	Att.	14:05 - 14:10
3.5	Neonatal Transport ODN – Additional Funding Release	Director of Planning	Att.	14:10 - 14:20
3.6	Neonatal Cot Configuration Project	Director of Planning	Att.	14:20 - 14:35
3.7	IPFR Engagement Update – ToR and All Wales Policy	Medical Director	Att.	14:35 - 14:45
3.8	WHSSC Governance & Accountability Framework – SOs and SFIs	Committee Secretary	Att.	14:45 - 15:00

ITEM		LEAD	PAPER / ORAL	TIME
4.0	**ROUTINE REPORTS AND ITEMS FOR INFORMATION**			
4.1	Performance & Activity Report Month 9 2022-2023	Director of Finance	Att.	15:00 - 15:05
4.2	Financial Performance Report Month 10 2022-2023	Director of Finance	Att.	15:05 - 15:10
4.3	Neonatal Delivery Assurance Group (DAG) Update	Director of Planning	Att.	15:10 - 15:15
4.4	Corporate Governance Matters Report	Committee Secretary	Att.	15:15 - 15:20
4.5	Reports from the Joint Sub-Committees 4.5.1 Audit and Risk Committee (ARC) Assurance Report 4.5.2 Management Group Briefings 4.5.3 Individual Patient Funding Request (IPFR) Panel 4.5.4 Integrated Governance Committee (IGC) 4.5.5 Quality & Patient Safety Committee (QPSC) 4.5.6 Welsh Kidney Network (WKN)	Joint Sub-Committee Chairs	Att.	15:20 - 15:30
5.0	**CONCLUDING BUSINESS**			
5.1	Any Other Business	Chair	Oral	
5.2	Date of Next Meeting (Scheduled) - 16 May 2023 at 09.30hrs	Chair	Oral	
5.3	In Committee Resolution The Joint Committee is recommended to make the following resolution: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960)".	Chair	Oral	15:30 - 15:35

Unconfirmed Minutes of the Meeting of the WHSSC Extraordinary Joint Committee Meeting held In Public on Tuesday 10 January 2023 via MS Teams

Members Present:

Kate Eden	(KE)	Chair
Sian Lewis	(SL)	Managing Director, WHSSC
Carole Bell	(CB)	Director of Nursing & Quality Assurance, WHSSC
Stuart Davies	(SD)	Director of Finance, WHSSC
Iolo Doull	(ID)	Medical Director, WHSSC
Jacqui Evans	(JE)	Committee Secretary & Associate Director of Corporate Services, WHSSC
Mark Hackett	(MH)	Chief Executive Officer, Swansea Bay UHB
Gill Harris	(GH)	Deputy CEO/Executive Director Of Integrated Clinical Services, Betsi Cadwaladr UHB
Nicola Johnson	(NJ)	Director of Planning, WHSSC
Paul Mears	(PM)	Chief Executive Officer, Cwm Taf Morgannwg UHB
Steve Moore	(SM)	Chief Executive Officer, Hywel Dda UHB
Nicola Prygodzicz	(NP)	Chief Executive Officer, Aneurin Bevan UHB
Suzanne Rankin	(SR)	Chief Executive Officer, Cardiff & Vale UHB
David Roberts	(DR)	Director for Mental Health and Vulnerable Groups
Carol Shillabeer	(CS)	Chief Executive Officer, Cwm Taf Morgannwg UHB
Steve Spill	(SS)	WHSSC Independent Member, Audit & Finance Lead

Apologies:

Chantal Patel	(ChP)	Independent Member, Hywel Dda UHB
Ceri Phillips	(CP)	Independent Member, Cardiff & Vale UHB
Ian Phillips	(IP)	Independent Chair of the Welsh Kidney Network (WKN)

In Attendance:

Claire Harding	(CH)	Assistant Director of Planning, WHSSC
Emma King	(EK)	Senior Specialised Services Planning Manager for Mental Health and Vulnerable Groups
Helen Tyler	(HE)	Corporate Governance Manager, WHSSC
Nick Wood	(NW)	Deputy Chief Executive NHS Wales, Welsh Government

Minutes:

Gemma Trigg	(GT)	Corporate Governance Officer, WHSSC

The meeting opened at 13:30hrs

Min Ref	Agenda Item
JC23/01	**1.1 Welcome and Introductions** The Chair welcomed members to the meeting in Welsh and English and reminded them that meetings will continue to be held virtually via MS Teams. There were no objections raised to the meeting being recorded for administrative purposes. It was noted that a quorum had been achieved. The Chair welcomed Members and introduced Steve Spill as the new Independent Member (IM) for Finance and Audit to the meeting.
JC23/02	**1.2 Apologies for Absence** Apologies for absence were noted as above.
JC23/03	**1.3 Declarations of Interest** The Joint Committee noted the standing declarations and that there were no additional declarations of interest relating to the items for discussion on the agenda.
JC23/04	**2.1 Single Commissioner for Secure Mental Health Proposal** The report presenting the feedback received from Health Boards (HBs) on the options assessment for a single national organisation to commission integrated secure mental health services for Wales and to request support for the recommended course of action to be given to Welsh Government (WG) to achieve a single commissioner for secure mental health services in Wales was **received**. The Chair introduced the report and reminded Members that they had received a previous version of the report in November 2022 and that the report being presented provided an update on progress. David Roberts (DR) provided a summary and members noted: • the feedback received from the seven HBs on the options assessment for a single national organisation to commission integrated secure Mental Health Services for Wales, • That one of the seven HBs did not support the proposal of WHSSC being the Single Commissioner for Secure Mental Health Services as they did not support the principle that there should be a single commissioner for these services and Aneurin Bevan UHB (ABUHB) had written to WG to outline their concerns,

	• Key challenges raised by the HBs included processes and procedures, clarity on responsibilities of Organisations, decision making and accountability, assurance of relationships with local services and ensuring retention of expertise, consideration of a "provider collaborative" approach, and financial contributions. Nicola Prygodzicz (NP) advised that ABUHB would meet with her team to discuss the proposal again recognising that the recommendation was to be presented to WG. Members resolved to: • **Note** the report, • **Note** the feedback received from the seven HBs on the options assessment circulated by the WHSSC team, • **Note** that six of the seven HBs supported WHSSC as the single commissioner with one HB raising concerns regarding the need for a single commissioner, • **Note** that feedback emphasised a number of issues which would need to be addressed to ensure successful implementation of the change; and • **Support** the following recommendations going forward to Welsh Government: – That secure mental health services in Wales should be commissioned by WHSSC, – That a national programme of work, including representatives from Welsh Government, WHSSC and all the seven Health Boards (HBs) should be set up to manage the transfer of the commissioning of low secure services; and – That more detailed work needs be done to define the appropriate timescales but that the programme of work is unlikely to be completed before April 2024 at the earliest.
JC23/05	**2.2 Audit Wales WHSSC Committee Governance Arrangements – Update** The report providing an update on progress against the recommendations outlined in the Audit Wales WHSSC Committee Governance Arrangements report was **received**. Jacqui Evans (JE) advised that the majority of the actions relating to WHSSC had been completed and that there are only two areas of partial compliance remaining concerning the actions relating to R3b appointing an Assistant Medical Director and R4a & to develop a new Specialised Services Strategy. Members noted that recommendations 6 and 7 relating to WG were categorised as partially completed as the Auditor General for Wales had

	indicated that it was premature to consider the recommendations as closed and instructed that they would like to keep them open and received an update from WG in six months' time once the new NHS Wales executive body had been introduced. Members noted that Audit Wales had confirmed they were content for the Joint Committee to receive an update on progress and that an additional update will be given in May 2023, thereafter an update will be submitted to Audit Wales and to HB Audit Committees for assurance in July 2023. This will 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. Members resolved to: • **Note** the report, • **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 • **Note** that a further update on progress will be brought to the May 2023 Joint Committee meeting; thereafter an update will be submitted to Audit Wales and to HB Audit Committees for assurance in June/July 2023.
JC23/06	**2.3 Preparedness for the COVID-19 Public Inquiry** The report providing an update on WHSSC's preparedness for the COVID-19 Public Inquiry was **received**. JE presented the report and members noted that: • WHSSC has maintained contact with NWSSP Legal & Risk Services (L&RS) in relation to preparation for the Inquiry since summer 2021 and in December 2022 formally engaged L&RS as its legal representative for the Inquiry, • It was not felt necessary or appropriate for WHSSC to apply for Core Participant status in respect of Modules 1, 2 or 3, however WHSSC may be required to respond to written enquiries and/or provide relevant documents to the Inquiry in due course; and • In December 2022, L&RS advised WHSSC that a letter from the Inquiry team informally seeking information pertinent to Module 3 was likely to be received imminently with a January 2023 response deadline – the letter had not yet been received but work had begun on a draft response. Members resolved to:

	• **Note** the information presented within the report.
JC23/07	**2.4 Review of Financial Limits and Reporting** The report requesting that the increased financial delegation limits introduced in March 2020 to enable effective financial governance as a consequence of the COVID-19 pandemic were approved as new permanent limits was **received.** JE introduced the report and advised that to ensure effective governance and to comply with the provisions of the WHSSC Standing Orders (SOs) it was important that the SOs and Standing Financial Instructions (SFIs) were kept up to date to comply with the need for: • The Joint Committee to take appropriate action to assure itself that all matters delegated are effectively carried out, and that • The framework of delegation is kept under active review and, where appropriate, is revised to take account of organisational developments, review findings or other changes. Stuart Davies (SD) outlined the key changes and members noted: • that the proposed changes were an attempt to deliver a balance between continuing to ensure appropriate governance and accountability, and recognition of the significantly higher unit costs associated with some specialised services packages of care and the need for them to be signed off on an urgent basis. The recommendations recognise that in most cases there is little discretion in many of these packages given existing NICE mandates. In order to provide a counter-balance the proposed changes include the requirement for a new accountability report to be presented to the Audit & Risk Committee (ARC) and to the Joint Committee which summarised all approvals above designated financial limits, • the requirement for Joint Committee approval was recommended to be discharged by Chairs action which is commensurate with the practice used in HBs regarding urgent matters and formalisation of some contracts; and • discussion had been held with HB finance colleagues on the proposed approach. Members advised they were in agreement to approve the recommendations, subject to further discussion with the HB Board Secretaries. Members noted that the governance and accountability framework which included the SOs and SFIs, including the updated scheme of delegation and financial matrix would be brought back to the Joint Committee for approval on 14 March 2023.

	Members resolved to: • **Note** the report, • **Note** the rationale for the increase in financial delegation limits as a consequence of the COVID-19 pandemic, • **Approve** the updated financial authorisation matrix, which includes the increased financial delegation limits introduced in March 2020 to enable effective financial governance as a consequence of the COVID-19, • **Approve** the updated process for the current SFI requirement for Joint Committee "approval" of non-contract cases above defined limits for annual and anticipated lifetime cost, to be replaced by an assurance report to Joint Committee and the CTMUHB Audit & Risk Committee (ARC) notifying of all approvals above the defined limit and Chairs action to reflect the need for timely approval action, subject to further discussion with the HB Board Secretaries, • **Note** that the Standing Financial Instructions (SFIs), and the scheme of delegation will be updated to reflect the changes; and • **Note** that the updated scheme of delegation and the financial matrix will be appended to the SFI's for completeness.
JC23/08	**3.1 Date and Time of Next Scheduled Meeting** The Joint Committee noted that the next scheduled meeting would be at 13.30 on 17 January 2023. There being no other business other than the above the meeting was closed.

Chair's Signature: ……

Date: ……

Unconfirmed Minutes of the Meeting of the WHSSC Extraordinary Joint Committee Meeting held In Public on Tuesday 17 January 2023 via MS Teams

Members Present:

Kate Eden	(KE)	Chair
Sian Lewis	(SL)	Managing Director, WHSSC
Carole Bell	(CB)	Director of Nursing & Quality Assurance, WHSSC
Stuart Davies	(SD)	Director of Finance, WHSSC
Iolo Doull	(ID)	Medical Director, WHSSC
Jacqui Evans	(JE)	Committee Secretary & Associate Director of Corporate Services, WHSSC
Mark Hackett	(MH)	Chief Executive Officer, Swansea Bay UHB
Steve Ham	(SH)	Chief Executive Officer, Velindre University NHS Trust
Gill Harris	(GH)	Acting Chief Executive Officer , Betsi Cadwaladr UHB
Nicola Johnson	(NJ)	Director of Planning, WHSSC
Steve Moore	(SM)	Chief Executive Officer, Hywel Dda UHB
Chantal Patel	(ChP)	Independent Member, WHSSC
Ceri Phillips	(CP)	Independent Member, WHSSC
Ian Phillips	(IP)	Chair of the Welsh Kidney Network (WKN) Member,
Nicola Prygodzicz	(NP)	Chief Executive Officer, Aneurin Bevan UHB
Suzanne Rankin	(SR)	Chief Executive Officer, Cardiff & Vale UHB
David Roberts	(DR)	Director for Mental Health and Vulnerable Groups
Carol Shillabeer	(CS)	Chief Executive Officer, Cwm Taf Morgannwg UHB
Steve Spill	(SS)	Independent Member – Audit & Finance, WHSSC

Apologies:

Jason Killens	(JK)	Chief Executive Officer, Welsh Ambulance Service Trust
Paul Mears	(PM)	Chief Executive Officer, Cwm Taf Morgannwg UHB

In Attendance:

Luke Archard	(LA)	Senior Planning Manager, WHSSC
Elizabeth Beadle (for Paul Mears)	(EB)	Head of Planning, Cwm Taf Morgannwg UHB
Claire Harding	(CH)	Assistant Director of Planning, WHSSC
James Leaves	(JL)	Assistant Director of Finance, WHSSC
Sarah McAllister	(SM)	PET Programme Manager, WHSSC
Helen Tyler	(HE)	Corporate Governance Manager, WHSSC
Karla Williams	(KW)	Risk and Governance Officer, WHSSC

Nick Wood (NW) Deputy Chief Executive Officer, Welsh Government

Observing

Charlotte Adams Member of the Public

Minutes:

Gemma Trigg (GT) Corporate Governance Officer, WHSSC

The meeting opened at 09:30hrs

Min ref	Agenda Item
JC23/08	**1.1 Welcome and Introductions** The Chair welcomed members to the meeting in Welsh and English and reminded them that meetings will continue to be held virtually via MS Teams. There were no objections raised to the meeting being recorded for administrative purposes. It was noted that a quorum had been achieved.
JC23/09	**1.2 Apologies for Absence** Apologies for absence were noted as above.
JC23/10	**1.3 Declarations of Interest** The Joint Committee noted the standing declarations and that there were no additional declarations of interest relating to the items for discussion on the agenda.
JC23/11	**1.4 Minutes of the meeting held on 8 November 2022 and Matters Arising** The minutes of the Joint Committee meeting held on 8 November 2022 were **received** and **approved** as a true and accurate record discussions subject to one correction on page 17 to change the initials from IW to IP. There were no matters arising.
JC23/11	**1.5 Action Log** The action log was **received**, and members **noted** the progress on the actions and actions closed.
JC23/12	**2.1 Integrated Commissioning Plan (ICP) 2023-2024** The report presenting the final Integrated Commissioning Plan (ICP) 2023-24 for approval was **received**.

Min ref	Agenda Item
	Nicola Johnson (NJ) presented the report, supported by a slide presentation. Members noted that the ICP had been updated following the Joint Committee ICP workshop on 10 January 2023, during which a range of scenarios were considered to address the increasing financial challenges within NHS Wales. Members noted that there was a need for the Joint Committee to make over choices on investment and that development of the plan must maximise value from core resources, whilst giving due consideration to quality of care and equity. Stuart Davies (SD) outlined the ongoing under occupancy levels across Children and Adolescent Mental Health Services (CAMHS), Eating Disorders and Medium Secure Mental Health Services which was causing an increase in the number of patients placed out of area at a very high cost and that there was a plan to reduce this by improving performance in these services. James Leaves (JL) highlighted the financial adjustments made since the ICP workshop and the rationale, which had enabled the reductions. Members noted the offset created by Transcatheter aortic valve replacement (TAVI) and the non-recurrent underperformance assumptions outlined within the financial table and the risks associated with each scenario. Carol Shillabeer (CS) thanked the team for the hard work that had gone into compiling and amending the report in such a short timeframe and advised that she was keen to see progress and delivery on the areas outlined. CS requested that progress updates be given under the financial report as a standing item going forward so the progress could be reviewed and deliverability could be assessed and monitored. CS advised that PTHB was largely supportive of the Clinical Impact Assessment Group (CIAG) scheme proposal, and requested that the Management Group assess the deliverability of the scheme in light of workforce challenges, cost profile and implications based on the risks outlined as there was a need to ensure flexibility for decisions in year. CS queried the governance process for the sequencing of the ICP and advised that PTHB were not in a position to sign off the final plan on behalf of the Board at this time. SL responded and advised that the custom and practice adopted was in accordance with the WHSSC Standing Orders (SOs) and the WG NHS Planning framework and that the ICP was approved by the Joint Committee at an early stage to support HBs in finalising their respective IMTPs. Suzanne Rankin (SR) thanked the WHSSC team for undertaking the additional work.

Min ref	Agenda Item
	Mark Hackett (MH) outlined a number of concerns around reducing or disinvesting in Thoracic Services and different levels of Capital Improvement Plan (CIP) cost assumptions across HBs and asked the Joint Committee to consider that element. SD provided further rationale around the underspend and the financial planning assumptions based on lessons learned from this financial year and confirmed that Thoracic Services would not be reduced below their current level. Nicola Prygodzicz (NP) asked if disinvestment in services, for example Paediatrics, was possible if providers had a plan in place to combat the consistent under performance. SD responded and emphasised that the underperformance disinvestment assumption was not on a recurrent basis but provided a realistic recovery position that reflected the current situation and allowed providers more time to recover. Members discussed the need to make efficiencies on the financial elements of the plan given the constrained economic environment, recovery challenges and the volatile inflationary pressures currently faced by HBs. Sian Lewis (SL) summarised discussions noting the significant concerns raised around the risks and suggested approving the plan in principle today and considering another meeting in early February to approve a recast plan prior to submission to WG with the caveats that ongoing work was required to track the progress and efficiency outcomes. Members agreed to support the plan in principle and requested that additional work was required to focus on risks, efficiencies, monitoring and reporting, and agreed to it being brought back to an extraordinary Joint Committee meeting in February 2023, in order to approve the ICP in readiness for inclusion in Health Board (HB) IMTPs. The Joint Committee resolved to: • **Note** that the Plan has been finalised following the Joint Committee Workshop held on 10 January 2023, • **Agree** to support the plan in principle but requested additional work be undertaken to focus on risks, efficiencies, monitoring and reporting before they could provide final approval, • **Agree** to convene an extraordinary Joint Committee meeting in February 2023 to: – **Approve** the requirements of the Integrated Commissioning Plan (ICP) for inclusion in Health Board Integrated Medium Term Plans (IMTPs); and – **Approve** the Integrated Commissioning Plan (ICP) 2023-2024 for submission to Welsh Government.

Min ref	Agenda Item
JC23/13	**3.1 Chair's Report** The Chair's report was **received** and members **noted**: • Key meetings attended. The Joint Committee resolved to: • **Note** the report.
JC23/14	**3.2 Managing Director's Report** The Managing Director's Report was **received** and members **noted** the following updates on: • **National Skin Camouflage Pilot Service** - WHSSC had received a formal request from Welsh Government (WG) following agreement at the NHS Wales Leadership Board (NWLB) for WHSSC to commission the national skin camouflage pilot service, • **Individual Patient Funding Request (IPFR) Engagement Update** – The formal engagement process to review the WHSSC Individual Patient Funding Request (IPFR) panel Terms of Reference (ToR) and the specific and limited review of the all Wales IPFR policy, commenced on 10 November 2022 for a 6 week period following the Joint Committee supporting the proposed engagement process at its meeting on the 8 November 2022. The feedback was being reviewed and an update will be provided to the Joint Committee in March 2023; and • **Board Development - Compassionate and Collective Leadership in Health and Social Care -** On 29 November 2022, the Corporate Directors Group Board (CDGB) received a briefing from Professor Michael West CBE on Compassionate and Collective Leadership in Health and Social Care as part of his mandate to visit all NHS bodies, which was being led by Health Education & Improvement Wales (HEIW). Professor West will facilitate a session with the Joint Committee in 2023 to support discussions on working in partnership, developing cross-boundary team-based working and system leadership. The Joint Committee resolved to: • **Note** the report.
JC23/15	**3.3 Plastic Surgery: realignment of future commissioning responsibilities between WHSSC and Health Boards** The report outlining the outcome of the plastic surgery commissioning workshop held with the Management Group in September 2022 and to request support for WHSSC to establish a project to realign commissioning responsibilities for plastic surgery between WHSSC and HBs was **received.** NJ presented the report and members noted that the specialised element of plastic surgery equated to around 10% of the service. It was proposed

Min ref	Agenda Item
	that WHSSC would continue to commission the specialised element but that non-specialised plastic surgery would be returned to the HBs for commissioning. NJ assured Members that any risks related to the transfer would be mitigated by the two-year hand over project. MH advised that he supported the transition timeline but raised concerns around the Long Term Agreement (LTA) framework and asked if the LTA process could be reformed as part of the work. MH asked if the commissioners would commit to support HBs in any cases of stranded costs. NJ advised that she expected SBUHB would put those issues forward and assured Members that a contingency plan would be embedded to ensure the right level of support was given to HBs. MH advised that it was important to recognise that the service was internationally recognised, and that the burns service was provided for the whole superregional national service and that the issues were interrelated. Members recognised the excellence within the service as it was currently and SL reminded members of the reasons for the proposed changes and the intension to improve the services further without losing the expertise available at present. Members discussed the need for a comprehensive review of LTA services which needs to be worked through on a pan Wales basis before any services were disaggregated. NJ advised that option 2 was the preferred option and acknowledged that some elements of the LTAs were outside the scope of WHSSC's responsibilities and that more work was needed around the wider contracting of services for the HBs to work through. SD advised that WHSSC were happy to review the contracting mechanisms and contracts for plastic surgery, as referred to in the ICP to ensure the balance was right. NP advised that if the Management Group had supported and agreed this, there was a need to support the work and disentangle the data and in particular SBUHB and HDUHB non-specialised work. The Chair thanked everyone for their contributions to the discussion and advised that WHSSC would ensure a focus on any potential unintended consequence of this work. The Joint Committee resolved to: • **Note** the report,

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	• **Note** the outcome of the Management Group plastic surgery workshop held in September 2022, • **Consider** and **approve** the proposed realignment of commissioning arrangements for plastic surgery so that non-specialised surgery will be commissioned by Health Boards (HBs) and specialised surgery will be commissioned by WHSSC; • **Support** a project led by WHSSC to undertake the work to transfer commissioning responsibility for non-specialised plastic surgery to Health Boards (HBs) and retain specialised surgery as commissioned by WHSSC and as part of that project the contractual arrangements will be reviewed.
JC23/16	**3.4 WHSSC Cardiac Review** The report addressing a number of recent events and trends that had impacted the WHSSC commissioned cardiac surgery and TAVI services, and which sought to identify how they might be coherently and collectively addressed was **received.** NJ highlighted the key detail within the report and members noted that the analysis identified the following drivers: • The 2021 GIRFT review of cardiac surgery, • Changes to the volume of TAVI and cardiac surgery, together with cardiac surgery performance and escalation issues; and • The clinical rationale for the selection of TAVI valves, in view of their differential costs. Members noted that the TAVI activity had been updated in the latest version of the report for the Powys population reflecting that for the 100,000 per population Powys had the highest and not the lowest rates as had been previously shown. Suzanne Rankin (SR) thanked the team for the work that had gone into the report and requested clarity concerning the timetabling for rebasing and the TAVI Policy. NJ advised that the rebasing element would look at the historical activity and benchmarking against other areas and the Commissioning Policy would look at the evidence base for TAVI so it would be possible to proceed in parallel as suggested in the report. SD added that due to the changes which were already apparent and that were set to continue throughout the year there would be a clear understanding of the trends, which was likely to be increased TAVI and reduced cardiac surgery activity. CS asked whether this might be a good opportunity to review the benefits and outcomes of these procedures. SL agreed and advised that it was one of the areas that was being piloted using the SAIL Database and

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	further work would be done around population impact on this cohort for both TAVI and cardiac surgery. MH requested more detail around the pathway as a whole including diagnostics and non-specialised services that fell within that. NJ provided assurance that those discussions were taking place and that all constraints and steps within each area were being looked at to ensure that any changes aligned with capacity and demand. The Chair thanked the group for their contributions and summarised the outcome of discussions below with a note around the benefits work and the SAIL Database, and consideration of the pathway issues highlighted, which may become apparent as the work was undertaken. The Joint Committee resolved to: • **Note** the report, • **Note** the impact of the recent events and trends as drivers change in the commissioning of cardiac surgery and TAVI services, • **Note** the important link between the cardiac review and the Integrated Commissioning Plan (ICP) in that the work will conclude what level of cardiac surgery is required and inform the scale of any resultant de-commissioning, • **Approve** the development of new contract baselines for cardiac surgery and TAVI, (Stage 1), to be completed by June 2023, • **Approve** the proposal that the current TAVI commissioning policy be reviewed (Stage 1), to be completed by June 2023; and • **Approve** the recommendation that further demand and capacity planning be undertaken, concluding with an options appraisal to identify the preferred future service configuration of WHSSC-commissioned cardiac surgery and TAVI activity (Stage 2), to be undertaken during 2023-24 and 2024-25.
JC23/17	**3.5 Governance Review of Welsh Kidney Network (WKN)** The report which outlined the recommendations from the recent independent Governance Review for the Welsh Kidney Network (WKN) and which provided an assurance that the recommendations were being enacted through an action plan that had been developed, agreed and monitored through the WKN Board was **received.** Karen Preece (KP) outlined the recommendations documented within the report and provided assurance that the recommendations were being enacted via the action plan that had been developed, agreed and monitored through the WKN Board. Members noted:

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	• the Network had not been reviewed since 2011 and any governance concerns as a result of this review would be raised and addressed, • Steve Combe had been appointed as the independent governance advisor and the review had looked at the Network's functions and any strengths and weaknesses in governance areas so that they could be improved where needed, • The importance of working closely as a Network with other Networks and WG to ensure alignment in accordance with some further recommendations which would be made in the future on the future of the WKN and that an options report would be brought back to the Joint Committee in May 2023. CS thanked the team for their work and advised that she recalled the network being established and highlighted the importance of keeping this area tied into the Joint Committee to align process for the WKN and Joint Committee's governance procedure. Ian Phillips (IP) provided assurance that there was a planned approach to proceeding to address the recommendations and that positive progress had been made. The Chair advised that it was timely for the review to be undertaken now and that an update on progress and an options appraisal for the future of the network would be brought back in May 2023. The Joint Committee resolved to: • **Note** the report; and • **Receive assurance** that there are robust processes in place to ensure delivery of the recommendations detailed within the recent Governance Review of the Welsh Kidney Network (WKN).
JC23/18	**3.6 South Wales Trauma Network Delivery Assurance Group (DAG) Report Quarter 2 2022-2023** The report providing a summary of the Quarter 2 2022-23 Delivery Assurance Group (DAG) report of the South Wales Major Trauma Network (SWTN) was **received.** NJ presented the report and opened the floor to comments and questions. NP asked for clarity around the figures in the financial table, as they did not appear to tally. NJ assured Members that although the financial figures were correct the balance in the column was not. However, there was no further slippage expected for this year.

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	NP asked if the variation in patients and the areas they had come from could be added to the detail to reflect the disparity between areas and demand. KP confirmed that a review had been undertaken through the DAG and the outcomes showed that the patients presenting at the Major Trauma Centre (MTC) were appropriate patients. NJ informed the group that further analysis on place of residence rather than provider hospitals was underway and will be reflected within the report once complete. The Joint Committee resolved to: • **Note** the South Wales Major Trauma Network (SWTN) Delivery Assurance Group (DAG) Report for Quarter 2 2022-2023.
JC23/19	**3.7 Corporate Risk Assurance Framework (CRAF)** The report presenting the updated Corporate Risk Assurance Framework (CRAF) which outlined the risks scoring 15 or above on the commissioning teams and directorate risk registers, which provided an update on the progress made to develop the CRAF following the risk management workshop held in September 2022 and which presented a revised risk appetite statement for approval was **received**. Jacqui Evans (JE) presented the report and members noted the key changes within the CRAF and the number of risks attributed to commissioning and organisational risks as at 31 December 2022 and provided assurance that the management of risks aligned with the processes adopted and agreed. The Joint Committee resolved to: • **Note** the report; • **Approve** the updated Corporate Risk Assurance Framework (CRAF) and **note** the changes to the risks outlined in the report as at 31 December 2022, • **Note** that a risk workshop was held in September 2022 to review the CRAF and WHSSC's risk appetite; and • **Approve** the updated risk appetite statement.
JC23/20	**3.8 All Wales Positron Emission Tomography (PET) Programme Board Update** The report providing an update on the All Wales Positron Emission Tomography (PET) Programme, including an assessment of clinical demand and growth for PET scanning in Wales and requests support for the recommendation to WG that a fourth scanner will be needed to meet predicted scanning demand was **received**. SL outlined the key elements of the report on the All Wales Positron Emission Tomography (PET) Programme, including an assessment of clinical demand and growth for PET scanning in Wales and requested

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	support for the recommendation to WG that a fourth scanner will be needed to meet predicted future scanning demand. Members noted that WHSSC would not usually undertake capital investment programmes, however, WG had asked WHSSC to provide the Programme Management for the implementation of the programme and as extension of the work that was carried out to develop the Business Case. It had been identified that the predicted 20% annual growth would mean an additional fixed site scanner (a fourth) would be needed in 2026. CS advised that she recognised that a lot of work had gone into the project and queried the improvements for the Powys population given the change of location of the scanner in north Wales, and requested that arrangements be made to mitigate the risks in terms of access. SL responded and advised that the location of the north Wales scanner was part of a wider programme of centralisation of radio-isotope services being taken forward by BCUHB. WHSSC were working closely with BCUHB on this and equity of access was a key element in this service change. The overall approach was supported by the CEO of Velindre University NHS Trust. The Joint Committee resolved to: • **Note** the report, • **Consider** and **approve** a recommendation to Welsh Government (WG) (Programme Sponsor) for a fourth fixed PET scanning site within Wales, based upon up-to-date assessment of clinical demand, which confirms growth is in line with that described in the original Programme Business Case (PBC); and • **Receive assurance** that there are robust processes in place to ensure delivery of the All Wales Positron Emission Tomography (PET) Programme.
JC23/21	**4.1 COVID-19 Period Activity Report Month 7 2022-2023** The report highlighting the scale of the decrease in activity levels during the peak COVID-19 period and whether there were any signs of recovery in specialised services activity was received. Members noted that the activity decreases were shown in the context of the potential risk re patient harms and of the loss of value from nationally agreed financial block contract arrangements. The Joint Committee resolved to: • **Note** the report.
JC23/22	**4.2 Financial Performance Report Month 8 2022-2023**

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	The financial performance report setting out the financial position for WHSSC for month 8 2022-2023 was **received**. Members noted that the financial position was reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2022. The financial position reported at Month 8 for WHSSC was a year-end outturn forecast under spend of £14,195k. The Joint Committee resolved to: • **Note** the current financial position and forecast year-end position.
JC23/23	**4.3 Corporate Governance Matters Report** The report providing an update on corporate governance matters that had arisen since the previous meeting was received. The Joint Committee resolved to: • **Note** the report.
JC23/24	**4.4 Reports from the Joint Sub-Committees** The Joint Committee Sub-Committee reports were received as follows: **i. Audit and Risk Committee (ARC) Assurance Report** The JC noted the assurance report from the CTMUHB Audit and Risk Committee meetings held on 24 October 2022 and 12 December 2022. **ii. Management Group Briefing** The JC noted the core briefing documents from the meetings held on 24 November 2022, and 15 December 2022. **iii. Individual Patient Funding Request (IPFR) Panel** The JC noted the Chair's report from the meeting held on 1 December 2022. **iv. Welsh Kidney Network (WKN)** The JC noted the Chair's report from the meeting held on 23 November 2022.
JC23/25	**5.1 Any Other Business** No additional items of business were raised.
JC23/26	**5.2 Date of Next Meeting** The Joint Committee noted that the next scheduled meeting would be on 14 March 2023. There being no other business other than the above the meeting was closed.

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JC23/27	**5.3 In Committee Resolution** The Joint Committee is recommended to make the following resolution: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960)".

Chair's Signature: .....

Date:.....

Unconfirmed Minutes of the Meeting of the WHSSC Extraordinary Joint Committee Meeting held In Public on Monday 13 February 2023 via MS Teams

Members Present:

Kate Eden	(KE)	Chair
Sian Lewis	(SL)	Managing Director, WHSSC
Carole Bell	(CB)	Director of Nursing & Quality Assurance, WHSSC
Stuart Davies	(SD)	Director of Finance, WHSSC
Iolo Doull	(ID)	Medical Director, WHSSC
Jacqui Evans	(JE)	Committee Secretary & Associate Director of Corporate Services, WHSSC
Mark Hackett	(MH)	Chief Executive Officer, Swansea Bay UHB
Gill Harris	(GH)	Interim Chief Executive Officer, BCUHB
Paul Mears	(PM)	Chief Executive Officer, Cwm Taf Morgannwg UHB
Steve Moore	(SM)	Chief Executive Officer, Hywel Dda UHB
Chantal Patel	(ChP	Independent Member, WHSSC
Ceri Phillips	(CP)	Independent Member, WHSSC
Ian Phillips	(IP)	Chair of the Welsh Kidney Network (WKN)
Suzanne Rankin	(SR)	Chief Executive Officer, C&V UHB
Carol Shillabeer	(CS)	Chief Executive Officer, Cwm Taf Morgannwg UHB

Deputies:

Rob Holcombe	(RH)	Executive Director of Finance, ABUHB
Nick Wood	(NW)	Deputy Chief Executive Officer, Welsh Government

Apologies:

Tracey Cooper	(TC)	Chief Executive Office, PHW
Jason Killens	(JK)	Chief Executive Officer, Welsh Ambulance Service Trust
Nicola Prygodzicz	(NP)	Chief Executive, Aneurin Bevan UHB
Steve Spill	(SP)	Independent Member, WHSSC

In Attendance:

Claire Harding	(CH)	Assistant Director of Planning, WHSSC
Nicola Johnson	(NJ)	Director of Planning, WHSSC
James Leaves	(JL)	Assistant Director of Finance, WHSSC
Karla Williams	(KW	Risk and Governance Officer, WHSSC

Minutes:
Gemma Trigg (GT) Corporate Governance Officer, WHSSC

The meeting opened at 13.00

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JC23/28	**1.1 Welcome and Introductions** The Chair welcomed Members bilingually and outlined the purpose of the additional extraordinary meeting and thanked Members for attending the additional meeting. It was noted that a quorum had been achieved. No objections were raised to the meeting being recorded for administrative purposes.
JC23/29	**1.2 Apologies for Absence** Apologies for absence were noted as above.
JC23/30	**1.3 Declarations of Interest** The Joint Committee (JC) noted the standing declarations and that there were no additional declarations of interest other than Chantal Patel declaring an interest concerning her designation as an Independent Member (IM) for Hywel Dda UHB.
JC23/31	**2.1 Integrated Commissioning Plan (ICP) 2023-2024** The report presenting the final Integrated Commissioning Plan (ICP) 2023-24 for approval was **received**. The Chair introduced the report and reminded members that the Joint Committee had considered the draft plan on the 17 January 2023 and had agreed to support the plan in principle but requested additional work be undertaken to focus on risks, efficiencies, monitoring and reporting before they could provide final approval. As a consequence the plan had been reviewed and was being re-presented for approval. The Chair invited Stuart Davies (SD) and Nicola Johnson (NJ) to provide any updates made to the plan. NJ gave a presentation and Members noted that the ICP had been updated following the Joint Committee ICP workshop on 10 January 2023 and the Management Group (MG) meeting on 26 January 2023. Members noted that the feedback received from the MG was as follows:

- CIAG and Horizon-scanning Prioritisation – No issues raised in relation to the risk-assessment and recommendations on these schemes (including a further assessment of deliverability) and no changes were advised,
- Strategy Planning Assumptions – No issues raised in relation to the assumptions that had been made and it was recognised that savings would be released to be reinvested in the system to recommission services and add value and no changes were advised,
- Performance Assumptions – the MG were concerned about the potential impact on the ability to respond to recovery in Paediatric Surgery and any potential need for outsourcing. It was agreed to handle the non-recurrent adjustment for underperformance as a financial planning assumption rather than a 'hard target', thereby balancing the provider and commissioner risks and opportunities, WHSSC have subsequently discussed this with both SBUHB and CVUHB in the recent Service Level Agreement meetings; and
- Contingency – the MG were concerned about the low level of funding in the baseline to cover in-year pressures and risks. However, it was agreed that this would be presented to the Joint Committee as a choice in the final agreement of the Plan rather than making a firm recommendation.

Members noted that during the second workshop with the MG it was agreed how the indicative 1% shared systems saving target would be presented. Taking into account discussions with Welsh Government (WG), this would not be applied as a Capital Improvement Plan (CIP) across all commissioning budgets but would be managed through a set of cross-cutting commissioning schemes and will be further worked up and impact assessed.

Members noted that a programme will be developed to support the planning and recommissioning work across pathways and WHSSC will work closely with Health Boards (HBs) to embed the schemes. Opportunities for new Clinical Networks structure and pathway re-design will also continue.

NJ also highlighted that GIRFT recommendations will be used in the continuous programme and Policy and Service Specification development and review, and NHS England (NHSE) will be consulted to explore opportunities emerging across the border. It was noted that the commissioning landscape for NHSE was changing considerably which did make it more difficult to pick out opportunities but it will continue to be progressed.

Members noted that after consideration, a significant number of disinvestments and recommissioning actions were identified, and an assessment of associated risks had also been undertaken.

SD provided an overview around the financial summary and members noted:

- The financial summary remained unchanged and there was approximately £300k left in contingency which had been put in place two years ago,
- Benchmarking work with NHSE had been undertaken and it was noted that NHSE had agreed a 6% total increase in budget for specialist commissioning, including an 8% uplift on drugs expenditure.

Rob Holcombe (RH) asked that in terms of process and pace for the 1% whether there was an emerging plan with willing volunteers from HBs to analyse target areas to ensure the traction that would be needed. SD responded and advised that WHSSC would engage quickly with HBs to ensure there was a firm plan in place with set timelines, and that some of the work had already been undertaken through the re-commencement of the Finance Sub-Group. Members noted that some key items were included in the efficiency forecast concerning contracting currencies, and that WHSSC would prioritise key areas of work, ensuring that it was possible to give appropriate notice to the providers on changing contracts.

NJ advised that as much planning as possible would be done before the end of the financial year and a programme management approach will be presented to the MG in March 2023. RH acknowledged that there was a considerable amount of work to be undertaken to engage with HBs and advised that he was willing to assist.

Paul Mears (PM) requested clarity around the governance framework for approving the ICP and the fixed nature of the financial plan if the ICP was approved, in the context that HBs had not yet agreed their own financial plans. The Chair responded and advised that the approach adhered to the process that was used each year, and that the ICP was approved by the Joint Committee at an early stage to be able to give certainty to the HBs on WHSSC expenditure to support HBs in approving their own Integrated Medium Term Plans (IMTPs).

Sian Lewis (SL) advised that the process was in accordance with the WHSSC Standing Orders (SOs) and the WG NHS Planning framework and that the sequencing for the ICP approval by the Joint Committee prior to HB approval of the IMTPs was well established.

	NJ added that the Director of Planning in WG expected the WHSSC plan to be agreed before HBs could consider signing off their IMTPs as it reduced the HBs' financial uncertainties. Mark Hackett (MH) advised that it had been helpful to hear about the position in NHSE concerning funding growth, and requested that WHSSC review the NHSE processes and consider any lessons that could be learnt at a future session, as commissioners should be concerned for the consequences for their residents of a lower uplift. SD agreed to share the reports which will outline the detail when NHSE have published them. Once released, the learning will be pulled out of the report and shared here to provide assurance that we have not under anticipated growth in Wales. **Action:** NHSE funding growth approach to be considered at a future JC session with a discussion on the variation and impact of investment between Scotland, England and Wales. MH advised that reductions in spend were previously looked at and it was agreed that a provider strategy response associated with some of the disinvestments would need to be developed in the cases where this work could cause any service reconfiguration, especially the effects of disinvestment on the two tertiary providers, the need to maintain configurations and the need to look at alternatives and reconfiguration. Suzanne Rankin (SR) advised that she agreed and that it was helpful provocation to move at pace. However, collaborative support would be required from the Joint Committee members and that timetabling would need to align to the budget allocations and disinvestments and ensure that patients received good quality care. SR queried decisions concerning disinvestment for areas that were under-delivering and highlighted that care may still need to be delivered, and what provisions would be put in place in those circumstances. SD responded and outlined the rationale for the assumptions of non-recovery and that, although HBs were planning to reach full recovery by the end of the calendar year, a predicted 50% was a reasonable financial planning assumption. He noted the ongoing challenges including the impact of industrial action on services. The ICP considered a non-recurrent gain.

	Action: A review of the potential impacts on providers in Wales on strategic reinvestment, disinvestment and any subsequent reconfiguration to be discussed at a future JC meeting. Carol Shillabeer (CS) thanked the team for the work that had gone into developing the plan and raised a query concerning contingency planning, as previously there had been underspends in year. SD suggested that it could be managed flexibly within the budget and that any impact would be shared in the financial returns element of the monthly report. Referring to the previous discussion on the sign off of the WHSSC budget SD advised that the Joint Committee were accountable for the budget, and that this was stated in the WG accountability letters and that custom and practice has been that the Joint Committee agree the lCP and then slot it into their IMTPs. Steve Moore (SM) thanked the team for the work that had been done in such a short period of time and that it was pleasing to note the positive progress made. SM requested that the governance process for firming the ICP saving targets be looked at and to consider the implications as they could be significant. Members agreed that an outline governance system and process will be presented and considered at the 14 March 2023. CS requested that WHSSC consider looking at the NHS Scotland position to enable more than one comparator group. **Action:** An outline governance system and process for the Joint Committee to monitor achievement of the 1% WHSSC and HB shared pathway savings target be brought back to the Joint Committee for approval on 14 March 2023. RH asked if there was a need for regular quarterly or half yearly reviews in terms of investments and savings against the ICP to track any areas in need of additional support. SD advised that the MG received monthly reports on progress against the plan and achievements, slippage and acceleration; and that Joint Committee received full reports on progress at each meeting as per the agreed work plan. The Chair thanked everyone for their commitment to work with the team at WHSSC to achieve the savings over the year, and gave thanks to the MG members for their input. The Chair advised that the primary

	focus for discussions to achieving the 1% efficiency savings will be Mental Health and Cardiac Services before moving on to other areas. The Joint Committee resolved to: • **Note** that the Plan has been finalised following the Joint Committee meeting on 17 January 2023, and subsequent discussions at Management Group, • **Approve** the Integrated Commissioning Plan (ICP) 2023-2024 for submission to Welsh Government, • **Approve** the requirements of the Integrated Commissioning Plan (ICP) for inclusion in Health Board Integrated Medium Term Plans (IMTPs); and • **Agree** that an outline governance system and process for the Joint Committee to monitor achievement of the 1% WHSSC and HB shared pathway savings target be brought back to the Joint Committee for approval on 14 March 2023.
JC23/32	**3.1 Any Other Business** Members also **noted** updates on other matters of business as follows: • **WHSSC Proposed Changes to Specialist Fertility Services CP37, Pre-implantation Genetic Testing-Monogenic Disorders, Commissioning Policy & CP38, Specialist Fertility Services: Assisted Reproductive Medicine, Commissioning** Members noted that in an effort to improve outcomes for patients and reflect current evidence, two fertility policies had been reviewed and were issued for consultation in accordance with the process outlined in the WHSSC 'Policy for Policies' (which aligns to the process used by NICE and the All Wales Medicines Strategy Group (AWMSG)). The consultation documents were sent directly to a wide stakeholder group via email and the consultation was also signposted on the WHSSC website. SL advised that due to the emotive nature of these areas of policy WHSSC sought both ethical and legal advice prior to release. SL advised that in response to the consultation the Board of Community Health Councils (CHCs) in Wales had written to WHSSC concerning the process and their interpretation that the policy development should be considered as a service change for patients and that Section 183 of the National Health Services (Wales) Act 2006 applied. In the light of this interpretation by the Chief Officers of the Board of CHCs WHSSC has sought further legal advice. They also asked that the consultation was paused however WHSSC explained that they were reluctant to do this because:

- Doing so would go outside of the published WHSSC policy update process and therefore risk future challenge regarding the policy development process,
- The consultation period had been extended to 12 weeks, and was due to close on the 17 February 2023 therefore there were no decision points or stop points in the immediate future which needed to be avoided; and
- It might inadvertently disadvantage stakeholders who have developed their consultation responses and were ready to submit.

Iolo Doull (ID) advised Members that a review of Fertility Services was planned by NICE for approximately two years' time. He noted that the WHSSC Policies were out of date and therefore due for review. He explained there was an extensive engagement process to develop the policy which included the Fertility Network. However, they had subsequently issued a press statement that was factually inaccurate which had caused members of the public to gain a false perception that WHSSC were proposing to reduce the service when the intention was in fact to improve equity of access. ID reiterated that this consultation was open to stakeholders and not a public consultation, the same process followed by NICE. He emphasised that if the CHCs' argument was upheld, it would have a huge impact on all clinical access policy development. WHSSC had therefore sought further legal advice to ensure we were doing the right thing and it was a clear and transparent process.

SL also reiterated that the process had been followed in alignment with NHS England, NICE and AWMSG and if the process were required to be changed according to the CHC interpretation, it would have a wider impact across the whole of the NHS.

CS asked if dialogue had taken place with the CHC to understand their interpretation and whether HBs should initiate dialogue with them to mitigate the risk of getting to a point where a judicial review might be required. SL reassured Members that WHSSC and the CHCs had had regular discussions concerning this. Members noted that the CHCs were content to wait for the expert legal advice and that SL was meeting with the Board and Chief Officers of the CHC on 16 February 2023 to discuss. CS asked that HBs' Engagement and Comms Leads would be involved and informed due to the legal duty that sat with the HBs.

NJ informed Members that the HB Directors of Planning, Board Secretaries and Engagement Leads had been involved and kept up to

	date. WHSSC had offered to draft a briefing for Engagement Leads and were updating them via the Engagement Leads Group Meetings. **ACTION:** HB Comms and Engagement Leads to be included in the circulation list for the feedback on the expert legal advice and discussions with the CHCs. **TransVision Cymru – Letter and WHSSC Response** Members noted that WHSSC had received a letter of concern from Trans Vision Cymru concerning moving services into the Welsh Gender Service, and which requested further engagement and a request to meet with WHSSC and WG. Carole Bell (CB) advised that a response letter had been issued acknowledging their requests and concerns and advising them that children's services were different to adult services and any service changes or developments would need to be led by the Children's Hospital for Wales. CB advised that the referral pathway was also different as referrals were made directly to Children and Adolescent mental Health Services (CAMHS), as a result of that they also received the support of Umbrella Cymru which English children did not have when accessing the pathway. The Chair advised the Group that discussions had taken place with WG around this as they had received a similar letter.
JC23/33	**3.2 Date of Next Meeting** The Joint Committee noted that the next scheduled meeting would be on 14 March 2023 at 13.30hrs via Teams. There being no other business other than the above the meeting was closed.

Chair's Signature: .....

Date:.....

JOINT COMMITTEE MEETING
14 March 2023 Action Log

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
8 November 2022					
JC22/026	**JC22/134 Delivering Thrombectomy Capacity in South Wales** **ACTION:** The Delivering Thrombectomy Capacity in South Wales report and accompanying documents to be updated to provide greater emphasis on the networked approach, interdependencies around the network approach and pick up additional elements including the stroke review. The updated report should be presented to the JC in March 2023 for further discussion.	NJ	March 2023	**27.02.2023 –** On the Agenda – Item number 3.3.	**OPEN**
JC22/029	**JC22/138 Individual Patient Funding Request (IPFR) Governance Engagement Update** **ACTION:** An update on the Individual Patient Funding Request (IPFR)	SL	March 2023	**27.02.2023 –** On the Agenda – Item number 3.7.	**OPEN**

	Engagement process to be provided to the JC in early 2023.				
13 February 2023					
JC23/001	**JC23/31 Integrated Commissioning Plan (ICP) 2023-2024** **ACTION:** the NHS England (NHSE) funding growth approach to be considered at a future JC session with a discussion on the variation and impact of investment between Scotland, England and Wales.	SD/NJ	July 2023	Not yet due.	**OPEN**
	ACTION: A review of the potential impacts on providers in Wales on strategic reinvestment, disinvestment and any subsequent reconfiguration to be discussed at a future JC meeting.	SD/NJ	July 2023	Not yet due.	**OPEN**
	ACTION: An outline governance system and process for the Joint Committee to monitor achievement of the 1% WHSSC and HB shared pathway savings target to be brought back to the Joint Committee for approval on 14 March 2023.	SD/NJ	March 2023	**27.02.2023 –** On the Agenda – Item number 2.1.	**OPEN**
JC23/002	**JC23/32 Any Other Business** • **WHSSC Proposed Changes to Specialist Fertility Services**	SL/ID	March 2023	**27.02.2023 -** the circulation list for sharing the feedback from the policy engagement exercise, the expert legal advice and the outcome of discussions	**CLOSED**

	CP37, Pre-implantation Genetic Testing-Monogenic Disorders, Commissioning Policy & CP38, Specialist Fertility Services: Assisted Reproductive Medicine, Commissioning **ACTION:** HB Comms and Engagement Leads to be included in the circulation list for the feedback on the expert legal advice and discussions with the CHCs.			with the CHCs has been updated to include the HB Communication and Engagement Leads and the HB Board Secretaries. Action Completed.	

Report Title	**Chair's Report**	**Agenda Item**	3.1
Meeting Title	**Joint Committee**	**Meeting Date**	14/03/2023
FOI Status	Public		
Author (Job title)	Chair of WHSSC		
Executive Lead (Job title)	Committee Secretary and Head of Corporate Services		

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 Chairs action taken on 2 February 2023 to approve expenditure for Advanced Medicinal Therapeutic Products (ATMPs) through the Blueteq High Cost Drugs (HCD) software programme; and
- **Approve** the recommendation to extend the tenure of the interim Chair of the Individual Patient Funding Request Panel (IPFR) to 30 September 2023 to ensure business continuity.

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

At each Joint Committee (JC) meeting, the Chair presents a report on key issues that have arisen since its last meeting.

3.0 ASSESSMENT

3.1 Chair's Action – Approval of Blueteq Expenditure

A Chair's Action was taken on 2 February 2023 to approve expenditure for Advanced Medicinal Therapeutic Products (ATMPs) through the Blueteq High Cost Drugs (HCD) software programme, and a letter was issued to Joint Committee members on the 2 February 2023 confirming the action taken. The letter is presented at ***Appendix 1*** for information.

3.2 Extension of Chair of the Individual Patient Funding Request (IPFR) Panel

On 12 July 2022, the Joint Committee approved the appointment of Jim Hehir, IM CTMUHB as the interim Chair of the Individual Patient Funding Request (IPFR) Panel for a 6 month period on an unremunerated interim basis until January 2023 to ensure business continuity.

On the 6 September 2022 the Joint Committee approved the proposal for WHSSC to embark on an engagement process with key stakeholders, including the All Wales Therapeutics and Toxicology Centre, IPFR Quality Assurance Advisory Group (AWTTC QAG), the Medical Directors, Directors of Public Health and the Board Secretaries of each of the HBs and Velindre University NHS Trust (VUNT), to update the WHSSC IPFR Panel Terms of Reference (ToR) and on the specific and limited review of the All Wales IPFR Policy. The review of the WHSSC ToR will include the role, tenure and remuneration of the IPFR Chair position.

On the 8 November 2022, the Joint Committee agreed to extend the interim chair arrangement until 31 March 2023 to enable sufficient time to be given to reviewing the feedback from the engagement process and to reviewing the person specification for the substantive Chair role with a view to undertaking an open and transparent recruitment campaign in early 2023. Given the timescale of the reporting back to the JC in March and May 2023 to ensure business continuity, it is proposed that the interim arrangement is extended further from 31 March 2023 to 30 September 2023.

3.3 WG Review of National Commissioning Functions

On 20 January 2023, the Director General/NHS Wales Chief Executive wrote to WHSSC advising that the Minister for Health & Social Services had approved a review of the national commissioning functions. This was a commitment within A Healthier Wales and forms part of a set of actions to strengthen and streamline the NHS landscape in Wales. The terms of reference were shared and discussed at the NHS Wales Leadership Board on 24 January 2023.

WG have requested that a facilitated discussion is held with Joint Committee members and a joint workshop has been scheduled for 14 March 2023 to coincide with the EASC and WHSSC meetings scheduled for that day.

3.3 Key Meetings

I have attended the following meetings:

- Regular catch up meetings with WHSSC IMs and WKN Chair
- Regular bi-monthly meetings with the Chair of the QPS Committee,
- Integrated Governance Committee,
- NHS Wales Chairs Peer Group Meeting.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report,
- **Ratify** the Chairs action taken on 2 February 2023 to approve expenditure for Advanced Medicinal Therapeutic Products (ATMPs) through the Blueteq High Cost Drugs (HCD) software programme; and
- **Approve** the recommendation to extend the tenure of the interim Chair of the Individual Patient Funding Request Panel (IPFR) to 30 September 2023 to ensure business continuity.

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	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	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 to any of the issues outlined 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	Appendix 1 – Letter Concerning Chairs Action Taken for Blueteq Expenditure

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

Your ref/eich cyf:
Our ref/ein cyf: KE.JE
Date/dyddiad: 2 February 2023
Tel/ffôn: 01443 443 443 ext. 8131
Email/ebost: Jacqueline.Evans8@wales.nhs.uk

WHSSC Joint Committee Members,

Dear Colleague,

Re: Approval of Blueteq Expenditure

I am writing to you to inform you that a Chair's action has been undertaken to approve expenditure for Advanced Medicinal Therapeutic Products (ATMPs) through the Blueteq High Cost Drugs (HCD) software programme. The medicine in question - Paediatric Zolgensma - is a gene therapy and is given once in a patient's lifetime.

This therapy has been approved through the NICE Highly Specialised Technology appraisal process and therefore there is Welsh Government commitment to making this treatment available to eligible patients in Wales:

- Press release: *NICE final draft guidance approves life-changing gene therapy for treating spinal muscular atrophy | News | News | NICE*
- Full guidance: *Overview | Onasemnogene abeparvovec for treating spinal muscular atrophy | Guidance | NICE*

ATMPs are currently funded from a direct financial allocation from Welsh Government to WHSSC. All expenditure must go through the agreed financial governance processes.

This action was taken in accordance with provisions of the WHSSC Standing Orders (SOs), 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 addition, this requirement was specifically identified in the updated process for the current Standing Financial Instruction (SFI) considered at the Joint Committee on 10 January 2023. This specified that Joint Committee "approval" of non-contract cases above defined limits for annual and anticipated lifetime cost, should be replaced by an assurance report to Joint Committee and the CTMUHB Audit & Risk Committee (ARC) notifying of all approvals above the

defined limit and Chair's action to reflect the need for timely approval action. This includes individual annual costs of drugs that are automatically approved via the Blueteq software system which ensures compliance with current eligibility criteria for high cost medicines.

Therefore, to ensure effective governance a Chair's action has been taken to approve the use of Paediatric Zolgensma for Paediatric Neurology treatment at the University Hospital Bristol NHS Foundation Trust for two patients at a cost of £1,713,523 per patient. The total cost is therefore £3,427,045.36.

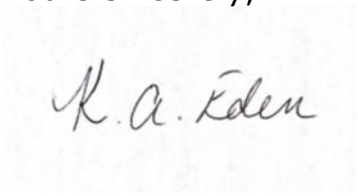
Chair's Action

I confirm that by this letter, acting in conjunction with Dr Sian Lewis, Managing Director of WHSSC, Steve Spill, Independent Member (IM) of WHSSC, and Professor Ceri Phillips, IM of WHSSC I have taken Chair's Action to approve the Blueteq expenditure.

This matter will be reported on at the next Joint Committee meeting on the 14 March 2023 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 – Dr Sian Lewis, Managing Director, WHSSC
Cc – Stuart Davies, Director of Finance, WHSSC

Welsh Health Specialised Services Committee
Unit G1, The Willowford,
Treforest,
Pontypridd
CF37 5YL

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Uned G1, The Willowford,
Trefforest,
Pontypridd
CF37 5YL

Chair/Cadeirydd: *Kate Eden*
Managing Director of Specialised and Tertiary Services Commissioning/Rheolwr Gyfarwyddwr Dros Dro Comisiynu Gwasanaethau Arbenigol a Thrydyddol: *Dr Sian Lewis*

Report Title	**Managing Director's Report**	**Agenda Item**	3.2
Meeting Title	**Joint Committee**	**Meeting Date**	14/03/2023
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 that 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 matters 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 Plastic Surgery Outreach Clinics in BCUHB: Update on Quality Concerns

During the plastic surgery workshop held with the Management Group on 22 September 2022 to consider the future commissioning model for plastic surgery, significant quality concerns were raised by the clinical leads from St Helen's & Knowsley NHS Trust (SHKNT). This related to the management of the outreach clinics delivered by SHKNT, but managed by BCUHB, in Ysbyty Gwynedd and Ysbyty Glan Clwyd, including waiting times, waiting list management and other operational issues. These issues had previously, been raised in SLA meetings with SHKNT and had been escalated via the WHSSC/BCUHB executive-to-executive meeting. Further to the workshop in September, the following actions were undertaken:

- A meeting was held between WHSSC and BCUHB quality leads, including operational managers from BCUHB and SHKNT, to consider how to address the issues,
- The Cancer & Blood (C&B) commissioning team considered the evidence in relation to the Escalation Framework, however at that time had not recommended that the service goes into WHSSC escalation due to a lack of formal evidence (patient concerns, SUIs etc.) on record from SHKNT. It was agreed the C&B commissioning team would review the escalation status on a monthly basis. This issue was added to the C&B commissioning team risk register,
- This issue would be kept under review at SLA meetings with SHKNT and BCUHB, and at the WHSSC-BCUHB interface meetings; and
- WHSSC wrote formally to the Health Board (HB) to notify the CEO of the issues raised at the workshop and to request further information to assist consideration of escalation status and risk.

WHSSC understands that further to the plastic surgery workshop, the concerns raised were immediately escalated internally within BCUHB. WHSSC further understand that BCUHB has established a Task & Finish Group to consider and address these concerns.

During a SLA meeting on 8 February 2023 the Associate Medical Director from SHKNT once again raised serious safety concerns regarding the service and the lack of progress made to address them. It was reported that further SUIs had occurred and there was a lack of engagement from the UHB regarding their concerns and therefore they were considering withdrawing the service. WHSSC has discussed the issues with colleagues in Welsh Government (WG) and it was agreed that given the issues did not lie directly within the WHSSC commissioning responsibility WG will lead on the escalation process but in liaison with WHSSC.

In addition, a Harm Review has been commissioned by BCUHB and the Terms of Reference (ToR) are in the process of being signed off through internal HB processes. Once this has occurred the clinical reviews can commence and the findings will feed into both the escalation process and future management of the patients on the waiting list.

3.2 Cochlear Implant and Bone Conduction Hearing Implant Hearing Device Service – Engagement Process Update

On the 6 September 2022 the Joint Committee supported a report which suggested the process for a period of targeted engagement on the future configuration of the South Wales Cochlear Implant and Bone Conduction Hearing Implant Device Service.

A report was considered by each HB Board meeting in September 2022. The engagement documentation was circulated to HBs before Christmas and the formal engagement ran between 4 January 2023 and 14 February 2023. The consultation feedback is now being analysed and will be presented to members at the Joint Committee meeting on 16 May 2023 with a view to inclusion on HB Board agendas at the end of May 2023.

3.3 Spinal Operational Delivery Network (ODN)

The implementation of the Spinal Operational Delivery Network (ODN) has been delayed due to unforeseen circumstances. The Spinal ODN network manager has been appointed and is reviewing the programme plan. A more detailed update will be presented to the Joint Committee meeting on 16 May 2023. It is likely that the programme timescale will have slipped by around 6 months.

4. RECOMMENDATIONS

Members are asked to:

- **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	This report provides an update on key areas of work linked to Commissioning Plan deliverables.
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 Care for those with the greatest health need first Only do what is needed Reduce inappropriate variation
NHS Delivery Framework Quadruple Aim	Choose an item. Choose an item. Choose an item. Choose an item.
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	**Delivering Thrombectomy Capacity in South Wales**	**Agenda Item**	3.3
Meeting Title	**Joint Committee**	**Meeting Date**	14/03/2022
FOI Status	Open		
Author (Job title)	Associate Medical Director, Neurosciences and Trauma Services		
Executive Lead (Job title)	Director of Planning		

Purpose of the Report	The purpose of this report is to outline WHSSC's position on the commissioning of Mechanical Thrombectomy for the population of Wales.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☐	INFORM ☒

Recommendation(s):
Members are asked to:

- **Note** the report,
- **Note** the WHSSC Position Statement on the Commissioning of Mechanical Thrombectomy,
- **Note** the associated risks with the current delivery model for Welsh stroke patients requiring access to tertiary Thrombectomy centres; and
- **Note** the NHS Wales Health Collaborative (NWHC) proposal to strengthen and improve regional clinical stroke pathways in Wales to support the Mechanical Thrombectomy pathway to ensure that patients receive this time-critical procedure in a timely manner.

DELIVERING THROMBECTOMY CAPACITY IN SOUTH WALES

1.0 SITUATION

The purpose of this report is to outline WHSSC's position on the commissioning of Mechanical Thrombectomy for the population of Wales.

2.0 BACKGROUND

WHSSC is responsible for commissioning Mechanical Thrombectomy for the Welsh population on behalf of the seven Health Boards (HBs). Mechanical Thrombectomy Services are currently commissioned from NHS England (NHSE) providers: from the Walton Centre NHS Foundation Trust (WCNFT) for the population of North Wales (a 24/7 service), from the North Bristol NHS Trust (NBNT) for the population of South Wales (currently an 8am-8pm service, with a 24/7 service planned from December 2022), and from the University Hospitals of Birmingham NHS Foundation Trust (UHBNFT) for the Powys population.

In September 2020 the Management Group received a report on the provision of image transfer and the associated risks with the transfer of images from Welsh HBs to the tertiary Thrombectomy centres. These risks have now been resolved. The report also set out a proposal to deliver a long term solution to improve patient outcomes.

Subsequently, at the October 2020 Management Group meeting, members agreed to appoint a Project Manager to initiate and scope a Mechanical Thrombectomy service at the Neurosciences Centre, Cardiff and Vale UHB (CVUHB). However, the scoping of the project was delayed due to the operational pressures arising from the COVID-19 pandemic.

Work started in earnest in 2021-2022, culminating in a Mechanical Thrombectomy workshop which was held in March 2022. The workshop highlighted that the current Mechanical Thrombectomy pathway was subject to a number of challenges and barriers, and an action plan was created which would be monitored and progressed by the Thrombectomy Oversight Group (chaired by the Stroke Implementation Group Chair).

Of additional note, the NHS Wales Health Collaborative Executive Group (NWHCEG) met in February 2022 and described the vision for stroke services across Wales to establish Comprehensive Regional Stroke Centres (CRSCs) and four Stroke Operational Delivery Networks (ODNs) – see ***Appendix 1.*** To progress this work, WHSSC were represented at the recent Stroke Programme stakeholder event in January 2023. The workshop concerned the development of stroke pathway modelling and service specifications, and a timeline and next steps are due to be published shortly.

3.0 ASSESSMENT

A key priority for the Neurosciences and Trauma services Commissioning Team in 2022-2023 is the proposed plan for a Mechanical Thrombectomy service at the Neurosciences centre, CVUHB. To this end, WHSSC has worked collaboratively with CVUHB to develop a Mechanical Thrombectomy Centre business case. The financial model has been shared and worked through, and a number of constraints have been resolved or mitigated. Although the appointment of a third Interventional Neuro-Radiologist remains an outstanding issue, CVUHB will be advertising the post imminently and there is an optimism that the recruitment process will be successful. The final business case will be submitted through CVUHB's governance structures during February and early March 2023. At the time of writing, WHSSC had not had sight of the full and final business case. The service will be implemented in a phased approach as outlined in ***Appendix 2***.

In addition, and as highlighted in the minutes of the 17 January 2023 WHSSC Joint Committee meeting, it is important for CVUHB to maintain a commitment to its Thrombectomy service in view of the close link between having a Thrombectomy service and an Interventional Neuroradiology (INR) service, and the concurrent link between having an INR service and a neurosurgery service. In view of these interdependencies, it is apparent that the long-term development of the CVUHB Thrombectomy service has other, wider strategic implications.

3.1 WHSSC Position Statement

Alongside the business case, WHSSC has also developed a position statement on the commissioning of Mechanical Thrombectomy. This document (see ***Appendix 2***) describes:

- The current commissioning arrangements for access to Mechanical Thrombectomy, for the population of Wales,
- The plan for the phased development of a Mechanical Thrombectomy service at the Neurosciences centre in South Wales,
- The current numbers of Welsh patients receiving Mechanical Thrombectomy,
- The steps that have been taken and are being taken to improve flow along the stroke pathway; and
- New recent evidence on expanding the access criteria for Thrombectomy services.

The position statement outlines where some progress has been made with Mechanical Thrombectomy services in Wales but highlights that there is a significant deficit in patients accessing this service when compared to other regions, nations and projected numbers – see ***Appendix 2, table 1***.

NHSE are forecasting that 10% of Stroke patients will be eligible for Thrombectomy which when extrapolated for Wales, would see 500 eligible

patients per year when all elements of the stroke pathway are fully embedded. 1.2% of eligible Welsh patients were accessing the Mechanical Thrombectomy service between January and December 2022); and 1.45% accessed the service in the three months to December 2022 (during which 47% of Thrombectomy procedures were undertaken in Cardiff and Vale).

There is a sustained drive to improve door- to- needle times across Wales, but this is hampered by infrastructure and workforce fragility which is evident in all Welsh HBs. Challenges remain with the Welsh Ambulance Services Trust (WAST) relating to the transfer of patients to the HB Acute Stroke units. Thrombectomy is a time critical procedure where the patient needs to be triaged and moved quickly through the clinical pathway: the longer the delay the less likely of a successful outcome.

Nonetheless, a number of improvements have been made:

- All inter-hospital Thrombectomy transfers are now managed by the trauma desk with a red-call priority; and
- Designated hospitals in the south Wales region are all able to access the Biotronics 3D IT platform for image transfer to the English centres. The north Wales team are currently using the Image Exchange Portal (IEP).

3.2 Financial Resource

WHSSC acknowledges that there will be a requirement to "pump prime" the CVUHB Mechanical Thrombectomy centre through the implementation (phase 1) stage. It is proposed that there should be a gateway review after phase 1 to establish whether the operational and financial assumptions are still aligned with the original business case before committing to further phases. This will ensure that the whole stroke clinical pathway is aligned with the development of Comprehensive Regional Stroke centres and Stroke ODN services, as there may be opportunities for economies of scale.

3.3 Networked Approach and Interdependencies

WHSSC were approached by the North Bristol Thrombectomy Centre in November 2022 and again in January 2023, and asked to support the "go live" of the 24/7 Mechanical Thrombectomy service on an interim basis. Bristol had identified significant challenges and workforce constraints.

The Cardiff team were keen to work with Bristol on a networked approach that delivered a more sustainable model for the south Wales region. It was also acknowledged that, pending the delivery of a WHSSC-commissioned Mechanical Thrombectomy Centre in South Wales, there was a need to arrange the secondment of two staff to Bristol to offer support on an interim basis. Scoping will now be undertaken in order to establish the requirements and ascertain how the arrangements might work in practice.

In the meantime, the North Bristol Thrombectomy service commenced their 24/7 service on 5 December 2022. The impact of this decision has been an inequity of

Thrombectomy provision for the South Wales region when compared to the North Wales and Powys regions, where a 24/7 service is already provided by the Walton Centre and Birmingham University Hospital.

WHSSC has also had recent discussions with Bristol about the imperative of agreeing a start date for the 24/7 service for the South Wales population. Bristol has thus far provided a caveated response, indicating a provisional date of May 2023. This date was, however, dependent on the Bristol clinical teams receiving assurance that the South Wales referring centres are compliant with two pathway standards to which all referring hospitals must adhere:

- CT and CTA scanning are done in tandem at all the south Wales referring hospitals; and
- Superstat reporting produced by the company Everlight is turned around in 30 minutes.

A recent update from the Delivery Unit has indicated that most referring hospitals are achieving these standards, but this will continue to be monitored over the coming months in order to provide Bristol with assurance.

3.4 New Clinical Evidence

MR-CLEAN- LATE is a multicentre randomised trial to explore whether the current criteria for assessing patients for a Thrombectomy can be extended to a wider group of people, for whom the procedure would deliver benefits and improved functional outcomes.

The impact of including this group would bring forward the forecast of 10% of Stroke patients being eligible for Thrombectomy. This would increase the workload for Bristol, creating further capacity challenges that could reduce access to these services for Welsh patients, thereby underlining the need to expedite the commissioning of the Cardiff service.

4.0 RECOMMENDATIONS

- **Note** the report,
- **Note** the WHSSC Position Statement on the Commissioning of Mechanical Thrombectomy,
- **Note** the associated risks with the current delivery model for Welsh stroke patients requiring access to tertiary Thrombectomy centres; and
- **Note** the NHS Wales Health Collaborative (NWHC) proposal to strengthen and improve regional clinical stroke pathways in Wales to support the Mechanical Thrombectomy pathway to ensure that patients receive this time-critical procedure in a timely manner.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	**Yes**
Health and Care Standards	Safe Care Effective Care Timely Care
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Reduce inappropriate variation Choose an item.
NHS Delivery Framework Quadruple Aim	People in Wales have improved health and well-being with better prevention and self-management Choose an item. Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	To ensure sustainability and deliverability of the Mechanical Thrombectomy service to improve patient outcomes.
Finance/Resource Implications	The financial framework for the Mechanical Thrombectomy centre to be based in Cardiff are still being considered.
Population Health	Delivery of Mechanical Thrombectomy services in a time critical manner will improve patient outcomes and quality of life. All components of the clinical pathway need to be effective and efficient to streamline processes to achieve the desired outcomes.
Legal Implications (including equality & diversity, socio economic duty etc)	To ensure an equitable service is being accessed by all patients across Wales.
Long Term Implications (incl WBFG Act 2015)	-
Report History (Meeting/Date/ Summary of Outcome	28 February 2023 – Corporate Directors Group Board (CDGB) 8 November 2022 – Joint Committee
Appendices	Appendix 1 - Developing Regional Stroke Services Appendix 2 **-** WHSSC Position Statement on Mechanical Thrombectomy service

Developing Regional Stroke Services:

Authors:
Rhys Blake, Head of Planning, NHS Wales Health Collaborative; Dr Shakeel Ahmad, National Stroke Clinical Lead, Stroke Implementation Group; Dr Dinendra Gill, Clinical Lead, Wales Trauma Network; Lynda Kenway, Stroke Implementation Group Coordinator; Mark Dickinson, Director, NHS Wales Health Collaborative

Date: 16 February 2022	**Version:** 0c

Purpose and Summary of Document:

This paper seeks the agreement of the Collaborative Executive Group for work to be undertaken by the Collaborative team, in support of the Stroke Implementation Group (SIG), to develop, and prepare a business case to implement a new model of high quality, patient focused stroke services in Wales that will:

- establish Comprehensive Regional Stroke Centres (CRSCs), working across appropriately defined geographies
- establish regional Stroke Operational Delivery Networks (ODNs), centred on the CRSCs, that will incorporate designated Acute Stroke Units (ASUs) and be responsible for the delivery of a comprehensive range of stroke service
- be informed by the experience of improving stroke services elsewhere in the UK and of developing and implementing Major Trauma Networks in Wales
- meet quality standards, and deliver individual and population outcomes, comparable with the best in the UK within five years
- meet the vision set out in the NHS Wales Quality Statement for Stroke

The initial phase of work will result in the development of a business case, by the end of 2022, describing the proposed specific configuration of services and justifying and seeking the required local and central investment from health boards and Welsh Government This will align with the NHS Wales planning cycle for the period commencing 2023/24.

1 The case for nationally co-ordinated activity to support the design and implementation of comprehensive regional stroke networks

Stroke services in Wales face significant challenges. Workforce fragility and lack of key specialist skills mean that treatment and outcomes are often sub optimal. Despite a strong evidence base, informed by experience elsewhere in the UK, indicating how services and outcomes could be significantly improved, very limited progress has been made over many years.

The solution to providing sustainable service models, for both acute and highly specialised treatment, lies beyond individual health boards trying to maintain their own local services. These services are too fragile; they are poorly staffed, lack 24/7 models of care and are not delivered in units designed to treat stroke as a true medical emergency.

This paper proposes a programme of work, to be undertaken by the Collaborative team, working with health boards and in support of the Stroke Implementation Group, that will address how best to organise and deploy existing resources and new investment to address current weaknesses. The programme will undertake the work to design and produce a business case for sustainable service models that delivers the outcomes that the Welsh population deserves.

The case for designing and implementing stroke services in a prudent and optimised way is clear:

- Stroke is estimated to cost NHS Wales £220 million annually and all sectors of the Welsh economy a combined £1.63 billion (£45,409 per patient in the first year). The latter cost is forecast to rise to £2.8bn by 2035 if no action is taken to mitigate against this.
- The thrombectomy rate in Wales is currently only 0.7%. This compares with a target of 10% (equivalent of 750 patients), which, over 10 years, would enable 300 extra patients to live independently per year. A recent study by Guijarro et al demonstrated that utilising thrombectomy for eligible patients represents a saving of £47,000 per patient, over a 5-year period. If Welsh targets are met this equates to a saving of £350 million over the 10-year period.
- The thrombolysis rate in Wales is currently only 11.8%. This compares with a target of 20%, which would deliver an outcome of 110 patients free of disability and would increase by a further 22% (24 patients) if the patients were treated within 90 minutes of the onset of stroke. This equates to 134 patients free of disability per year, 11 patients per month.

- Only 21.8% of patients are currently admitted to stroke units within four hours. Over 11,000 bed days could be saved annually if the target level of 95% was achieved.
- The average length of stay in Wales is currently 21.5 days against a national average across the UK of 16.5 days. High performance 'level A stroke centres' have an average stay of 14.5 days. By achieving the equivalent of those centres, Wales would save 33,901 bed days, a cost saving of £13.56 million.
- The current Early Supported Discharge (ESD) rate is 25.5%, against a target of 60%, with huge variation across Wales. Increasing and meeting an ESD target of just 40% would save 10 lives per year and £51,000 per 100,000 population, saving £479,000 to the Welsh NHS. From a patient perspective, ESD is shown to improve a stroke survivor's motor capacity, improving functional independence and reducing the burden on carers.
- None of the existing Welsh stroke units have consistently scored 'A' in the Sentinel Stroke National Audit Programme (UK) assessment. It is estimated that achieving a SSNAP 'A' score would reduce the 90-day mortality by 5%. An estimated 85 deaths per year could, therefore, be prevented by reaching this standard alone.

Click here to read the Stroke Association's publication; 'Current, Future and Avoidable Costs of Stroke').

In 2016, the Stroke Implementation Group (SIG) jointly commissioned the Royal College of Physicians and The National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) South West Peninsula, to provide an analysis of the options for the reconfiguration of hyperacute stroke services in Wales in order to address longstanding issues of sustainability and quality deficiencies, including those summarised above.

The report[1] detailed the net clinical benefit, taking into account institutional activity and co-dependency with other critical services such as vascular and interventional neuroradiology. The model demonstrated that equivalent clinical benefit could be obtained from as few as three **Comprehensive Regional Stroke Centres** (CRSCs) in Wales, provided that those centres consistently achieve an average door-to-needle time[2] of 45 minutes[i], as demonstrated in other CRSCs elsewhere in the United Kingdom. Nearly six

[1] A new hyperacute stroke service for W

[2] **Door-to-needle time**: the time from arrival at hospital door to the start of IVT

years on, Wales has not moved towards these recommendations and so it has been determined that a nationally co-ordinated approach to deliver a model of service in keeping with the rest of the UK is necessary.

2 Defining the vision, model, pathways and minimum viable size of CRSCs

The NHS Wales Stroke Quality Statement states that NHS Wales should:

1. *Support a new model of provision of stroke services through comprehensive stroke centres and a networked approach to cross boundary working that seeks to improve the whole patient pathway including access to diagnostics, interventions, rehabilitation, including early supported discharge and psychological support services.*
2. *Services will be reconfigured to produce the outcomes expected in high quality, patient focused services and to ensure national standards can be met consistently and sustainably.*

In support of this vision, it is proposed that work should be undertaken by the Collaborative team, in support of the SIG, to develop, and prepare a business case to implement a new model of high quality, patient focused stroke services in Wales that will:

- establish Comprehensive Regional Stroke Centres (CRSCs), working across appropriately defined geographies
- establish regional Stroke Operational Delivery Networks (ODNs), centred on the CRSCs, that will incorporate designated Acute Stroke Units (ASUs) and be responsible for the delivery of a comprehensive range of stroke services
- be informed by the experience of improving stroke services elsewhere in the UK and of developing and implementing Major Trauma Networks in Wales
- meet quality standards, and deliver individual and population outcomes, comparable with the best in the UK within five years

As stated in the previous section, a minimum of three CRSCs could service the population of Wales, in terms of viable critical mass. The SIG has considered the following factors in assessing the most appropriate number of CRSCs to serve the population of Wales:

- Travel times[3] for patients (in relation to the targets included in the standards in Appendix 1)
- Critical mass
- Sustainability

[3] **Travel time**: the time is takes for a patient to get from the scene of their stroke to the most appropriate care setting for treatment

- Access to specialist diagnostics
- Workforce requirements
- Cost effectiveness

Taking these factors into account, it is recommended that **four** CRSCs be established. To prevent the South East Wales centre from becoming too large (the largest in the UK), it is advised that two CRSCs be developed in this region (South East and South Central). By ensuring that there are no more than four CRSCs there is the opportunity to utilise the existing workforce to maximise benefit, develop rehabilitation closer to home and keep costs to a minimum. By utilising sites with existing primary PCI there is an opportunity to develop thrombectomy services as part of the service model.

Each CRSC would be the focal point of a regional Stroke **Operational Delivery Network** (ODN), covering the following areas:

- North Wales
- South West
- South Central
- South East

Clear arrangements linking to the above CRSCs and to services in England will need to be determined for the population of Powys, in liaison with the health board.

The model of regional CRSCs operating as part of regional Stroke ODNs has strong parallels with, and will build on, the work done to establish Major Trauma Networks in Wales with an agreement to review continually to ensure they model is configured in the optimum way.

This paper seeks agreement to undertake the work necessary to identify and agree on the necessary configuration and specific location of CRSCs, supported by designated **Acute Stroke Units** (ASUs) as part of Stroke ODNs. As part of this work, there will be a workstream to determine managerial arrangements (particularly where services will be organised across more than one organisation). This will enable a co-ordinated programme of work, with a common 'go live' date for the regional networks, to be formally established.

By the end of 2022, the work will generate a business case describing the proposed specific configuration of services and justifying and seeking the required local and central investment from health boards and Welsh Government. This will align with the NHS Wales planning cycle for the period commencing 2023/24. The case will follow the 'five case model' and will set out:

- the Strategic Case
- the Economic Case
- the Commercial Case
- the Financial Case
- the Management Case

3 Process for determining the future configuration of acute stroke services

In order to devise the most appropriate configuration of CRSCs and ASUs, grouped into regional ODNs, it is proposed that the Collaborative should design, and work with health boards to implement a formal process to:

- allow health boards, individually or in partnership, to put forward 'candidate CRSCs' and 'candidate ASUs'
- determine the criteria against which 'candidate CRSCs' and 'candidate ASUs' will be assessed (based on the NHS England quality indicators set out in Appendix 1)
- enable health boards to self-assess the candidate CRSCs and ASUs against explicit criteria (including assessments of the work and time necessary to meet unmet standards/targets)
- enable the SIG, led by the Stroke Clinical Lead and supported by internal and external expertise, to challenge and confirm the assessments of candidate CRSCs and ASUs
- consider service change interdependencies and ensure that WHSSC and EASC are fully engaged in relation to their commissioned elements
- informed by the above, produce a formal recommendation to the Collaborative Executive Group as to the recommended configuration of specified CRSCs and ASUs, grouped into regional ODNs
- produce recommendations as to the to which standards/indicators need to be met for 'go live' of regional services (day 1) and which could follow once operational for a defined period

The above process will be undertaken by Autumn 2022 and will draw on the similar successful approach taken by the South Wales Major Trauma Programme. The resulting configuration of services will then form the basis of the subsequent business case.

The designation of CRSCs and ASUs should be reviewed after the first year of being operational and completion of national annual stroke peer review

4 Engagement and consultation

The need for informing and engaging communities and their statutory advocacy groups with respect to the designation of CRSCs and the formation of Stroke ODNs is recognised. Health boards will be principally responsible for this through normal processes, supported by the SIG and the Collaborative.

To ensure the consultation process is meaningful, consideration needs to be given to key messages to be shared with the public and the evidence available to support the proposed development of a reconfigured stroke network.

The key messages should include:

- Stroke is a serious life-threatening medical condition that happens when blood flow to the brain is blocked by a clot in an artery, or because a blood vessel has burst in the brain. This leads to damage and the rapid death of brain tissue resulting in long-term disability or death.
- Time is Brain; rapid access to the appropriate diagnostics and interventions can reduce the impact of a stroke and improve the outcomes for the patient.
- A Stroke network is a group of hospitals, emergency services and rehabilitation services, that work together to make sure a patient receive the best care for life threatening or life changing injuries.
- You are more likely to survive and have better outcomes if you have access to a comprehensive regional stroke centre or an acute stroke unit for less acute cases.
- Good stroke care involves getting the patient to the right place, at the right time, for the right care; having accurate imaging investigations and access to thrombolysis and thrombectomy where needed as well as a continuum of high-quality trained nursing support.
- A Regional stroke network normally has one CRSC supported by a number of locally provided ASUs. Rehabilitation and nursing are key components of the stroke network and an essential part of providing high quality stroke care and in achieving good patient outcomes.
- You will go to the most appropriate facility. If you are not seriously ill or have a stroke which does not need the highly specialist services, you will go to a local acute unit.

In light of the key messages, the consultation will ask people to respond to three questions:

1. Do you agree or disagree regional Stroke Networks should be established?
2. Do you agree or disagree that the configuration should be based on the recommendations from an independent panel/report?
3. If we develop regional stroke networks in Wales, is there anything else we should consider?

The timing of the consultation, in relation to the production and consideration of the business case requires further consideration and views are welcomed on this point.

5 Related work

This paper seeks only to describe the specific steps necessary to identify and agree the configuration and organisation of regional Stroke ODNs, focused on CRSCs and incorporating ASUs.

It is, however, recognised by the SIG and the Collaborative that this is only one strand of work that is required as part of a comprehensive approach to reducing the health burden of stroke on the population and on services.

With regards to stroke prevention, since the Stroke Implementation Group supported the 'Stop A Stroke' project, we have seen anticoagulation for AF go up from 72% to 85% across Wales.

Services will need to work with Public Health Wales to consider a nationally co-ordinated approach to hypertension control as there is an unmet need that has been exacerbated by health inequalities. A comprehensive stroke prevention strategy will be required as part of this overall work programme. **9 in every 10 strokes are preventable.**

Public Health Wales will continue to work closely with the Stroke Association and SIG to highlight the importance of recognising early the symptoms of stroke through the FAST campaign. Early treatment not only saves lives but results in a better chance of recovery and a likely reduction in disability.

Rehabilitation services are pressured and must also be strengthened. There are recognised workforce challenges in therapy delivery, with shortages in Speech and Language Therapy and Clinical Psychology. Stroke specialist, Early Supported Discharge (ESD) and community rehabilitation services are in place in only some health boards. Evidence suggests that this is not utilised to its fullest extent, with around one quarter of stroke patients transferred on discharge from hospital to an ESD team. In order to support changes within hyperacute stroke delivery, there is a need to reconfigure acute and community rehabilitation services to address some of these gaps. This can be facilitated by the regional Stroke ODNs proposed above.

Ambulance services are critical in the population being able to receive timely interventions. Alongside public recognition of stroke using the FAST campaign, a model for triage and redirection of flow will need to be developed in conjunction with EASC and the Welsh Ambulance NHS Trust. An opportunity exists to adopt work completed to implement the major trauma programme, as similarities between models mean that there is potential to expand the existing triage tool with which ambulance staff are already familiar.

The reconfiguration of stroke services or re-designation of units will almost certainly require a similar exercise in radiology services to be able support the service model.

6 Resources

The £1m funding allocation for the national Stroke Implementation Group has been secured for a further year (2022/23) and is considered sufficient for the Collaborative and SIG to support health boards with the approach described in this paper up to the point of:

- The agreement of the configuration of regional Stroke ODNs and the designation of CRSCs and ASUs
- The development of a business case in support of the implementation of the proposed new arrangements

In parallel with the work described above, the Collaborative will work with chief executives to lay the ground work for potential central capital and revenue funding (including pump priming funding) in support of the necessary implementation work. The details of the required funding will then form a core element of the business case.

7 Recommendations

The Collaborative Executive Group is invited to:

- Agree with the strategic aim to establish regional Stroke Operational Delivery Networks (ODNs) across Wales, each focused on a Comprehensive Regional Stroke Centre (CRSC) and incorporating an appropriate configuration of Acute Stroke Units (ASUs)
- Agree that there should be four ODNs/CRSCs, serving the following regions:
  - North Wales
  - South West
  - South Central
  - South East

- Commission the Collaborative, in support of the Stroke Implementation Group (SIG), to undertake the work, as described in this paper to:
  - recommend the configuration of regional Stroke ODNs and the designation of specific CRSCs and ASUs
  - develop a business case in support of the implementation of the proposed new arrangements

Appendix – Minimum standards and volumes for CRSCs and ASUs

	Comprehensive Regional Stroke Centre	**Acute Stroke Unit**
Minimum Volume	600 patients	
Travel Times	85% within 30 minutes	
	95% within 45 minutes	
	98% within 60 minutes	
CLINICAL STANDARDS		
Admitted to hyper acute unit within 4 hours of arrival to hospital	95%	95% admission from CRSC within 24hrs of referral
Brain Imaging	48% of patients scanned within 1 hour	
	95% of patients scanned within 12 hours	
Stroke specialist nurse assessment under 30 minutes	95%	
Door to needle thrombolysis	50% - 30 mins	
	90% - 45 mins	
	95% - 60 min	
Swallow screen assessment within 4 hrs	95%	
Patients have assessment by one of PT, OT or SLT within 24hrs of admission.	95%	95% patients receiving the equivalent of at least 45 minutes, 5 days a week of PT, OT & SLT.
Patients complete therapy assessments within 72hrs of admission	95%	
100% stroke consultant review within 24hrs	100%	
Patients receiving mood and cognition screening by discharge		95%
Patients receiving a continence assessment by discharge		100%
Applicable patients receiving a joint health and social care plan on discharge		100%

WORKFORCE REQUIREMENTS ***Please note:*** *therapy workforce recommendations are based on provision of 5-day therapy services and should be adjusted accordingly for units which are delivering 6- and 7-day services. These workforce recommendations may be subject to change in the case of any updates to the UK national clinical guidelines for stroke services.*		
Consultant Stroke Physician	24/7 availability; minimum 8 thrombolysis trained physicians on rota	Consultant led ward round 5 days/week
Specialist nurses for thrombolysis/thrombectomy	24/7	
WTE per bed		
Nurse (WTE Per Bed)	2.9 (80:20) registered: unregistered	1:35 (65:35) registered: unregistered
Whole time equivalent (WTE) per 5 beds		
Physiotherapist	0.73	0.84
Occupational therapist	0.68	0.81
Speech and language therapist	0.34	0.40
Clinical neuro-psychologist/ clinical psychologist	0.2	0.20
Dietician	0.15	0.15
Access to		
Clinical Psychology		X
Oral Health		X
Orthoptics		X
Orthotics		X
Social Worker	X	X
Infrastructure		
Radiology Service (Brain & Vascular Imaging)	24/7	24/7
CT/MRI	X	X
CTA/MRA	X	X
CTP	X	
Doppler Imaging	X	X
Appropriately trained staff in eligibility assessment & administering thrombolysis treatment & referral to thrombectomy	24/7	
Access to neurosurgery, interventional neuroradiology and vascular surgery for appropriate patients	X	
Availability of Angio-suite for future development of thrombectomy locally.	X	

Repatriation/ Patient transfer: • If patient transfer is required from hyper acute to acute care services appropriate pathway protocols are in place and followed	X	
Access to neurosurgery, vascular surgery & endoscopy for appropriate patients	X	X
Rehab facilities (Gym/OT Kitchen)		X
Access to ESD		X

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

WHSSC POSITION STATEMENT ON THE COMMISSIONING OF MECHANICAL THROMBECTOMY

1. Purpose of document

This paper provides details of:

- The current commissioning arrangements for access to Mechanical Thrombectomy, for the population of Wales.
- The plan for the phased development of a Mechanical Thrombectomy service at the Neurosciences centre in South Wales.
- The current numbers of Welsh patients receiving Mechanical Thrombectomy
- Steps that have been taken and are being taken to improve flow along the Stroke pathway.

2. Background

There are around 5,000 confirmed stroke events in Wales each year and approximately one quarter of these occur in people under the age of 65 years. NHS England are forecasting that 10% of Stroke patients will be eligible for Thrombectomy, which extrapolated for Wales, would see 500 patients per year eligible when all elements of the stroke pathway are fully embedded. For every 4 to 6 people with an acute ischaemic stroke who present with an identifiable occlusion in the anterior cerebral circulation who undergo mechanical thrombectomy, one more person will be functioning independently at three months compared with if they had received intravenous thrombolysis alone.

Current service

Welsh Health Specialised Services Committee (WHSSC) commissions Mechanical Thrombectomy for people of all ages with acute Ischaemic Stroke in accordance with the criteria outlined in the Commissioning Policy: CP168, Mechanical Thrombectomy.

A Mechanical Thrombectomy service for the population of North Wales is currently commissioned from the Walton hospital, and this is a 24/7 service.

A Mechanical Thrombectomy service for the population of South Wales is currently commissioned from North Bristol Foundation Trust and this is currently an 8am-8pm service, with a 24/7 service planned to be

operational in Bristol from December 2022. Further work is underway to clarify when this extension will be available to South Wales patients.

3. Proposed plan for a Mechanical Thrombectomy service at the Neurosciences centre at C&VUHB

With the proportionate anticipated demand for Mechanical Thrombectomy for South Wales being in the region of 350 patients/year (pending the anticipated improvements in the pathway), WHSSC plan to commission a Mechanical Thrombectomy service for the population of South Wales at the Neurosciences centre in Cardiff. However, the development of this service is currently constrained by a shortage of Interventional Neuro-Radiologists (there are currently only two Consultants in Cardiff). WHSSC is working with the National Clinical Lead for Stroke, colleagues at Cardiff and Vale UHB and Health Education and Improvement Wales on imaginative and flexible workforce solutions, in order to create an attractive workplace for specialist trained staff which will be key in establishing the required 24/7 specialist rota in a globally competitive employment market. One option currently being explored is a scheme developed by colleagues in Scotland for training Interventional Radiologists to undertake Mechanical Thrombectomy.

It is intended that the CVUHB service will be developed in a phased approach, in a partnership arrangement with Bristol, as outlined below:

- Phase 1: 9am-5pm Mon-Fri service when there are 3 INR Consultants in post,
- Phase 2: 8am-8pm Mon-Fri service when there are 4 INR Consultants in post,
- Phase 3: 8am-8pm 7 days/week when there are 5 INR Consultants in post,
- Phase 4: 24hour 7 days /week when there are 6 INR Consultants in post,

It is proposed that after Phase 1 implementation, a gateway review will be undertaken to establish whether the operational and financial assumptions are still aligned to the original business case, before committing and progressing to phases 2, 3 & 4. The readiness to proceed to each phase thereafter will be assessed based on the development of regional stroke services, workforce, financial and operational issues. There is an agreement from Bristol to work with Cardiff in ensuring 24/7 access to Thrombectomy as the service is established.

A full financial appraisal has been received from Cardiff, WHSSC are currently working with the team to understand the assumptions made within the model.

WHSSC would expect to pump prime the Cardiff service through the implementation stage but further work is being undertaken on the sustainable contractual agreement.

A sustainable interventional neuroradiology/radiology service for Thrombectomy requires:

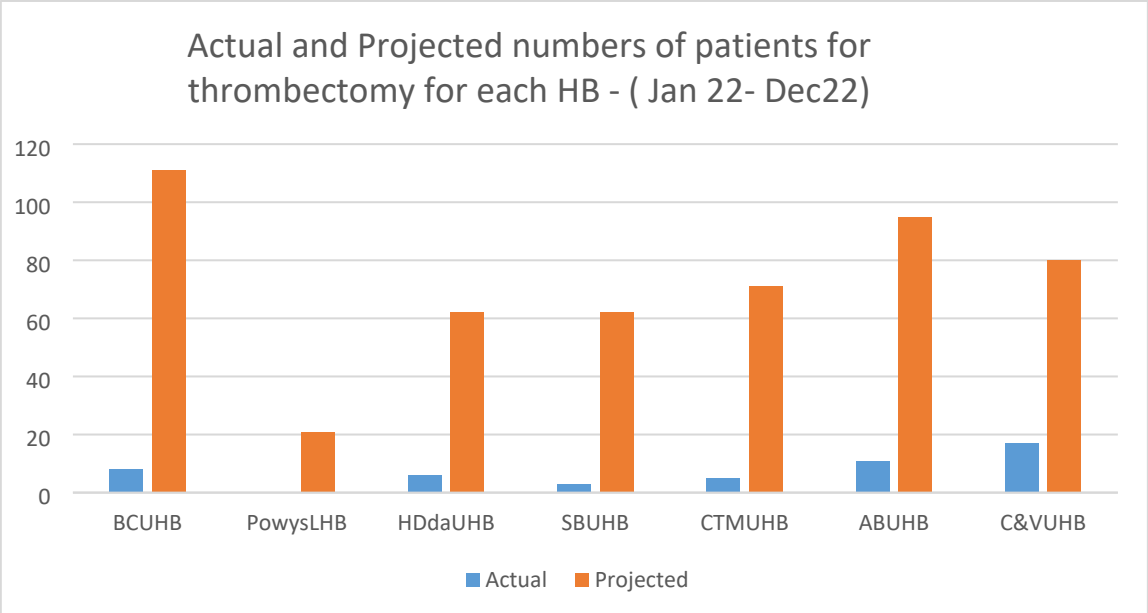
- A volume of work that satisfies the agreed numbers for maintaining competency and training.
- Workforce planning futureproofed for the anticipated increase in workload once a service has commenced and the inevitable effect of extending time windows for intervention as advancements in therapies emerge.
- Cognisance that 60% of potential cases will present out of hours - work patterns, job plans and rotas will need to reflect this in order to provide equity of access and avoid the "weekend effect".
- Adoption of cutting-edge technological innovation including advancements in Artificial Intelligence (AI) and neuro-interventional robotic solutions- deployment to be completed by June 2023.
- Consideration of the need to establish additional 'Thrombectomy' centres in Wales, based on the number of eligible patients, which will need to be reviewed on an annual basis.
- Other challenges highlighted at the recent Thrombectomy Wales Oversight Group meeting in February 2023:
- C&V UHB are unable to perform CTP at the moment due to imaging software issues. This is being investigated by the team.[1] (CTP is used for advanced brain imaging for patients who meet the eligibility inclusion criteria and who present >6 hours and<24 hours from onset of symptoms). Access to AI would negate the issue where CTP was not available. CTP is being progressed by all Health Boards.
- Patients presenting late to be transferred to Bristol and complications with the transfer to Bristol due to patients presenting late in the afternoon and by the time they arrive at Bristol they would be outside of the access hours for treatment. Expediting the access to 24/7 would mitigate this issue.
- Need to establish a Clinical Pathway case management presentation by each Health Board to support education and training for clinicians. *[NB The inaugural case management presentation was conducted in February 2023]*.
- Effective Superstat reporting by Everlight to be turned around in 30 minutes - one of the pathway standards. Currently there are intermittent delays reported by the referring hospitals. Refining the reporting process will mitigate this risk.
- CT and CTA scanning done in tandem - A recent update from the Delivery Unit has indicated that most referring hospitals are achieving this standard.

[1] https://whssc.nhs.wales/commissioning/whssc-policies/all-policy-documents/mechanical-thrombectomy-for-the-treatment-of-acute-ischaemic-stroke-commissioning-policy-cp168-march-2022/

4. Mechanical Thrombectomy activity for the population of Wales

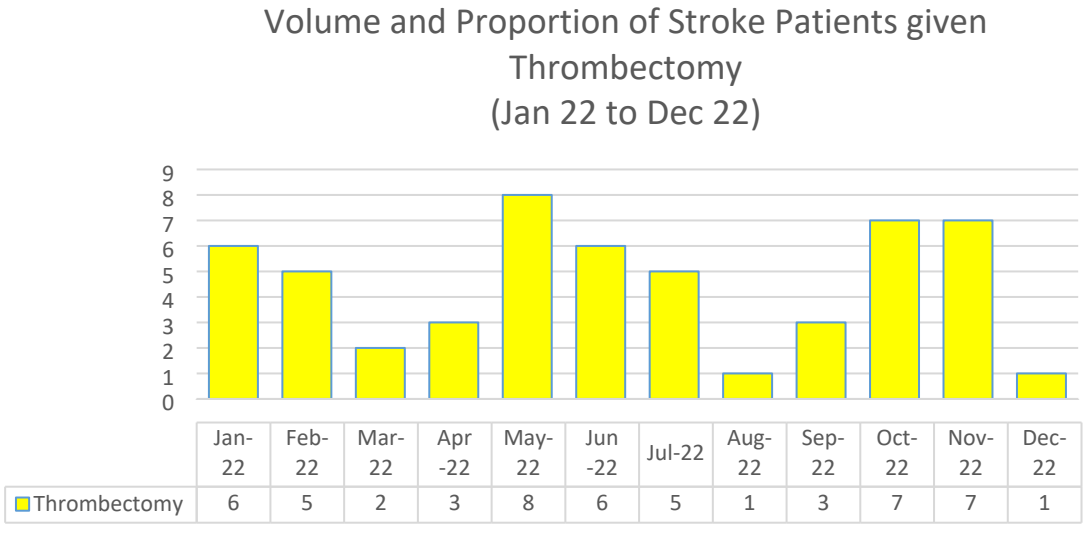
All patients eligible for Thrombectomy should receive the intervention with the minimum delay in order to optimise outcomes. However, as shown below patients in Wales are not progressing through the pathway in the required timeframe, and are therefore not benefiting from Thrombectomy, even though they have commissioned access.

Table 1: The number of Welsh patients who have received Thrombectomy compared with the projected number who should have based on the fact that 10% of stroke patients are eligible for Thrombectomy



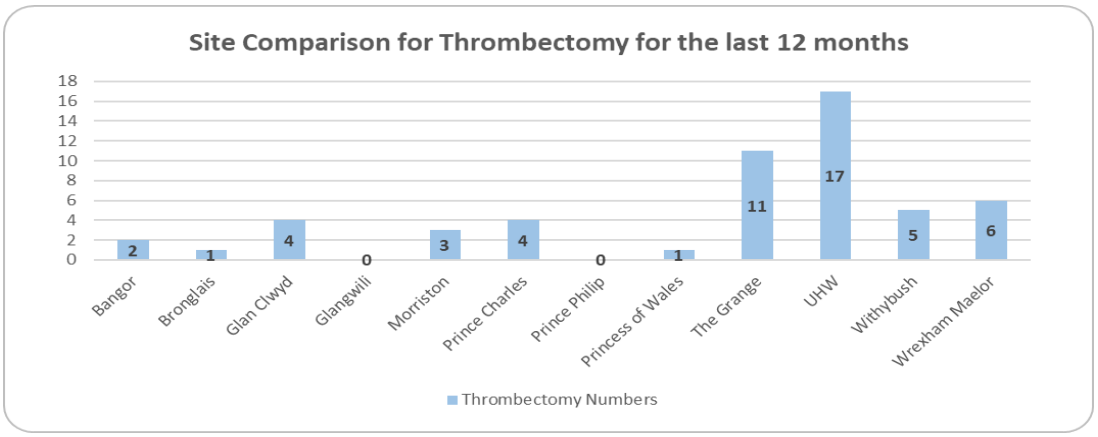
- *Projected figures are based on Health Board population size and the 10% Thrombectomy target.*

Table 2: shows the volume of patients receiving a Thrombectomy – based on the fact that 10% of stroke patients can benefit from Thrombectomy, there should be over 40 Welsh patients per month receiving Thrombectomy



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Thrombectomy	6	5	2	3	8	6	5	1	3	7	7	1

Table 3: illustrates the number of patients receiving a Thrombectomy per Health Board as at December 2022



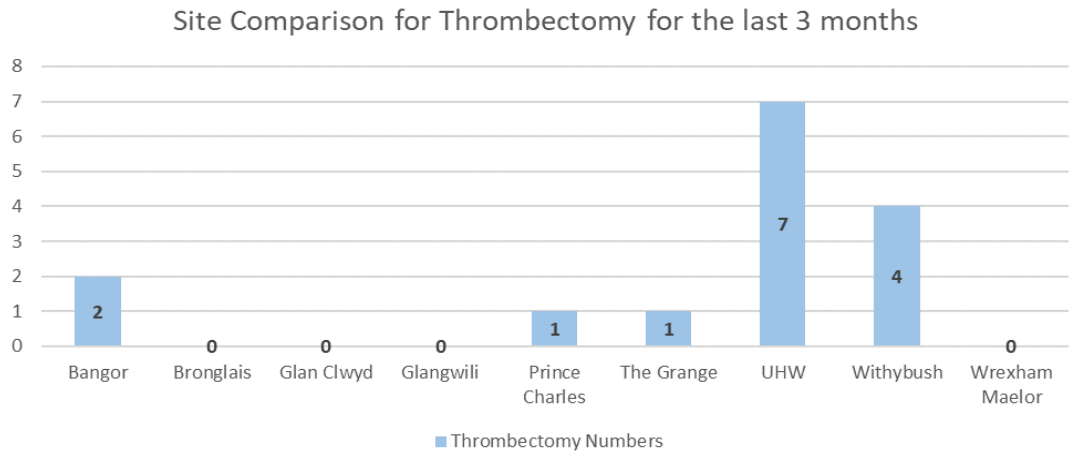
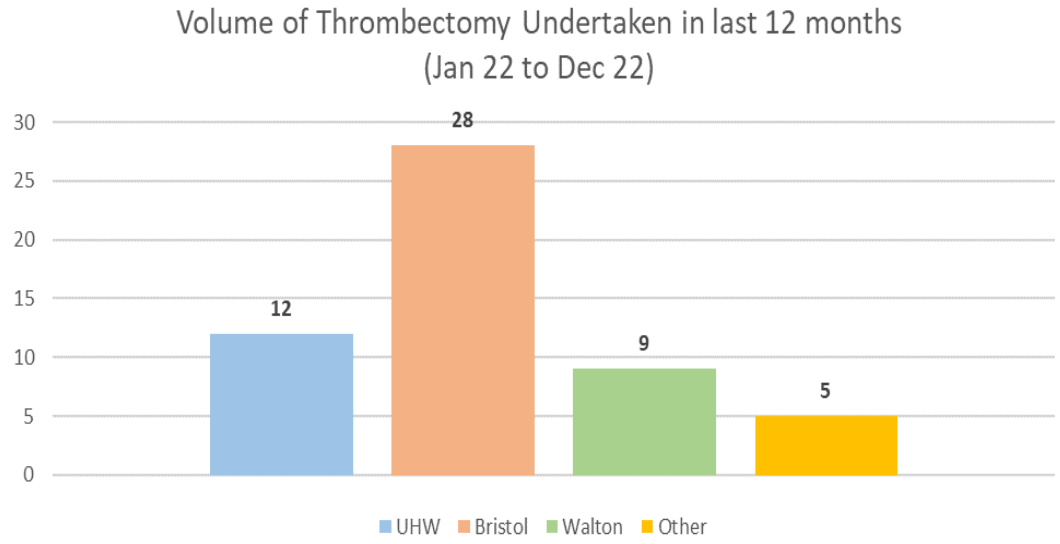


Table 4: illustrates the volume of Thrombectomy undertaken in the last 12 months by site – (Jan 22- Dec 22)



There is therefore currently a sustained drive to improve door-to-needle times across Wales, with a focus by Local Health Boards, The Welsh Ambulance Service Trust, the Delivery Unit and the recently established

National Stroke Programme Board on reducing the barriers to patient flow across the Stroke Pathway.

A number of initiatives to improve flow along the pathway, have already been implemented with the aim of addressing:

Referral and image transfer to a Thrombectomy service
Designated hospitals in the south wales region are all able access Biotronics 3D who have now secured Cyber Essentials Plus certification. This imaging platform is currently being used to transfer images across to Bristol. BCUHB have submitted a paper to their Executive team to gain approval for the use of Biotronics 3D, as they are still using the PACS platform to send images to the Walton.

After a long procurement process, Brainomix have been awarded a 3-year contract. This system provides state-of –the-art artificial intelligence algorithms to support doctors by providing real-time interpretation of brain scans to help guide treatment and transfer decisions for stroke patients, allowing more patients to get the right treatment, in the right place at the right time.

Full deployment of the All Wales Artificial Intelligence (AI) technology provided by Brainomix, with a revised "go live" date of June 2023. This will have the ability to streamline the clinical pathway, increasing the patient survival rate and assisting rapid recovery. Both Bristol and the Walton centre have this technology already in place.

Timely patient transfer
All inter-hospital Thrombectomy transfers are now managed by the trauma desk with a red-call priority.

The development of comprehensive regional stroke networks by the Collaborative team, in support of the newly established National Stroke Programme Board will improve flow along the pathway further, and enable 10% of Stroke patients in Wales to access Mechanical Thrombectomy.

The National Stroke Programme Board are collaborating with Welsh Ambulance Services Trust (WAST) to trial a small feasibility study of a pre-hospital triage system for stroke patients using an app based product. Approval was given on 7th January 2023. The system will aim to improve the pre-hospital stroke pathway for suspected stroke mimic patients, provide access to stroke expertise earlier in the stroke pathway to ensure safe patient outcomes with a prompt and timely diagnosis, reduce admittance to ED for stroke mimic, and improve the overall patient experience. Those patients requiring a Mechanical Thrombectomy will be identified and transferred earlier to the tertiary Thrombectomy centre.

New Evidence

MR-CLEAN-LATE is a multicentre randomised trial to explore whether the current criteria for assessing patients for a Thrombectomy can be extended to a wider group of people, who would benefit and have improved functional outcome from this procedure.

The impact of including this group would bring forward the forecast of 10% of Stroke patients being eligible for Thrombectomy. This would increase the workload for Bristol, creating further capacity challenges that could reduce access to these services for Welsh patients, thereby underlining the need to expedite the commissioning of the Cardiff service.

Report Title	**Eating Disorder In-Patient Provision for Adults**	**Agenda Item**	3.4
Meeting Title	**Joint Committee**	**Meeting Date**	14/03/2023
FOI Status	Open/Public		
Author (Job title)	Senior Specialised Services Planning Manager for Mental Health and Vulnerable Groups		
Executive Lead (Job title)	Director of Mental Health		

Purpose of the Report	The purpose of this report is to outline the medium-term options for adult inpatient eating disorder placements following the end of the contract for eating disorder services between WHSSC and Oxford Health NHS Trust (OHNT) and the current interim arrangements.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☒	INFORM ☒

Recommendation(s):

Members are asked to:

- **Note** the information presented within the report to progress tendering and procurement options with the independent sector in line with service need for Welsh patients requiring specialist eating disorder services,
- **Note** the medium-term options for adult inpatient eating disorder placements following the end of the contract for eating disorder services between WHSSC and Oxford Health NHS Trust (OHNT) and the current interim arrangements; and
- **Receive assurance** that there are robust processes in place to ensure delivery of eating disorder services for adults.

EATING DISORDER IN-PATIENT PROVISION FOR ADULTS

1.0 SITUATION

The purpose of this report is to outline the medium-term options for adult inpatient eating disorder placements following the end of the contract for eating disorder services between WHSSC and Oxford Health NHS Trust (OHNT) and the current interim arrangements.

2.0 BACKGROUND

In January 2022, Oxford Health NHS Trust (OHNT) served notice on the contract with WHSSC for the provision of eating disorder beds for Welsh Patients. This contract ended in August 2022.

Since August 2022 an interim solution has been put in place to purchase 6 beds from the Priory Group to enable access to beds for our patients. This interim solution was in place until January 2023 with an option to extend. Following further discussions, NHS England (NHSE) have raised issues concerning the block purchase of beds in the Priory Marlow and Bristol as they feel these are NHS stock beds and cannot be "ring-fenced" for NHS Wales' patients on a block booked basis. The 2 beds procured at the Priory Cheadle are unaffected and this contract will continue until the end of March 2023.

The Specialised Services Strategy for Mental Health is due to be published in March 2023, and will consider the long-term options for service provision going forward. However, the stability of services is required in the interim, and this report therefore seeks to gain approval for a medium term (approx. 3 year) contract with the independent sector to ensure bed provision, and to set out clear referral pathways for adult patients requiring specialised eating disorder placements.

For the purposes of this report:

- Short term will be within the next 12 months,
- Medium term will be the next 2-3 years; and
- Long term will mean beyond 3 years.

3.0 ASSESSMENT

The Specialised Services Strategy for Mental Health will include the development of an options appraisal for a long-term solution for Welsh patients including the development of an eating disorders unit for Wales, the development of our own provider collaborative, contracting with the independent sector, and

consideration of the current arrangements to accommodate Welsh patient based on clinical need.

This report aims to bring forward the option of opening discussions with the independent sector to provide services for our population separate to those in the provider collaborative system in NHSE to ensure access to services for our patients as close to home as possible whilst the full options for a long-term solution are considered.

A Procurement Tender process is proposed to secure the provision of eating disorder beds for Welsh patients from Spring 2023 onwards. These arrangements would be on an interim 2-3 year basis, and would allow access to 8-10 beds for use by Welsh patients. This would provide stability for the next 2-3 years whilst the strategy is developed and implemented for a long term provision.

Table 1 outlines the proposed Weighting Criteria for the tendering process:

Table 1 – Proposed Weighting criteria for the Procurement Exercise

Total	**100%**
Quality	60%
Social Value	20%
Price	20%

The requirement is for a 2 year contract with fixed pricing with the option to extend at 12 month intervals.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the information presented within the report to progress tendering and procurement options with the independent sector in line with service need for Welsh patients requiring specialist eating disorder services,
- **Note** the medium-term options for adult inpatient eating disorder placements following the end of the contract for eating disorder services between WHSSC and Oxford Health NHS Trust (OHNT) and the current interim arrangements; and
- **Receive assurance** that there are robust processes in place to ensure delivery of eating disorder services for adults.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Implementation of the Plan Governance and Assurance Choose an item.
Link to Integrated Commissioning Plan	Mental Health
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.
NHS Delivery Framework Quadruple Aim	People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement Choose an item. Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	One provider for South Wales will reduce risk of patients experiencing poor care and improve access.
Finance/Resource Implications	Potential to reduce current financial exposure.
Population Health	None
Legal Implications (including equality & diversity, socio economic duty etc)	None
Long Term Implications (incl WBFG Act 2015)	None
Report History (Meeting/Date/ Summary of Outcome	16 February 2023 - CDGB 26 January 2023 - Management Group
Appendices	**-**

Report Title	**Neonatal Transport ODN – Additional Funding Release**	**Agenda Item**	3.5
Meeting Title	**Joint Committee**	**Meeting Date**	14/03/2023
FOI Status	Open		
Author (Job title)	Senior Project Manager		
Executive Lead (Job title)	Director of Planning		

Purpose of the Report	In December 2023 the Management Group approved the release of £125k for the establishment of the Neonatal Transport Operational Delivery Network (ODN) by Swansea Bay UHB as the host provider. The purpose of this report is to seek approval from the Joint Committee for an additional £54k of funding to bridge the shortfall from the original funding request from SBUHB and to allow the implementation of the ODN to proceed.				
Specific Action Required	RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☐	INFORM ☒

Recommendation(s):

Members are asked to:

- **Note** the report; and
- **Approve** the release of an additional £54k funding for the Neonatal Transport ODN to allow the implementation of the Operational Delivery Network (ODN) to proceed.

NEONATAL TRANSPORT ODN – ADDITIONAL FUNDING

1.0 SITUATION

In December 2023 the Management Group approved the release of £125k for the establishment of the Neonatal Transport Operational Delivery Network (ODN) by Swansea Bay UHB (SBUHB) as the host provider. The purpose of this report is to seek approval from the Joint Committee for an additional £54k of funding to bridge the shortfall from the original funding request from SBUHB and to allow the implementation of the ODN to proceed.

2.0 BACKGROUND

The Neonatal Transfer service is a dedicated service designed to move babies safely from one hospital to another for specialised or ongoing care and exists to make sure the transfer is as safe and efficient as possible. In April 2021 at an extraordinary Joint Committee meeting, the establishment of an Operational Delivery Network (ODN) for Neonatal Transport in South Wales was agreed to address the governance concerns and to ensure the on-going management and development of the service.

SBUHB agreed to take on the role of the lead provider and to establish an ODN Implementation Board. This was established in March 2022, chaired by the Executive Director of Nursing at Swansea Bay to develop the ODN and associated governance structure. A Delivery Assurance Group (DAG) has also been established, chaired by the WHSSC Director of Planning.

Funding release papers were presented to the Management Group on 28 July 2022 and again on 22 September 2022 – see ***Appendix 1*** - requesting the release of funding to establish the ODN. The summary of the funding requested is included at ***Appendix 2.***

It was noted on both occasions that the funding requested was within the £186k envelope in the Integrated Commissioning Plan (ICP) 2022-23 but members expressed concerns at the high cost of the ODN staffing structure. It was felt it did not provide value for money when benchmarked against the staffing models in other larger ODNs. The Management Group requested that SBUHB explore synergies between the Neonatal Transport ODN and the Maternity and Neonatal Network with a view to reducing the cost of the proposal in line with benchmarking that had been undertaken previously. This suggested that the benchmarked cost of the ODN would be around a 30% reduction in the costs of the £179k proposal (i.e. a total of £125k).

Following discussion between WHSSC, SBUHB and the NHS Wales Health Collaborative (NWHC) a further report requesting release of £125k was presented

and approved by the Management Group on 15 December 2022 – see ***Appendix 3***. This was released by the Management Group, whilst noting that SBUHB were continuing to work through the synergies with the Network and a detailed implementation plan would be brought forward in the New Year.

3.0 ASSESSMENT

Further to the release of the £125k, the NWHC confirmed that it was not possible for them to address the staffing capacity gap to support the implementation of the ODN. Subsequently discussions took place at the Collaborative Executive Group (CEG) meeting in January 2023 on how this gap could be bridged given the importance of the service.

Health Board (HB) CEOs subsequently made a request for WHSSC to find the additional £54k to ensure that SBUHB can develop and operationalise the ODN. This report requests that the Joint Committee approve the release of an additional £54k funding for the Neonatal Transport ODN to allow the implementation of the ODN to proceed.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report; and
- **Approve** the release of an additional £54k funding for the Neonatal Transport ODN to allow the implementation of the ODN to proceed.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	The development of a Neonatal Operational Delivery Network was supported in the ICP 2021-22
Health and Care Standards	Staff and Resourcing Governance, Leadership and Accountability Safe Care
Principles of Prudent Healthcare	Reduce inappropriate variation Only do what is needed Choose an item.
NHS Delivery Framework Quadruple Aim	Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcome Choose an item. Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	-
Finance/Resource Implications	There is sufficient provision in the ICP to support the funding requested in the report
Population Health	-
Legal Implications (including equality & diversity, socio economic duty etc)	There are no equality and diversity implications
Long Term Implications (incl WBFG Act 2015)	-
Report History (Meeting/Date/ Summary of Outcome	**15 December 2022 –** Management Group – supported **22 September 2022** – Management Group **28 July 2022** - Management Group
Appendices	Appendix 1 – Management Group Report - Funding Release for South Wales Neonatal Transport ODN 22/09/22 Appendix 2 – Summary of Funding requests Appendix 3 – Management Group Report Funding Release for South Wales Neonatal Transport ODN 15/12/22

Report Title	**Funding Release for South Wales Neonatal Transfer ODN**	**Agenda Item**	3.2
Meeting Title	**Management Group**	**Meeting Date**	22/09/2022
FOI Status	Open		
Author (Job title)	Senior Project Manager		
Executive Lead (Job title)	Director of Planning		

Purpose of the Report	The purpose of this report is to seek support for the release of funding for the proposed South Wales Neonatal Transfer Operational Delivery Network (ODN) staffing model in accordance with the funds approved in the Integrated Commissioning Plan (ICP) 2022-2025.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☒	ASSURE ☐	INFORM ☐

Recommendation(s):

Members are asked to:

- **Support** the release of funding for the appointment of the South Wales Neonatal Transfer Operational Delivery Network (ODN) staffing model and the associated non pay costs.

FUNDING RELEASE FOR THE SOUTH WALES NEONATAL TRANSFER OPERATIONAL DELIVERY NETWORK (ODN)

1.0 SITUATION

The purpose of this report is to seek support for the release of funding for the proposed South Wales Neonatal Transfer Operational Delivery Network (ODN) staffing model in accordance with the funds approved in the Integrated Commissioning Plan (ICP) 2022-2025.

2.0 BACKGROUND

The Neonatal Transfer service is a dedicated service designed to move babies safely from one hospital to another for specialised or ongoing care and exists to make sure the transfer is as safe and efficient as possible.

In April 2021, at an extraordinary Joint Committee meeting, the establishment of an ODN for South Wales was agreed to address the governance concerns and to ensure the on-going management and development of the service.

Swansea Bay University Health Board (SBUHB) agreed to take on the role of the lead provider and to establish an ODN Board. This was subsequently established in March 2002, chaired by the Executive Director of Nursing at SBUHB to develop the ODN and associated governance structure. A Delivery Assurance Group (DAG) has also been established, chaired by the Director of Planning at WHSSC.

In August 2022, MG members received a funding release report seeking support to appoint to the requested posts. Members expressed concerns at the high cost of the proposed staffing model and requested further clarification on the specific duties of the proposed roles and the job profiles to provide a rationale for the job bandings to demonstrate value for money. Members agreed not to support the request for the release of funding for the proposed south Wales Neonatal Transfer ODN staffing model and asked that the ODN Board reconsider the options and that a new proposal be brought back to a future meeting for consideration.

SBUHB, in collaboration with the ODN Board have subsequently submitted a revised business case; the resource requirements remain unchanged but additional rationale for the posts requested is provided. The updated business base for the proposed Neonatal ODN Staffing model is presented at ***Appendix 1.***

3.0 ASSESSMENT

Table 1 below shows the staffing and the associated total investment requested from SBUHB in its role as the host Health Board (HB) for the ODN.

Table 1.

Revenue	WTE	PYE	Recurrent FYE
Clinical Lead	2 sessions	12,500	25,000
ODN Network Manager Band 8b	0.80	34,779	69,558
Administrative Officer Band 4	0.60	10,163	20,326
Governance Lead Band 7	0.80	24,964	49,928
Total Pay costs		**82,406**	**£164,812**
IT Equipment	-	3,000	£3,000
Travelling Expenses	-	3,000	£3,000
Hosting Costs (5% overhead)	-	4,270	£8,540
Total non-pay costs	**-**	**10,270**	**£14,540**
Total revenue requirements	**-**	**92,676**	**£179,352**
Available transfer funding in the Plan			**£186,000**

Table 2 below sets out the rational for the preferred option which reflects the increased responsibilities and oversight required to meet the revised and updated governance structure for Neonatal transport. The additional scrutiny introduced through the establishment of the DAG requires additional clinical time and overall management, these additional demands cannot be met by SBUHB core services. In addition, the preferred model enables the 'future proofing' of the Transport service including the development of a single point of access.

Table 2. Rational for the requested posts

Staff Group	WTE	Source of Staff	Rationale/ reason for uplift
Clinical Lead	2 sessions	Currently in post – 1 session at local level at each Health Board (AB, C&V and SBU) plus 1 session overarching ODN Network	The original proposal included 1 clinical session. An increase from 1 session to 3 is required to strengthen the clinical leadership of the ODN and build stronger collaborative networked provision of services. An overarching lead is needed to co-ordinate operational, educational and governance activity between the 3 centres and facilitate a link between the ODN and provider services and UK national transport group. It will also provide clinical input into the

Staff Group	WTE	Source of Staff	Rationale/ reason for uplift
			development of the neonatal transport services within the Welsh neonatal network along with providing continuous advice to the local clinical leads, commissioners and the Network Manager in relation to the neonatal transport service. These functions have been undertaken in clinicians own time previously.
Network Manager (Band 8b)	0.80	Recruitment	The original proposal included 1.0wte Network Manager. The project board recommends that this role be 30hrs (0.80wte). While the Neonatal Operational Delivery Network will form part of the Children's services at SBUHB, it will be a stand-alone service and as such will require an individual whom possesses strong leadership and management skills to co-ordinate the delivery of the safe transportation of new-borns whilst adhering to the All Wales Standards of Care. The core Children's services are unable to absorb any additional management responsibilities the ODN will require – hence the request for the seniority of this role.
Admin. Officer (Band 4)	0.60	Recruitment	Administrative support is currently provided by the NHS Wales Collaborative, Wales Maternity & Neonatal Network, however the requirements expected from the newly formed Delivery Assurance Group (DAG) have increased significantly in relation to increased data and scrutiny. The ODN will sit in SBUHB Children's services, and core services are unable to absorb any additional administrative functions. There is

Staff Group	WTE	Source of Staff	Rationale/ reason for uplift
			also no formal confirmation that the network will be able to maintain this function moving forward, leaving a potential gap
Governance Lead (Band 7)	0.80	Recruitment	It is imperative that the clinical governance framework is robust ensuring appropriate quality and safety policies and protocols are in place to support the effective delivery of neonatal transport. The Governance Lead will also co-ordinate and support all Clinical Leads in ensuring all relevant documentation is prepared for DAG and COB and will address any matters escalated relating to the commissioning and service delivery. Again the collaborative currently provides support in this area, with no formal confirmation that this will be maintained moving forward.

SBUHB in its role as host HB is responsible for the delivery of all elements of the Neonatal Transport ODN service specification. SBUHB will also be expected to provide HR support, finance support, accommodation and other support functions as deemed necessary by the ODN management team - the preferred option is not over-reliant on SBUHB core services. The preferred option provides:

- Sustainable development of the Transport service and future proofing, recognising the increasing demand and complexity of Neonatal Transfers;
- an enhanced layer of assurance and governance as required by the Joint Committee; and
- allows the ODN to become a stand-alone service providing strong leadership with the management skills required, without an over-reliance on SBUHB Core Paediatric Services.

4.0 RECOMMENDATIONS

Members are asked to:

- **Support** the release of funding for the appointment of the South Wales Neonatal Transfer Operational Delivery Network (ODN) staffing model and the associated non pay costs.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	The development of a Neonatal Operational Delivery Network was supported in the ICP 2021-22
Health and Care Standards	Safe Care Staff and Resourcing Governance, Leadership and Accountability
Principles of Prudent Healthcare	Only do what is needed Reduce inappropriate variation Choose an item.
NHS Delivery Framework Quadruple Aim	Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcome People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	Any issues are identified in the report.
Finance/Resource Implications	There is sufficient provision in the ICP to support the funding requested in the report
Population Health	Any issues are identified in the report.
Legal Implications (including equality & diversity, socio economic duty etc.)	There are no equality and diversity implications.
Long Term Implications (incl. WBFG Act 2015)	Any issues are identified in the report.
Report History (Meeting/Date/ Summary of Outcome	**CDGB –** 5 September 2022
Appendices	Appendix 1 – Swansea Bay UHB Updated Business Case for the Neonatal ODN Staffing

Appendix 2

Neonatal Transport ODN Funding

Swansea Bay University Health Board (SBUHB), in its role as host Health Board is responsible for the delivery of all elements of the Neonatal Transport ODN service specification.

Table 1 sets out the staffing and the associated total investment requested from SBUHB in in July and September 2022 to provide:

- Sustainable development of the Transport service and future proofing, recognising the increasing demand and complexity of Neonatal Transfers;
- an enhanced layer of assurance and governance as required by the Joint Committee; and
- allows the ODN to become a stand-alone service providing strong leadership with the management skills required, without an over-reliance on Swansea Bay Core Paediatric Services.

Table 1.

Revenue	**WTE**	**PYE**	**Recurrent FYE**
Clinical Lead	2 sessions	12,500	25,000
ODN Network Manager Band 8b	0.80	34,779	69,558
Administrative Officer Band 4	0.60	10,163	20,326
Governance Lead Band 7	0.80	24,964	49,928
Total Pay costs		**82,406**	**£164,812**
IT Equipment	-	3,000	£3,000
Travelling Expenses	-	3,000	£3,000
Hosting Costs (5% overhead)	-	4,270	£8,540
Total non-pay costs	**-**	**10,270**	**£14,540**
Total revenue requirements	**-**	**92,676**	**£179,352**
Available transfer funding in the Plan			**£186,000**

As noted in section 2.0 in the main report, there is sufficient funding to support the additional £54k within the 2022/23 Integrated Commissioning Plan.

Report Title	**Funding Release for South Wales Neonatal Transfer ODN**	**Agenda Item**	3.4
Meeting Title	**Management Group**	**Meeting Date**	15/12/2022
FOI Status	Open		
Author (Job title)	Senior Project Manager		
Executive Lead (Job title)	Director of Planning		

Purpose of the Report	The purpose of this report is to seek approval for the release of funding for the South Wales Neonatal Transfer ODN staffing in accordance with the funds approved in the Integrated Commissioning Plan (ICP) 2022-25.				
Specific Action Required	RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☐	INFORM ☐

Recommendation(s):

Members are asked to:

- **Note** the report; and
- **Approve** the release of funding for the appointment of the South Wales Neonatal Transfer ODN staffing and the associated non-pay costs.

FUNDING RELEASE FOR THE SOUTH WALES NEONATAL TRANSFER OPERATIONAL DELIVERY NETWORK (ODN)

1.0 SITUATION

The purpose of the report is to seek approval for a funding release for South Wales Neonatal Transfer ODN in accordance with the funds approved in the Integrated Commissioning Plan (ICP) 2022-2025.

2.0 BACKGROUND

The Neonatal Transfer service is a dedicated service designed to move babies safely from one hospital to another for specialised or ongoing care and exists to make sure the transfer is as safe and efficient as possible.

In April 2021, at an extraordinary Joint Committee meeting, the establishment of an Operational Delivery Network (ODN) for South Wales was agreed to address the governance concerns and to ensure the on-going management and development of the service.

Swansea Bay University Health Board (SBUHB) agreed to take on the role of the lead provider and to establish an ODN Board. This was subsequently established in March 2002, chaired by the Executive Director of Nursing at SBUHB to develop the ODN and associated governance structure. A Delivery Assurance Group (DAG) has also been established, chaired by the WHSSC Director of Planning.

Members have previously received papers in July and September 2022 (***appendices 1 & 2***) requesting the release of funding to establish the ODN. On both occasions members expressed concerns at the high cost of the staffing model as it did not provide value for money particular when benchmarked against the staffing in other larger ODN's.

Management Group members requested that the proposal be reconsidered by SBUHB with a view to re-presenting the proposal to reduce the cost of the proposal in line with benchmarking that had been done previously (a 30% reduction in the costs in the current proposal of £179k), to outline what synergies had been explored to integrate the service within existing teams and the anticipated timeline for delivery. In addition, if this were not possible, whether the Emergency Medical Retrieval and Transfer Service (EMRTS) would offer an alternative solution.

3.0 ASSESSMENT

SBUHB have confirmed with the WHSS team that EMRTS was not considered an appropriate solution for delivering the ODN. A meeting was held in November between SBUHB and the NHS Wales Health Collaborative (NWHC) to discuss the options and explore synergies between the ODN and the Maternity and Neonatal Network. Discussion is ongoing to agree the overall support that can be provided by the Network to enable the agreed 30% reduction in the cost of the previous proposal.

Therefore, SBUHB, as the host provider are currently working through the plans to operationalise the ODN within the funding envelope of **£125k.** This is considered an acceptable level of funding based on the benchmarking of other ODN staffing structures, activity undertaken and the geographical cover undertaken.

Whilst the final configuration of the team is to be decided and to prevent further delay to go live, the WHSS team recommend that funding is released.

For transparency, the WHSS team will bring the implementation plan, including the final staffing configuration to the Management Group early in the new year.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report; and
- **Approve** the release of funding for the appointment of the South Wales Neonatal Transfer ODN staffing and the associated non-pay costs.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item.
Link to Integrated Commissioning Plan	The development of a Neonatal Operational Delivery Network was supported in the ICP 2021-22
Health and Care Standards	Safe Care Staff and Resourcing Governance, Leadership and Accountability
Principles of Prudent Healthcare	Only do what is needed Reduce inappropriate variation
NHS Delivery Framework Quadruple Aim	Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcome People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	-
Finance/Resource Implications	There is sufficient provision in the ICP to support the funding requested in the report
Population Health	
Legal Implications (including equality & diversity, socio economic duty etc.)	There are no equality and diversity implications.
Long Term Implications (incl. WBFG Act 2015)	
Report History (Meeting/Date/ Summary of Outcome	
Appendices	**Appendix 1 –** MG Paper 28 July 2022 Funding Release for South Wales Neonatal Transfer ODN **Appendix 2 -** MG Paper 22 September 2022 Funding Release for South Wales Neonatal Transfer ODN

Report Title	**Neonatal Cot Configuration Project**	**Agenda Item**	3.6
Meeting Title	**Joint Committee**	**Meeting Date**	14/03/2023
FOI Status	Open		
Author (Job title)	Women and Children's Commissioning Team		
Executive Lead (Job title)	Director of Planning		

Purpose of the Report	This report notes the outcomes of the Neonatal Cot Configuration project, the proposed preferred option as recommended by the Project Board and seeks approval for the required long-term next steps.				
Specific Action Required	RATIFY ☐	APPROVE ☒	SUPPORT ☒	ASSURE ☐	INFORM ☒

Recommendation(s):

Members are asked to:

- **Note** the background within the report,
- **Note** the outcomes of the Neonatal Cot Configuration Project,
- **Note** the financial assessment,
- **Note** the preferred option of the Project Board,
- **Approve** the recommended preferred option and the release of funding in line with the provision within the 2022/25 Integrated Commissioning Plan (ICP) as an interim measure; and
- **Approve** the recommendation of the Management Group for a phase 2 programme of works to be undertaken.

NEONATAL COT CONFIGURATION PROJECT

1.0 SITUATION

This report notes the outcomes of the Neonatal Cot Configuration project, the proposed preferred option as recommended by the Project Board and seeks approval for the required long-term next steps.

The Joint Committee supported a review of Neonatal Cot Capacity and Neonatal tariff in September 2021, and agreed the Neonatal Cot Capacity Review as a strategic priority in the WHSSC 2022/25 Integrated Commissioning Plan (ICP).

2.0 BACKGROUND

2.1 Current Configuration

In south Wales there are three Neonatal Intensive Care Units located in The Grange University Hospital (ABUHB), The Children's Hospital for Wales (CVUHB) and Singleton Hospital (SBUHB). All surgery required for south Wales Neonates is undertaken at the Children's Hospital for Wales (CHW) with the exception of Cardiac Surgery which is delivered by University Hospitals Bristol NHS Foundation Trust (UHBNFT). There are three Special Care Baby Units located across the network; one in Prince Charles Hospital (CTMUHB), one in the Princess of Wales Hospital (CTMUHB) and one in Glangwili Hospital (HDdUHB). CTMUHB is the only Health Board (HB) within south Wales with two units. The description of each level of unit is provided in **Appendix 1.**

All units are currently funded through the agreed neonatal tariff which is a cot day tariff dependent on the level of care delivered. The current contract baselines were developed in 2015/16 following a review of the 3 year average activity between 2012/13 and 2014/15. Average activity data was used and the contract currency is a cot day, when converted to funded cots this does not equate to whole numbers of cots per unit. The current number of funded cots is outlined **Table 1** below.

Table 1 - Current Number of Funded cots

Unit:	NICU	HDU	SCBU	Total
Aneurin Bevan UHB (The Grange)	5.87	7.81	18.17	31.85
Cardiff & Vale UHB (CHfW)	8.24	11.05	13.54	32.83
Cwm Taf Morgannwg UHB (PCH)	1.39	1.95	12.53	15.87
Cwm Taf Morgannwg UHB (POW)	0.30	2.09	7.85	10.24
Hywel Dda UHB (Glangwilli)	0.16	1.59	8.94	10.69
Swansea Bay UHB (Singleton)	5.69	5.54	13.55	24.78
Total South Wales	**21.65**	**30.03**	**74.58**	**126.27**

2.2 Drivers for Change

In 2019, WHSSC commissioned a review into Neonatal Transport by Dr Grenville Fox which recommended that due to the high volume of capacity transfers undertaken by the Neonatal Transfer service a review of the cot configuration across south Wales should be undertaken.

The South Wales Plan was published in 2014 and this proposed changes to flow following the re-designation of the Royal Glamorgan Hospital (RGH) and the opening of The Grange University Hospital. Since the publication of the South Wales Plan the boundary change impacting on the PoWH has also taken place.

As previously noted the contract re-basing was undertaken in 2014/15 and other than annual inflationary rises neither the tariff, or the configuration of cots has been reviewed despite a number of changes to the broader configuration taking place as noted above.

In addition, the Neonatal units, provider HBs and the Maternity and Neonatal Network have raised concerns about capacity for some time and the current arrangement is not fit for purpose with some units underperforming and some units over-performing against the contract.

Over recent years, WHSSC has received through the development of the ICP, schemes from providers seeking additional revenue to increase the neonatal units' workforce. Providers have reported that the current tariff is not sufficient to meet the British Association of Perinatal Medicine (BAPM) Standards for workforce. The standards have recently been updated with the latest version published in November 2022.

Throughout 2019/20 and 2020/21 the Maternity and Neonatal Network co-ordinated peer reviews of each of the Neonatal units across the south and west Wales. All peer reviews referenced shortages in the established workforce however the results were variable demonstrating that each unit is spending the tariff differently with some units reporting shortages at nursing level and others at Allied Health Professional level.

There have been significant staffing shortages in 2022 particularly in nursing across the Network, this has resulted in cot closures being a regular occurrence. This has directly impacted on all units as they have absorbed the activity from the pressure points.

2.3 Maternity and Neonatal Safety Improvement Programme

As Neonatal and Maternity care is intrinsically linked, in January 2022 Welsh Government (WG) announced the establishment of the Maternity and Neonatal Safety Support Programme in Wales to ensure a clear and consistent approach to maternity and neonatal safety across Wales. Having the right number of cots in the right place that are appropriately funded is a key foundation in the programme achieving its goals. Maternity care is outside of the remit of WHSSC

however having babies delivered in the right place at the right time is a shared system goal, and the project structure of the Neonatal Cots Configuration Review reflected this.

It is worth noting that not all capacity transfers are due to the unavailability of a neonatal cot, some babies are transferred as there is insufficient maternity capacity despite capacity being available within a Neonatal Unit, this again emphasises the interdependencies.

2.4 NHS England

NHS England (NHSE) have recently undertaken a Review of Neonatal Critical Care[1] and have published the 'Implementing the Recommendations of the Neonatal Critical Transformation Review'. Within this document there are 5 key findings outcomes: activity, demand and capacity, transfers, staffing levels and pricing. The changes being implemented in NHSE will positively impact on the neonates that are transferred across the border and the principles outlined in the scope of the WHSSC project align.

2.5 Neonatal Transport

For the purposes of the Project the funding for Neonatal Transport and the Operational Delivery Network (ODN) has been removed in its entirety. It is however recognised that Neonatal Services, Neonatal Transport and the ODN are interdependent of each other.

2.6 Project Scope

As outlined in the September 2021 report the scope of the project included a demand and capacity exercise which has been undertaken following the proposed methodology:

- Review contract baseline for 2018/19, 2019/20 and 2020/21,
- Review activity for each of 2018/19, 2019/20 and 2020/21 against the baseline,
- Include English activity in a Welsh unit to balance the unknown flow of Welsh babies to England,
- Calculate three year average (two year average to be used for SBUHB and CTMUHB to take account of the boundary change and the south wales plan flow changes); and
- Using three year average data, model occupancy at 100%, 90%, 80% and 70%.

It was later agreed that a two year average for all HBs would be used due to the boundary change impacting on flow across the Network. It was also agreed that the designation of the level of any unit would not change as part of the project.

[1] Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk)

Neonatal Transport is out of the scope of the project as a separate Strategic Project to establish a permanent 24 hour service and Operational Delivery Network is currently underway.

In order to take forward the project the Women and Children's Commissioning Team established a full project structure with representation from all six affected HBs on both the Project Board and the Clinical Working Group.

3.0 ASSESSMENT

During August 2022 the Project Board was established with a Clinical Working Group sub-group. It was agreed the existing WHSSC Finance Working Group would undertake the financial assessment. During the lifespan of the project there have been five Project Board meetings, four Clinical Working Group meetings and one Finance Working Group meeting.

Through the Project Structure to date six of the agreed products are on track to be completed by the end of the financial year:

- Baseline Assessment of demand and capacity,
- Commissioning Policy for Neonatal Care,
- Service Specification for Neonatal Care,
- Reconfiguration - Preferred Option developed; and
- Optimum workforce for each reconfiguration option.

The Neonatal Commissioning Policy and service Specification remain in development however are scheduled to be issued for consultation before the end of March 2023.

3.1 Literature and Data Review

Prior to developing the products a literature and data review was undertaken. There is a significant amount of Literature for Neonatal Care published by the BAPM. NHSE have recently developed and consulted upon a revised Service Specification following the publication of the England's Implementing the Recommendations of the Neonatal Critical Care Transformation Review[2] as well as recommendations from the Final Report of the Ockenden Review[3] and Getting it Right First Time (GIRFT)[4] reports. A full list of all of the Literature considered throughout the development of the Project is available in **Appendix 2**.

[2] NHS England » Implementing the Recommendations of the Neonatal Critical Care Transformation Review
[3] Final report of the Ockenden review - GOV.UK (www.gov.uk)
[4] Neonatology - Getting It Right First Time - GIRFT

3.2 Baseline Assessment of Demand and Capacity

The demand and capacity assessment in its entirety is available in **Appendix 3**. The data source used was the neonatal system 'Badgernet' and all HBs took the opportunity to verify the data in advance of the exercise taking place. Birth rates and delivery numbers at each District General Hospital (DGH) have also been included as a consideration within the project as alignment with maternity care is paramount; the data is available in **Appendix 4**.

There are a number of caveats for consideration, in particular that the assumptions consider the activity where it was delivered not where it 'should' or 'could' have been delivered. This is a constraint of the availability of the required robust data set. For example, a baby may have received its care in a different unit to that was expected due to a number of potential reasons:

- the transport service was unable to retrieve the baby,
- insufficient maternity capacity,
- insufficient cot capacity due to being at capacity,
- insufficient cot capacity due to commissioner cots being closed due to lack of staff; and
- the mother booked to deliver out of area.

3.2.1 Key Findings

Birth rates have declined across Wales and the Office of National Statistics (ONS) is projecting a further reduction over the next five years. Delivery numbers across each DGH are not declining equitably, with some of the bigger units seeing an increase in deliveries in 2021/22 to that seen in 2020/21.

With regards to Neonatal activity there has been a reduction in activity across the Intensive Care and Special Care levels, with an increase in High Dependency activity, which is consistent across all units. It is worth noting that the reduction has been in activity not necessarily admissions, this demonstrates that although there are potentially more babies accessing Neonatal Care their length of stay is decreasing. This is in the main due to a number of quality improvement programmes that have been actively taking place across the Network aligned with a number of units proactively managing flow between levels of care and between units, ensuring babies are cared for as close to home as possible. It is also evident that those units with HB funded Transitional Care units have lower Special Care activity.

BAPM standards, the NHSE Service Specification and the NHSE Recommendations from the Neonatal Critical Care Transformation Review all note that a Neonatal Intensive Care unit should undertake more than 2,000 Intensive Care level cot days per year as there is published evidence of improved outcomes if Neonatal Intensive Care Units (NICUs) look after at least 100 very low birth weights (VLBW) and perform over 2000 IC cot days per year. The activity data demonstrates that only one of the three Neonatal Units across the south and west Wales delivers in excess of 2,000 days. The standards also note that a NICU

should also admit at least 100 VLBW babies per year, the three year average for low birth rates across the network is 405.

As well as an overall reduction in Intensive Care level activity, the level of stabilisation cot activity has reduced, this is in part due to the Neonatal Transport service increasing its hours of operation from 12 hours to 24 hours, and ensuring babies are moved to the right unit as promptly as possible.

Based on the literature and data review, the first phase of the project focussed on the development of the Commissioning Policy and Service Specification. There were delays in the development of these discussions as there are differences in current practice in NHS Wales to that in NHSE, particularly at Special Care Level. The documents are in draft and the WHSSC Medical Director and Assistant Director of Evidence and Evaluation are currently reviewing all evidence to inform the position we will be consulting upon. The final versions are planned to be presented to the Policy Group on 15 March 2023.

3.3 Configuration Options

Based on the demand and capacity review, the Clinical Working Group initially developed and discussed three potential options for the configuration of cots across the Network. Following the development of the three options by the Clinical Working Group, concerns were expressed on presentation to Project Board that all three options were against the 80% occupancy level and there was variability in occupancy, particularly between the NICU and the Special Care Units.

The Women and Children's Commissioning Team therefore met with each provider unit and, separately, the clinical lead from the Maternity and Neonatal Network to understand any unintended consequences of the three existing options. Throughout the discussions the current designation of units across the Network was raised, in particular the dilution of activity, as the activity was split between three NICUs and three Special Care Units, meaning in the crudest terms that not all units were meeting the standards of minimum activity as noted in the literature outlined above.

Concerns were expressed around the use of the 80% occupancy level as noted by BAPM[5]. It was suggested that applying 70% for both Intensive Care and High Dependency was more appropriate and 80% for Special Care.

The discussions also highlighted that the flows predicted within the South Wales Plan had not materialised as expected. SBUHB in particular were absorbing patients from Prince Charles Hospital (PCH) that were intended through the South Wales Plan to go to CVUHB. Also, maternity flow was impacting on Neonatal activity however as maternity is outside of the scope of WHSSC access to the

[5] SW Neonatal Networks Pseudomonas Task and Finish Group (hubble-live-assets.s3.amazonaws.com)

data was not as readily available and therefore further exploration is recommended by the Maternity and Neonatal Network and HBs.

None of the options are proposing a change to the designation of a unit therefore access should remain the same. Also, as the activity is against 70% occupancy and there has been rounding to whole cot numbers there is additional capacity built into the system and this includes PCH. On this basis it is understood that this recommendation would not affect a future decision, about the timing of a strategic pathway change in relation to obstetric and neonatal services, by PtHB, in line with the outcome of public consultation on the South Wales Programme.

Based on the discussions a fourth option was therefore developed, a summary of each of the options is outlined in **Table 2** below:

Table 2 - Summary of All 4 Options for the Configuration of Cots Across the Network

	3 year ave . occupancy 12/13 - 14/15				Proposed Cots based on 80% occupancy uplifted to staffing ratio				Proposed Cots based on clinical working group				NICU 70% HDU 70% SCBU 80% Occupancy			
Unit:	**NICU**	**HDU**	**SCBU**	**Total**	**NICU**	**HDU**	**SCBU**	**Total**	**NICU**	**HDU**	**SCBU**	**Total**	**NICU**	**HDU**	**SCBU**	**Total**
AB The Grange	5.87	7.81	18.17	31.85	6.00	8.00	18.00	32.00	6.00	9.00	18.00	33.00	6	9	17	33
C&V UHW	8.24	11.05	13.54	32.83	10.00	11.00	14.00	35.00	10.00	12.00	14.00	36.00	11	12	14	37
CTM PCH	1.39	1.95	12.53	15.87	0.00	4.00	10.00	14.00	1.00	4.00	10.00	15.00	0.54	3	9	12
CTM POW	0.30	2.09	7.85	10.24	0.00	2.00	8.00	10.00	1.00	2.00	8.00	11.00	0.25	2	7	9
HD Glangwilli	0.16	1.59	8.94	10.69	0.00	4.00	8.00	12.00	1.00	4.00	10.00	15.00	0.09	3	7	10
SB Singleton	5.69	5.54	13.55	24.78	6.00	8.00	10.00	24.00	6.00	9.00	8.00	23.00	6	9	9	24
Total South Wales	**21.65**	**30.03**	**74.58**	**126.27**	**22.00**	**37.00**	**68.00**	**127.00**	**25.00**	**40.00**	**68.00**	**133.00**	**24.07**	**38**	**64**	**125**

3.3.1 Option 1 – Do Nothing

Option 1 is to keep the current cot configuration as it is, as outlined in **table 3** below.

Table 3 – Option 1

Unit:	**NICU**	**HDU**	**SCBU**	**Total**
Aneurin Bevan UHB (The Grange)	5.87	7.81	18.17	31.85
Cardiff & Vale UHB (CHfW)	8.24	11.05	13.54	32.83
Cwm Taf Morgannwg UHB (PCH)	1.39	1.95	12.53	15.87
Cwm Taf Morgannwg UHB (POW)	0.30	2.09	7.85	10.24
Hywel Dda UHB (Glangwilli)	0.16	1.59	8.94	10.69
Swansea Bay UHB (Singleton)	5.69	5.54	13.55	24.78
Total South Wales	**21.65**	**30.03**	**74.58**	**126.27**

Considering the two year average activity against the configuration in Option 1, impacts on occupancy are outlined in **table 4**.

Table 4 – Option 1 against 2 year average activity

Option 1						
Provider	**Number of Intensive Care Cots (IC)**	**Average activity against cot numbers**	**Number of High Dependency Cots (HD)**	**Average activity against cot numbers**	**Number of Special Care Cots (SC)**	**Average activity against cot numbers**
Aneurin Bevan UHB	5.88	94%	7.81	101%	18.2	96%
Cardiff and Vale UHB	8.25	114%	11.05	96%	13.5	101%
Cwm Taf Morgannwg UHB (PCH)	1.39	34%	1.95	130%	12.5	72%
Cwm Taf Morgannwg UHB (POW)	0.3	72%	2.09	67%	7.9	90%
Hywel Dda UHB	0.16	46%	1.59	153%	8.9	81%
Swansea Bay UHB	5.7	95%	5.54	143%	13.6	67%
Total	**21.68**	**97%**	**30.03**	**93%**	**74.6**	**85%**
2 year average based on 80% occupancy	**21**		**33**		**64**	
Difference	**0.68**		**-2.97**		**10.6**	

The average activity against the cot numbers calculation in **Table 4** has been done using the 80% occupancy standard, therefore the cot configuration in Option 1 would allow close to the right number of cots across the Network at the recommended 80% occupancy level as per BAPM standards assuming a similar flow of patients. However, when considered at individual unit level there are significant inconsistencies. CVUHB would report 114% activity against the baseline cots in comparison to ABUHB whose activity would be at 79%.

In this option the stabilisation of cot activity has been categorised as Intensive Care level days against a high baseline, therefore the three Special Care Units would significantly underperform at Intensive Care level (<40%). The introduction of the 24 hour neonatal transport service in 2021/22 has seen a direct reduction in the activity at this level at all three Special Care Units as babies are transferred sooner. At High Dependency level the overall occupancy would be 111% across the Network, similar to Intensive Care this is variable across units. HDdUHB would have the highest occupancy against the configuration proposed in Option 1, at 153% and CVUHB the lowest at 96%. Overall the Special Care occupancy level would perform at 87% with variability across the Network similar to the other levels of care noted above.

It has been recognised throughout this project that Option 1 has significant risk particularly as all three Neonatal Intensive Care Units would continue to over-perform. The Project Board considered that this option would not offer improved sustainability or access for patients and would continue to result in babies being transferred to alternative units.

3.3.2 Option 2 – Desk top modelled option

Option 2 was developed by aligning the cots with two year average activity data building in the national standard of 80% occupancy, with rounding. Additional capacity was built in to take account of nursing ratios at each level of care. In Option 2 the stabilisation cot activity from Special Care Units has been removed from the Intensive Care level activity and added to High Dependency activity.

Option 2 models additional cots at Intensive Care level and High Dependency level compared with the current configuration. **Table 5** outlines the cot configuration in Option 2. **Table 6** outlines the cot configuration for option 2 against 2 year average activity.

Table 5 – Cot Configuration in Option 2

Unit:	NICU	HDU	SCBU	Total
Aneurin Bevan UHB (The Grange)	6.00	8.00	18.00	32.00
Cardiff & Vale UHB (CHfW)	10.00	11.00	14.00	35.00
Cwm Taf Morgannwg UHB (PCH)	0.00	4.00	10.00	14.00
Cwm Taf Morgannwg UHB (POW)	0.00	2.00	8.00	10.00
Hywel Dda UHB (Glangwilli)	0.00	4.00	8.00	12.00
Swansea Bay UHB (Singleton)	6.00	8.00	10.00	24.00
Total South Wales	**22.00**	**37.00**	**68.00**	**127.00**

Considering the two year average activity against the configuration in Option 2, two impacts on occupancy as noted in Table 6.

Table 6 – Option 2 against 2 year average activity

Option 2						
Provider	**Number of Intensive Care Cots (IC)**	**Average activity against cot numbers**	**Number of High Dependency Cots (HD)**	**Average activity against cot numbers**	**Number of Special Care Cots (SC)**	**Average activity against cot numbers**
Aneurin Bevan UHB	6	92%	8	99%	18	97%
Cardiff and Vale UHB	9.37	100%	11	97%	14	97%
Cwm Taf Morgannwg UHB (PCH)	0	0%	4	63%	10	90%
Cwm Taf Morgannwg UHB (POW)	0	0%	2	71%	6	121%
Hywel Dda UHB	0	90%	4	61%	8	91%
Swansea Bay UHB	6	99%	8	100%	10	91%
Total	**21.37**	**99%**	**37**	**89%**	**66**	**96%**
2 year average based on 80% occupancy	**21**		**33**		**64**	
Difference	**-0.37**		**4**		**2**	

By running the two year average activity data against the proposed configuration the occupancy levels are far more stable across the Network however there remains variability and inequity, particularly between the NICU's and the Special Care Units. Again, this option assumes similar flow. The configuration adds cots in to the system overall particularly at High Dependency level, where the increase in activity across the system (both in Wales and the UK) has been seen, related to change in practice.

There are notable risks in option 2 particularly the removal of stabilisation cots within the Special Care Units and NICU would continue to run close to capacity at both Intensive Care and High Dependency levels. However, consideration needs to be given to the fact that all units should have a supernumerary shift manager,

which allows for flexibility in the system, and mitigates the loss of the stabilisation cot.

3.3.3 Option 3 – Clinical Working Group Option

Option 3 was developed through an interactive session at the Clinical Working Group and again has been developed using the National Standard of 80% occupancy. Members were invited to complete a Microsoft form at regular intervals throughout the meeting to develop a configuration option. Members were set six questions, of which three asked the optimum cot numbers overall for each level of care followed by three questions that sought a view on the configuration across the Network. **Table 7** outlines Option 3.

Table 7 – Option 3

Unit:	NICU	HDU	SCBU	Total
Aneurin Bevan UHB (The Grange)	6.00	9.00	18.00	33.00
Cardiff & Vale UHB (CHfW)	10.00	12.00	14.00	36.00
Cwm Taf Morgannwg UHB (PCH)	1.00	4.00	10.00	15.00
Cwm Taf Morgannwg UHB (POW)	1.00	2.00	8.00	11.00
Hywel Dda UHB (Glangwilli)	1.00	4.00	10.00	15.00
Swansea Bay UHB (Singleton)	6.00	9.00	8.00	23.00
Total South Wales	**25.00**	**40.00**	**68.00**	**133.00**

Considering the two year average activity against the configuration in Option 3, impacts on occupancy as noted in **table 8.**

Table 8 – Option 3 against 2 year average activity

Option 3						
Provider	**Number of Intensive Care Cots (IC)**	**Average activity against cot numbers**	**Number of High Dependency Cots (HD)**	**Average activity against cot numbers**	**Number of Special Care Cots (SC)**	**Average activity against cot numbers**
Aneurin Bevan UHB	6	92%	9	88%	18	97%
Cardiff and Vale UHB	10	94%	12	89%	14	97%
Cwm Taf Morgannwg UHB (PCH)	1	47%	4	63%	10	90%
Cwm Taf Morgannwg UHB (POW)	1	22%	2	71%	8	91%
Hywel Dda UHB	1	8%	4	61%	10	72%
Swansea Bay UHB	6	90%	9	89%	8	114%
Total	**25**	**84%**	**40**	**82%**	**68**	**94%**
2 year average based on 80% occupancy	**21**		**33**		**64**	
Difference	**4**		**7**		**4**	

By running the two year average activity data against the proposed configuration the occupancy levels are variable. The proposed option adds 15 additional cots in to the system and as a consequence all units are below the recommended 80% occupancy standard. As the calculations are based on this standard the occupancy at each level of care ranges between 60% and 70%.

The variability between occupancy at NICU's and Special Care units is greater in this option, in particular at Intensive Care and High Dependency levels.

Of all of the options, option 3 has the greatest increase in overall cot numbers, this will have a direct impact on the numbers of staff required in line with BAPM standards. The recruitment requirements will require a feasibility assessment and planned recruitment programme.

3.3.4 Option 4 – Differential Occupancy Rate Model

As previously noted, Option 4 was developed following discussions with all provider units and applies 70% occupancy for Intensive Care and High Dependency and 80% occupancy for Special Care. Taking account of the concerns around stabilisation cot activity this is included for all Special Care Units. Taking account of the concerns around stabilisation cot activity this is included for all Special Care Units. Option 4 has an overall increase of 10 cots at Intensive Care and High Dependency level combined. There is a reduction in Special Care however in option 2, 3 and 4 there is a reduction in Special Care as activity has declined. This is more prevalent in units that have developed Transitional Care Units. **Table 9** outlines option 4.

Table 9 – Option 4

Unit:	NICU	HDU	SCBU	Total
Aneurin Bevan UHB (The Grange)	6.00	9.00	17.00	32.00
Cardiff & Vale UHB (CHfW)	11.00	12.00	14.00	37.00
Cwm Taf Morgannwg UHB (PCH)	0.54	3.00	9.00	12.00
Cwm Taf Morgannwg UHB (POW)	0.25	2.00	7.00	9.00
Hywel Dda UHB (Glangwilli)	0.09	3.00	7.00	10.00
Swansea Bay UHB (Singleton)	6.00	9.00	9.00	24.00
Total South Wales	**24.07**	**38.00**	**64.00**	**125.00**

Considering the two year average activity against the configuration in Option 4, impacts on occupancy as noted in **table 10**.

Table 10 - Option 4 against 2 year average activity

Option 4						
Provider	**Number of Intensive Care Cots (IC)**	**Average activity against cot numbers (70% occupancy)**	**Number of High Dependency Cots (HD)**	**Average activity against cot numbers (70% occupancy)**	**Number of Special Care Cots (SC)**	**Average activity against cot numbers (80% occupancy)**
Aneurin Bevan UHB	6	74%	9	70%	17	82%
Cardiff and Vale UHB	11	68%	12	71%	14	78%
Cwm Taf Morgannwg UHB (PCH)	0.54		3	67%	9	80%
Cwm Taf Morgannwg UHB (POW)	0.25		2	56%	7	83%
Hywel Dda UHB	0.09		3	65%	7	83%
Swansea Bay UHB	6	72%	9	71%	9	81%
Total	**23.88**	**72%**	**38**	**71%**	**63**	**81%**
2 year average based on 80% occupancy	**21**		**33**		**64**	
Difference	**4**		**7**		**4**	

By running the two year average activity data against the proposed configuration the occupancy levels are far more stable and consistent ensuring greater equity. There remains a low occupancy rate at the one Special Care Unit in CTMUHB as the activity level is split across two sites. This option allows more cots at both Intensive Care and High Dependency compared to the current configuration, with the greatest increase of Intensive Care seen at CVUHB, as the only surgical unit. The stabilisation cots at Special Care Units are included in this option which mitigates the risks identified in options 2 and 3.

3.4 Optimum workforce for each reconfiguration option

For each of the four options the Women and Children Commissioning Team applied the BAPM workforce standards to develop the optimum workforce and in order to ensure equity across all levels of the service and staff groups, the standards have been applied in the purest form. The standards are described in **Appendix 5 (tab 1)**. We are aware that across all levels there is a significant difference to what is currently happening now, whether that be a greater or fewer numbers within each professional group.

This approach was discussed with the Clinical Working Group and there were concerns particularly around the levels of medical workforce included within the standards. Potential scenarios were checked against the usual operational assumptions of a Consultant working 42 weeks of the year and undertaking 7 Direct Clinical Care (DCC) sessions and 3 Supporting Professional Activity sessions per week and this would suggest that the BAPM standards provide the required medical cover.

From a nursing perspective the current WTE used per cot for 1:1 nursing is 5.69, however for paediatric and critical care the ratio is 7 x WTE. The Clinical Working Group requested further exploration and the Commissioning Team established that 6 x WTE allowed for annual leave, sickness, maternity and mandatory

training. The difference between paediatrics and adult critical care was due to the supernumerary nursing being added to the equation, for the purposes of this exercise that has been done separately.

Allied Health Professional representatives on the Clinical Group noted that further guidance has been published by a number of the professional groups that differed to BAPM however as previously noted to ensure consistency and equity the BAPM standards have been applied for all professional groups.

The workforce standards and how these convert to WTE numbers for each option is available in **Appendix 5 (tab 2)**.

3.5 Financial Assessment

The options derived by the clinical working group have been assessed to identify the financial implications of both the cot reconfiguration and tariff uplift against the 'do nothing' status quo baseline configuration and then to assess affordability against the plan provision that was agreed in the 2022/23 WHSSC ICP.

The cot reconfiguration impact is identified by calculating the total cost of each option configuration at the current contract tariff. The tariff uplift impact is separately identified by calculating total cost of each option configuration at the proposed uplifted benchmarked UH Bristol tariff, and deducting the cot reconfiguration impact form the total. The two components as an aggregated total is the total cost of the proposed options.

As illustrated below in **table 11**, options 2 & 3 increase the baseline capacity costs as they uplift the proposed configuration at an assumed 80% occupancy rate. In option 4 where the occupancy rate for NICU and HDU activity is assumed at 70% the configuration cost is reduced against the current option 1 baseline.

When the tariff uplift is identified, as expected option 4 required the lowest uplift as the total proposed occupied cot days is significantly lower than in options 2 & 3.

Table 11 - Cot Re-alignment & Tariff Uplift Financial Impact

Re-alignment:	Option 1			Option 2			Option 3			Option 4		
South Wales Total	Days @80%	Tariff £	Baseline £	Days @80%	Tariff £	Baseline £	Days @80%	Tariff £	Baseline £	NICU & HDU @70% SCBU @80%.	Tariff £	Baseline £
NICU	6,329	1,273	8,059,757	6,424	1,273	8,180,736	7,300	1,273	9,296,291	6,099	1,273	7,767,458
HDU	8,771	848	7,436,416	10,804	848	9,160,078	11,680	848	9,902,787	9,709	848	8,231,691
SCBU	20,754	468	9,704,943	21,024	468	9,831,200	21,316	468	9,967,745	18,396	468	8,602,300
Total	35,854		25,201,116	38,252		27,172,013	40,296		29,166,822	34,204		24,601,450
Financial Impact of Cot Re-alignment			0			1,970,897			3,965,706			(599,666)
Tariff Uplift	Option 1			Option 2			Option 3			Option 4		
South Wales Total	Days @80%	Tariff £	Baseline £	Days @80%	Tariff £	Proposed Baseline £	Days @80%	Tariff £	Proposed Baseline £	NICU & HDU @70% SCBU @80%.	Tariff £	Proposed Baseline £
NICU	6,329	1,273	8,059,757	6,424	1,562	10,036,793	7,300	1,562	11,405,447	6,099	1,562	9,529,751
HDU	8,771	848	7,436,416	10,804	1,000	10,807,781	11,680	1,000	11,684,088	9,709	1,000	9,712,398
SCBU	20,754	468	9,704,943	21,024	601	12,628,465	21,316	565	12,048,869	18,396	601	11,049,907
Total			25,201,116			33,473,040			35,138,404			30,292,056
Financial Impact of Tariff Uplift			0			6,301,026			5,971,582			5,690,606
Total Financial Impact of Re-alignment and Tariff Uplift						8,271,924			9,937,288			5,090,940

3.5.1 Affordability Assessment

The 2022-25 WHSSC ICP included a provision for the cot reconfiguration and tariff uplift investment as a strategic priority. A full year commissioner rebasing adjustment was also included to reflect the changes in commissioner activity flows since the baseline configuration was established through the initial 2015/16 rebasing. An offsetting saving target for a reduction in out of area capacity transfers into NHSE providers was also added on the anticipation of the project being implemented in year.

The full year effect of the ICP provision was reviewed in development of the 2023/24 ICP and as phasing assumption the original full year provision was reduced by £0.314m to £3.496m in recognition of overall plan affordability.
This available funding also includes a re-alignment of provider wage awards to allocate the cumulative 2022/23 pay award due to pay costs for neonatal provision.

This is to enable comparison with the 2022/23 NHSE UH Bristol tariff which fully reflects all pay awards up to and including the 2022/23 award.

The total funding available and source is detailed in the table 12 below:

Table 12 - Total Funding Available

		Funding Available	
		2022/23	2023/24
	Source	£	£
Current Funding	**Baseline**	**25,201,116**	**25,201,116**
Rebasing block	Baseline	297,097	297,097
ICP Provision	Plan	1,905,028	3,496,136
Commissioner Rebasing	Plan	(554,312)	(554,312)
Cumulative WG Pay Award funding to re-allocate	WG	1,992,092	1,992,092
Funding to be allocated through project:		**3,639,905**	**5,231,013**
Total Funding Available		**28,841,021**	**30,432,129**
Offsetting reduction in NHSE transfers	Plan	(250,000)	(500,000)

An assessment of the options against the available 2023/24 ICP provision is set out in table 13 below:

Table 13 – Options Affordability Appraisal

	Option 1	Option 2	Option 3	Option 4
	Do Nothing: Current Baseline from initial rebasing 2012 - 2015 at current tariff, based on 14/15 UH Bristol tariff adjusted for inflation	Desktop exercise: Rebase to 2 year average (2019 - 2021) & round up to whole nursing rations at 80% occupancy. Apply 2022/23 UH Bristol Tariff	Clinical Working Group Initial Cot Model: Apply 2022/23 UH Bristol Tariff	Clinical Working Group new option: Rebase to 2 year average and reduce NICU & HDU occupancy rate to 70%. Apply 2022/23 UH Bristol Tariff
Unit:	**£000's**	**£000's**	**£000's**	**£000's**
AB The Grange	6,601	8,231	8,523	7,677
C&V UHW	7,652	10,231	10,523	9,914
CTM PCH	2,713	2,922	3,379	2,577
CTM POW	1,701	1,987	2,444	1,837
HD Glangwilli	1,674	3,273	4,256	2,029
SB Singleton	4,859	6,828	6,769	6,274
Total South Wales	**25,201**	**33,473**	**35,893**	**30,308**
Re-alignment Change	-	1,971	3,966	(600)
Tariff Uplift	-	6,301	6,727	5,691
Provider Protection				16
Investment required:	**-**	**8,272**	**10,692**	**5,107**
Funding Available through 23/24 WHSSC Plan (& Pay awards)	**5,231**	**5,231**	**5,231**	**5,231**
	Option 1	**Option 2**	**Option 3**	**Option 4**
Affordability against 23/24 ICP Provision	(5,231)	3,041	5,461	(124)
	Affordable	Unaffordable	Unaffordable	Affordable

This assessment outcome is that only the clinical working group options 1 'do nothing' and 4 'standardise occupancy rates' are affordable within the approved plan provision.

If option 4 was approved commissioners would be handed back £124k from current ICP provision.

3.5.2 Value for Money Test

To test the value for money of the proposed investment the BAPM standards were applied to the South Wales Neonatal activity volumes to assess what the minimum financial requirement would be.

This analysis shows that the minimum cost to meet standards at the current south wales activity level is £30.265m, which is £5.064m above the current baseline of £25.201m and within £0.050m of the investment proposed in option 4 of £5.107m.

This is consistent from a review of provider costing returns which demonstrated material deficits in current neonatal expenditure against the current commissioned income.

Table 14 – Value for Money test

	VFM Test: BAPM hypothetical S wales volume configuration:
	BAPM Costing £000's
Medical	5,267
Nursing	15,714
AHP	1,947
Total BAPM Staffing	**22,928**
Non Pay (@10%)	2,293
Other Overheads (@20%)	5,044
Total Option Costing	**30,265**
Total Funding Available	30,432
Funding Surplus	(167)

Following agreement for the preferred option from this project it is proposed that the conclusions of the VFM test work are used to take forward a Phase 2 programme of work to review the commissioned service model.

3.5.3 Current Unit Configuration costing to BAPM standards

When costing the current 6 unit configuration to BAPM standards, there are material gaps due to the lower volumes delivered by the individual units are not consistent with the BAPM recommended volumes.

Table 15 – Costing to BAPM standards

	Costing of current unit configuration to BAPM standards			
	Option 1	Option 2	Option 3	Option 4
	£000's	£000's	£000's	£000's
Medical	7,231	7,418	7,743	8,256
Nursing	17,939	19,422	20,831	19,574
AHP	2,125	2,152	2,247	2,296
Total BAPM Staffing	**27,294**	**28,992**	**30,821**	**30,126**
Non Pay (@10%)	2,729	2,899	3,082	3,013
Other Overheads (@20%)	6,005	6,378	6,781	6,628
Total Option Costing	**36,029**	**38,270**	**40,683**	**39,767**
Total Funding Available	25,201	30,432	30,432	30,432
Funding Gap	(10,828)	(7,838)	(10,251)	(9,334)

The application of the BAPM staffing standards assumes that the capacity required is for 100% cot occupancy, but as the income is only generated by occupied cots, the lower the occupancy assumption the larger the built in flex capacity is, this accounts for approx. £1.5m of the funding gap in option 4 over option 2.

3.6 Constraints

3.6.1 Workforce

All of the proposed options require a significant uplift against the current workforce particularly at nursing and Allied Health Professional level during a time when the workforce numbers across Wales are low. We therefore appreciate that meeting the optimum workforce levels will take providers some time and will require a phased programme to achieve this.

3.6.2 Maternity Services

As previously noted Maternity services are outside of the current remit of WHSSC however there is clear evidence that the outcomes for babies are far better if a pregnant mother is transferred whilst the baby is in-utero to a maternity unit co-located with a Neonatal Intensive Care unit rather than transferring a baby ex-utero[6]. In order to ensure that the preferred option has optimum impact further consideration of maternity services is required by the Maternity and Neonatal Network and Health Boards.

[6] Re: Perinatal Outcomes; Marlow et al 2014;99:F181-8. (researchgate.net)

3.6.3 Transitional Care

We currently do not commission Transitional Care, however we are aware how paramount transitional care is to maximise flow out of neonatal care, particularly from Special Care. BAPM categorise Transitional Care as; *"Neonatal Transitional Care (NTC) is care additional to normal infant care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals".*[7]

BAPM note that having transitional care provision has the potential to prevent thousands of admissions annually to UK neonatal units. Of the three existing Neonatal Intensive Care Units only two have Transitional Care within their HB, CVUHB and SBUHB. It is evident from the data in **Appendix 1** that both units have less Special Care activity in comparison to ABUHB.

In order to ensure efficiency within the system, improve flow and ultimately keep as many babies with their mothers in an appropriate setting, this requires further review by individual health boards.

3.6.4 Minimum Activity levels as per BAPM

As noted within the document the BAPM standards have been applied when considering the workforce, however these are considered in alignment with minimum activity levels which are linked to improved outcomes[8]. The current configuration in Wales dilutes activity across 6 units of varying levels, therefore the Neonatal Units in particular are not achieving 2000 Intensive Care cot days with the exception of Cardiff and Vale UHB. As well as the BAPM standards there is reference to these minimum activity numbers within the recently consulted NHSE Service Specification for Neonatal Care and the NHSE 'Implementing the Recommendations of the Neonatal Critical Transformation Review'. Within the Action Plan of the Review document there is clear mandate for ODN's in NHSE to consider where activity falls below this standard that activity will need to be combined on a single site, re-designating other sites as Local Neonatal Units or Special Care Units.

3.7 Conclusions

3.7.1 Project Board Recommendation

The Project Board considered all of the options and the financial assessment as noted above and could not reach a consensus on the day. It was also noted that whilst the Board meeting was quorate, key HBs were also not present. Due to the make-up of the Project Board there were tensions between commissioner and provider priorities evident in the discussion. It was therefore agreed that a Microsoft Form would be shared with members who were present and those that sent apologies to provide all members with the opportunity to vote. All HBs submitted a return as well as the two Neonatal Network representatives meaning

[7] British Association of Perinatal Medicine (hubble-live-assets.s3.amazonaws.com)

[8] Microsoft Word - Optimal size of NICUs final June 2014 (hubble-live-assets.s3.amazonaws.com)

the responses were quorate. Following this exercise the preferred option of the Project Board was option 3.

Option 3 is currently unaffordable against the funding allocation within the plan by £4.752m. The workforce requirements for option 3 are also unaffordable by £10.296m as noted in Table 15.

From a Commissioner perspective there are a number of additional risks to those included within the assessment in paragraph 3.3.3 and the financial assessment in 3.5. There is a risk that option 3 further dilutes the activity across the Network, driving a greater disparity against the minimum standards for activity, with implications for staff skill maintenance. These standards as previously mentioned are linked to the improved outcomes of neonates, as low throughput is associated with worse outcomes, as in essence staff have less exposure to complex neonates. A request was made by the Project Board to consider a full tariff contracting mechanism, therefore any under or over performance would be paid / paid back at full cost not a marginal rate. Option 3 puts significantly more occupancy in to the system than the average activity levels, therefore there is a potential unintended consequence to provider as they will be required to pay back a significant amount due to under performance. This could potentially disincentives the timely flow and discharge of babies.

3.7.2 Commissioning Team Recommendation

Taking account of the clinical viewpoint, the financial assessment and the risks associated with the Project Board recommendation of option 3, the Women and Children Commissioning Team recommend option 4 as the preferred option. Although there is funding gap for the workforce elements of this option to be fully compliant with the BAPM standards it is recognised that the recruitment required to uplift the current workforce from the current position will require a phased approach across a number of years.

When benchmarking compliance with BAPM workforce standards at nursing level with the South West Neonatal Network, they consistently do not meet standards, with a worse position for night time shifts. Compliance is variable across the units with some only achieving 50% compliance in comparison to others achieving >80%. The reasons for no-compliance require further investigation to understand if it is due to recruitment, sickness, maternity or a combination.

The Commissioning Team are therefore requesting approval the release of £5.107m, which is below the available funding in the plan, as per table 13, to support the reconfiguration of the cots in line with option 4 and the uplift of the tariff across all three levels of care. The Management Group support the recommendation of the option and the required funding.

3.8 Phase 2

The Management Group supported the recommendation that a Phase 2 programme of work is taken forward to consider the future service model in the context of the funding gap against the BAPM workforce standards.

There is a clear disparity between the required investments to meet workforce standards in each of the 4 options than if the BAPM standards were applied to the South Wales Neonatal volumes. Option 2 requires £5.764m more investment, option 3 requires £10.418m more investment and option 4 requires £9.502m more investment than Table 14.

There is published evidence from England that survival of babies born before 27 weeks gestation is higher when this occurs in a maternity service with a NICU, and that survival for this group is higher still when born in a service that either carries out more than 2000 respiratory care days per year[11] or is in the top quartile of intensive care activity in the UK[12]. This concept, that busier services have better outcomes, is supported by international data, mainly from the USA.

The NHSE Review of neonatal services advised that reconfiguration of services will lead to improvements in survival, and to significant economies of scale that permits better staffing and less variation in admission rates. Although this may increase either the need for transfers or increased travel times in some settings, the trade-off for improved survival and economy of scale requires further consideration.

The introduction of the 24 hour Neonatal Transport service will provide the capacity to undertake the required transfers. The development of the Operational Delivery Network will also provide a robust mechanism for monitoring to support future planning assumptions.

It is therefore suggested that a further review of the current designation of units and configuration is undertaken in line with the WHSSC principles set out in the 2023/26 ICP:

- maximise value from our core resources,
- make overt choices on new developments and investments on a risk assessed basis,
- ensure that considerations of equality and equity are central to planning and commissioning,
- ensure that repatriation of services maximises value for patients and wherever possible is delivered within existing resource envelope,
- maintain the renewed focus on performance management and value for money from contracts in line with the Escalation Framework,
- work with Health Boards in-year on value, cost-avoidance and demand management across whole pathways; and
- evaluate previous investments and bring forward recommissioning choices in year in conjunction with HBs.

The Management Group noted that due to the shortfall in the required investment to meet the workforce standards, the scope and remit of phase 2 is developed at pace. The Women and Children's Commissioning Team are recommending that the scope and remit of the project is presented to the Joint Committee by the end of quarter 1 of 2023/24.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the background within the report,
- **Note** the outcomes of the of the Neonatal Cot Configuration Project,
- **Note** the financial assessment,
- **Note** the preferred option of the Project Board,
- **Approve** the recommended preferred option and the release of funding in line with the provision within the 2022/25 Integrated Commissioning Plan (ICP) as an interim measure; and
- **Approve** the recommendation of the Management Group for a phase 2 programme of works to be undertaken.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Implementation of the Plan
Link to Integrated Commissioning Plan	The configuration of Neonatal cots and a review of the tariff is a strategic priority within the 2022/25 WHSSC ICP.
Health and Care Standards	Safe Care Effective Care Staff and Resourcing
Principles of Prudent Healthcare	Reduce inappropriate variation Care for Those with the greatest health need first Reduce inappropriate variation
NHS Delivery Framework Quadruple Aim	People in Wales have improved health and well-being with better prevention and self-management People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement The health and social care workforce is motivated and sustainable Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcome
Organisational Implications	
Quality, Safety & Patient Experience	-
Finance/Resource Implications	The funding for the reconfiguration of Neonatal cots and a review of the tariff is a strategic priority within the 2022/25 WHSSC ICP.
Population Health	-
Legal Implications	-
Long Term Implications	-
Report History	23 February – Management Group – supported. 16 February 2023 – CDGB
Appendices	Appendix 1 – Neonatal Unit descriptors Appendix 2 – Literature review Appendix 3 – Demand and capacity Appendix 4 – Birth rates and delivery numbers Appendix 5 – Workforce against BAPM

Appendix 1 - Description of each Neonatal Unit[1]

Neonatal Intensive Care Unit

A Neonatal Intensive Care Unit will provide:

- Neonatal services commensurate with national guidelines and professional standards where births are anticipated from 22+0 weeks gestation (Perinatal Management of Extreme Preterm Birth Before 27 weeks of Gestation: A BAPM Framework for Practice (2019)).
- Intensive care for all babies born within the network according to approved care pathways including those less 27+0 weeks gestation, or with a birth weight <800g and any baby requiring complex or prolonged intensive care.
- Neonatal intensive care service for other neonatal networks or out of area neonatal units due to lack of capacity in their network NICU. This also requires discussion with the regional neonatal transfer service.
- Leadership within neonatology for other units and 24-hour acute clinical telephone consultations as required by the network hospitals and, if required neonatal transport services. Where more than one NICU within the Network there will be a sharing of responsibility to provide 24-hour acute clinical consultations.
- Care for local network babies repatriated from elsewhere requiring ongoing care from a NICU.

Neonatal Intensive Care Units should admit more than 100 very low birth weight (VLBW) (i.e. birth weight <1500g) babies per year and should be undertaking more than 2000 intensive care days per year, or working towards this number. There may be a small number of exceptions for geographically remote services where the alternative would result in very long travel times. However, these exceptions should be agreed with the commissioners prior to local implementation and be subject to quarterly review to ensure that safety and quality are not compromised.

A Neonatal Intensive Care Unit would not necessarily be expected to provide the following, which are only available in specialist centres to optimise outcome and remove inequity:

- Extra - Corporeal Membrane Oxygenation (ECMO)
- Surgical care
- Specialised cardiac care

Local Neonatal Unit

In addition to all the services provided by SCUs, LNUs will provide:

- Neonatal services commensurate with national guidelines and professional standards where; births are anticipated after 26+6 weeks gestational age providing the anticipated birth weight is above 800g. This threshold may be higher for multiple births dependent on staffing and capacity.

[1] 6e69e665-7b75-41c7-b2ee-ed8768122c06 (vuelio.co.uk)

- High dependency care and special care for their local population.
- Care for local babies repatriated from neonatal units who require ongoing high dependency or special care.
- Ongoing care for local babies who have undergone specialist surgery following repatriation from a surgical NICU.
- Referrals from within network neonatal units who are unable to undertake high dependency care and special care, due to capacity reasons and/or network guidelines.
- Where possible, women will be transferred in-utero to the Network NICU when gestational age, anticipated birth weight or need for complex or prolonged intensive care is anticipated in accordance with ODN care pathways.
- Limited intensive care (i.e. usually less than 24 hours) in accordance with approved care pathways. This may include short periods of invasive ventilatory support, however the clinical condition of any baby requiring this care must be discussed with a consultant in the Network NICU by 48 hours and every 24 hours thereafter if intubated ventilatory support continues. In these instances, an agreed management plan, including decisions regarding transfer criteria, must be documented.
- Initial stabilisation prior to transfer for babies requiring complex or ongoing (i.e. prolonged) intensive care. These babies will be transferred to the nearest NICU in accordance with approved care pathways.

LNUs should admit more than 25 very low birth weight (VLBW) (i.e. birth weight <1500g) babies per year and undertake 500 combined intensive and high dependency days per year working towards undertaking more than 1000 combined intensive and high dependency days per year. There may be a small number of exceptions for geographically remote services where the alternative would result in very long travel times. However these exceptions should be agreed with commissioners prior to local implementation and be subject to quarterly review to ensure that safety and quality are not compromised.

A Local Neonatal unit will not ordinarily be commissioned to provide the following:

- On-going intensive care beyond initial stabilisation and intensive care to babies less than 27+0 weeks of gestation
- On-going intensive care beyond initial stabilisation to babies with a birth weight below 800g
- Complex intensive care including babies requiring respiratory support with symptoms of additional organ failure (e.g. hypotension, disseminated intravascular coagulation (DIC), renal failure, metabolic acidosis) or babies requiring the following treatment and support:
  - Support of more than one organ, for example ventilation via a tracheal tube plus any one of the following: Inotrope infusion,

insulin infusion, presence of a chest drain, exchange transfusion and prostaglandin infusion.
- Inhaled Nitric Oxide (INO)
- High frequency oscillatory ventilation (HFOV)
- Therapeutic hypothermia beyond initial stabilisation.
- Prolonged Intensive care (intubated ventilatory support) for greater than 48 hours

Special Care Unit

A Special Care Unit (SCU) will provide:

- Neonatal services commensurate with national guidelines and professional standards where singleton births are anticipated after 31+6 weeks gestational age provided the anticipated birth weight is above 1,000g. This threshold maybe higher for multiple births depending on staffing levels and unit capacity.[2]
- Care pathways will define antenatal factors or conditions present soon after birth which increase the likelihood that transfer to a Neonatal Intensive Care Unit (NICU) for complex or prolonged neonatal intensive care OR a Local Neonatal Unit for short term neonatal intensive /high dependency care will be required.
- Stabilisation of babies prior to transfer to an (Local Neonatal Unit (LNU) or NICU predominantly, but not exclusively for intensive care.
- Care for local babies with high dependency or special care needs following repatriation from LNUs or NICUs within the network or from out of area in accordance with approved care pathways.
- Referrals for ongoing special care from other network neonatal units who are unable to undertake this work due to capacity reasons.
- Care for local babies post specialist surgery following repatriation from the network surgical unit or step down from other LNUs in accordance with approved care pathways.

A Special Care Unit will not be expected to provide the following, except under exceptional circumstances which have been agreed and formally documented by the Network NICU on an individual case basis:

- Care beyond initial stabilisation to babies less than 31+6 weeks of gestation.
- Care beyond initial stabilisation to babies with a birth weight < 1,000g.
- Intensive care for any baby apart from initial stabilisation prior to transfer

- **NHS Wales**
  - All Wales Neonatal Standards (3rd Edition), September 2017

- **National Institute of Health and Care Excellence (NICE) guidance**
  - Specialist neonatal respiratory care for babies born preterm: Quality standard QS193 July 2020

- **Relevant NHS England documents**
  - Specialised Services Quality Dashboard (SSQD): Neonatal Critical Care (Intensive Care, HDU and Special Care), E08/S/a, 2022/23
  - NHS England and NHS Improvement, Implementing the Recommendations of the Neonatal Critical Care Transformation Review, January 2020
  - NHS Improvement on behalf of the National Quality Board (NQB), Safe, sustainable and productive staffing: An improvement resource for neonatal care, June 2018
  - Neonatal Critical Care (Intensive Care, HDU and Special Care), E08/S/a, 2015

- **Other published documents**
  - The British Association of Perinatal Medicine Service and Quality Standards for Provision of Neonatal Care in the UK, Draft for Consultation, August 2022
  - https://www.bapm.org/resources/157-calculating-unit-cot-numbers-and-nurse-staffing-establishment-and-determining-cot-capacity
  - The British Association of Perinatal Medicine, Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: a framework for practice, November 2018
  - The British Association of Perinatal Medicine, Neonatal Service Quality Indicators: Standards relating to Structures and Processes supporting Quality and Patient Safety in Neonatal Services, June 2017
  - GIRFT Programme National Specialty Report: Neonatology, April 2022
  - GIRFT Programme National Specialty Report: Neonatology – Workforce, April 2022
  - Royal College of Midwives and Royal College of Obstetricians and Gynaecologists Review of Maternity Services at Cwm Taf Health Board, January 2019

- Office for National Statistics, Births in England and Wales 2021, August 2022
- Bliss Baby Charter: Helping to make family-centred care a reality on your neonatal unit 2020
- Royal College of Obstetricians and Gynaecologists (RCOG) in partnership with the Royal College of Midwives (RCM), the Royal College of Paediatrics and Child Health (RCPCH) and the London School of Hygiene and Tropical Medicine (LSHTM), National Maternity and Perinatal Audit: Organisational report 2017

Aneurin Bevan - The Grange

	Current Baselines				2019/20				2020/21				2019/20 & 2020/21 Average Activity			
	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total
Aneurin Bevan	1460	2071	4948	8479	1499	2143	4829	8471	1231	1931	4731	7893	1365	2037	4780	8182
Cardiff & Vale	59	57	61	177	23	34	91	148	25	37	35	97	24	36	63	123
Cwm Taf Morgannwg	103	51	46	200	133	178	71	382	170	145	67	382	152	162	69	382
Hywel Dda	43	19	24	86	20	22	5	47	40	23	14	77	30	23	10	62
Powys	48	82	228	358	28	39	131	198	13	29	155	197	21	34	143	198
Swansea Bay	3	1	1	5	2	4	5	11	53	29	9	91	28	17	7	51
	1716	**2281**	**5308**	**9305**	**1705**	**2420**	**5132**	**9257**	**1532**	**2194**	**5011**	**8737**	**1619**	**2307**	**5072**	**8997**

Cardiff and Vale - UHW

	Current Baselines				2019/20				2020/21				2019/20 & 2020/21 Average Activity			
	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total
Aneurin Bevan	369	431	251	1051	463	350	186	999	216	388	162	766	340	369	174	883
Cardiff & Vale	1232	1808	2961	6001	1436	2360	3447	7243	1501	1856	3448	6805	1469	2108	3448	7024
Cwm Taf Morgannwg	437	627	528	1592	388	345	173	906	738	463	239	1440	563	404	206	1173
Hywel Dda	175	181	121	477	119	102	34	255	144	171	167	482	132	137	101	369
Powys	22	21	11	54		5	5	10	0	0	0	0	0	3	3	5
Swansea Bay	173	159	84	416	290	129	51	470	177	48	52	277	234	89	52	374
Total	**2408**	**3227**	**3956**	**9591**	**2696**	**3291**	**3896**	**9883**	**2776**	**2926**	**4068**	**9770**	**2736**	**3109**	**3982**	**9827**

CTM - Prince Charles

	Current Baselines				2019/20				2020/21				2019/20 & 2020/21 Average Activity			
	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total
Aneurin Bevan	33	68	421	522	19	76	368	463	13	79	306	398	16	78	337	431
Cardiff & Vale	17	35	179	231	0	7	47	54	0	15	56	71	0	11	52	63
Cwm Taf Morgannwg	350	458	3014	3822	118	697	2397	3212	111	535	1912	2558	115	616	2155	2885
Hywel Dda	4	3	13	20	0	3	2	5	0	0	0	0	0	2	1	3
Powys	0	2	14	16	1	13	48	62		9	20	29	1	11	34	46
Swansea Bay	3	4	19	26	0	16	28	44	2	18	55	75	1	17	42	60
Total	**407**	**570**	**3660**	**4637**	**138**	**812**	**2890**	**3840**	**126**	**656**	**2349**	**3131**	**132**	**734**	**2620**	**3486**

CTM - Princess of Wales

	Current Baselines				2019/20				2020/21				2019/20 & 2020/21 Average Activity			
	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total
Aneurin Bevan	0	2	12	14	0	4	21	25	0	0	0	0	0	2	11	13
Cardiff & Vale	4	45	91	140	6	51	142	199	1	3	19	23	4	27	81	111
Cwm Taf Morgannwg	57	409	1389	1855	52	307	1865	2224	57	418	1819	2294	55	363	1842	2259
Hywel Dda	0	15	42	57	0	4	19	23	0	0	0	0	0	2	10	12
Powys	1	1	7	9	0	0	1	1	0	0	5	5	0	0	3	3
Swansea Bay	25	139	752	916	6	27	189	222	4	15	157	176	5	21	173	199
Total	**87**	**611**	**2293**	**2991**	**64**	**393**	**2237**	**2694**	**62**	**436**	**2000**	**2498**	**63**	**415**	**2119**	**2596**

CTM - Combined Units

	Current Baselines				2019/20				2020/21				2019/20 & 2020/21 Average Activity			
	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total
Aneurin Bevan	33	70	433	536	19	80	389	488	13	79	306	398	16	80	348	443
Cardiff & Vale	21	80	270	371	6	58	189	253	1	18	75	94	4	38	132	174
Cwm Taf Morgannwg	407	867	4403	5677	170	1004	4262	5436	168	953	3731	4852	169	979	3997	5144
Hywel Dda	4	18	55	77	0	7	21	28	0	0	0	0	0	4	11	14
Powys	1	3	21	25	1	13	49	63	0	9	25	34	1	11	37	49
Swansea Bay	28	143	771	942	6	43	217	266	6	33	212	251	6	38	215	259
Total	**494**	**1181**	**5953**	**7628**	**202**	**1205**	**5127**	**6534**	**188**	**1092**	**4349**	**5629**	**195**	**1149**	**4738**	**6082**

Hywel Dda - Glangwilli

	Current Baselines				2019/20				2020/21				2019/20 & 2020/21 Average Activity			
	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total
Aneurin Bevan	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Cardiff & Vale	0	0	17	17	0	0	0	0	0	0	0	0	0	0	0	0
Cwm Taf Morgannwg	4	3	16	23	0	0	0	0	0	0	0	0	0	0	0	0
Hywel Dda	43	450	2522	3015	0	740	2367	3107	22	678	1863	2563	11	709	2115	2835
Powys	0	9	21	30	0	0	0	0	0	0	0	0	0	0	0	0
Swansea Bay	0	1	34	35	0	0		0	0	0	0	0	0	0	0	0
	48	**463**	**2610**	**3121**	**0**	**740**	**2367**	**3107**	**22**	**678**	**1863**	**2563**	**11**	**709**	**2115**	**2835**

Swansea Bay - Singleton

	Current Baselines				2019/20				2020/21				2019/20 & 2020/21 Average Activity			
	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total	NICU	HDU	SCBU	Total
Aneurin Bevan	44	9	9	62	40	25	23	88	7	5	47	59	24	15	35	74
Cardiff & Vale	31	5	21	57	1	13	20	34	18	8	1	27	10	11	11	31
Cwm Taf Morgannwg	330	186	72	588	536	464	81	1081	444	429	125	998	490	447	103	1040
Hywel Dda	458	425	476	1359	320	390	315	1025	450	723	269	1442	385	557	292	1234
Powys	32	53	72	157	14	59	46	119	62	120	80	262	38	90	63	191
Swansea Bay	769	940	2277	3986	685	1298	2294	4277	570	1137	1976	3683	628	1218	2135	3980
Total	**1664**	**1618**	**2927**	**6209**	**1596**	**2249**	**2779**	**6624**	**1551**	**2422**	**2498**	**6471**	**1574**	**2336**	**2639**	**6548**

Birth rates and projections – Office of National Statistics

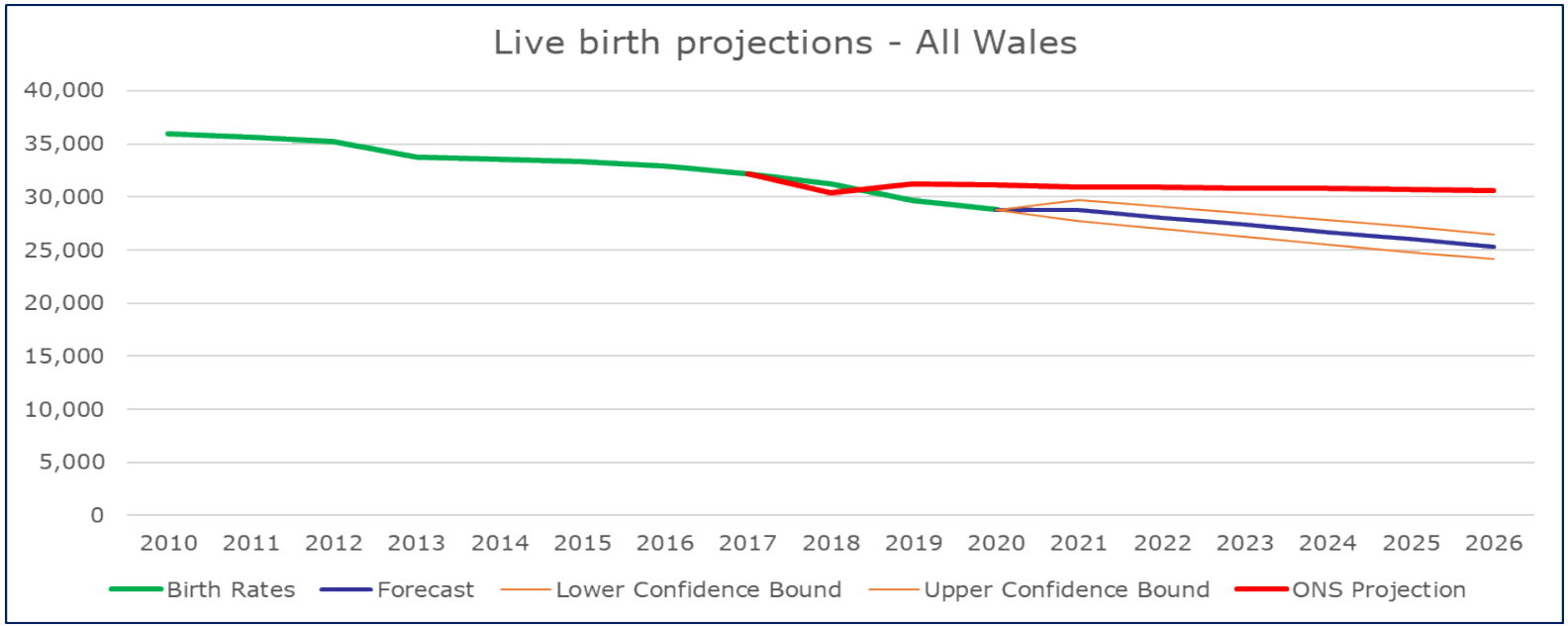


Table 1: births in Wales, by hospital and financial year 2019/20 to 2021/22

	2019/20		2020/21		2021/22	
Hospital	Live births	Still births	Live births	Still births	Live births	Still births
Breconshire War Memorial Hospital	35	0	29	0	34	0
Bronglais General Hospital	429	3	446	1	451	1
Builth Wells Cottage Hospital	1	0	0	0	0	0
Glangwili General Hospital	2447	8	2360	11	2381	10
Knighton Hospital	16	0	7	0	8	0
Llandrindod Wells Hospital	11	0	21	0	17	0
Llanidloes and District War Memorial Hospital	14	0	14	0	15	0
Montgomeryshire County Infirmary	32	0	30	0	36	0
Morriston Hospital	0	0	0	1	2	0
Neath Port Talbot Hospital	294	0	244	0	125	0
Nevill Hall Hospital	1839	6	1227	3	55	0
Prince Charles Hospital	2629	9	2483	11	2480	11
Princess of Wales Hospital	1894	10	1779	10	1893	6
Royal Glamorgan Hospital	170	0	48	0	156	0
Royal Gwent Hospital	3525	24	2104	5	98	0
Singleton Hospital	3232	14	3100	13	3352	19
The Grange University Hospital	0	0	1723	7	5126	26
University Hospital of Wales	5395	19	5253	19	5482	28
Victoria Memorial Hospital	24	0	21	0	28	0
Withybush General Hospital	189	0	154	0	122	0
Wrexham Maelor Hospital	2421	10	2243	10	2297	11
Ysbyty Aneurin Bevan	2	0	12	0	26	0
Ysbyty Glan Clwyd	2063	14	1896	6	2003	9
Ysbyty Gwynedd	1679	3	1654	4	1660	3
Ysbyty Ystrad Fawr	281	0	204	0	155	0
Not a hospital site	181	3	300	0	270	0
Null	1	0	4	0	0	0

Data source: maternity indicators data set

Standard	Calculation	WTE	Band
Medical Workforce Neonatal Unit			
Tier 1: Rotas should be EWTD compliant and have a minimum of 8 WTE staff*	1 in 8	8	• Medical staff at FY2 & ST1-3 • GPST 1-2 level (training and non-training) • Specialty doctor (up to threshold 1) • ENNPs • ANNPs • Physician Associates
Tier 2: EWTD compliant rota with a minimum of 8 WTE staff*.	1 in 8	8	• Medical staff at ST3-8 level (training and non-training) • Specialty doctor (post threshold 1) • ANNPs • Trained neonatal medical staff (Certificate of Completion of Training (CCT) holders)
Tier 3: Consultant neonatologists. Minimum of 7 WTE consultants on the on-call rota with 24/7 availability of a consultant neonatologist**.	1 in 7	7	
• Units with more than 7000 deliveries should have more than one Tier 1 medical support. • NICUs undertaking more than 2500 IC days per annum should augment their Tier 2 medical cover (more than one staff member per shift) and provide two consultant led teams during normal working hours. • Neonatal consultant staff should be available on site in all NICUs for at least 12 hours a day, generally expected to include two ward rounds/handovers. • For units undertaking more than 4000 IC days per annum, consideration should be given to 24-hour consultant presence. • All NICU consultants appointed from 2010 should have CCT in Neonatal Medicine.			
Medical Workforce Special Care Unit			

Tier 1: Rotas should be European working time directive (EWTD) compliant (58) and have a minimum of 8 whole-time equivalent (WTE) staff who may additionally cover paediatrics if this does not reduce safety and quality of care delivery***.	1 in 8	8	
There should be a resident Tier 1 practitioner dedicated to the neonatal service during weekday day-time hours and an immediately available resident Tier 1 practitioner 24/7***.			
Tier 2: Shared rota with paediatrics comprising a minimum of 8 WTE staff.	1 in 8	8	
Tier 3: A minimum of 7 WTE consultants on the on-call rota with a minimum of 1 consultant with a designated lead interest in neonatology****.	1 in 7	7	
**All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics.			
*** Tiers 1 and/or 2 may be able to be covered by appropriately skilled nursing staff.			
**** Tier 3 consultants should have a Certificate of CCT in paediatrics or Certificate of Eligibility for Specialist Registration (CESR) in paediatrics or an equivalent overseas neonatal or paediatric qualification. They must demonstrate knowledge, skills and CPD appropriate for the level of neonatal care through annual appraisal. Minimum of 1 consultant with a designated lead interest in neonatology, who should have completed a special interest (SPIN) module in Neonatology.			
Standard	**Calculation**	**WTE**	**Band**
Nursing Workforce			

Intensive Care - Due to the complex needs of both the baby and their family the ratio of neonatal nurses QIS to baby should be 1 nurse: 1 baby. This nurse should have no other managerial responsibilities during the time of clinical care but may be involved in the support of a less experienced nurse working alongside them in caring for the same baby.	6 WTE per cot		
High Dependency - The ratio of neonatal nurses QIS responsible for the care of babies requiring HD care should be 1 nurse: 2 babies. More stable and less dependent babies may be cared for by registered nurses not QIS, but who are under the direct supervision and responsibility of a neonatal nurse QIS.	3 WTE per cot		
Special Care - The ratio of nurses looking after SC babies should be at least 1 nurse: 4 babies. Registered nurses and non-registered clinical staff may care for these babies under the direct supervision and responsibility of a neonatal nurse QIS. Staffing in SC must be sufficient to ensure that discharge is properly planned and organised, including adequate support for parents.	1.5 WTE per cots		

Neonatal Outreach - Additional nursing staff to support parents at home must be resourced to achieve the national benchmark of reducing separation of mother and baby. Robust provision of outreach services has potential significantly to reduce in-patient stays. Formalised standards for neonatal outreach services have not been developed to date but we recommend that this should be available 7 days per week	3 WTE eqiuvelant nurses to ensure 12 hours a day 7 days a week		
Supernumerary Nurse - Day to day management of nursing care provision on NNUs should be undertaken by a senior nurse (generally Band 7 level) who has no clinical commitment during the shift (often referred to as the shift coordinator). This role may also include supporting other nurses during periods when additional workload impacts on their bedside caring time, e.g., during the acute period of admissions or the internal and external transfer of babies.	6 WTE to ensure day and night cover		
Allied Health Professional Workforce*			
Dietetics	ICU - 0.1 HD - 0.05 SC - 0.033		Minimum 7
Physiotherapy	0.05 per cot		Minimum 7
Occupational Therapy	0.05 per cot		Minimum 7
Speech and Language Therapy	ICU – 0.04 HD – 0.03		Minimum 7

	SC – 0.02		
Pharmacy	1.68WTE**		Band 7
Psychology	1WTE per 20 cots***		Band 8A
* all AHPs include an uplift for oureach with the exception of SaLT			
**7 day a week service this is for (1IC cot, 2HD cots and 4SCBU cots)			
***High risk units should have 1.2WTE			

Aneurin Bevan - The Grange

Standard	Calculation	WTE	Option 1	Option 2	Option 3	Option 4
Medical Workforce Neonatal Unit						
Tier 1	1 in 8	8	8	8	8	8
Tier 2	1 in 8	8	8	8	8	8
Tier 3	1 in 7	7	7	7	7	7

Nursing	Option 1		Option 2		Option 3		Option 4	
	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
NICU	5.87	35	6	36	6	36	6	42
HDU	7.81	23	8	24	9	27	9	32
SCBU	18.17	27	18	27	18	27	17	30
Outreach	-	3.0	-	3.0	-	3.0	-	3.0
Supernumerary	-	6	-	6	-	6	-	6
Total Nursing		95		96		99		112

AHP	WTE per cot	Option 1		Option 2		Option 3		Option 4	
		Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
Dietetics									
NICU	0.1	5.87	0.59	6	0.60	6.00	0.60	6.00	0.60
HDU	0.05	7.81	0.39	8	0.40	9.00	0.45	9.00	0.45
ScBU	0.033	18.17	0.60	18	0.59	18.00	0.59	17.00	0.56
Total Dietetics			1.58		1.59		1.64		1.61
Physio	WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
NICU	0.05	5.87	0.29	6	0.30	6.00	0.30	6.00	0.30
HDU	0.05	7.81	0.39	8	0.40	9.00	0.45	9.00	0.45
ScBU	0.05	18.17	0.91	18	0.90	18.00	0.90	17.00	0.85
Total physio			1.59		1.60		1.65		1.60
OT	WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
NICU	0.05	5.87	0.29	6	0.30	6.00	0.30	6.00	0.30
HDU	0.05	7.81	0.39	8	0.40	9.00	0.45	9.00	0.45
ScBU	0.05	18.17	0.91	18	0.90	18.00	0.90	17.00	0.85
Total OT			1.59		1.60		1.65		1.60
SALT	WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
NICU	0.04	5.87	0.23	6	0.24	6.00	0.24	6.00	0.24
HDU	0.03	7.81	0.23	8	0.24	9.00	0.27	9.00	0.27
ScBU	0.02	18.17	0.36	18	0.36	18.00	0.36	17.00	0.34
Total SALT			0.83		0.84		0.87		0.85
Pharmacists	WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
NICU		5.87		6		6.00		6	0.04
HDU		7.81		8		9.00		9	0.03
ScBU		18.17		18		18.00		17	0.02
Total Pharmacist			1.01		1.01		1.01		1.01
Psychology	WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
NICU		5.87		6		6.00		6	
HDU		7.81		8		9.00		9	

	ScBU		18.17		18		18.00		17	
	Total Psychology		31.85	1.59	32.00	1.60	33.00	1.65	32.00	1.60
* This is the required workforce for neonatal and paediatrics										
WHSSC are only responsible to fund the neonatal elements of the rota.										
Cardiff and Vale - CHfW										
	Standard	**Calculation**	**WTE**	**Option 1**	**Option 2**	**Option 3**	**Option 4**			
	Medical Workforce Neonatal Unit									
	Tier 1	1 in 8	8	8	8	8	8			
	Tier 2**	1 in 9	15	15	15	15	15			
	Tier 3	1 in 7	7	7	7	7	7			
	Nursing	Option 1		Option 2		Option 3		Option 4		
		Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE	
	NICU	8.24	49	10	60	10	60	11	66	
	HDU	11.05	33	11	33	12	36	12	36	
	SCBU	13.54	20	14	21	14	21	14	21	
	Outreach	-	3.0	-	3.0	-	3.0	-	3.0	
	Supernumerary	-	6	-	6	-	6	-	6	
	Total Nursing		112		123		126		132	
	AHP	WTE per cot	Option 1		Option 2		Option 3		Option 4	
			Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
Dietetics	NICU	0.1	8.24	0.82	10	1.00	10	1.00	11	1.10
	HDU	0.05	11.05	0.55	11	0.55	12	0.60	12	0.60
	ScBU	0.033	13.54	0.45	14	0.46	14	0.46	14	0.46
	Total Dietetics			1.82		2.01		2.06		2.16
Physio		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	0.05	8.24	0.41	10	0.50	10	0.50	11	0.55
	HDU	0.05	11.05	0.55	11	0.55	12	0.60	12	0.60
	ScBU	0.05	13.54	0.68	14	0.70	14	0.70	14	0.70
	Total physio			1.64		1.75		1.80		1.85
OT		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	0.05	8.24	0.41	10	0.50	10	0.50	11	0.55
	HDU	0.05	11.05	0.55	11	0.55	12	0.60	12	0.60
	ScBU	0.05	13.54	0.68	14	0.70	14	0.70	14	0.70
	Total OT			1.64		1.75		1.80		1.85
SALT		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	0.04	8.24	0.33	10	0.40	10	0.40	11	0.44
	HDU	0.03	11.05	0.33	11	0.33	12	0.36	12	0.36
	ScBU	0.02	13.54	0.27	14	0.28	14	0.28	14	0.28
	Total SALT			0.93		1.01		1.04		1.08
Pharmacists		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU		8.24		10		10		11	0.04
	HDU		11.05		11		12		12	0.03
	ScBU		13.54		14		14		14	0.02
	Total Pharmacist			1.01		1.01		1.01		1.01

Psychology		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU		8.24		10		10		11	
	HDU		11.05		11		12		12	
	ScBU		13.54		14		14		14	
	Total Psychology		32.83	1.97	35	2.10	36	2.16	37	2.22

**NICUs undertaking more than 2500 IC days per annum should augment their Tier 2 medical cover (more than one staff member per shift) and provide two consultant led teams during normal working hours.

CTM - PCH*

	Standard	Calculation	WTE	Option 1	Option 2	Option 3	Option 4
	Medical Workforce Neonatal Unit						
	Tier1	1 in 8	8	8	8	8	8
	Tier 2	1 in 8	8	8	8	8	8
	Tier 3	1 in 7	7	7	7	7	7

	Nursing	Option 1		Option 2		Option 3		Option 4	
		Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	1.39	8	0	0	1	6	0.54	3
	HDU	1.95	6	4	12	4	12	3.00	9
	SCBU	12.53	19	10	15	10	15	9.00	14
	Outreach	-	3.0	-	3.0	-	3.0	-	3.0
	Supernumerary	-	6	-	6	-	6	-	6
	Total Nursing		42		36		42		35

	AHP	WTE per cot	Option 1		Option 2		Option 3		Option 4	
			Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
Dietetics	NICU	0.1	1.39	0.14	0	0.00	1	0.10	0.54	0.05
	HDU	0.05	1.95	0.10	4	0.20	4	0.20	3.00	0.15
	ScBU	0.033	12.53	0.41	10	0.33	10	0.33	9.00	0.30
	Total Dietetics			0.65		0.53		0.63		0.50
Physio		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	0.05	1.39	0.07	0	0.00	1	0.05	0.54	0.03
	HDU	0.05	1.95	0.10	4	0.20	4	0.20	3.00	0.15
	ScBU	0.05	12.53	0.63	10	0.50	10	0.50	9.00	0.45
	Total physio			0.79		0.70		0.75		0.63
OT		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	0.05	1.39	0.07	0	0.00	1	0.05	0.54	0.03
	HDU	0.05	1.95	0.10	4	0.20	4	0.20	3.00	0.15
	ScBU	0.05	12.53	0.63	10	0.50	10	0.50	9.00	0.45
	Total OT			0.79		0.70		0.75		0.63
SALT		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	0.04	1.39	0.06	0	0.00	1	0.04	0.54	0.02
	HDU	0.03	1.95	0.06	4	0.12	4	0.12	3.00	0.09
	ScBU	0.02	12.53	0.25	10	0.20	10	0.20	9.00	0.18
	Total SALT			0.36		0.32		0.36		0.29
Pharmacists		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU		1.39		0		1		0.54	0.04
	HDU		1.95		4		4		3.00	0.03

	ScBU		12.53		10		10		9.00	0.02
	Total Pharmacist			1.01		1.01		1.01		1.01
Psychology		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU		1.39		0		1		0.54	
	HDU		1.95		4		4		3.00	
	ScBU		12.53		10		10		9.00	
	Total Psychology		15.87	0.79	14	0.70	15	0.75	13	0.63

CTM - POW*

	Standard	Calculation	WTE	Option 1	Option 2	Option 3	Option 4			
	Medical Workforce Neonatal Unit									
	Tier1	1 in 8	8	8	8	8	8			
	Tier 2	1 in 8	8	8	8	8	8			
	Tier 3	1 in 7	7	7	7	7	7			

	Nursing	Option 1		Option 2		Option 3		Option 4		
		Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE	
	NICU	0.3	2	0	0	1	6	0.25	2	
	HDU	2.09	6	2	6	2	6	2.00	6	
	SCBU	7.85	12	8	12	8	12	7.00	11	
	Outreach	-	3.0	-	3.0	-	3.0	-	3.0	
	Supernumerary	-	6	-	6	-	6	-	6	
	Total Nursing		29		27		33		27	

	AHP	WTE per cot	Option 1		Option 2		Option 3		Option 4	
			Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
Dietetics	NICU	0.1	0.3	0.03	0	0.00	1	0.10	0.25	0.03
	HDU	0.05	2.09	0.10	2	0.10	2	0.10	2.00	0.10
	ScBU	0.033	7.85	0.26	8	0.26	8	0.26	7.00	0.23
	Total Dietetics			0.39		0.36		0.46		0.36
Physio		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	0.05	0.3	0.02	0	0.00	1	0.05	0.25	0.01
	HDU	0.05	2.09	0.10	2	0.10	2	0.10	2.00	0.10
	ScBU	0.05	7.85	0.39	8	0.40	8	0.40	7.00	0.35
	Total physio			0.51		0.50		0.55		0.46
OT		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	0.05	0.3	0.02	0	0.00	1	0.05	0.25	0.01
	HDU	0.05	2.09	0.10	2	0.10	2	0.10	2.00	0.10
	ScBU	0.05	7.85	0.39	8	0.40	8	0.40	7.00	0.35
	Total OT			0.51		0.50		0.55		0.46
SALT		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	0.04	0.3	0.01	0	0.00	1	0.04	0.25	0.01
	HDU	0.03	2.09	0.06	2	0.06	2	0.06	2.00	0.06
	ScBU	0.02	7.85	0.16	8	0.16	8	0.16	7.00	0.14
	Total SALT			0.23		0.22		0.26		0.21
		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU		0.3		0		1		0.25	0.04

Pharmacists	HDU		2.09		2		2		2.00	0.03
	ScBU		7.85		8		8		7.00	0.02
	Total Pharmacist			1.01		1.01		1.01		1.01
		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
Psychology	NICU		0.3		0		1		0.25	
	HDU		2.09		2		2		2.00	
	ScBU		7.85		8		8		7.00	
	Total Psychology		10.24	0.51	10	0.50	11	0.55	9	0.46

Hywel Dda - Glangwili*

	Standard	Calculation	WTE	Option 1	Option 2	Option 3	Option 4			
	Medical Workforce Neonatal Unit									
	Tier 1	1 in 8	8	8	8	8	8			
	Tier 2	1 in 8	8	8	8	8	8			
	Tier 3	1 in 7	7	7	7	7	7			
	Nursing	Option 1		Option 2		Option 3		Option 4		
		Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE	
	NICU	0.16	1	0	0	1	6	0.09	1	
	HDU	1.59	5	4	12	4	12	3.00	9	
	SCBU	8.94	13	8	12	10	15	7.00	11	
	Outreach	-	3.0	-	3.0	-	3.0	-	3.0	
	Supernumerary	-	6	-	6	-	6	-	6	
	Total Nursing		28		33		42		29	

	AHP	WTE per cot	Option 1		Option 2		Option 3		Option 4	
			Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
Dietetics	NICU	0.1	0.16	0.02	0	0.00	1	0.10	0.09	0.01
	HDU	0.05	1.59	0.08	4	0.20	4	0.20	3.00	0.15
	ScBU	0.033	8.94	0.30	8	0.26	10	0.33	7.00	0.23
	Total Dietetics			0.39		0.46		0.63		0.39
		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
Physio	NICU	0.05	0.16	0.01	0	0.00	1	0.05	0.09	0.00
	HDU	0.05	1.59	0.08	4	0.20	4	0.20	3.00	0.15
	ScBU	0.05	8.94	0.45	8	0.40	10	0.50	7.00	0.35
	Total physio			0.53		0.60		0.75		0.50
		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
OT	NICU	0.05	0.16	0.01	0	0.00	1	0.05	0.09	0.00
	HDU	0.05	1.59	0.08	4	0.20	4	0.20	3.00	0.15
	ScBU	0.05	8.94	0.45	8	0.40	10	0.50	7.00	0.35
	Total OT			0.53		0.60		0.75		0.50
		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
SALT	NICU	0.04	0.16	0.01	0	0.00	1	0.04	0.09	0.00
	HDU	0.03	1.59	0.05	4	0.12	4	0.12	3.00	0.09
	ScBU	0.02	8.94	0.18	8	0.16	10	0.20	7.00	0.14
	Total SALT			0.23		0.28		0.36		0.23
		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE

Pharmacists	NICU		0.16		0		1		0.09	0.04
	HDU		1.59		4		4		3.00	0.03
	ScBU		8.94		8		10		7.00	0.02
	Total Pharmacist			1.01		1.01		1.01		1.01
Psychology		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU		0.16		0		1		0.09	
	HDU		1.59		4		4		3.00	
	ScBU		8.94		8		10		7.00	
	Total Psychology		10.69	0.53	12	0.60	15	0.75	10	0.50
Swansea Bay - Singleton										
	Standard	**Calculation**	**WTE**	**Option 1**	**Option 2**	**Option 3**	**Option 4**			
	Medical Workforce Neonatal Unit									
	Tier 1	1 in 8	8	8	8	8	8			
	Tier 2	1 in 8	8	8	8	8	8			
	Tier 3	1 in 7	7	7	7	7	7			
	Nursing	Option 1		Option 2		Option 3		Option 4		
		Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE	
	NICU	5.69	34	6	36	6	36	6	36	
	HDU	5.54	17	8	24	9	27	9	27	
	SCBU	13.55	20	10	15	8	12	9	14	
	Outreach	-	3.0	-	3.0	-	3.0	-	3.0	
	Supernumerary	-	6	-	6	-	6	-	6	
	Total Nursing		80		84		84		86	
	AHP	WTE per cot	Option 1		Option 2		Option 3		Option 4	
			Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
Dietetics	NICU	0.1	5.69	0.57	6	0.60	6	0.60	6	0.60
	HDU	0.05	5.54	0.28	8	0.40	9	0.45	9	0.45
	ScBU	0.033	13.55	0.45	10	0.33	8	0.26	9	0.30
	Total Dietetics			1.29		1.33		1.31		1.35
Physio		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	0.05	5.69	0.28	6	0.30	6	0.30	6	0.30
	HDU	0.05	5.54	0.28	8	0.40	9	0.45	9	0.45
	ScBU	0.05	13.55	0.68	10	0.50	8	0.40	9	0.45
	Total physio			1.24		1.20		1.15		1.20
OT		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	0.05	5.69	0.28	6	0.30	6	0.30	6	0.30
	HDU	0.05	5.54	0.28	8	0.40	9	0.45	9	0.45
	ScBU	0.05	13.55	0.68	10	0.50	8	0.40	9	0.45
	Total OT			1.24		1.20		1.15		1.20
SALT		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU	0.04	5.69	0.23	6	0.24	6	0.24	6	0.24
	HDU	0.03	5.54	0.17	8	0.24	9	0.27	9	0.27
	ScBU	0.02	13.55	0.27	10	0.20	8	0.16	9	0.18
	Total SALT			0.66		0.68		0.67		0.69

Pharmacists		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU		5.69		6		6		6	0.04
	HDU		5.54		8		9		9	0.03
	ScBU		13.55		10		8		9	0.02
	Total Pharmacist			1.01		1.01		1.01		1.01
Psychology		WTE per cot	Cots	WTE	Cots	WTE	Cots	WTE	Cots	WTE
	NICU		5.69		6		6		6	
	HDU		5.54		8		9		9	
	ScBU		13.55		10		8		9	
	Total Psychology		24.78	1.24	24	1.20	23	1.15	24	1.20

Report Title	**IPFR Engagement Update – ToR and All Wales Policy**	**Agenda Item**	3.7
Meeting Title	**Joint Committee**	**Meeting Date**	14/03/2023
FOI Status	Open		
Author (Job title)	Senior Project Manager		
Executive Lead (Job title)	Director of Nursing & Quality		

Purpose of the Report	The purpose of this report is to present the outcomes from the WHSSC engagement process with key stakeholders to update the WHSSC Individual Patient Funding Request (IPFR) Panel Terms of Reference (ToR) and on the specific and limited review of the All Wales IPFR Policy.				
Specific Action Required	RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☐	INFORM ☒

Recommendation(s):

Members are asked to:

- **Note** the report,
- **Note** the feedback received from the WHSSC engagement process with key stakeholders to update the WHSSC Individual Patient Funding Request (IPFR) Panel Terms of Reference (ToR) and on the specific and limited review of the All Wales IPFR Policy,
- **Approve** the proposed changes to the WHSSC IPFR Panel ToR,
- **Note** that the additional feedback on the specific and limited review of the All Wales IPFR Policy is being reviewed and an update will be presented to the Joint Committee on 16 May 2023; and
- **Note** that when the limited review of the policy is completed and approved by the Joint Committee, the updated All Wales IPFR Policy (including the WHSSC ToR) will go to each Health Board (HB) for final approval**.**

IPFR ENGAGEMENT UPDATE – TOR AND ALL WALES POLICY

1.0 SITUATION

The purpose of this report is to present the outcomes from the WHSSC engagement process with key stakeholders to update the WHSSC Individual Patient Funding Request (IPFR) Panel Terms of Reference (ToR) and the specific and limited review of the All Wales IPFR Policy.

2.0 BACKGROUND

2.1 IPFR Governance Framework

The All Wales IPFR Policy is an NHS Wales policy owned by each of the seven Health Boards (HBs) who have statutory responsibilities in relation to IPFR decisions. Each HB has its own HB IPFR Panel.

The WHSSC All Wales IPFR panel considers requests for treatment for rare or specialist conditions that fall within the service remit of WHSSC on behalf of NHS Wales. The terms of reference are outlined within the All Wales IPFR Policy.

2.2 Rationale for Review of the Policy Framework

On 28 July 2022, Welsh Government (WG) wrote to WHSSC and advised that a process of engagement for a specific and limited review of the All Wales IPFR policy wording and changes to the WHSSC IPFR Panel ToR should be undertaken. (A copy of this letter is attached as ***Appendix 1***). Following the engagement process, the amended Policy and new TORs, should be submitted to the Joint Committee for consideration, and then go to HBs for final approval in keeping with the previous approaches taken by WHSSC when making complex or contentious decisions and in keeping with the WHSSC Standing Orders (SOs).

WG also advised that any changes should be submitted to the Joint Committee for consideration and then go back to HBs for final approval. Any changes agreed with HBs should then be shared with WG. In addition, they advised that they fully supported a move to appoint a remunerated chair for WHSSC's IPFR panel and were agreeable to further discussions on this.

The WHSSC IPFR Panel is a sub-committee of the WHSSC Joint Committee, it is within its authority to update and approve the terms of reference (ToR).

2.3 Engagement Methodology for the Review

On the 6 September 2022, the Joint Committee (JC) approved the proposal for WHSSC to embark on an engagement process with key stakeholders, including the All Wales Therapeutics and Toxicology Centre (AWTTC), the IPFR Quality Assurance Advisory Group (AWTTC QAG), the Medical Directors and the Board Secretaries of each of the HB and Velindre University NHS Trust (VUNT), to

update the WHSSC IPFR Panel ToR and on the specific and limited review of the All Wales IPFR Policy.

On the 8 November 2022, the Joint Committee approved the methodology for engagement for WHSSC to embark on an engagement process, and were assured that the process adhered to the specific request from WG for the engagement for the IPFR panel ToR and the specific and limited review of the All Wales IPFR Policy.

This report presents the outcomes from the engagement process and requests that the Joint Committee approve the revised WHSSC IPFR Panel ToR and note the progress made to review the All Wales IPFR policy.

3.0 ASSESSMENT

3.1 Stakeholder Engagement Process

The stakeholder engagement process was undertaken between the 10 November 2022 to 22 December 2022, and the consultation documentation was issued to a broad range of stakeholders including the WHSSC IPFR panel, the AWTTC QAG, the NHS Wales IPFR Policy Implementation Group (PIG), the Medical Directors and the Board Secretaries of each of the HB, WG and VUNT.

3.1.1 Stakeholder Engagement Workshop

To support the engagement process a hybrid stakeholder event was held on the 2 December 2022 in Cardiff with a mix of in person and virtual attendance.

Due to the complexities of the proposed changes to the All Wales IPFR Policy, David Locke KC, who was involved in the judicial review concerning "Maria Wallpott –v- WHSSC & ABUHB" in December 2021, was in attendance to present the rationale for the changes based on the judgment handed down. This enabled stakeholders to discuss the legal technicalities and the proposed changes directly with the KC.

3.1.2 Engagement Briefings

As part of the engagement process briefings and discussions were held including:

- WHSSC IPFR Team & WHSSC Director of Nursing discussing with the IPFR PIG And IPFR QAG,
- WHSSC Medical Director updating the NHS Wales Medical Directors peer group,
- WHSSC Committee Secretary updating the NHS Wales Board Secretaries peer group; and
- WHSSC Chair and Committee Secretary discussing the engagement exercise and the recruitment of a substantive IPFR Chair and potential remuneration with Welsh Government.

3.1.3 Stakeholder Feedback

Feedback was received from all HBs, the AWTTC, and individual IPFR Panel members. The feedback from HBs and the AWTTC was co-ordinated by the IPFR Policy Implementation Group (PIG) and as such the comments received were consistent across all HBs.

3.2 WHSSC IPFR Panel ToR

A summary of the main key themes from the engagement process on the proposed changes to the WHSSC IPFR Panel ToR is presented at ***Table 1***. The full responses are presented at ***Appendix 2*** for information.

Table 1 – Key Themes Identified from the feedback on the WSSC IPFR Panel ToR

Theme	WHSSC Response
1.WHSSC Staff in attendance at Panel Meetings Comments were received in regards to the changes made to the WHSSC Staff in attendance at the panel meetings, with a recommendation made to include a finance advisor and pharmacist as and when required to be in line with HB's Panel The need for a Corporate Governance Manager in attendance was questioned.	The document has been updated to include the finance advisor. Unlike the situation in HBs, the vast majority of IPFRs submitted to WHSSC are for non-medicines. In addition, WHSSC does not have a Pharmacist available to attend panels, however there is access to an expert in evidence evaluation who supports the Panel as needed. The requirement for a pharmacist therefore has not been included The IPFR Panel of WHSSC is formally constituted as a sub-committee of the WHSSC Joint Committee. Each of the Joint Committee's sub-committees is supported by a governance advisor (Committee Secretary or Head of Corporate Governance). This ensures that the Chair and members can seek advice and support on any aspect related to the conduct of their role, and to ensure that the sub-committee's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner, e.g. declarations of interest. Therefore, the reference to the Head of Corporate

Theme	WHSSC Response
	Governance being in attendance remains in the WHSSC ToR.
2.Quoracy The reduction in the number of Health Boards to maintain quoracy was accepted but Health Boards comment on the need for all clinical members, suggesting that a quorate number of clinical members is required but not limit this to just clinical representatives and consider the merits of other staff who may have better policy or financial understanding Lay person included in quoracy was considered to be problematic. And HB suggested that whilst recognising the value Lay members bring that they should not be included in quoracy.	WHSSC recognises the merits of other staff who may have better policy or financial understanding. This proposal aligns the WHSSC panel membership more closely with the current HB Panel membership. In keeping with HB Panel membership non-clinical representatives are there in attendance. No changes have therefore been made to document. The WHSS team have carefully considered this point and taken into account membership of equivalent Panels in NHS England as well as the WG commitment to patient and public involvement in NHS processes. We have therefore taken the view that the lay member should be integral to the panel and therefore should be required for quoracy. However, we recognise the points raised by stakeholders and the requirement for the lay person to be in attendance for quoracy has been removed from this version of the ToRs. WHSSC will therefore undertake further work on how this could be achieved, in order that it can be included in future versions of the ToRs.
Training All Health Boards noted the need for training for IPFR Panel members but this needed to be developed at an all wales level. Rewording was suggested	The ToRs have been amended to reflect the current position and further discussions will take place with HB's and the AWTTC regarding how this can be further developed.
Process for clinically urgent cases	The wording in the proposed ToRs is unchanged from that set out in the

Theme	WHSSC Response
All Health Boards challenged the process for Clinically urgent cases in that the ToR state: *Where possible a virtual panel will be held to consider urgent cases. If this is not possible due to the urgency of the request or availability of panel members, then the Managing Director of Specialised and Tertiary Services with either the Medical Director or the Director of Nursing Quality and the Chair (or Vice Chair) of the WHSSC Panel are authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits, on behalf of the Panel.* Health Boards suggest replace with: *Where possible a virtual panel will be held to consider urgent cases. If this is not possible due to the urgency of the request or availability of panel members then the IPFR Panel Chair will make a Chairs Action decision which is supported and advised by core panel members with a clinical background, outside of a full meeting of the panel, within their delegated financial limits."*	current WHSSC ToR and aligns to the WHSSC SFIs. Within the WHSSC Financial Scheme of Delegation, the WHSSC IPFR Chair/Vice Chair does not have any financial delegated limit. The WHSSC Medical Director and Director of Nursing do not have sufficient delegated financial authority.

The WHSSC Team have considered all of the comments received and have addressed each individually, and made changes to the ToR as appropriate - see ***Appendix 3***.

3.3 All Wales IPFR Policy

In January 2023, a meeting was held with the IPFR PIG Group to review the comments received regarding the All Wales IPFR Policy. WHSSC are working in conjunction with the PIG to review the feedback and to revise the policy and an update report will be presented to Joint Committee in May 2023.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report,
- **Note** the feedback received from the WHSSC engagement process with key stakeholders to update the WHSSC Individual Patient Funding Request

(IPFR) Panel Terms of Reference (ToR) and on the specific and limited review of the All Wales IPFR Policy,

- **Approve** the proposed changes to the WHSSC IPFR Panel ToR; and
- **Note** that the additional feedback on the specific and limited review of the All Wales IPFR Policy is being reviewed and an update will be presented to the Joint Committee on 16 May 2023; and
- **Note** that when the limited review of the policy is completed and approved by the Joint Committee, the updated All Wales IPFR Policy (including the WHSSC ToR) will go to each Health Board (HB) for final approval**.**

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	**No**
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.
NHS Delivery Framework Quadruple Aim	The health and social care workforce is motivated and sustainable Choose an item. Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	An Individual Patient Funding Request (IPFR) is the process Health Boards (HBs) and the Welsh Health Specialised Services Committee (WHSSC) use to consider providing a patient with a treatment, which is not routinely available in NHS Wales. The IPFR Quality Assurance Group (QAG) monitor the quality of the decisions made by HBs and WHSSC concerning IPFR decisions.
Finance/Resource Implications	The financial resource implication concerning remuneration of the Chair is under discussion.
Population Health	No adverse implications relating to population health have been identified.
Legal Implications (including equality & diversity, socio economic duty etc)	The purpose of the WHSSC IPFR Panel is to act as a Sub Committee of WHSSC 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 Governance framework for the WHSSC IPFR panel is outlined within the "All NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR)", published in June 2017, which includes specific terms of reference (ToR) for the WHSSC IPFR panel.
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	16 February 2023 – CDGB supported. 8 November 2022 – Joint Committee - approved the methodology for engagement for WHSSC to embark on an engagement process 6 September 2022 – Joint Committee approved the proposal for WHSSC to embark on an engagement process 12 July 2022 – IPFR update 10 May 2022 - IPFR update 15 March 2022 - IPFR update 17 January 2023 - IPFR update
Appendices	Appendix 1 – AE NP Letter to SL re IPFR ToR July 2022 Appendix 2 - Responses to the IPFR Stakeholder Engagement Exercise Appendix 3 - Proposed Amendment to the WHSSC All Wales IPFR Panel ToR post engagement

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health and Social Services Group
Cangen Fferylliaeth a Rhagnodi
Pharmacy & Prescribing Branch

Llywodraeth Cymru
Welsh Government

Dr Sian Lewis
Managing Director
Welsh Health Specialised Services Committee

By email to: Jacqueline.evans8@wales.nhs.uk

28 July 2022

Dear Sian,

Re: WHSSC Individual Patient Funding Request (IPFR) Panel – Terms of Reference

Further to your letters of 1 April and 23 May, our meeting on 10 May, and the subsequent discussion with health board (HB) and NHS Trust Medical Directors on 1 July, this letter sets out a proposal for addressing the issues you have raised in relation to the operation of the Welsh Health Specialised Services Committee's Individual Patient Funding Request (IPFR) Panel and the review of the NHS Wales Policy Making Decisions on Individual Patient Funding Requests (IPFR) ("The IPFR Policy").

We are broadly in agreement that the current IPFR policy on the whole works well. Since introducing the policy in 2017 there has been a significant reduction in the number of IPFR requests made to NHS organisations and an increasing proportion of requests are approved. These measures indicate the IPFR policy is working for patients and their clinicians, and this is supported by the findings of the quality assurance processes put in place to support the policy.

That said, we note 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 treatment was quashed by the court. Subsequently, legal advice has indicated the IPFR policy is now to be interpreted in such a way that is contrary to the original policy intention and the IPFR policy would need to be updated if its original and intended meaning was to be reinstated.

Review of the All NHS Wales IPFR policy

We have taken the opportunity to revisit the findings of the independent review of the IPFR process and the report published by Welsh Government in 2017 which states (emphasis added):

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Caerdydd • Cardiff
CF10 3NQ

Ffôn • Tel: 0300 0615 919
Pharmacyand.PrescribingBranch@gov.wales
Gwefan • website: www.wales.gov.uk

"6. The patient's clinical circumstances should be considered in comparison with other patients with the same condition and at the same stage in the progression of that condition.

7. 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. For a patient to be significantly different, their particular clinical presentation was unlikely to have been considered as being part of the population for which the policy was made."

This accords with your interpretation of the policy and strengthens the arguments for revisions to the wording of the IPFR policy to put beyond doubt how the policy should be interpreted. To that end we are content to agree a *de minimis* review of the IPFR policy subject to the conditions set out below.

- The IPFR Policy is an NHS Wales' policy owned by each of the HBs who have statutory responsibilities in relation to IPFR decisions. The outcome of any review must therefore be agreed by each of the HBs; retaining an all-Wales approach to IPFR decisions is of primary importance given reducing variability in decision making has been a key success of the policy; and

- WHSSC is constituted as a sub-committee of all seven HBs and its Joint Committee (JC) can delegate certain activities to WHSSC directors as described in section 3.3.1 of the WHSSC Standing Orders (SO's). On this basis, it was agreed at the All Wales Medical Directors Group (AWMDG) meeting, at which you were in attendance, that a de-minimis review with comprehensive stakeholder engagement could be taken forward by the WHSSC team. It was also agreed that this should report into WHSSC's JC but with final approval being sought from HBs in keeping with the previous approach taken by WHSSC when making complex or contentious decisions and in keeping with WHSSC's SOs.

Terms of Reference (ToR) of the All Wales IPFR Panel

The All Wales IPFR Panel is a sub-committee of the WHSSC JC and therefore it is within its authority to update and approve the terms of reference (ToR).

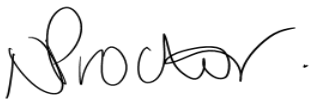
As agreed at the AWMDG meeting a process of engagement for both the de-minimis review of the Policy wording and the changes to the ToR should be undertaken with key stakeholders including the All Wales Therapeutics a Toxicology Centre IPFR Quality Assurance Advisory Group (AWTTC QAG), the Medical Directors and the Board Secretaries of each of the HBs and Velindre University NHS Trust (VUNT).

Following the engagement process, an amended Policy and new TORs should be submitted to the JC for consideration, and then go to HBs for final approval. Finally, we would ask you share any changes, agreed with HBs, with us prior to their adoption. As we discussed we would fully support moves to appoint a remunerated chair for WHSSC's IPFR panel and would be happy to discuss this with you in the future.

We trust the letter provides a clear outline of next steps, however if you have any queries, please do not hesitate to contact us directly.

Given the implications for HBs we are copying this letter to Chief Executives, Medical Directors, Directors of Public Health, Board Secretaries/ Directors of Corporate Governance and the AWTTC QAG, all of whom will have an interest.

Yours sincerely



Andrew Evans
Prif Swyddog Fferyllol/ Chief Pharmaceutical Officer

Natalie Proctor
Pennaeth y Gangen Fferylliaeth a Rhagnodi/ Head of Pharmacy & Prescribing

Cc:

Chief Executives, Health Boards
Medical Directors, Health Boards
Directors of Public Health
Board Secretaries, Health Boards
All Wales Therapeutics and Toxicology Centre IPFR Quality Assurance Group

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

Engagement on draft WHSSC IPFR Panel Terms of Reference Review
Stakeholder comments table December 2022

Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
1.	**Panel Lay person**	1	27	2	Two lay members suggested, agree. I agree that ideally there should be one 'lay' and one perhaps with some background in health care. Definitions of lay members are not clear. I see myself as a lay member? I.e., I am not currently a healthcare worker, and I am no longer registered as a health professional, I am retired. Should the rules state that one lay member must have a healthcare background? Also, in the future some financial compensation for lay members should be considered. Some NHS panels pay lay members for attendance. I was appointed with a clear understanding the role was not paid. However, I think the demands are considerable. I spend at least 4-6 hours reading the papers before the meeting. This should be made clear to applicants. Should lay members be counted in quoracy? I am often the only lay member present? Can the meeting go ahead if no lay member present?	**Thank you for your comments** These issues are important and will be given consideration outside of this consultation.
2.			25	2	In my experience having a medically qualified Chairperson brought distinct advantages to the panel. I found that the discussion was more robust and logical when a medical profession	Comments noted

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

Engagement on draft WHSSC IPFR Panel Terms of Reference Review
Stakeholder comments table December 2022

Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
					chaired. Ruth Alcolado brought clarity and logic to the decision-making process. I also felt appreciated, I was thanked for my comments.	
3.	**Gail Woodland on behalf of AWTTC QAG**	general			Suggest TOR retained as an appendix in main document, would need to ensure consistency with formatting across HBs and WHSSC TORs so they look similar.	**Thank you for your comments**. The document was separated only for ease of consultation and will be included within the policy as is the case now. The format of the revised WHSSC document is considered to be more detailed and therefore would propose this format is used for main policy
4.		1	29	2	Consider whether there is a quorate number of clinical members overall, not just from the HB panels, as this may be harder to attain quoracy. Consider merits of having other staff who may have for example, better policy or financial understanding that would benefit the discussion at WHSSC panel.	WHSSC recognises the merits of other staff who may have better policy or financial understanding. This proposal aligns the WHSSC panel membership more closely with the current HB Panel membership. In keeping with HB Panel membership non-clinical representatives are there in attendance.

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

Engagement on draft WHSSC IPFR Panel Terms of Reference Review
Stakeholder comments table December 2022

Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
						No changes have therefore been made to document.
5.		1	31	2	Unclear what see below is referring to.	This refers to the appointment of other members at the discretion of the Chair. Noting that there may not always be a someone in this post, the section has been amended
6.		2	1	2	Consider adding in a finance member here	Finance member has been included
7.		2	2	2	Unlikely to be replicated across HBs. If the policy is clear this member may not be needed.	Each of the Joint Committee's sub-committees is supported by a governance advisor (Committee Secretary or Head of Corporate Governance) to ensure that the Chair and members can seek advice and support on any aspect related to the conduct of their role, and to ensure that the sub-committees decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner, e.g. declarations of interest. Therefore, it is proposed that the reference to the Head of Corporate Governance being in

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

Engagement on draft WHSSC IPFR Panel Terms of Reference Review
Stakeholder comments table December 2022

Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
						attendance remains in the WHSSC ToR.
8.		2	3	2	To clarify function of these staff at the meeting. Does this relate to lines 10-12? Or perhaps add: to clarify on policy position. As assume this would be their main role?	Section amended to reflect comments and to aid documents flow
9.		2	4-6	2	Is this covered by lines 10-12?	Lines 10 – 12 are staff who may be required for specific panel discussion but would not normally be expected to be in attendance
10.		2	21	3	Add: or vice chair(s)	Vice chair added
11.		2	21	3	Lay attendance can be problematic and is an issue for HBs at present. This is something the QA group is trying to help with. However, not withstanding what they bring to the role, it may be better to not put the additional pressure of having a lay as a quorate member. Would encourage this as good practice.	The WHSS team have carefully considered this point and taken into account membership of equivalent Panels in NHS England as well as the WG commitment to patient and public involvement in NHS processes. We have therefore taken the view that the lay member should be integral to the panel and therefore should be required for quoracy. However, we recognise the points raised by stakeholders and the requirement for the lay person to be in attendance for

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						quoracy has been removed from this version of the ToRs. WHSSC will therefore undertake further work on how this could be achieved in order that it can be included in future versions of the ToRs.
12.		2	26	3	Suggest length of meeting is operational and not policy.	Document amended. Length of meeting removed
13.		3	6-9	3.5	Suggest that any decisions should be reached by consensus as per rationale included in the main document.	The WHSS team cannot locate a section on consensus in the current All Wales IPFR Policy. However, taking on board the feedback from stakeholders the wording has been revised to reflect comments and the need to vote removed.
14.		3	14 (and 17-18)	3.6	Suggest that any use of transcripts is done at a local level as needed and not included as part of the policy as this adds an onus on the group and a layer of additional complexity. Also would need to consider whether this would have to be kept for 6 years as part of the retention of records.	Section amended to reflect comments. The need for recording for transcription purposes removed from ToR
15.		3	15-16	3.6	Consider whether this is operational rather than mandated though the policy.	Section amended and lines removed

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16.		3	19	3.6	National IPFR database.	Wording amended to reflect comments
17.		3	22-23	4	The IPFR QA group are keen to support any training initiatives but this has not formally been agreed and would need to be developed and subsequently approved.	The WHSSC team feel that this is an important element for panel members and would value further discussions on how this could be developed and implemented more formally. Section revised as per other stakeholder comments
18.		3	26	4	We would very much welcome attendance at training events but suggest may be better to say 'have the opportunity'	Wording revised to reflect comments
19.		3	34	5	Unclear as to why this has such a short review time, given that the policy could be reviewed more frequently than three years for any minor changes such as updates to TORs. It is suggested that this is reviewed in line with the policy to ensure consistency.	The review time was considered and thought appropriate given the proposed changes. However the document has been updated to reflect that the review will take place alongside the policy
20.	**Fraser Campbell/Sarah Davies** **BCUHB**	general			**Structure** The Terms of Reference for WHSSC Panel should be presented in the same structure as that for HB Panels, for consistency across NHS Wales.	**Thank you for your comments**. The format of the revised WHSSC document is considered to be more detailed and therefore would propose

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						this format is used for main policy
21.		General			**Status** The Terms of Reference for WHSSC Panel should remain as an appendix within the main Policy, for consistency across NHS Wales.	The document was separated only for ease of consultation and will be included within the policy as is the case now
22.		1	12+	1	Panel Purpose has been edited down & 3 paragraphs have been removed from the original IPFR Policy document. These are retained for the HB Panel Terms of Reference and should be reinstated within the WHSSC Terms of Reference for consistency across NHS Wales. Any amendments should be applied to all Panel Terms of Reference, for consistency across NHS Wales.	Section amended and the 3 original paragraphs added
23.		1	30		HB Vice Chair – Is this role proposed to be drawn from the pool of 7 IPFR Panel Chairs, or an additional core member. If from the pool, can they be appointed on attendance, or is 1 person intended to be named as an appointed Vice Chair?	The intention would be to draw from within and have a named individual appointed to the role as Vice Chair
24.		1	30		2nd Vice Chair –It does not seem logical to have a Vice Chair from a discretionary role, as they may not always be in post.	This section has been amended to include 2 vice chairs from panel membership
25.		2	20	3.1	Quoracy - re-word for clarity. Would also suggest	

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					• re-instate the statement 'Chair or Vice-Chair'; proposed quoracy is limiting if the named Chair is always required • remove the need for a lay-person, as this would limit convening a quorate Panel at short notice	Statement re-instated. The WHSS team have carefully considered this point and taken into account membership of equivalent Panels in NHS England as well as the WG commitment to patient and public involvement in NHS processes. We have therefore taken the view that the lay member should be integral to the panel and therefore should be required for quoracy. However, we recognise the points raised by stakeholders and the requirement for the lay person to be in attendance for quoracy has been removed from this version of the ToRs. WHSSC will therefore undertake further work on how this could be achieved in order that it can be included in future versions of the ToRs.
26		2	25	3.2	Remove the time limit statement, this is operational and unnecessary.	section removed

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27.		2	32	3.3	The proposal as worded allows for urgent decisions to be considered by the Managing Director of Specialised and Tertiary Services, with support from nominated Panel Members. The Managing Director is not a core IPFR Panel Member and therefore should not be able to influence Panel decisions. Urgent Cases should be determined by nominated role(s) from the core Panel membership, for consistency across NHS Wales. This is typically the Panel Chair and Vice Chairs.	The wording in the proposed ToRs is unchanged from that set out in the current WHSSC ToR and aligns to the WHSSC SFIs. Within the WHSSC Financial Scheme of Delegation, the WHSSC IPFR Chair/Vice Chair does not have any financial delegated limit. The WHSSC Medical Director and Director of Nursing do not have sufficient delegated financial authority.
28.		3	2+	3.4	This section has been added. It is standard practice for formal meetings and not specifically required for IPFR Panels. If deemed significant, this should be added to the Terms of Reference for all IPFR Panels within the NHS Wales Policy, for consistency across NHS Wales	Comments noted and considered but no change to document as considered importance from a governance point of view. It is for the HB's to review and consider any changes to their ToR
29.		3	5+	3.5	This section has been added. In practice, IPFR Panels will reach a consensus, so this section is not necessary. If deemed significant, this should be added to the Terms of Reference for all IPFR Panels	Comments noted and considered. Wording revised to remove the reference to a vote but section retained.

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					within the NHS Wales Policy, for consistency across NHS Wales	It is for the HB's to review and consider any changes to their ToR
30.		3	11	3.6	Remove 1st sentence, not required. This is operational / administrative and covered within the main IPFR Policy.	Sentence removed
31.		3	14 & 17-18	3.6	Recordings have not been required previously and should not be mandatory. Full transcripts of meetings are not required. If deemed significant, this should be added to the Terms of Reference for all IPFR Panels within the NHS Wales Policy, for consistency across NHS Wales. Compliance with Information Governance legislation should determine the correct retention period for any recordings held.	This section has been amended and the need to mandate transcripts removed
32.		3	21+	4	This section has been added. If deemed significant, this should be added to the Terms of Reference for all IPFR Panels within the NHS Wales Policy. AWTTC should be consulted regarding the development of a suitable induction programme and the administration of its rollout across all IPFR Panel members. This proposal should be fully costed before being include within the Policy.	The WHSS team feel that this is an important element for panel members and would value further discussions on how this could be developed and implemented more formally The section has been amended to reflect comments from stakeholders

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33.		3	34	5	This section has been added. These Terms of Reference should be part of the main IPFR Policy, with review cycles set consistently for all Panels.	The review time was considered and thought appropriate given the changes. However the document has been updated to reflect that the review will take place alongside the policy.
34	**James Calvert, MD Ann-Marie Matthews ABUHB**	general			Suggest TOR retained as an appendix in main document.	**Thank you for your comments** The document was separated only for ease of consultation and will be included within the policy as is the case now.
35.		General			The same format/structure should be used for the WHSSC TOR as those for the Health Boards to ensure consistency.	The format of the revised WHSSC document is considered to be more detailed and therefore would propose this format is used for main policy
36.		General			As a general observation, the panel membership proposed seems stricter, therefore the feasibility of those members suggested attending has been questioned.	Comments noted
37.		1	14	1.1	Should read – the IPFR Panel – for clarity.	Section amended and IPFR added for clarity

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38.		1	29	2	Suggest that a quorate number of clinical members is required, and not limit this to just clinical representatives, as this renders it harder to attain quoracy. Consider merits of having other staff who may have for example, better policy or financial understanding that would benefit the discussion at WHSSC panel.	WHSSC recognise the importance and value of other staff. The proposal was to bring WHSSC panel members more in line with the current Health Board Panel Members which in the main are clinical other than those in attendance Comments noted and considered. No change
39.		1	31	2	What is meant by a 'discretionary' panel member.	This is referring to the Chairs discretion to appoint additional 2 panel members for example a member of an ethics panel. This is as stated in the current HB and WHSSC Panel ToR. Amendment made to wording for clarity
40.		2	2	2	The wording in the current TOR should be reinstated – finance advisor if required and senior pharmacist of required.	Finance Advisor has been included WHSSC does not have a Pharmacist available to attend panels, however there is access to an expert in evidence evaluation who supports the Panel as needed.

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					The relevance for a Corporate Governance Manager in attendance is questioned, unless WHSSC are not content that panel members are adhering to policy- this should then be regarded as a training issue. Where possible consistency for those in attendance should be retained across HBs and WHSSC. This role is unlikely to be attendance at IPFR panels in HB's.	The requirement for a pharmacist therefore has not been included Each of the Joint Committee's sub-committees is supported by a governance advisor (Committee Secretary or Head of Corporate Governance) to ensure that the Chair and members can seek advice and support on any aspect related to the conduct of their role, and to ensure that the sub-committees decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner, e.g. declarations of interest. Therefore, it is proposed that the reference to the Head of Corporate Governance being in attendance remains in the WHSSC ToR.
41.		2	3	2	Remove this bullet point as lines 10-12 would cover this.	Lines 10 – 12 are staff who may be required for specific panel discussion but would not normally be expected to be in attendance

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42.		2	4-6	2	Again, this is covered in lines 10-12.	As above
43.		2	20	3.1	Suggest stating that the panel will be quorate if 4 of the 7 Health Boards representatives (3 of which must be clinical). See point 4 above.	This proposal aligns the WHSSC panel membership more closely with the current HB Panel membership. In keeping with HB Panel membership non-clinical representatives are there in attendance. No changes have therefore been made to document.
44.		2	21	3.1	Add in 'or Vice Chair' after Chair	Vice Chair added
45.		2	21	3.1	Remove 'lay person' from the quoracy. Whilst recognition is given to the role they play, it can be difficult to recruit. Lay representatives are encouraged as good practice but should not form part of the quoracy. This should also be consistently applied for the HB TOR.	The WHSS team have carefully considered this point and taken into account membership of equivalent Panels in NHS England as well as the WG commitment to patient and public involvement in NHS processes. We have therefore taken the view that the lay member should be integral to the panel and therefore should be required for quoracy. However, we recognise the points raised by stakeholders and the requirement for the

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						lay person to be in attendance for quoracy has been removed from this version of the ToRs. WHSSC will therefore undertake further work on how this could be achieved in order that it can be included in future versions of the ToRs.
46.		2	25-26	3.2	The length of time a meeting takes is an operational issue and should not be stated in the policy.	Section amended and reference to length of time removed
47.		3	6-9	3.5	Suggest that any decisions should be reached by consensus as per rationale included in the main document.	The WHSS team cannot see any reference to reaching a consensus in the current main document. Wording has been revised to reflect comments and the need to vote removed
48.		3	11-13	3.6	Reinstate the wording from the existing TOR. Note – Standardised letters and decision record templates are in place and WHSSC should be encouraged to adopt these for use going forward to maintain consistency across Wales.	Wording amended to reflect comments
49.		3	14	3.6	Suggest that any use of transcripts is done at a local level as needed and not included as part of the policy as this	This section has been amended and the need for

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					adds an onus on the group and a layer of additional complexity. Would need to consider whether this would have to be kept for 6 years as part of the retention of records.	record for transcription purposes
50.		3	15-16	3.6	Consider whether this is operational rather than mandated though the policy.	This section has been amended to reflect comments
51.		3	22-25	4	This needs to be formally developed and agreed at an All-Wales level. Suggest removing until this has been done.	Section amended to reflect comments
52.		3	26-28	4	Re-word to – *All Panel members will receive a local induction and will have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively*.	Section amended to reflect comments
53.		3	29-31	4	Remove this section	Section removed
54.		3	34	5	Unclear as to why this has such a short review time, given that the policy could be reviewed more frequently than three years for any minor changes such as updates to TORs. It is suggested that this is removed because its covered in the IPFR policy document.	The review time was considered and thought appropriate given the changes. However the document has been updated to reflect that the review will take place alongside the policy
55.	**Melanie Wilkey C&VUHB**	General			We don't mind if the ToRs are separated from the policy as it means they can be updated independently from the policy and without the same level of	**Thank you for your comments** The document was separated only for ease of consultation

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					consultation and engagement. It would be helpful to have consistency across the ToRs.	and will be included within the policy as is the case now The format of the revised WHSSC document is considered to be more detailed and therefore would propose this format is used
56.		1	12+	1	The IPFR Panel Purpose has been edited down, 3 paragraphs have been removed from the original IPFR Policy document. These are retained for the HB Panel terms of reference which brings inconsistency between the WHSSC and HB ToRs. It would be helpful to have consistency across the ToRs.	Section amended and the 3 original paragraphs added
57.		1	14	1.1	Re-insert the acronym "*IPFR*" – "*The IPFR Panel cannot.*"	Section amended and IPFR added for clarity
58.		1	27	2	Lay panel members have been moved from 'in attendance' to core members. If we want consistency across the ToRs, then we need to be mindful that some LHBs struggle to recruit lay members.	The WHSS team have carefully considered this point and taken into account membership of equivalent Panels in NHS England as well as the WG commitment to patient and public involvement in NHS processes. We have therefore taken the view that the lay member should be integral to the panel and therefore should be required for quoracy.

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						However, we recognise the points raised by stakeholders and the requirement for the lay person to be in attendance for quoracy has been removed from this version of the ToRs. WHSSC will therefore undertake further work on how this could be achieved in order that it can be included in future versions of the ToRs.
59.		2	1-3	2	The members in attendance is no longer consistent with the Health Board ToR. '*Finance advisor if required*' has been removed from the existing ToR, suggest this should remain, especially in relation to the discussions regarding value for money.	It is noted that the current WHSSC and HB ToR are not consistent in regards to membership. This proposal aligns the WHSSC panel membership more closely with the current HB Panel membership. In keeping with HB Panel membership non-clinical representatives are there in attendance. The requirement for a fiancé member to be in attendance has been included but no changes have therefore been made to document.

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					We don't mind WHHSC including the Corporate Governance Manager in attendance at IPFR Panel meetings. However, if consistency is required with the HB's the HBs are unlikely to be able to replicate this.	Each of the Joint Committee's sub-committees is supported by a governance advisor (Committee Secretary or Head of Corporate Governance) to ensure that the Chair and members can seek advice and support on any aspect related to the conduct of their role, and to ensure that the sub-committees decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner, e.g. declarations of interest. Therefore, it is proposed that the reference to the Head of Corporate Governance being in attendance remains in the WHSSC ToR.
60.		2	20	3.1	Suggest re-instating the statement 'Chair or Vice-Chair'; proposed quoracy is limiting if the named Chair is always required. Suggest removing the need for a lay-person, whilst it is good practice for a lay member to attend this is not mandatory and this may limit convening a quorate Panel at short notice.	Vice Chair added The WHSS team have carefully considered this point and taken into account membership of equivalent Panels in NHS England as well as the WG commitment to patient and public involvement

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						in NHS processes. We have therefore taken the view that the lay member should be integral to the panel and therefore should be required for quoracy. However, we recognise the points raised by stakeholders and the requirement for the lay person to be in attendance for quoracy has been removed from this version of the ToRs. WHSSC will therefore undertake further work on how this could be achieved in order that it can be included in future versions of the ToRs.
61.		2	25	3.2	Suggest removal of "The Panel will run for no more than 4 hours with adequate breaks." as this is unnecessary in the ToR.	Section amended to reflect comments and the length of meeting removed
62.		2	23-26	3.2	The meeting frequency has increased from once to twice a month. Members may find it difficult attending meetings more frequently.	Comments noted. It has been necessary to increase the frequency of the WHSSC IPFR Panel meetings to appropriately manage the number of IPFR requests received
63.		2	30-31	3.3	The wording has been changed from 'Virtual meeting' to 'videoconferencing'.	Wording amended to virtual

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					Whilst we would support an urgent virtual panel where possible it does not necessarily need to be by video conferencing specifically.	
64.		3	2+	3.4	This section has been added. It is standard practice for formal meetings and not specifically required for IPFR Panels. If deemed significant, this should be added to the Terms of Reference for all IPFR Panels within the NHS Wales Policy, for consistency.	Comments noted and considered but no change to document as considered important from a governance point of view. It is for the HB's to review and consider any changes to their ToR
65.		3	10-19	3.6	Suggest removal of: "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. "This level of detail is operational / administrative therefore not required in the ToR. The original ToR provided sufficient detail.	Section reworded to reflect comments
66.		3	14	3.6	This is operational / administrative therefore not required in the ToR. Recordings have not been required previously. Whilst this is good practice this is not mandatory therefore this should not be included in the ToR. Full transcripts of meetings are not required and it would be difficult to record face-	The need for transcripts of meetings have been removed

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					to-face meetings in the same manner for consistency. Information Governance and Retention Policies would need adhering to and permission would also be required by panel members.	
67.		3	15-18	3.6	This level of detail is operational and not required in the ToR.	Section removed
68.		3	19	3.6	This section references an electronic database, the policy and ToR; suggest updating to specify that this is the All AWTTC IPFR Database.	Section amended
69.		3	21+	4	This section has been added. If this is agreed, this should be added to the Terms of Reference for all IPFR Panels within the NHS Wales Policy. An induction programme and training approved by the All Wales Therapeutics and Toxicology Centre (AWTTC) has not yet been created. AWTTC would need to be consulted regarding the development of a suitable induction programme and the administration of its rollout across all IPFR Panel members. This should be agreed with AWTTC before being included within the Policy.	This section has been amended to reflect the comments from stakeholders. It is for HB's to consider their ToR's The WHSSC team feel that this is an important element for panel members and would value further discussions on how this could be developed and implemented more formally.

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					In the absence of the confirmation of AWTTC training, this section could note that all Panel members will receive a local induction and will have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.	Section revised as per other stakeholder comments
70.		3	34	5	This section has been added. If this is agreed, this should be added to the Terms of Reference for all IPFR Panels within the NHS Wales Policy.	Comments noted It is for HB's to consider their ToR's
71.	**Bev Thorne HDUHB**	General			For consistency across NHS Wales WHSSC ToR should keep within the same formatting/structure as the rest of the Appendixes/ToR for Health Boards.	**Thank you for your comments.** The format of the revised WHSSC document is considered to be more detailed and therefore would propose this format is used for main policy
72.		1	31	2	Need clarity on what is meant by '*discretionary*'. Also, say (See below) – not clear which part/bullet point the 'see below' refers to.	This is referring to the Chairs discretion to appoint additional 2 panel members for example a member of an ethics panel. This is as stated in the current HB and WHSSC Panel ToR. Amendment made to wording for clarity

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73.		2	2 & 3	2	Current ToR states *Finance advisor if required*' and '*Senior Pharmacist if required*' – these have been replaced with '*Corporate Governance Manager*'. Why the relevance for Corporate Governance attending? Unless there is concern over whether the Policy is being followed during meetings? Other WHSSC staff as and when required – who are these? Lines 10, 11 & 12 lists pharmacy or commission experts – are these not sufficient?	It is noted that the current WHSSC and HB ToR are not consistent in regards to membership. HB membership is currently clinical. This proposal aligns the WHSSC panel membership more closely with the current HB Panel membership. In keeping with HB Panel membership non-clinical representatives are there in attendance. Each of the Joint Committee's sub-committees is supported by a governance advisor (Committee Secretary or Head of Corporate Governance) to ensure that the Chair and members can seek advice and support on any aspect related to the conduct of their role, and to ensure that the sub-committees decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner, e.g. declarations of interest. Therefore, it is proposed that the reference to the Head of Corporate Governance being in

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					For Health Boards, Finance and Pharmacy are much more appropriate attendees and add a great wealth of information with regards to the individual requests.	attendance remains in the WHSSC ToR. Finance advisor has been added. WHSSC does not have a Pharmacist available to attend panels, however there is access to an expert in evidence evaluation who supports the Panel as needed. The requirement for a pharmacist therefore has not been included
74.		2	21	3.1	Should include "Vice Chair" as well as Chair, therefore line reads: "WHSSC clinical director or deputy plus the Chair and Vice Chair".	Section amended. Vice Chair added
75.		2	21	3.1	Quoracy: *"lay person"* must be present. The "lay person" should be removed from quoracy. Lay persons are difficult to recruit and will both health boards and WHSSC. If lay representation is missing, means they will not be quorate, makes it more difficult to manage meetings. Lay representatives are highly important members however, should not be included in the quoracy – especially for critically clinical meetings with a high urgency.	The WHSS team have carefully considered this point and taken into account membership of equivalent Panels in NHS England as well as the WG commitment to patient and public involvement in NHS processes. We have therefore taken the view that the lay member should be integral to the panel and therefore should be required for quoracy. However, we recognise the points raised by stakeholders

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						and the requirement for the lay person to be in attendance for quoracy has been removed from this version of the ToRs. WHSSC will therefore undertake further work on how this could be achieved in order that it can be included in future versions of the ToRs.
76.		2	25-26	3.2	"*The Panel will run for no more than 4 hours with adequate breaks.*" – this is an operational matter and not a Policy statement.	Section amended to reflect comments
77.		2	29	3.3	There is a working 'PROCESS FOR CLINICALLY URGENT CASES'. Insert: "*Please refer to the Process for Clinically Urgent Cases*"	The wording in the proposed ToRs is unchanged from that set out in the current WHSSC ToR and aligns to the WHSSC SFIs. Within the WHSSC Financial Scheme of Delegation, the WHSSC IPFR Chair/Vice Chair does not have any financial delegated limit. The WHSSC Medical Director and Director of Nursing do not have sufficient delegated financial authority. No changes to document

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

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
78.		2	32	3.3	The Manager of Specialised & Tertiary Services making decisions on URGENT IPFR Cases. This Manager is NOT a voting Member of the IPFR Panel. This has great implications on the validity of the IPFR Panel/s and would open up the WHSSC IPFR to greater scrutiny and challenge.	As above
79.		2	32	3.3	REPLACE: "*the Managing Director of Specialised and Tertiary Services with either the Medical Director or the Director of Nursing Quality and the Chair (or Vice Chair) of the WHSSC Panel are authorised to make a decision*" With the following: "*then the IPFR Panel Chair will make a Chairs Action decision which is supported and advised by core panel members with a clinical background, outside of a full meeting of the panel, within their delegated financial limits.*"	
80.		2	35-36	3.3	Sentence can end after financial limits. Remove: "*on behalf of the Panel*."	Sentence amended
81.		3	3-4	3.4	Declaration of any personal or prejudicial interests – this is standard practice. If deemed necessary, for consistency this should be added to the Terms of Reference for all IPFR Panel	Comments considered. Section to remain as is, as considered to be good governance. It is for Health Boards to consider their Panel ToR's

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Welsh Health Specialised Services Committee (WHSSC)

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
82.		3	6-9	3.5	The Panel will reach a consensus, - replace with the following: "*Panel Members will seek to achieve decisions by consensus.*"	Section amended to reflect comments
83.		3	11-18	3.6	'Recording of meetings' – Presently it is not mandatory to record meetings. If this is deemed necessary then it should be added to ToR's for all health boards for consistency across Wales. The storage of those recordings will need to be considered. Currently, standardised letters and Decision Record templates are in place for all health boards and WHSSC	Section amended and the need for recording meetings removed
84.		3	19		Add electronic database will be maintained by AWTTC	Sentence amended
85.		3	22-31	4	**Training:** There needs to be consistent training across all HBs and WHSSC. Panel members should receive a local induction and there is an opportunity to attend a separate annual refresher sessions to ensure appropriate skills. AWTTC should be consulted regarding the development of a suitable induction programme.	The WHSSC team feel that this is an important element for panel members and would value further discussions on how this could be developed and implemented more formally. Section revised as per other stakeholder comments

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Welsh Health Specialised Services Committee (WHSSC)

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
86.		3	34	5	Remove this section. This is covered in the IPFR Policy. Currently states annually but looking to change to every three years.	Section has been amended rather than removed
87.	**SHG SBUHB**	general			WHSSC ToR should keep within the same formatting/structure as the rest of the Appendixes/ToR for Health Boards.	The format of the revised WHSSC document is considered to be more detailed and therefore would propose this format is used for main policy
88.		general			ToR should be kept as an Appendix in the IPFR Policy document and not separated from it.	The document was separated only for ease of consultation and will be included within the policy as is the case now
89.		1	14	1.1	Re-insert the acronym "*IPFR*" – "*The IPFR Panel cannot.*"	Section amended for clarity
90.		1	31	2	Need clarity on what is meant by '*discretionary*'. Also, say (See below) – not clear which part/bullet point the 'see below' refers to.	This is referring to the Chairs discretion to appoint additional 2 panel members for example a member of an ethics panel. This is as stated in the current HB and WHSSC Panel ToR. Amendment made to wording for clarity
91		2	2	2	Currently '*Finance advisor if required*' and '*Senior Pharmacist if required*'. These should be reinstated and replace '*Corporate Governance Manager*'.	Finance advisor added. WHSSC does not have a Pharmacist available to attend

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
						panels, however there is access to an expert in evidence evaluation who supports the Panel as needed. The requirement for a pharmacist therefore has not been included
					Query the relevance for Corporate Governance attending unless there is concern over whether the Policy is being followed during meetings? For Health Boards, Finance and Pharmacy are much more appropriate attendees and add a great wealth of information with regards to the individual requests.	Each of the Joint Committee's sub-committees is supported by a governance advisor (Committee Secretary or Head of Corporate Governance) to ensure that the Chair and members can seek advice and support on any aspect related to the conduct of their role, and to ensure that the sub-committees decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner, e.g. declarations of interest. Therefore, it is proposed that the reference to the Head of Corporate Governance being in attendance remains in the WHSSC ToR.
92.		2	3	2	Remove this bullet point and replace with lines 10, 11, 12.	No change. Lines 10,11,12 relate to when specific

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
						expertise may be required to support the decision making of the panel other than the usual WHSSC in attendance members Section 2 amended to aid document flow
93.		2	10-12	2	Move up to line 3 and replace line 3 (as a sentence and not as a bullet point.)	As above
94.		2	21	3.1	Include "Vice Chair" so the line reads: "WHSSC clinical director or deputy plus the Chair and Vice Chair".	Vice Chair added
95.		2	21	3.1	Remove "*lay person*" from quoracy. This will also impact HBs where lay members are difficult to recruit. This also has implications for WHSSC and HBs if lay representation is missing, means they will not be quorate, makes it more difficult to manage meetings. Lay representatives are highly important members however, should not be included in the quoracy – especially for critically clinical meetings with a high urgency.	The WHSS team have carefully considered this point and taken into account membership of equivalent Panels in NHS England as well as the WG commitment to patient and public involvement in NHS processes. We have therefore taken the view that the lay member should be integral to the panel and therefore should be required for quoracy. However, we recognise the points raised by stakeholders and the requirement for the lay person to be in attendance for quoracy has been removed

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
						from this version of the ToRs. WHSSC will therefore undertake further work on how this could be achieved in order that it can be included in future versions of the ToRs.
96.		2	25-26	3.2	Remove: "*The Panel will run for no more than 4 hours with adequate breaks.*" Does not need to be in ToR as this is an operational matter and not a Policy statement.	Sentence removed
97.		2	29	3.3	There is a working 'PROCESS FOR CLINICALLY URGENT CASES'. Insert: "*Please refer to the Process for Clinically Urgent Cases*"	Section 7.7 of the All Wales Policy provides for this but this process is not suitable for WHSSC as it does not align with its SOs and SFIs. Within the WHSSC Financial Scheme of Delegation, the WHSSC IPFR Chair/Vice Chair does not have any financial delegated limit. The WHSCC ToR refers to a process for WHSSC clinically urgent cases.
98.		2	32	3.3	The Manager of Specialised & Tertiary Services making decisions on URGENT IPFR Cases. This Manager is NOT a voting Member of the IPFR Panel. This has great implications on the validity of the IPFR Panel/s and would open up the	The wording in the proposed ToRs is unchanged from that set out in the current WHSSC ToR and aligns to the WHSSC SFIs.

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
					WHSSC IPFR to greater scrutiny and challenge.	The WHSSC Medical Director and Director of Nursing do not have sufficient delegated financial authority.
99.		2	32	3.3	REPLACE: "*the Managing Director of Specialised and Tertiary Services with either the Medical Director or the Director of Nursing Quality and the Chair (or Vice Chair) of the WHSSC Panel are authorised to make a decision*" With the following: "*then the IPFR Panel Chair will make a Chairs Action decision which is supported and advised by core panel members with a clinical background, outside of a full meeting of the panel, within their delegated financial limits.*"	The original wording is retained to ensure alignment to the WHSSC SFIs and financial limits as set out in its Governance and Accountability Framework.
100.		2	35-36	3.3	Remove: "*on behalf of the Panel*." As this is not necessary at the end of the sentence.	Wording removed
101.		3	3-4	3.4	Recognised this section is not needed, as is an operational point however, understand the point of declaring in the paperwork.	Comments noted. Section retained as considered good governance
102.		3	6-9	3.5	Remove paragraph and replace with the following: "*Panel Members will seek to achieve decisions by consensus.*"	Section amended to reflect comments

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
103.		3	11-18	3.6	Remove these lines and reinstate wording from original/existing ToR: "*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.*" Noted: Standardised letters and Decision Record templates are in place and WHSSC should adopt these for use going forward.	This section has been reworded Comments noted
104.		3	22-25	4	Remove this section. Needs to be consistent training across all HBs and WHSSC.	Section 4 to remain but has been reworded to reflect comments received
105.		3	26-28	4	Reword this: "*All Panel members will receive an induction programme and training*" To read: "*All Panel members will receive a local induction and will have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.*"	The WHSSC team feel that this is an important element for panel members and would value further discussions on how this could be developed and implemented more formally. Section revised as per other stakeholder comments
106.		3	29-31	4	Remove this section.	removed
107.		3	34	5	Remove this section.	Section 5 to remain but has been amended to reflect

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
					This is covered in the IPFR Policy. Currently states annually but looking to change to every three years.	comments received and to be in line with the Policy
108.		general			Panel Membership: - The panel membership seems stricter. How feasible will it be to have all those individuals meet so regularly – establishing quoracy currently seems difficult at times.	Comment noted No change to document
109.	**Carole Phillip, Senior Commissioning Manager PTHB**	general			WHSSC ToR should keep within the same formatting/structure as the rest of the Appendixes/ToR for Health Boards.	The format of the revised WHSSC document is considered to be more detailed and therefore
110.		general			ToR should be kept as an Appendix in the IPFR Policy document and not separated from it.	The document was separated only for ease of consultation and will be included within the policy as is the case now
111.		1	14	1.1	Re-insert the acronym "*IPFR*" – "*The IPFR Panel cannot.*"	section amended for clarity
112.		1	31	2	Need clarity on what is meant by '*discretionary*'. Also, say (See below) – not clear which part/bullet point the 'see below' refers to.	This is referring to the Chairs discretion to appoint additional 2 panel members for example a member of an ethics panel. This is as stated in the current HB and WHSSC Panel ToR. Amendment made to wording for clarity

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
113.		2	2	2	Currently '*Finance advisor if required*' and '*Senior Pharmacist if required*'. These should be reinstated and replace '*Corporate Governance Manager*'. Query the relevance for Corporate Governance attending unless there is concern over whether the Policy is being followed during meetings? For Health Boards, Finance and Pharmacy are much more appropriate attendees and add a great wealth of information with regards to the individual requests.	Finance advisor added. WHSSC does not have a Pharmacist available to attend panels, however there is access to an expert in evidence evaluation who supports the Panel as needed. The requirement for a pharmacist therefore has not been included Each of the Joint Committee's sub-committees is supported by a governance advisor (Committee Secretary or Head of Corporate Governance) to ensure that the Chair and members can seek advice and support on any aspect related to the conduct of their role, and to ensure that the sub-committees decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner, e.g. declarations of interest. Therefore, it is proposed that the reference to the Head of Corporate Governance being in attendance remains in the WHSSC ToR.

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
114.		2	3	2	Remove this bullet point and replace with lines 10, 11, 12.	No change. Lines 10,11,12 relate to when specific expertise may be required to support the decision making of the panel other than the usual WHSSC in attendance members Section 2 amended to aid document flow
115.		2	10-12	2	Move up to line 3 and replace line 3 (as a sentence and not as a bullet point.)	As above no change
116.		2	21	3.1	Include "Vice Chair" so the line reads: "WHSSC clinical director or deputy plus the Chair and Vice Chair".	Vice Chair added to section
117.		2	21	3.1	Remove "*lay person*" from quoracy. This will also impact HB's where lay members are difficult to recruit. This also has implications for WHSSC and HB's if lay representation is missing, means they will not be quorate, makes it more difficult to manage meetings. Lay representatives are highly important members however, should not be included in the quoracy – especially for critically clinical meetings with a high urgency.	The WHSS team have carefully considered this point and taken into account membership of equivalent Panels in NHS England as well as the WG commitment to patient and public involvement in NHS processes. We have therefore taken the view that the lay member should be integral to the panel and therefore should be required for quoracy. However, we recognise the points raised by stakeholders

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
						and the requirement for the lay person to be in attendance for quoracy has been removed from this version of the ToRs. WHSSC will therefore undertake further work on how this could be achieved in order that it can be included in future versions of the ToRs.
118.		2	25-26	3.2	Remove: "*The Panel will run for no more than 4 hours with adequate breaks.*" Does not need to be in ToR as this is an operational matter and not a Policy statement.	Sections amended to reflect comments
119.		2	29	3.3	There is a working 'PROCESS FOR CLINICALLY URGENT CASES'. Insert: "*Please refer to the Process for Clinically Urgent Cases*"	Section 7.7 of the All Wales Policy provides for this but this process is not suitable for WHSSC as it does not align with its SOs and SFIs. Within the WHSSC Financial Scheme of Delegation, the WHSSC IPFR Chair/Vice Chair does not have any financial delegated limit. The WHSCC ToR refers to a process for WHSSC clinically urgent cases.
120.		2	32	3.3	The Manager of Specialised & Tertiary Services making decisions on URGENT	The wording in the proposed ToRs is unchanged from that

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
					IPFR Cases. This Manager is NOT a voting Member of the IPFR Panel. This has great implications on the validity of the IPFR Panel/s and would open up the WHSSC IPFR to greater scrutiny and challenge.	set out in the current WHSSC ToR and aligns to the WHSSC SFIs. The WHSSC Medical Director and Director of Nursing do not have sufficient delegated financial authority.
121.		2	32	3.3	REPLACE: "*the Managing Director of Specialised and Tertiary Services with either the Medical Director or the Director of Nursing Quality and the Chair (or Vice Chair) of the WHSSC Panel are authorised to make a decision*" With the following: "*then the IPFR Panel Chair will make a Chairs Action decision which is supported and advised by core panel members with a clinical background, outside of a full meeting of the panel, within their delegated financial limits.*"	The original wording is retained to ensure alignment to the WHSSC SFIs and financial limits as set out in its Governance and Accountability Framework.
122.		2	35-36	3.3	Remove: "*on behalf of the Panel*." As this is not necessary at the end of the sentence.	Section amended
123.		3	3-4	3.4	Recognised this section is not needed, as is an operational point however, understand the point of declaring in the paperwork.	Comments noted. No change to document as considered important from a governance point of view

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
124.		3	6-9	3.5	Remove paragraph and replace with the following: "*Panel Members will seek to achieve decisions by consensus.*"	Section amended to reflect comments and the need to vote removed
125.		3	11-18	3.6	Remove these lines and reinstate wording from original/existing ToR: "*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.*" Noted: Standardised letters and Decision Record templates are in place and WHSSC should adopt these for use going forward.	Section amended to reflect comments Comments noted and for further consideration
126.		3	22-25	4	Remove this section. Needs to be consistent training across all HBs and WHSSC.	Comments noted and section has been revised but retained
127.		3	26-28	4	Reword this: "*All Panel members will receive an induction programme and training*" To read: "*All Panel members will receive a local induction and will have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.*"	Section amended to reflect comments
128.		3	29-31	4	Remove this section.	Section removed
129.		3	34	5	Remove this section.	Section reworded to reflect comments and in line with review of the main Policy

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
					This is covered in the IPFR Policy. Currently states annually but looking to change to every three years.	
130.					Panel Membership: - The panel membership seems stricter. How feasible will it be to have all those individuals meet so regularly – establishing quoracy currently seems difficult at times. -	Comments noted
131.	**James Hehir WHSCC IPFR Panel Chair**	general			I agree with the draft generally	Thank you for your comments
132.		1	24		This will enable the chair to be selected from a wider pool than existing board members of NHS organisations, some of whom are only appointed to serve for a short period of time. Selection should be open and transparent. To ensure the best fit for the role and the sub committee	Comments noted
133.		1	32-33		These post holders should have full membership status and voting rights to reflect their expertise and competence in ensuring the committee understands the key medical issues and patient comparison cohort under consideration in each individual case	These members are now panel full members rather than as previously in attendance with no voting right
134.					The chair of the panel should review the membership as necessary , but in association with the WHSSC Medical	Comments considered and amendment made to reflect comments

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Comment no.	Name of stakeholder organisation / individual	Page No.	Line Number	Section	Comments	WHSSC Responses
					Director and/or the Director of Nursing before exercising discretion to appoint 2 further members from the NHS in Wales	
135.		2	24-26	3.3	Have we considered the impact on those responsible for recording and transcribing the decisions made in each case for lengthy sessions of up to 4 hours? Would it not be better to have an additional meeting scheduled on an ad hoc basis to deal with unexpected surges in demand rather than try to shoehorn extra cases into a busy agenda?	The need to record meetings have been considered and this section has been amended
136.		3	22-23	4	Induction training should be delivered before panel members start dealing with cases. This could be delivered online via ESR or face to face as for refresher sessions. New panel members should be encouraged to observe a panel meeting following appointment but before their induction where possible.	Comments considered and recognised as an important element of support. For further discussion on how this could be supported
137.		general			Whilst not included in the stakeholder consultation, in order to give assurance to the WHSSC Joint Committee and the wider NHS Wales the chair should be subject to an annual performance appraisal; particularly so if the post is remunerated, commensurate with the responsibilities of the position and the time commitment.	To be considered outside of the consultation

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

3.7.3 Appendix 3

DRAFT TERMS OF REFERENCE – WHSSC IPFR PANEL v 0.~~6~~9 (Tracked)

1. PANEL PURPOSE

The Welsh Health Specialised Services Committee (WHSSC) Individual Patient Funding Request (IPFR) Panel (*"the Panel")* is constituted to act as a Sub-Committee of the Welsh Health Specialised Services Committee (*"the Joint Committee"*) and holds 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 (HB) has agreed to routinely provide.

The IPFR 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 IPFR Panel will normally reach its decision on the basis of all the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support of the application.

The IPFR 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.

1.1 IPFR Panel Authority

The IPFR Panel cannot make policy/commissioning decisions for the HB. Any policy proposal arising from the Panel's consideration and decisions will be reported to the WHSSC Management Group and/or the Joint Committee for ratification.

The financial authorisation limit is set at £750,000 for one off patient packages and £1 million for lifetime packages.

Any decisions resulting in a financial cost in excess of these limits must be reported to the Managing Director of Specialised and Tertiary Services for authorisation and the relevant Health Board for information and if over £1

million to the Joint Committee for approval or ratification (if a chairs action was undertaken).

2. MEMBERSHIP

The IPFR panel will have a core membership of:

- ~~Independent chair (from open recruitment) or existing members of the boards of NHS organisations)~~
- 2 Lay representatives **
- HB IPFR Panel Chairs from each of the 7 Health Boards or nominated clinical deputy
- 2 vice chairs (~~1~~ appointed from within the ~~HB~~ panel membership) ~~and 1 discretionary panel member (See below))~~
- WHSSC Medical Director or nominated deputy
- WHSSC Director of Nursing, or nominated deputy

A further two panel members from the NHS in Wales may be appointed at the discretion of the Chair of the Panel in conjunction with the WHSSC Medical and / or Director of Nursing, for example, a member of an ethics committee.

In attendance from WHSSC:

- IPFR Manager/co-ordinator
- Finance Advisor (if required)
- Head of Corporate Governance
- ~~Corporate Governance Manager~~
- Other WHSSC staff as and when required to clarify on policy/commissioning arrangements/evidence evaluation.~~,~~

The Chair of the Panel will review the membership as necessary and in conjunction with the WHSSC Medical Director and / or Director of Nursing.

For particularly complex cases the IPFR Panel may invite other individuals with clinical, pharmacy or commissioning expertise and skills, unconnected with the requesting provider to support decision making.

**** Definition: Not registered as a healthcare professional, either lay (not currently a healthcare worker) or lay plus (no healthcare experience ever) (Health Research Authority (HRA) 2014) will be eligible).**

3. PROCEDURAL ARRANGEMENTS

3.1 Quoracy:

The IPFR panel will be quorate if 4 of the 7 Health Boards representative, 1 WHSSC ~~c~~Clinical ~~d~~Director or deputy plus the Chair or Vice Chair.

3.2 Meeting Frequency

The IPFR panel will normally be held twice per month either virtually, ~~via video conferencing,~~ face to face or a combination of both. ~~The Panel will run for no more than 4 hours with adequate breaks.~~

3.3 Urgent Cases

Provision will be made for occasions when a decision may be required urgently.

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

Urgent cases will be reported at the next scheduled IPFR panel.

3.4 Members Interest during the meeting

At the start of the meeting, members must declare any personal or prejudicial interests relating to the discussions of the panel.

3.5 Situations where the panel cannot reach a consensus

IPFR panel members will seek to achieve decisions by~~reach~~ consensus where possible~~., but if a consensus cannot be achieved, decisions will be made by a majority vote with each member present having an equal vote.~~ If the panel is equally split the Chair of the Panel will ~~have the casting vote~~ make the final decision.

3.6 Documentation, Reporting and Monitoring:

~~It is the responsibility of the WHSSC IPFR Co-ordinator to process all requests.~~ The IPFR Co-ordinator will document the meetings to ensure panel discussions and decisions are appropriately documented.

~~The meeting will be recorded for transcription purposes.~~

~~The IPFR Coordinator will circulate draft minutes of the decision making to the Panel members within 5 days. Minutes will be ratified at the next IPFR~~

~~panel meeting. The recording of the meeting will be deleted after ratification of the notes.~~

An electronic National IPFR database of all cases will be ~~maintained.~~maintained by AWTTC.

4. TRAINING FOR IPFR PANEL MEMBERS

All Panel members will receive a~~n~~ local induction programme. ~~and training approved by the All Wales Therapeutics and Toxicology Centre (AWTTC).~~

~~This should cover the principles of IPFR decision making, legal considerations and case law.~~

Panel members should have the ~~will be expected to~~opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.

~~When complex clinical, ethical or scientific matters are under consideration further specialist support and advice will be made available to the Panel members.~~

5. REVIEW OF THE TERMS OF REFERENCE

The Terms of Reference of the Panel will be reviewed in line with the All Wales IPFR Policy ~~annually~~.

DRAFT TERMS OF REFERENCE – WHSSC IPFR PANEL v 0.9 (CLEAN)

1. PANEL PURPOSE

The Welsh Health Specialised Services Committee (WHSSC) Individual Patient Funding Request (IPFR) Panel (*"the Panel")* is constituted to act as a Sub-Committee of the Welsh Health Specialised Services Committee ("*the Joint Committee"*) and holds 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 (HB) has agreed to routinely provide.

The IPFR 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 IPFR Panel will normally reach its decision on the basis of all the written evidence which is provided to it, including the request form itself and any other documentary evidence which is provided in support of the application. The IPFR 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.

1.1 IPFR Panel Authority

The IPFR Panel cannot make policy/commissioning decisions for the HB. Any policy proposal arising from the Panel's consideration and decisions will be reported to the WHSSC Management Group and/or the Joint Committee for ratification.

The financial authorisation limit is set at £750,000 for one off patient packages and £1 million for lifetime packages.

Any decisions resulting in a financial cost in excess of these limits must be reported to the Managing Director of Specialised and Tertiary Services for authorisation and the relevant Health Board for information and if over £1 million to the Joint Committee for approval or ratification (if a chairs action was undertaken).

2. MEMBERSHIP

The IPFR panel will have a core membership of:

- Independent chair (from open recruitment 2 Lay representatives **
- HB IPFR Panel Chairs from each of the 7 Health Boards or nominated clinical deputy
- 2 vice chairs (appointed from within the panel membership)
- WHSSC Medical Director or nominated deputy
- WHSSC Director of Nursing, or nominated deputy

A further two panel members from the NHS in Wales may be appointed at the discretion of the Chair of the Panel in conjunction with the WHSSC Medical and / or Director of Nursing, for example, a member of an ethics committee.

In attendance from WHSSC:

- IPFR Manager/co-ordinator
- Finance Advisor (if required)
- Head of Corporate Governance
- Other WHSSC staff as and when required to clarify on policy/commissioning arrangements/evidence evaluation.

The Chair of the Panel will review the membership as necessary and in conjunction with the WHSSC Medical Director and / or Director of Nursing.

For particularly complex cases the IPFR Panel may invite other individuals with clinical, pharmacy or commissioning expertise and skills, unconnected with the requesting provider to support decision making.

**** Definition: Not registered as a healthcare professional, either lay (not currently a healthcare worker) or lay plus (no healthcare experience ever) (Health Research Authority (HRA) 2014) will be eligible).**

3. PROCEDURAL ARRANGEMENTS

3.1 Quoracy:

The IPFR panel will be quorate if 4 of the 7 Health Boards representative, 1 WHSSC Clinical Director or deputy plus the Chair or Vice Chair.

3.2 Meeting Frequency

The IPFR panel will normally be held twice per month either virtually, face to face or a combination of both.

3.3 Urgent Cases

Provision will be made for occasions when a decision may be required 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 or availability of panel members, then the Managing Director of Specialised and Tertiary Services with either the Medical Director or the Director of Nursing Quality and the Chair (or a Vice Chair) of the WHSSC Panel are authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits, on behalf of the Panel.

Urgent cases will be reported at the next scheduled IPFR panel.

3.4 Members Interest during the meeting

At the start of the meeting, members must declare any personal or prejudicial interests relating to the discussions of the panel.

3.5 Situations where the panel cannot reach a consensus

IPFR panel members will seek to achieve decisions by consensus where possible. If the panel is equally split the Chair of the Panel will make the final decision.

3.6 Documentation, Reporting and Monitoring:

The IPFR Co-ordinator will document the meetings to ensure panel discussions and decisions are appropriately documented.

An electronic National IPFR database of all cases will be maintained by AWTTC.

4. TRAINING FOR IPFR PANEL MEMBERS

All Panel members will receive a local induction programme.

Panel members should have the opportunity to attend a separate annual refresher session to ensure all members maintain the appropriate skills and expertise to function effectively.

5. REVIEW OF THE TERMS OF REFERENCE

The Terms of Reference of the Panel will be reviewed in line with the All Wales IPFR Policy.

Report Title	**WHSSC Governance and Accountability Framework**	**Agenda Item**	3.8
Meeting Title	**Joint Committee**	**Meeting Date**	14/03/2023
FOI Status	Open		
Author (Job title)	Committee Secretary		
Executive Lead (Job title)	Committee Secretary & Director of Finance		

Purpose of the Report	The purpose of this report is to provide an update on the WHSSC Governance and Accountability Framework.				
Specific Action Required	RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☒	INFORM ☒

Recommendation(s):

Members are asked to:

- **Note** the report,
- **Approve** the proposed changes to the Standing Orders (SOs), prior to being issued to the seven HB's for approval and inclusion as schedule 4.1 within their respective HB SO's,
- **Approve** the proposed changes of the Memorandum of Agreement (MoA) and Hosting Agreement in place with CTMUHB, prior to being issued to the seven HB's for approval and inclusion as schedule 4.1 within their respective HB SO's; and
- **Approve** the proposed changes to the financial scheme of delegation and financial authorisation matrix updating the Standing Financial Instructions (SFIs).

WHSSC GOVERNANCE AND ACCOUNTABILITY FRAMEWORK

1.0 SITUATION

The purpose of this report is to provide an update on the WHSSC Governance and Accountability Framework.

2.0 BACKGROUND

2.1 Model Standing Orders and Standing Financial Instructions

In accordance with the WHSSC Regulations 2009, each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Joint Committee proceedings and business. These Joint Committee standing orders form a schedule to each LHB's own standing orders, and have effect as if incorporated within them. Together with the adoption of the Scheme of Decisions Reserved to the Joint Committee; the Scheme of Delegations to Officers and Others; and the Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

These documents, together with the Memorandum of Agreement setting out the governance arrangements for the seven LHBs and a Hosting Agreement between the Joint Committee and Cwm Taf Morgannwg University Health Board (as the Host LHB), form the basis upon which the Joint Committee's Governance and Accountability Framework is developed.

Updated Model Standing Orders and Model Standing Financial Instructions were issued by the Minister for Health and Social Services in correspondence received on the 7 April 2021.

The revised Governance and Accountability Framework documents, including the SOs and SFIs, for WHSCC were last approved by the Joint Committee on 13 July 2021, and were subsequently taken forward for approval by the seven LHBs for inclusion as schedule 4.1 within their respective LHB SOs.

To ensure effective governance and to comply with the provisions of the WHSSC Standing Orders (SOs) it is important that the SOs and Standing Financial Instructions (SFIs) are kept up to date to comply with the need for:

- The Joint Committee to take appropriate action to assure itself that all matters delegated are effectively carried out, and that
- The framework of delegation is kept under active review and, where appropriate, is revised to take account of organisational developments, review findings or other changes.

3.0 CHANGES TO THE GOVERNANCE & ACCOUNTABILITY FRAMEWORK

3.1 Financial Limits and Reporting

On the 10 January 2022 the Joint Committee approved that the increased financial delegation limits introduced in March 2020 to enable effective financial governance as a consequence of the COVID-19 pandemic could be adopted as new permanent limits, and approved the updated process for the current SFI requirement for Joint Committee "approval" of non-contract cases above defined limits for annual and anticipated lifetime cost, to be replaced by an assurance report to Joint Committee and the CTMUHB Audit & Risk Committee (ARC) notifying of all approvals above the defined limit and Chairs action to reflect the need for timely approval action, subject to further discussion with the HB Board Secretaries.

The Committee Secretary at WHSSC shared the report and discussed the proposed changes with the NHS Wales HB Board Secretaries on 3 February 2023, and requested views on the proposal. Two queries were received as outlined in ***Table 1*** below:

Table 1 – Queries Received on the Proposed Changes

Query	Response
What is the process of Chairs action?	Section3.1 of the WHSSC SO's state: ***3.1 Chair's action on urgent matters*** *3.1.1 There may, occasionally, be circumstances where 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 these circumstances, the Joint Committee Chair and the Lead Director, supported by the Committee Secretary, may deal with the matter on behalf of the Joint Committee - after first consulting with at least one other Independent Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Joint Committee for consideration and ratification.* The process is the same as the process adopted by HB's. Also, any chairs action undertaken is always shared with the Joint Committee in writing via a letter being issued to JC members sent via email, and it is also ratified by the Joint Committee under the Chairs report at the next available meeting with a specific recommendation to ratify the decision. This is captured in minutes etc.

Query	Response
Financial thresholds – appear higher than those in place in other NHS bodies	Advanced Medicinal Therapeutic Products (ATMPs) are commissioned by WHSSC and the Blueteq system is used to procure, prescribe and manage the ever increasing complexities associated with high cost therapies. The scale of the ATMP's has increased with an average minimum of £25k per annum up to £500,000 per annum for high cost drugs and potentially up to £2m for one-off new ATMPS all of which are NICE approved. Therefore, the financial thresholds are set reflect this.

The proposed changes were also discussed with the Head of NHS Board Governance on the 14 February 2023 and with the Board Secretary at CTMUHB on 17 February to provide assurance on the changes being made and an assurance was given that the changes did not deviate from the model SO's and SFI's in place, and any changes were in relation to bespoke changes for WHSSC's scheme of delegation, financial authorisation matrix and MoA with CTMUHB.

3.2 Welsh Renal Clinical Network (WRCN) – Governance Review

Further to the recent governance review undertaken on the Welsh Renal Clinical Network (WRCN) to evaluate and determine the adequacy of the systems and controls in place within WHSSC, the scheme of delegation has been updated in response to the recommendations made concerning:

- Delegated authority for the network board including which matters are reserved to itself to include executive officer responsibilities and financial delegation limits; and
- Delegated financial limits within the Standing Financial Instructions.

3.3 Memorandum of Agreement – Designation of Audit & Finance Lead Independent Member (IM)

On the 18 January 2022, the Joint Committee approved that the existing arrangements for appointing a CTM audit lead IM, could 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. Section 7.3 of the MoA has been updated to reflect this.

4.0 SUMMARY OF PROPOSED CHANGES

The updated SOs, MoA, Hosting Agreement, and SFIs are presented at ***Appendices 1-3*** for information. Note no changes have been made to the Welsh Government model guidance element of the SO's or the SFI's, and that the proposed changes only relate to the bespoke elements required for WHSSC.

For assurance, a summary of the updates made is outlined in ***table 2*** below:

Table 2 - Summary of Proposed Changes to the WHSSC Governance and Accountability Framework

Standing Orders – see Appendix 1	
Page 52 -	**Delegation of Powers to Sub-Committees and Others** Amendment from "Audit Committee", to "Audit and Risk Committee" (ARC) to reflect the correct title of the CTM ARC for hosted bodies. Amendment from "Welsh Renal Clinical Network", to the "Welsh Kidney Network", to reflect the name change agreed by the Joint Committee on 12 July 2022.
Page 54	**Scheme of Delegation to WHSST Directors and Officers** Addition of Welsh Kidney Network (WKN) and Programme Director, Executive Lead to comply with the following recommendations from the WKN governance review: • *The Joint Committee should agree a scheme of delegation for the Network Board and agree which matters it wishes to reserve to itself to include executive officer responsibilities and financial delegation limits. This should explicitly include staff and non-staff costs; and* • *The role of the executive lead should be clearly set out and referenced in the individual's job description and personal objectives, as well as in the schemes off delegation within Standing Orders. This should include accountability arrangements.*
Page 56	**Annexe 3 – Joint Committee Sub-Committee Arrangements** Amendment from "Welsh Renal Clinical Network", to the "Welsh Kidney Network", to reflect the name change agreed by the Joint Committee on 12 July 2022.
Memorandum of Agreement & Hosting Agreement – see appendix 2	
Page 12	**Appointment and Role of Non-Officer Members** **Section 7.3 Audit Lead Independent Member** Section 7.3 states that: *"7.3 One non-officer member will be selected from the Host LHB. This non-officer member will act as the Audit Lead"* On the 18 January 2022, the Joint Committee approved that the existing arrangements for appointing a CTM audit lead IM, could 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. Therefore section 7.3 will be amended to: *"7.3 the audit lead non-officer member role will be recruited through a fair and open recruitment process. To enable the WHSSC Independent Member Remuneration appointment arrangements to be consistent with the other two HB IM roles, with an emphasis on the skills required to participate in the Audit & Risk Committee (ARC). The audit lead IM will be required to attend the CTMUHB part 2 ARC meetings which WHSSC attends to discharge its audit and accountability requirements"*
P16	**13. Accountability & Audit Committee** Amendment from "Audit Committee", to "Audit and Risk Committee" to reflect the correct title of the CTM ARC for hosted bodies.
Pages 22 & 23	**27.Review** Amendments made to reflect the names of the newly appointed Chief Executive Officers (CEOs).
Page 24	**Annex (i) to MoA** **Services delegated from LHBs to WHSSC for planning and funding** The list has been updated to reflect the full list of services for 2023-2024.
Pages 40 & 41	**Annex (ii) to MoA – Hosting Agreement** Amendments made to reflect the names of the newly appointed Chief Executive Officers (CEOs).
Page 66	**Annex (iv) to MoA – Clinical Networks** Amendment from "Welsh Renal Clinical Network", to the "Welsh Kidney Network", to reflect the name change agreed by the Joint Committee on 12 July 2022.
Standing Financial Instructions (SFI's) – Scheme of Delegation – see Appendix 3a	
Page 2	**Budget delegation and virements** **Section A1 Delegation of the management of defined Revenue budgets to budget holders** Updated to reflect the following recommendations from the WKN governance review: • *The Joint Committee should agree a scheme of delegation for the Network Board and agree which matters it wishes to reserve to itself to include executive officer responsibilities and financial*

	delegation limits. This should explicitly include staff and non-staff costs. • *The role of the executive lead should be clearly set out and referenced in the individual's job description and personal objectives, as well as in the schemes off delegation within Standing Orders*
Page 2	**Budget delegation and virements** **Section A1 Delegation of the management of defined Revenue budgets to budget holders** Updated to reflect budget holder status for Traumatic Stress Wales (TSW).
Page 4	**A1 Long Term Agreements with other NHS bodies** Wording updated to describe "In accordance with delegated authority within the Standing Financial Instructions".
Page 5	**A4 Individual NHS patient treatment charges outside of LTAs and SLAs** Updated to include reference to the updated process for the current SFI requirement for Joint Committee "approval" of non-contract cases above defined limits for annual and anticipated lifetime cost, to be replaced by an assurance report to Joint Committee and the CTMUHB Audit & Risk Committee (ARC) notifying of all approvals above the defined limit and Chairs action to reflect the need for timely approval action.
Standing Financial Instructions (SFI's) – Financial Authorisation Matrix – see Appendix 3b	
Column R	Updated to reflect the following recommendations from the WKN governance review: • *The Joint Committee should agree a scheme of delegation for the Network Board and agree which matters it wishes to reserve to itself to include executive officer responsibilities and financial delegation limits. This should explicitly include staff and non-staff costs.* • *The role of the executive lead should be clearly set out and referenced in the individual's job description and personal objectives, as well as in the schemes off delegation within Standing Orders. This should include accountability arrangements.*
All	Updated to include the increased financial delegation limits introduced in March 2020 to enable effective financial governance as a consequence of the COVID-19, approved by the Joint Committee on 10 January 2023.

Column Q	Updated to reflect Traumatic Stress Wales

5.0 GOVERNANCE & RISK

To ensure effective governance the WHSSC Governance and Accountability Framework is reviewed annually, and the Integrated Governance Committee were informed of proposed changes to the Framework verbally on 14 February 2023.

Once the Joint Committee approve the updated governance and accountability framework document they will then be taken forward for approval by the Boards of the seven HBs for inclusion as schedule 4.1 within their respective HB SOs. Thereafter, a report will be taken to the CTMUHB ARC for hosted bodies for assurance.

6.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report,
- **Approve** the proposed changes to the Standing Orders (SOs), prior to being issued to the seven HB's for approval and inclusion as schedule 4.1 within their respective HB SOs,
- **Approve** the proposed changes of the Memorandum of Agreement (MoA) and Hosting Agreement in place with CTMUHB, prior to being issued to the seven HB's for approval and inclusion as schedule 4.1 within their respective HB SOs; and
- **Approve** the proposed changes to the financial scheme of delegation and financial authorisation matrix updating the Standing Financial Instructions (SFIs).

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	Yes
Health and Care Standards	Governance, Leadership and Accountability Choose an item. Choose an item.
Principles of Prudent Healthcare	Reduce inappropriate variation Choose an item. Choose an item.
NHS Delivery Framework Quadruple Aim	People in Wales have improved health and well-being with better prevention and self-management Choose an item. Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	A strong financial governance framework is essential to ensuring patients experience the greatest possible levels of safety and quality in the services commissioned by WHSSC Informed decisions within the environment of a clear financial governance framework are more likely to impact favourably on the quality, safety and experience of patients and staff.
Finance/Resource Implications	The WHSSC Standing Financial Instructions (SFI's) outline the financial scheme of delegation, non-pay expenditure limits and accountability arrangements.
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)	The Model Standing Orders, Reservations and Delegation of Powers (SO's) were last issued by Welsh Government in September 2019 for Local Health Boards, Trusts, the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC). They were reviewed by officials in association with representatives of the NHS Wales Board Secretaries and the NHS Wales Directors of Finance group. The revised model documents are issued in accordance the Ministerial direction contained within sections 12(3) (for Local Health Boards) and 19(1) (for NHS Trusts) and 23(1) (Special Health Authorities) of the National Health Service (Wales) Act 2006.

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	14 February 2023 – Integrated Governance Committee – verbal update on progress 10 January 2023 – JC approved the financial limits and financial reporting report.
Appendices	Appendix 1 – Updated Standing Orders (SOs) Appendix 2 – Updated Memorandum of Agreement and Hosting Agreement Appendix 3 - Updated Standing Financial Instructions (SFIs) Appendix 3a – Updated Financial Scheme of Delegation Appendix 3b – Updated Financial Authorisation Matrix

Schedule 4.1

STANDING ORDERS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

Foreword

Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. When agreeing Standing Orders Local Health Boards must ensure they are made in accordance with directions as may be issued by Welsh Ministers. Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Welsh Health Specialised Services Committee's (the WHSSC or the Joint Committee) proceedings and business1. These WHSSC Standing Orders (WHSSC SOs) form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Welsh Health Specialised Services Committee (Wales) Regulations 20092 and LHB Standing Order 3 into day to day operating practice. Together with the adoption of a Schedule of decisions reserved to the Joint Committee; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

These documents, together with the Memorandum of Agreement dated made between the Joint Committee and the seven LHBs in Wales that defines the respective roles of the seven LHB Accountable Officers and a hosting agreement dated between the Joint Committee and Cwm Taf Morgannwg University LHB (the host LHB), form the basis upon which the Joint Committee governance and accountability framework is developed. Together with the adoption of a Values and Standards of Behaviour framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members, Joint Committee members, LHB and Welsh Health Specialised Services Team (WHSST) staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Committee Secretary of the Joint Committee will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements for the Joint Committee. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

1 Reference Part 3, Regulation 12 of WHSSC Regulations 2009 and Regulation 14(b) and 15(5) of the LHB Regulations 2009.
2 (2009/3097 (W.270)

Contents

Section: A – Introduction

Statutory framework

i) The Welsh Health Specialised Services Committee (the Joint Committee) is a joint committee of each LHB in Wales, established under the **Welsh Health Specialised Services Committee (Wales) Directions 2009** (the WHSSC Directions). The functions and services of the Joint Committee are listed in Annex 1 of the WHSSC Directions and are subject to variations to those functions agreed from time to time by the Joint Committee**.** Annex 1 was amended by the **Welsh Health Specialised Services Committee (Wales) (Amendment) Directions 2014** following the establishment of the Emergency Ambulance Services Committee. The Joint Committee is hosted by the host LHB on behalf of each of the seven LHBs.

ii) The principal place of business of the WHSSC is Unit G1, The Willowford, Treforest Industrial Estate, Pontypridd CF37 5YL.

iii) All business shall be conducted in the name of the Welsh Health Specialised Services Committee on behalf of LHBs.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006**[3] which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006**[4] applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

v) Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHBs' statutory functions are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009.

vi) However in some cases the relevant function may be contained in other legislation.

vii) Each LHB's functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and specialised services for the citizens in their respective areas. The WHSSC Directions provide that the seven LHBs in Wales will work jointly to exercise

3 c.42
4 c.41

functions relating to the planning and securing of specialised and tertiary services and will establish the joint committee for the purpose of jointly exercising those functions.

viii) Under powers in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006 the Minister has made the **Welsh Health Specialised Services Committee (Wales) Regulations 2009**[5] (the WHSSC Regulations) which set out the constitution and membership arrangements of the Joint Committee. Certain provisions of the **Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009**[6] (the Constitution Regulations) will also apply to the operations of the Joint Committee, as appropriate.

ix) In addition to directions the Welsh Ministers may from time to time issue guidance relating to the activities of the Joint Committee which LHBs must take into account when exercising any function.

x) The Host LHB shall issue an indemnity to the Chair, on behalf of the LHBs

NHS framework

xi) In addition to the statutory requirements set out above, the Joint Committee, on behalf of each of the LHBs, must carry out all its business in a manner that enables it to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

xii) Adoption of the principles will better equip the Joint Committee to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

xiii) The overarching NHS governance and accountability framework within which the Joint Committee must work incorporates the LHBs SOs; Schedule of Powers reserved for the Board; and Scheme of Delegation to others and SFIs, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; the *'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

5 (2009/3097 (W.270)
6 (2009/779 W.67)

xiv) The Welsh Ministers, reflecting their constitutional obligations and legal duties under the **Well-being of Future Generations (Wales) Act 2015**, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

xv) The **Well-being of Future Generations (Wales) Act 2015** also places duties on LHBs and some NHS Trusts in Wales. Sustainable development in the context of the act means the process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

xvi) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Ministers' Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/..Directions or guidance on specific aspects of Committee/LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Joint Committee Framework

xvii) The specific governance and accountability arrangements established for the Joint Committee are set out within:

- These WHSSC SOs and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation to others;
- The WHSSC SFIs;
- A Memorandum of Agreement defining the respective roles of the seven LHB Accountable Officers; and
- A hosting agreement between the Joint Committee and the host LHB in relation to the provision of administrative and any other services to be provided to the Joint Committee.

xviii) Annex 2 to these SOs provides details of the key documents that, together with these SOs, make up the Joint Committee's governance and accountability framework. These documents must be read in conjunction with the WHSSC SOs.

xix) The Joint Committee may from time to time, subject to the prior approval of each LHB's Board, agree operating procedures which apply to Joint Committee members and/or members of the WHSST and others. The decisions to approve these operating procedures will be recorded in an appropriate Joint Committee minute and, where appropriate, will also be considered to be an integral part of these WHSSC SOs and SFIs. Details

of the Joint Committee's key operating procedures are also included in Annex 2 of these SOs.

Applying WHSSC Standing Orders

xx) The WHSSC SOs (together with the WHSSC SFIs and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any joint sub-Committees established by the Joint Committee, including any Advisory Groups. The WHSSC SOs may be amended or adapted for the joint sub-Committees or Advisory Groups as appropriate, with the approval of the Joint Committee. Further details on joint sub-Committees and Advisory Groups may be found in Annexes 3 and 4 of these WHSSC SOs, respectively.

xxi) Full details of any non-compliance with these WHSSC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Committee Secretary, who will ask the nominated Audit Committee to formally consider the matter and make proposals to the Joint Committee on any action to be taken. All Joint Committee members and Joint Committee officers have a duty to report any non-compliance to the Committee Secretary as soon as they are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with WHSSC SOs is a disciplinary matter.**

Variation and amendment of WHSSC Standing Orders

xxii) Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the Joint Committee determines that it is necessary to vary or amend the SOs during the year. In these circumstances, the Chair of the Joint Committee, advised by the Committee Secretary, shall submit a formal report to each LHB Board setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the seven LHBs are in favour of the amendment; or
- In the event that agreement cannot be reached, Welsh Ministers determine that the amendment should be approved.

Interpretation

xxiii) During any Joint Committee meeting where there is doubt as to the applicability or interpretation of the WHSSC SOs, the Chair of the Joint Committee shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair should take appropriate advice from the Committee Secretary.

xxiv) The terms and provisions contained within these SOs aim to reflect those

covered within all applicable health legislation. The legislation takes precedence over these WHSSC SOs when interpreting any term or provision covered by legislation.

Relationship with LHB Standing Orders

xxv) The WHSSC SOs form a schedule to each LHB's own SOs, and shall have effect as if incorporated within them.

The role of the Committee Secretary

xxvi) The role of the Committee Secretary is crucial to the ongoing development and maintenance of a strong governance framework within the Joint Committee, and is a key source of advice and support to the Chair and Joint Committee members. Independent of the Joint Committee, the Committee Secretary acts as the guardian of good governance within the Joint Committee:

- Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance;
- Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, its joint sub-Committees and Advisory Groups;
- Ensuring that Joint Committee members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the Joint Committee's compliance with the law, WHSSC SOs and the framework set by the LHBs and Welsh Ministers.

xxvii) As advisor to the Joint Committee, the Committee Secretary's role does not affect the specific responsibilities of Joint Committee members for governing the Committee's operations. The Committee Secretary is directly accountable for the conduct of their role to the Chair of the Joint Committee.

Section: B – WHSSC Standing Orders

1. THE JOINT COMMITTEE

1.1 Purpose and Delegated functions[7]

1.1.1 The Joint Committee has been established for the purpose of jointly exercising those functions relating to the planning and securing of certain specialised and tertiary services on a national all-Wales basis, on behalf of each of the seven LHBs in Wales.

1.1.2 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of specialised and tertiary services for residents within their area.

1.1.3 Each LHB will have appropriate arrangements to equip the Chief Executive to represent the views of the individual Board and discharge their delegated authority appropriately.

1.1.4 The Joint Committee's role is to:

- Determine a long-term strategic plan for the development of specialised and tertiary services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services;
- Develop national policies for the equitable access to safe and sustainable, high quality specialised and tertiary healthcare services across Wales, whether planned, funded and secured at national, regional or local level;
- Agree annually those services that should be planned on a national basis and those that should be planned locally;
- Produce an Integrated Commissioning Plan, for agreement by the Committee in conjunction with the publication of the individual LHB's Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of specialised and tertiary services at a national level, and determining the

7 The WHSSC (Wales) Directions 2009 and The WHSSC (Wales) Regulations 2009

contribution from each LHB for those services (which will include the running costs of the Joint Committee and the WHSST) in accordance with any specific directions set by the Welsh Ministers;

- Establish mechanisms for managing the in year risks associated with the agreed service portfolio and new pressures that may arise;

- Secure the provision of specialised and tertiary services planned at a national level, including those to be delivered by providers outside Wales; and

- Establish mechanisms to monitor, evaluate and publish the outcomes of specialised and tertiary healthcare services and take appropriate action.

1.1.5 The Joint Committee must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its roles. In the event that the Joint Committee is unable to reach agreement, then the matter shall be escalated to the Welsh Government for resolution ultimately by Welsh Ministers.

1.1.6 To fulfil its functions, the Joint Committee shall lead and scrutinise the operations, functions and decision making of the Management Team undertaken at the direction of the Joint Committee.

1.1.7 The Joint Committee shall work with all its partners and stakeholders in the best interests of its population across Wales.

1.2 Membership of the Joint Committee[8]

1.2.1 The membership of the Joint Committee shall be 15 voting members and three associate members, comprising the *Chair* (appointed by the Minister for Health and Social Services) and the *Vice-Chair* (appointed by the Joint Committee from existing non-officer members of the seven LHBs)[9], together with the following:

Non-Officer Members [known as Independent Members] [10]

1.2.2 A total of 2, appointed by the Joint Committee from existing non-officer members of the seven LHBs.

8 Ref. Welsh Health Specialised Services Committee (Wales) Directions 2009, 5(1) and Welsh Health Specialised Services Committee (Wales) Regulations 2009, Part 2
9 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009, Regulation 4(1) & 4(2)
10 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009, Regulation 4(3)

Chief Executives

1.2.3 A total of 7, drawn from each Local Health Board in Wales.

Officer Members [known as WHSST Directors]

1.2.4 A total of 4, appointed by the Joint Committee, consisting of a Director of Specialised and Tertiary Services[11]; a Medical Director of Specialised and Tertiary Services; a Finance Director of Specialised and Tertiary Services, and a Nurse Director of Specialised and Tertiary Services. These officer members may have other responsibilities as determined by the Joint Committee and set out in the scheme of delegation to officers. These officer members comprise the Management Team.

1.2.5 Where a post of WHSST Director is shared between more than one person because of their being appointed jointly to a post:

i. Either or both persons may attend and take part in Joint Committee meetings;
ii. If both are present at a meeting they shall cast one vote if they agree;
iii. In the case of disagreement no vote shall be cast; and
iv. The presence of both or one person will count as one person in relation to the quorum.

Associate Members

1.2.6 The following Associate Members will attend Joint Committee meetings on an ex-officio basis, but will not have any voting rights:

- Chief Executive of Velindre NHS Trust
- Chief Executive of the Welsh Ambulance Services NHS Trust
- Chief Executive of Public Health Wales NHS Trust.

In attendance

1.2.7 The Joint Committee Chair may invite other members of the WHSST or others to attend all or part of a meeting on an ex-officio basis to assist the Joint Committee in its work.

Use of the term 'Independent Members'

1.2.8 For the purposes of these WHSSC SOs, use of the term 'Independent Members' refers to the following voting members of the Joint Committee:

11 The Director of Specialised and Tertiary Services is also known as the Managing Director of Specialised and Tertiary Services Commissioning

- Chair
- Vice-Chair
- Non-Officer Members

unless otherwise stated.

1.3 Member Responsibilities and Accountability

1.3.1 The Joint Committee will function as a decision-making body, all voting members being full and equal members and sharing corporate responsibility for all the decisions of the Joint Committee.

1.3.2 Independent Members who are appointed to the Joint Committee must act in a balanced manner, ensuring that any opinion expressed is impartial and based upon the best interests of the health service across Wales.

1.3.3 All members must comply with the terms of their appointment to the Committee. They must equip themselves to fulfil the breadth of their responsibilities on the Joint Committee by participating in relevant personal and organisational development programmes, engaging fully in the activities of the Joint Committee and promoting understanding of its work.

The Chair

1.3.4 The Chair is responsible for the effective operation of the Joint Committee:

- Chairing Joint Committee meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Joint Committee business is conducted in accordance with WHSSC SOs; and
- Developing positive and professional relationships amongst the Joint Committee's membership and between the Joint Committee and each LHB's Board.

1.3.5 The Chair shall work in close harmony with the Chair of each LHB and, supported by the Committee Secretary, shall ensure that key and appropriate issues are discussed by the Joint Committee in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.6 The Chair is directly accountable to the Minister for Health and Social Services in respect of their performance as Chair, to each LHB Board in relation to the delivery of the functions exercised by the Joint Committee on its behalf and, through the host LHB's Board, for the conduct of business in accordance with the defined governance and operating framework.

The Vice-Chair

1.3.7 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed[12].

1.3.8 The Vice-Chair is accountable to the Chair for their performance as Vice Chair.

Non-Officer Members

1.3.9 Non-Officer members are accountable to the Chair for their performance as Non-Officer members.

WHSST Director of Specialised and Tertiary Services

1.3.10 The WHSST Director of Specialised and Tertiary Services (Lead Director), as head of the Management Team reports to the Chair and is responsible for the overall performance of the WHSST. The Lead Director is accountable to the Joint Committee in relation to those functions delegated to them by the Joint Committee. The Lead Director is also accountable to the Chief Executive of the host LHB in respect of the administrative arrangements supporting the operation of the team.

WHSST Directors (excluding the WHSST Director of Specialised and Tertiary Services)

1.3.11 The Medical Director of Specialised and Tertiary Services, the Finance Director of Specialised and Tertiary Services, and the Nurse Director of Specialised and Tertiary Services are accountable to the Joint Committee and the Chief Executive of the host LHB through the Lead Director.

1.4 Appointment and tenure of Joint Committee members

1.4.1 The ***Chair,*** shall be appointed by the Minister for Health and Social Services for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. The Chair may be reappointed but may not serve a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term[13].

1.4.2 The ***Vice-Chair*** and two other ***Independent Members*** shall be appointed by the Joint Committee from existing Independent Members of the seven

12 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 3, Regulation 13
13 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 7

Local Health Boards for a period of no longer than two years in any one term. These members may be reappointed but may not serve a total period of more than 4 years, in line with that individual's term of office on any LHB Board. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term[14].

1.4.3 The appointment process for the Vice Chair and the two other Independent Members shall be determined by the Joint Committee, subject to the approval of each LHB Board and any directions made by the Welsh Ministers. In making these appointments, the Joint Committee must ensure:

- A balanced knowledge and understanding amongst the membership of the needs of all geographical areas served by the Joint Committee;
- That wherever possible, the overall membership of the Joint Committee reflects the diversity of the population; and
- Potential conflicts of interest are kept to a minimum.

1.4.4 The ***WHSST Directors*** shall be appointed by the Joint Committee[15], and employed by the host LHB in accordance with the eligibility requirements set out in the Welsh Health Specialised Services Committee (Wales) Regulations 2009 and the employment policies of the host LHB, as appropriate. The appointments process shall be in accordance with the workforce policies and procedures of the host LHB and any directions made by the Welsh Ministers.

1.4.5 WHSST Directors tenure of office as Joint Committee members will be determined by their contract of employment.

1.4.6 All Joint Committee members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements set for their role, so far as they are applicable, and as specified in the relevant regulations. Any member must inform the Joint Committee Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office[16].

2. RESPONSIBILITIES AND RELATIONSHIPS WITH EACH LHB BOARD, THE HOST LHB AND OTHERS[17]

2.0.1 The Joint Committee is not a separate legal entity from each of the LHBs. It shall report to each LHB Board on its activities, to which it is formally

14 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 7
15 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 4(3)
16 Ref. Welsh Health Specialised Services Committee (Wales) Regulations 2009 Part 2, Regulation 6,7,8 and 11
17 Ref. Welsh Health Specialised Services Committee (Wales) Directions 2009 3(4)

accountable in respect of the exercise of the functions carried out on their behalf. The Joint Committee shall also be held to account by the Welsh Government through the NHS performance management system.

2.0.2 The Board of the host LHB will not be responsible or accountable for the planning, funding and securing of specialised services, save in respect of residents within the areas served. The Board of the host LHB shall be responsible for ensuring that the WHSST acts in accordance with its administrative policies and procedures.

2.0.3 Each LHB Board may agree that designated board members or LHB officers shall be in attendance at Joint Committee meetings. The Joint Committee Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the relevant LHB Chair.

2.0.4 The LHBs jointly shall determine the arrangements for any meetings between the Joint Committee and LHB Boards.

2.0.5 The LHB Chairs *[through the lead Chair]* shall put in place arrangements to meet with the Joint Committee Chair on a regular basis to discuss the Joint Committee's activities and operation.

3. RESERVATION AND DELEGATION OF JOINT COMMITTEE FUNCTIONS

3.0.1 Within the framework approved by each LHB Board and set out within these WHSSC SOs - and subject to any directions that may be given by the Welsh Ministers - the Joint Committee may make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made.

3.0.2 The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i. Schedule of matters reserved to the Joint Committee;
ii. Scheme of delegation to joint sub-Committees and others; and
iii. Scheme of delegation to Officers.

all of which must be formally adopted by the Joint Committee.

3.0.3 The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.

3.1 Chair's action on urgent matters

3.1.1 There may, occasionally, be circumstances where 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 these circumstances, the Joint Committee Chair and the Lead Director, supported by the Committee Secretary, may deal with the matter on behalf of the Joint Committee - after first consulting with at least one other Independent Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Joint Committee for consideration and ratification.

3.1.2 Chair's action may not be taken where either the Joint Committee Chair or the Lead Director has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or another WHSST Director acting on behalf of the Lead Director will take a decision on the urgent matter, as appropriate.

3.2 Delegation to joint sub-Committees and others

3.2.1 The Joint Committee shall agree the delegation of any of its functions to joint sub-Committees or others (including networks), setting any conditions and restrictions it considers necessary and following any directions agreed by the LHBs or the Welsh Ministers.

3.2.2 The Joint Committee shall agree and formally approve the delegation of specific powers to be exercised by joint sub-Committees which it has formally constituted or to others.

3.3 Delegation to Officers

3.3.1 The Joint Committee will delegate certain functions to the Lead Director. For these aspects, the Lead Director, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Lead Director will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers.

3.3.2 This must be considered and approved by the Joint Committee (subject to any amendment agreed during the discussion). The Lead Director may periodically propose amendment to the Scheme of Delegation and any such amendments must also be considered and approved by the Joint Committee.

3.3.3 Individual Directors are in turn responsible for delegation within their own teams in accordance with the framework established by the Lead Director

and agreed by the Joint Committee.

4. JOINT SUB-COMMITTEES

4.0.1 In accordance with WHSSC Standing Order 4.0.3, the Joint Committee may and, where directed by the LHBs jointly or the Welsh Ministers 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).

4.0.2 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.

4.0.3 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 constituent LHBs. As a minimum, it shall establish joint sub-Committees which cover the following aspects of Joint Committee business:

- Quality and Safety
- Audit

4.0.4 The Joint Committee may make arrangements to receive and provide assurance to others through the establishment and operation of its own joint sub-Committees or by placing responsibility with the host LHB or other designated LHB. Where responsibility is placed with the host LHB or other designated LHB, the arrangement shall be detailed within the hosting agreement between the Joint Committee and the host LHB or the agreement between the seven LHB Accountable Officers (as appropriate).

4.0.5 Full details of the joint sub-Committee structure established by the Joint Committee, including detailed terms of reference for each of these joint sub-Committees are set out in Annex 3 of these WHSSC SOs.

4.0.6 Each joint sub-Committee established by or on behalf of the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;

- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

4.0.7 In doing so, the Joint Committee shall specify which aspects of the WHSSC SOs are not applicable to the operation of the joint sub-Committee, keeping any such aspects to the minimum necessary.

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.

4.0.9 WHSST Directors or officers should not normally be appointed as joint sub-Committee Chairs, nor should they be appointed to serve as members on any committee set up to review the exercise of functions delegated to officers. Designated WHSST Directors or officers shall, however, be in attendance at such joint sub-Committees, as appropriate.

4.1 Other Groups

4.1.1 The Joint Committee may also establish other groups to help it in the conduct of its business.

4.2 Reporting activity to the Joint Committee

4.2.1 The Joint Committee must ensure that the Chairs of all joint sub-Committees and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the Joint Committee on their activities. Joint sub-Committee Chairs' shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4.2.2 Each joint sub-Committee shall also submit an annual report to the Joint Committee through the Chair within 10 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

5. EXPERT PANEL AND OTHER ADVISORY GROUPS

5.0.1 The Joint Committee may, and where directed by the LHBs jointly or the Welsh Ministers must appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the Joint Committee, including detailed terms of reference are set out in Annex 4 of the WHSSC SOs.

5.0.2 Any Expert Panel or Advisory Group established by the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.0.3 In doing so, the Joint Committee shall specify which aspects of the WHSSC SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

5.0.4 The membership of any Expert Panel or Advisory Group - 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 or directions agreed by the LHBs or the Welsh Ministers.

5.1 Reporting activity

5.1.1 The Joint Committee shall ensure that the Chairs of any Expert Panel or Advisory Group reports formally, regularly and on a timely basis to the Joint Committee on their activities. Expert Panel or Advisory Group Chairs shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.1.2 Any Expert Panel or Advisory Group shall also submit an annual report to the Joint Committee through the Chair within 10 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has

established.

6. MEETINGS

6.1 Putting Citizens first

6.1.1 The Joint Committee's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The Joint Committee, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read, where requested or required, and in electronic formats;
- Requesting that attendees notify the Committee Secretary of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g. Disability Discrimination Act, as well as its Communication Strategy and the provisions made by the host body in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

6.1.2 The Joint Committee Chair will ensure that, in determining the matters to be considered by the Joint Committee, full account is taken of the views and interests of all citizens served by the Joint Committee on behalf of each LHB, including any views expressed formally.

6.2 Working with Community Health Councils

6.2.1 The Joint Committee shall make arrangements to ensure arrangements are in place to liaise with CHC members as appropriate.

6.3 Annual Plan of Committee Business

6.3.1 The Committee Secretary, on behalf of the Joint Committee Chair, shall produce an Annual Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Plan shall also set out any standing items that shall appear on every Joint Committee agenda.

6.3.2 The plan shall set out the arrangements in place to enable the Joint Committee to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Joint Committee members to contribute in either English or Welsh languages, where appropriate.

6.3.3 The plan shall also incorporate formal Joint Committee meetings, regular Committee Development sessions and, where appropriate, the planned activities of joint sub-Committees, Expert Panel and Advisory Groups.

6.3.4 The Joint Committee shall agree the plan for the forthcoming year by the end of March, and this plan shall be published on the organisation's website.

6.4 Calling Meetings

6.4.1 In addition to the planned meetings agreed by the Joint Committee, the Joint Committee Chair may call a meeting of the Joint Committee at any time. Any LHB may request that the Chair call a meeting, or an individual committee member may also request that the Joint Committee Chair call a meeting provided that in either case at least one third of the whole number of Committee members supports such a request.

6.4.2 If the Chair does not call a meeting within seven days after receiving such a request from Joint Committee members, then those Joint Committee members may themselves call a meeting.

6.5 Preparing for Meetings

Setting the agenda

6.5.1 The Joint Committee Chair, in consultation with the Committee Secretary and the Lead Director, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Joint Committee business; any standing items agreed by the Joint Committee; any applicable items received from joint sub-Committees and other groups as well as the priorities facing the Joint Committee. The Joint Committee Chair must ensure that all relevant matters are brought before the Joint Committee on a timely basis.

6.5.2 Any Joint Committee member may request that a matter is placed on the Agenda by writing to the Joint Committee Chair, copied to the Committee Secretary, at least 12 calendar days before the meeting. The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of Joint Committee business.

Notifying and equipping Joint Committee members

6.5.3 Joint Committee members should be sent an Agenda and a complete set of supporting papers at least 10[18] calendar days before a formal Joint Committee meeting. This information may be provided to Joint Committee members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Joint Committee Chair is satisfied that the Joint Committee's ability to consider the issues contained within the paper would not be impaired.

6.5.4 No papers should be included for decision by the Joint Committee unless the Joint Committee Chair is satisfied (subject to advice from the Committee Secretary, as appropriate) that the information contained within it is sufficient to enable the Joint Committee to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Joint Committee, and the outcome of that assessment shall accompany the report to the Joint Committee to enable the Joint Committee to make an informed decision.

6.5.5 In the event that at least half of the Joint Committee members do not receive the Agenda and papers for the meeting as set out above, the Joint Committee Chair must consider whether or not the Joint Committee would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Joint Committee Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.5.6 In the case of a meeting called by Joint Committee members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.5.7 Except for meetings called in accordance with WHSSC Standing Order 6.4, at least 10 calendar days before each meeting of the Joint Committee a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On each LHB's website, together with the papers supporting the public part of the Agenda; as well as

18 See Schedule 3, 2(3) of the LHB (Constitution, Membership and Procedures) Regulations 2009

- Through other methods of communication as set out in the Joint Committee's communication strategy.

6.5.8 When providing notification of the forthcoming meeting, each LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

6.6 Conducting Joint Committee Meetings

Admission of the public, the press and other observers

6.6.1 The Joint Committee shall encourage attendance at its formal Joint Committee meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the Joint Committee. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility.

6.6.2 The Joint Committee shall conduct as much of its formal business in public as possible[19]. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter affecting a WHSST officer or a patient. In such cases the Chair (advised by the Committee Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Joint Committee shall resolve:

> *That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].*

6.6.3 In these circumstances, when the Joint Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Joint Committee in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Joint Committee meeting held in public session.

6.6.4 The Committee Secretary, on behalf of the Joint Committee Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.6.5 In encouraging entry to formal Joint Committee Meetings from members of

19 Schedule 3, 8 of the LHB(Constitution, Membership and Procedures) Regulations 2009

the public and others, the Joint Committee shall make clear that attendees are welcomed as observers. The Joint Committee Chair shall take all necessary steps to ensure that the Joint Committee's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

6.6.6 Unless the Joint Committee has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Joint Committee, its joint sub-Committees, Expert Panel or Advisory Groups

6.6.7 The Joint Committee shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the Joint Committee, its joint sub-Committees, Expert Panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Joint Committee will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Joint Committee (whether directly or through the activities of bodies such as Community Health Councils) and to demonstrate openness and transparency in the conduct of business.

Chairing Joint Committee Meetings

6.6.8 The Chair of the Joint Committee will preside at any meeting of the Joint Committee unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice-Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

6.6.9 The Chair must ensure that the meeting is handled in a manner that enables the Joint Committee to reach effective decisions on the matters before it. This includes ensuring that Joint Committee members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Joint Committee must have access to appropriate advice on the conduct of the meeting through the attendance of the Committee Secretary. The Chair has the final say on any matter relating to the conduct of Joint Committee business.

Quorum

6.6.10 At least 8 voting members, at least 4 of whom are LHB Chief Executives and 2 are Independent Members, must be present to allow any formal business to take place at a Joint Committee meeting.

6.6.11 If a LHB Chief Executive is unable to attend a Joint Committee meeting they may nominate a deputy to attend on their behalf. The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have delegated voting rights.

6.6.12 If the Lead Director or another WHSST Director is unable to attend a Joint Committee meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, their voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Joint Committee member in their own right, e.g., a person deputising for the Lead Director will usually be another WHSST Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

6.6.13 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Joint Committee member or their deputy disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.6.14 In the normal course of Joint Committee business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Joint Committee member may put forward a motion proposing that a formal review of that service area is undertaken. The Committee Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Joint Committee unless moved by a Joint Committee member and seconded by another Joint Committee member (including the Joint Committee Chair).

6.6.15 **Proposing a formal notice of Motion –** Any Joint Committee member wishing to propose a motion must notify the Joint Committee Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and

the Joint Committee Chair has determined that the proposed motion is relevant to the Joint Committee's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the Joint Committee Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.6.16 The Joint Committee Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Joint Committee business.

6.6.17 **Amendments –** Any Joint Committee member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Joint Committee alongside the motion.

6.6.18 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

6.6.19 **Motions under discussion –** When a motion is under discussion, any Joint Committee member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Joint Committee member may not be heard further;
- The Joint Committee decides upon the motion before them;
- An ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.6.20 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.6.21 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Joint Committee Chair.

6.6.22 **Motion to rescind a resolution –** The Joint Committee may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Joint Committee members.

6.6.23 A Motion that has been decided upon by the Joint Committee cannot be proposed again within six months except by the Joint Committee Chair, unless the motion relates to the receipt of a report or the recommendations of a joint sub-Committee/WHSSC Director to which a matter has been referred.

Voting

6.6.24 The Joint Committee Chair will determine whether Joint Committee members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Joint Committee Chair must require a secret ballot or recorded vote if the majority of voting Joint Committee members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Joint Committee.

6.6.25 In determining every question at a meeting the Joint Committee members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of citizens in Wales. Such views may be presented to the Joint Committee through the Chairs of the LHB's Advisory Groups.

6.6.26 The Joint Committee will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

6.6.27 A nominated deputy of a LHB Chief Executive may vote. In no circumstances may a nominated deputy of a WHSST member vote. Absent Joint Committee members may not vote by proxy. Absence is defined as being absent at the time of the vote.

6.7 Record of Proceedings

6.7.1 A record of the proceedings of formal Joint Committee meetings (and any other meetings of the Joint Committee where the Joint Committee members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Joint Committee member attendance (including the Joint Committee Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Joint Committee, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.7.2 Agreed minutes shall be circulated in accordance with Joint Committee

members' wishes, and, where providing a record of a formal Joint Committee meeting shall be made available to the public on each LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act, the Joint Committee's Communication Strategy and the host LHB's Welsh language requirements.

6.8 Confidentiality

6.8.1 All Joint Committee members (including Associate Members), together with members of any joint sub-Committee, Expert Panel or Advisory Group established by or on behalf of the Joint Committee and Joint Committee and/or LHB officials must respect the confidentiality of all matters considered by the Joint Committee in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Joint Committee Chair or relevant joint sub-Committee or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the WHSSC Values and Standards of Behaviour (including Gifts and Hospitality) Policy or legislation such as the Freedom of Information Act 2000, etc.

7. VALUES AND STANDARDS OF BEHAVIOUR

7.0.1 The Joint Committee must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, WHSST officers and others, as appropriate. The framework adopted by the Joint Committee will form part of the WHSSC SOs.

7.1 Declaring and recording Joint Committee members' interests

7.1.1 **Declaration of interests –** It is a requirement that all Joint Committee members should declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Joint Committee member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Joint Committee's business. Joint Committee members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations. Joint Committee members must notify the Joint Committee of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Joint Committee members.

7.1.2 Joint Committee members must also declare any interests held by family members or persons or bodies with which they are connected. The Committee Secretary will provide advice to the Joint Committee Chair and the Joint Committee on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Joint Committee members are in any doubt about what may be considered as an interest, they should seek advice from the Committee Secretary. However, the onus regarding declaration will reside with the individual Joint Committee member.

7.1.3 **Register of interests –** The Lead Director, through the Committee Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Joint Committee members. The register will include details of all Directorships and other relevant and material interests which have been declared by Joint Committee members.

7.1.4 The register will be held by the Committee Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Joint Committee members. The Committee Secretary will also arrange an annual review of the register, through which Joint Committee members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the Joint Committee's commitment to openness and transparency, the Committee Secretary must take reasonable steps to ensure that citizens served by the Joint Committee are made aware of, and have access to view the Joint Committee's Register of Interests. This may include publication on the Joint Committee's website.

7.1.6 **Publication of declared interests in Annual Report –** Joint Committee members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in each LHB Board's Annual Report.

7.2 Dealing with Members' interests during Joint Committee meetings

7.2.1 The Joint Committee Chair, advised by the Committee Secretary, must ensure that the Joint Committee's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Joint Committee members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the Joint Committee and as a member of the Board of an LHB that provides

specialised and tertiary services.

7.2.2 Where individual Joint Committee members identify an interest in relation to any aspect of Joint Committee business set out in the Joint Committee's meeting agenda, that member must declare an interest at the start of the Joint Committee meeting. Joint Committee members should seek advice from the Joint Committee Chair, through the Committee Secretary, before the start of the Joint Committee 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 Joint Committees minutes.

7.2.3 It is the responsibility of the Joint Committee Chair, on behalf of the Joint Committee, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may include determination that:

i. The declaration is formally noted and recorded, but that the Joint Committee member should participate fully in the Joint Committee's discussion and decision, including voting.

ii. The declaration is formally noted and recorded, and the Joint Committee member participates fully in the Joint Committee's discussion, but takes no part in the Joint Committee's decision;

iii. The declaration is formally noted and recorded, and the Joint Committee member takes no part in the Joint Committee discussion or decision;

iv. The declaration is formally noted and recorded, and the Joint Committee member is excluded for that part of the meeting when the matter is being discussed. A Joint Committee member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Joint Committee.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Joint Committee member is compatible with an identified conflict of interest.

7.2.5 Where the Joint Committee Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice-Chair, on behalf of the Joint Committee.

7.2.6 In all cases the decision of the Joint Committee Chair (or the Vice-Chair in the case of an interest declared by the Joint Committee Chair) is binding on all Joint Committee members. The Joint Committee Chair should take

advice from the Committee Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 **Members with pecuniary (financial) interests –** Where a Joint Committee member, or any person they are connected with[20] has any direct or indirect pecuniary interest in any matter being considered by the Joint Committee including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Joint Committee may determine that the Joint Committee member concerned shall be excluded from that part of the meeting.

7.2.8 **The Local Health Boards (Constitution, Membership and Procedures) Wales Regulations 2009** define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. The WHSSC SOs must be interpreted in accordance with these definitions.

7.2.9 **Members with Professional Interests –** During the conduct of a Joint Committee meeting, an individual Joint Committee member may establish a clear conflict of interest between their role as a Joint Committee member and that of their professional role outside of the Joint Committee. In any such circumstance, the Joint Committee shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Committee Secretary.

7.3 Dealing with officers' interests

7.3.1 The Joint Committee must ensure that the Committee Secretary, on behalf of the Lead Director, establishes and maintains a system for the declaration, recording and handling of WHSST officers' interests in accordance with the Values and Standards of Behaviour Framework.

7.4 Reviewing how Interests are handled

7.4.1 The Joint Committee's Audit Committee will review and report to the LHBs upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

7.5 Dealing with offers of gifts,[21] hospitality and sponsorship

7.5.1 The Standards of Behaviour (including Gifts and Hospitality) Policy adopted by the Joint Committee prohibits Joint Committee members and WHSST

[20] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

[21] The term gift refers also to any reward or benefit.

officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any Joint Committee member or WHSST officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Joint Committee member or WHSST officer. Failure to observe this requirement may result in disciplinary and/or legal action.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Committee Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Joint Committee;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Joint Committee; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it must always be declined.

7.5.4 A distinction shall be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

7.6 Sponsorship

7.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

7.6.2 All sponsorship must be approved prior to acceptance in accordance with the WHSSC Values and Standards of Behaviour (including Gifts and Hospitality) Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

7.7 Register of Gifts, Hospitality and Sponsorship

7.7.1 The Committee Secretary, on behalf of the Joint Committee Chair, will maintain a Register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Joint Committee members. WHSST Directors will adopt a similar mechanism in relation to WHSST officers working within their areas.

7.7.2 Every Joint Committee member and WHSST officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship made in their capacity as Joint Committee members, including those offers that have been refused. The Committee Secretary, on behalf of the Joint Committee Chair and Lead Director, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship is kept under active review, taking appropriate action where necessary.

7.7.3 When determining what should be included in the register with regard to gifts and hospitality, individuals must apply the following principles, subject to the considerations in WHSSC Standing Order 7.5:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value would not usually need to be recorded, e.g., seasonal items such as diaries/calendars with normally fall within this category.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[22]' hospitality need not be included in the Register.

7.7.4 Joint Committee members and WHSST Officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the Joint Committee;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.7.5 The Committee Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Joint Committee to be submitted to the designated Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the LHBs jointly upon the adequacy of the Joint Committees arrangements for dealing with offers of gifts, hospitality and sponsorship.

8. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

8.0.1 The Joint Committee shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

8.0.2 The Joint Committee shall ensure that its assurance arrangements are operating effectively, advised by the Joint Committee's Audit Committee.

8.1 The role of Internal Audit in providing independent internal assurance

8.1.1 The Joint Committee shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Ministers.

[22] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

8.2 Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups

8.2.1 The Joint Committee shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its joint sub-Committees, Expert Panel and any other Advisory Groups. Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated.

8.2.2 Each joint sub-Committee and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the Joint Committee through the Chair within 10 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

8.2.3 The Joint Committee, and in turn the LHBs jointly shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Committee Development Programme, as part of an overall Organisation Development framework; and
- Inform each LHBs report of its alignment with the Welsh Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

8.3 External Assurance

8.3.1 The Joint Committee shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

8.3.2 The Joint Committee may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Joint Committee itself may commission specifically for that purpose.

8.3.3 The Joint Committee shall keep under review and ensure that, where appropriate, the Joint Committee implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the National Assembly for Wales's Public Accounts Committee and other appropriate bodies.

8.3.4 The Joint Committee shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

9. DEMONSTRATING ACCOUNTABILITY

9.0.1 Taking account of the arrangements set out within these WHSSC SOs, the Joint Committee shall demonstrate to the LHBs jointly, citizens and other stakeholders and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the citizens it serves, its officers and healthcare professionals.

9.0.2 The Joint Committee shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

9.0.3 The Joint Committee shall ensure that within the WHSST, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

9.1 Support to the Joint Committee

9.1.1 The Committee Secretary, on behalf of the Joint Committee Chair, will ensure that the Joint Committee is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the Joint Committee;
- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Joint Committee Chair on the conduct of its business and its relationship with LHBs, the host LHB and others;
- Ensuring the provision of secretariat support for Joint Committee meetings;
- Ensuring that the Joint Committee receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups;
- Ensuring an effective relationship between the Joint Committee and its host LHB; and

- Facilitating effective reporting to each LHB

enabling each LHB Board to gain assurance on the conduct of business carried out by Joint Committee on its behalf.

10. REVIEW OF STANDING ORDERS

10.0.1 The WHSSC SOs shall be reviewed annually by the Joint Committee, which shall report any proposed amendments to the LHBs jointly for consideration and approval. The requirement for review extends to all documents having the effect as if incorporated in WHSSC SOs, including the appropriate impact assessment.

Annex 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

Introduction

As set out in WHSSC Standing Order 3, the Welsh Health Specialised Services Committee (the Joint Committee) - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively, and in a manner that secures the achievement of the Joint Committee's aims and objectives. The Joint Committee may delegate functions to:

i. A sub-Committee of the Joint Committee, e.g., Audit Committee;

ii. A Group, Expert Panel or Advisory Group , e.g., with other LHBs established to take forward certain matters relating to specialist services; and

iii. Officers of the Joint Committee (who may, subject to the Joint Committee's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Joint Committee is notified of any matters that may affect the operation and/or reputation of the Joint Committee.

The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Joint Committee;
- Scheme of delegation to sub-Committees or sub-Groups and others; and
- Scheme of delegation to officers.

all of which form part of the WHSSC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Joint Committee will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- *Everything is retained by the Joint Committee unless it is specifically delegated in accordance with the requirements set out in WHSSC SOs or WHSSC SFIs*

- *The Joint Committee must retain that which it is required to retain (whether by statute or as determined by the Welsh Government) as well as that which it considers is essential to enable it to fulfil its role in setting the Joint Committee's direction, equipping the Joint Committee to deliver and ensuring achievement of its aims and objectives through effective performance management*

- *Any decision made by the Joint Committee to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility*

- *The Joint Committee must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development*

- *The Joint Committee must take appropriate action to assure itself that all matters delegated are effectively carried out*

- *The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes*

- *The Joint Committee may delegate authority to act, but retains overall responsibility and accountability*

- *When delegating powers, the Joint Committee will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.*

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Joint Committee

The Joint Committee will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Lead Director

The Lead Director will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Joint Committee must formally agree this scheme.

In preparing the scheme of delegation to officers, the Lead Director will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in WHSSC SFIs);
- The Memorandum of Agreement agreed with the seven LHBs and approved by the Joint Committee; and
- The Hosting Agreement agreed with the host LHB and approved by the Joint Committee.

The Lead Director may re-assume any of the powers they have delegated to others at any time.

The Committee Secretary

The Committee Secretary will support the Joint Committee in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Joint Committee is presented to the Joint Committee for its formal agreement;
- Effective arrangements are in place for the delegation of Joint Committee functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Joint Committee for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Joint Committee of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Lead Director of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the Joint Committee has set out alternative arrangements.

If the Lead Director is absent their nominated Deputy may exercise those powers delegated to the Lead Director on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Lead Director or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Joint Committee. The Scheme is to be used in conjunction with the system of control and other established procedures within the Joint Committee.

SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE[23]

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
1	FULL	GENERAL	The Joint Committee may determine any matter for which it has statutory or delegated authority, in accordance with WHSSC SOs
2	FULL	GENERAL	The Joint Committee must determine any matter that will be reserved to the whole Joint Committee. These are detailed below:
3	FULL	GENERAL	Approve the Joint Committee's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Vary, amend and recommend for approval to the Boards of the Local Health Boards: ▪ WHSSC SOs ; ▪ WHSSC SFIs; ▪ Schedule of matters reserved to the Joint Committee; ▪ Scheme of delegation to sub-Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING	Ratify any urgent decisions taken by the Chair and the Lead Director in accordance

[23] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

		ARRANGEMENTS	with WHSSC Standing Order requirements
6	NO – Nominated Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Committee Secretary on any non-compliance with WHSSC Standing Orders, making proposals to the Joint Committee on any action to be taken.
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with WHSSC Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's Values and Standards of Behaviour framework
9	NO - Chair on behalf of Joint Committee, Vice-chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Joint Committee members' interests, in accordance with advice received, e.g. From Audit Committee or Committee Secretary.
10	FULL	STRATEGY & PLANNING	Determine the long term strategic plan for the development of specialised services and tertiary services in Wales, in conjunction with Welsh Ministers.
11	FULL	STRATEGY & PLANNING	Approve the Joint Committee's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan

			▪ The development and delivery of patient and population centred specialised and tertiary services for the population of Wales ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
12	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
13	FULL	STRATEGY & PLANNING	Approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
14	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's framework and strategy for performance management.
15	FULL	STRATEGY AND PLANNING	Approve the LHBs framework and strategy for risk and assurance
16	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with Putting Things Right and health and safety requirements.
17	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Joint Committee, including standards/requirements determined by Welsh Government, regulators, professional bodies/others, e.g., National Institute of Health and Care Excellence (NICE)
18	FULL	STRATEGY & PLANNING	Approve the Joint Committee's patient, public, staff, partnership and stakeholder engagement and co-production.
19	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Joint Committee determines

			it so based upon its contribution/impact on the achievement of the Joint Committee's aims, objectives and priorities
20	FULL	ORGANISATION STRUCTURE & STAFFING	Appointment, appraisal, discipline and dismissal of the officer members of the Joint Committee (Directors) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions.
21	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Joint Committee level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Committee Secretary.
22	FULL	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
23	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the Joint Committee's top level organisation structure and Joint Committee policies
24	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Joint Committee sub-Committees, including any joint sub-Committees directly accountable to the Joint Committee
25	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any sub-Committee, joint sub-Committee or Group set up by the Joint Committee
26	FULL	ORGANISATION STRUCTURE &	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Joint Committee on outside bodies and groups

		STAFFING	
27	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all sub-Committees, joint sub-Committees and groups established by the Joint Committee
28	FULL – except where Chapter 6 specifies appropriate to delegate to Officers.	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
29	FULL – except where Chapter 6 specifies appropriate to delegate to Officers.	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Lead Director and officers
30	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Joint Committee
31	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Lead Director set out in the WHSSC SFIs
32	FULL	PERFORMANCE & ASSURANCE	Approve the Joint Committee's audit and assurance arrangements

33	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Joint Committee's WHSST Directors on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
34	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the Joint Committee's sub-Committees, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans
35	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Joint Committee's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-Committees (as appropriate)
36	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Joint Committee's Chief Internal Auditor and approve action required, including improvement plans
37	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Joint Committee's external auditor and approve action required, including improvement plans
38	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the Joint Committee's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
39	FULL	REPORTING	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required.
40	FULL	REPORTING	Receive, approve and ensure the publication of Joint Committee reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE-CHAIR AND INDEPENDENT MEMBERS			
	Chair		Chair of the Integrated Governance Committee
	Independent Member or Vice-Chair		Audit Lead
	Independent Member or Vice-Chair		Chair of the Quality and Patient Safety Committee

DELEGATION OF POWERS TO SUB-COMMITTEES AND OTHERS[24]

WHSSC Standing Order 3 provides that the Joint Committee may delegate powers to sub-Committees and others. In doing so, the Joint Committee has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such sub-Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others.

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Joint Committee has delegated a range of its powers to the following sub-Committees and others:

- Audit & Risk Committee (of the host organisation)
- Quality and Patient Safety Committee
- Individual Patient Funding Request (IPFR) Panel (WHSSC)
- Integrated Governance Committee
- Welsh ~~Renal Clinical~~Kidney Network (WKN)
- Management Group

The scope of the powers delegated, together with the requirements set by the Joint Committee in relation to the exercise of those powers are as set out in i) sub-Committee terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the Joint Committee's Scheme of Delegation to sub-Committees.

[24] As defined in Standing Orders.

SCHEME OF DELEGATION TO WHSST DIRECTORS AND OFFICERS

The WHSSC SOs and WHSSC SFIs specify certain key responsibilities of the Lead Director, the Director of Finance and other officers. The Lead Director's Job Description sets out their specific responsibilities, and the individual job descriptions determined for other WHSST Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the WHSSC SFIs form the basis of the Joint Committee's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
Agreeing and signing Health Care Agreements and Contracts with service providers for health care services	Lead Director Director of Finance (Deputy)
Approval to commission Specialist healthcare services	Lead Director
Information Governance arrangements	Committee Secretary (in conjunction with the host LHB)
Management of Concerns	Director of Nursing & Quality Assurance
Health and Safety arrangements	Lead Director/ Committee Secretary (in conjunction with the host LHB)
Investigate any suspected cases of irregularity not related to fraud and corruption in accordance with government directions.	Chair/ Lead Director Director of Finance (Deputy)
Issuing tenders and post tender negotiations.	Lead Director Director of Finance (Deputy)
Legal advice	Committee Secretary

Action on litigation	Lead Director/ Committee Secretary
Operation of detailed financial matters, including bank accounts and banking procedures	Director of Finance (in conjunction with the host LHB Director of Finance)
Workforce	Committee Secretary
Public consultation	Lead Director
Manage central reserves and contingencies	Director of Finance
Management and control of stocks other than pharmacy stocks	Lead Director
Management and control of computer systems and facilities	Committee Secretary
Monitor and achievement of management cost targets	Lead Director
Recording of payments under the losses and compensation regulations	Director of Finance
Individual Patient Funding Requests	Director of Nursing & Quality Assurance
Approve and ensure the publication of non-statutory Annual Report	Lead Director
Welsh Kidney Network (WKN)	Programme Director

This scheme only relates to matters delegated by the Joint Committee to the Lead Director and other WHSST Directors, together with certain other specific matters referred to in WHSSC SFIs.

Each WHSST Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Annex 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

Joint Committee framework

The Joint Committee's governance and accountability framework comprises these WHSSC SOs, incorporating schedules of Powers reserved for the Joint Committee and Delegation to others, together with the following documents:

- ***WHSSC SFIs***
- ***Values and Standards of Behaviour Framework (link to document)***
- ***Risk Management Strategy (link to document)***
- ***Key policy documents***

agreed by the Joint Committee. These documents must be read in conjunction with the WHSSC SOs and will have the same effect as if the details within them were incorporated within the WHSSC SOs themselves.

These documents may be accessed from the Committee Secretary by written request.

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.Directions or guidance on specific aspects of Joint Committee business are also issued electronically, usually under cover of a Welsh Health Circular.

Annex 3

JOINT COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

Management Group

Quality & Patient Safety Committee

Integrated Governance Committee

Welsh ~~Renal Clinical Netwtork~~ Kidney Network (WKN)

Annex 4

ADVISORY GROUPS AND EXPERT PANELS TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

MEMORANDUM OF AGREEMENT

RELATING TO

WELSH HEALTH SPECIALISED SERVICES COMMITTEE

(WALES) DIRECTIONS 2009

MEMORANDUM OF AGREEMENT

THIS MEMORANDUM OF AGREEMENT is made the ***13 July 2021***
BETWEEN

(1) ANEURIN BEVAN UNIVERSITY LOCAL HEALTH BOARD, having headquarters at St Cadoc's Hospital, Lodge Road, Caerleon, Newport, NP18 3XQ

(2) BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

(3) CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD, having headquarters at 2nd Floor, Woodland House, Maes-y-coed Road, Cardiff CF14 4HH,

(4) CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ynysmeurig House, Navigation Park, Abercynon, Rhondda Cynon Taff, CF45 4SN.

(5) HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ystwyth Building, St David's Park Carmarthen, SA31 3BB.

(6) POWYS TEACHING LOCAL HEALTH BOARD, having headquarters at Mansion House, Bronllys, Brecon, Powys, LD3 0LS

(7) SWANSEA BAY UNIVERSITY LOCAL HEALTH BOARD, having headquarters at 1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot, SA12 7BR

WHEREAS:

A. In accordance with the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009 No.35), the LHBs are required to establish a Joint Committee for the purpose of jointly exercising its Delegated Functions and providing the Relevant Services from 1 April 2010.

B. The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (SI 2009 No 3097) make provision for the constitution of the Joint Committee including its procedures and administrative arrangements.

C. Cwm Taf Morgannwg University Local Health Board (CTMUHB) has been identified as Host LHB to provide administrative support for the running of the Joint Committee and to establish the Welsh Health Specialised Services Team as per Direction 3(4) and Regulation 3(1)(d) and the interpretation

sections of both the Directions and the Regulations and the Joint Committee Standing Orders: Statutory Framework and Joint Committee Framework.

D. The Joint Committee has been established in accordance with the Directions and Regulations to enable the seven LHBs in NHS Wales to make collective decisions on the review, planning, procurement and performance monitoring of agreed specialised and tertiary services (Relevant Services) and in accordance with their defined Delegated Functions. The Joint Committee therefore comprises, and is established by, all the LHBs.

E. The LHBs have been given the financial responsibility for all of the specialised and tertiary health needs for their respective populations. Refer to Standing Order 1.1.

F. The Directions and Regulations require that the Chief Executives of each of the 7 LHBs listed as Parties to this Agreement be members of the Joint Committee. This Agreement defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executives of the constituent LHBs as individual members of the Joint Committee. This is in accordance with their objective to make collective decisions as to the provision of national services as described above and in the interests of NHS Wales and the health needs of their individual populations. Refer to Standing Orders: Statutory Framework, NHS Framework and Joint Committee Framework (for governance arrangements); and to Standing Orders 1.2 and 1.3 (for membership, responsibilities and accountability).

1. INTERPRETATIONS

'the Act'	the National Health Service (Wales) Act 2006 (C.42)
'Associate Members'	the Chief Executives of Public Health Wales NHS Trust, Velindre University NHS Trust, Welsh Ambulance Services NHS Trust. Refer to Regulation 3(3) and Standing Order 1.2.6
'the Directions'	the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)
'Chair'	the person appointed by the Minister to lead the Welsh Health Specialised Services Committee and to ensure it successfully discharges its overall responsibility on behalf of the LHBs. Refer to Regulation 4(1) and Standing Orders 1.3.4 to 1.3.6.
'Chief Executives'	the Chief Executives of the constituent LHBs
'Committee Secretary'	the person appointed by the Welsh Health Specialised Services Committee as its principal advisor on all aspects of governance. Refer to Standing Orders: The Role of the Committee Secretary.
'Role of the Joint Committee	the role ascribed to the Joint Committee ascribed to the Joint Committee in section 4 of this Agreement. Refer to Standing Order 1.1.
'Dispute Process'	the arbitration process agreed with WG.
'WHSST Directors'	the Officer Members of the Joint Committee as defined in Regulation 3(2) of the Regulations.
'Host LHB'	Cwm Taf Morgannwg University Local Health Board
'Joint Committee'	the Welsh Health Specialised Services Committee established in accordance with the Directions and Regulations
'LHB'	Local Health Board established in accordance with s 11(2) of the Act
'Management Group'	the purpose of the Management Group is to be the Specialised Services Commissioning operational body

	responsible for the implementation of the Specialised Services Strategy. It will underpin the commissioning of Specialised Services to ensure equitable access to safe, effective, sustainable and acceptable services for the people of Wales. The Membership of the Group is determined locally but as a minimum consists of LHB planning/commissioning representation and/or Finance representation.
'Management Team'	the team appointed in accordance with paragraph 10.2 of the Agreement, comprising of the Lead Director, Medical Director, Finance Director and Nurse Director of Specialised and Tertiary Services. Refer to Regulations 3(2) and Standing Order 1.2.4.
'NHS Wales'	the comprehensive health service for Wales established by the NHS (Wales) Act 2006 (C.42)
'Provider LHB'	a LHB which provides specialised and tertiary services to the Joint Committee
'the Regulations'	the Welsh Health Specialised Services Committee (Wales) Regulations 2009 (2009/3097 (W.270))
'Relevant Services'	the planning and securing of specialised and tertiary services consisting of those functions and services listed in Annex (i) of the Welsh Health Specialised Services Committee (Wales) Directors 2009, and incorporated as Annex (i) in this this Agreement, subject to any variations to those functions agreed from time to time by the Joint Committee.
'WG'	Welsh Government as announced by the First Minister of Wales on 12 May 2011
'WHSST'	the Welsh Health Specialised Services Team consisting of staff employed by the Host LB to provide the Relevant Services, including WHSST Directors.

2. CORPORATE IDENTITY

2.1 The corporate identity for the Joint Committee will be in accordance with the Corporate Identity Guidelines issued by Welsh Government to LHBs. The Joint Committee will be referred to as the 'Welsh Health Specialised Services Committee' on stationery and signage.

3. PRINCIPLES

3.1 The Joint Committee is a statutory committee established under sections 12 (1)(b) and (3), 13(2)(c), (3)(c) and (4)(c) and 203(9) and (10) of the Act. The LHBs are required to jointly exercise the Relevant Services. Refer to Standing Orders: Statutory Framework

3.2 The principle of subsidiarity will apply so that the Joint Committee will agree annually a List of Specialist Services which has approved by the Joint Committee as part of the Annual Planning process. The Joint Committee will be only responsible for the provision of those services which are identified in the List of Specialist Services. Any other service not identified in the List of Specialist Services will be the responsibility of each LHB to provide locally. Nothing in this paragraph shall prevent any LHB from exercising its discretion as to how to provide these services, either individually, or in conjunction with other LHBs or other bodies. Refer to Standing Order 1.1.2

3.3 Each LHB is accountable, through its statutory responsibilities, to use its resources to plan, fund, design, develop and secure the delivery of primary, community, in-hospital care services and specialised services for their population. For a number of national services, this can only be achieved by working collaboratively with all LHBs. The Joint Committee is established on this basis of a shared, national approach to the joint planning of specialised and tertiary services on behalf of each LHB, ultimately accountability to citizens and other stakeholders for the provision of specialised and tertiary services for residents within their area remains with individual LHBs. Refer to Standing Order 1.1.2.

3.4 In performing its role, the Joint Committee and each individual Chief Executive shall work in the wider interest of NHS Wales. In so doing, they shall work with all of the Joint Committee's appropriate partners and stakeholders in the best interests of NHS Wales. In so doing, the Joint Committee will take account of the following key principles:

3.4.1 Collaboration should be designed to deliver changes in services and demonstrable population benefit;

3.4.2 Collaboration should ensure a more extensive and consistent use of evidence supported by a robust analysis of need;

3.4.3 Collaboration must not diminish clinical engagement;

3.4.4 Collaboration should support LHBs in working together more effectively, in an open and transparent way, for the benefit of the local population;

3.4.5 Collaboration must enhance resource utilisation in the planning process to reduce duplication and overlap;

3.4.6 Collaboration should focus upon articulating need, reviewing evidence of good practice, designing models of care and producing clear service specification;

3.4.7 Collaboration should promote equity in service delivery.

Refer to Standing Orders 1.1 and 1.4

3.5 Each LHB acknowledges the following principles:

3.5.1 the Management Team will be held to account by the Joint Committee for the delivery of a strategy for the provision of specialised and tertiary services for Wales as well as providing assurance that the systems of control in place are robust and reliable.

3.5.2 that any decision taken and approved by the Joint Committee in respect of the provision of the Relevant Services is binding on the constituent LHBs and may not be undermined by any subsequent decision or action taken by a constituent LHB. Refer to Standing Order 1.1.5

3.5.3 that each individual LHB is responsible for the people who are resident in their area. This means that the Joint Committee of which each Chief Executive is a member is acting on behalf of the 7 LHBs in undertaking its role. Refer to Standing Order 1.1.2.

3.5.4 that their respective Chief Executives have an individual responsibility to contribute to the performance of the role of the Joint Committee and to share in the decision making in the interests of the wider population of NHS Wales. At the same time, they acknowledge their own Chief Executive's individual accountability to their constituent LHB and their obligation to

act transparently in the performance of their functions. Refer to Standing Orders 1.1.2 and 1.1.4.

3.5.5 that each Chief Executive as a member of the Joint Committee will require the Management Team of the Joint Committee to ensure that, in the timetabling of the annual work programme, sufficient time will normally be allowed to enable each Chief Executive to consult with their own LHB and appropriate local partners and stakeholders.

3.5.6 that when an individual Chief Executive is unable to attend a meeting of the Joint Committee, he/she will appoint in advance and identify to the Committee Secretary a deputy to attend on their behalf. The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have delegated voting rights. Refer to Standing Order 6.6.10 and 6.6.11

3.6 Each Chief Executive will agree to advise the Chair of any circumstances where it is considered that there may be a conflict of interest between the performance of the national planning functions of the Joint Committee and the effect of any such decision on the scope of the services which the constituent LHB provides. Refer to Standing Order 7: Values and Standards of Behaviour

3.6.1 where the Chair considers that the conflict is not clear he will consult with the remainder of the Committee and reach a collective view.

3.6.2 where the Chair decides that there is a clear conflict of interest the Chief Executive will be required to abstain from the discussion.

3.7 The Joint Committee will strive to make decisions by consensus, failing which it will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no two thirds majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

4. ROLE OF THE JOINT COMMITTEE

4.1 The role of the Joint Committee as determined by the Welsh Ministers are (refer to Standing Order 1.1.4):

- Determine a long-term strategic plan for the development of specialised and tertiary services in Wales, in conjunction with the

Welsh Ministers;

- Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services;

- Develop national policies for the equitable access to safe and sustainable, high quality specialised and tertiary healthcare services across Wales, whether planned, funded and secured at national, regional or local level;

- Agree annually those services that should be planned on a national basis and those that should be planned locally;

- Produce an Integrated Commissioning Plan, for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans;

- Agree the appropriate level of funding for the provision of specialised and tertiary services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the WHSST) in accordance with any specific directions set by the Welsh Ministers;

- Establish mechanisms for managing the in year risks associated with the agreed service portfolio and new pressures that may arise;

- Secure the provision of specialised and tertiary services planned at a national level, including those to be delivered by providers outside Wales; and

- Establish mechanisms to monitor, evaluate and publish the outcomes of specialised and tertiary healthcare services and take appropriate action.

5. ANNUAL WORK PROGRAMME AND PLANNING

5.1 The Joint Committee and its Management Team will adhere to the standards of good governance set for the NHS in Wales and which are based on Welsh Government's Citizen Centred Governance Principles. Refer to Standing Order: NHS Framework.

5.2 The Joint Committee will:

5.2.1 report to the individual LHBs on its activities. It is formally accountable to the individual LHBs in respect of its role carried

out on their behalf. Refer to Standing Order 9: Demonstrating Accountability.

5.2.2 lead and scrutinise the operations, functions and decision making of the Management Team. It will require the Management Team to report to it on its activities and it will hold the Management Team to account on behalf of the seven LHBs. Refer to Standing Order 1.1.6.

5.3 The Joint Committee will therefore require:

5.3.1 the Management Team to co-operate with them as members of the Joint Committee in securing agreed processes so that patients in Wales may have the equal opportunity to access new advances in treatment but in a way which ensures that services which no longer require collaborative planning are stepped down at the appropriate time to the individual LHBs as local providers.

5.3.2 the Management Team to prepare for their approval a Plan of Business for the year. They will also require the Management Team to agree with the Joint Committee an appropriate way of working. This will include submitting to the Joint Committee for discussion and agreement (following an appropriate internal and external consultation process) a Priorities Programme, an annual List of Specialised Services to be planned nationally and identifying the services to be stepped down for local provision, national Planning Policies and a Schedule of other appropriate policies for development and review on an annual basis.

5.3.3 in developing any new or amended policy the Management Team will prepare a suggested process which will be subject to an approved corporate standard for agreement by the Joint Committee.

5.3.4 the Management Team will undertake on an annual basis a mapping exercise of the Healthcare Standards which apply to the Joint Committee. An annual return will be submitted to the LHBs for inclusion in their annual return to Welsh Government.

5.3.5 a Quality and Patient Safety Sub Committee will be established to provide evidence based and timely advice to the Joint Committee to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare. The Quality and Patient Safety Sub Committee will also provide assurance to the Joint Committee in relation to the

arrangements for safeguarding and improving the quality and safety of specialised healthcare services within the remit of the Joint Committee. The Quality and Patient Safety Sub-Committee will operate in accordance with the Terms of Reference annexed to the Standing Orders. Refer to Standing Order 4.0.3

5.3.6 the production of an Annual Report (to be prepared by the Committee Secretary) each year. Refer to Standing Order 9.0.2.

5.3.8 the Director of Finance for the Joint Committee to agree with the relevant Provider LHBs information requirements and reporting timescales to enable the Joint Committee to discharge its duties on behalf of each LHBs

5.3.9 the Management Team to act in accordance with the Welsh Language Scheme of the Host LHB in preparing papers on behalf of the Joint Committee. Refer to Standing Order 6.1.1.

5.3.10 the Lead Director to lead the consultation process on behalf of each LHB where the Joint Committee supports proposals which result in a major change in service provision.

6. ROLE OF CHAIR

6.1 The LHBs acknowledge that the Regulations require that the Chair be appointed by the Minister for Health and Social Services as an independent appointment and in accordance with the Nolan Principles. It is further acknowledged that the Chair is accountable to the Minister for Health and Social Services and is required by the Minister to act in accordance with the terms of his/her Accountability Agreement. Refer to Standing Orders 1.2.1 and 1.3.6.

6.2 The Chair will:

6.2.1 be accountable to the individual LHBs in relation to the delivery of the role of the Joint Committee exercised by the Committee on their behalf.

6.2.2 be required to secure consensus where possible in the making of collective decisions in the wider interests of NHS Wales and in accordance with the individual obligations of the Chief Executives and the non-officer members.

6.2.3 the Chair will work in close collaboration with the Chairs of LHBs to ensure that the strategic development of Specialised and Tertiary Services meets the needs of NHS Wales.

6.2.4 the Chair will attend the All Wales Chairs Meeting at least twice a year.

7. APPOINTMENT AND ROLE OF NON-OFFICER MEMBERS

7.1 Each non-officer member (including the Vice-Chair) appointed to the Committee in accordance with the Regulations is individually accountable to the Chair. Refer to Standing Orders 1.3.8 and 1.3.9.

7.2 The Chair will seek nominations from the Chair of each individual LHB for the appointment of a non-officer member. The Chair will determine and agree with the Chairs of the LHBs the appropriate process for the selection of the non-officer member but in so doing must take account of the following requirements: Refer to Standing Orders 1.4. 2 and 1.4.3

7.2.1 A balanced knowledge and understanding amongst the membership of the needs of all geographical areas served which will include consideration as to whether the constituent LHB is regarded as a major provider of services to the Joint Committee;

7.2.2 wherever possible, the overall membership of the Joint Committee reflects the diversity of the population.

7.3 ~~One non-officer member will be selected from the Host LHB. This non-officer member will act as the Audit Lead.~~The audit lead non-officer member role will be recruited through a fair and open recruitment process. To enable the WHSSC Independent Member Remuneration appointment arrangements to be consistent with the other two HB IM roles, with an emphasis on the skills required to participate in the Audit 7 Risk Committee (ARC). The audit lead IM will be required to attend the CTMUHB part 2 ARC meetings which WHSSC attends to discharge its audit and accountability requirements"

Each non-officer member will be required to acknowledge their individual responsibility to contribute to the performance of the Delegated Functions of the Joint Committee and to share in the decision making in the interests of the wider NHS Wales.

~~7.3~~7.4 The Chair and non-officer members will participate fully in the Performance Review Process as set down by the Welsh Government. Refer to the appropriate Accountability Agreements.

8. STATUS AND ROLE OF ASSOCIATE MEMBERS

8.1 The LHBs acknowledge that the Associate Members will attend the Joint Committee meetings on an ex-officio basis but in accordance with the directions will not have the right to vote in any meetings or proceedings of the Joint Committee. Refer to Standing Order 1.2.6.

8.2 Associate Members will be entitled to engage and participate in the discussions. It will be the responsibility of the Chair to secure that they may seek to influence and/or challenge the decision making by their participation during the course of the debate.

9. ROLE OF MANAGING DIRECTOR OF SPECIALISED AND TERTIARY SERVICES COMMISSIONING (LEAD DIRECTOR)

9.1 The Lead Director will:

9.1.1 be the head of the Management Team and will report to the Chair. In so doing the Director will be accountable to the Joint Committee in relation to its role delegated to the Management Team by the Joint Committee. Refer to Standing Order 1.3.10

9.1.2 be accountable to the Chief Executive of the Host LHB in respect of the administrative arrangements supporting the operation of the team. Refer to Standing Order 1.3.10

9.2 The Lead Director is responsible for ensuring that the Joint Committee enters into suitable Health Care Agreements and Contracts with service providers for health care services. The Lead Director will need to ensure that regular reports are provided to the Joint Committee detailing performance and associated financial implications of all health care agreements. Refer to Standing Order 3: Reservations and Delegations of Joint Committee Delegated Functions.

10. MANAGEMENT ARRANGEMENTS

10.1 In accordance with the Standing Orders, the Joint Committee may delegate certain functions to the WHSST Directors. Refer to Standing Order 3: Reservations and Delegations of Joint Committee Delegated Functions.

10.2 The Joint Committee will determine the nature and extent of any functions which it is appropriate to delegate to a Sub Committee and to the WHSST Directors.

10.3 The Joint Committee's approach to delegation will be set out in the Standing Orders, Standing Financial Instructions and Scheme of Reservations and Delegation.

10.4 The delegation of any function will be subject to regular review by the Joint Committee to ensure that the distribution of functions is accurately and appropriately described and continues to remain appropriate to respond to the requirements of the Joint Committee.

10.5 The LHBs acknowledge that the WHSST Directors will constitute the Management Team.

10.6 Any Chief Executive or other member of the Joint Committee who wishes to attend a Management Team meeting will agree their attendance with the Lead Director in advance.

10.7 The individual WHSST Directors are employed by the Host LHB but in exercising the performance of their functions they are individually accountable to the Joint Committee. Refer to Standing Orders 1.3.10 and 1.3.11.

10.8 The Management Group reports directly to the Joint Committee and membership includes the WHSST Directors and representation from the LHBs. The Membership of the Group is determined locally but as a minimum consists of LHB planning/commissioning representation and/or Finance representation. The purpose of the Management Group is to be the Specialised Services Commissioning operational body responsible for the implementation of the Specialised Services Strategy. It will underpin the commissioning of Specialised Services to ensure equitable access to safe, effective, sustainable and acceptable services for the people of Wales.

11. ROLE OF COMMITTEE SECRETARY

11.1 The LHBs acknowledge that the role of the Committee Secretary is crucial to the ongoing development and maintenance of a strong governance framework within the Joint Committee, and is a key source of advice and support to the Chair and Joint Committee members. Independent of the Joint Committee, the Committee Secretary will be required to act as the guardian of good governance within the Joint Committee by: Refer to Standing Orders: The role of the Committee Secretary

11.1.1 providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance;

11.1.2 facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, its sub-committees

and Advisory Groups and producing an Annual Plan of Committee Business;

11.1.3 ensuring that Joint Committee members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these Standing Orders;

11.1.4 ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination;

11.1.5 contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and

11.1.6 monitoring the Joint Committee's compliance with the law, Joint Committee Standing Orders and the framework set by the LHB and Welsh Government.

11.2 It is agreed that the Committee Secretary is directly accountable for the conduct of his/her role to the Chair of the Joint Committee. The Committee Secretary will also be accountable to the Board Secretaries of the LHBs to ensure that robust governance arrangements are in place for the Joint Committee.

12. RELATIONSHIP WITH HOST

12.1 The responsibilities of the Host LHB are:

12.1.1 to appoint and employ such officers as may be required to support the commissioning of the Relevant Services and provide all necessary corporate services and management support, to include human resources, estates, procurement, banking and accountancy services, as may be required, including the making of payments to providers of the Relevant Services;

12.1.2 to provide advice to the Joint Committee on compliance with CTMUHB's policies, Standing Financial Instructions, Procurement Rules, Human Resource policies and other procedures;

12.1.3 to be the legal entity which enters into agreed tenders, procurement contracts, service level agreements and terms of engagement commissioned by the Joint Committee, and to ensure that the individuals appointed and employed to support the functions of the Joint Committee carry out those tasks which are stated in this Agreement to be the role of the Joint Committee;

12.1.4 to hold the management budget for the Joint Committee/Relevant Services and make payments and receive income as necessary;

12.1.5 to be authorised to appoint lawyers and other professional advisors (in consultation with the Host LHB's Procurement Services team), and to agree the terms and conditions of their engagement and give them instructions from time to time on behalf of the Joint Committee.

12.1.6 All banking arrangements are the responsibility of the host LHB.

12.2 The Host LHB will not be responsible or accountable for the planning, funding and securing of the Relevant Services save in respect of the residents within the area of the Host LHB. Refer to Standing Order 2.0.2

12.3 The Joint Committee will require the Host LHB to enter into a separate Hosting Agreement, annexed to this Agreement as Annex (ii) to record the agreed accounting arrangements and resulting responsibilities. Refer to Standing Orders: Joint Committee Framework.

13. ACCOUNTABILITY AND AUDIT & RISK COMMITTEE

13.1 Audit & Risk Committee arrangements will be the responsibility of the Host LHB.

13.2 The WHSSC Director of Finance and the WHSSC Committee Secretary will attend all Audit & Risk Committee meetings held by the Host LHB.

13.3 The Audit Lead will provide reports to the Joint Committee following the Host LHB Audit & Risk Committee meetings.

14. PROCUREMENT

14.1 Each LHB will ensure that appropriate internal arrangements are made to delegate their respective functions to the Joint Committee for the procurement of the Relevant Services. The Joint Committee (acting through the Host LHB) will establish collaborative commissioning and managerial arrangements to negotiate, agree and manage all aspects of service level agreements/contracts for the Relevant Services on such terms and for such purposes as may be agreed by the Joint Committee.

14.2 Agreed tenders, procurement contracts, service level agreements and terms of engagement will be entered into and signed by the Host LHB on behalf of the Joint Committee in accordance with the Host LHB's procurement policy and Standing Financial Instructions.

15. FINANCIAL PRINCIPLES

15.1 The following represent the key financial principles to be adhered to by the LHBs:

15.1.1 to achieve financial neutrality and stability, where possible, for LHBs;

15.1.2 to adopt a fair and practical approach to the challenges of establishing the Joint Committee and to the functioning of the Joint Committee;

15.1.3 to ensure that funds are to be blocked back to the Joint Committee;

15.1.4 to ensure that the status quo with England is maintained until further review;

15.1.6 to ensure that a risk sharing methodology will be reviewed and agreed annually.

16. BUDGET AND FUNDING

16.1 In accordance with the Joint Committee's Standing Orders, the Joint Committee must agree the total budget to plan and secure the Relevant Services delegated to it. The Joint Committee must also agree the appropriate contribution of funding required from each LHB. Refer to Standing Order 1.1.4

16.2 Each year the Joint Committee will prepare an annual plan which shall outline the funding requirements in relation to the Relevant Services and be analysed by each constituent LHB as providers and purchasers. Refer to Standing Order 1.1.4

16.3 Each LHB will be required to make available to the Joint Committee the level of funds outlined in the annual plan and calculated in accordance with paragraph 16.1. The funds shall be drawn down in cash on a monthly basis from each of the LHB's as proposed by the Director of Finance for the Joint Committee.

16.4 On a monthly basis, the Director of Finance for the Joint Committee shall prepare a report to the Joint Committee which outlines the performance of the Joint Committee, highlighting any variances from the original annual plan, in total, and also broken down to each LHB commissioner level.

16.4.1 in cases where the performance report highlights an adverse variance to the annual plan or where the report anticipates future unfunded cost pressures, the Joint Committee will be required to put in place contingency measures to ensure that a break-even position is maintained.

16.4.2 in cases where the performance report highlights a favourable variance to the annual plan, the Joint Committee shall be required to return the funding to each LHB in accordance with the risk sharing agreement.

16.5 The Joint Committee will comply with all Welsh Government financial monitoring arrangements. The Director of Finance of the Joint Committee is responsible for ensuring that a financial monitoring return is submitted to WG in the prescribed format and to the required deadlines.

16.6 Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its delegated functions. Any disputes over the level of funding proposed by Joint Committee shall be referred to the Welsh Government for resolution by the Welsh Minsters.

17. GIFTS AND HOSPITALITY

17.1 Each member of the Joint Committee is required to declare any gifts and hospitality in accordance with the Joint Committee Standing Orders to the Committee Secretary in relationship to their membership of the Joint Committee. The Committee Secretary will maintain a register of such declarations. Refer to Standing Orders: Values and Standards of Behaviour.

18. DISPUTES AND ARBITRATION

18.1 In accordance with the principles set out at paragraph 3 of this Agreement, the LHBs will seek to work cooperatively with each other as constituent members of the Joint Committee, with the Joint Committee as a whole, and with the Management Team. Where there is an impasse which cannot be resolved by means of conciliation between appropriate individuals, then as a last resort the Chair will be requested to invoke the Dispute Process which is set out in the Business Framework (Annex (iii)).

19. CONCERNS

19.1 **Concerns about treatment funded through the Joint Committee arrangements**

Concerns notified about care and treatment will be dealt with by the organisation providing the treatment. Concerns will be considered under The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Provider organisations must, as part of the contractual agreement, advise the LHB in which the patient lives that a complaint has been made and the LHB will ensure that this is reviewed in conjunction with the Quality and Patient Safety Sub Committee.

19.2 **About individual patient funding decisions**

These concerns will be handled by the LHB in which the patient lives, in accordance with the All Wales Individual Patient Funding Request Policy agreed by the Welsh Government.

19.3 **About any function of the Joint Committee, its staff or its performance**

Concerns notified about the function of the WHSS Team (for these purposes including Joint Committee members and WHSS staff), if not resolved internally, will be dealt with by the Host LHB on behalf of all LHBs in Wales.

19.4 An Operational Agreement will be developed between the LHBs which sets out clearly operationally how concerns will be dealt with.

19.5 **Financial or other Redress**

When qualifying liability in tort has been determined, following an investigation of a concern, each constituent LHB is responsible for managing and funding the redress payment arising from their resident populations.

20. INDEPENDENT PATIENT REVIEWS

20.1 Where a matter is considered to be a review of funding decisions it will be dealt with in accordance with the Review Process set out in All Wales Policy for Making Decisions on Individual Patient Funding Requests (IPFR).

21. COMMUNICATION

21.1 The Committee Secretary and the Board Secretaries of the respective LHBs will develop a Communication Strategy to ensure robust communication methods are in place to support the operation of the Joint Committee.

21.2 Each LHB will ensure that they utilise appropriate mechanisms to facilitate active debate amongst stakeholders, professionals and communities served to ensure appropriate independent representation and participation on the planning of the Relevant Services.

21.3 Each LHB is responsible for responding to individual enquires concerning their individual geographical population. Where it is an issue relating to a decision made by the Joint Committee, for example, as to the planning of a service, then the Committee Secretary will be responsible for co-ordinating the response in consultation with the Board Secretaries for the respective LHBs.

21.4 Each Member of the Management Team is required to work in collaboration with their colleagues in the LHBs to ensure the planning of the Relevant Services.

21.5 Where a request under the Freedom of Information Act is received by the Joint Committee, the request will be dealt with in accordance with the Host LHB's Freedom of Information Act procedure. Where the request is considered to be an issue relating to a specific LHB and it relates to recorded information which is held by that LHB, then the request will be forwarded to the respective LHB to respond in accordance with the Freedom of Information Act Code of Practice.

22. INTERFACE WITH CLINICAL NETWORKS

22.1 The arrangements with the Clinical Networks are set out at Annex (iv).

23. MENTAL HEALTH RESPONSIBILITIES

23.1 It will be the responsibility of the Lead Director to prepare a report for each meeting of the Joint Committee (where appropriate) on the conduct by the Management Team of the Committee's responsibilities to mental health patients who are detained under the Mental Health Legislation including any requirement by the Crown Court or the Mental Health Tribunal to give evidence as to appropriate placement of a patient detained under the Mental Health Legislation.

24. CROSS BORDER SLA ARRANGEMENTS

24.1 The Director of Finance of the Joint Committee will agree appropriate contracts with a defined list of English NHS Trusts and Foundation Trusts for the purposes of delivering specialised services for the Welsh population.

24.2 The Director of Finance for the Joint Committee will be responsible for securing that the contracts are cost effective and achieve the delivery of services of appropriate quality.

24.3 In the interests of simplified patient care pathways and reducing administrative complexity these contracts may include non-specialised activity.

24.4 The Director of Finance of the Joint Committee will prepare performance reports on these contracts for each Joint Committee meeting.

24.5 The Lead Director will ensure that NHS Wales continues to maintain and develop appropriate relationships with the counterpart specialised planning arrangements in England and Scotland. The Lead Director will represent the LHBs in this regard and will be given the appropriate delegated authority to do so. These arrangements currently include English Specialist Commissioning Groups, the Scottish National Services Division of Scotland, the National Specialist Commissioning Groups and the National Commissioning Advisory Group or National Commissioning Group for highly specialised services.

25. ROLE OF PUBLIC HEALTH

25.1 A Service Level Agreement will be entered into between the Host LHB and Public Health Wales describing the services which Public Health Wales will provide to the Joint Committee and the process of engagement which will take place.

26. EQUALITY AND DISCRIMINATION

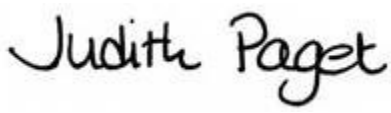
26.1 The LHBs undertake, in relation to the provision of the Relevant Services by the Joint Committee to the public or any member of the public, to exercise the role of the Joint Committee so as to have regard to the need to eliminate discrimination, and other prohibited conduct, in accordance with human rights and equality legislation.

27. REVIEW

27.1 This Agreement will be reviewed on a bi-annual basis.

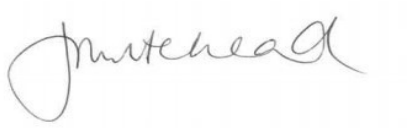
SIGNED under hand and delivered the day and year first above written

SIGNED and DELIVERED
by **Aneurin Bevan University Local Health Board**
acting by



~~Judith Paget~~ Nicola Prygodzicz
Chief Executive

SIGNED and DELIVERED
by **Betsi Cadwaladr University Local Health Board**
acting by



~~Jo Whitehead~~ Gill Harris
Chief Executive

SIGNED and DELIVERED
by **Cardiff and Vale University Local Health Board**
acting by

~~Len Richards~~
Suzanne Rankin
Chief Executive

SIGNED and DELIVERED
by **Cwm Taf Morgannwg University Local Health Board**
acting by

Paul Mears
Chief Executive

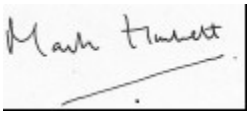
SIGNED and DELIVERED
by **Hywel Dda University Local Health Board**
acting by

Steve Moore
Chief Executive

SIGNED and DELIVERED
by **Powys Teaching Local Health Board**
acting by

Carol Shillabeer
Chief Executive

SIGNED and DELIVERED
by **Swansea Bay University Local Health Board**
acting by



Mark Hackett
Chief Executive

Annex (i) to Memorandum of Agreement

Services delegated from LHBs to WHSSC for planning and funding in ~~2020-21~~2023-2024

Range of Services Commissioned by WHSSC

Assistant Director of Planning Lead
Intestinal Failure
Home Parental Nutrition
Hyperbaric Oxygen Therapy

Mental Health & Vulnerable Groups
High Secure Psychiatric Services
Medium Secure Psychiatric Services
All Wales Traumatic Stress Quality Improvement Initiative (Traumatic Stress Wales)
Gender Identity Services for Adults
Gender Identity Development Service for Children and Young People
Specialised Eating Disorder Services (Tier 4)
Mental Health Services for Deaf People (Tier 4)
Specialised Perinatal Services
CAMHS (Child and Adolescent Mental Health Services) Tier 4
Forensic Adolescent Consultation and Treatment Service (FACTS)
Neuropsychiatry

Cancer & Blood
PET scanning
All Wales Lymphoma Panel
Specialist services for Sarcoma
Haematopoietic Stem Cell Transplantation (BMT)
Extra corporeal photopheresis for graft versus host disease
CAR-T therapy for lymphoma and acute lymphoblastic leukaemia
Thoracic surgery
Hepatobiliary cancer surgery
Microwave ablation for liver cancer
Brachytherapy (prostate and gynaecological cancers)
Proton Beam Therapy
Radiofrequency Ablation for Barrett's Oesophagus
Stereotactic Ablative Body Radiotherapy
Specialist service for Neuroendocrine Tumours
Peptide Receptor Radionuclide Therapy (PRRT) for Neuroendocrine Tumours
Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for Pseudomyxoma Peritonei

All Wales Medical Genomics Service

Burns and Plastics
Specialist service for Paroxysmal Nocturnal Haemoglobinuria
Inherited Bleeding Disorders
Welsh Blood Service
Hereditary Anaemias specialist service
ECMO
Long Term Ventilation
Immunology

Cardiac Services
Cardiac Surgery
Heart Transplantation including VAD's
Electrophysiology, ablation and complex ablation
Complex Cardiac devices
Interventional Cardiology, (PPCI, PCI, PFO closures, TAVI, PMVLR)
Inherited Cardiac Conditions
Adult Congenital Heart Disease
Pulmonary Hypertension
Cystic Fibrosis
Cardiac Networks (SWSWCHD Network, NWNWCHD Network, All Wales Cardiac Network)
Bariatric Surgery

Neurosciences & Long Term Conditions
Neurosurgery Emergency and elective neurosurgery (including stereotactic radiosurgery and Deep Brain Stimulation)
Neuroradiology (diagnostic and interventional undertaken by neuroradiologists)
Neurorehabilitation
Spinal rehabilitation
Artificial Limbs and Appliances Service including: o Wheelchair and special seating o Prosthetics o Orbital prosthetics
Electronic assistive technology
Alternative Augmentative Communication (AAC)
Immunology for Primary Immuno Deficiency
Cochlear and BAHA
Rare Diseases – RDIG

Women and Children
Fetal Cardiology
Fetal Medicine
Neonatal

Neonatal Transport
Paediatric Cardiology

Paediatric Cystic Fibrosis
Paediatric Endocrinology
Paediatric ENT
Paediatric Gastroenterology
Paediatric Intensive Care
Paediatric Immunology
Paediatric Inherited Metabolic Disease
Paediatric Nephrology
Paediatric Neurology
Paediatric Neuro-rehab
Paediatric Oncology
Paediatric Radiology
Paediatric Radiotherapy
Paediatric Rheumatology
Paediatric Surgery

North Wales
IVF

Annex (ii) to Memorandum of Agreement

HOSTING AGREEMENT

THIS HOSTING AGREEMENT is made the ~~13 July 2021~~14 March 2023

BETWEEN

(1) CWM TAF MORGANNW~~Y~~G UNIVERSITY LOCAL HEALTH BOARD ("Cwm Taf Morgannwg UHB")

and

(2) ANEURIN BEVAN UNIVERSITY LOCAL HEALTH BOARD, having headquarters at St Cadoc's Hospital, Lodge Road, Caerleon, Newport NP18 3XQ,

BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW,

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD, having headquarters at 2nd Floor, Woodland House, Maes-y-coed Road, Cardiff CF14 4HH,

CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ynysmeurig House, Navigation Park, Abercynon, Rhondda Cynon Taff, CF45 4SN,

HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ystwyth Building, St David's Park, Carmarthen, Sa31 3BB.

POWYS TEACHING LOCAL HEALTH BOARD, having headquarters at Mansion House, Bronllys, Brecon, Powys, LD3 0LS,

SWANSEA BAY UNIVERSITY LOCAL HEALTH BOARD, having headquarters at 1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot, SA12 7BR,

Collectively established as the Joint Committee of
WELSH HEALTH SPECIALISED SERVICES COMMITTEE ("Joint Committee").

WHEREAS:

(1) In accordance with the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009 No.35), the seven Local Health Boards are required to establish the WHSSC for the purpose of jointly exercising its Delegated Functions and providing the services from 1 April 2010.

(2) The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (SI 2009 No 3097) makes provision for the constitution of the Joint Committee including its procedures and administrative arrangements.

(3) Cwm Taf Morgannwg University Local Health Board has been identified as the Host LHB to provide administrative and management support as further described in section 2 for the running of the WHSSC and to establish the Welsh Health Specialised Services Team (WHSST).

(4) This Agreement should be read in conjunction with the Memorandum of Agreement made between the 7 Local Health Board themselves which defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executives of the constituent LHBs as individual members of the Joint Committee.

(5) The purpose of this Agreement is to outline what the accountability arrangements and resulting responsibilities will mean, both for Cwm Taf Morgannwg UHB and for the Joint Committee.

AGREEMENT

Index **Page No.**

1. INTERPRETATION

'the Act'	the National Health Service (Wales) Act 2006
'Delegated Functions'	those functions ascribed to the Joint Committee in section 4 of the Memorandum of Agreement and reproduced at Annex (i) 1.
'the Directions'	the Welsh Health Specialised Services Committee (Wales) Directions 2009
'Director'	the Director of Specialised and Tertiary Services appointed in accordance with regulation 3 (2) of the Regulations
'Joint Committee'	the Welsh Health Specialised Services Committee established in accordance with the Directions and Regulations
'LHB'	Local Health Board established in accordance with s 11(2) of the Act
'Management Team'	the team appointed in accordance with paragraph 10.2 of the Memorandum of Agreement. Refer to Standing Order 1.2.4.
'Memorandum of Agreement'	the agreement dated 1 April 2010 between the 7 LHBs and described at paragraph (4) of the recital
'NHS Wales'	the comprehensive health service for Wales established by the NHS (Wales) Act 2006
'the Regulations'	the Welsh Health Specialised Services Committee (Wales) Regulations 2009
'Relevant Services'	the planning and securing of specialised and tertiary services consisting of those functions and services listed in Annex (i) of the Memorandum of Agreement, subject to any variations to those functions and services agreed from time to time by the Joint Committee.

'.

'WG' Welsh Government as announced by the First Minister of Wales on 12th May 2011.

'WHSST' the Welsh Health Specialised Services Team consisting of staff employed by the Host Board to provide the Relevant Services

2. ROLE OF CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD

The responsibilities of Cwm Taf Morgannwg UHB are:

2.1 To appoint and employ such officers as may be required to support the commissioning of the Relevant Services and provide all necessary corporate services and management support, to include human resources, estates, procurement, banking and accountancy services, as may be required, including the processing of orders and the making of payments to providers of the Relevant Services, with such officers being members of the WHSST;

2.2 To provide advice to the Joint Committee on compliance with Cwm Taf Morgannwg UHB's policies, Standing Financial Instructions, Procurement Rules, Human Resource policies and other procedures;

2.3 To be the legal entity which enters into agreed procurement arrangements to include, but not restricted to, quotations, tenders, procurement contracts, service level agreements and terms of engagement commissioned by the Joint Committee and to ensure that the individuals appointed and employed to support the functions of the Joint Committee carry out those tasks which are stated in Annex (i) to be the role of the Joint Committee;

2.4 To have in place such appropriate governance arrangements and Schemes of Delegation as may be necessary and required on the part of Cwm Taf Morgannwg UHB to enable the Joint Committee's role to be carried out;

2.5 To hold the management budget for the Joint Committee/Relevant Services and make payments and receive income as necessary;

2.6 To be authorised to appoint lawyers and other professional advisors (in consultation with Cwm Taf Morgannwg UHB's Procurement Services team), and to agree the terms and conditions of their engagement and give them instructions from time to time on behalf of the Joint Committee.

2.7 Cwm Taf Morgannwg UHB will not be responsible or accountable for the planning, funding and securing of the Relevant Services save in respect of the residents within the geographical area of responsibility of Cwm Taf Morganng UHB. Refer to Standing Order 2.0.2

2.8 In fulfilling its obligations and responsibilities under this Agreement, Cwm Taf Morgannwg UHB shall not be required to do or not do and shall not do or omit to do anything which does not comply with Cwm Taf Morgannwg UHB's statutory powers and duties, Standing Orders and Standing Financial Instructions, corporate governance requirements generally, procurement requirements or any legal obligations not covered by the foregoing.

3. EMPLOYMENT OF STAFF

3.1 New Officers who are appointed to work with the Joint Committee from the 1 April 2010 will be employed by Cwm Taf Morgannwg UHB.

3.2 The Officers working with the Joint Committee, and comprising the Management Team and WHSST, will therefore be employees of Cwm Taf Morgannwg. They will be required to abide by Cwm Taf Morgannwg UHB's Policies, Procedures and Guidance and will be entitled to be treated as any other employee of Cwm Taf Morgannwg UHB and have the benefit of all applicable policies and procedures.

3.3 The Officers will also be accountable for their performance to the Joint Committee.

3.4 The human resource services which will be provided are identified at **Appendix B**.

4. PROCEDURES FOR TENDERS & PROCUREMENT

4.1 Cwm Taf Morgannwg UHB will provide all the support services to the Joint Committee as described at **Appendix C**.

4.2 Agreed procurement arrangements via quotations, tenders, procurement contracts, service level agreements and terms of engagement will be entered into and signed by Cwm Taf Morgannwg on behalf of the Joint Committee in accordance with Cwm Taf Morgannwg UHB's procurement policy and Standing Financial Instructions.

4.3 Cwm Taf Morgannwg UHB shall not execute or, through performance create, any third party contract in respect of the Joint Committee unless authorised to do so by the Director.

4.4 The Joint Committee will provide sufficient funds and other relevant resources to meet the requirements of all third party contracts entered into by Cwm Taf Morgannwg UHB in pursuance of paragraph 4.3.

4.5 Cwm Taf Morgannwg UHB shall provide the Lead Director with drafts of all third party contracts and the Lead Director and/or the Joint Committee shall be entitled to require Cwm Taf Morgannwg UHB to use its reasonable endeavours to negotiate such amendments to the terms of such contract as the Lead Director and/or the Joint Committee reasonably see fit.

5. GOVERNANCE ARRANGEMENTS

5.1 The Joint Committee will utilise Cwm Taf Morgannwg UHB's Committee arrangements to assist it in discharging its governance responsibilities.

5.2 Where the Joint Committee utilises Cwm Taf Morgannwg UHB's sub-committee arrangements such as the Quality, Safety and Risk Committee, Cwm Taf Morgannwg UHB will ensure that the appropriate responsibilities are afforded to the Joint Committee and the agenda is constructed to ensure relevant issues are to be properly managed to allow the Joint Committee to satisfy itself from a risk management and controls assurance perspective.

5.3 The Joint Committee will adopt the risk assessing mechanisms of the host subject to appropriate adaptation to take into account the specific functions WHSSC.

5.5 The Lead Director will provide reports from the Joint Committee to Cwm Taf Morgannwg UHB's Board in line with Cwm Taf Morgannwg UHB's scheme of delegation to enable Cwm Taf

Morgannwg UHB to assure itself that appropriate control measures are in place in accordance with the requirements of the Statement of Internal Control.

6. BUDGET AND FUNDING

6.1 The Joint Committee will transfer funds to Cwm Taf Morgannwg UHB on a quarterly basis in advance to allow Cwm Taf Morgannwg UHB to perform its functions on behalf of the Joint Committee, provided that the Joint Committee may attach conditions to the expenditure of such funds.

6.2 The Joint Committee will meet Cwm Taf Morgannwg UHB's overhead costs reasonably incurred in the support of the Joint Committee as may be agreed by the Joint Committee acting reasonably at all times.

6.3 The Director of Finance for the Joint Committee will authorise the transfer of funds to Cwm Taf Morgannwg UHB in line with agreed funding levels, which funds shall be accounted for by Cwm Taf Morgannwg UHB as income to the Joint Committee.

6.4 Cwm Taf Morgannwg UHB will set up and manage an Income and Expenditure Account for the Joint Committee, namely a Joint Committee Account. This includes all the income for the Joint Committee received from the LHBs and all other Joint Committee expenditure. This account shall be separate from all other Cwm Taf Morgannwg UHB funds. The Director of Finance for the Joint Committee shall make decisions relating to expenditure from this account provided that Cwm Taf Morgannwg UHB shall not at any time be obligated to operate the Joint Committee Account in deficit.

6.5 The Director of Finance for the Joint Committee is responsible for ensuring that all relevant reports, financial information and commentary are provided to the Host LHB so that the appropriate monitoring return can be prepared.

7. OWNERSHIP OF ASSETS

7.1 All assets (including intellectual property rights) acquired by Cwm Taf Morgannwg UHB in connection with the Joint Committee shall belong to Cwm Taf Morgannwg UHB but be held upon trust for the Joint Committee.

7.2 Cwm Taf Morgannwg UHB shall, to the extent it is legally entitled to do so, transfer ownership and any other rights in such assets to such party or body as the Joint Committee shall require and within such timescales as are reasonably required.

7.3 In the event that any income is derived from such assets or from their disposal, such revenues shall be regarded as part of the Joint Committee income and accounted for accordingly.

8. ACCOUNTABILITY ARRANGEMENTS

8.1 The accountability arrangements of the Management Team and their relationship with Cwm Taf Morgannwg UHB are set out in Appendix D

8.2 The constituent LHBs will delegate to the Chief Executive of Cwm Taf Morgannwg UHB and the Chair of the Joint Committee their responsibility for performance appraisal and all employment related issues of the Lead Director In exercising those responsibilities, the Chief Executive of Cwm Taf Morgannwg UHB is required to liaise with the Chief Executives of the constituent LHBs as members the Joint Committee and the Chair of the Joint Committee.

8.3 The constituent LHBs will delegate to the Lead Director the performance appraisal of the individual members of the Management Team. In exercising those responsibilities, the Director is required to liaise with the Chief Executives of the constituent LHBs as members of the Joint Committee and the Chair of the Joint Committee.

9. DUTY OF CARE

9.1 Cwm Taf Morgannwg UHB shall be responsible for ensuring that all reasonable skill, care and diligence are exercised in carrying out those services which it is required to perform under this Agreement properly and efficiently in accordance with this Agreement and the Memorandum of Agreement and its overall responsibilities under the Act and all other appropriate legislation. Cwm Taf Morgannwg UHBshall keep the Joint Committee informed of any foreseeable or actual changes in circumstances which are likely to affect its ability to comply with the terms of this Agreement as the Host LHB.

10. CWM TAF MORGANNWG UHB ORGANISATION

10.1 Cwm Taf Morgannwg UHB shall provide and maintain an organisation having the necessary facilities, equipment and employees of appropriate experience, to undertake the specific functions and provide all the services identified in this Agreement

10.2 All personnel deployed on work relating to the Agreement must have appropriate skills and competence.

11. LEGISLATION

11.1 Cwm Taf Morgannwg UHB shall ensure that it, and its employees and agents, shall in the course of this agreement comply with all relevant legislation, Welsh Government Directions and Guidance and procedures.

12. AUDIT

12.1 Cwm Taf Morgannwg UHB, through the Shared Services arrangements, will provide an effective independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Government. Refer to Standing Order 8.1.1

12.2 Cwm Taf Morgannwg UHB will ensure that relevant external audit arrangements are in place which give due regard to the functions of the Joint Committee. Refer to Standing Order 8.3. External Assurance

13. MANAGEMENT OF CONCERNS (INCLUDING INCIDENTS, COMPLAINTS & CLAIMS)

13.1 Paragraph 19 of the Memorandum of Agreement sets out the procedures to be followed for the management of concerns relating to the Joint Committee.

13.2 Where a matter is regarded as an individual concern, Cwm Taf Morgannwg UHB will only be responsible for the management of those concerns where qualifying liability in Tort is established, which relate to its geographical area of responsibility. In such circumstances, the Chief Executive of

Cwm Taf Morgannwg UHB will be responsible for investigating and responding to the concern in accordance with The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

13.3 Individual concerns relating to patients resident outside Cwm Taf Morgannwg UHB's geographical area of responsibility will be referred to the Chief Executive of the LHB in the appropriate geographical area.

13.4 Where a matter is regarded as a concerns and where qualifying liability in Tort has been established, Cwm Taf Morgannwg will only be responsible for managing the arrangements for redress arising from its own resident population.

13.5 Where a matter is considered to be a review of funding decisions it will be dealt with in accordance with the Review Process set out in All Wales Policy for Making Decisions on Individual Patient Funding Requests (IPFR).

14. MANAGEMENT OF FOIA / DPA REQUESTS

14.1 Where a request under the Freedom of Information Act or Data Protection Act is received by the Joint Committee, the request will be dealt with in accordance with Cwm Taf Morgannwg UHB's procedures. Where the request is considered to be an issue relating to a specific LHB, other than Cwm Taf Morgannwg UHB, and it relates to recorded information which is held by that other LHB, then the request will be forwarded to the Board Secretary of the respective LHB to respond in accordance with the Freedom of Information Act Code of Practice.

15. NOTICES

15.1 Any notices served in respect of matters covered by this Agreement shall be sent to the Chief Executive of Cwm Taf Morgannwg on behalf of Cwm Taf Morgannwg UHB and the Lead Director on behalf of the Joint Committee.

16. DISPUTE

16.1 In the event of any dispute between Cwm Taf Morgannwg UHB and those involved in the Joint Committee, such dispute shall be escalated in line the Business Framework.

16.2 If such dispute cannot be resolved in accordance with the provisions of paragraph 16.1 it shall be referred to the Joint Committee and the Chief Executive of Cwm Taf Morgannwg UHB.

16.3 If such a dispute cannot be resolved in accordance with the provisions of paragraph 16.2, it shall be referred to Welsh Government's Minister for Health and Social Services for resolution.

17. GENERAL

17.1 This agreement shall be capable of being varied only by a written instrument signed by a duly authorised officer or other representative of each of the parties.

17.2 No third party shall have any right under the Contracts (Rights of Third Parties) Act 1999 in connection with this Agreement.

17.3 This Agreement shall be governed and construed in accordance with the laws of England and Wales. Subject to paragraph 16, the parties hereby irrevocably submit to the exclusive jurisdiction of the Courts of England and Wales.

17.4 In the event of Cwm Taf Morgannwg UHB's Board determining (acting reasonably) that the performance by Cwm Taf Morgannwg UHB of its obligations under this Agreement is having a detrimental or prejudicial effect on the Cwm Taf Morgannwg UHB's ability to fulfil its core functions, Cwm Taf Morgannwg UHB's Board may instruct the Lead Director and Cwm Taf Morgannwg UHB's Chief Executive to review the operation of this Agreement further to clause 16.

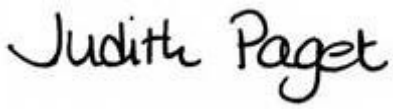
17.5 In carrying out a review of this Agreement further to clause 17.4, the Lead Director and Cwm Taf Morgannwg UHB's Chief Executive shall consider the source and manner of any detriment identified by Cwm Taf Morgannwg UHB's Board further to clause 17.4 and shall put forward such amendments and variations to this Agreement and the associated governance arrangements between the Joint Committee and Cwm Taf Morgannwg as they may consider appropriate.

17.6 Cwm Taf Morgannwg's UHB Board shall consider the recommendations made further to clause 16.5 and may recommend to the Joint Committee and the Chief Executive of Cwm Taf Morgannwg UHB that this Agreement and the

associated governance arrangements are amended accordingly.

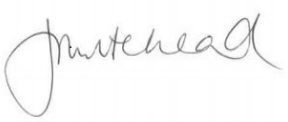
SIGNED under hand and delivered the day and year first above written

SIGNED and DELIVERED
by Aneurin Bevan University Local Health Board acting
by



~~Judith Paget~~Nicola Prygodzicz
-Chief Executive

SIGNED and DELIVERED
by Betsi Cadwaladr University Local Health Board acting
by



~~Jo Whitehead~~ Gill Harris
Chief Executive

SIGNED and DELIVERED
by Cardiff and Vale University Local Health Board acting
by

~~Len Richards~~

Suzanne Rankin

-Chief Executive

SIGNED and DELIVERED
by Cwm Taf Morgannwg University Local Health Board
acting by

Paul Mears
Chief Executive

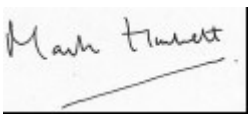
SIGNED and DELIVERED
by Hywel Dda University Local Health Board
acting by

Steve Moore
Chief Executive

SIGNED and DELIVERED
by Powys Teaching Local Health Board
acting by

Carol Shillabeer
Chief Executive

SIGNED and DELIVERED
by Swansea Bay University Local Health Board
acting by



Mark Hackett
Chief Executive

APPENDIX A

Role of the Joint Committee
The Joint Committees role is: (refer to Standing Order 1.1.):

- Determine a long-term strategic plan for the development of specialised and tertiary services in Wales, in conjunction with the Welsh Ministers;

- Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services;

- Develop national policies for the equitable access to safe and sustainable, high quality specialised and tertiary healthcare services across Wales, whether planned, funded and secured at national, regional or local level;

- Agree annually those services that should be planned on a national basis and those that should be planned locally;

- Produce an Integrated Commissioning Plan, for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans;

- Agree the appropriate level of funding for the provision of specialised and tertiary services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the WHSST) in accordance with any specific directions set by the Welsh Ministers;

- Establish mechanisms for managing the in year risks associated with the agreed service portfolio and new pressures that may arise;

- Secure the provision of specialised and tertiary services planned at a national level, including those to be delivered by providers outside Wales; and

- Establish mechanisms to monitor, evaluate and publish the outcomes of specialised and tertiary healthcare services and take appropriate action.

APPENDIX B

EMPLOYMENT OF STAFF
Identified human resources services

Service	Description
Recruitment and Selection	• To provide a comprehensive recruitment and selection service which complies with employment legislation and standards of good practice as directed by the Welsh Government.
Employee Relations	• To provide support to the Welsh Health Specialised Services Team in the management of sensitive issues relating to all employment policies including discipline, grievance, collective disputes, performance and capability, allegations of bullying and harassment whistle blowing and sickness absence etc.
Policy Development	• To develop, implement and advise on employment policies and procedures which comply with employment legislation and NHS guidance; and • To provide training to WHSST Managers in the interpretation and use of policies and procedures.
Remuneration and Payroll	• To provide advice on pay (including assimilation to new A4C bands) and associated terms and conditions of employment; • To provide a comprehensive payroll service; and • To undertake the matching and evaluation of all new and revised roles.
Training and Development	• To provide appropriate training and development to WHSST.
HR administration	• To maintain securely employment records for WHSST and provide accurate workforce data and information as required.
Occupational health	• To provide a comprehensive Occupational health service to employees of WHSSC

APPENDIX C

3.1 Procedures for Tenders & Procurement

Service	Description
Procurement (Tendering and ordering goods and services)	• Tendering for goods & services in accordance with SOs and SFIs • Entering into procurement contracts and agreements • Raise orders for properly approved requisitions
Creditor Payments (Payment of suppliers, contractors and service providers)	• Pay all duly authorised invoices • Deal with supplier queries etc • Provide management information on payment performance in accordance with WAG requirements
Systems maintenance and administration (ORACLE)	• Process feeders into WHSSC ledger and maintain financial management system • Maintain passwords and hierarchies (cost centre and approval) • Oracle training as and when required including external training if required • Access to help desk facility • Undertake testing of upgrades • Liaise with Oracle Central Team and All Wales groups
Accounting Services (bank accounts, annual accounts consolidation, VAT)	• Provision of bank accounts and petty cash facilities • Consolidation of Annual Accounts and other returns as required by WG • Provide VAT advice and consolidate VAT returns, including access to contracted out VAT advisory services • Payment of Tax, National Insurance and Superannuation to appropriate authorities

Financial Governance (internal and external audit, counter fraud, audit committee)	• Responsible for the securing of internal audit service via external contract • Access to Local Counter Fraud Specialist • Advice on financial procedures and other issues of governance • Ensure appropriate external audit provision in place

3.2 **Estates, Facilities and IT Support**

Service	**Description**
Estates Maintenance	• To provide an efficient service in response to all aspects of estates maintenance in the running of the WHSSC offices.
Fire Safety	• To provide professional advice and support in relation to all aspects of Fire Safety ensuring compliance with legislation and guidance issued by the Welsh Government; and • To provide appropriate training to WHSST.
Health and Safety	• To provide a Health and Safety Policy statement as and when required. The Policy must comply with the requirements of the Health and Safety at Work Act. All other relevant rules and regulations must be observed at all times; • To be responsible for the testing, where appropriate, labelling and recording of all portable appliances in their ownership under the Electricity at Work Act 1989; • To provide advice and support on the operational delivery of health and safety arrangements in WHSST in accordance with Cwm Taf Morgannwg UHB policies and procedures; and • To provide appropriate training to WHSST.

IT Support	• To provide a comprehensive IT support service including :
	  ○ User registration;
	  ○ Resolution of faults reporting via the Helpdesk;
	  ○ Purchase and set up new IT equipment;
	  ○ Supply of printing consumables
	• To provide support in relation to the management of files and databases;
	• To ensure the secure storage of data, back up, restore and recovery

3.3 **Others**

Service	**Description**
Corporate Support	• To provide access to the Board Secretary for advice and support on Corporate Governance matters as required.
Welsh Language	• Offer advice and information about the Welsh Language • Promote and encourage the use of Welsh within the workplace • Encourage the use of bilingual aids within the workplace such as signage, stationery etc • Provide Welsh Language taster lessons for staff • Give bilingual front-line telephone training • Translate small in-house, day-to-day, translations • Help co-ordinate the translation of larger documents • Attend public meetings to provide a Welsh Language service for Welsh speakers.

Equality and Diversity	• To provide advice and information to the Welsh Health Specialised Services Committee; • To ensure the business of WHSSC is included within plans and policies of the Host LHB; • To develop a work plan and meet quarterly to review progress against the plan; • To ensure that relevant training is provided to the WHSST in relation to awareness raising and impact assessment; • To provide an assurance mechanism on behalf of the LHBs that robust processes are in place to meet the Equality and Diversity agenda
Risk Management	• To provide advice and information on all areas of Risk Management to the Welsh Health Specialised Services Committee; • To support the development of a Risk Assurance Framework for WHSSC • To provide support (structure and advice) for the use of DATIX to facilitate the management of risk within WHSSC • To develop a work plan and meet quarterly to review progress against the plan
Concerns	• To provide training and awareness for all staff in relation to the management of concerns; • To provide advice and support in relation to the concerns process; • To provide support (structure and advice) for the use of DATIX to facilitate the management of concerns within WHSSC To be responsible for all claims relating to staff and services commissioned which relate to Cwm Taf Morgannwg UHB Residents
Information Governance	• To provide timely advice to all information governance related enquires; • To support the WHSSC Information Governance Group providing relevant advice as required; • To provide training and awareness for all staff in all areas of Information Governance

APPENDIX D

Accountability Arrangements

1. The Directions state that the LHBs will jointly exercise the Delegated Functions from 1 April 2010.

2. This means that the Delegated Functions are those of the individual constituent LHBs and not Cwm Taf Morgannwg UHB.

3. The Directions state that Cwm Taf Morgannwg UHB will exercise its functions so as to provide administrative support for the running of the Joint Committee and establish the WHSST.

4. The membership of the Joint Committee consists of the Chief Executives and the Chair, who is appointed by the Minister.

5. The Chair is directly accountable to the Minister.

6. The Director of Specialised and Tertiary Services is appointed as an Officer member of the Joint Committee to have such responsibilities as may be prescribed by the Joint Committee.

7. For the performance of the Delegated Functions on behalf of the Joint Committee and each constituent LHB, the Director can only be accountable to the Chief Executives of the constituent LHBs.

8. The Chief Executives of the Constituent LHBs are individually accountable to the Director General and Chief Executive of the NHS in Wales.

9. The Chief Executive of Cwm Taf Morgannwg UHB is only accountable to the Director General and Chief Executive of the NHS in Wales insofar as his/her functions relate to administrative support.

10. The Director of Specialised and Tertiary Services is jointly accountable to the Joint Committee and Chief Executive of Cwm Taf Morgannwg UHB.

11. The Finance Director of Cwm Taf Morgannwg UHB is only accountable to the Director of Finance for the NHS in Wales insofar as his functions relate to administrative support.

12. The Finance Director of the Joint Committee has a dual responsibility to the Joint Committee and to the Finance Director of Cwm Taf Morgannwg UHB.

13. The Audit Committee of the host LHB is the central means by which the Joint Committee ensures effective internal control arrangements are in place.

Annex (iii) to Memorandum of Agreement

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

JOINT COMMITTEE BUSINESS FRAMEWORK

~~July~~ March 2023~~1~~

1. INTRODUCTION

1.1 WHSSC in the exercise of its statutory duties is expected to maintain public confidence in a process which is free of actual conflict.

1.2 LHBs, who are constituent members of WHSSC, have differing or conflicting local priorities and objectives which may impede collaboration. Different priorities may arise from the immediate need to support local health services. Yet WHSSC is required to commission specialist services to the benefit of NHS Wales as a whole and acting in accordance with its statutory obligations.

1.3 WHSSC through each constituent member remains accountable for the commissioning decisions it makes and for ensuring that conflicts between the exercise of the commissioning and provider functions are managed appropriately.

1.4 The Chief Executive of each constituent LHB is personally accountable to NHS Wales for the good governance and accountability of WHSSC. This includes ensuring that WHSSC manages transparently any potential conflict of interest.

1.5 The purpose of this document is to set out a framework so that Members of the Joint Committee and sub-committees/sub groups have a clear understanding of the decision making processes.

2. KEY PRINCIPLES

The Joint Committee will:

2.1 Support Members in striving to reduce the inequalities in access to and delivery of services for the populations the Members serve;

2.2 Support the cost effective utilisation of the funds made available by Members to commission specialised services;

2.3 In commissioning and procuring services, comply with all applicable statutory duties;

2.4 Establish Management Group which will ensure provider issues are dealt with at a local level.

2.5 At all times demonstrate value for money and an effective and efficient commissioning programme;

2.6 Ensure that the financial risks to individual Members of unforeseen/unplanned activity are minimised, and that inequalities in access to and delivery of services are reduced;

2.7 Review, plan, develop and monitor the Services in partnership with clinicians, providers and service users; and

2.8 Use, where practically possible, other mechanisms to keep Members updated in terms of progress rather than the formal Joint Committee meetings.

The following additional key principles will also apply:

2.9 Commitments made by the Joint Committee in accordance with the delegated powers will be binding on all Members until the Joint Committee agrees otherwise;

2.10 Whilst agreement on the proposed way forward can be discussed and agreed at other forums (e.g. CEO Peer Group) all decisions will be taken at Joint Committee meetings unless otherwise delegated; and

2.11 A standard facilitation/arbitration procedure will apply.

3. BUSINESS PROCESSES

3.1. The Joint Committee's key business processes and products will be delivered through a clear and consistent annual business cycle. Each product that will be developed and implemented through appropriate structures that already exist and include:

3.1.1 Chief Executive Peer Group

3.1.2 Executive Directors Peer Groups

3.1.3 Programme Teams

3.1.4 Existing Governance structures

4. MEETINGS OF THE JOINT COMMITTEE

4.1 General Principles

4.1.1 The dates of Joint Committee meetings will be agreed in advance with the membership for a rolling period of one year.

4.1.2 It is expected that the Joint Committee will meet up to five times each year.

4.1.3 All reports will be concise and clear. The body (introduction to conclusion) of the report will be a maximum of six A4 pages in length, where reasonably practical.

4.1.4 The Annual Plan for Specialised Services will be agreed annually. Any requests for additional funding outside of the agreed annual planning business cycle will need to demonstrate exceptionality. *(Refer to the All Wales Policy on Dealing with Individual Funding Requests for guidance).*

4.1.5 All reports prepared for meetings of the Joint Committee will include a summary which will be no longer than one A4 page in length. This summary should include the title of the report, its purpose and the name of the responsible Executive Director. It should also clearly state what is required from the Joint Committee and outline the potential and/or likely implications of the decision.

4.1.6 All reports will be agreed by the Management Group before consideration by the Joint Committee.

4.1.7 The Joint Committee will not normally consider reports for information during the meetings. These will be circulated outside of the meetings. This will ensure that time is maximised during Joint Committee Meetings. Where further discussion and agreement is required on specific items this will be undertaken through the Management Group and the decision will be taken at the Joint Committee in accordance with the Governance and Accountability Framework.

4.1.8 All papers will be sent electronically to Joint Committee Members, Directors of Finance and

Directors of Planning (see *WHSSC Standing Orders* reference 6.5.3). Copies of the agenda and papers will also be available on the WHSSC website http://www.whssc.wales.nhs.uk/

4.1.9 On the occasions when the Chief Executive of the LHB is unable to attend the meeting, an Executive Director must be nominated to attend the Joint Committee meetings. The nomination must be approved by the Chair of the Joint Committee before the meeting (please refer to *WHSSC Standing Orders* reference 6.6.11). The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have delegated voting rights.

4.1.10 On the occasions where the Joint Committee meeting is not quorate (please refer to *WHSSC Standing Orders* reference 6.6.10), the Chair may seek the views of those Members present and request that the Committee Secretary writes to each Member of the Joint Committee to support the decisions.

4.1.11 In dealing with such issues requiring an urgent decision, and if timescales allow, the Chair may call a meeting of the Joint Committee using video or telephone conferencing facilities. Emails may also be used to gather views and/or reach a consensus. All such decisions will be ratified by the Joint Committee at its next formal meeting.

4.2 Confidential Agenda

The Joint Committee will discuss items in confidence that would be exempt under the Freedom of Information Act 2000. Such items would generally be considered to be personal and confidential in nature or their disclosure would be otherwise prejudicial to the public interest.

4.3 Declaration of Interests

Please refer to *WHSSC Standing Orders* reference 7.1.

4.4 Managing Conflict

4.4.1 The Joint Committee must exercise its functions in a way which ensures that any conflicts of interest and local and prejudicial interests are dealt with as a preliminary to the decision making.

4.4.2 At each meeting any specific conflicts pertinent to an issue on the agenda must be declared at the start and then recorded in the Minutes. In each meeting the Chair will ask Members to agree as preliminary whether the conflicted LHB should remain in the meeting and/or be able to participate in the discussion and to what degree.

4.5 Decision Making

4.5.1 The Joint Committee will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no two thirds majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

4.5.2 On reaching a Joint Committee decision, all members will support that decision and its consequences in every respect.

4.6 Additional Items of Business

The Chair will be notified in advance of any items of other business to be raised for discussion at a meeting of the Joint Committee (see *WHSSC Standing Orders* reference 6.5.2). Where this is not possible or in exceptional circumstances, items of other business may be raised by a member at the appropriate point on the agenda. Acceptance of items of other business is at the discretion of the Chair.

4.7 Chair's Ruling

The decision of the Chair of the Joint Committee on questions of order, relevancy and regularity and the Chair's interpretation of the Business Framework and the Governance and Accountability Framework shall be final. In this interpretation the Chair shall be advised by the Director of Specialised and Tertiary Services and the Committee Secretary.

5. MINUTES AND ACTIONS

5.1 Minutes

5.1.1 The proceedings of each meeting of the Joint Committee will be formally recorded. The Committee Secretary will be responsible for the production of these minutes.

5.1.2 The Chair will be responsible for summarising action points and decisions after each item of business during the meeting.

5.1.3 The Director of Specialised and Tertiary Services will write out to all Joint Committee Members with a summary of the discussions and actions following the meetings.

5.1.4 Following a meeting of the Joint Committee, the Director of Specialised and Tertiary Services will review the accuracy of the unconfirmed minutes with the Committee Secretary, prior to submission to the Chair for approval.

5.1.5 Once reviewed and approved by the Chair, the unconfirmed minutes will be circulated to Joint Committee Members and the Board Secretary of each LHB.

5.1.6 At the next meeting of the Joint Committee, all members will review the minutes and confirm that they are an accurate record. If any changes are required, the amendments will be discussed and agreed at the meeting.

5.1.7 The Chair will sign a copy of the minutes when agreed as an accurate record. This creates an official record of the meeting.

5.2 Actions

5.2.1 Actions resulting from the Joint Committee meetings will be summarised in tabular form which clearly indicates who is responsible and the agreed timescales.

5.2.2 The summary of actions should be circulated with the papers of the next Joint Committee meeting.

5.3. Briefing

5.3.1 A Joint Committee Briefing summarising the key discussion and decisions at Joint Committee meetings will be distributed within 7 days of each Joint Committee meeting.

6. DISPUTE RESOLUTION

6.1 In accordance with the Governance and Accountability Framework the Health Boards will seek to work cooperatively with each other as constituent Members of the Joint Committee. Where there is an impasse which cannot be reached by means of conciliation between appropriate individuals, then the dispute process set out in Annex (iii) of the Governance and Accountability Framework will be followed.

6.2 Disputes relating to the Hosting Agreement between Cwm Taf Health Board and the Health Boards will be dealt with in accordance with Section 16 of the Hosting Agreement.

6.3 Most disputes arising between the Commissioners and Providers should be managed and resolved locally. Where there is need for escalation, the objectives of the Welsh Health Specialised Services Committee (WHSSC) ("Joint Committee") Dispute Resolution Process are:

6.3.1 To resolve disputes promptly, transparently, fairly and consistently;

6.3.2 To provide confidence to parties that the process is fair and transparent;

6.3.3 To mitigate risks and protect the reputation of the NHS in Wales;

6.3.4 To prevent where possible legal challenge or other external referral processes.

6.4 Facilitation and/or arbitration (Stage 1 and Stage 2) of disputes may be required in the following circumstances:

6.4.1 The Chair or any Member of the Joint Committee requests facilitation because an impasse has been reached between Members of the Committee.

6.5 Formal dispute resolution may be required in the following circumstances but shall not be limited to:

6.5.1 Any Provider dispute concerning the contractual agreement between WHSSC and the Provider which has not been able to be resolved with Officers of WHSSC;

6.5.2 Any dispute concerning the contractual agreement between the Provider and WHSSC which has not

been able to be resolved with Officers of the Provider organisation;

6.6 This document should be read in conjunction with the Governance and Accountability Framework *Disputed Debts within the NHS in Wales Arbitration Process* (see Appendix A).

6.6.1 There is no formal arbitration process between England and Wales, however in the past disputes have been resolved through intervention by Welsh Government and DoH representatives.

6.6.2 The final decision made by the route followed is final and on completion the dispute cannot be taken through the alternative route.

6.7 Definitions

6.7.1 *Locally*, within this section, means amongst the individuals raising the dispute.

6.7.2 *NHS Wales* refers to all Local Health Boards and NHS Trusts

6.7.3 *Member*, within this section, refers to both Voting Members, Officer Members and Associate Members of the Joint Committee.

6.8. Raising a Dispute

6.8.1 In the case of any dispute arising out of or in connection with the Commissioning of Specialised Services for NHS Wales, the parties involved will make every reasonable effort to communicate and co-operate with each other with a view to resolving the dispute, before formally referring the dispute for local resolution.

6.8.2 In the event of a dispute arising between two or more parties which cannot be resolved between "WHSSC" the Commissioner and the Provider, the parties should refer to section 6.6.6.

6.8.3 Disputes may arise over any aspect of a Heads of Agreement, or Service Level Agreement including that is deemed to be fair and reasonable, the management of performance variations and the imposition of penalties.

6.8.4 Where any conflicts are identified between the requirements of the Heads of Agreement and any national directives and circulars, the requirements of the latter shall take precedence.

6.8.5 All parties recognise that it is in the best interests of patients, the organisations themselves, and the services they provider, for any disputes to be resolved locally.

Local Dispute Resolution

6.8.6 The first level of resolution should be:

For WHSSC: Mr. Stuart Davies, Director of Finance or nominated Officer.

For Provider: Director of Finance or nominated Officer.

6.8.7 The second resolution shall be:

For WHSSC: The Director of Specialised & Tertiary Services

For the Provider: The Chief Executive

Formal Dispute Resolution

6.8.8 In the event that the dispute is not resolved at the local resolution stage one or more parties may submit a formal request for dispute resolution.

The request for formal dispute should be addressed to:

Committee Secretary
Welsh Health Specialised Services Committee
Unit G1
The Willowford
Treforest Industrial Estate
Pontypridd
CF37 5YL

6.8.8.1 The names of the parties to the dispute;

6.8.8.2 A brief statement describing the nature of the circumstances of the dispute and

outlining the reasons why the commissioner/providers are in disagreement; and

6.8.8.3 What has been done to try and resolve matters.

6.8.9 On receipt of formal referral for review of case, the request will be acknowledged within five working days.

6.8.10 The decision shall be so referred immediately upon receipt of such notice and the effect of that decision shall be suspended until the conclusion of dispute resolution.

6.8.11 A decision not required to be referred to dispute resolution within the time specified shall be binding on all Members.

6.8.12 A record of all disputes (formal and informal) will be maintained and will be made available to Members and the Chief Executive of NHS Wales (and their Executive team) on request.

6.9 Process for Dispute Resolution

6.9.1 Stage 1 – Facilitation

6.9.1.1 All parties involved in the dispute must try to reach an agreement. This will involve meeting to discuss and try to resolve the issues. All reasonable efforts must have been made (local resolution level 1 and 2).

6.9.1.2 A meeting is held which includes the following:

- a representative of the Chief Executive Officer for the LHB area of the Member(s) in dispute;
- an appropriate Director from the NHS organisation(s) in dispute; and
- a representative of WHSSC

6.9.1.3 The meeting will be chaired by the Chair of WHSSC or Vice-Chair and involve expert advice (clinical/commissioning/financial) where appropriate.

6.9.1.4 If resolution is reached, the process will conclude at this stage.

6.9.2 Stage 2 – Arbitration

6.9.2.1 Both the party raising the dispute and the Director of Specialised and Tertiary Services or deputy (acting on behalf of the Joint Committee) will produce a joint statement of facts as well as a separate report setting out their positions and submit them to the Chair of the Dispute Resolution Panel.

6.9.2.2 The Chair of the Dispute Resolution Panel may invite the Director of Specialised and Tertiary Services or deputy (acting on behalf of the Joint Committee) and the Member bringing their dispute to present their positions or they may choose to decide on the basis of the information submitted.

6.9.2.3 Each Member of the Panel hereby recognises and agrees the role and responsibility of the Dispute Resolution Panel in relation to dispute resolution both as part of any initial Facilitation process and, further, as part of any Arbitration process. In resolving any such dispute the Panel shall have regard to ensuring each Member is fulfilling its statutory responsibilities and ensuring the highest clinical standards and patient safety issues are upheld.

6.9.2.4 The decision of the arbitration process will be binding.

6.10 Dispute Resolution Panel

6.10.1 Each formal dispute will be conducted by a panel appointed by the Chair of the Joint Committee. The panel will have a minimum of three members, including one member with commissioner and one member with provider experience. The panel may call on expert advice at its discretion. None of the

panel will have strong prior relationships with the key staff involved in the adjudication.

6.10.2 The exact make up of the panel and advice to be taken by it will be decided by the Chair and one Independent Member once Stage 1 (level 1 and 2) of the process has been completed and there has not been any resolution.

6.10.3 Disputes will be heard by the panel (where possible given the criteria outlined in 6.9) within 8 weeks of the dispute being raised formally.

6.10.4 The panel will make decisions based on a simple majority vote.

6.11 Dispute Resolution Panel Acceptance Criteria

The panel will only accept disputes that meet the following criteria:

6.11.1 Stage 1 of the process has been completed but there is no resolution;

6.11.2 There must have been a full and frank disclosure of all relevant and applicable information. (This does not preclude the panel from asking for further information as it requires);

6.11.3 Individuals connected to the dispute should be able to make themselves available to provide further evidence as required;

6.11.4 There must be evidence that the party bringing the dispute has made reasonable effort to have this resolved at NHS Wales level, or can demonstrate that this was inappropriate, and that all other attempts at resolution have been completed;

6.11.5 All disputes must be formally lodged with the Dispute Resolution Panel within 3 weeks of the date the issue arose, otherwise the dispute will be invalid;

6.11.6 The dispute must not be not trivial, vexatious or an abuse of the Joint Committee Governance and Accountability Framework;

6.11.7 There must be adequate time to hear the dispute.

6.12 Timescales for Dispute Resolution

The maximum timescales for action in relation to resolution of disputes is outlined below:

Age of Dispute (weeks)	Action
0 – 3	Referral of a dispute to resolution Local agreement sought
3 - 5	Escalation of dispute to formal stage of dispute resolution
5	Preparation for Panel (Stage 2)
6	Case Submission
7	Final Submission Deadline
8	Panel held and decision made

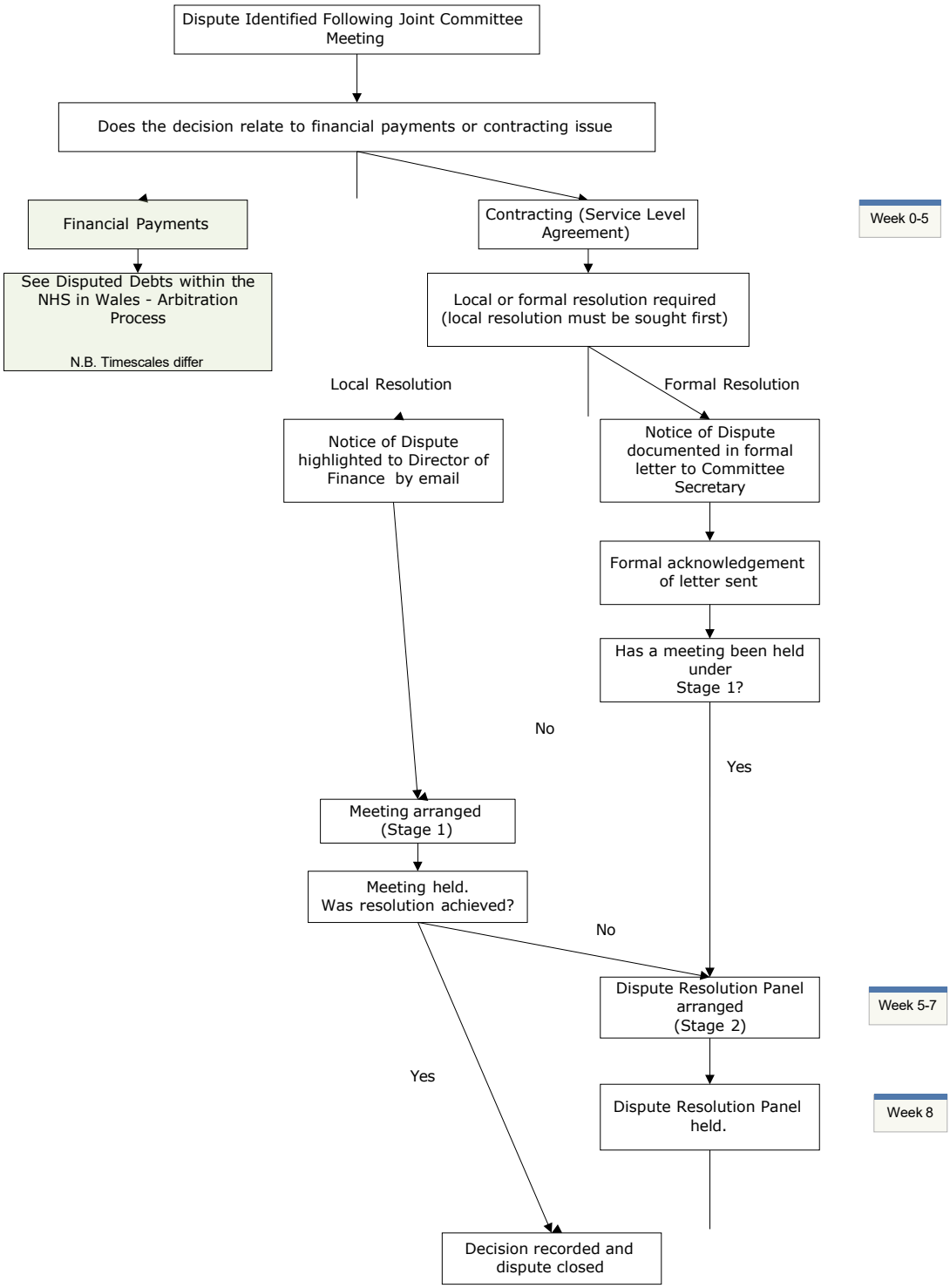
Appendix A

Disputed Debts within the NHS in Wales - Arbitration Process

Disputed debts between Welsh NHS organisations will be dealt with in accordance with the 'Disputed Debts within the NHS in Wales - Arbitration Process 2010/11' or such subsequent relevant arbitration process as is issued by or on behalf of Welsh Government from time to time.

Appendix B

Flow Chart for Dispute Resolution



Annex (iv) to Memorandum of Agreement

CLINICAL NETWORKS

Welsh ~~Clinical Renal Network~~ Kidney Network (WKN)

The Welsh ~~Clinical Renal~~ Kidney Network (WKN) is established as a Sub-Committee of the Welsh Health Specialised Services Committee. This arrangement will be reviewed on a regular basis as part of the Governance and Accountability Framework for the Joint Committee.

The Chair of the Welsh ~~Clinical Renal~~Kidney Network will be accountable to the Chair and will be an Associate Member of the Joint Committee.

The Welsh ~~Clinical Renal~~Kidney Network will provide a national focus for planning and performance management of all renal services, work closely with each LHB to support service improvement, local planning, and resource management. It will be the focal point to inform the LHBs and WG on the effectiveness and efficiency of adult renal services in Wales as well as the strategic implementation of the Renal National Service Framework and performance against the Annual Operating Framework and the associated Local Delivery Plans.

The Welsh ~~Clinical Renal~~ Kidney Network Chair / Lead Clinical Advisor will be directly accountable to the Chair of the Joint Committee but will also provide advice to WG through the Director of Strategy and Planning and the NHS Medical Director and Chief Medical Officer on an agreed sessional basis.

The Renal Network Manager will be managerially responsible to the Director of Finance and accountable to the Network Chair / Lead Clinical Advisor for the development and delivery of the Network objectives and work plan as appropriate to this role.

Annex 2.1

STANDING FINANCIAL INSTRUCTIONS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders and the Local Health Board Standing Orders (incorporated as Schedule 2.1 of SOs).

Foreword

These Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Each Local Health Board (LHB) in Wales must agree Standing Financial Instructions (SFIs) for the regulation of the Welsh Health Specialised Services Committee's (the "WHSSC" or the "Joint Committee") financial proceedings and business. These WHSSC Standing Financial instructions (WHSSC SFIs) are an annex to the WHSSC Standing Orders (WHSSC SOs) which form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them. They are designed to translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of a schedule of decisions reserved to the Joint Committee; a scheme of delegations to officers and others; and WHSSC Standing Orders, they provide the regulatory framework for the business conduct of the WHSSC.

These documents, together with a written Memorandum of Agreement defining the respective roles of the seven LHB Accountable Officers and a hosting agreement between the Joint Committee and Cwm Taf Morgannwg LHB (the host LHB), form the basis upon which the WHSSC's governance and accountability framework is developed. Together with the adoption of a Values and Standards of Behaviour framework is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Joint Committee members, host LHB and Welsh Health Specialised Services Team (WHSST) staff must be made aware of these WHSSC Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The WHSSC's Committee Secretary or the Director of Finance will be able to provide further advice and guidance on any aspect of the WHSSC SFIs or the wider governance arrangements for WHSSC. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/

Contents

Welsh Health Specialised Services Committee

1. INTRODUCTION

1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. Each Local Health Board (LHB) in Wales must agree Standing Financial Instructions (SFIs) for the regulation of the Welsh Health Specialised Services Committee's (the "WHSSC" or the "Joint Committee") financial proceedings and business. The Standing Financial Instructions shall apply equally to members and officers of the Joint Committee.

1.1.2 **These SFIs shall have effect as if incorporated in the WHSSC Standing Orders (SOs) (incorporated as Schedule 2.1of SOs), and both should be used in conjunction with the host LHB's SOs and SFIs**.

1.1.3 These SFIs detail the financial responsibilities, policies and procedures adopted by WHSSC. They are designed to ensure that the WHSSC's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Committee and the Scheme of delegation adopted by the WHSSC.

1.1.4 These SFIs identify the financial responsibilities which apply to everyone working for the Joint Committee, including its joint sub-Committees, staff of the host LHB and staff of WHSST. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial control procedure notes. All financial procedures must be approved by the Finance Director of Specialised and Tertiary Services (and referred to as the Director of Finance within these SFIs) and Audit Committee that deals with WHSSC matters.

1.1.5 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Committee Secretary or Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the WHSSC SOs.

1.2 Overriding Standing Financial Instructions

1.2.1 Full details of any non compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Finance and the Committee Secretary, who will ask the Audit Committee that deals with WHSSC matters to formally consider the matter and make proposals to the Joint Committee on any action to be taken. All Joint Committee members, members of joint sub-Committees, host LHB staff and WHSST staff have a duty to report any non compliance to the Director of Finance and the Committee Secretary as soon as they are aware of any circumstance that has not previously been reported.

1.2.2 Ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Joint Committee.

1.3 Financial provisions and obligations of LHBs and the WHSSC

1.3.1 The financial provisions and obligations for LHBs are set out under Sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 (c. 42). The Joint Committee exists for the purpose of jointly exercising those functions relating to the planning and securing of certain specialised and tertiary services on a national All-Wales basis, on behalf of each of the seven LHBs in Wales. Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its delegated functions. The Joint Committee must agree an appropriate level of funding for the provision of these services and determine the contribution from each LHB to allow the Joint Committee to plan and secure those services, including the running costs of WHSS. The Joint Committee will prepare an Integrated Medium Term Plan (IMTP) which shall outline the funding requirements in relation to the Relevant Services. The Joint Committee will also be responsible for developing a risk sharing framework which sets out the basis on which each LHB will contribute to any variation from the agreed Integrated Medium Term Plan.

2. RESPONSIBILITIES AND DELEGATION

2.1 The Joint Committee

2.1.1 The Joint Committee via WHSST exercises financial supervision and control by:

a) Formulating and approving the Medium Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium Term Plan (IMTP);

b) Requiring the submission and approval of balanced budgets within approved allocations/overall funding;

c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability); and

d) Defining specific responsibilities placed on Joint Committee members and officers, and joint sub-Committees, as indicated in the Scheme of delegation document.

2.1.2 The Joint Committee has adopted the WHSSC SOs and resolved that certain powers and decisions may only be exercised by the Joint Committee in formal session. These are set out in the 'Schedule of matters reserved to the Joint Committee' section of the WHSSC SOs. The Joint Committee, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of WHSSC may be carried out effectively, and in a manner that secures the achievement of the organisations aims and objectives. This will be via powers and authority delegated in accordance with the 'Scheme of delegation' schedules in the WHSSC SOs.

2.2 The Managing Director and Director of Finance

2.2.1 The Managing Director and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Managing Director is ultimately accountable to the Joint Committee in relation to those functions delegated to them by the Joint Committee; and is also accountable to the host Chief Executive in respect of the administrative arrangements supporting the operation of the WHSST by ensuring that the Joint Committee meets its obligation to perform its functions within the available financial resources. The Managing Director has overall executive responsibility for WHSST's activities; is responsible to the Chair and the Joint Committee for ensuring that financial obligations and targets are met; and has overall responsibility for the WHSST's system of internal control.

2.2.3 It is a duty of the Managing Director to ensure that Joint Committee members, staff and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The Director of Finance

2.3.1 The Director of Finance is responsible for:

a) Implementing the Joint Committee's financial policies and for co-coordinating any corrective action necessary to further these policies;

b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) Ensuring that sufficient records are maintained to show and explain the Joint Committee's transactions, in order to disclose, with reasonable accuracy, the financial position of the Joint Committee at any time; and

d) Without prejudice to any other functions of the Joint Committee, and employees of the host LHB and WHSST, the duties of the Director of Finance include:

(i) The provision of financial advice to other members of the Joint Committee, joint sub-Committees, Advisory Groups and officers;
(ii) The design, implementation and supervision of systems of internal financial control; and
(iii) The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Joint Committee may require for the purpose of carrying out its statutory duties.

2.3.2 The Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.

2.4 Joint Committee members and officers, and joint sub-Committees

2.4.1 All members of the Joint Committee, its joint sub-Committees, employees of the host LHB (including those employed to perform WHSST functions), severally and collectively, are responsible for:

a) The security of the property of the Joint Committee and host LHB;

b) Avoiding loss;

c) Exercising economy and efficiency and sustainability in the use of

resources; and

d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.

2.4.2 For all Joint Committee members and officers, and joint sub-Committees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Joint Committee, joint sub-Committee and officers discharge their duties must be to the satisfaction of the Director of Finance.

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the host LHB to commit the Joint Committee to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Managing Director to ensure that such persons are made aware of this.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit Committee

3.1.1 An independent Audit Committee is a central means by which the Joint Committee ensures effective internal control arrangements are in place. In addition, the Audit Committee that deals with WHSSC matters provides a form of independent check upon the executive arm of the Joint Committee. Detailed terms of reference and operating arrangements for the Audit Committee that deals with WHSSC matters are set out in Annex 3 to the WHSSC SOs. This Audit Committee will follow the guidance set out in the NHS Wales Audit Committee Handbook**.**

http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Audit%20Committee%20Handbook%20%28June%202012%29.pdf

3.2 Chief Executive

3.2.1 As Chief Executive of the host LHB, the Chief Executive is responsible for:

a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer;

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Joint Committee. The report must cover:

- A clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards;
- Major internal financial control weaknesses discovered;
- Progress on the implementation of Internal Audit recommendations;
- Progress against plan over the previous year;
- A strategic audit plan covering the coming three years; and
- A detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land or property owned or leased by the host LHB;

c) Access at all reasonable times to Joint Committee members and employees of the host LHB and WHSST;

d) The production of any cash, stores or other property of the host LHB under a Joint Committee member or WHSSC official's control; and

e) Explanations concerning any matter under investigation.

3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within a Public Sector Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Internal Audit Standards. Standing Order 9.1 (of the host LHB's SOs) details the relationship between the Head of Internal Audit and the Joint Committee. The role of the Audit Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Annex 3 of the WHSSC SOs, and the Audit Committee Handbook.

3.3.2 The Chief Executive shall ensure that the annual plan of the Internal Auditor gives due regard to the activities of the Joint Committee in order to inform the audit opinion and the overall internal controls system.

3.4 External Audit

3.4.1 The Joint Committee is not itself a statutory body but is hosted by the host LHB on behalf of the seven LHBs in Wales.

3.4.2 The financial results of the Joint Committee will be separately identified when consolidated into the financial statements of the host LHB and therefore the host LHB must ensure that the Auditor General's representative, give due regard to the transactions and financial affairs of the Joint Committee, in its plan.

3.4.3 More detailed information about the purpose and responsibilities of external audit can be found in section 3.4 of the host LHB's SFIs.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the Managing Director and Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The Managing Director and Director of Finance shall report to the Joint Committee and the host LHB's Local Counter Fraud Specialist any matters relating to fraud or corruption.

3.5.3 More detailed information about counter fraud can be found in section 3.5 of the

host LHB's SFIs.

3.6 Security Management

3.6.1 Security matters are the responsibility of the Chief Executive of the host LHB but the Managing Director will ensure that adequate processes are in place to comply with the requirements.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 As the Joint Committee exists for the purpose of jointly exercising functions on behalf of each of the seven LHBs in Wales it must be cognisant of the Local Health Boards two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. Those duties are then set out and retained in the Welsh Health Circular "WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts." They are as follows:

- First Duty - A duty to secure that its expenditure, which is attributable to the performance by it of its functions, does not exceed the aggregate of the funding allotted to it over a period of 3 financial years;
- Second Duty - A duty to prepare a plan to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers

4.1.2 The details and requirements for the two duties for LHBs are set out in the Welsh Health Circular "WHC/2015/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts."

http://www.wales.nhs.uk/sitesplus/documents/863/12b%29%20Statutory%20Duties%20of%20Welsh%20Health%20Boards.pdf

4.2 First Financial Duty – The Breakeven Duty

4.2.1 WHSSC has a duty to secure that its expenditure does not exceed the aggregate of the funding allotted to it over a period of 3 financial years, that is to breakeven over a 3-year rolling period.

4.2.2 In accordance with the WHSSC SOs, the Joint Committee must agree the appropriate level of funding required from each LHB to fulfil its obligations. This will include the running costs of WHSST and will be separately identifiable.

4.2.3 WHSST must ensure the Joint Committee approve balanced revenue and capital plans in line with their notified funds before the start of each financial year. Each LHB will be required to make available to the Joint Committee the level of funds approved in the balanced plans which shall be drawn down in cash on a monthly basis from each of the LHBs as proposed by the Director of Finance and agreed by the Joint Committee.

4.2.4 The Director of Finance will:

a) Prior to the start of each financial year submit to the Joint Committee for approval a report showing the total funding to be received, including assumed in-year funding adjustments, and their proposed distribution to delegated budgets, including any sums to be held in reserve;

b) Be responsible for the development and operation of the risk sharing framework for any in year variations from the Medium Term Financial Plan. The Director of Finance will also provide monthly reports to the Joint Committee explaining any variations from the Integrated Medium Term Plan and the contributions from each of the LHB under this framework. In cases where the performance report highlights an adverse variance to the Integrated Medium Term Plan or where the report anticipates future unfunded cost pressures, the Joint Committee will be required to put in place contingency measures to ensure that a financially balanced position is maintained. In cases where the performance report highlights a favourable variance to the Integrated Medium Term Plan the Joint Committee shall be required to return the funding to each LHB in accordance with the risk sharing agreement;

c) Ensure that any ring-fenced or non-discretionary allocations are disbursed in accordance with Welsh Ministers' requirements;

d) Periodically review any assumed in-year funding to ensure that these are reasonable and realistic; and

e) Regularly update the Joint Committee on significant changes to the initial funding and the application of such funds.

4.2.5 The Chief Executive of the host LHB is not responsible for the outturn of WHSSC – this is the responsibility of the Joint Committee. Any variations to the Medium Term Financial Plan must be managed by the Joint Committee in accordance with the approved risk sharing framework. Each LHB will be responsible for its share under this risk sharing framework, and any consequent impact on their own LHB First Financial Duty.

4.3. **Second Financial Duty – The Planning Duty**

4.3.1 Health Boards have a statutory duty under section 175(2A) of the National Health Service (Wales) Act 2006 to prepare a plan, the Integrated Medium Term Plan (IMTP), to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

4.3.2 To support the LHBs statutory duty the Joint Committee has a duty to prepare an Integrated Medium Term Plan. The Integrated Medium Term Plan(IMTP) must reflect longer-term planning and delivery objectives for the ongoing development of specialised and tertiary services in Wales, in conjunction with the Welsh Ministers. The Integrated Medium Term Plan should be continually reviewed based on latest Welsh Government policy and national and local priority requirements. The Integrated Medium Term Plan, produced and approved annually, will be 3 year rolling plans. In particular the Integrated Medium Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.

https://gov.wales/sites/default/files/publications/2019-09/nhs-wales-planning-framework-2020-23%20.pdf

4.3.3 The NHS Planning Framework directs NHS organisations to develop, approve and submit an Integrated Medium Term Plan (IMTP) for approval by Welsh Ministers. The plan must:

- describe the context, including population health needs, within which the Joint Committee will deliver key policy directives and operational targets from Welsh Government,
- demonstrate how the Joint Committee are:
  - delivering their well-being objectives, including how the five ways of working have been applied,
  - contributing to the seven Well-being Goals,
  - establishing preventative approaches across all care and services,
- demonstrate how the Joint Committee will utilise its existing services and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to efficiency of services,
- demonstrate how the three-year rolling financial breakeven duty is to be achieved.

4.3.4 Integrated Medium Term Plans should be based on a reasonable expectation of future service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost

pressures and savings plans to ensure that the Integrated Medium Term Plan(including a balanced Medium Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium Term Plan will be the overarching planning document enveloping component plans and service delivery plans. The Integrated Medium Term Plan will incorporate the balanced Medium Term Financial Plan and will incorporate the Joint Committee's response to delivering the

- NHS Planning Framework,
- Quality, governance and risk frameworks and plans, and
- Outcomes Framework

4.3.6 The Integrated Medium Term Plan will be developed in line with the Integrated Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based;
- Details of major changes in activity, service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans; and
- Profiled activity, service, quality, workforce and financial schedules
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures;

4.3.7 The Joint Committee will:

a) Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services;

b) Develop national policies for the equitable access to safe and sustainable, high quality specialised and tertiary healthcare services across Wales, whether planned, funded and secured at national, regional or local level; and

c) Agree annually those services that should be planned on a national basis and those that should be planned locally.

4.3.8 The Managing Director has overall executive responsibility to develop and submit to the Committee, on an annual basis, the rolling 3 year Integrated Medium Term Plan. The Committee approved Integrated Medium Term Plan will be submitted to Local Health Boards and Welsh Government in line with the requirements set out in the Integrated Planning Framework.

4.3.9 The Joint Committee will:

a) Approve the Integrated Medium Term Plan prior to the beginning of the financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Committee approval the Plan will be submitted to Local Health Boards and Welsh Government prior to the beginning of the financial year of implementation;
b) Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all financial duties, probity and value for money requirements;
c) Agree the appropriate level of funding for the provision of specialised and tertiary services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the WHSST) in accordance with any specific directions set by the Welsh Ministers;
d) Prepare and agree with the Local Health Boards a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the Committee plan is not in place or in balance.

4.3.10 The development, submission and approval of the Integrated Commissioning Plan will discharge the Joint Committee's Integrated Medium Term Plan responsibilities.

5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1 Budget Setting

5.1.1 Prior to the start of the financial year the Director of Finance will, on behalf of the Managing Director, prepare and submit budgets for approval and delegation by the Joint Committee. Such budgets will:

a) Be in accordance with the aims and objectives set out in the Joint Committee Integrated Medium Term Plan, and Medium Term Financial Plan, and focussed on delivery of improved population health, safe patient centred quality services;

b) Be in line with Revenue, Capital, Commissioning, Activity, Service, Quality, Performance, and Workforce plans contained within the Joint Committee approved balanced IMTP;

c) Take account of approved business cases and associated revenue costs and funding;

d) Be produced following discussion with appropriate Directors and budget holders;

e) Be prepared within the limits of available funds;

f) Take account of ring-fenced, specified and non-recurring allocations and funding;

g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents);

h) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and

i) Identify potential risks and opportunities.

5.2 Budgetary Delegation

5.2.1 The Managing Director may delegate the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget;
b) The purpose(s) of each budget heading;
c) Individual or committee responsibilities;
d) Arrangements during periods of absence;
e) Authority to exercise virement;
f) Achievement of planned levels of service; and
g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Managing Director, Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Joint Committee.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Managing Director, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Managing, as advised by the Director of Finance.

5.2.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and managed appropriately.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

5.2.7 The Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

5.3 Financial Management, Reporting and Budgetary Control

5.3.1 The Director of Finance shall monitor financial performance against budget and plans and report the current and forecast position on a monthly basis and at every Joint Committee meeting. Any significant variances should be reported to Joint Committee as soon as they come to light and the Joint Committee shall be advised on any action to be taken in respect of such variances.

5.3.2 The Director of Finance will devise and maintain systems of financial management performance reporting and budgetary control. These will include:

a) Regular financial reports, for revenue and capital, to the Joint Committee in a form approved by the Joint Committee containing sufficient information for the Joint Committee to:
- Understand the current and forecast financial position
- Evaluate risks and opportunities
- Use insight to make informed decisions
- Be consistent with other Board reports, and as a minimum the reports will cover:
  - Details of variations from the medium term financial plan showing the contributions to be made by each LHB under the risk sharing framework;
  - Actual income and expenditure to date compared to budget and showing trends and run rates;
  - Forecast year end positions;
  - A statement of assets and liabilities, including analysis of cash flow and movements in working capital;
  - Explanations of material variances from plan;

- Capital expenditure and projected outturn against plan;
- Investigations and reporting of variances from financial, activity and workforce budgets;
- Details of any corrective action being taken as advised by the relevant budget holder and the Managing Director's and/or Director of Finance's view of whether such actions are sufficient to correct the situation,;
- Statement of performance against savings targets;
- Key workforce and other cost drivers;
- Income and expenditure run rates, historic trends, extrapolation and explanations; and
- Clear assessment of risks and opportunities;

- Provide a rounded and holistic view of financial and wider organisational performance.

b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible;

c) An accountability and escalation framework to be established for the organisation to formally address material budget variances;

d) Investigation and reporting of variances from financial, activity and workforce budgets;

e) Monitoring of management action to correct variances;

f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will:

- be held to account for managing services within the delegated budget
- investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Managing Director subject to the Joint Committee's scheme of delegation;

b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of

virement; and

c) No permanent employees are appointed without the approval of the Managing Director other than those provided for within the available resources and workforce establishment as approved by the Joint Committee.

5.3.5 The Managing Director is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Integrated Medium Term Plan and medium term financial plans.

5.4 Capital Financial Management, Reporting and Budgetary Control

5.4.1 The general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans, budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Managing Director is responsible for ensuring that the appropriate monitoring returns for the Joint Committee are submitted to the Welsh Ministers in accordance with published guidance and timescales.

https://gov.wales/health-boards-and-trusts-financial-monitoring-guidance-2019-2020-whc-2019013

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the Director of Finance and Managing Director. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the Joint Committee. There must be consistency between the medium term financial plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Joint Committee reports.

6. ANNUAL ACCOUNTS AND REPORTS

6.1 The Joint Committee is not a corporate body and does not therefore have a statutory duty to prepare annual accounts and reports

6.2 However, the Joint Committee is hosted by the host LHB and therefore the Chief Executive of the host LHB is required to ensure that the financial results of the

Joint Committee are consolidated into its own financial statements and disclosed as appropriate.

6.3 The Managing Director and Director of Finance shall be required to provide all relevant information, financial and non-financial, to the Chief Executive as he or she requires to enable the Chief Executive to fulfil his or her statutory reporting responsibilities.

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The Joint Committee is legally hosted by the host LHB and therefore all banking arrangements are the responsibility of the host LHB. Further details of the banking arrangements can be found in section 7of the host LHB's SFIs.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1.1 The Joint Committee is generally only an expenditure incurring segment of the host LHB. Any cash requirements for the Joint Committee is likely to be incidental to its main activities.

8.1.2 All aspect relating to the recording, handling and collection of cash will be the responsibility of the host LHB.

8.1.3 Further details of the processes and responsibilities can be found in section 8 of the host LHB's SFIs.

9. INCOME, FEES AND CHARGES

9.1 General

9.1.1 The Joint Committee is generally only an expenditure incurring segment of the host LHB. Any income generated by the Joint Committee is likely to be incidental to its main activities.

9.1.2 All aspect relating to the recording, handling and collection of income will be the responsibility of the host LHB.

9.1.3 Further details of the processes and responsibilities can be found in section 9 of

the host LHB's SFIs.

10. NON PAY EXPENDITURE

10.1 Scheme of Delegation, Non Pay Expenditure Limits and Accountability

10.1.1 The Managing Director will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the Joint Committee's Scheme of Reservation and Delegation of Powers.

10.1.2 The Managing Director will set out in the operational scheme of delegation and authorisation:

a) The list of managers who are authorised to place requisitions for the supply of goods and services; and

b) The maximum level of each requisition and the system for authorisation above that level.

10.2 The Director of Finance's responsibilities

10.2.1 The Director of Finance will:

a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs;

b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure;

c) Ensure systems are in place for the authorisation of all accounts and claims;

d) Ensure Directors and officers strictly follow NHS Wales' system and procedures of verification, recording and payment of all amounts payable;

e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices;

f) Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed;

g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs; and

h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures.

10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Director of Finance and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged;

b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by Welsh Ministers prior to any commitment being made;

d) goods have been duly received, examined and are in accordance with specification and order;

e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

f) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Joint Committee members or WHSST staff, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7. of the host LHB's SFIs.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Managing Director;

h) All goods, services, or works are ordered on official orders except works and services executed in accordance with a contract and purchases from petty cash;

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit WHSSC to a future uncompetitive purchase;

k) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance.

10.3.2 The Managing Director and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. WHSSC must consult with NWSSP Procurement Services, Director of Finance and Committee Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of WHSSC, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable.

10.6 Prepayments

10.3.1 Prepayment should be exceptional, and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- It is in line with requirements of Managing Welsh Public Money;
- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact;
- The prepayment is part of the routine cash flow system agreed by the Directors of Finance.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate WHSST Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the host LHB or Joint Committee if the supplier is at some time during the course of the prepayment agreement unable to meet his/her commitments;

b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations where the contract is above a stipulated financial threshold); and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Managing Director if problems are encountered.

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

11.1 Policies and procedures

11.1.1 The host LHB shall be responsible for all aspects of the procurement and non pay process on behalf of the Joint Committee. Further details can be found in section 11 of the host LHB's SFIs.

11.1.2 In particular, and where appropriate, the Joint Committee should follow the host LHB's SFIs with regards to obtaining consent to enter into contracts exceeding £1m and the monitoring arrangements for contracts below £1m. This is shown as Schedule 1 in the LHB SFI's.

11.2 Requisitioning

11.2.1 The budget manager in choosing the item to be supplied (or the service to be

performed) shall always obtain the best value for money for the Joint Committee. The budget holder will source those goods or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services.

11.2.2 Where a required item is not on catalogue or on framework contract the budget manager shall request the NWSSP Procurement Services to undertake quotation / tendering exercises on their behalf in line with host LHB's SFI 11.11 thresholds.

11.2.3 All orders for goods and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.3 No Purchase Order, No Pay

11.3.1 WHSSC will ensure compliance with the 'No Purchase Order, No Pay' policy. The All Wales policy was introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.

11.3.2 The new policy ensures that a purchase order is raised at the beginning of a purchase. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.4 Official orders

11.4.1 Official Orders must:

a) Be consecutively numbered; and

b) State the Joint Committee's terms and conditions of trade.

11.4.2 Official Orders will be issued on behalf of WHSSC by NWSSP Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The Joint Committee will commission healthcare services for the resident population of all Local Health Boards, both from the LHB provided services, and from Trusts and other providers. The Managing Director is responsible for ensuring the Joint Committee enters into suitable Health Care Agreements, Individual Patient Commissioning Agreements and Contracts with service providers for health care services.

12.1.2 All Health Care Agreements, Individual Patient Commissioning Agreements and Contracts should aim to implement the agreed priorities contained within the Integrated Medium Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Managing Director should take into account:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);
- The provision of reliable information on quality, volume and cost of service; and
- That the agreements are based on integrated care pathways.

All agreements must be in accordance with the functions delegated to WHSSC by the Welsh Ministers.

12.2 Statutory provisions

12.2.1 The National Health Service (Wales) Act 2006 (c. 42) enables Health Boards to commission certain healthcare services. As WHSSC is hosted by the host LHB the Joint Committee will have the same responsibilities. In particular, the following sections are highlighted in relation to the statutory requirements of LHBs and therefore WHSSC for contracting with other bodies for the provision of health services:

- Section 7 sets out the definition of an NHS contract, being an arrangement under which one health service body arranges for the provision to it by another of goods or services which it reasonably requires for the purposes of its functions. It also provides a definition of a health service body;
- Section 9 sets out arrangements to be treated as NHS contracts for ophthalmic and pharmaceutical services;
- Sections 32 makes provision in relation to services which can be provided

to Health Boards by local authorities;

- Section 33 enables the Welsh Ministers to make provision which enables Health Boards and Local Authorities to enter into prescribed arrangements as to the provision of services which are in connection with specified circumstances, if they are likely to lead to an improvement in the way in which each of their functions are exercised;
- Part 4 enables Health Boards to make arrangements for the provision of primary medical services;
- Part 5 enables Health Boards to make arrangements for the provision of primary dental services;
- Part 6 enables Health Boards to make arrangements for the provision of general ophthalmic services;
- Part 7 enables Health Boards to make arrangements for the provision of pharmaceutical services;
- Section 188 enables the Welsh Ministers to make provision which enables Health Boards and the prison service to enter into prescribed arrangements as to the provision of services which are in connection with specified circumstances, if they are likely to lead to an improvement in the way in which each of their functions are exercised;
- Section 194 sets out the Health Boards powers to make payments towards expenditure on community services; and
- Section 195 sets out the conditions for payment where expenditure proposed under section 194 is in connection with services to be provided by a voluntary organisation.

12.3 Reports to Committee on Health Care Agreements (HCAs)

12.3.1 The Managing Director will need to ensure that regular reports are provided to the Joint Committee detailing performance, quality and associated financial implications of all health care agreements. These reports will be linked to, and consistent with, other Committee reports on commissioning and financial performance.

12.4 Tendering for supply of health care services

12.4.1 Where the Joint Committee is required or elects to invite quotes or tenders for the supply of healthcare services, the host LHB's SFIs in relation to procurement shall apply in relation to such competitive exercises.

12.4.2 The procurement arrangements surrounding the provision of healthcare services is a complex area and as such legal advice must be secured where there is doubt over the applicability or not of applying competitive processes. Further guidance is provided in the host LHB's SFI, Annex A.

13. GRANT FUNDING

13.1 Policies and procedures

13.1.1 The host LHB shall be responsible for all aspects of the grant funding process on behalf of the Joint Committee. Further details can be found in section 13 of the host LHB's SFIs.

14. PAY EXPENDITURE

14.1 Appointments and Remuneration

14.1.1 Appointments to the Joint Committee shall be in accordance with section 1.4 of the WHSSC SOs and the Welsh Health Specialised Services Committee (Wales) Regulations 2009.

14.1.2 All other appointments or recruitments to WHSST and any remuneration or employment contract related matters shall be dealt with by the host LHB on behalf of the Joint Committee in accordance with the host LHB's own SOs and SFIs.

14.1.3 Further details of the host LHB's responsibilities can be found in section 14 of the host LHB's SFIs.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 General

15.1.1 Capital plans, and annual capital programmes, must be approved by the Joint Committee before the commencement of a financial year and should be in line with the objectives set out in the approved Integrated Medium Term Plan (IMTP) for the organisation. The actual capital plan and programmes must be delivered within capital finance resource limits.

15.1.2 Any capital plans, and capital investment and expenditure incurred, by the Joint Committee or WHSST shall be dealt with in accordance with section 15 of the host LHB's SFIs. This includes the recording and safeguarding of assets.

16. LOSSES AND SPECIAL PAYMENTS

16.1 Losses and Special Payments

16.1.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

16.1.2 The Director of Finance is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

16.1.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Managing Director and/or the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or the Managing Director.

16.1.4 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the host LHB's Local Counter Fraud Specialist (LCFS) and the CFS Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.

16.1.5 The Director of Finance or the host LCFS must notify the Audit Committee dealing with WHSSC matters, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Health and Social Services Group Finance Directorate of all frauds.

16.1.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must notify:

a) The Audit Committee on behalf of the Joint Committee, and

b) An Auditor General's representative.

16.1.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the Joint Committee's and the host LHB's interests in bankruptcies and company liquidations.

16.1.8 The Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).

16.1.9 The Audit Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in in Annex 3 of the WHSSC SOs.

16.1.10 For any loss or special payments, the Director of Finance should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

16.1.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Health and Social Services Group Director of Finance.

16.1.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Health and Social Services Group Finance Directorate, irrespective of the delegated limit.

16.1.13 The Director of Finance shall ensure all losses and special payments are reported to the Audit Committee at every meeting.

16.1.14 WHSSC must obtain the Health and Social Services Group Director General's approval for special severance payments.

17. DIGITAL, DATA and TECHNOLOGY

17.1 Digital Data and Technology

17.1.1 The Joint Committee and WHSST shall operate within the guidance set out in section 18 of the host LHB's SFIs.

18. RETENTION OF RECORDS

18.1 Responsibilities of the Chief Executive

18.1.1 The Managing Director shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic

law considerations via the Data Protection Act 2018, and the Freedom of Information Act 2000 (c .36).

18.1.2 The records held in archives shall be capable of retrieval by authorised persons.

18.1.3 Records held in accordance with regulation shall only be destroyed at the express instigation of the Managing Director. Details shall be maintained of records so destroyed.

Welsh Health Specialised Services - Additional Delegations Linked to the SFI's

Contents

Welsh Health Specialised Services - Additional Delegations Linked to the SFI's

1. Budget delegation and virements

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Delegation of the management of a budget to permit the performance of a defined range of activities	6.2.1	Lead Director	Director of Finance
B	All budget holders are required to sign up to their allocated budgets at the start of the financial year.	6.1.4	Budget holders	All budget holders
C	Delegation to include the authority to exercise virement and budget transfers	6.2.1	Lead Director	See C1below

		Delegated to:	Signed off by:
A1	Delegation of the management of defined Revenue budgets to budget holders: i. Direct Running Costs WHSSC ii. Direct Running Costs WKN iii. Direct Running Costs TSW	i. Committee Secretary ii. WKN Manager iii. TSW Manager	i. Committee Secretary to £20,000 ii. WKN Manager to £10,000 iii. TSW Manager to £10,000 Thereafter Director of Finance to £50,000

C1-Approval of variation of budgets, including authority to vire

Delegated Authority	Between budget lines	Capital to revenue *& vice versa*
Between directorates	Director of Finance	Not allowed
Budget transfers between Reserves and Delegated budgets	Director of Finance	

Welsh Health Specialised Services - Additional Delegations Linked to the SFI's

2. Banking arrangements

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	The Director of Finance of the Host LHB will prepare detailed instructions on the operation of bank accounts which must include: i. The conditions under which bank accounts is to be operated ii. Those authorised to sign cheques or other orders drawn on the LHB accounts	9.1.1	Director of Finance of the Host LHB	As per Host LHB SFI's

3. Income, fees and charges.

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority Delegated to
A	**Fees and Charges**- The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges , other than those determined by the Welsh ministers or by statute	10.1.2	Director of Finance	Financial Accountant
B	**Debt recovery-** The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.	10.1.4	Director of Finance	Financial Accountant

	Fees and Charges:	**Authority Delegated to**
A1	**Risk Sharing Funding** i. Approval and Signing of the Risk Sharing Agreements and Annual Financial Plan	i. Joint Committee ii. WHSSC Management Group

Welsh Health Specialised Services - Additional Delegations Linked to the SFI's

4. Procurement and contracts for good and services

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Maintaining detailed policies and procedures for procurement, tendering and contracting	11.1.4	Host LHB	As per Host LHB SFI's

5. Contracts for Health Care Services

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority Delegated to
A	The Lead Director is responsible for ensuring the LHB enters into suitable Health Care Agreements or individual patient commissioning agreements where appropriate.	12.1.1	Lead Director on behalf of the Joint Committee	Director of Finance
B	The Lead Director will need to ensure that regular reports are provided to the Joint Committee detailing performance and associated financial implications of all health care agreements	12.3.1	Lead Director	Director of Finance

	Agreements for the purchase of services	Authority delegated to
A1	**Long Term Agreements with other NHS bodies** i. Approval and Signing of the Long Term Agreement ii. Variations to the Agreement	Level 1 – Lead Director – In accordance with delegated authority within the Standing Financial Instructions Level 2 – Director of Finance – In accordance with delegated authority within the Standing Financial Instructions

Welsh Health Specialised Services - Additional Delegations Linked to the SFI's

A4	**Individual NHS patient treatment charges outside of LTAs and SLAs** Agreement to fund treatment: i. Individual Patient Packages ii. Lifetime Costs	>£1,000,000 – Included in ARC & JC assurance report >£1,000,000 Level 1 – Lead Director <£1,000,000 Level 2 – Director of Finance <£500,000 Level 3 Directors >£1,000,000 – Included in ARC & JC assurance report >£1,000,000 Level 1 – Lead Director <£1,000,000 Level 2 – Director of Finance <£500,000 Level 3 Directors Below these limits individual directors can delegate their authority to officers as detailed in the Standing Financial Instructions

6. Pay expenditure

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	All appointments or recruitments	13.1.2	Host LHB	Committee Secretary

7. Non Pay expenditure

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	The Lead Director will approve the level of non pay expenditure and operational scheme of delegation and authorisation to budget holders the scheme of delegation	SFI 14.1.0	Lead Director	Director of Finance

B	The Director of Finance will advise the board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders should be sought.	14.3.1	Director of Finance	Financial Accountant

8. Losses and special payments

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
B	**Losses and Special payments** • Ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses and special payments cases are properly managed in accordance with the guidance set out in the Assembly Government's Manual for Accounts. • Ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write off' action is recorded on the system. • The Audit Committee shall approve the writing off of losses or the making of special payments within delegated limits determined by Welsh Ministers and as set out in Schedule 3 of the SOs. • Ensure that all losses and special payments are reported to the Audit Committee at every meeting	**16.1.2** **16.1.6** **16.1.7** **16.1.11**	Director of Finance Director of Finance Audit committee Director of Finance	Financial Accountant Financial Accountant See Below Financial Accountant

Welsh Health Specialised Services - Additional Delegations Linked to the SFI's

B1	**Approve losses, write-offs and compensation payments due to:** i. losses of cash (theft, fraud, etc) ii. damage to buildings, fittings, furniture and equipment and property in stores and in use due to culpable cause (theft, fraud, arson) iii. extra contractual payments to contractors; iv. ex-gratia payments to patients and staff for loss of personal effects v. fruitless payments including abandoned capital schemes vi. ex-gratia payments - voluntary release payments to staff vii. bad debts and claims abandoned - <£10,000 - £10,000 to £50,000 - No delegated approval over £50,000 – WG approval required	i to iv Lead Director (within delegated limits issued by Welsh Government - £50,000) v. Lead Director (delegated limits - £250,000) vi. Remuneration Committee (within delegated limits issued by Welsh Government - £50,000) vii. Director of Finance (to £10,000) and Lead Director (£10,000 to £50,000).
B2	**Approve compensation payments made under legal obligation:** • Personal injury claims i. up to £20,000 ii. £20,000 to £50,000 iii. Over £50,000 • Employment matters	• Personal injury- On receipt of legal advice to pay i. Committee Secretary ii. Director of Finance iii. Lead Director (within delegated limits issued by Welsh Government - £1million • Employment matters Lead Director (with advice from Committee Secretary)

B3	**Approve compensation payments made without legal obligation**	• Lead Director (within delegated limits issued by Welsh Government - £50,000)

9. IM&T

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	The Director of IM&T has specific responsibilities within this Section which need to be reviewed to determine if any formal delegation is required.	17.1.1	Host LHB	As per Host LHB SFI

10. Retention of Records

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	The Lead Director shall be responsible for maintaining archives for all records required to be retained in accordance with Welsh Ministers guidance.	18.1.1	Lead Director	• Committee Secretary

WHSSC Delegated Authorisation Matrix 01 March 2023

		Corporate Directors Direct Authority Through Financial Limits Policy						
		Tier 1 Director	Tier 1 Director	Tier 2 Director	Tier 3 Director			
Post	**Cost Centre**	**Director of EASC**	**Director of Specialised Services**	**Director of Finance & Information**	**Director of Planning & Performance**	**Committee Secretary**	**Nurse Director**	**Medical Director**
Current Post Holder		**Stephen Harrhy**	**Sian Lewis**	**Stuart Davies**	**Nicola Johnson**	**Jacqueline Evans**	**Carole Bell**	**Iolo Doull**
Corporate Responsibility as per the Standing Financial Instructions								
Sign off of Annual Financial Plan for JC		√	√	√				
		Cost Centres H700-H799	*Cost Centre H100*	*Cost Centre H100*				
Service Level Agreements in line with Standing Financial Instructions								
SLA Contract Agreements		√	√	√	√			
SLA Contract Payments in Line With Contract Agreements - Wales	*Cost Centres Wales H200-H290*	√ >£2m	√ >£2m	√ <£2m	√ <£1m			
SLA Contract Payments in Line With Contract Agreements - England	*Cost Centres England H300-H399, H400*	√ >£2m	√ >£2m	√ <£2m	√ <£1m			
IPFR Requests and Other Non Contract Payments								
All Patient Funding Requests	*Cost Centres H400-H411*		√* >£1m	√* <£1m	√* <£500k	√* <£500k	√* <£500k	√* <£500k
Non Contract and Emergency Activity	*Cost Centre H412*	√ >£100k	√* >£1m	√* <£1m	√* <£500k		√ <£250k	
Payments Supporting Approved Funding Releases and Developmetns	*Cost Centre H900 - H998*	√ >£100k	√* >£1m	√* <£1m	√* <£500k		√ <£250k	
Mental Health								
Mental Health CAMHS Contracts	*Cost Centre H550*		√* <£1m	√* <£1m	√* <£500k	√* <£500k	√* <£500k	√* <£500k
Other Mental Health Contracts	*Cost Centres H510-H530*		√* <£1m	√* <£1m	√* <£500k	√* <£500k	√* <£500k	√* <£500k
Mental Health Secure Services Contracts	*Cost Centres H500 / H505*	√	√	√	√			
Networks Running Costs								
Networks According to Oracle Authorisation Limits			√ <£100k	√ <£50k				
Committee Running Costs								
DRC Requisitions and Orders According to Oracle Authorisation Limits		√ <£100k	√ <£100k	√ <£50k		√ <£20k		
		Cost Centre H090	*Cost Centre H090*	*Cost Centre H090*		*Cost Centre H090*		
Payroll	*Cost Centres H001-H089*		*Cost Centre H001*	*Cost Centre H004*	*Cost Centre H002*	*Cost Centre H005*	*Cost Centre H003*	*Cost Centre H006*
Payroll New Starters		√	√	√	√	√	√	√
Payroll Leavers		√	√	√	√	√	√	√
Establishment Vacancy Authorisation		√	√					
Payroll Changes Financial		√	√	√	√	√	√	√
Payroll Changes Non Financial (eg Financial Coding)		√	√	√	√	√	√	√
Payroll Travel Expenses		√	√	√	√	√	√	√
Payoll Study Leave						√		
Operational Finance Teams Only								
Ledger Journals - Reversing				√				
Ledger Journals - Standard				√				
Ledger Journals - Final Accounts				√				
Delegated to External Bodies								
Bank Account Management								
Ledger Integrity								
Payroll Calculations								
PANISU								

	Delegated Authority										
	Assistant Directors			Commissioning					Corporate		
Post	**Assistant Director of Finance**	**Assistant Director of Planning**	**Assistant Medical Director**	**MH & CAMHS Commissioner**	**CAMHS Case Manager**	**Gender Services Manager**	**Traumatic Stress Wales**	**Renal Network Manager**	**Corporate Governance Manager**	**Corporate Governance Officer**	**Office Manager**
Current Post Holder	**James Leaves**	**Claire Harding**	**Various**	**Emma King**	**VACANCY**	**Krysta Hallewell**	**Emma Smith**	**Susan Spence**	**Helen Tyler**	**VACANCY**	**Laura Holburn**
Corporate Responsibility as per the Standing Financial Instructions											
Sign off of Annual Financial Plan for JC											
Service Level Agreements in line with Standing Financial Instructions											
SLA Contract Agreements	√	√									
SLA Contract Payments in Line With Contract Agreements - Wales	√ <£750k	√ <£750k									
SLA Contract Payments in Line With Contract Agreements - England	√ <£750k	√ <£750k									
IPFR Requests and Other Non Contract Payments											
All Patient Funding Requests	√**	√**	√**								
Non Contract and Emergency Activity	√ <£250k	√ <£250k						√ <£50k			
Payments Supporting Approved Funding Releases and Developmetns	√ <£250k	√ <£250k						√ <£50k			
								Cost Centre H600 / H601			
Mental Health											
Mental Health CAMHS Contracts	√**	√**	√**	√ <£50k	√ <£30k	√ <£30k					
Other Mental Health Contracts	√**	√**	√**	√ <£50k							
Mental Health Secure Services Contracts				√ <£50k							
Networks Running Costs											
Networks According to Oracle Authorisation Limits							√ <£10k	√ <£10k			
							Cost Centre H040	*Cost Centre H050*			
Committee Running Costs											
DRC Requisitions and Orders According to Oracle Authorisation Limits									√ <£10k	√ <£3k	√ <£0.5k
									Cost Centre H090	*Cost Centre H090*	*Cost Centre H090*
Payroll							*Cost Centre H040*	*Cost Centre H050*			
Payroll New Starters							√	√			
Payroll Leavers							√	√			
Establishment Vacancy Authorisation											
Payroll Changes Financial							√	√	√		
Payroll Changes Non Financial (eg Financial Coding)							√	√	√		
Payroll Travel Expenses							√	√	√		
Payoll Study Leave									√		
Operational Finance Teams Only											
Ledger Journals - Reversing	√										
Ledger Journals - Standard	√										
Ledger Journals - Final Accounts	√										
Delegated to External Bodies											
Bank Account Management											
Ledger Integrity											
Payroll Calculations											
PANISU											

	Delegated Authority												
	Finance Delegations				Clinical		EASC / NCCU					Delegated Functions	
Post	**Financial Accountant**	**Head of Contracting**	**Head of Financial Planninng**	**Assistant Financial Accountant**	**Head of Quality & Patient Care**	**IPFR Manager**	**Commissioning**	**Corporate**	**NEPTS**	**Clinical**	**Quality**	**Delegated to NWSSP**	**Delegated to Cwm Taf**
Current Post Holder	**Helen Harris**	**VACANCY**	**Kendal Smith**	**Nicola Skinner**	**Adele Roberts**	**Catherine Dew**	**VACANCY**	**Gwenan Roberts**	**Nicola Bowen**	**Jo Mower**	**Shane Mills**		
Corporate Responsibility as per the Standing Financial Instructions													
Sign off of Annual Financial Plan for JC													
Service Level Agreements in line with Standing Financial Instructions													
SLA Contract Agreements													
SLA Contract Payments in Line With Contract Agreements - Wales													
SLA Contract Payments in Line With Contract Agreements - England													
IPFR Requests and Other Non Contract Payments													
All Patient Funding Requests	√ <£50k	√ <£50k	√ <£50k		√ <£50k	√ < £10k ***							
Non Contract and Emergency Activity					√ <£50k	√ < £10k ***							
Payments Supporting Approved Funding Releases and Developmetns													
Mental Health													
Mental Health CAMHS Contracts	√ <£50k	√ <£50k	√ <£50k		√ <£50k	√ < £10k ***							
Other Mental Health Contracts	√ <£50k	√ <£50k	√ <£50k		√ <£50k	√ < £10k ***							
Mental Health Secure Services Contracts													
Networks Running Costs													
Networks According to Oracle Authorisation Limits													
Committee Running Costs													
DRC Requisitions and Orders According to Oracle Authorisation Limits							√ <£20,000	√ <£20,000	√ <£20,000	√ <£20,000	√ <£20,000		
Payroll													
Payroll New Starters							√	√	√	√	√		
Payroll Leavers							√	√	√	√	√		
Establishment Vacancy Authorisation													
Payroll Changes Financial	√	√					√	√	√	√	√		
Payroll Changes Non Financial (eg Financial Coding)	√	√					√	√	√	√	√		
Payroll Travel Expenses	√	√					√	√	√	√	√		
Payoll Study Leave													
Operational Finance Teams Only													
Ledger Journals - Reversing	√	√											
Ledger Journals - Standard	√	√											
Ledger Journals - Final Accounts	√												
Delegated to External Bodies													
Bank Account Management													√
Ledger Integrity	√												√
Payroll Calculations												√	
PANISU													√

√*	√*	**IPFR packages to be authorised according to the financial limits policy.**
√**	√**	**Assistant Directors can authorise in lieu of Directors in certain circumstances according to the financial limits policy**
√***	√***	**IPFR manager can authorise to delegated limit in absence of Head of Nursing & Quality**
		Delegated authority to Level 2 and 3 Directors for staff budgets and payroll appointments

Report Title	**Performance & Activity Report Month 9 2022-2023**	**Agenda Item**	4.1
Meeting Title	**Management Group**	**Meeting Date**	14/03/2023
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

PERFORMANCE AND ACTIVITY REPORT
MONTH 9 2022-2023

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, along with the relevant new Performance Measures set out by Welsh Government.

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, 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. The DHCW data used in this report was refreshed on January 31st 2023.

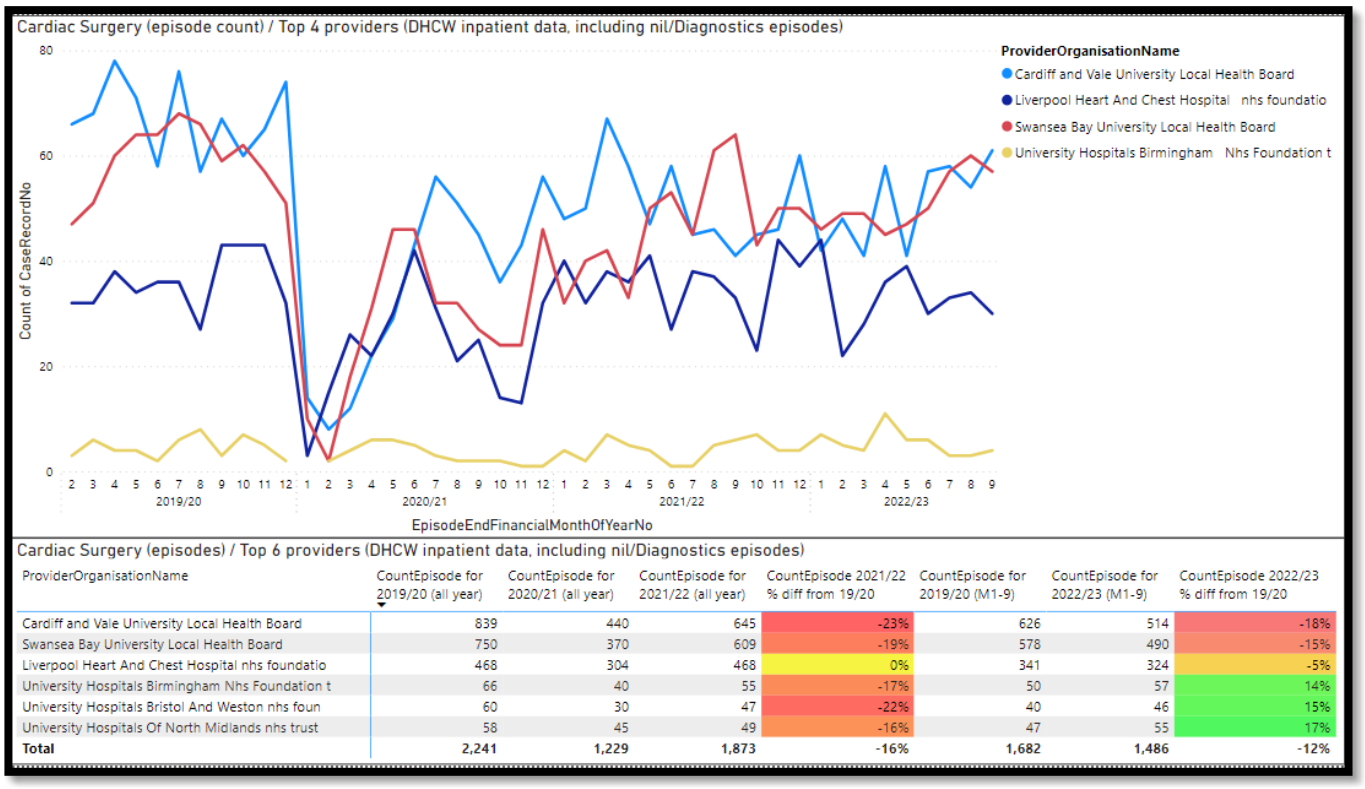
3.0 ASSESSMENT

Specialties/areas covered in this report include:

- Cardiac Surgery
- Thoracic Surgery
- Neurosurgery
- Plastic Surgery
- Paediatric Cardiac Surgery
- Paediatric Surgery
- Bariatric Surgery (new sub-heading added this month)
- English provider activity (all specialist and non-specialist)
- Annex A – summary of recovery across main specialties/providers
- Annex B and C – summary of Cardiff & Vale and Swansea Bay contracts
- Appendix 1 – charts of DHCW data showing inpatient activity at NHS England Trusts with a WHSSC contract (specialist and non-specialist)
- Appendix 2 – tables including the relevant Performance measures as directed by Welsh Government

3.1 Cardiac Surgery

3.1.1 Cardiac Surgery – Activity and Access Rate Summary



Cardiac Surgery (episodes) / Top 6 providers (DHCW inpatient data, including nil/Diagnostics episodes)

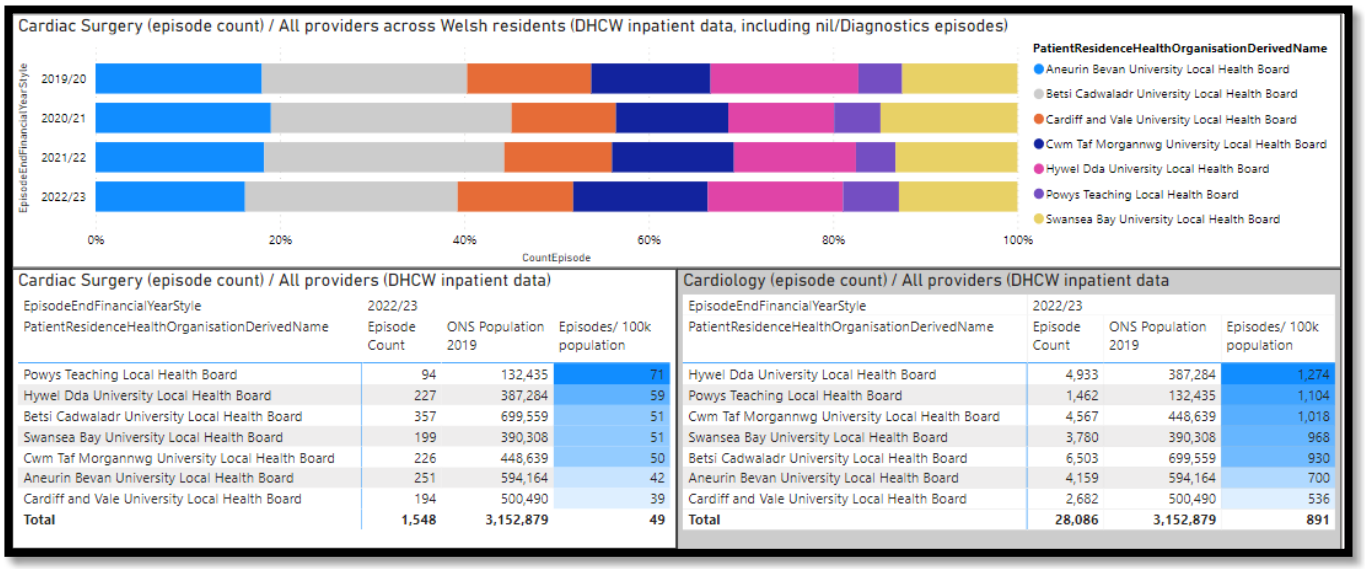
ProviderOrganisationName	CountEpisode for 2019/20 (all year)	CountEpisode for 2020/21 (all year)	CountEpisode for 2021/22 (all year)	CountEpisode 2021/22 % diff from 19/20	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
Cardiff and Vale University Local Health Board	839	440	645	-23%	626	514	-18%
Swansea Bay University Local Health Board	750	370	609	-19%	578	490	-15%
Liverpool Heart And Chest Hospital nhs foundatio	468	304	468	0%	341	324	-5%
University Hospitals Birmingham Nhs Foundation t	66	40	55	-17%	50	57	14%
University Hospitals Bristol And Weston nhs foun	60	30	47	-22%	40	46	15%
University Hospitals Of North Midlands nhs trust	58	45	49	-16%	47	55	17%
Total	**2,241**	**1,229**	**1,873**	**-16%**	**1,682**	**1,486**	**-12%**

Data source: DHCW central data warehouse; **Note: inpatient activity includes the nil/diagnostics procedure episodes as there is currently significant procedure coding backlogs for recent months for all main providers**

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 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, and 21%/16% less in 2021/22 (excluding non-procedure/diagnostics episodes/including them). Using all activity to date this year (Month 9 of 2022/23), activity is 12% 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 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 (Transcatheter Aortic Valve Implant) procedures for selected sub groups of patients, but numbers are not material.



Cardiac Surgery (episode count) / All providers (DHCW inpatient data)

EpisodeEndFinancialYearStyle: 2022/23 PatientResidenceHealthOrganisationDerivedName	Episode Count	ONS Population 2019	Episodes/ 100k population
Powys Teaching Local Health Board	94	132,435	71
Hywel Dda University Local Health Board	227	387,284	59
Betsi Cadwaladr University Local Health Board	357	699,559	51
Swansea Bay University Local Health Board	199	390,308	51
Cwm Taf Morgannwg University Local Health Board	226	448,639	50
Aneurin Bevan University Local Health Board	251	594,164	42
Cardiff and Vale University Local Health Board	194	500,490	39
Total	**1,548**	**3,152,879**	**49**

Cardiology (episode count) / All providers (DHCW inpatient data

EpisodeEndFinancialYearStyle: 2022/23 PatientResidenceHealthOrganisationDerivedName	Episode Count	ONS Population 2019	Episodes/ 100k population
Hywel Dda University Local Health Board	4,933	387,284	1,274
Powys Teaching Local Health Board	1,462	132,435	1,104
Cwm Taf Morgannwg University Local Health Board	4,567	448,639	1,018
Swansea Bay University Local Health Board	3,780	390,308	968
Betsi Cadwaladr University Local Health Board	6,503	699,559	930
Aneurin Bevan University Local Health Board	4,159	594,164	700
Cardiff and Vale University Local Health Board	2,682	500,490	536
Total	**28,086**	**3,152,879**	**891**

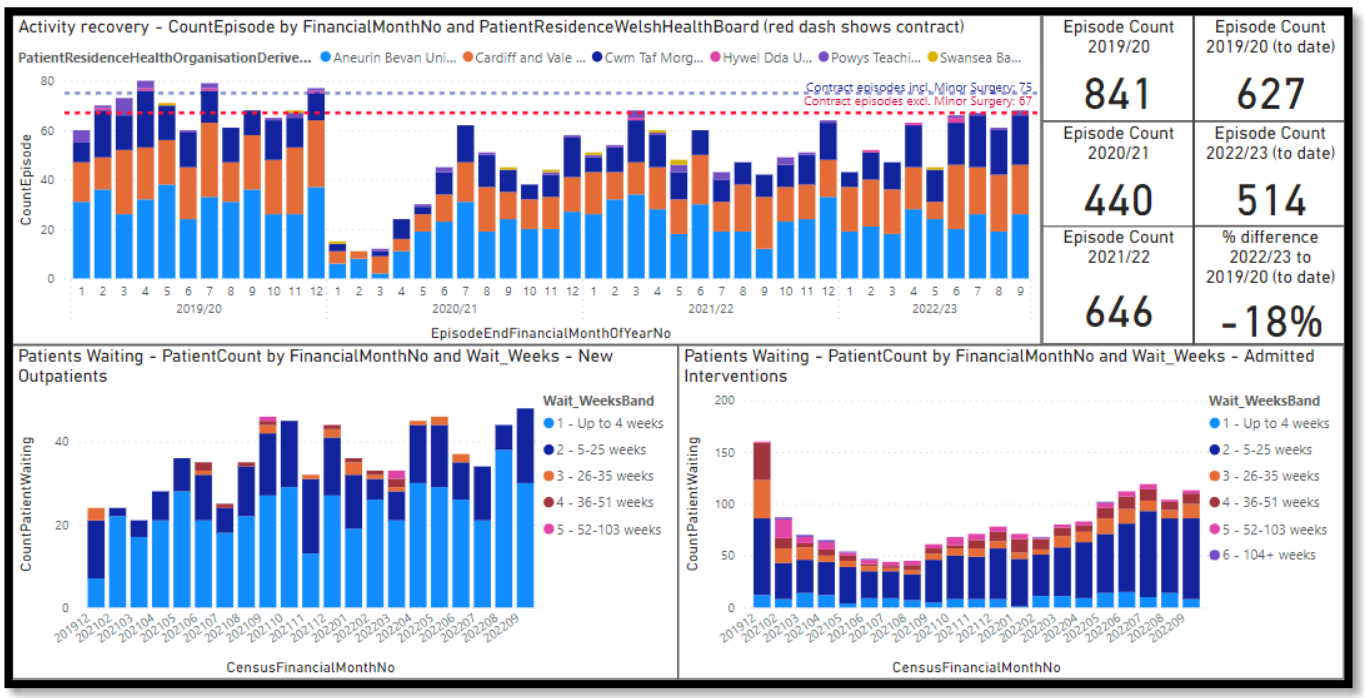
Data source: DHCW central data warehouse; **Note: inpatient activity includes non-procedure/diagnostic episodes**

Access rates across the Health Boards varied the most during the initial COVID-19 wave due to the earlier recovery of English providers, but have stabilised in recent months to almost the same split of the available activity as 2019/20.

Inpatient episodes per 100k population varies overall across the Health Board areas, from 39 to 71 so far in 2022/23 as per the small table above to the left.

The access rate data for Cardiology is shown for information only as a related specialty, as this is not WHSSC-commissioned, except for some specific devices/interventions.

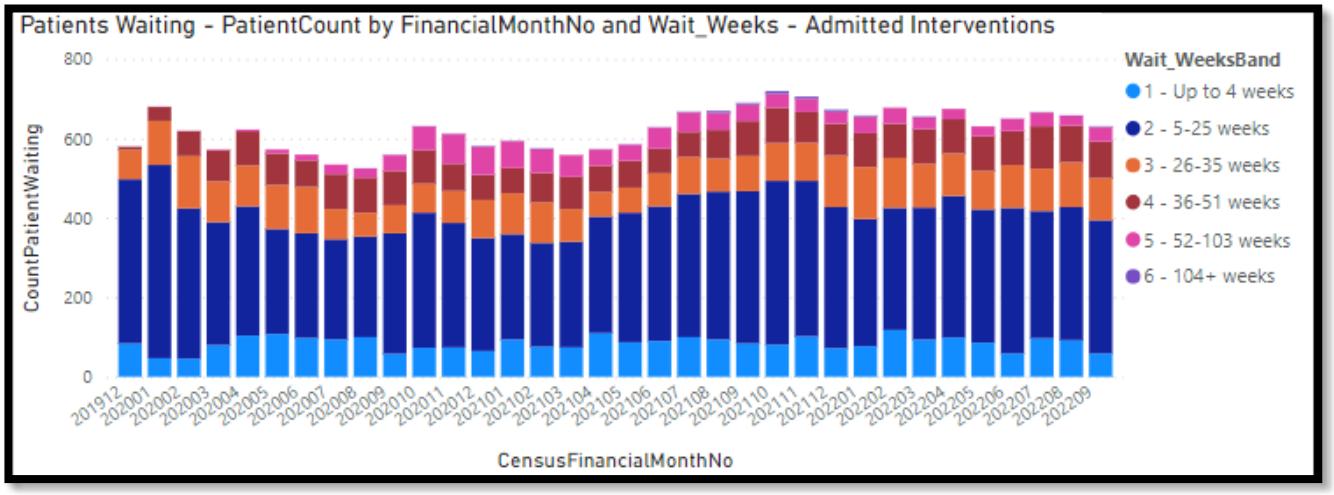
3.1.2 Cardiac Surgery – Recovery and Waiting Lists
Cardiff & Vale UHB



Data source: DHCW central data warehouse; **Note: inpatient activity includes non-procedure/diagnostic episodes**

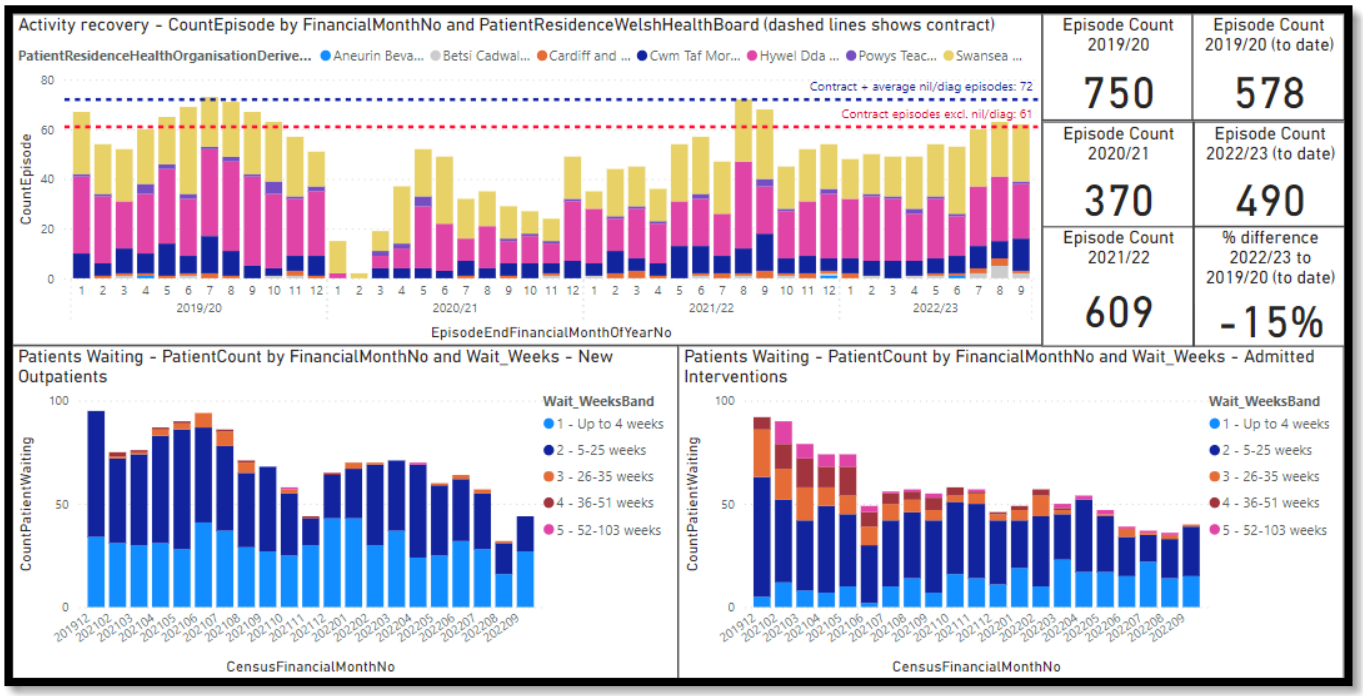
The tables above show a summary of the position at Cardiff & Vale in relation to Cardiac Surgery. Whilst the chart showing New Outpatients shows a small increase in new referrals (those between 0-4 weeks) again, elective activity had kept pace to the point that the waiting list for admissions had reduced to almost a third of pre-COVID-19 demand by the winter of 2021, with few patients now waiting over 26 weeks, although this waiting list has been growing again over the past few months.

It is worth noting that patients waiting for admissions for Cardiology treatments have increased marginally at Cardiff, although some are now waiting longer.



Data source: DHCW central data warehouse; all Cardiology patients waiting at Cardiff – admitted interventions (specialist and non-specialist).

Swansea Bay UHB

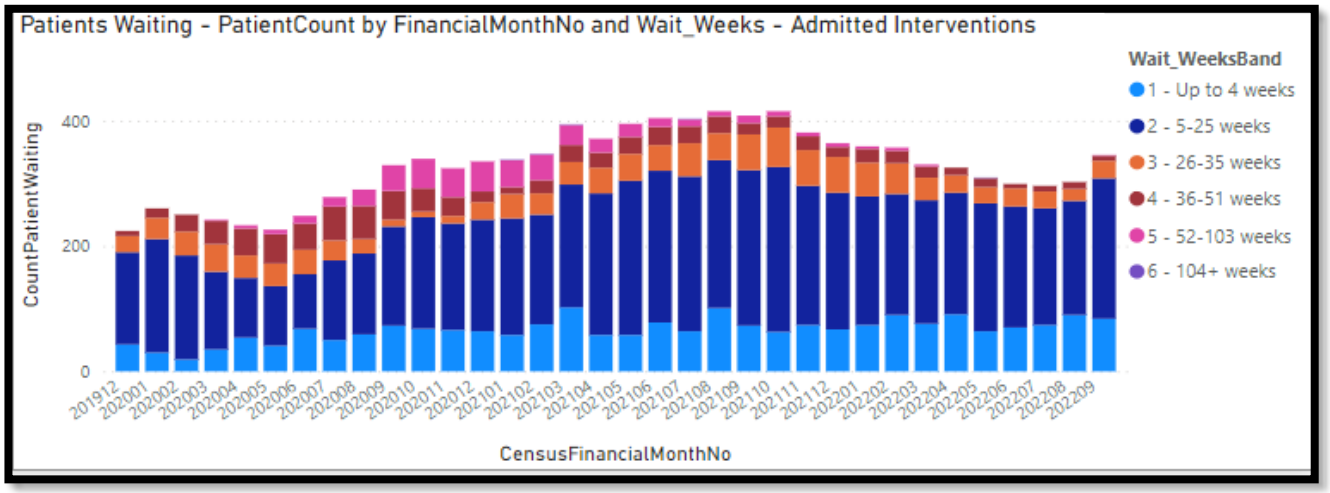


Data source: DHCW central data warehouse; **Note: inpatient activity incudes non-procedure/diagnostic episodes**

The tables above show a summary of the position at Swansea Bay in relation to Cardiac Surgery. Whilst the chart showing New Outpatients shows new referrals

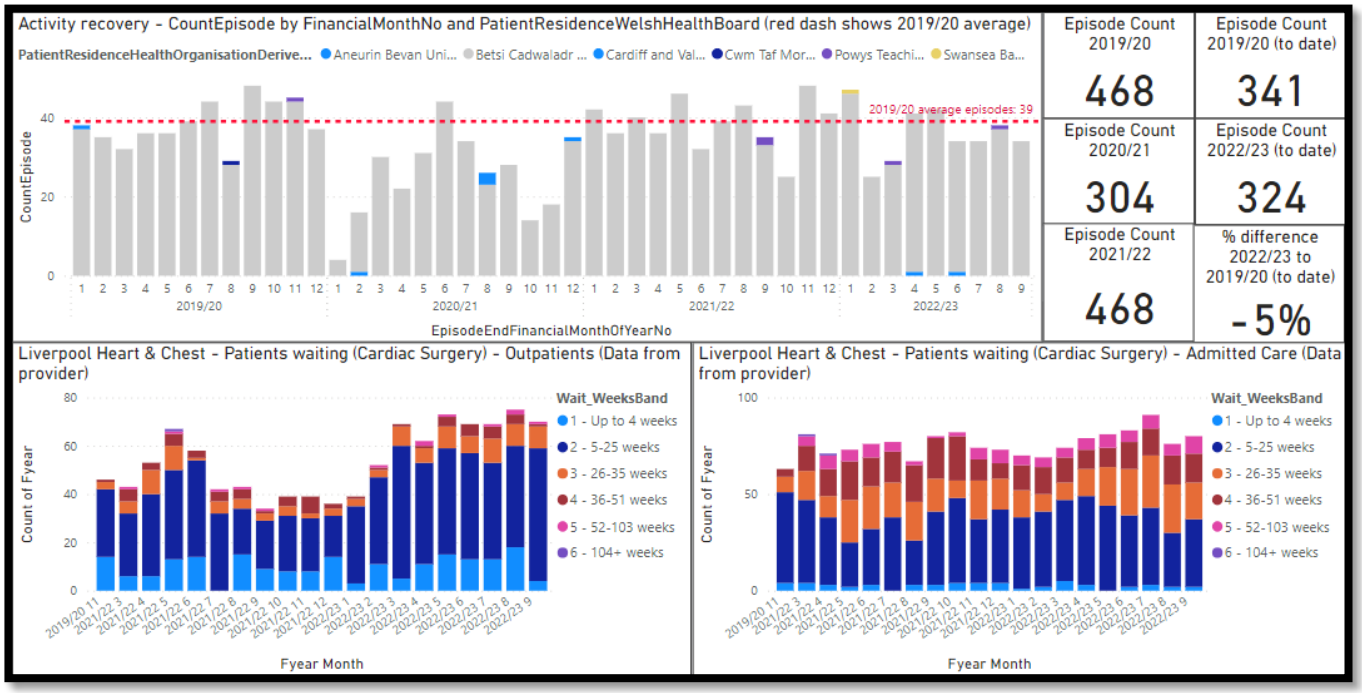
(those between 0-4 weeks) back again to Pre-COVID-19 levels, elective activity has kept pace to the point that the waiting list for admissions has reduced to about half of Pre-COVID-19 demand, with few patients now waiting over 26 weeks.

It is worth noting that patients waiting for admissions for Cardiology treatments had almost doubled at Swansea Bay but has been steadily reducing since January 2022; it is unknown how many of these are waiting for specialist procedures.



Data source: DHCW central data warehouse; all Cardiology patients waiting at Swansea Bay – admitted interventions (specialist and non-specialist).

Liverpool Heart & Chest Hospital



Data source: Inpatient activity from DHCW central data warehouse; **Note: inpatient activity includes non-procedure/diagnostic episodes.** Waiting list data from provider direct.

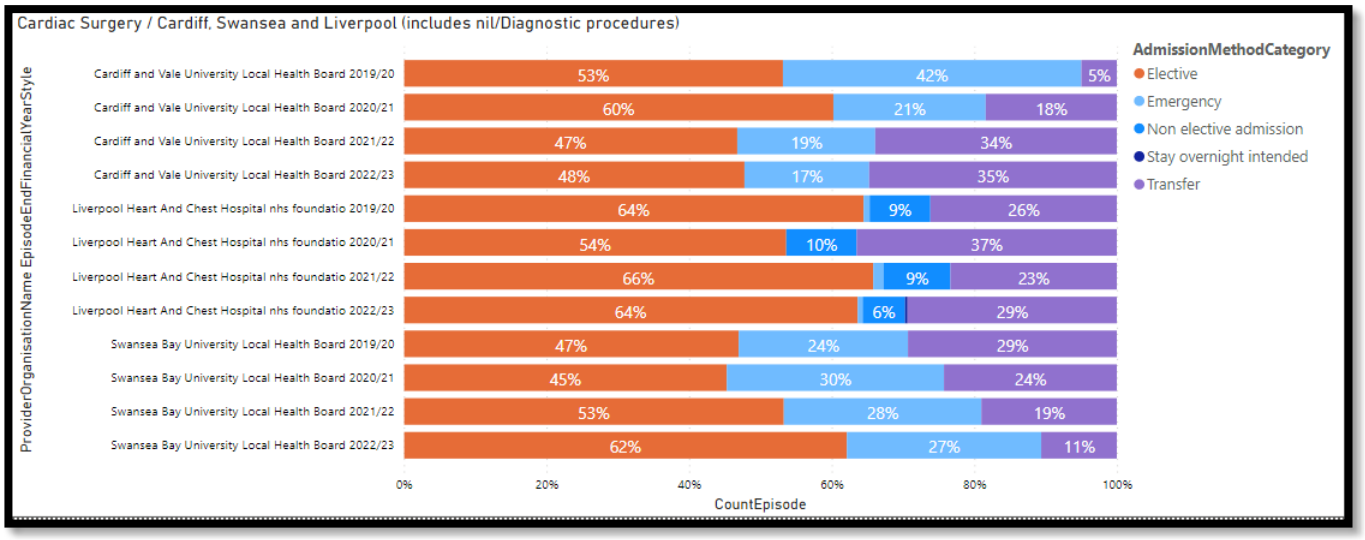
The tables above show a summary of the position at Liverpool Heart & Chest in relation to Cardiac Surgery. Whilst the chart showing New Outpatients shows a similar pattern in new referrals (those between 0-4 weeks) again to Pre-COVID-19 levels, elective activity is also back to almost the same Pre-COVID-19 levels. The

waiting list for admissions has remained roughly steady over the past 2 years, but with over half now waiting over 26 weeks.

Other activity 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 Bay has seen a decrease in Non-elective and Transferred activity percentages.



Data source: DHCW central data warehouse; all inpatient activity including non-procedure/diagnostic episodes

Specialised Planner comments:

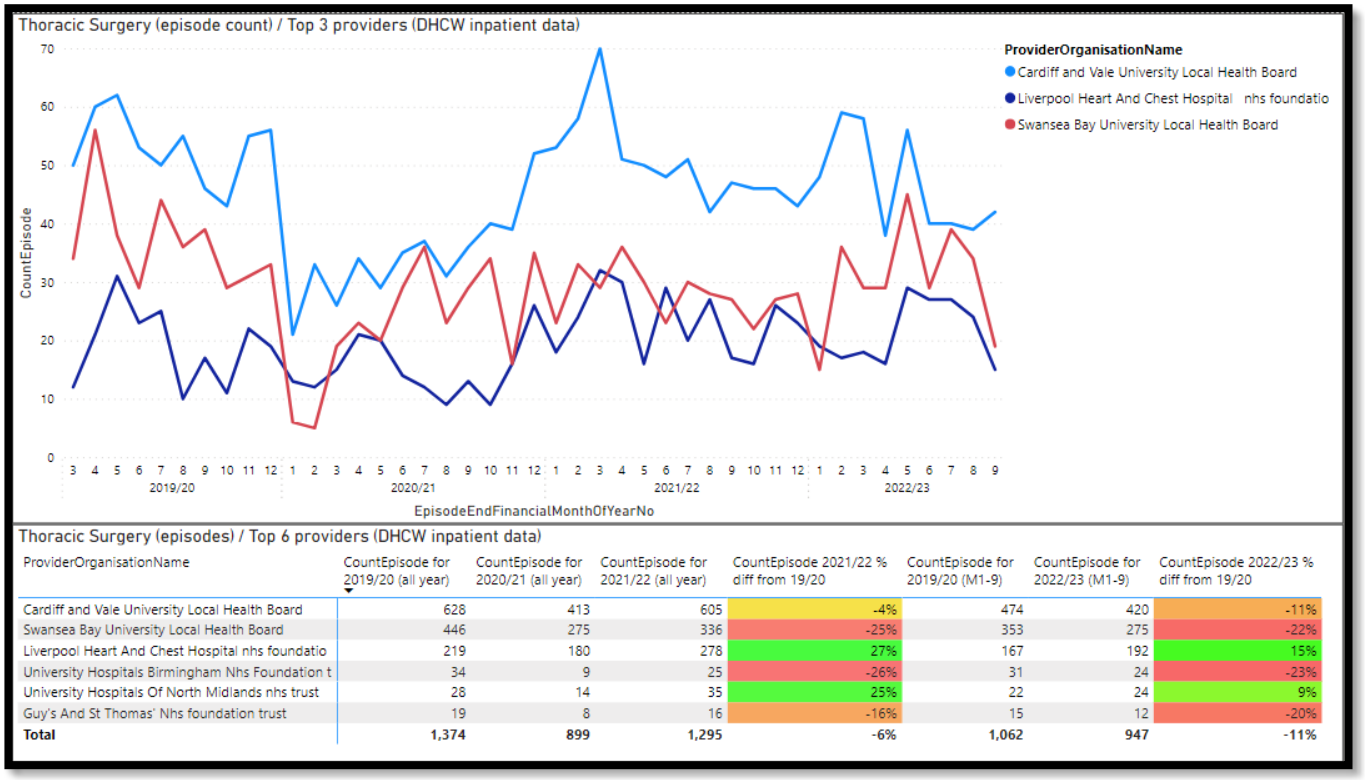
As highlighted in the last update, in view of CVUHB's growing waiting list, it was agreed CTMUHB cardiac surgery patients (excluding PMVR) would be referred to SBUHB for an initial period of six weeks, commencing December 2022. This arrangement is understood to have worked well, and it was agreed in January 2023 it would be extended for an additional six weeks. Potential for a further extension and/or formalised long-term arrangements will be discussed at the next CVUHB Cardiac Risk, Assurance and Recovery meeting. Of note, there are indications that, following a sustained downward trend, SBUHB's waiting list has grown. This will be monitored to ascertain whether the increase is a one-off, or the beginning of an upwards trend.

Previous iterations of this report have highlighted the risk that Cardiac Surgery referrals and waiting times will increase over the coming months as a result of the efforts of local health boards to manage the recovery of cardiology services. As identified previously, indications that increases have not been as significant as anticipated has led to the risk being deescalated, but Cardiff and Vale's waiting list position has precluded the risk being removed from the CRAF. Waits will continue to be closely monitored lest possible risk re-escalation be required.

This report has also previously highlighted the work underway to investigate the continuing growth in the number of TAVI procedures, the profile of devices employed, and any resultant impact on the volume of cardiac surgery commissioned by WHSSC. The outcomes of this exercise were incorporated into the 'WHSSC Cardiac Review' report, which was endorsed by WHSSC Joint Committee in January 2023. Work has now commenced on the development and delivery of Phase 1 of the planned review, which will seek to re-baseline the TAVI/cardiac surgery contract and ascertain whether the TAVI policy remains fit for purpose. Phase 1 is due to be completed by June 2023.

3.2 Thoracic Surgery

3.2.1 Thoracic Surgery – Activity and Access Rate Summary



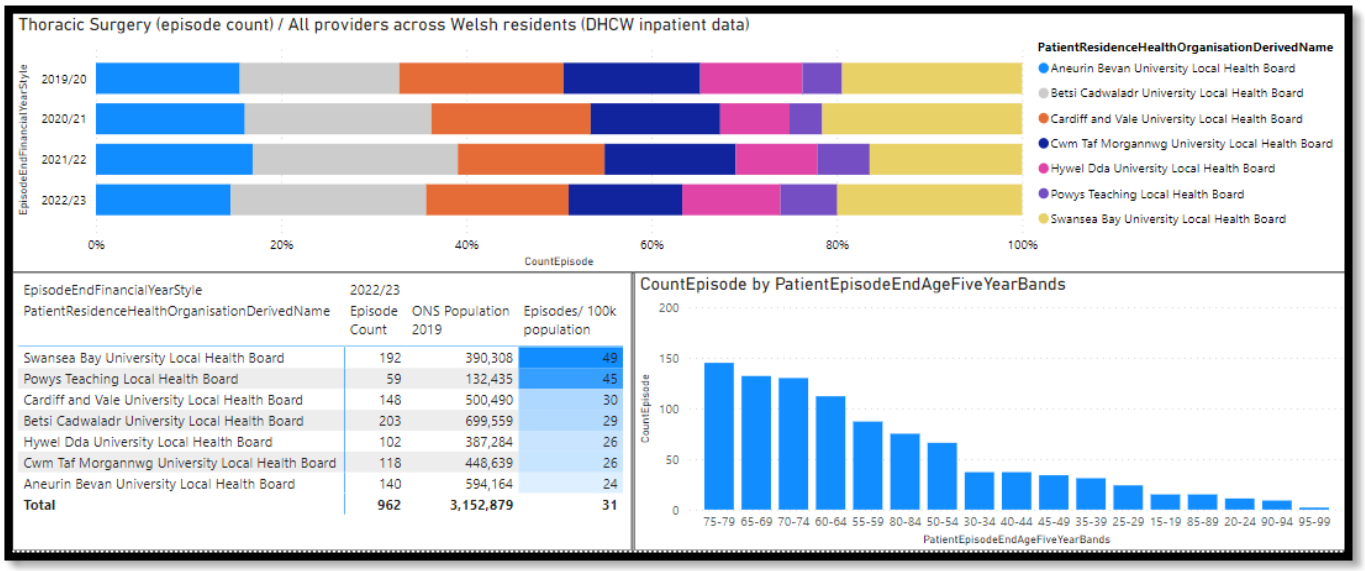
Thoracic Surgery (episodes) / Top 6 providers (DHCW inpatient data)

ProviderOrganisationName	CountEpisode for 2019/20 (all year)	CountEpisode for 2020/21 (all year)	CountEpisode for 2021/22 (all year)	CountEpisode 2021/22 % diff from 19/20	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
Cardiff and Vale University Local Health Board	628	413	605	-4%	474	420	-11%
Swansea Bay University Local Health Board	446	275	336	-25%	353	275	-22%
Liverpool Heart And Chest Hospital nhs foundatio	219	180	278	27%	167	192	15%
University Hospitals Birmingham Nhs Foundation t	34	9	25	-26%	31	24	-23%
University Hospitals Of North Midlands nhs trust	28	14	35	25%	22	24	9%
Guy's And St Thomas' Nhs foundation trust	19	8	16	-16%	15	12	-20%
Total	**1,374**	**899**	**1,295**	**-6%**	**1,062**	**947**	**-11%**

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 performed inpatient episodes 27% higher in 2021/22 than 2019/20, and 15% higher so far this year (2022/23). Cardiff & Vale is showing a small drop in activity of 11% to 2019/20 to the same month this year. However, Swansea Bay is showing a 22% drop in activity to date compared to 2019/20, although the later section showing more detail indicates the total numbers on the waiting list is not suffering due to this.

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, and 6% less in 2021/22. Using activity to date this year 2022/23 (Month 9), activity is 11% less than 2019/20.



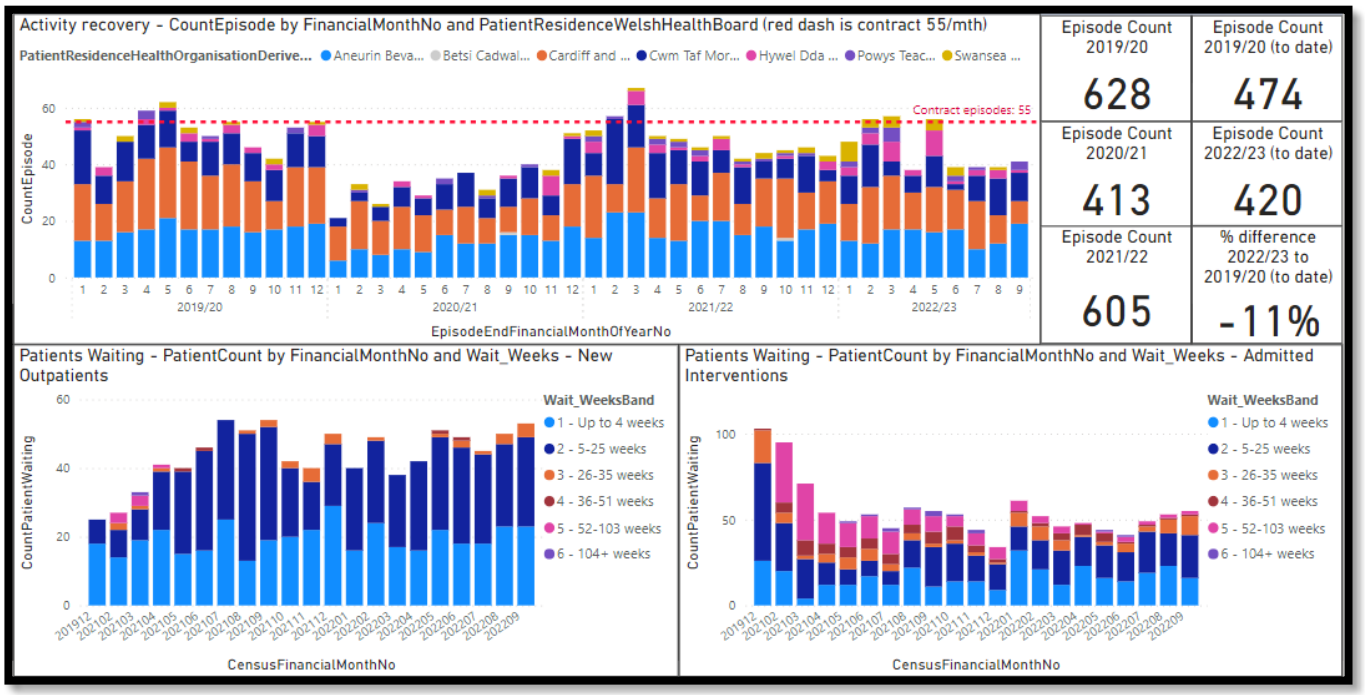
EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2022/23 Episode Count	ONS Population 2019	Episodes/ 100k population
Swansea Bay University Local Health Board	192	390,308	49
Powys Teaching Local Health Board	59	132,435	45
Cardiff and Vale University Local Health Board	148	500,490	30
Betsi Cadwaladr University Local Health Board	203	699,559	29
Hywel Dda University Local Health Board	102	387,284	26
Cwm Taf Morgannwg University Local Health Board	118	448,639	26
Aneurin Bevan University Local Health Board	140	594,164	24
Total	**962**	**3,152,879**	**31**

Data source: DHCW central data warehouse; all inpatient activity

Access rates of the Health Boards varied slightly across the past two years, which is to be expected given the relatively low activity numbers (about 100/month), but are now close again to the pre-Covid splits in 2019/20.

Inpatient episodes per 100k population varies significantly overall across the Health Board areas, from 24 to 49 as per the small table above for 2022/23.

3.2. Thoracic Surgery – Recovery and Waiting Lists Cardiff and Vale UHB

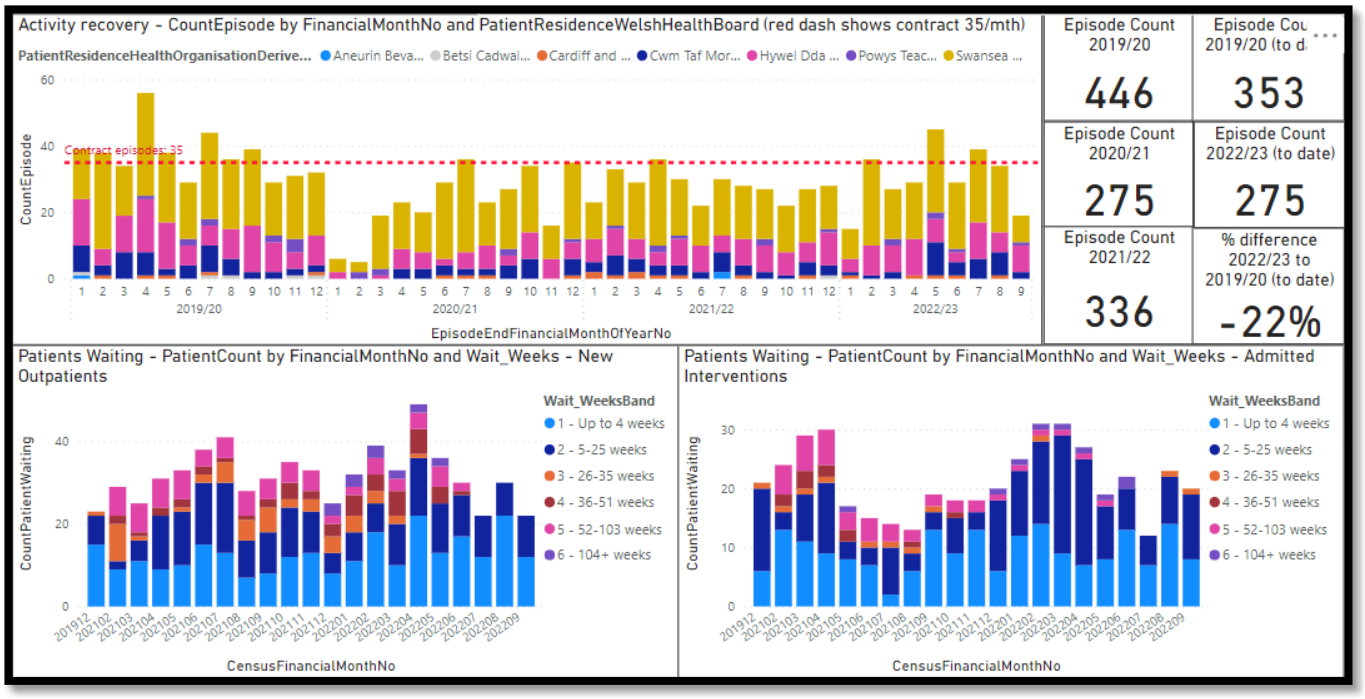


Data source: DHCW central data warehouse; all patients waiting with an open pathway

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 return to pre-Covid levels of new referrals (those between 0-4 weeks) again, elective activity has recovered to an equivalent episode count compared to 2019/20. The waiting list for admissions has reduced to around half of pre-COVID-19 demand.

It is worth noting that Cardiff had recently picked up some activity from Swansea Bay, due to an agreement between the two centres. This can be seen by the Swansea Bay resident episodes, shown in mustard in the top chart.

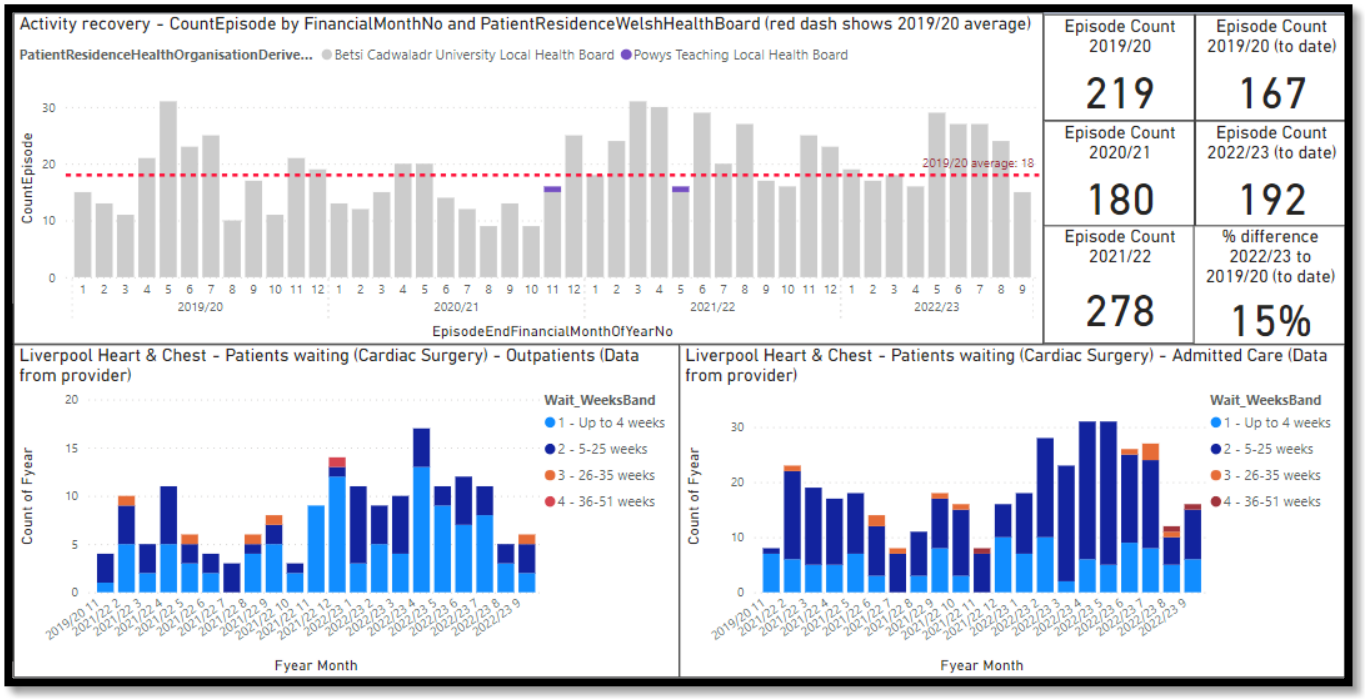
Swansea Bay UHB



Data source: DHCW central data warehouse; all patients waiting with an open pathway

The previous tables show a summary of the position at Swansea Bay in relation to Thoracic Surgery. Whilst the chart showing New Outpatients shows consistent numbers, elective activity is still lower than 2019/20. However, the overall waiting list for admissions has not deteriorated from the position at March 2020, although the numbers are not high.

Liverpool Heart & Chest Hospital



Data source: DHCW central data warehouse; Waiting list data from provider directly

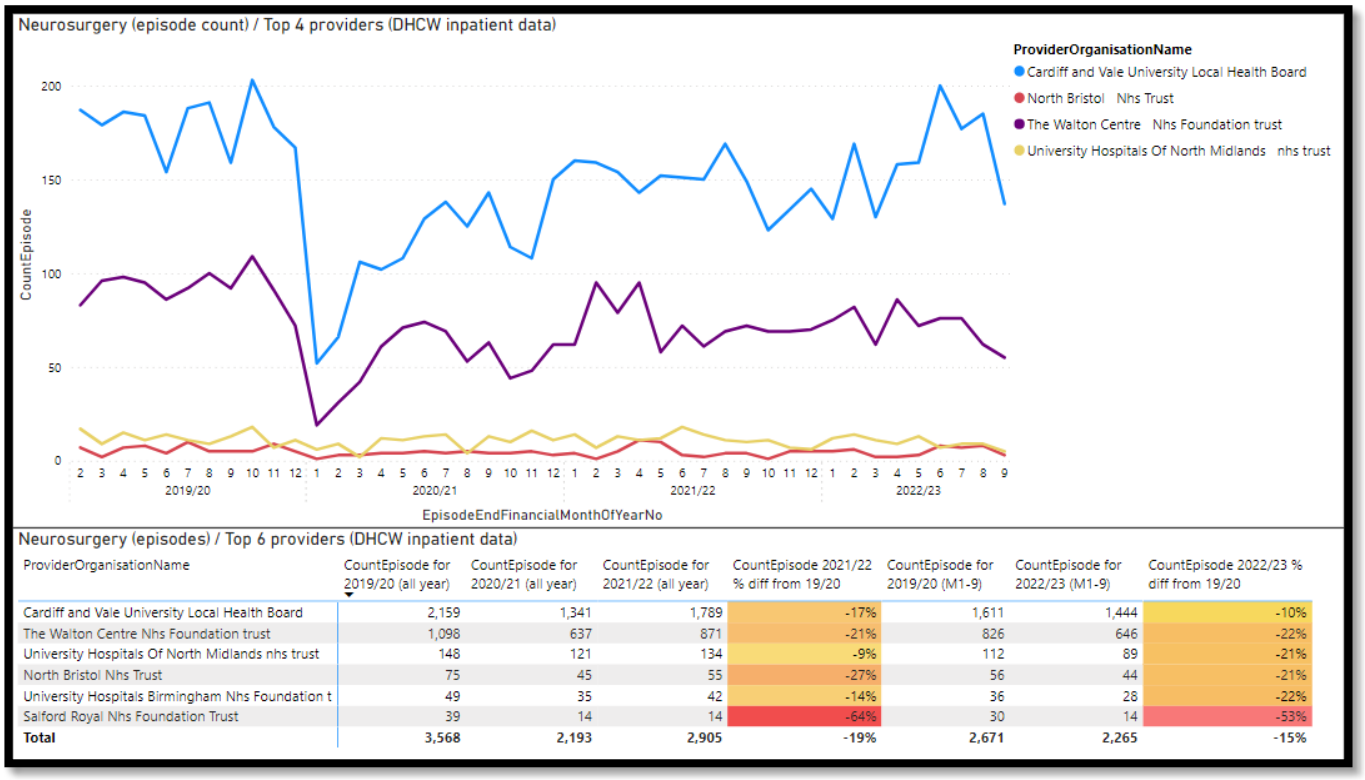
The tables above show a summary of the position at Liverpool Heart & Chest in relation to Thoracic Surgery. Whilst the chart showing New Outpatients shows a quick increase in new referrals (those between 0-4 weeks) after the pandemic started, inpatient activity has increased by 15% this year compared to 2019/20. Despite this, the patients waiting for admission had increased from pre-Covid levels, although these are not material numbers and are easily skewed month-on-month.

Specialised Planner comments:
In interpreting the data above, it is important to note that collaborative arrangements are 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.

However, to date, the joint meeting has focused on primary lung cancer patients. The service has been providing elective operations for non-cancer patients but a small number of long waiters still remain within the backlog.

3.3 Neurosurgery

3.3.1 Neurosurgery – Activity and Access Rate Summary



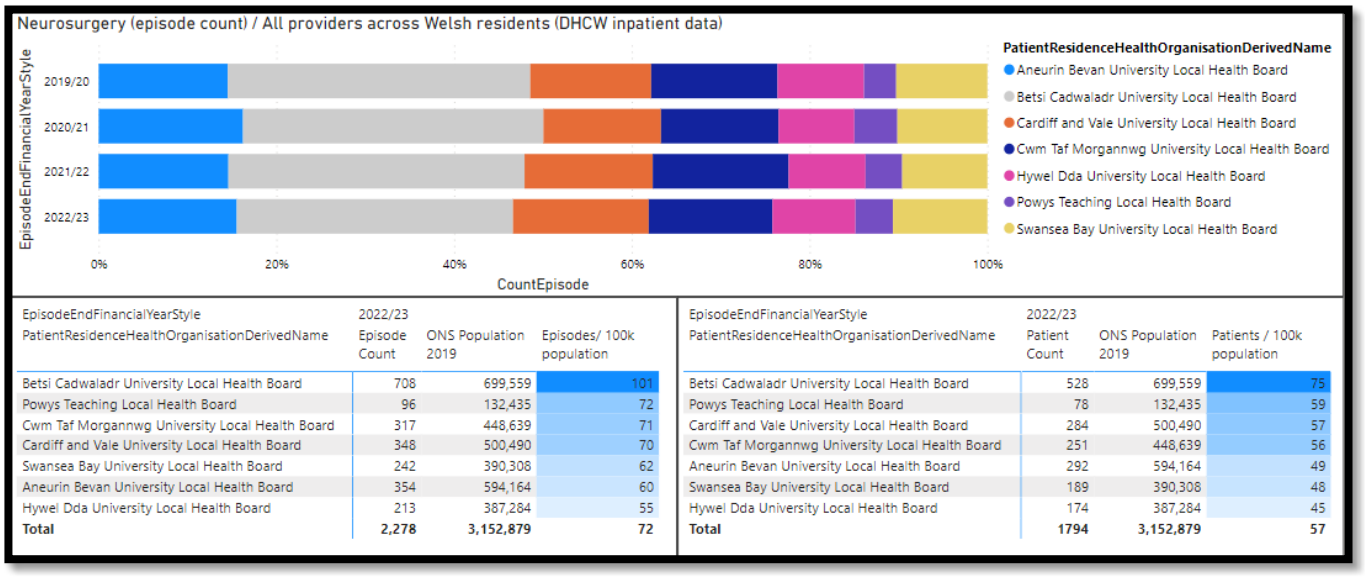
Neurosurgery (episodes) / Top 6 providers (DHCW inpatient data)

ProviderOrganisationName	CountEpisode for 2019/20 (all year)	CountEpisode for 2020/21 (all year)	CountEpisode for 2021/22 (all year)	CountEpisode 2021/22 % diff from 19/20	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
Cardiff and Vale University Local Health Board	2,159	1,341	1,789	-17%	1,611	1,444	-10%
The Walton Centre Nhs Foundation trust	1,098	637	871	-21%	826	646	-22%
University Hospitals Of North Midlands nhs trust	148	121	134	-9%	112	89	-21%
North Bristol Nhs Trust	75	45	55	-27%	56	44	-21%
University Hospitals Birmingham Nhs Foundation t	49	35	42	-14%	36	28	-22%
Salford Royal Nhs Foundation Trust	39	14	14	-64%	30	14	-53%
Total	**3,568**	**2,193**	**2,905**	**-19%**	**2,671**	**2,265**	**-15%**

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 11% and 18% 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 19% less in 2021/22, and 15% less so far in 2022/23.

Please note that about 2/3rds of the UH North Midlands activity above relates to North Wales residents, which is paid for through a local contract and not WHSSC. The remaining activity relates to Powys residents, which does flow through WHSSC contracting.



EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2022/23 Episode Count	ONS Population 2019	Episodes/ 100k population
Betsi Cadwaladr University Local Health Board	708	699,559	101
Powys Teaching Local Health Board	96	132,435	72
Cwm Taf Morgannwg University Local Health Board	317	448,639	71
Cardiff and Vale University Local Health Board	348	500,490	70
Swansea Bay University Local Health Board	242	390,308	62
Aneurin Bevan University Local Health Board	354	594,164	60
Hywel Dda University Local Health Board	213	387,284	55
Total	**2,278**	**3,152,879**	**72**

EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2022/23 Patient Count	ONS Population 2019	Patients / 100k population
Betsi Cadwaladr University Local Health Board	528	699,559	75
Powys Teaching Local Health Board	78	132,435	59
Cardiff and Vale University Local Health Board	284	500,490	57
Cwm Taf Morgannwg University Local Health Board	251	448,639	56
Aneurin Bevan University Local Health Board	292	594,164	49
Swansea Bay University Local Health Board	189	390,308	48
Hywel Dda University Local Health Board	174	387,284	45
Total	**1794**	**3,152,879**	**57**

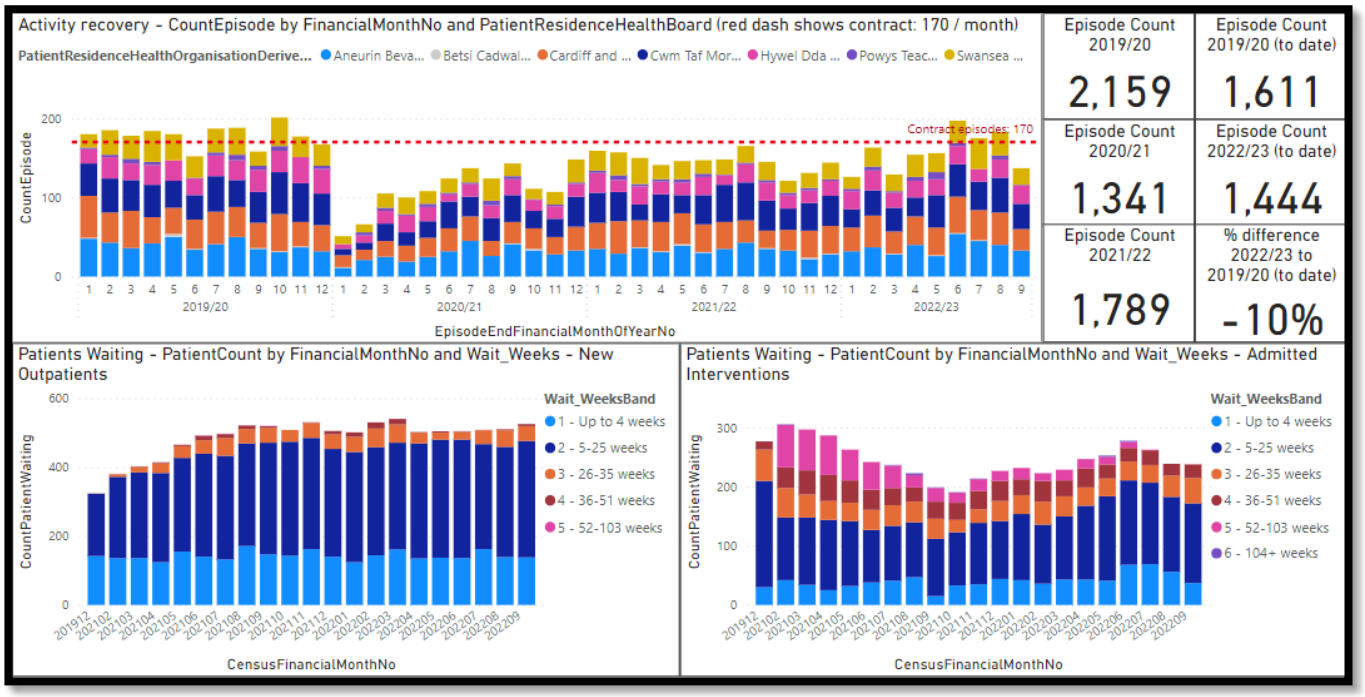
Data source: DHCW central data warehouse; all inpatient activity

Access rates across the Health Boards have not varied much across the past four years, as shown in the charts above. Inpatient episodes per 100k population in 2022/23 so far vary from 55 to 101 across Health Boards in the bottom left chart, with North Wales having the highest access.

Using individual patient counts (bottom right chart) also shows a similar access order. It is worth noting that the outlying access rate for Betsi Cadwaladr is related to the way activity is reported between the two main centres as being in different NHS countries. For example, as a Specialist centre, the Walton reports activity under the Neurosurgery specialty that is reported under others within Welsh providers, and the ratios are also reflected in this way in the waiting list numbers for Neurosurgery.

Please note a separate deep dive report into Neurosurgery was produced in July 2022 – please see that for further analysis if required.

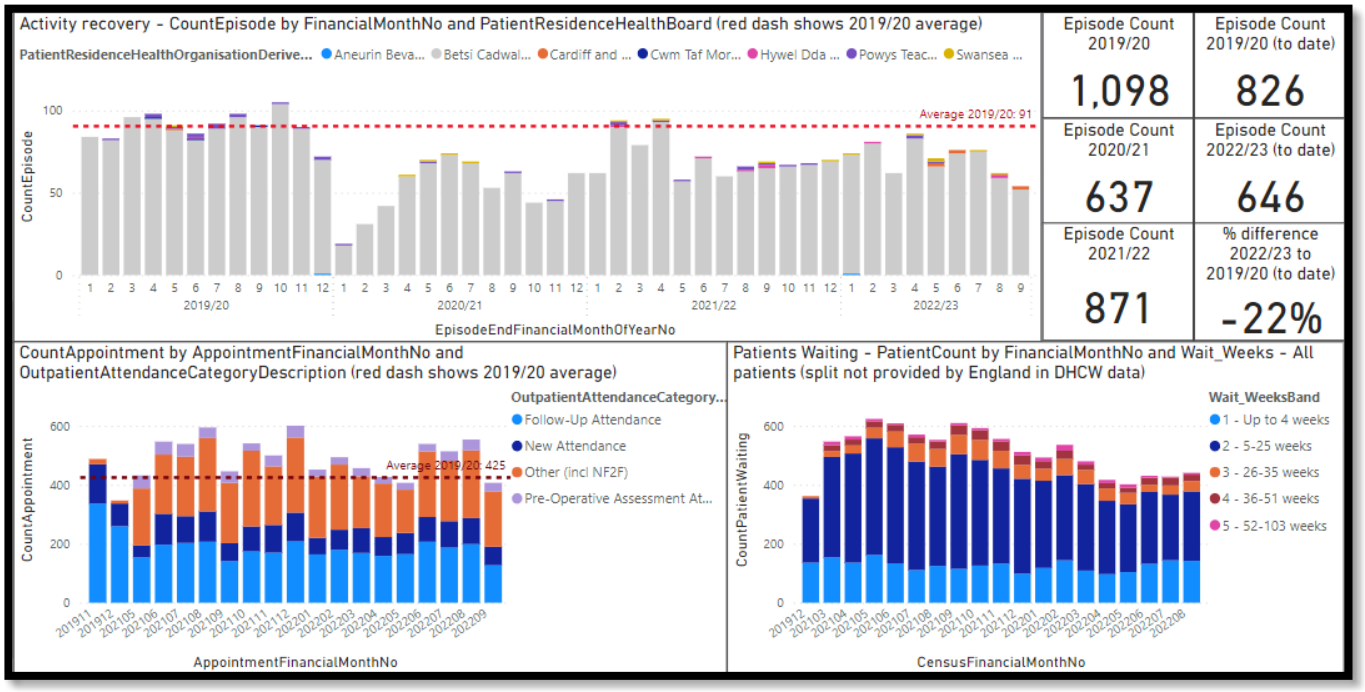
3.3.2 Neurosurgery – Recovery and Waiting Lists
Cardiff & Vale UHB



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 waiting is now higher. Admitted activity increased from the initial reduction, then stayed static for a few months, although the total waiting list for admissions had 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 22% less this year than 2019/20, the total patients waiting is similar in total compared to what it was as COVID-19 struck, although some patients are now waiting longer. However, the past few months had shown an improvement in the total waiting list numbers, and this should continue.

One point to note is the bottom left chart, which shows the movement across types of Outpatient appointment since March 2020. It is clear that non face-to-face appointments have been well-utilised during the COVID-19 period, and have actually increased to above pre-Covid levels.

Specialised Planner comments:
Cardiff
Cardiff's Neurosurgery Recovery Plan was discussed with the service in November 2022 at the regular Performance meeting.

There has been a rise in Level 2 patients and the team are balancing emergencies with the operational pressures.

Theatre Utilisation rates are now at the levels that were pre covid ie 75-85% It is difficult to consistently achieve 85% target due to make of the sub specialties within the Neuro directorate. They do not have small cases to add onto the end of a list.

DSA backlog has improved considerably through the additional WLI's running on the weekends. There are 66 backlog patients waiting for a DSA (Oct 22). There are 2 more WLI's scheduled for November and December.

In September this was the first time the Neuro team managed to achieve contract activity levels, this was as a result of the increase in DSA work which was done during this month.

Outpatient numbers are growing with 516 patients waiting. There are plans to repatriate the outpatient clinics from Rookwood to UHW in January 2023. The past two months the Directorate have seen a significant number of follow up patients with 467 patients seen in October 2022.

There are significant workforce challenges with theatre staff and shortfall of ODP recruitment. However, the service is still planning extended days as they have done previously – this will commence in January 2023. Staff will be paid an enhanced rate, but this needs to be signed off by the Health Board.

Please note that due to improved and consistent inpatient activity, this service has been de-escalated.

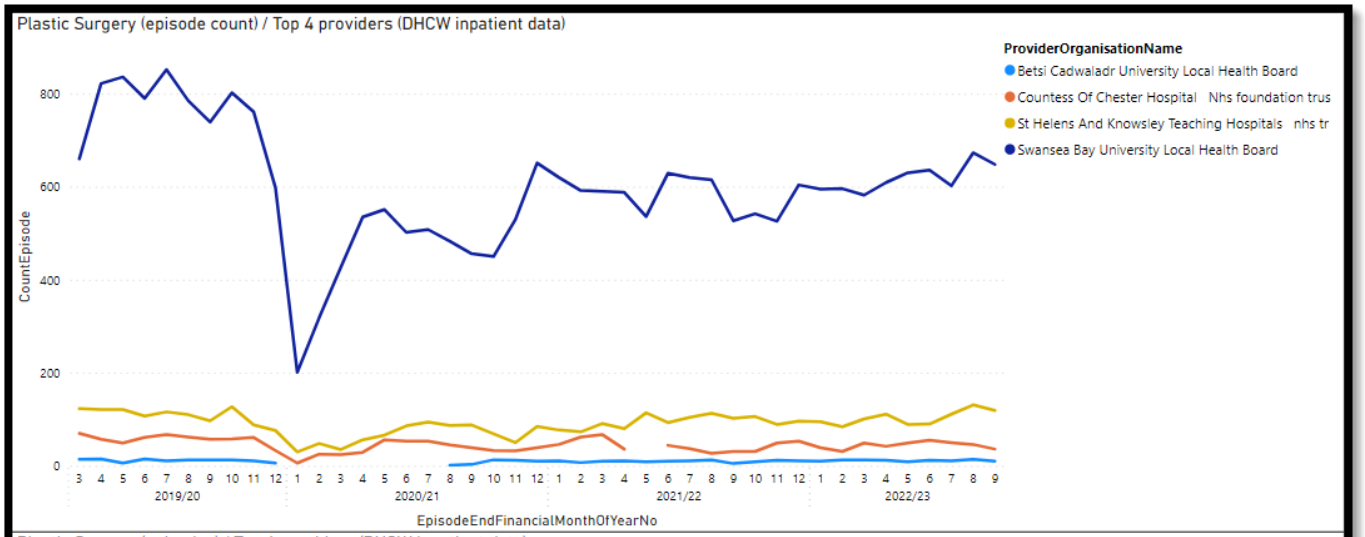
The Walton
In a recent contract meeting, the Walton Centre confirmed that Spinal patients would be cleared by the summer 2022. The 52-week wait patients are on track to be cleared by the end of this calendar year – December 2022.

The Centre has a restoration and recovery plan for all of their long waiters which includes a regular clinical validation of patients who have waited over 6 months, to ensure that symptoms and imaging are up to date. The Walton centre have been managing this with Consultant and Nurse led consultations and they have the ability to operate on weekend lists as Waiting List Initiatives.

A physical visit to the Centre is planned for 2023.

3.4 Plastic Surgery (excl. Burns)

3.4.1 Plastic Surgery (excl. Burns) – Activity and Access Rate Summary



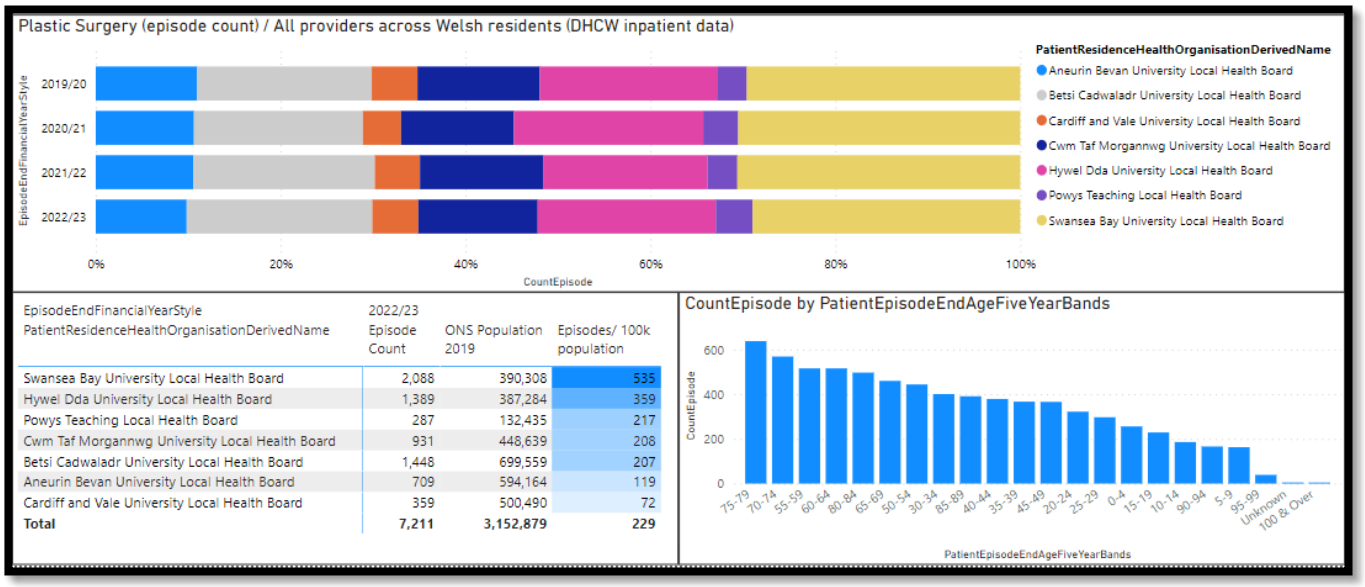
Plastic Surgery (episodes) / Top 6 providers (DHCW inpatient data)

ProviderOrganisationName	CountEpisode for 2019/20 (all year)	CountEpisode for 2020/21 (all year)	CountEpisode for 2021/22 (all year)	CountEpisode 2021/22 % diff from 19/20	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
Swansea Bay University Local Health Board	9,245	5,611	6,989	-24%	7,084	5,571	-21%
St Helens And Knowsley Teaching Hospitals nhs tr	1,324	794	1,138	-14%	1,033	931	-10%
Countess Of Chester Hospital Nhs foundation trus	674	434	483	-28%	522	397	-24%
Betsi Cadwaladr University Local Health Board	150	39	119	-21%	120	104	-13%
Wye Valley Nhs Trust	52	81	87	67%	41	89	117%
North Bristol Nhs Trust	42	45	31	-26%	38	43	13%
Total	**11,487**	**7,004**	**8,847**	**-23%**	**8,838**	**7,135**	**-19%**

Data source: DHCW central data warehouse; all inpatient activity

The previous table highlights the variance in Plastic Surgery inpatient recovery across the main specialist providers, with an overall reduction of 19% so far this year compared to 2019/20. The total reduction was 39% across the full year of 2020/21, and 23% in 2021/22. All providers 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. The Swansea Bay figures primarily relate to the WHSSC specialist contract, but include some small numbers relating to a local Dermatology contract they hold with Hywel Dda.



EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2022/23 Episode Count	ONS Population 2019	Episodes/ 100k population
Swansea Bay University Local Health Board	2,088	390,308	535
Hywel Dda University Local Health Board	1,389	387,284	359
Powys Teaching Local Health Board	287	132,435	217
Cwm Taf Morgannwg University Local Health Board	931	448,639	208
Betsi Cadwaladr University Local Health Board	1,448	699,559	207
Aneurin Bevan University Local Health Board	709	594,164	119
Cardiff and Vale University Local Health Board	359	500,490	72
Total	**7,211**	**3,152,879**	**229**

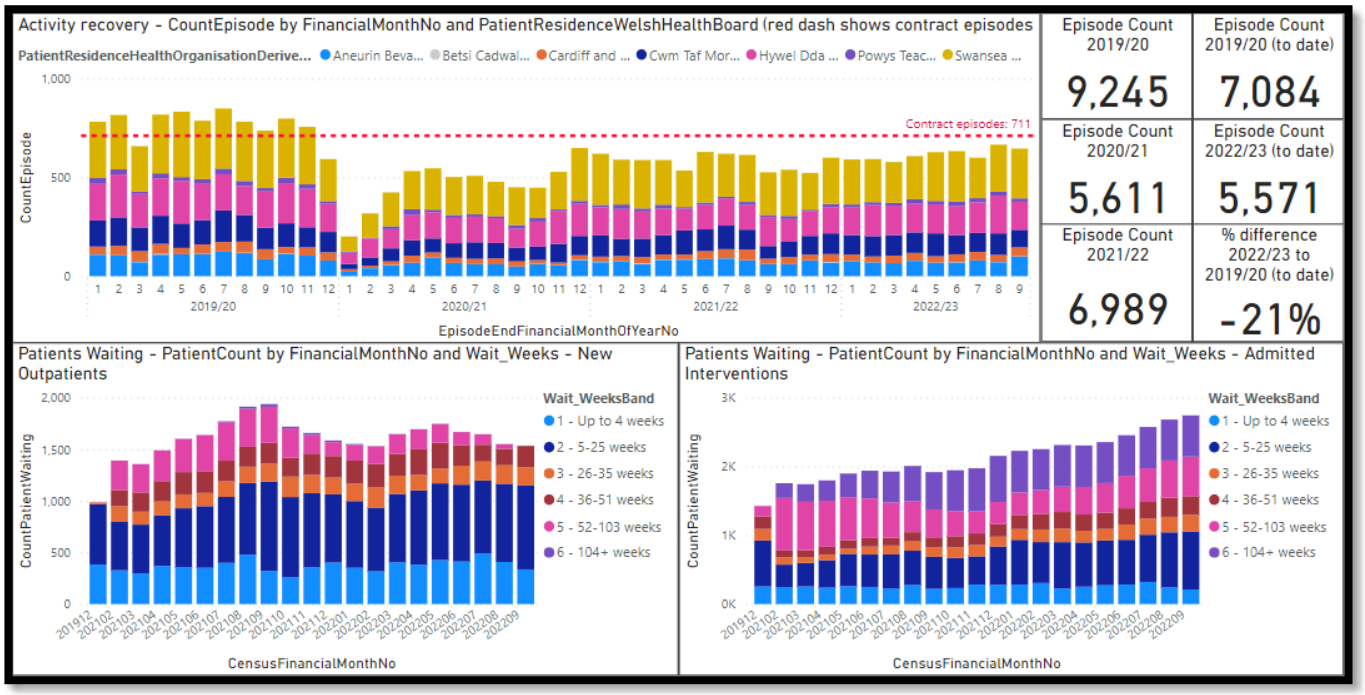
Data source: DHCW central data warehouse; all inpatient activity

Access rates shares 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 an apparent variation between Health Boards in relation to episodes/100k population, with inpatient episodes per 100k population in 2022/23 to date varying from 72 to 535 across Health Boards. This is related to the 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. Non-specialist activity for other Health Boards is reported under non-WHSSC areas/specialties.

This has been discussed internally, with a wider workshop with Management Group members held in September. The decision has been made to hand back non-specialist Plastics commissioning to resident Health Boards, and a Project Management team is being set up to work out the details of this transfer in the future.

3.4.2 Plastic Surgery (excl. Burns) – Recovery and Waiting lists Swansea Bay UHB

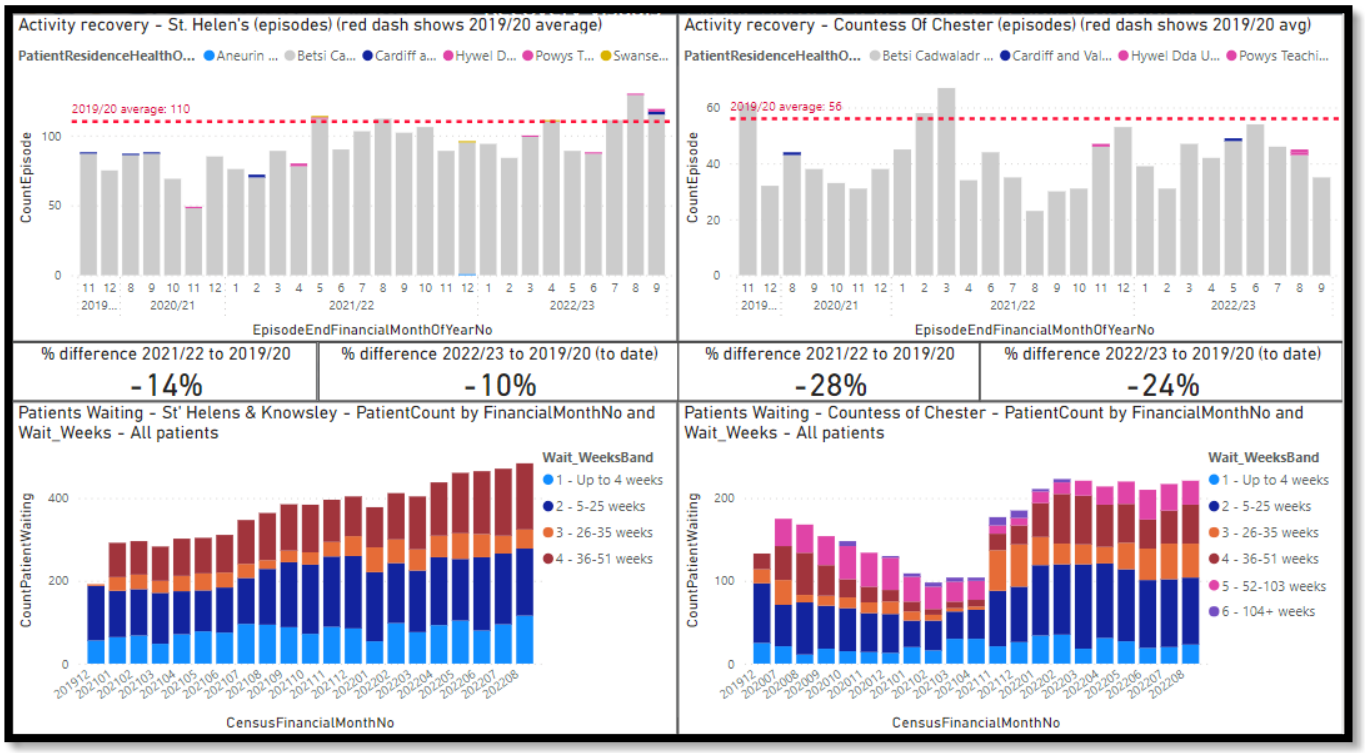


Data source: DHCW central data warehouse; all patients waiting with an open pathway Note: DHCW data includes a small amount of activity related to a local Dermatology contract between SBU/HDU

The tables above show a summary of the position at Swansea Bay in relation to Plastic Surgery. Whilst activity is now 21% less this year than 2019/20, which is better than the 39% drop 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 2 years. Within the total of patients waiting, those waiting for new outpatient appointments has increased by about half again since February 2020, but has been falling over the past few months and no patients have now been waiting over a year. However, it is concerning that those waiting for admissions have increased by around 35% and the total is still steadily rising; currently 598 patients have now been waiting for over 2 years for an admission.

It is worth noting that the over performance against contract levels in 2019/20 (shown by the red dash on the inpatient activity graph) relates to Surgical Day cases and Emergency Short Stays.

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 has varied at Countess of Chester (local BCU contract) but is now increasing, with some patients now waiting for over a year (note months 5-10 of 2021/22 were not submitted and are hence blank).

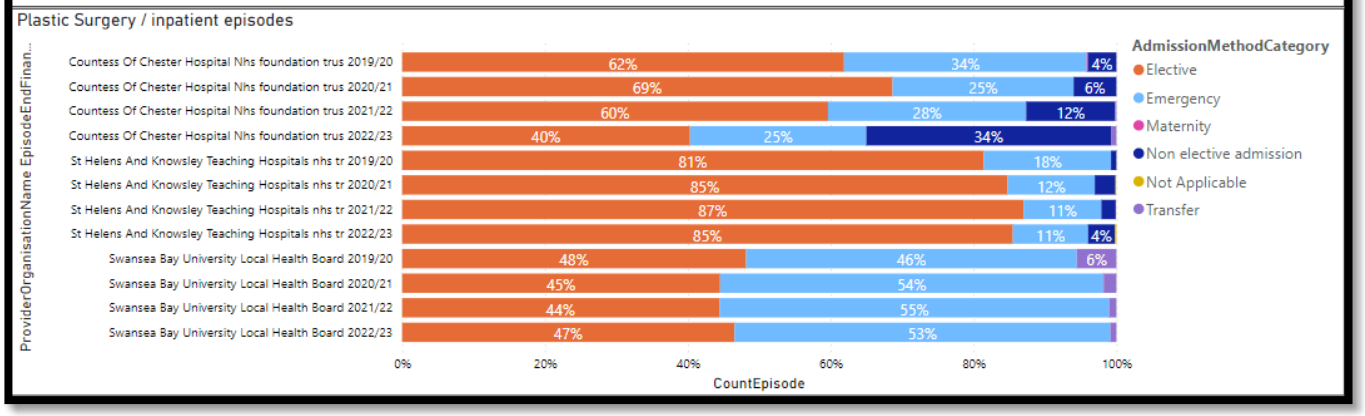
Other notes

Interestingly, data on the inpatient episodes shows an inverse of the elective/non-elective split for Swansea Bay and the English providers, with Swansea Bay having a higher proportion of emergency activity. Please see the below chart for the movements across the past 4 years. The episode counts have been included to give some perspective on the numbers, as Swansea Bay 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.

Plastic Surgery / all providers (episode count)

EpisodeEndFinancialYearStyle	2021/22													2022/23										Total
ProviderOrganisationName	1	2	3	4	5	6	7	8	9	10	11	12	Total	1	2	3	4	5	6	7	8	9	Total	
Swansea Bay University Local Health Board	620	592	590	588	536	629	620	615	527	542	526	604	6,989	595	596	582	609	630	636	602	673	648	5,571	12,560
St Helens And Knowsley Teaching Hospitals nhs tr	77	73	91	80	114	93	104	113	102	106	89	96	1,138	95	84	101	111	89	90	111	131	119	931	2,069
Countess Of Chester Hospital Nhs foundation trus	46	62	67	36		44	37	27	31	31	49	53	483	39	31	49	42	49	55	50	46	36	397	880
Total	743	727	748	704	650	766	761	755	660	679	664	753	8,610	729	711	732	762	768	781	763	850	803	6,899	15,509



Data source: DHCW central data warehouse; all inpatient activity

Specialised Planner comments:

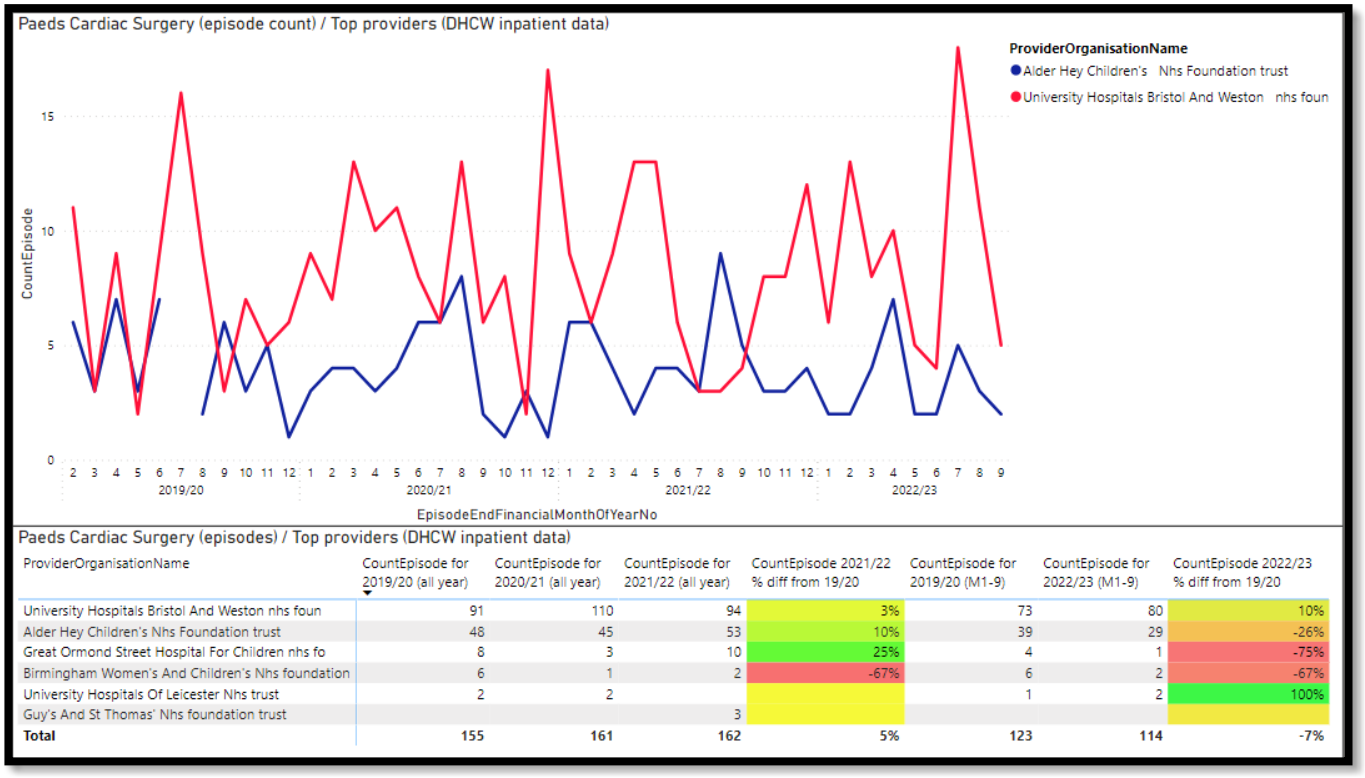
As noted in the comments above, variation across heath boards in utilisation of plastic surgery does not necessarily reflect variation in access to appropriate treatment, since many procedures (the majority of activity) provided by plastic surgery are also provided by other specialties. Whether a particular 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 Swansea Bay to support the recovery plan for plastic surgery to address the significant backlog of patients with long waiting times for treatment.

In addition the Joint Committee meeting on 12 July had a workshop to focus on HB recovery plans. Details on plastic surgery were specifically provided from the service for this meeting.

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 2019/20 (all year)	CountEpisode for 2020/21 (all year)	CountEpisode for 2021/22 (all year)	CountEpisode 2021/22 % diff from 19/20	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
University Hospitals Bristol And Weston nhs foun	91	110	94	3%	73	80	10%
Alder Hey Children's Nhs Foundation trust	48	45	53	10%	39	29	-26%
Great Ormond Street Hospital For Children nhs fo	8	3	10	25%	4	1	-75%
Birmingham Women's And Children's Nhs foundation	6	1	2	-67%	6	2	-67%
University Hospitals Of Leicester Nhs trust	2	2			1	2	100%
Guy's And St Thomas' Nhs foundation trust			3				
Total	**155**	**161**	**162**	**5%**	**123**	**114**	**-7%**

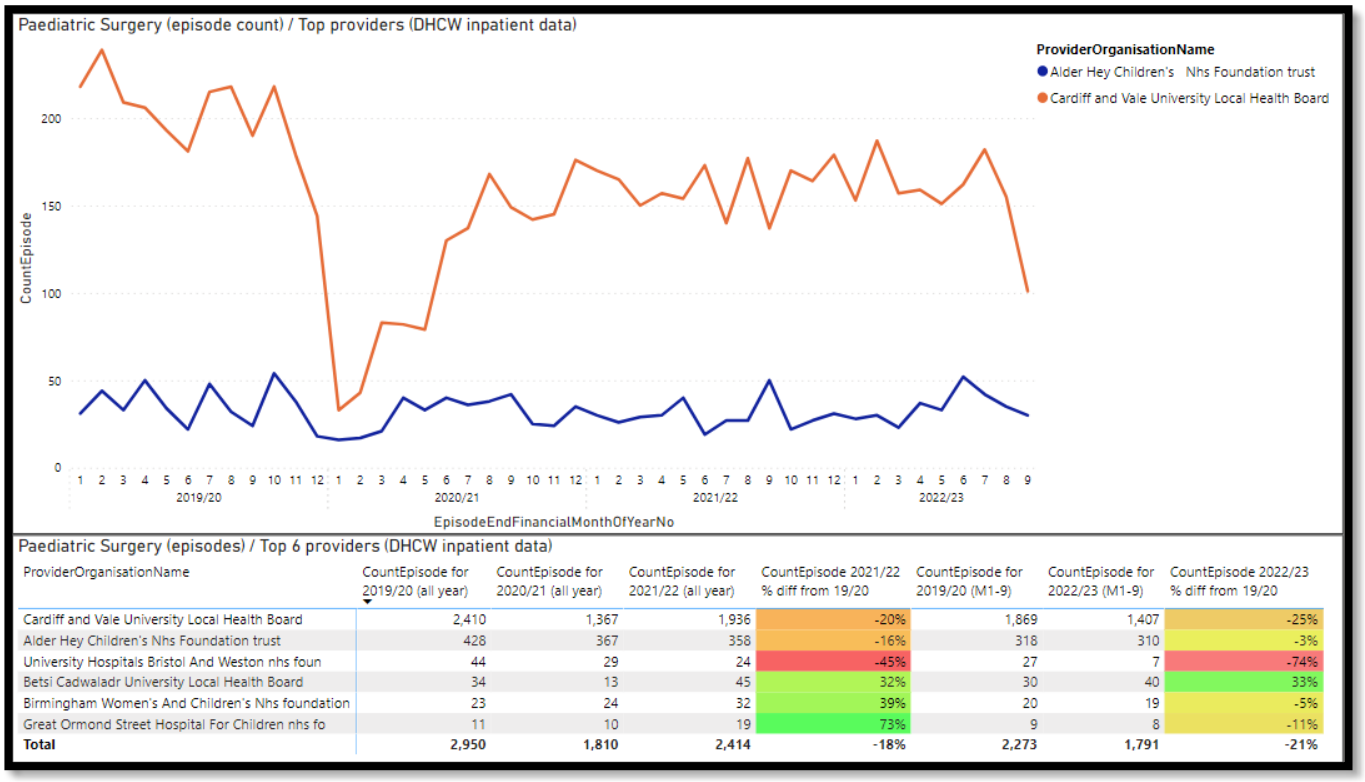
Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Paediatric Cardiac Surgery inpatient recovery across the main specialist providers.

Case volumes are traditionally small but with high importance in terms of outcomes. Encouragingly, figures show little change in either 2020/21, 2021/22 or 2022/23 to date compared to 2019/20.

3.6 Paediatric Surgery

3.6.1 Paediatric Surgery – Activity and Access Rate Summary



Paediatric Surgery (episodes) / Top 6 providers (DHCW inpatient data)

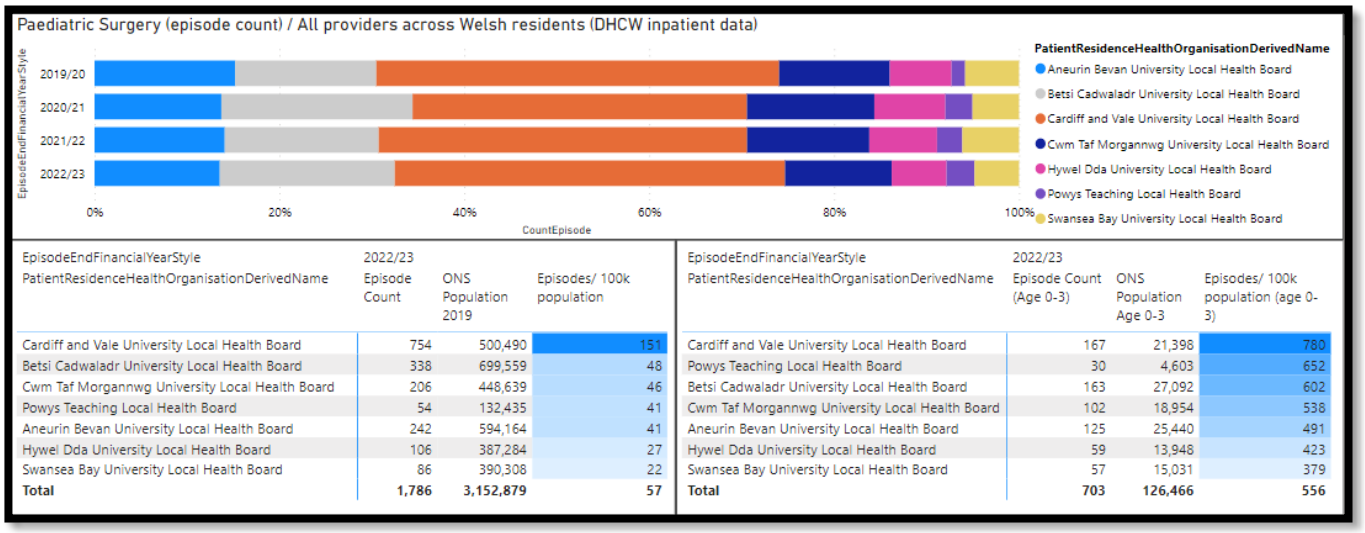
ProviderOrganisationName	CountEpisode for 2019/20 (all year)	CountEpisode for 2020/21 (all year)	CountEpisode for 2021/22 (all year)	CountEpisode 2021/22 % diff from 19/20	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
Cardiff and Vale University Local Health Board	2,410	1,367	1,936	-20%	1,869	1,407	-25%
Alder Hey Children's Nhs Foundation trust	428	367	358	-16%	318	310	-3%
University Hospitals Bristol And Weston nhs foun	44	29	24	-45%	27	7	-74%
Betsi Cadwaladr University Local Health Board	34	13	45	32%	30	40	33%
Birmingham Women's And Children's Nhs foundation	23	24	32	39%	20	19	-5%
Great Ormond Street Hospital For Children nhs fo	11	10	19	73%	9	8	-11%
Total	**2,950**	**1,810**	**2,414**	**-18%**	**2,273**	**1,791**	**-21%**

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. 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, and 18% less in 2021/22.

Activity so far in 2022/23 shows 21% less than 2019/20, with Alder Hey having a better recovery figure than Cardiff, although their inpatient activity is only about 17% of the total.



EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2022/23 Episode Count	ONS Population 2019	Episodes/ 100k population
Cardiff and Vale University Local Health Board	754	500,490	151
Betsi Cadwaladr University Local Health Board	338	699,559	48
Cwm Taf Morgannwg University Local Health Board	206	448,639	46
Powys Teaching Local Health Board	54	132,435	41
Aneurin Bevan University Local Health Board	242	594,164	41
Hywel Dda University Local Health Board	106	387,284	27
Swansea Bay University Local Health Board	86	390,308	22
Total	**1,786**	**3,152,879**	**57**

EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2022/23 Episode Count (Age 0-3)	ONS Population Age 0-3	Episodes/ 100k population (age 0-3)
Cardiff and Vale University Local Health Board	167	21,398	780
Powys Teaching Local Health Board	30	4,603	652
Betsi Cadwaladr University Local Health Board	163	27,092	602
Cwm Taf Morgannwg University Local Health Board	102	18,954	538
Aneurin Bevan University Local Health Board	125	25,440	491
Hywel Dda University Local Health Board	59	13,948	423
Swansea Bay University Local Health Board	57	15,031	379
Total	**703**	**126,466**	**556**

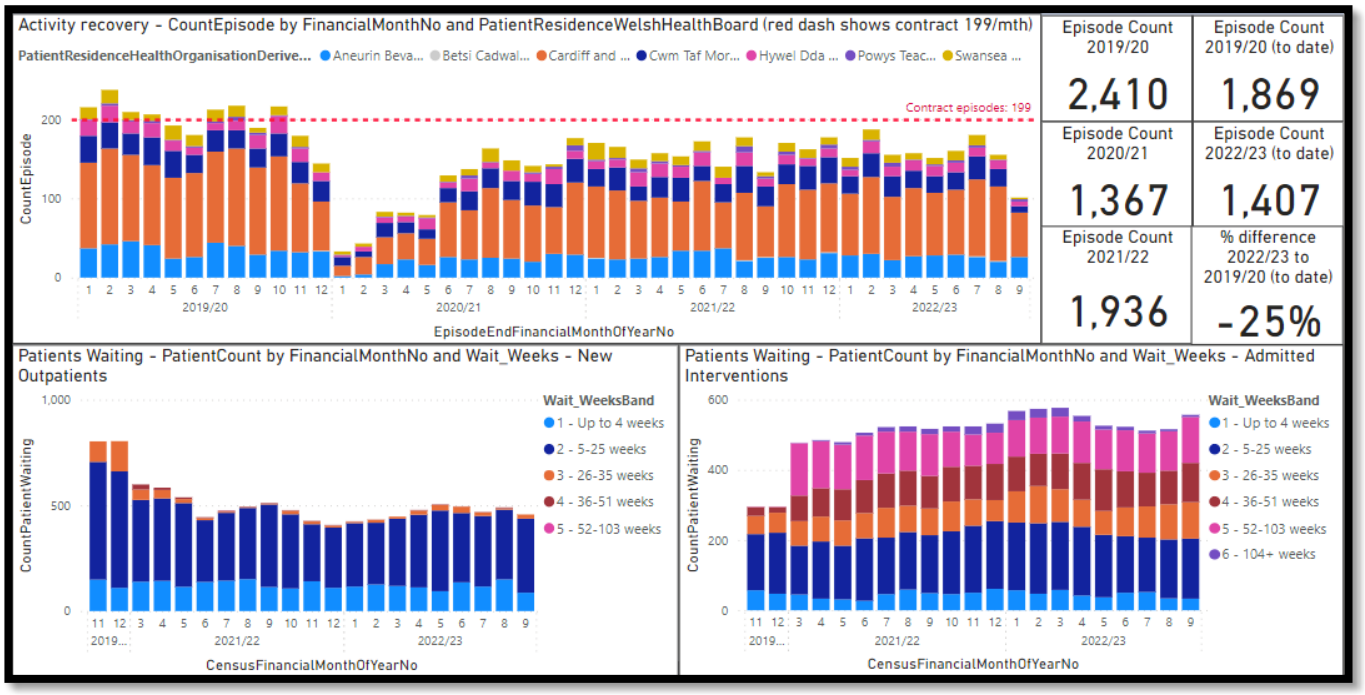
Data source: DHCW central data warehouse; all inpatient activity

Access rates across the Health Boards varied as the pandemic initially hit, but have now stabilised to roughly the same split as before the pandemic.

However, inpatient episodes per 100k population varies significantly overall across the Health Board areas, from 22 to 151 as per the small table above, with Cardiff being by far the highest. This is linked to Cardiff being the contracted provider of this service, with all South Wales specialist activity passing through the WHSSC contract, along with the local more general activity. The general age group within Paediatric Surgery is 0-3 age group, and this specific activity and population rates are also shown in the table on the bottom right; this shows a closer range of access across Health Boards.

Please note a separate deep dive presentation on Paediatric Surgery was prepared for discussion by Joint Committee members in August 2022.

3.6.2 Paediatric Surgery – Recovery and Waiting lists Cardiff & Vale UHB

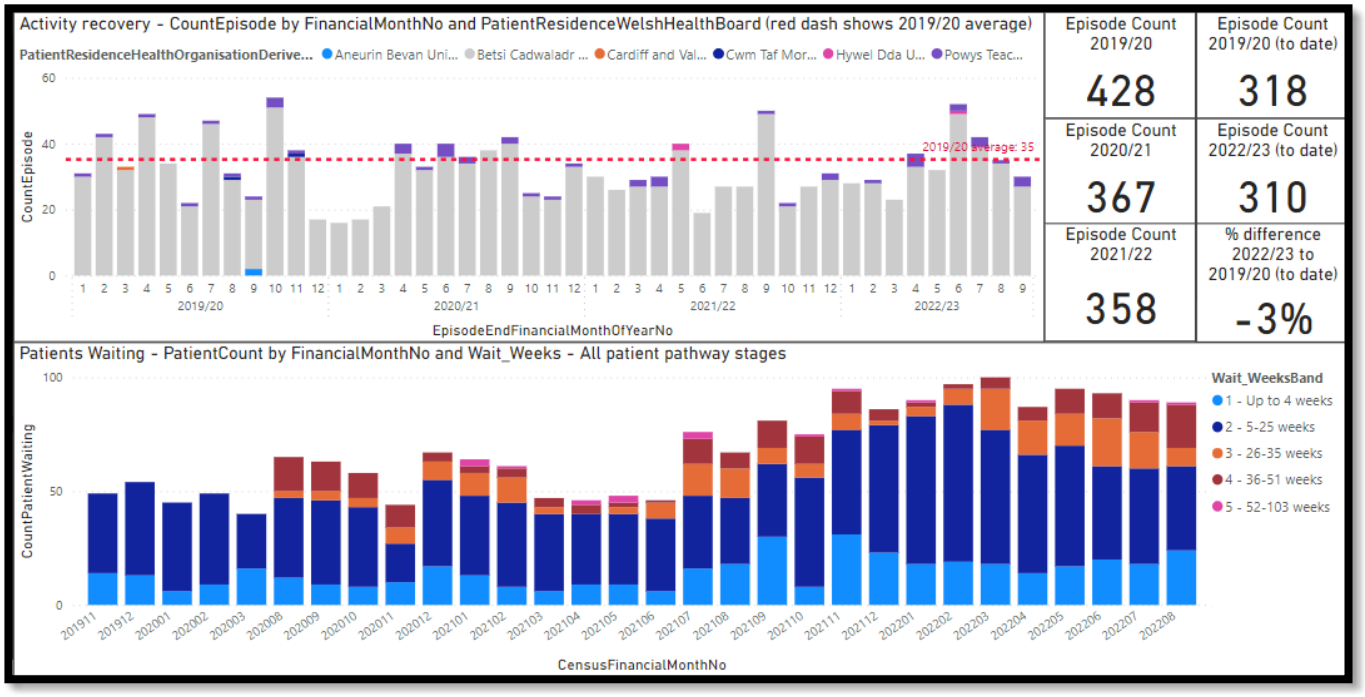


Data source: DHCW central data warehouse; all patients waiting with an open pathway

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 about 30% now having waited for over a year. Given that the main age band treated by this specialty is in the 0-3 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 further down the pathway.

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 is essential for the provider to have in place appropriate systems to monitor the risk of these patients waiting for surgery.

Alder Hey Children's Hospital



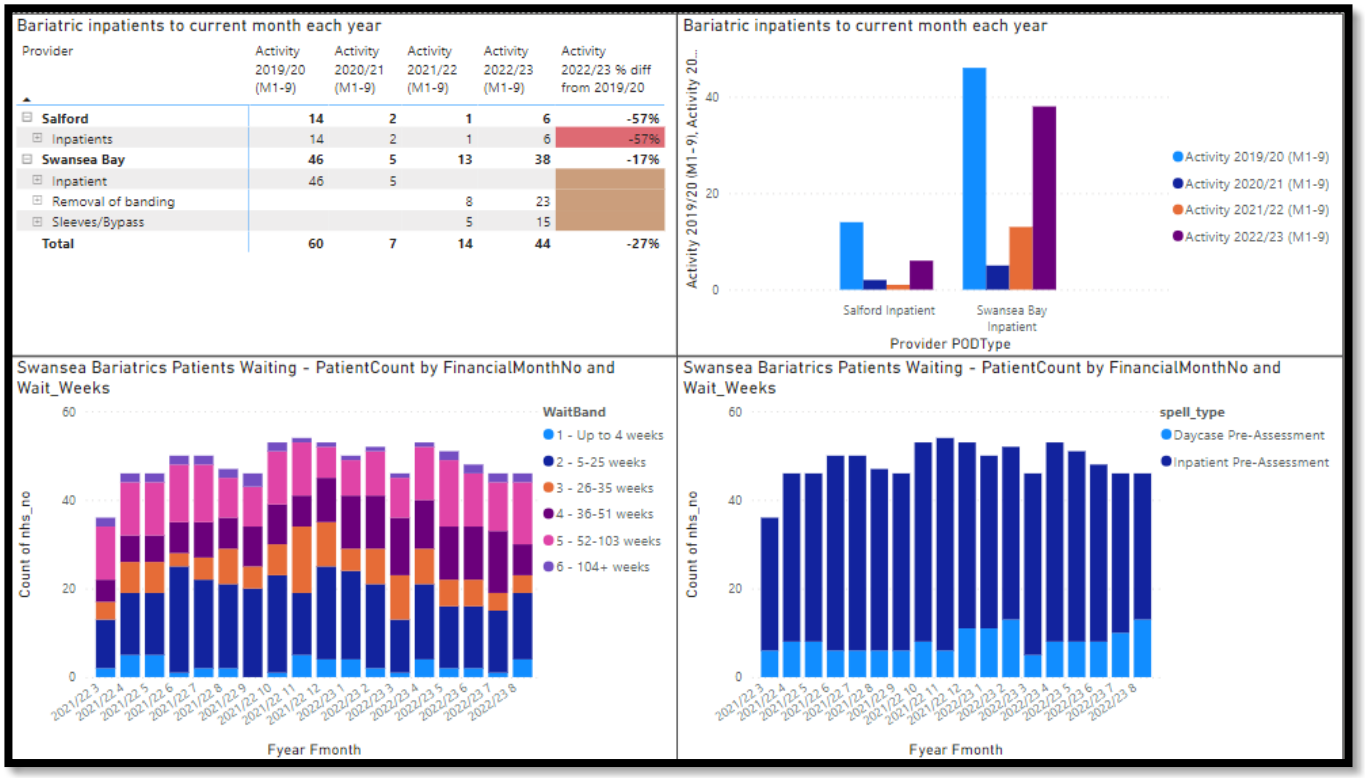
Data source: DHCW central data warehouse; all inpatient activity

The tables above show a summary of the position at Alder Hey in relation to Paediatric Surgery. The recovery position to the current month this year is 3% lower than last year (14% less in 2020/21 compared to 2019/20 in total, and 17% less in 2021/22 compared to 2019/20). The total waiting list had remained fairly static until October 2021, where it has started to increase again.

Specialised Planner comments:
Alder Hey had previously reported to WHSSC through their recovery plans that activity was currently higher than pre-pandemic levels and a robust plan is in place to manage the small number of patients waiting over 52 weeks. The provider had confirmed that all patients waiting over 52 weeks would 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 is reporting a significant number of patients waiting over 52 weeks. It was noted there are currently 8 children on the list who have waited over 104 weeks however there is a plan in place to ensure there are zero patients waiting over 104 weeks by the end of March 2023. In dialogue with the provider, there are a number of contributing factors to the waiting list including nurse capacity, bed capacity, anaesthetic support and theatre availability. The HB confirmed that there is a plan in place to utilise the support of Anaesthetists from SBUHB to increase capacity. Joint Committee has requested a revised recovery plan from CVUHB. Outsourcing is currently being explored.

3.7 Bariatric Surgery



Data source: direct submissions from providers

Bariatric Surgery is provided at two main centres – Salford predominantly for North Wales residents, and Swansea Bay for South Wales' residents. Numbers are small and were greatly affected early on in the Covid-19 pandemic.

Although activity is now creeping up in 2022/23, there remains a high waiting list at Swansea compared to activity, with about a third of patients now waiting over a year. The service has been in Level 1 escalation since November 2022, with weekly performance monitoring being received.

Specialised Planner comments:
As noted previously, notwithstanding the challenges of post-Covid recovery, WHSSC has long-standing concerns with the volume of procedures delivered by both commissioned centres. SBUHB has previously committed to returning to commissioned levels and has been placed in Level 1 (enhanced monitoring) escalation. Although there has been a significant increase in the number of procedures delivered by SBUHB, this is not yet apparent in the monthly monitoring data, and cancellation rates have remained relatively high. WHSSC is also continuing to work with Aneurin Bevan University Health Board to support the possibility that the health board be a bariatric surgery designated provider. An initial self-assessment has been submitted, and the health board is now developing formal proposals.

3.8 NHS England Providers – Organisations with WHSSC Contracts

The key summaries and analysis relating to English providers are set out in Appendix A.

3.8.1 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. Activity for 2021/22 improved to just 13% less than 2019/20, and this increase in performance is expected to continue into 2022/23; to the current month the comparison is 10% lower than 2019/20.

The following chart shows the activity drop classified between contracts that are major Powys/North Wales providers and the remaining ones that are either South/all Wales. Providers predominantly to Powys/North Wales have a higher recovery to pre-Covid rates, although they have much higher activity overall than the other Health Boards; please see the appendix for data on each provider by name.

It is worth noting that activity under A&E/Trauma specialties make up 16% of the pre-Covid inpatient episodes, which reduced to only 10% in 2020/21, but has increased to 14% of the 2022/23 activity to date. This is likely due to reduced travelling, and means that the rest of the activity has reduced less than the total 10% so far this year.

Episodes by provider - full years except current year (data: DHCW inpatient episodes)

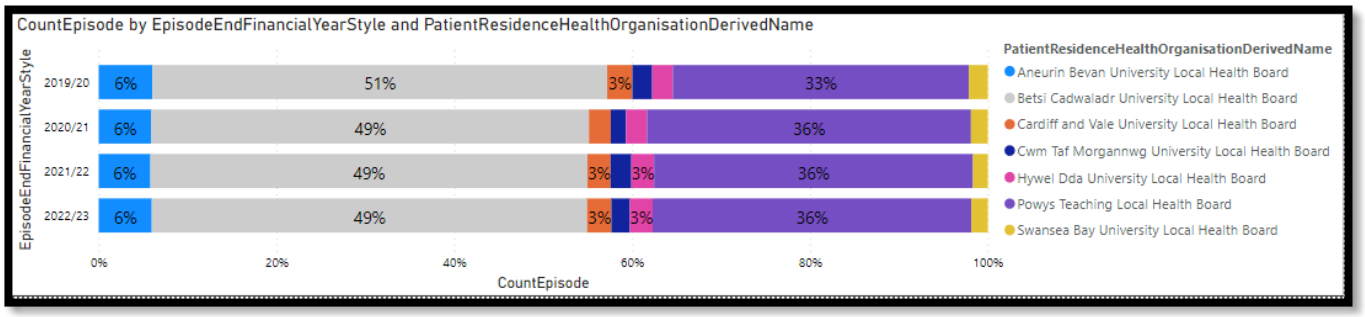
Main HB	2019/20	2020/21	2021/22	2022/23	Total	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2020/21 (M1-9)	CountEpisode for 2021/22 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
⊞	4,213	2,529	3,495	2,774	13,011	3,290	1,929	2,653	2,774	-16%
⊞ Major North Wales provider	14,810	9,783	12,735	9,889	47,217	11,185	7,207	9,521	9,889	-12%
⊞ Major Powys provider	17,649	11,590	15,701	12,455	57,395	13,340	8,466	11,978	12,455	-7%
Total	36,672	23,902	31,931	25,118	117,623	27,815	17,602	24,152	25,118	-10%

Episodes by provider - full years except 2022/23 (data: DHCW)

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	2022/23	TreatmentSpecialtyDescription	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2020/21 (M1-9)	CountEpisode for 2021/22 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
⊞ Accident & Emergency	384	194	298	176	⊞ Accident & Emergency	315	150	224	176	-44%
⊞ Paediatric Trauma and Orthopaedics	143	95	131	136	⊞ Paediatric Trauma and Orthopaedics	112	69	98	136	21%
⊞ Trauma & Orthopaedics	5,429	2,170	4,089	3,291	⊞ Trauma & Orthopaedics	4,055	1,650	3,158	3,291	-19%
Total	5,956	2,459	4,518	3,603	Total	4,482	1,869	3,480	3,603	-20%

Data source: DHCW central data warehouse; all inpatient activity at English Trusts with WHSSC contracts

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, and Betsi Cadwaladr, whose share has decreased 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: DHCW 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 3-8) – Whilst overall inpatient activity has decreased by 12% to date this financial year, compared to 2019/20, this had not translated into higher waiting lists due to lower demand for inpatient admissions. Cardiff's waiting list for admissions had actually reduced to about one third of pre-COVID-19 levels, but has been increasing again since December 2021 (now about 100 patients), and Swansea Bay's has steadily reduced to just over half (about 35 patients), although Liverpool's list has increased slightly (about 70 patients).

Referrals for New outpatient appointments are 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.

It is worth noting that waiting lists for admissions for Cardiology have increased at both Cardiff and Swansea Bay – a small increase at Cardiff to about 620 patients (from about 590 in March 2020), but a larger increase at Swansea Bay to around 320 patients (from about 220 in March 2020), although this has been decreasing each month lately. These figures include non-specialist activity, as well as specialised interventions.

Thoracic Surgery (pages 9-12) – Whilst inpatient activity overall has decreased by 11% to date in 2022/23 compared to 2019/20, this varies across the 3 main providers. Cardiff have performed a similar episode volume to 2019/20, and have halved their waiting list for admissions (now about 50 patients). Liverpool have increased their inpatient activity by 15%, and their waiting list for admissions is around 15 patients. Swansea Bay's activity is 22% lower than 2019/20 so far this year, but their waiting list is similar to pre-Covid levels with about 20 patients. Cardiff have been seeing some Swansea patients by agreement.

Similar to Cardiac Surgery, New Outpatient referrals appear to be now increasing again though, so the good work needs to be maintained.

Neurosurgery (pages 13-17) – Inpatient activity has decreased by 15% in 2022/23 compared to 2019/20, with both Cardiff and the Walton showing similar recovery rates. Both Cardiff's and the Walton's waiting lists for admissions are roughly the same as pre-Covid (about 230 patients at Cardiff and 400 at the Walton), although Cardiff have now seen all the patients that had been waiting for admission over a year from pressures at the start of the Covid period.

New outpatient referrals appear to be consistent, but Cardiff now has a growing waiting list for new appointments, which could translate into pressure on the waiting list for admissions.

Plastic Surgery (pages 17-21) – Inpatient activity is still 19% 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 Bay and St. Helen's and Knowsley) are now showing large waiting lists for admissions, with large numbers having now waited over a year, or even two years. Swansea Bay's inpatient waiting list has grown from about 1,450 in March 2020 to about 2,700 in December 2022, with almost half having waited over a year.

The new performance measures from Welsh Government show that almost 600 patients have now waited over 2 years for admission at Swansea Bay. WHSSC is working with the Health Board to support the recovery plan for plastic surgery to address the significant backlog of patients with long waiting times for treatment.

St. Helen's and Knowsley's total waiting list for all pathway points has grown from just under 200 in March 2020 to over 430 in November 2022, although none have waited over a year.

It is noteworthy that Swansea Bay shows a far higher percentage of emergency activity (52% to date in 2022/23) than St Helen's (15% to date in 2022/23), although this was also the case Pre-COVID-19.

Paediatric Surgery (pages 23-26) - Inpatient activity overall has decreased by 21% to date this financial year, compared to 2019/20, but this is still significantly more than in 2020/21.

Whilst Cardiff has clearly worked hard to reduce the New Outpatient waiting list, the waiting list for admissions has been progressively growing from about 300 patients in March 2020 to over 500 in December 2022, with about 30% having now waited over a year (very few had waited over 36 weeks Pre-COVID-19). A few patients have now even tipped into the wait band of over 2 years. This is concerning, given that children aged 0-3 are the highest age band of admitted patients. However, WHSSC have been in discussions with the Health Board around their recovery plan, and there is a plan in place to ensure there are no patients waiting over 104 weeks by the end of March 2023.

Alder Hey's waiting list had remained fairly static since Pre-COVID-19, but has recently started growing again with about 80 patients waiting across all pathway points. The Trust had cleared all waiters over 36 weeks by October 2021, but that number is now growing again since then.

Bariatric Surgery (pages 27) - Bariatric Surgery is provided at two main centres – Salford predominantly for North Wales residents, and Swansea Bay for South Wales residents. Numbers are small and were greatly affected early on in the Covid-19 pandemic. Although activity is now creeping up in 2022/23, there remains a high waiting list at Swansea compared to activity, with about a third of patients now waiting over a year. However, early performance figures relating to January are showing a productive month.

NHS England providers (page 28, Appendix 1) – Overall, the English Trusts that WHSSC commission have performed by 10% 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, and that the specialist activity has reduced by less than this. For example, Trauma & Orthopaedics has reduced by 19% in total, and A&E by 44% in 2022/23. Appendix A lists all the specialties in order, and also shows the position by Health Board.

Other notes
Performance measurement is now increasing in priority, following the worst of the Covid-19 pandemic. Welsh Government have brought out a full range of measurements for 2022/23, and WHSSC will be considering performance and related reporting over the coming months.

5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Implementation of the Plan Governance and Assurance Choose an item.
Link to Integrated Commissioning Plan	This report provides assurance on delivery of the ICP.
Health and Care Standards	Governance, Leadership and Accountability Choose an item. Choose an item.
Principles of Prudent Healthcare	Reduce inappropriate variation Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Reducing the per capita cost of health care Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	Any issues are identified in the report.
Finance/Resource Implications	Any issues are identified in the report.
Population Health	Any issues are identified in the report.
Legal Implications (including equality & diversity, socio economic duty etc)	Any issues are identified in the report.
Long Term Implications (incl WBFG Act 2015)	Any issues are identified in the report.
Report History (Meeting/Date/ Summary of Outcome	
Appendices	**Appendix A** – Recovery summary of main specialties/providers **Appendix B** – contract monitoring return activity CVUHB **Appendix C** – contract monitoring return activity SBUHB **Appendix 1** – charts of DHCW data showing inpatient activity at NHS England Trusts with a WHSSC contract (specialist and non-specialist) **Appendix 2** – tables including the relevant Performance measures as directed by Welsh Government

***Appendix A*: Recovery summary of main specialties/providers (please see main body of the report for more detail)**

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

Annex A - Recovery summary
Data sources: DHCW inpatient episodes and RTT data; includes ALL episodes

Episode comparison to current month (DHCW data warehouse)

Specialty_WHSSC	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2020/21 (M1-9)	CountEpisode for 2021/22 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
Cardiac Surgery	**1,642**	**872**	**1,365**	**1,440**	**-12%**
Cardiff and Vale University Local Health Board	626	297	478	514	-18%
Liverpool Heart And Chest Hospital nhs foundatio	341	237	352	324	-5%
Swansea Bay University Local Health Board	578	270	458	490	-15%
University Hospitals Birmingham Nhs Foundation t	50	36	36	57	14%
University Hospitals Of North Midlands nhs trust	47	32	41	55	17%
Neurosurgery	**2,549**	**1,536**	**2,160**	**2,179**	**-15%**
Cardiff and Vale University Local Health Board	1,611	969	1,387	1,444	-10%
The Walton Centre Nhs Foundation trust	826	483	663	646	-22%
University Hospitals Of North Midlands nhs trust	112	84	110	89	-21%
Paediatric Surgery	**2,187**	**1,187**	**1,701**	**1,717**	**-21%**
Alder Hey Children's Nhs Foundation trust	318	283	278	310	-3%
Cardiff and Vale University Local Health Board	1,869	904	1,423	1,407	-25%
Plastic Surgery	**8,639**	**4,901**	**6,514**	**6,899**	**-20%**
Countess Of Chester Hospital Nhs foundation trus	522	330	350	397	-24%
St Helens And Knowsley Teaching Hospitals nhs tr	1,033	590	847	931	-10%
Swansea Bay University Local Health Board	7,084	3,981	5,317	5,571	-21%
Thoracic Surgery	**1,016**	**613**	**965**	**911**	**-10%**
Cardiff and Vale University Local Health Board	474	282	470	420	-11%
Liverpool Heart And Chest Hospital nhs foundatio	167	129	213	192	15%
Swansea Bay University Local Health Board	353	190	259	275	-22%
University Hospitals Of North Midlands nhs trust	22	12	23	24	9%
Total Specialty	**16,033**	**9,109**	**12,705**	**13,146**	**-18%**

Current Waiting List totals (DHCW data)

202208 Admitted diagnostic intervention	FUP OP appointment	New OP appointment	Unknown	Total
140	**38**	**76**	**161**	**415**
104	27	44		**175**
			156	**156**
36	11	32		**79**
			5	**5**
239	**324**	**510**	**441**	**1,514**
239	324	510		**1,073**
			441	**441**
516	**42**	**490**	**89**	**1,137**
			89	**89**
516	42	490		**1,048**
2,682	**107**	**1,551**	**705**	**5,045**
			221	**221**
			484	**484**
2,682	107	1,551		**4,340**
76	**81**	**80**	**17**	**254**
53	73	50		**176**
			17	**17**
23	8	30		**61**
3,653	**592**	**2,707**	**1,413**	**8,365**

Note: Cardiac Surgery includes ALL episodes, as current coding for 2022/23 has not been fully completed for the most recent months and minor/nil procedure episodes cannot be excluded

Appendix B: CVUHB – CONTRACT MONITORING RETURN - page 1 of 3

Notes:

1. **The new month's figure is the difference from the previous month's sub-total, so would include any retrospective adjustments made in the contract monitoring.**
2. **The charts in the main report body use DHCW data for consistency with other providers; year-to-date activity totals are checked to ensure any variation to the contract monitoring summarised below is not material. These small variations may include residency allocations (including border residents), episode/spell end months etc**
3. **The Cardiac Surgery inpatient line below includes minor surgeries.**

Heading	Sub-heading	Activity ty	Sum of Spend £ 2022/23 1	2	3	4	5	6	7	8	9	2022/23 Total	Sum of Activity 2022/23 1	2	3	4	5	6	7	8	9	2022/23 Total
CARDIO THORACIC	Cardiology- Specialist Services		999,585	1,073,683	1,092,218	1,331,502	1,103,030	1,120,002	1,166,352	1,007,767	1,202,094	**10,096,234**	149	148	143	164	168	161	140	188	150	**1,411**
	Prioritisation-Percutaneous mitral valve leaflet repair	(blank)	55,940	55,940	55,940	55,940	(120,181)	14,490	9,727	5,363	58,627	**191,787**										
	Cardiology for AB	FCE's	143,343	7,238	57,826	86,206	402,452	139,414	141,450	186,679	137,755	**1,302,363**	27	29	20	33	17	26	35	34	34	**255**
	AB ICD Repatriation	(blank)	(70,235)	(70,235)	(70,235)	(70,235)	(70,235)	(70,235)	(70,235)	(70,235)	(70,235)	**(632,117)**										
	Cwm Taf Cardiology ICD's	FCE's	23,426	13,510	33,343	111,053	30,458	42,358	51,614	39,903	9,594	**355,258**	3	2	1	8	2	4	3	0	2	**25**
	SB Cardiology	FCE's	3,445	3,445	3,445	20,311	3,445	6,818	2,883	(10,153)	16,340	**49,981**	1	0	1	0	0	0	-1	1		**2**
	Cardiac Surgery-TAVI	Procedure	289,410	722,014	367,564	415,690	386,316	436,200	481,574	526,179	214,805	**3,839,752**	15	31	18	20	18	21	21	12	21	**177**
	ACHD	OP	108,778	108,778	108,778	108,778	108,778	65,202	34,826	91,988	91,988	**827,894**	72	77	85	73	85	78	71	117	55	**713**
	Cardiac Surgery	FCE's	1,140,349	1,218,366	1,159,504	1,219,707	1,168,443	1,181,274	1,204,961	1,194,345	1,180,745	**10,667,694**	44	52	45	64	46	67	66	62	68	**514**
		OP											83	105	104	75	103	92	103	112	68	**845**
	Thoracic Surgery	FCE's	363,846	416,603	404,091	384,832	384,864	390,844	365,220	368,854	372,316	**3,451,469**	48	59	58	39	55	40	38	41	40	**418**
		OP											143	146	135	106	148	161	151	156	116	**1,262**
	CARDIO THORACIC Total		**3,057,887**	**3,549,343**	**3,212,474**	**3,663,783**	**3,397,370**	**3,326,367**	**3,388,373**	**3,340,690**	**3,214,029**	**30,150,315**	**585**	**649**	**610**	**582**	**642**	**650**	**627**	**723**	**554**	**5,622**
NEUROSCIENCE/ ALAS	Neurosurgery	FCE's	1,562,415	1,627,787	1,572,281	1,598,002	1,593,021	1,590,701	1,651,241	1,624,267	1,640,237	**14,459,952**	129	166	129	157	156	198	236	195	146	**1,512**
		OP											374	404	425	415	408	487	556	443	392	**3,904**
	Spinal Implants	Patients	138,206	119,536	86,418	195,593	58,876	119,726	251,783	145,041	187,562	**1,302,742**	8	12	9	16	8	14	8	11	13	**99**
	Spinal Implants - SB Intrathecal	(blank)																				
	INR Devices	Devices	105,049	165,685	67,228	145,621	161,889	129,092	194,435	197,752	191,182	**1,357,933**	12	14	9	11	9	17	18	21	12	**123**
	Excess INR Outsourcing	(blank)	0	0	0	0	0	0				**0**										
	Epilepsy Surgery	FCE's	1,919	63,909	32,914	(1)	(1)	19,748	10,148	24,880	31,678	**185,193**	0	2	1	0	0	0	1	1		**5**
	Prolonged Disorder of	(blank)	24,501	24,501	24,501	24,501	24,501	(14,128)	26,801	19,311	19,311	**173,798**										
	Neurosurgery Oncology Service	(blank)	42,833	42,833	42,833	42,833	42,833	(29,954)	16,226	28,634	28,634	**257,706**										
	Spinal Injuries	Bed-days	309,494	323,435	323,294	328,645	327,941	322,559	318,488	321,228	332,659	**2,907,741**	546	645	644	682	677	614	630	702	624	**5,764**
		OP											53	77	67	54	58	58	68	81	38	**554**
	Neuro Rehab	Bed-days	303,334	303,716	312,752	307,152	306,738	306,738	306,739	306,739	306,739	**2,760,646**	457	460	531	571	553	455	497	487	424	**4,435**
		OP											24	26	28	36	17	28	38	42	23	**262**
	Relocation of Rehabilitation Services	(blank)	42,833	42,833	42,833	42,833	42,833	(100,554)	(31,666)	11,707	11,707	**105,359**										
	ALAS	(blank)	1,546,961	1,547,003	1,547,004	1,546,836	1,547,136	1,376,853	1,518,764	1,461,841	1,565,710	**13,658,108**										
	MPK	(blank)	28,417	28,417	28,417	28,417	28,417	28,417	28,417	(71,583)	(54,944)	**72,389**										
	NEUROSCIENCE/ ALAS Total		**4,105,962**	**4,289,654**	**4,080,475**	**4,260,433**	**4,134,185**	**3,749,197**	**4,291,373**	**4,069,815**	**4,260,474**	**37,241,568**	**1,603**	**1,806**	**1,843**	**1,942**	**1,886**	**1,871**	**2,052**	**1,983**	**1,672**	**16,658**
RENAL	Renal Surgery	FCE's	338,099	388,232	342,681	377,601	332,553	355,833	331,937	333,278	351,714	**3,151,926**	76	93	81	97	68	86	87	94	74	**756**
		OP											307	353	366	315	391	230	401	409	292	**3,064**
	Nephrology	FCE's	555,329	548,863	539,164	548,863	563,412	551,127	565,459	551,019	563,816	**4,987,051**	109	86	106	103	129	163	147	183	180	**1,206**
		OP											439	525	469	628	824	542	614	777	526	**5,344**
	Home Renal Dialysis	Dialysis	129,488	127,562	129,965	145,421	144,537	135,394	111,732	128,027	141,846	**1,193,972**	644	624	649	718	782	508	634	664	621	**5,844**
	Renal CAPD (Dialysis)	Dialysis	128,813	129,970	128,284	133,615	132,013	130,539	119,863	131,710	126,037	**1,160,844**	1,644	1,691	1,636	1,735	1,645	1,450	1,737	1,565	1,617	**14,720**
	Hospital Renal Dialysis	Dialysis	1,241,309	1,235,502	1,280,881	1,188,665	1,262,369	1,241,745	1,355,532	1,274,028	1,289,134	**11,369,166**	7,281	7,283	7,574	6,952	7,487	8,137	7,557	7,671	7,085	**67,027**
	Renal Transplants	Transplant	521,308	573,623	562,281	523,168	495,583	503,652	466,090	487,212	550,008	**4,682,925**	10	12	12	10	8	5	8		24	**89**
	RENAL Total		**2,914,345**	**3,003,751**	**2,983,257**	**2,917,333**	**2,930,467**	**2,918,290**	**2,950,612**	**2,905,274**	**3,022,555**	**26,545,884**	**10,510**	**10,667**	**10,893**	**10,558**	**11,334**	**11,121**	**11,185**	**11,363**	**10,419**	**98,050**
HAEMATOLOGY	Haemophilia - Blood products	Units	448,436	479,466	426,136	507,624	761,737	524,680	633,513	260,093	517,668	**4,559,353**	1,374,003	1,402,611	1,756,043	1,506,823	2,063,128	1,435,927	232,723	2,135,134	1,925,808	**13,832,200**
	IBD Service Infrastructure	(blank)	159,097	159,097	159,097	159,097	159,097	92,213	147,950	147,950	147,950	**1,331,549**										
	Haemophilia Ref Centre	(blank)	6,419	6,419	6,419	6,419	6,419	6,419	6,419	6,419	6,419	**57,775**										
	BMT - Cardiff & SB	Transplant	739,972	765,336	854,475	637,533	808,277	761,118	786,172	728,101	547,622	**6,628,605**	11	13	12	9	12	9	10	7	14	**97**
	ATMPs - C&V Service	Patients	342,308	340,136	86,613	86,613	1,102,468	(1,224,694)	148,667	81,686	115,661	**1,079,459**	1	1	0	0	4	2			7	**15**
	Lymphoma Panel	Patients	127,370	132,305	111,918	127,154	124,099	124,567	132,520	127,987	126,330	**1,134,250**	207	228	141	206	193	224	208	203	179	**1,789**
	Clinical Immunology	Patients	675,785	891,994	807,137	721,865	940,516	793,567	880,896	963,360	886,008	**7,561,127**	135	223	224	235	228	247	242	246	254	**2,034**
	Hereditary Aneamia Service	(blank)	31,632	31,632	31,632	31,632	31,632	11,882	26,792	28,119	28,119	**253,070**										
	HAEMATOLOGY Total		**2,531,018**	**2,806,386**	**2,483,427**	**2,277,937**	**3,934,245**	**1,089,752**	**2,762,929**	**2,343,716**	**2,375,777**	**22,605,187**	**1,374,357**	**1,403,076**	**1,756,420**	**1,507,273**	**2,063,565**	**1,436,409**	**233,183**	**2,135,590**	**1,926,262**	**13,836,135**

Heading	Sub-heading	Activity ty	Sum of Spend £ 2022/23 1	2	3	4	5	6	7	8	9	2022/23 Total	Sum of Activity 2022/23 1	2	3	4	5	6	7	8	9	2022/23 Total
PAEDIATRICS/ NEONATAL	Paediatric Surgery	FCE's	566,155	592,537	565,352	569,176	561,612	570,966	571,380	586,911	567,806	**5,151,895**	153	188	152	157	147	160	178	156	102	**1,393**
		OP											236	281	235	174	178	279	281	289	213	**2,166**
	Paediatric Renal	FCE's	146,742	161,679	170,941	144,163	142,835	153,277	126,071	150,154	130,521	**1,326,383**	47	59	46	40	45	49	38	35	37	**396**
		OP											148	168	129	162	147	140	148	141	96	**1,279**
	Paediatric Oncology	FCE's -	945,745	964,767	900,347	944,574	944,050	939,894	893,424	929,671	987,643	**8,450,115**	164	153	114	162	134	81	174	160	138	**1,280**
		FCE's -											64	52	56	59	92	74	73	106	96	**672**
		OP											224	452	461	689	465	625	536	753	372	**4,577**
	Paediatric Neurology	FCE's	250,226	257,867	250,355	253,076	262,468	131,643	191,155	232,727	231,962	**2,061,482**	19	24	19	18	22	18	24	13	6	**163**
		OP											118	106	139	45	129	72	132	126	108	**975**
	Nusinersen Additional Costs	(blank)	5,505	5,505	5,505	5,505	5,505	5,505	5,505	5,505	5,505	**49,544**										
	Paediatric Ketogenic Diet	(blank)	8,546	8,546	8,546	8,546	8,546	8,546	8,546	8,546	8,546	**76,912**										
	Paediatric Rheumatology	(blank)	61,129	54,592	57,861	57,861	57,861	38,149	35,143	51,799	51,799	**466,193**										
	Paediatric Neuro Rehab	(blank)	22,889	22,889	22,889	22,889	22,889	22,889	22,889	22,889	22,889	**206,002**										
	Paediatric Gastroenterology	FCE's	163,788	136,769	158,342	154,845	171,005	148,770	119,369	168,525	133,422	**1,354,836**	66	57	77	61	66	88	73	10	12	**510**
		OP											72	84	86	55	79	117	85	120	75	**773**
	Paediatric ENT	FCE's	123,498	125,633	124,533	124,795	127,835	125,258	124,916	126,002	80,932	**1,083,402**	34	37	33	37	45	34	40	45	32	**337**
		OP											108	183	144	133	224	167	313	312	146	**1,730**
	Paediatric Cardiology	FCE's	250,466	256,477	280,342	250,648	214,577	235,878	227,059	241,887	250,241	**2,207,575**	17	18	21	18	12	8	13	18	10	**135**
		OP											171	224	224	186	183	218	199	226	165	**1,796**
	Foetal Cardiology	OP	22,135	22,135	22,135	22,135	22,135	22,136	22,135	22,135	22,136	**199,220**	42	64	59	38	37	50	40	33	65	**428**
	Paeds Cystic Fibrosis	(blank)	48,442	45,397	46,550	44,012	47,040	46,286	45,661	47,192	49,531	**420,112**										
	Children's Hospital for Wales	(blank)	109,858	109,858	109,858	109,858	109,858	109,858	109,858	109,858	109,858	**988,723**										
	Paeds Respiratory Equipment	(blank)	21,364	29,369	73,051	26,793	69,309	44,026	17,124	75,788	19,155	**375,979**										
	Paediatric Radiology	(blank)	51,400	23,600	37,500	37,500	37,500	(50,600)	2,867	19,967	19,967	**179,700**										
	Paeds Endocrinology	(blank)	61,944	61,944	61,944	61,944	61,944	61,944	61,944	61,944	61,944	**557,494**										
	Foetal Medicine	(blank)	27,184	27,184	27,184	27,184	27,184	27,184	97,184	27,184	(35,248)	**252,223**										
	PICU BH	Bed-days	409,420	420,061	512,561	392,789	338,871	414,740	376,432	443,923	423,917	**3,732,713**	86	115	133	99	81	31	124	172	221	**1,062**
	NICU BH	Bed-days	825,486	849,448	802,903	855,001	877,805	799,367	835,002	835,002	835,002	**7,515,015**	741	704	837	934	803	924	919	823	748	**7,433**
	Perinatal Pathology	(blank)	24,650	24,650	24,650	24,650	24,650	24,650	24,650	24,650	24,650	**221,852**										
	Paediatric IMD	(blank)	12,925	12,925	12,925	12,925	12,925	0	10,771	10,771	10,771	**96,938**										
	Paediatric MRI Investment	(blank)	39,609	39,609	39,609	39,609	39,609	(20,015)	29,672	29,672	29,672	**267,044**										
PAEDIATRICS/ NEONATAL Total			**4,199,106**	**4,253,443**	**4,315,882**	**4,190,479**	**4,188,012**	**3,860,349**	**3,958,756**	**4,232,701**	**4,042,620**	**37,241,349**	**2,510**	**2,969**	**2,965**	**3,067**	**2,889**	**3,135**	**3,390**	**3,538**	**2,642**	**27,105**
ADULT CRITICAL CARE	AICU	Bed-days	596,342	541,128	234,185	457,218	640,842	493,941	532,723	600,489	553,076	**4,649,944**	284	309	410	307	285	350	306	346	377	**2,973**
	HDU	Bed-days	55,913	48,093	75,463	74,681	80,936	67,018	158,067	96,080	69,539	**725,790**	22	14	48	47	55	137	87	27	81	**518**
	Critical Care Long Term Ventilation	(blank)	73,976	73,976	73,976	73,976	73,976	34,155	113,797	73,976	73,976	**665,783**										
	LTV Consultant Sessions	(blank)	3,338	3,338	3,338	3,338	3,338	3,338	3,338	3,338	3,338	**30,044**										
ADULT CRITICAL CARE Total			**729,569**	**666,535**	**386,962**	**609,213**	**799,093**	**598,451**	**807,925**	**773,883**	**699,929**	**6,071,561**	**306**	**323**	**458**	**354**	**340**	**487**	**393**	**373**	**458**	**3,491**
GENETICS/ LTC	Medical Genetics	(blank)	1,338,061	947,263	1,244,538	1,198,465	1,182,424	953,147	1,143,983	1,143,983	1,143,983	**10,295,848**										
	UK GTN Send out tests	Tests	38,167	38,167	38,167	38,167	38,167	38,167	38,845	46,111	(152,363)	**161,595**	6	23	20	32	20	18	40	24	18	**201**
	Lynch Syndrome	(blank)	26,043	26,043	26,043	26,043	26,043	26,043	26,043	26,043	26,043	**234,389**										
	Genetic Counsellor 8a	(blank)	5,550	5,550	5,550	5,550	5,550	5,550	5,550	5,550	5,550	**49,951**										
	Enzyme Replacement Therapy	(blank)	75,017	75,017	75,017	75,017	75,017	10,340	(20,288)	52,162	52,162	**469,460**										
	Cystic Fibrosis	(blank)	549,042	542,692	536,765	550,209	512,982	312,793	486,969	491,595	496,676	**4,479,723**										
	Home TPN	FCE's	277,621	202,333	213,171	292,073	350,379	213,439	330,338	324,772	262,591	**2,466,718**	325	218	224	360	455	411	420	326	251	**2,990**
	BAHAs & Cochlears	(blank)	422,054	422,054	422,054	580,046	461,552	461,553	461,552	461,552	461,551	**4,153,969**										
GENETICS/ LTC Total			**2,731,556**	**2,259,119**	**2,561,306**	**2,765,570**	**2,652,115**	**2,021,032**	**2,472,993**	**2,551,769**	**2,296,194**	**22,311,653**	**331**	**241**	**244**	**392**	**475**	**429**	**460**	**350**	**269**	**3,191**

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Heading	Sub-heading	Activity ty	Sum of Spend £ 2022/23 1	2	3	4	5	6	7	8	9	2022/23 Total	Sum of Activity 2022/23 1	2	3	4	5	6	7	8	9	2022/23 Total
	Liver Surgery	FCE's	107,958	107,958	83,738	81,774	91,083	79,278	77,836	115,320	78,197	**823,142**	13	12	10	4	10	10	14	9	10	**92**
	Liver Cancer Development	(blank)	2,537	2,537	2,537	2,537	2,537	2,537	2,537	2,537	2,537	**22,836**										
	Major Trauma Centre	(blank)	1,000,557	1,000,557	1,000,557	1,000,557	1,000,557	1,000,557	1,000,557	1,000,557	1,000,557	**9,005,016**										
	RF Ablation - Barretts Oesophagus	(blank)	26,178	26,178	32,779	46,982	25,339	31,489	72,619	37,367	12,749	**311,681**										
	Hepatology	(blank)	22,927	22,927	22,927	22,927	22,927	22,927	22,927	22,927	22,927	**206,342**										
	Hepatology Collective	(blank)	793	57,460	29,127	29,127	29,127	(55,890)	4,326	13,439	13,439	**120,947**										
OTHER	Neuropsychiatry	Days	252,818	256,324	255,645	252,001	255,042	250,431	255,467	247,501	259,993	**2,285,223**	311	334	329	306	326	309	283	351	364	**2,913**
	Regional Pharmaceutical Service	(blank)	64,854	64,854	64,854	64,854	64,854	64,854	64,854	64,854	64,854	**583,688**										
	NICE / High Cost Drugs	(blank)	104,691	60,879	113,998	51,183	103,091	86,769	114,047	126,418	173,891	**934,966**										
	ILD RHIG Funded	(blank)	13,336	13,336	13,336	13,336	13,336	13,336	13,336	13,336	13,336	**120,026**										
	Neuroendocrine Tumours (NETs)	(blank)	65,178	65,178	65,178	65,178	65,178	65,178	65,178	65,178	65,178	**586,601**										
	Gender Identity Service	OP	116,647	116,647	116,647	116,647	116,647	(16,275)	94,493	94,493	94,493	**850,439**	86	132	106	84	133	95	169	212	143	**1,160**
	Pay Award	(blank)	718,034	718,034	718,034	718,034	718,034	718,034	718,034	718,034	718,034	**6,462,305**										
	OTHER Total		**2,496,509**	**2,512,870**	**2,519,357**	**2,465,138**	**2,507,753**	**2,263,226**	**2,506,213**	**2,521,961**	**2,520,186**	**22,313,210**	**410**	**478**	**445**	**394**	**469**	**414**	**466**	**572**	**517**	**4,165**
	Grand Total		22,765,952	23,341,100	22,543,140	23,149,886	24,543,239	19,826,666	23,139,173	22,739,807	22,431,763	204,480,726	1,390,612	1,420,209	1,773,878	1,524,562	2,081,600	1,454,516	251,756	2,154,492	1,942,793	13,994,417

ANNEX C: SBUHB – CONTRACT MONITORING RETURN – Page 1 of 1

Notes:

1. The new month's figure is the difference from the previous month's sub-total, so would include any retrospective adjustments made in the contract monitoring.

Heading	Sub-heading	Activity type	Sum of Spend £ 2022/23 1	2	3	4	5	6	7	8	9	2022/23 Total	Sum of Activity 2022/23 1	2	3	4	5	6	7	8	9	2022/23 Total
RENAL	Renal - Other		700,618	700,618	700,618	700,618	700,618	700,618	700,618	711,950	673,259	6,289,532	991	991	991	991	991	991	991	1,092	974	9,000
	Hospital Dialysis	Dialysis	520,141	520,141	520,141	520,141	520,141	540,787	644,382	528,488	558,289	4,872,651	3,069	3,125	3,047	2,964	3,151	3,077	3,075	2,976	3,209	27,693
	Home Dialysis	Dialysis	152,964	152,964	152,964	152,964	152,964	152,964	152,964	152,964	162,745	1,386,456	81	81	81	81	81	81	81	82	87	734
	Renal Wwales Contract	Dialysis	335,320	295,016	126,317	191,608	350,489	259,735	259,748	259,748	259,747	2,337,729	2,288	2,256	2,303	2,318	2,382	2,306	2,283	2,236	2,248	20,620
	RENAL Total		**1,709,043**	**1,668,739**	**1,500,040**	**1,565,331**	**1,724,211**	**1,654,103**	**1,757,711**	**1,653,150**	**1,654,040**	**14,886,368**	**6,428**	**6,452**	**6,421**	**6,353**	**6,604**	**6,454**	**6,429**	**6,386**	**6,518**	**58,047**
CARDIO THORACIC	Cardiac Surgery	Minor/nil	1,275,459	1,260,770	1,290,509	1,238,815	1,265,777	1,239,566	1,300,550	1,332,112	1,336,013	11,539,572	38	38	40	29	29	38	46	45	43	346
		OP											9	13	11	17	3	14	11	11	15	104
													44	33	43	31	38	36	44	53	21	343
	TAVI		438,006	471,453	398,840	179,943	537,190	589,887	370,786	754,015	743,014	4,483,134	16	18	14	12	21	14	27	27	14	163
	TAVI (Add'l Develop)		33,083	33,083	33,083	33,083	33,083	33,083	-198,500			0										
	Cardiology		953,186	953,186	953,186	953,186	953,186	953,186	980,019	978,924	997,365	8,675,425	156	159	154	108	244	187	149	182	154	1,493
	Bariatrics		37,813	35,102	39,356	28,908	35,558	46,148	53,714	55,324	30,079	362,002	3	3	5	2	5	6	6	2	6	38
	ICC		25,015	25,015	25,015	25,015	21,192	24,250	24,250	24,250	24,250	218,250										
	CARDIO THORACIC Total		**2,762,563**	**2,778,609**	**2,739,989**	**2,458,950**	**2,845,986**	**2,886,120**	**2,530,819**	**3,144,625**	**3,130,721**	**25,278,383**	**266**	**264**	**267**	**199**	**340**	**295**	**283**	**320**	**253**	**2,487**
PAEDS / NEONATAL	CLP		115,139	125,131	115,395	148,147	126,079	128,678	140,195	135,061	129,229	1,163,053	4	7	4	14	8	11	12	12	13	85
	NICU		478,150	469,820	400,394	447,343	500,562	459,253	459,254	459,254	459,253	4,133,283	475	427	461	465	561	528	623	593	645	4,778
	BAHA		5,418	5,418	5,418	5,418	5,418	5,418	5,417	5,418	5,417	48,758										
	Paeds Onc		12,419	12,419	12,419	12,419	12,419	12,419	12,419	12,419	12,419	111,769										
	PAEDS / NEONATAL Total		**611,125**	**612,787**	**533,625**	**613,326**	**644,477**	**605,768**	**617,285**	**612,152**	**606,318**	**5,456,863**	**479**	**434**	**465**	**479**	**569**	**539**	**635**	**605**	**658**	**4,863**
CANCER & BLOOD	Plastics		1,552,784	1,532,747	1,523,606	1,561,446	1,542,927	1,461,702	1,596,869	1,589,536	1,626,592	13,988,210	657	642	624	659	708	657	663	668	639	5,917
		OP											1,842	2,152	1,896	1,898	2,141	2,303	2,315	2,283	1,943	18,773
	Burns		429,154	415,367	485,221	480,165	453,001	525,482	457,265	354,713	441,367	4,041,736	85	55	207	196	270	147	-47	113	57	1,083
	Thoracic		180,291	241,622	229,707	253,272	225,699	358,118	225,951	289,713	281,447	2,285,819	14	31	25	27	44	34	42	38	24	279
		OP											65	99	93	88	122	108	119	148	90	932
	SNB																					
	Haemophilia		75,113	117,253	84,261	59,604	84,335	152,513	71,713	42,970	85,970	773,732										
	Sarcoma		83,886	110,875	92,018	101,782	74,412	92,895	113,878	110,726	99,672	880,146	11	26	23	17	21	27	25	19	22	191
	Clinical Genetics		5,537	5,537	5,537	5,537	5,537	5,537	5,536	5,537	5,536	49,830										
	CANCER & BLOOD Total		**2,326,765**	**2,423,402**	**2,420,350**	**2,461,806**	**2,385,911**	**2,596,247**	**2,471,213**	**2,393,195**	**2,540,584**	**22,019,472**	**2,674**	**3,005**	**2,868**	**2,885**	**3,306**	**3,276**	**3,117**	**3,269**	**2,775**	**27,175**
NEUROSCIENCES	ALAC		194,435	194,435	194,435	194,435	111,582	177,864	177,865	177,864	177,865	1,600,780										
	Rehab		178,797	181,966	174,539	168,102	175,337	180,248	185,831	186,593	177,320	1,608,734	330	362	287	222	328	394	392	320	355	2,990
		OP											25	24	13	41	6	24	16	31	19	199
	NEUROSCIENCES Total		**373,232**	**376,402**	**368,974**	**362,537**	**286,919**	**358,112**	**363,696**	**364,457**	**355,185**	**3,209,514**	**355**	**386**	**300**	**263**	**334**	**418**	**408**	**351**	**374**	**3,189**
OTHER	NICE		8,707	19,455	25,936	20,619	19,256	112,995	52,927	52,176	82,580	394,651										
	East Forensics		1,256,167	1,256,167	1,256,167	1,256,167	1,256,167	1,256,167	1,256,166	1,256,167	1,256,166	11,305,499										
	Devices																					
	Academic Fee		11,368	11,368	11,368	11,368	11,368	11,368	11,368	11,368	11,368	102,312										
	IVF		270,435	259,041	268,562	329,982	296,899	285,010	284,988	284,988	284,988	2,564,893	80	70	86	86	89	82	114	122	72	801
		Cryopreservation											90	90	91	92	90	92	91	95	92	823
	Pay award		307,609	307,609	307,609	307,609	307,609	307,609	307,609	307,609	307,609	2,768,482										
	Major Trauma Plastics		79,516	79,516	79,516	79,516	79,516	79,516	79,516	79,516	79,516	715,643										
	Major Trauma ODN		44,389	44,389	44,389	44,389	44,389	44,389	44,389	44,389	44,389	399,501										
	Perinatal		152,083	152,083	152,083	152,083	152,083	-10,417	100,000	169,334	127,416	1,146,750										
	MPK		18,500	18,500	18,500	18,500	18,500	18,500	18,500	18,500	18,500	166,500										
	OTHER Total		**2,148,774**	**2,148,128**	**2,164,130**	**2,220,233**	**2,185,787**	**2,105,137**	**2,155,464**	**2,224,047**	**2,212,532**	**19,564,231**	**170**	**160**	**177**	**178**	**179**	**174**	**205**	**217**	**164**	**1,624**
	Grand Total		**9,931,502**	**10,008,066**	**9,727,109**	**9,682,183**	**10,073,291**	**10,205,487**	**9,896,188**	**10,391,626**	**10,499,380**	**90,414,832**	**10,372**	**10,701**	**10,498**	**10,357**	**11,332**	**11,156**	**11,077**	**11,148**	**10,742**	**97,385**

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 - full years except current year (data: DHCW inpatient episodes)

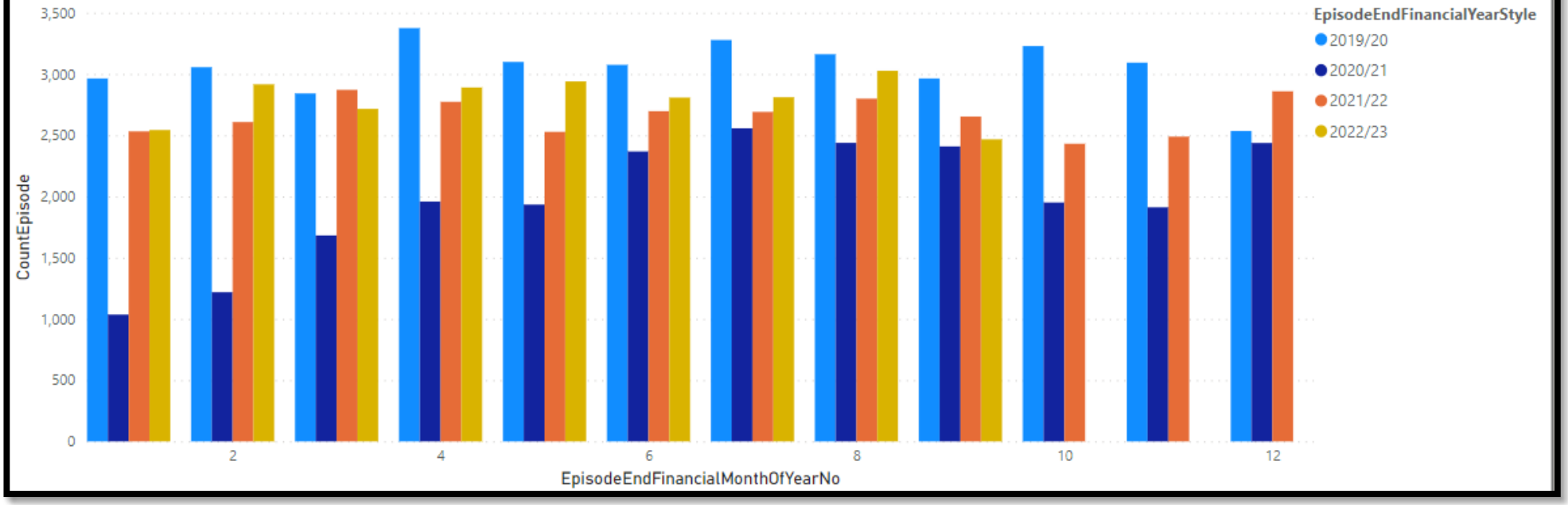
Main HB	2019/20	2020/21	2021/22	2022/23	Total	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2020/21 (M1-9)	CountEpisode for 2021/22 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
⊟	**4,213**	**2,529**	**3,495**	**2,774**	**13,011**	**3,290**	**1,929**	**2,653**	**2,774**	**-16%**
⊞ Cambridge University Hospitals Nhs Foundation tr	80	27	44	58	**209**	60	23	33	58	-3%
⊞ Great Ormond Street Hospital For Children nhs fo	326	193	354	195	**1,068**	267	161	306	195	-27%
⊞ Guy's And St Thomas' Nhs foundation trust	446	182	326	286	**1,240**	368	136	239	286	-22%
⊞ Imperial College Healthcare Nhs Trust	302	131	239	238	**910**	246	93	180	238	-3%
⊞ King's College Hospital Nhs Foundation trust	130	61	93	75	**359**	98	47	72	75	-23%
⊞ Leeds Teaching Hospitals Nhs Trust	80	24	56	21	**181**	68	23	42	21	-69%
⊞ Royal Free London Nhs Foundation trust	193	121	170	155	**639**	151	95	125	155	3%
⊞ Royal Papworth Hospital Nhs Foundation trust	105	32	63	48	**248**	85	28	45	48	-44%
⊞ The Newcastle Upon Tyne Hospitals nhs foundation	132	103	60	44	**339**	98	82	42	44	-55%
⊞ The Royal Marsden Nhs Foundation trust	52	54	57	61	**224**	41	41	44	61	49%
⊞ The Royal Orthopaedic Hospital Nhs foundation tr	159	98	145	103	**505**	121	66	111	103	-15%
⊞ University College London Hospitals Nhs foundati	357	216	350	326	**1,249**	277	183	246	326	18%
⊞ University Hospitals Bristol And Weston nhs foun	1,851	1,287	1,538	1,164	**5,840**	1,410	951	1,168	1,164	-17%
⊟ **Major North Wales provider**	**14,810**	**9,783**	**12,735**	**9,889**	**47,217**	**11,185**	**7,207**	**9,521**	**9,889**	**-12%**
⊞ Alder Hey Children's Nhs Foundation trust	3,669	2,816	3,205	2,677	**12,367**	2,831	2,053	2,395	2,677	-5%
⊞ Liverpool Heart And Chest Hospital nhs foundatio	1,400	1,129	1,542	1,096	**5,167**	1,039	804	1,183	1,096	5%
⊞ Liverpool University Hospitals Nhs Foundation tr	2,572	1,454	2,104	1,741	**7,871**	1,966	1,079	1,506	1,741	-11%
⊞ Manchester University Nhs Foundation Trust	1,106	571	973	579	**3,229**	830	408	715	579	-30%
⊞ Salford Royal Nhs Foundation Trust	301	109	166	181	**757**	214	81	120	181	-15%
⊞ Sheffield Teaching Hospitals Nhs Foundation trus	221	155	196	173	**745**	172	123	153	173	1%
⊞ St Helens And Knowsley Teaching Hospitals nhs tr	1,655	1,010	1,371	1,071	**5,107**	1,234	763	1,033	1,071	-13%
⊞ The Christie Nhs Foundation Trust	620	542	486	404	**2,052**	441	382	393	404	-8%
⊞ The Clatterbridge Cancer Centre Nhs foundation t	351	212	302	136	**1,001**	296	155	238	136	-54%
⊞ The Walton Centre Nhs Foundation trust	1,895	1,170	1,651	1,232	**5,948**	1,429	851	1,252	1,232	-14%
⊞ Wirral University Teaching Hospital Nhs foundati	1,020	615	739	599	**2,973**	733	508	533	599	-18%
⊟ **Major Powys provider**	**17,649**	**11,590**	**15,701**	**12,455**	**57,395**	**13,340**	**8,466**	**11,978**	**12,455**	**-7%**
⊞ Birmingham Women's And Children's Nhs foundation	413	313	403	279	**1,408**	311	231	292	279	-10%
⊞ The Robert Jones And Agnes Hunt Orthopaedic hospit	5,188	2,192	3,913	3,138	**14,431**	3,875	1,596	3,039	3,138	-19%
⊞ University Hospitals Birmingham Nhs Foundation t	1,154	702	890	747	**3,493**	876	570	641	747	-15%
⊞ University Hospitals Of North Midlands nhs trust	903	738	829	702	**3,172**	692	528	650	702	1%
⊞ Wye Valley Nhs Trust	9,991	7,645	9,666	7,589	**34,891**	7,586	5,541	7,356	7,589	0%
Total	**36,672**	**23,902**	**31,931**	**25,118**	**117,623**	**27,815**	**17,602**	**24,152**	**25,118**	**-10%**

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	2021/22										2022/23									
PatientResidenceHealthOrganisationDerivedName	4	5	6	7	8	9	10	11	12	**Total**	1	2	3	4	5	6	7	8	9	**Total**
Aneurin Bevan University Local Health Board	142	138	164	164	157	111	132	146	146	**1,770**	125	153	175	161	145	171	156	187	160	**1,433**
Betsi Cadwaladr University Local Health Board	1,221	1,174	1,220	1,264	1,374	1,279	1,172	1,197	1,325	**14,957**	1,204	1,346	1,303	1,361	1,432	1,302	1,345	1,377	1,088	**11,758**
Cardiff and Vale University Local Health Board	70	75	80	79	78	62	57	62	74	**794**	94	72	63	70	76	72	87	67	56	**657**
Cwm Taf Morgannwg University Local Health Board	79	60	70	58	61	57	43	38	78	**709**	81	60	51	51	42	52	53	71	36	**497**
Hywel Dda University Local Health Board	64	48	66	77	47	66	57	67	91	**779**	75	66	54	70	83	53	69	87	60	**617**
Powys Teaching Local Health Board	1,019	867	912	882	927	905	824	833	949	**10,913**	807	1,042	903	1,025	955	970	920	1,078	907	**8,607**
Swansea Bay University Local Health Board	49	52	41	50	39	46	26	29	64	**509**	37	47	51	42	59	63	59	39	49	**446**
Total	**2,644**	**2,414**	**2,553**	**2,574**	**2,683**	**2,526**	**2,311**	**2,372**	**2,727**	**30,431**	**2,423**	**2,786**	**2,600**	**2,780**	**2,792**	**2,683**	**2,689**	**2,906**	**2,356**	**24,015**

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 - full years except 2022/23 (data: DHCW)

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	2022/23
(Unknown)			2	13
Accident & Emergency	384	194	298	176
Adult Cystic Fibrosis Service	69	34	17	8
Adult Mental Illness	2			2
Allergy Service	91	54	137	70
Anaesthetics	20	15	156	107
Blood And Marrow Transplantation	137	83	113	56
Breast Surgery	89	61	84	70
Burns Care	95	77	78	42
Cardiac Rehabilitation				2
Cardiac Surgery	602	376	579	438
Cardiology	1,665	1,330	1,790	1,430
Cardiothoracic Surgery	72	52	63	66
Cardiothoracic Transplantation	71	29	53	32
Chemical Pathology	3	2		1
Child & Adolescent Psychiatry		2	2	1
Clinical Genetics	1		1	
Clinical Haematology	1,055	926	1,008	655
Clinical Immunology	22	6		17
Clinical Immunology And	17	15	46	14
Clinical Microbiology		2		
Clinical Neurophysiology	4		2	2
Clinical Oncology (previously Radiotherapy)	491	406	362	254
Clinical Pharmacology	7	23	20	6
Colorectal Surgery	270	204	242	172
Community Paediatrics				
Congenital Heart Disease	29	28	30	17
Critical Care Medicine	201	116	166	147
Dental Medicine Specialties		1	2	1
Dermatology	503	404	401	276
Total	**36,672**	**23,902**	**31,931**	**25,118**

TreatmentSpecialtyDescription	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2020/21 (M1-9)	CountEpisode for 2021/22 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
(Unknown)				13	
Accident & Emergency	315	150	224	176	-44%
Adult Cystic Fibrosis Service	55	29	15	8	-85%
Adult Mental Illness	1			2	100%
Allergy Service	65	28	86	70	8%
Anaesthetics	19	7	114	107	463%
Blood And Marrow Transplantation	97	70	100	56	-42%
Breast Surgery	59	46	60	70	19%
Burns Care	66	65	63	42	-36%
Cardiac Rehabilitation				2	
Cardiac Surgery	436	300	430	438	0%
Cardiology	1,264	943	1,366	1,430	13%
Cardiothoracic Surgery	59	38	49	66	12%
Cardiothoracic Transplantation	63	21	39	32	-49%
Chemical Pathology	3	1		1	-67%
Child & Adolescent Psychiatry		2	2	1	
Clinical Genetics	1		1		
Clinical Haematology	777	685	770	655	-16%
Clinical Immunology	14	5		17	21%
Clinical Immunology And	12	8	36	14	17%
Clinical Microbiology		2			
Clinical Neurophysiology	3		2	2	-33%
Clinical Oncology (previously Radiotherapy)	389	294	291	254	-35%
Clinical Pharmacology	6	15	14	6	0%
Colorectal Surgery	195	124	193	172	-12%
Community Paediatrics					
Congenital Heart Disease	16	17	22	17	6%
Critical Care Medicine	148	92	117	147	-1%
Dental Medicine Specialties		1	2	1	
Dermatology	344	284	297	276	-20%
Total	**27,815**	**17,602**	**24,152**	**25,118**	**-10%**

Episodes by provider - full years except 2022/23 (data: DHCW)

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	2022/23
Diabetic Medicine	29	20	29	19
Diagnostic Imaging	199	186	217	185
Endocrinology	91	72	109	75
ENT	322	127	222	155
Gastroenterology	1,695	1,343	1,852	1,364
General Medicine	3,018	2,431	2,562	1,698
General Surgery	1,799	1,101	1,445	1,291
Geriatric Medicine	376	367	441	420
Gynaecological Oncology	9	17	12	12
Gynaecology	448	238	364	326
Haemophilia Service		3	4	6
Hepatobiliary & Pancreatic Surgery	297	188	233	236
Hepatology	216	194	207	123
Infectious Diseases	38	17	28	15
Intermediate Care			2	2
Interventional Radiology	138	103	161	131
Maxillo-Facial Surgery	110	29	34	32
Medical Oncology	474	266	380	276
Midwifery Service	15	10	7	9
Neonatology	77	74	92	77
Nephrology	425	303	385	310
Neurology	962	652	925	664
Neurosurgery	1,376	830	1,103	805
Nuclear Medicine	9	6	15	23
Obstetrics Hospital Bed	343	366	419	310
Ophthalmology	1,530	689	1,119	922
Oral Surgery	198	101	112	88
Orthoptics	1			
Orthotics			1	
Paediatric Audiological		1		
Total	**36,672**	**23,902**	**31,931**	**25,118**

TreatmentSpecialtyDescription	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2020/21 (M1-9)	CountEpisode for 2021/22 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
Diabetic Medicine	22	15	16	19	-14%
Diagnostic Imaging	159	131	166	185	16%
Endocrinology	67	57	81	75	12%
ENT	254	106	171	155	-39%
Gastroenterology	1,273	905	1,339	1,364	7%
General Medicine	2,329	1,753	2,004	1,698	-27%
General Surgery	1,407	832	1,074	1,291	-8%
Geriatric Medicine	288	272	328	420	46%
Gynaecological Oncology	8	12	7	12	50%
Gynaecology	341	186	288	326	-4%
Haemophilia Service		3	2	6	
Hepatobiliary & Pancreatic Surgery	225	138	172	236	5%
Hepatology	162	153	160	123	-24%
Infectious Diseases	27	10	24	15	-44%
Intermediate Care			2	2	
Interventional Radiology	105	76	110	131	25%
Maxillo-Facial Surgery	84	25	26	32	-62%
Medical Oncology	379	196	301	276	-27%
Midwifery Service	13	6	6	9	-31%
Neonatology	60	53	62	77	28%
Nephrology	333	274	255	310	-7%
Neurology	718	465	695	664	-8%
Neurosurgery	1,037	627	846	805	-22%
Nuclear Medicine	9	5	8	23	156%
Obstetrics Hospital Bed	261	272	316	310	19%
Ophthalmology	1,030	527	830	922	-10%
Oral Surgery	161	76	86	88	-45%
Orthoptics					
Orthotics			1		
Paediatric Audiological		1			
Total	**27,815**	**17,602**	**24,152**	**25,118**	**-10%**

Episodes by provider - full years except 2022/23 (data: DHCW)

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	2022/23
Paediatric Burns Care	58	53	41	26
Paediatric Cardiac Surgery	153	159	162	112
Paediatric Cardiology	355	267	325	234
Paediatric Clinical Haematology	354	162	227	148
Paediatric Clinical Immunology And Allergy Service	47	18	22	34
Paediatric Dentistry	52	28	35	29
Paediatric Dermatology	31	18	38	29
Paediatric Diabetic Medicine		3	1	
Paediatric Ear Nose and Throat	205	107	148	85
Paediatric Endocrinology	122	78	101	72
Paediatric Epilepsy	24	11	12	7
Paediatric Gastroenterology	221	217	342	288
Paediatric Infectious Diseases	1			
Paediatric Intensive Care	158	132	185	96
Paediatric Interventional Radiology	26	12	20	16
Paediatric Maxillo-Facial	2	1	6	7
Paediatric Medical Oncology	679	553	448	479
Paediatric Metabolic Disease	17	17	19	15
Paediatric Nephrology	367	267	322	199
Paediatric Neuro-Disability		2	1	
Paediatric Neurology	151	99	120	73
Paediatric Neurosurgery	193	141	180	133
Paediatric Ophthalmology	95	94	109	67
Paediatric Pain Management			1	
Paediatric Plastic Surgery	187	141	164	164
Paediatric Respiratory Medicine	158	100	125	78
Paediatric Rheumatology	103	95	91	85
Paediatric Surgery	513	440	442	347
Paediatric Thoracic Surgery	6	2	5	2
Paediatric Transplantation	10	2	9	5
Total	**36,672**	**23,902**	**31,931**	**25,118**

TreatmentSpecialtyDescription	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2020/21 (M1-9)	CountEpisode for 2021/22 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
Paediatric Burns Care	47	41	32	26	-45%
Paediatric Cardiac Surgery	122	126	123	112	-8%
Paediatric Cardiology	281	204	241	234	-17%
Paediatric Clinical Haematology	255	105	168	148	-42%
Paediatric Clinical Immunology And Allergy Service	35	10	15	34	-3%
Paediatric Dentistry	41	25	29	29	-29%
Paediatric Dermatology	25	17	30	29	16%
Paediatric Diabetic Medicine		1			
Paediatric Ear Nose and Throat	161	71	121	85	-47%
Paediatric Endocrinology	94	52	77	72	-23%
Paediatric Epilepsy	21	9	12	7	-67%
Paediatric Gastroenterology	172	155	237	288	67%
Paediatric Infectious Diseases	1				
Paediatric Intensive Care	124	110	149	96	-23%
Paediatric Interventional Radiology	21	8	14	16	-24%
Paediatric Maxillo-Facial Surgery	2	1	5	7	250%
Paediatric Medical Oncology	492	438	291	479	-3%
Paediatric Metabolic Disease	11	10	16	15	36%
Paediatric Nephrology	303	190	256	199	-34%
Paediatric Neuro-Disability		2	1		
Paediatric Neurology	125	74	92	73	-42%
Paediatric Neurosurgery	154	108	138	133	-14%
Paediatric Ophthalmology	67	66	85	67	0%
Paediatric Pain Management			1		
Paediatric Plastic Surgery	149	102	126	164	10%
Paediatric Respiratory Medicine	119	71	95	78	-34%
Paediatric Rheumatology	81	66	73	85	5%
Paediatric Surgery	379	337	344	347	-8%
Paediatric Thoracic Surgery	6		3	2	-67%
Paediatric Transplantation	7	2	5	5	-29%
Total	**27,815**	**17,602**	**24,152**	**25,118**	**-10%**

Episodes by provider - full years except 2022/23 (data: DHCW)

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	2022/23
Paediatric Rheumatology	103	95	91	85
Paediatric Surgery	513	440	442	347
Paediatric Thoracic Surgery	6	2	5	2
Paediatric Transplantation Surgery	10	2	9	5
Paediatric Trauma and Orthopaedics	143	95	131	136
Paediatric Urology	331	235	325	280
Paediatrics	708	361	413	477
Pain Management	126	75	52	43
Palliative Medicine	1	5	4	
Physiotherapy				1
Plastic Surgery	1,490	939	1,316	1,092
Podiatric Surgery	109	22	78	68
Psychotherapy				3
Rehabilitation Service	46	37	32	21
Respiratory Medicine	875	510	665	719
Respiratory Physiology	4	3	4	10
Restorative Dentistry	2	3	1	
Rheumatology	728	550	902	783
Spinal Injuries	235	84	96	104
Spinal Surgery Service	27	39	35	64
Stroke Medicine	157	171	166	130
Thoracic Surgery	309	210	344	250
Transient Ischaemic Attack				1
Transplantation Surgery	242	158	163	143
Trauma & Orthopaedics	5,429	2,170	4,089	3,291
Tropical Medicine	2		2	1
Upper Gastrointestinal Surgery	87	46	72	73
Urology	1,103	718	1,107	856
Vascular Surgery	113	64	79	74
Well Babies	22	14	22	19
Total	**36,672**	**23,902**	**31,931**	**25,118**

TreatmentSpecialtyDescription	CountEpisode for 2019/20 (M1-9)	CountEpisode for 2020/21 (M1-9)	CountEpisode for 2021/22 (M1-9)	CountEpisode for 2022/23 (M1-9)	CountEpisode 2022/23 % diff from 19/20
Paediatric Rheumatology	81	66	73	85	5%
Paediatric Surgery	379	337	344	347	-8%
Paediatric Thoracic Surgery	6		3	2	-67%
Paediatric Transplantation Surgery	7	2	5	5	-29%
Paediatric Trauma and Orthopaedics	112	69	98	136	21%
Paediatric Urology	244	158	266	280	15%
Paediatrics	513	267	323	477	-7%
Pain Management	102	57	41	43	-58%
Palliative Medicine	1	2	3		
Physiotherapy				1	
Plastic Surgery	1,162	706	970	1,092	-6%
Podiatric Surgery	95	17	60	68	-28%
Psychotherapy				3	
Rehabilitation Service	33	28	22	21	-36%
Respiratory Medicine	683	359	499	719	5%
Respiratory Physiology	4	3	2	10	150%
Restorative Dentistry	2	3	1		
Rheumatology	555	377	676	783	41%
Spinal Injuries	188	66	77	104	-45%
Spinal Surgery Service	21	25	25	64	205%
Stroke Medicine	132	128	135	130	-2%
Thoracic Surgery	245	153	260	250	2%
Transient Ischaemic Attack				1	
Transplantation Surgery	167	125	110	143	-14%
Trauma & Orthopaedics	4,055	1,650	3,158	3,291	-19%
Tropical Medicine	2			1	-50%
Upper Gastrointestinal Surgery	65	37	53	73	12%
Urology	880	512	850	856	-3%
Vascular Surgery	86	50	58	74	-14%
Well Babies	14	6	17	19	36%
Total	**27,815**	**17,602**	**24,152**	**25,118**	**-10%**

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 and 2022/23 (All-Wales and each Health Board of residence)

4.1 All-Wales:

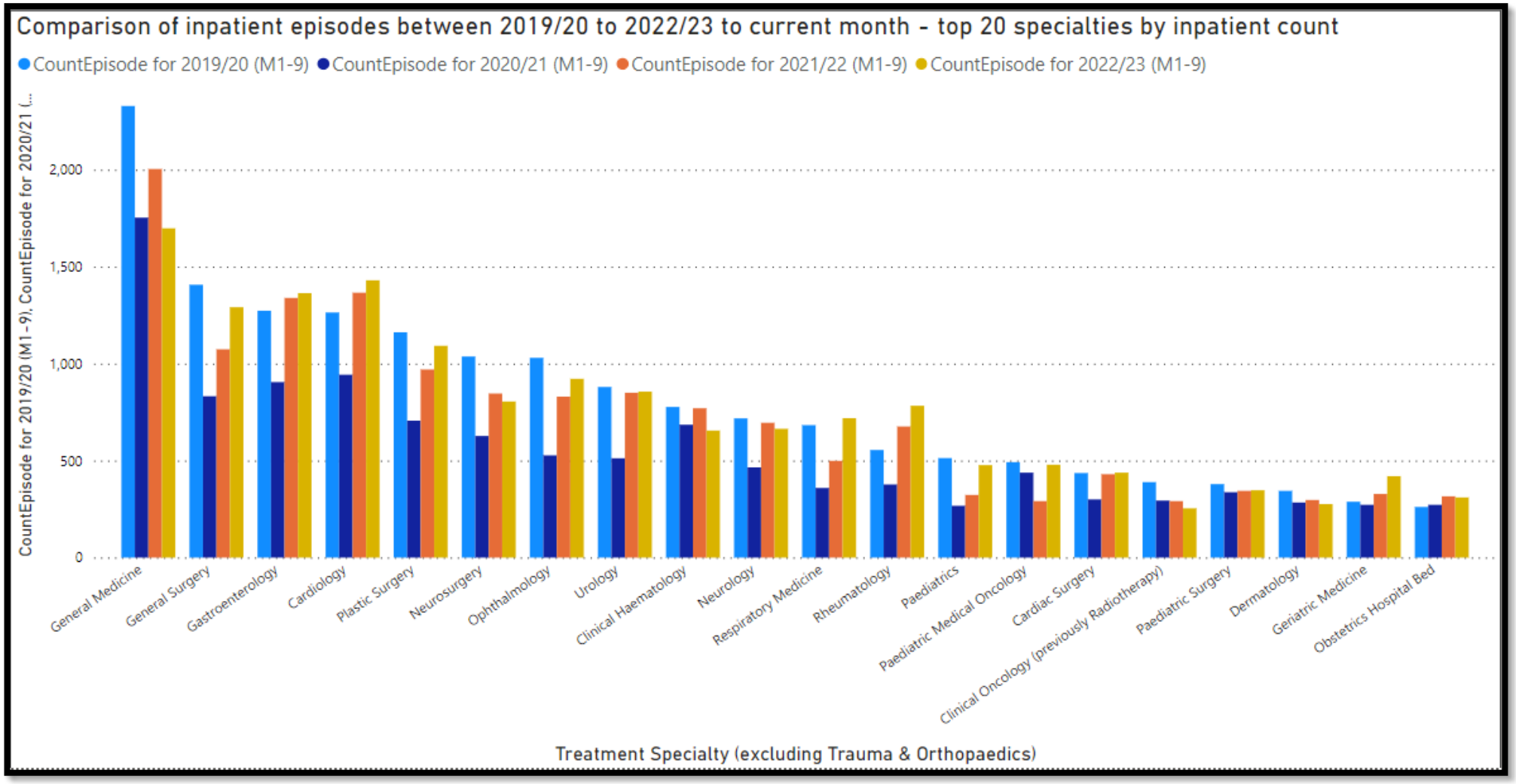


Table 4.2 – Aneurin Bevan UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23

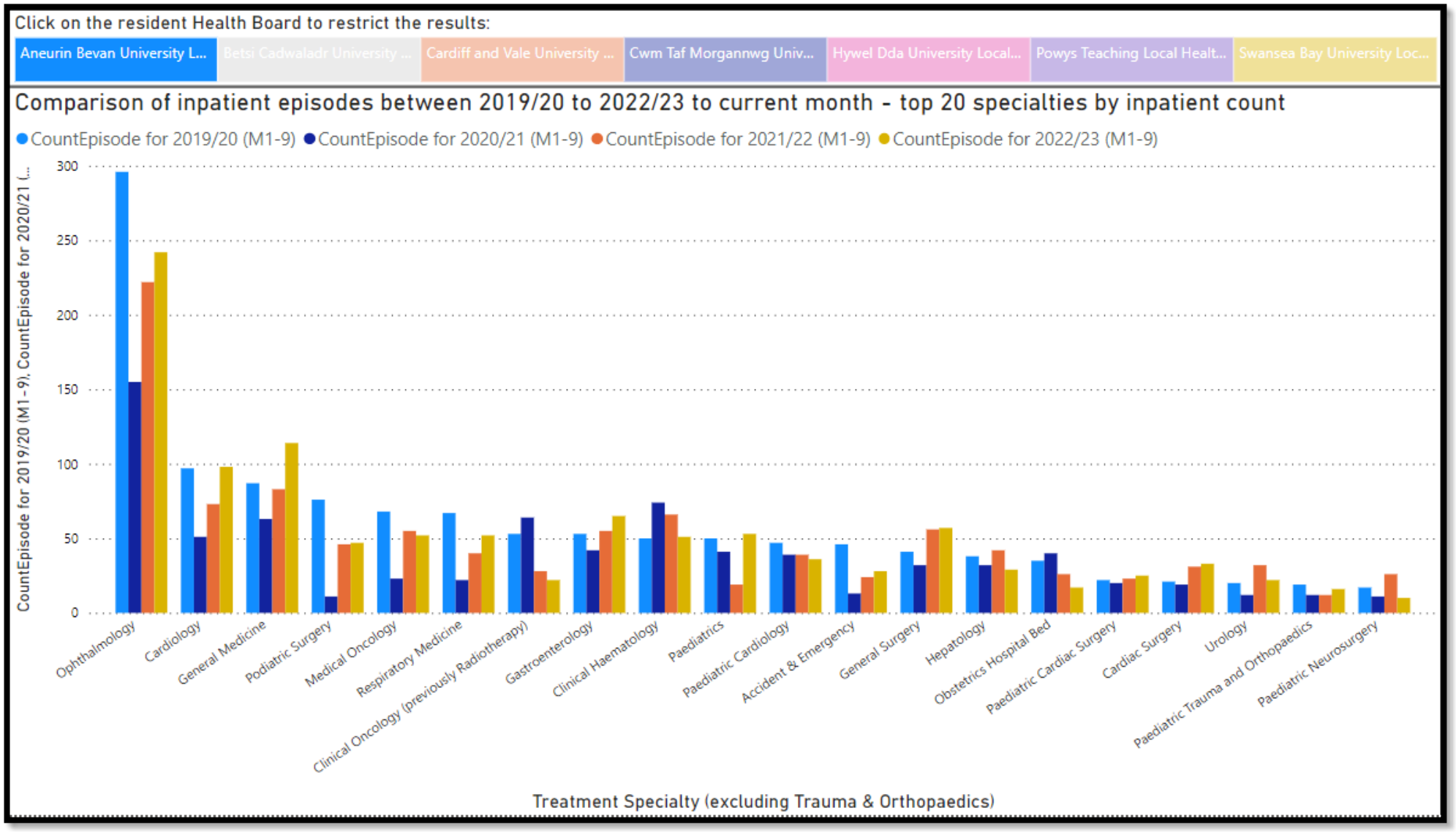


Table 4.3 – Betsi Cadwaladr UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23

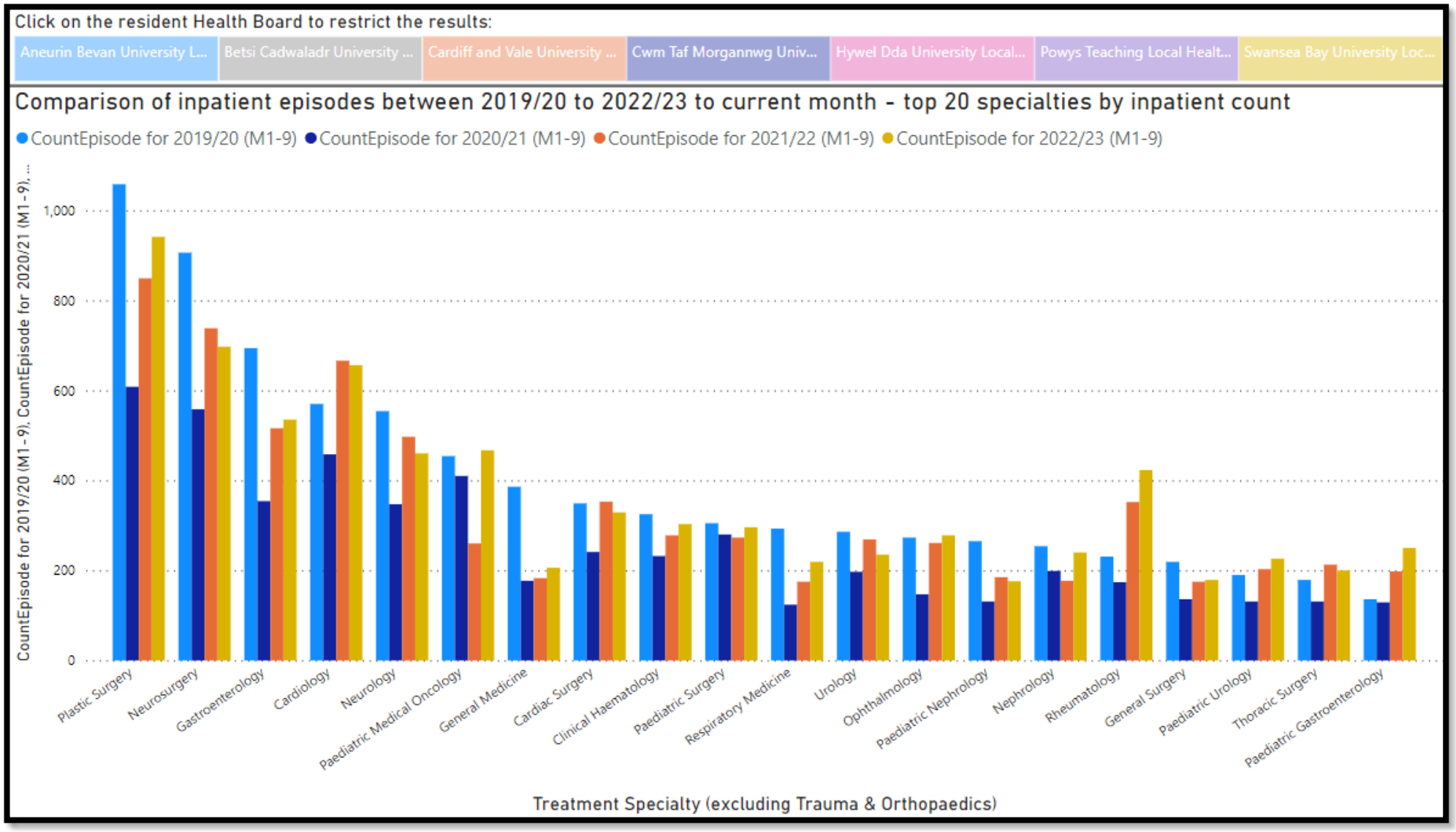


Table 4.4 – Cardiff & Vale UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23

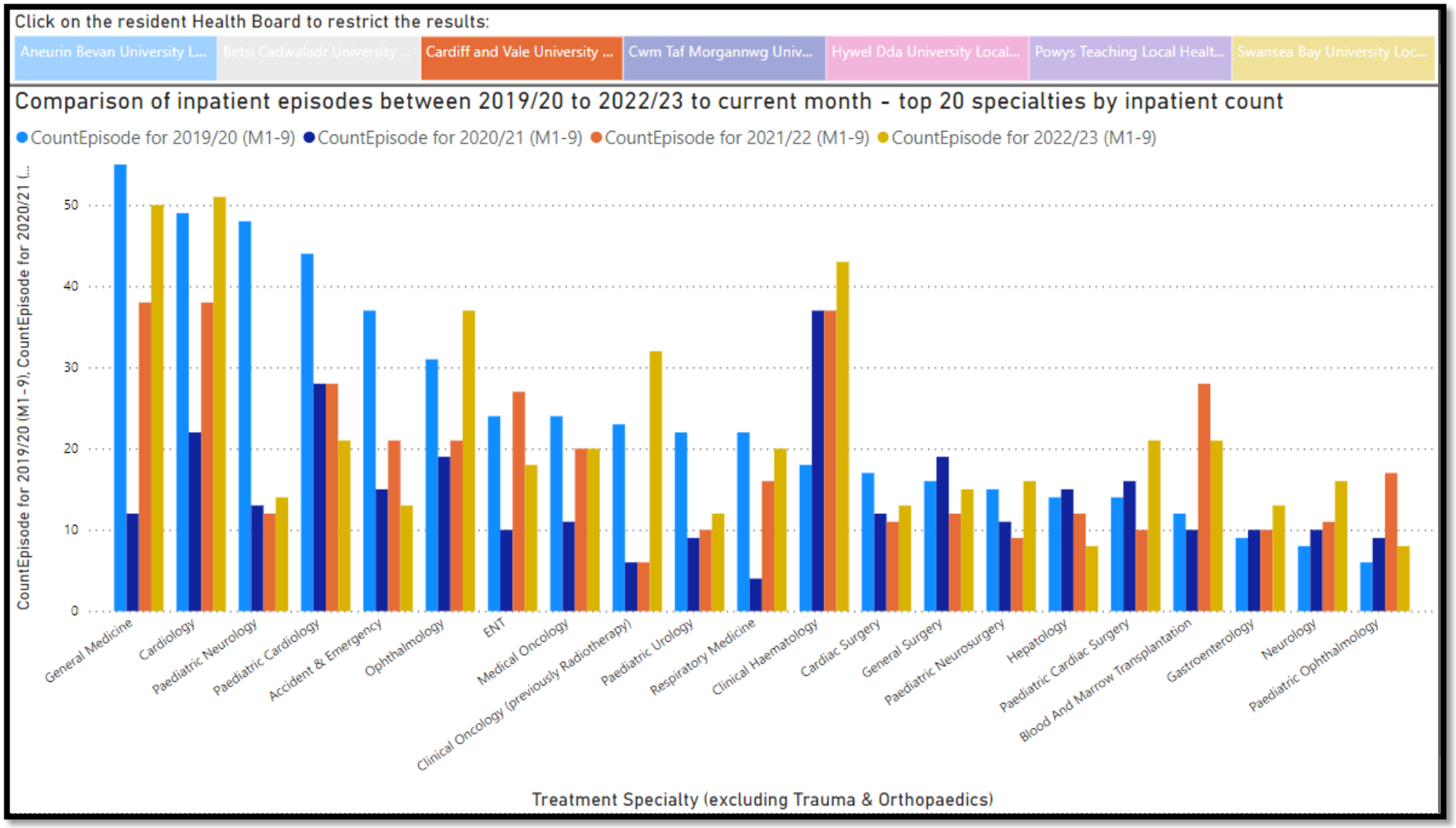


Table 4.5 – Cwm Taf Morgannwg UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23

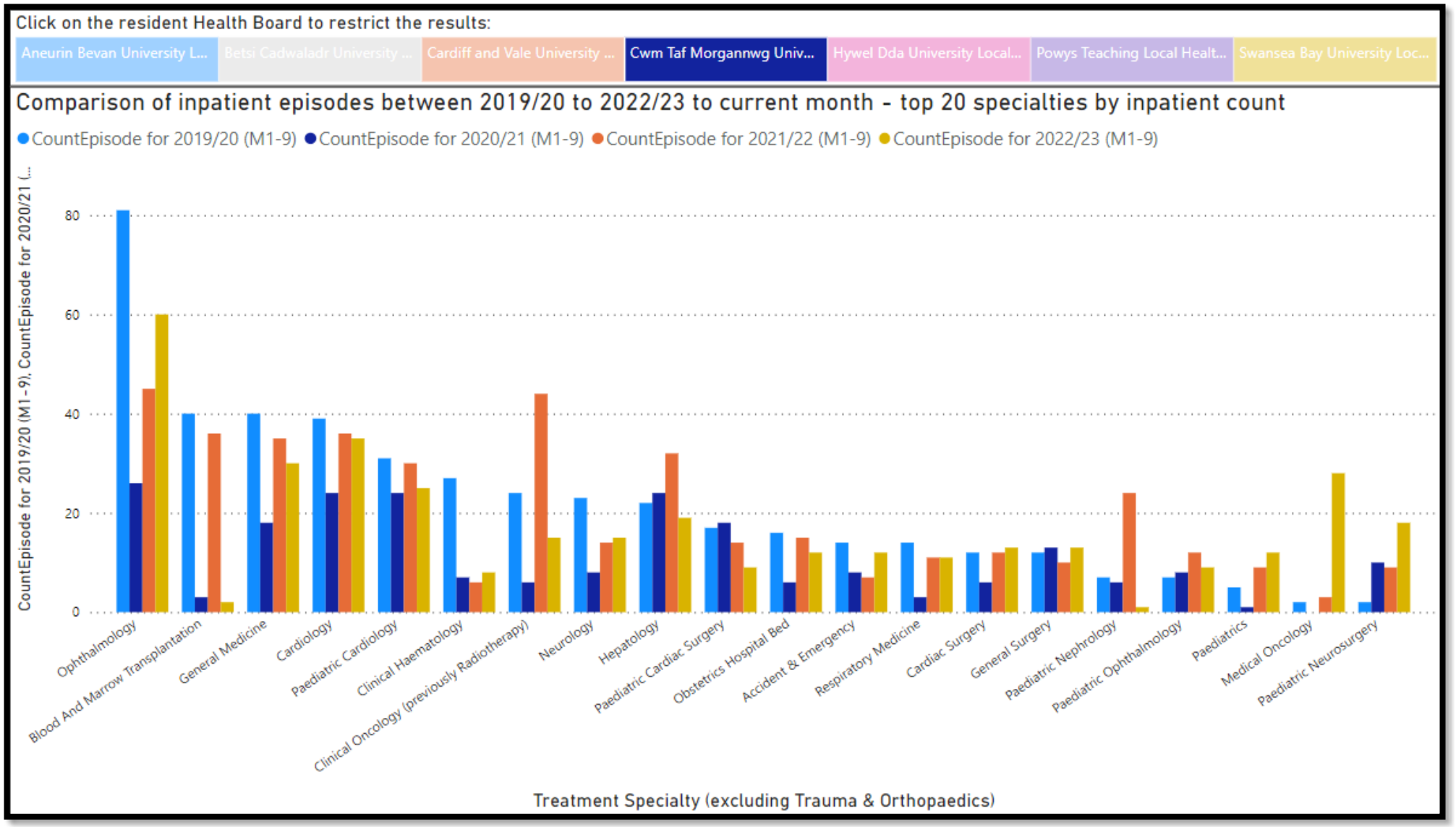


Table 4.6 – Hywel Dda HB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23

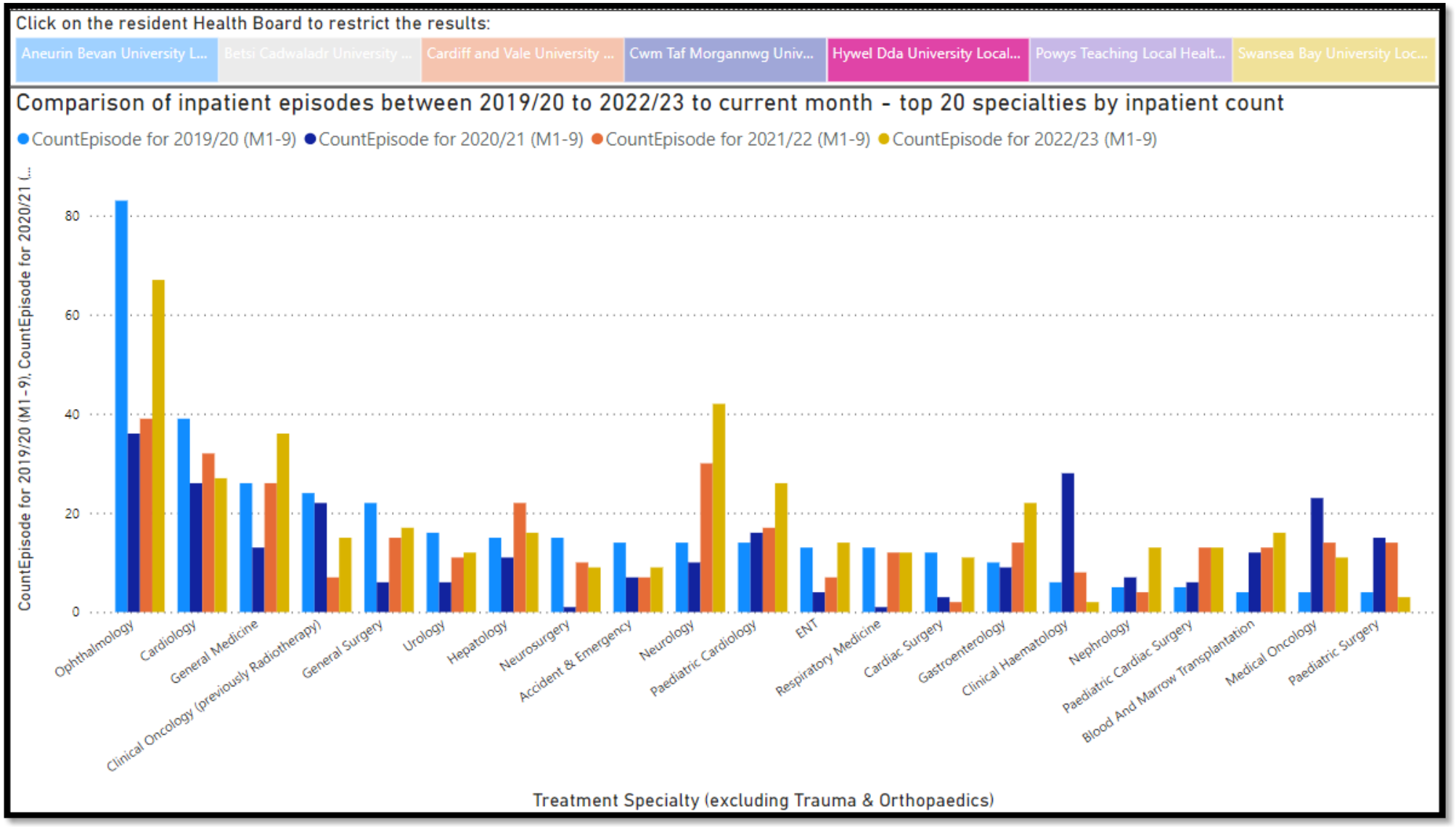


Table 4.7 – Powys THB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23

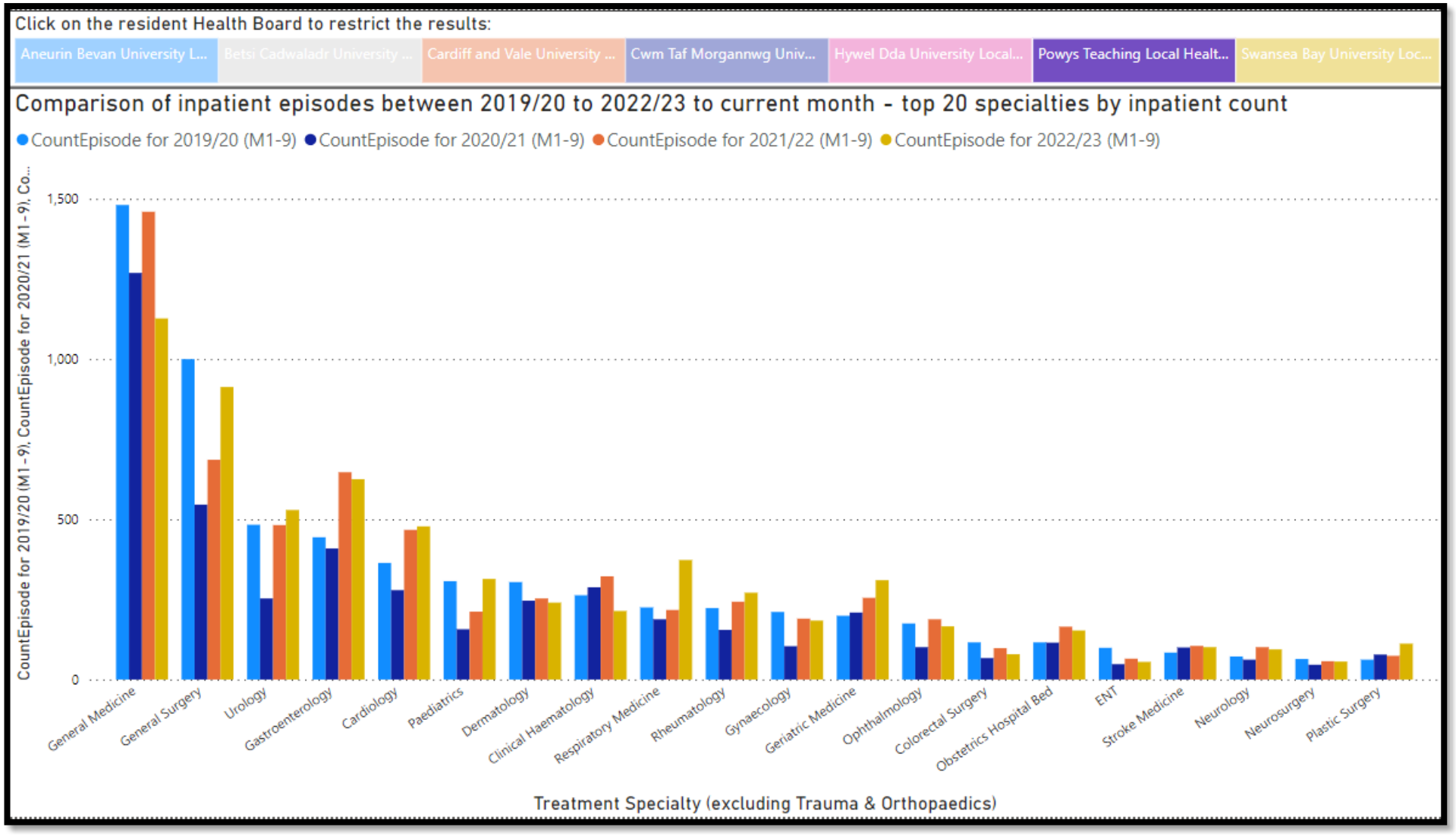
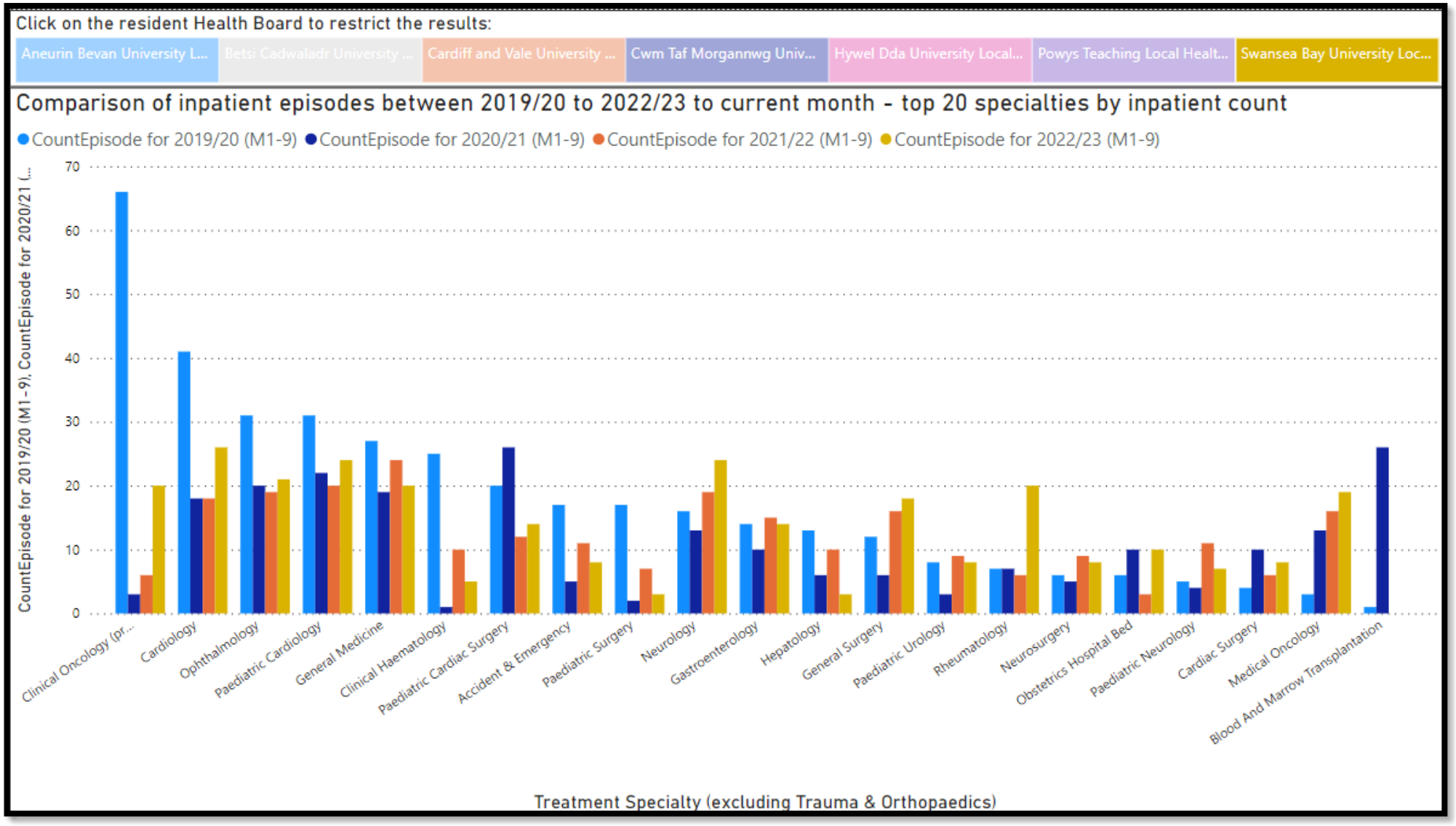


Table 4.8 – Swansea Bay UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23



APPENDIX 2

New Welsh Government performance measures

New performance measures were announced by Welsh Government in January 2022, with a new Performance Framework for 2022/23, as per the below extracts.

		Performance Measure	Target	Reporting Frequency	Source	Ministerial Priority
Elective Planned Care	38	**Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)**	**Improvement trajectory towards a national target of 80% by 2026**	**Monthly**	**Suspected Cancer Pathway Data Set (NDR – DHCW)**	✓
			Rationale: An early diagnosis and treatment of cancer will increase an individual's chance of survival and reduce the likely harm to the individual's health and quality of life. Therefore, there is a need to diagnose and treat patients with cancer as promptly as possible. This measure includes all suspected cancers and starts from the point a patient is suspected of having cancer.			
	39	**Number of patients waiting over 8 weeks for a diagnostic endoscopy**	**Improvement trajectory towards a national target of zero by Spring 2024**	**Monthly**	**Diagnostic & Therapies Waiting Times Dataset**	✓
			Rationale: Endoscopy services play an essential part in investigating suspected cancer and serious non-cancerous conditions such as inflammatory bowel disease. Due to population changes, a lower threshold for suspected cancer investigation and increasing cancer surveillance, the demand for endoscopy services is out of balance with core capacity. To address this, an improvement plan has been introduced to support health boards to develop sustainable endoscopy services.			
Elective Planned Care	40	**Number of patients waiting more than 8 weeks for a specified diagnostic**	**12 month reduction trend towards zero by spring 2024**	**Monthly**	**Diagnostic & Therapies Waiting Times Dataset**	
			Rationale: Diagnostic tests and investigations are used to identify a patient's condition, disease or injury. Diagnostic testing provides essential information to enable clinicians and patients to make the right clinical decisions. Early detection and diagnosis can prevent the patient suffering unnecessary pain and it can reduce the scale and cost of treatment.			
	41	**Number of patients waiting more than 14 weeks for a specified therapy**	**12 month reduction trend towards zero by spring 2024**	**Monthly**	**Diagnostic & Therapies Waiting Times Dataset**	
			Rationale: Patients receiving timely access to a specified therapy should experience improved outcomes. Reducing the time that a patient waits for a therapy service reduces the risk of the condition deteriorating and alleviates the patient's symptoms sooner. This measure provides greater transparency and encourages improvement in the timeliness of accessing NHS therapy services.			
	42	**Number of patients waiting over 52 weeks for a new outpatient appointment**	**Improvement trajectory towards eliminating over 52 week waits by 31 December 2022**	**Monthly**	**Referral to Treatment (combined) Dataset**	✓
			Rationale: The number of patients waiting for a new outpatient appointment has increased year on year whilst capacity has been unable to meet demand. NHS organisations are required to improve service planning and clinical pathways to deliver sustainable planned care services, where waiting lists are reduced to a manageable level.			
	43	**Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%**	**Improvement trajectory towards a reduction of 30% by March 2023 against a baseline of March 2021**	**Monthly**	**Outpatient Follow-Up Delay Monitoring Return (Welsh Government)**	✓
			Rationale: Delaying a follow-up outpatient appointment not only gives the service user a negative impression of NHS services, but it can be a clinical risk if the patient's condition deteriorates whilst waiting for the appointment. Through service re-design, health boards are required to reduce the number of patients waiting long delays for a follow-up outpatient appointment.			

		Performance Measure	Target	Reporting Frequency	Source	Ministerial Priority
Elective Planned Care	45	**Number of patients waiting more than 104 weeks for referral to treatment**	**Improvement trajectory towards a national target of zero by 2024**	**Monthly**	**Referral to Treatment (combined) Dataset**	✓
			Rationale: Patients receiving timely access to high quality elective treatment and care should experience improved outcomes. Reducing the time that a patient waits for treatment reduces the risk of the condition deteriorating and alleviates the patient's symptoms, pain and discomfort sooner. This measure provides greater transparency and encourages improvement in the timeliness of treatment across NHS services.			
	46	**Number of patients waiting more than 36 weeks for referral to treatment**	**Improvement trajectory towards a national target of zero by 2026**	**Monthly**	**Referral to Treatment (combined) Dataset**	✓
			Rationale: As above.			
	47	**Percentage of patients waiting less than 26 weeks for referral to treatment**	**Improvement trajectory towards a national target of 95% by 2026**	**Monthly**	**Referral to Treatment (combined) Dataset**	✓
			Rationale: As above.			

Please note the above schedule was slightly updated with the Planning Framework for the 23-26 ICP templates, as follows; this relates to the above measure numbers 42 and 45 and will be reported on from April onwards.

- **Planned Care, Recovery, Diagnostics and Pathways of Care**

52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by 30 June 2023 and maintained throughout 2023/24 moving to 36 weeks RTT standards by March 2024

This appendix contains the available performance data against the following specialties:

- Cardiac Surgery
- Thoracic Surgery
- Neurosurgery
- Plastic Surgery
- Paediatric Surgery

Please note that the Referral to Treatment (RTT) dataset does not split out the pathway point (eg. New outpatient, Inpatient treatment) for English providers, so the total patient set has been used.

The Suspected Cancer Pathway dataset is held by DHCW, and is currently being discussed internally by them around the format to make this data available (measure 38).

The Outpatient Follow-up delay data (measure 43) is available only from Welsh Government direct, but is reported by provider as totals, so is not applicable for Specialist-only reporting.

Cardiac Surgery (measures 42, 45-47)

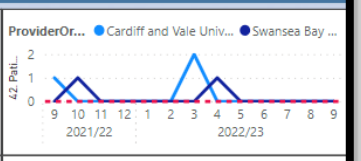
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WG Recovery measures - Cardiac Surgery (Welsh providers)
(DHCW RTT data; target lines in red dots)

42. Patients waiting more than 52 weeks for a new outpatient appointment

Target - Improvement trajectory towards a national target of 0 by December 2022

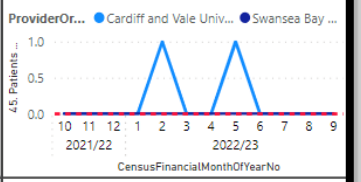
CensusFinancialYearStyle	2021/22									2022/23								
ProviderOrganisationCurrentName	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	0	0	0	0	1	0	0	0	0	0	2	0	0	0	0	0	0
Swansea Bay University Local Health Board	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**2**	**1**	**0**	**0**	**0**	**0**	**0**



45. Patients waiting more than 104 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2024

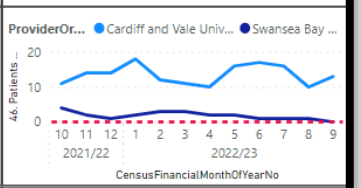
CensusFinancialYearStyle	2021/22									2022/23								
ProviderOrganisationCurrentName	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	1	1	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0
Swansea Bay University Local Health Board	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**



46. Patients waiting more than 36 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2026

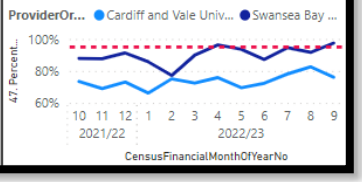
CensusFinancialYearStyle	2021/22				2022/23								
ProviderOrganisationCurrentName	9	10	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	9	11	14	14	18	12	11	10	16	17	16	10	13
Swansea Bay University Local Health Board	8	4	2	1	2	3	3	2	2	1	1	1	0
Total	**17**	**15**	**16**	**15**	**20**	**15**	**14**	**12**	**18**	**18**	**17**	**11**	**13**



47. Percentage of patients waiting less than 26 weeks for treatment

Target - Improvement trajectory towards a national target of 95% by 2026

CensusFinancialYearStyle	2022/23								
ProviderOrganisationCurrentName	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	66%	75%	73%	76%	70%	72%	78%	83%	76%
Swansea Bay University Local Health Board	86%	77%	90%	96%	94%	87%	95%	92%	98%
Total	**74%**	**76%**	**79%**	**84%**	**77%**	**76%**	**82%**	**85%**	**82%**



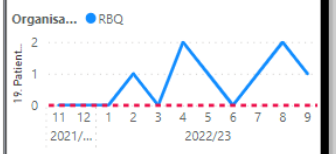
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WG Recovery measures - Cardiac Surgery (Liverpool Heart & Chest)
(Data from provider; target lines in red dots)

42. Patients waiting more than 52 weeks for a new outpatient appointment

Target - Improvement trajectory towards a national target of 0 by December 2022

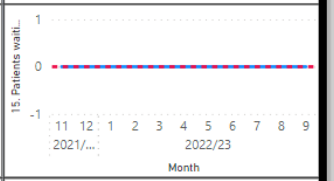
Fyear	2021/22												2022/23								
Organisation Code (Code of Provider)	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
RBQ	3	2	1	0	2	0	1	1	1	0	0	0	0	1	0	2	1	0	1	2	1
Total	**3**	**2**	**1**	**0**	**2**	**0**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**2**	**1**	**0**	**1**	**2**	**1**



45. Patients waiting more than 104 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2024

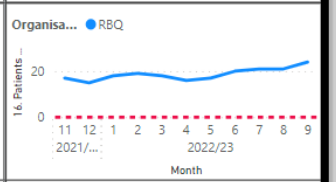
Fyear	2021/22												2022/23								
Organisation Code (Code of Provider)	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
RBQ	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**



46. Patients waiting more than 36 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2026

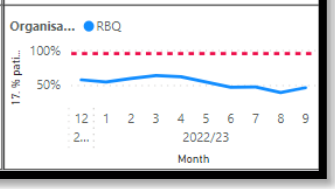
Fyear	2021/22												2022/23								
Organisation Code (Code of Provider)	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9			
RBQ	22	26	22	21	21	22	25	17	15	18	19	18	16	17	20	21	21	24			
Total	**22**	**26**	**22**	**21**	**21**	**22**	**25**	**17**	**15**	**18**	**19**	**18**	**16**	**17**	**20**	**21**	**21**	**24**			



47. Percentage of patients waiting less than 26 weeks for treatment

Target - Improvement trajectory towards a national target of 95% by 2026

Fyear	2021/22				2022/23								
Organisation Code (Code of Provider)	10	11	12	1	2	3	4	5	6	7	8	9	
RBQ	59%	50%	58%	54%	59%	64%	62%	54%	47%	47%	39%	46%	
Total	**59%**	**50%**	**58%**	**54%**	**59%**	**64%**	**62%**	**54%**	**47%**	**47%**	**39%**	**46%**	



Thoracic Surgery (measures 42, 45-47)

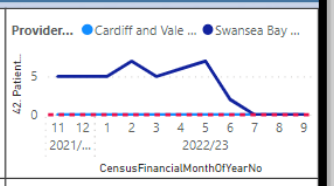
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WG Recovery measures - Thoracic Surgery (Welsh providers)
(DHCW RTT data; target lines in red dots)

42. Patients waiting more than 52 weeks for a new outpatient appointment

Target - Improvement trajectory towards a national target of 0 by December 2022

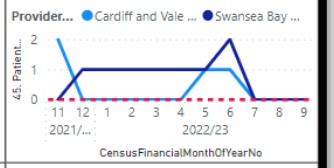
CensusFinancialYearStyle	2021/22									2022/23								
ProviderOrganisationCurrentName	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Swansea Bay University Local Health Board	7	4	5	6	5	5	5	5	5	7	5	6	7	2	0	0	0
Total	**7**	**4**	**5**	**6**	**5**	**5**	**5**	**5**	**5**	**7**	**5**	**6**	**7**	**2**	**0**	**0**	**0**



45. Patients waiting more than 104 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2024

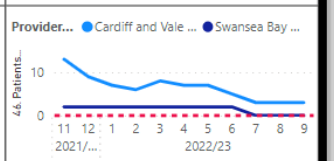
CensusFinancialYearStyle	2021/22									2022/23								
ProviderOrganisationCurrentName	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	1	1	2	1	3	1	2	0	0	0	0	0	1	1	0	0	0
Swansea Bay University Local Health Board	1	0	0	0	0	0	0	1	1	1	1	1	1	2	0	0	0
Total	**2**	**1**	**2**	**1**	**3**	**1**	**2**	**1**	**1**	**1**	**1**	**1**	**2**	**3**	**0**	**0**	**0**



46. Patients waiting more than 36 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2026

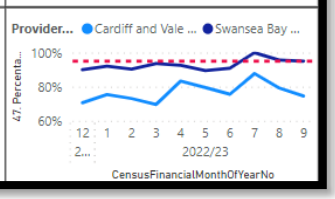
CensusFinancialYearStyle	2021/22									2022/23								
ProviderOrganisationCurrentName	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9			
Cardiff and Vale University Local Health Board	21	15	19	15	13	9	7	6	8	7	7	5	3	3	3			
Swansea Bay University Local Health Board	3	3	2	3	2	2	2	2	2	2	2	2	0	0	0			
Total	**24**	**18**	**21**	**18**	**15**	**11**	**9**	**8**	**10**	**9**	**9**	**7**	**3**	**3**	**3**			



47. Percentage of patients waiting less than 26 weeks for treatment

Target - Improvement trajectory towards a national target of 95% by 2026

CensusFinancialYearStyle	2022/23								
ProviderOrganisationCurrentName	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	75%	73%	70%	83%	80%	76%	88%	79%	75%
Swansea Bay University Local Health Board	92%	90%	94%	93%	89%	91%	100%	96%	95%
Total	**80%**	**80%**	**79%**	**87%**	**83%**	**81%**	**90%**	**84%**	**80%**



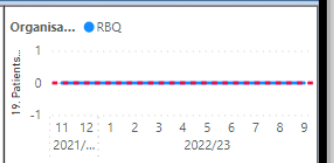
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WG Recovery measures - Thoracic Surgery (Liverpool Heart & Chest)
(Data from provider; target lines in red dots)

42. Patients waiting more than 52 weeks for a new outpatient appointment

Target - Improvement trajectory towards a national target of 0 by December 2022

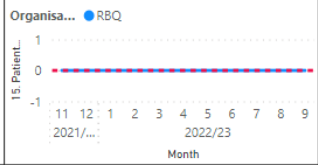
Fyear	2021/22												2022/23								
Organisation Code (Code of Provider)	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
RBQ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**



45. Patients waiting more than 104 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2024

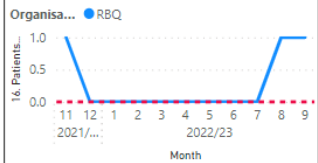
Fyear	2021/22												2022/23								
Organisation Code (Code of Provider)	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
RBQ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**



46. Patients waiting more than 36 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2026

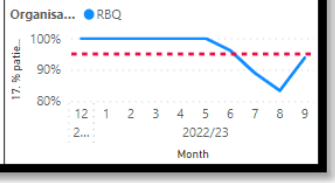
Fyear	2021/22												2022/23								
Organisation Code (Code of Provider)	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
RBQ	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	1
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**



47. Percentage of patients waiting less than 26 weeks for treatment

Target - Improvement trajectory towards a national target of 95% by 2026

Fyear	2021/22		2022/23							
Organisation Code (Code of Provider)	11	12	1	2	3	4	5	6	7	8	9
RBQ	88%	100%	100%	100%	100%	100%	100%	96%	89%	83%	94%
Total	**88%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**96%**	**89%**	**83%**	**94%**



Neurosurgery (measures 42, 45-47)

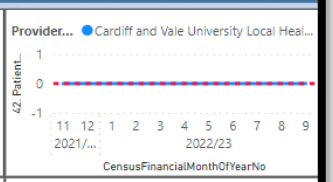
GIG CYMRU NHS WALES | Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC) Welsh Health Specialised Services Committee (WHSSC)

WG Recovery measures - Neurosurgery (Welsh providers) (DHCW RTT data; target lines in red dots)

42. Patients waiting more than 52 weeks for a new outpatient appointment

Target - Improvement trajectory towards a national target of 0 by December 2022

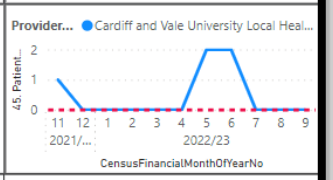
CensusFinancialYearStyle	2021/22												2022/23								
ProviderOrganisationCurrentName	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	0	0	0	0	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**



45. Patients waiting more than 104 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2024

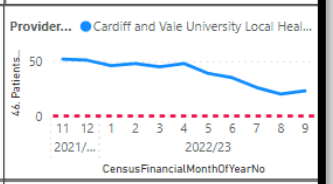
CensusFinancialYearStyle	2021/22												2022/23								
ProviderOrganisationCurrentName	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	0	1	0	0	0	0	1	3	1	1	1	0	0	0	0	0	2	2	0	0	0
Total	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**3**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**2**	**2**	**0**	**0**	**0**



46. Patients waiting more than 36 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2026

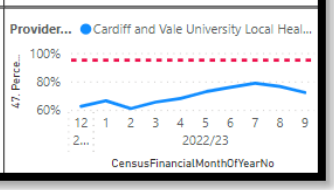
CensusFinancialYearStyle	2021/22							2022/23							
ProviderOrganisationCurrentName	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	81	68	48	53	47	52	51	46	48	45	48	39	35	26	20	23
Total	**81**	**68**	**48**	**53**	**47**	**52**	**51**	**46**	**48**	**45**	**48**	**39**	**35**	**26**	**20**	**23**



47. Percentage of patients waiting less than 26 weeks for treatment

Target - Improvement trajectory towards a national target of 95% by 2026

CensusFinancialYearStyle	2021/22		2022/23								
ProviderOrganisationCurrentName	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	65%	63%	66%	61%	66%	68%	73%	76%	79%	77%	72%
Total	**65%**	**63%**	**66%**	**61%**	**66%**	**68%**	**73%**	**76%**	**79%**	**77%**	**72%**



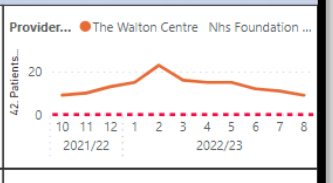
GIG CYMRU NHS WALES | Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC) Welsh Health Specialised Services Committee (WHSSC)

WG Recovery measures - Neurosurgery (English providers) (DHCW RTT data; target lines in red dots)

42. Patients waiting more than 52 weeks for a new outpatient appointment (data for all pathways used)

Target - Improvement trajectory towards a national target of 0 by December 2022

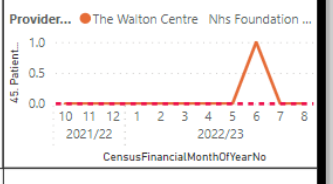
CensusFinancialYearStyle	2021/22												2022/23							
ProviderOrganisationCurrentName	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8		
The Walton Centre Nhs Foundation trust	23	12	11	6	9	11	10	9	10	13	15	23	16	15	15	12	11	9		
Total	**23**	**12**	**11**	**6**	**9**	**11**	**10**	**9**	**10**	**13**	**15**	**23**	**16**	**15**	**15**	**12**	**11**	**9**		



45. Patients waiting more than 104 weeks for treatment (data for all pathways used)

Target - Improvement trajectory towards a national target of 0 by 2024

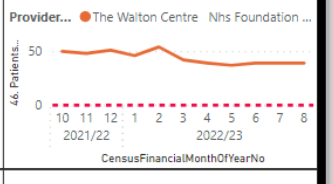
CensusFinancialYearStyle	2021/22												2022/23							
ProviderOrganisationCurrentName	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8
The Walton Centre Nhs Foundation trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**



46. Patients waiting more than 36 weeks for treatment (data for all pathways used)

Target - Improvement trajectory towards a national target of 0 by 2026

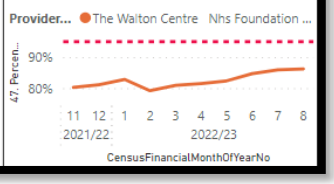
CensusFinancialYearStyle	2021/22									2022/23						
ProviderOrganisationCurrentName	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8
The Walton Centre Nhs Foundation trust	32	36	30	33	41	48	50	48	51	46	54	42	39	37	39	39	39
Total	**32**	**36**	**30**	**33**	**41**	**48**	**50**	**48**	**51**	**46**	**54**	**42**	**39**	**37**	**39**	**39**	**39**



47. Percentage of patients waiting less than 26 weeks for treatment (data for all pathways used)

Target - Improvement trajectory towards a national target of 95% by 2026

CensusFinancialYearStyle	2021/22				2022/23							
ProviderOrganisationCurrentName	9	10	11	12	1	2	3	4	5	6	7	8
The Walton Centre Nhs Foundation trust	82%	80%	80%	81%	83%	79%	81%	81%	82%	85%	86%	86%
Total	**82%**	**80%**	**80%**	**81%**	**83%**	**79%**	**81%**	**81%**	**82%**	**85%**	**86%**	**86%**



Plastic Surgery (measures 42, 45-47)

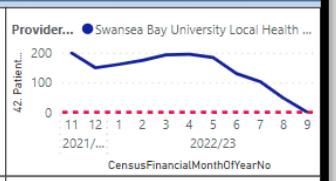
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WG Recovery measures - Plastic Surgery (Welsh providers)
(DHCW RTT data; target lines in red dots)

42. Patients waiting more than 52 weeks for a new outpatient appointment

Target - Improvement trajectory towards a national target of 0 by December 2022

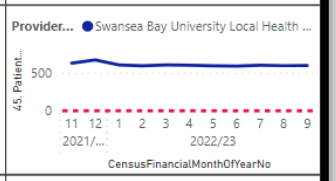
CensusFinancialYearStyle	2021/22						2022/23								
ProviderOrganisationCurrentName	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Swansea Bay University Local Health Board	382	389	376	302	199	150	161	174	193	195	184	130	103	47	0
Total	**382**	**389**	**376**	**302**	**199**	**150**	**161**	**174**	**193**	**195**	**184**	**130**	**103**	**47**	**0**



45. Patients waiting more than 104 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2024

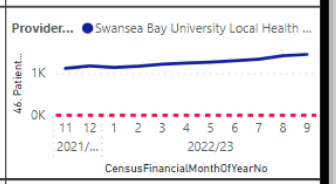
CensusFinancialYearStyle	2021/22						2022/23								
ProviderOrganisationCurrentName	8	9	10	11	12	1	2	3	4	5	6	7	8	9	
Swansea Bay University Local Health Board	515	542	593	628	670	605	594	605	602	595	590	600	596	598	
Total	**515**	**542**	**593**	**628**	**670**	**605**	**594**	**605**	**602**	**595**	**590**	**600**	**596**	**598**	



46. Patients waiting more than 36 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2026

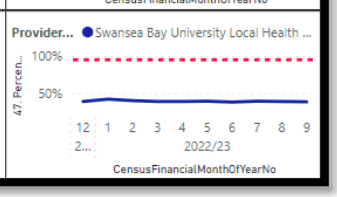
Financial Year	2021/22	2022/23								
Provider	12	1	2	3	4	5	6	7	8	9
Swansea Bay University Local Health Board	1,174	1,137	1,167	1,216	1,239	1,263	1,297	1,332	1,414	1,446
Total	**1,174**	**1,137**	**1,167**	**1,216**	**1,239**	**1,263**	**1,297**	**1,332**	**1,414**	**1,446**



47. Percentage of patients waiting less than 26 weeks for treatment

Target - Improvement trajectory towards a national target of 95% by 2026

CensusFinancialYearStyle	2021/22			2022/23								
Provider	10	11	12	1	2	3	4	5	6	7	8	9
Swansea Bay University Local Health Board	34%	35%	39%	42%	40%	39%	39%	39%	38%	39%	39%	38%
Total	**34%**	**35%**	**39%**	**42%**	**40%**	**39%**	**39%**	**39%**	**38%**	**39%**	**39%**	**38%**



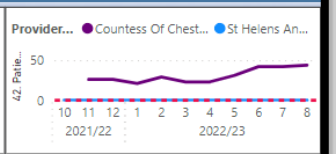
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WG Recovery measures - Plastic Surgery (English providers)
(DHCW RTT data; target lines in red dots)

42. Patients waiting more than 52 weeks for a new outpatient appointment (data for all pathways used)

Target - Improvement trajectory towards a national target of 0 by December 2022

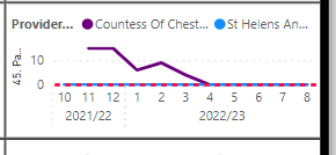
CensusFinancialYearStyle	2021/22						2022/23					
ProviderOrganisationCurrentName	8	9	10	11	12	1	2	3	4	5	6	7	8
Countess Of Chester Hospital Nhs foundation trus				26	26	21	29	23	23	31	42	42	44
St Helens And Knowsley Teaching Hospitals nhs tr	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**26**	**26**	**21**	**29**	**23**	**23**	**31**	**42**	**42**	**44**



45. Patients waiting more than 104 weeks for treatment (data for all pathways used)

Target - Improvement trajectory towards a national target of 0 by 2024

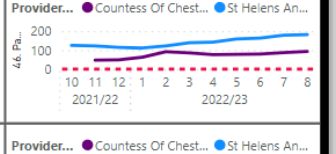
CensusFinancialYearStyle	2021/22								2022/23						
ProviderOrganisationCurrentName	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8
Countess Of Chester Hospital Nhs foundation trus							15	15	6	9	4	0	0	0	0	0
St Helens And Knowsley Teaching Hospitals nhs tr	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**15**	**15**	**6**	**9**	**4**	**0**	**0**	**0**	**0**	**0**



46. Patients waiting more than 36 weeks for treatment (data for all pathways used)

Target - Improvement trajectory towards a national target of 0 by 2026

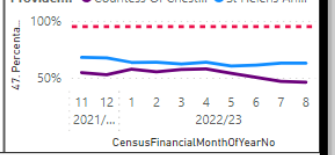
CensusFinancialYearStyle	2021/22	2022/23							
ProviderOrganisationCurrentName	12	1	2	3	4	5	6	7	8
Countess Of Chester Hospital Nhs foundation trus	49	63	92	86	76	78	80	87	93
St Helens And Knowsley Teaching Hospitals nhs tr	115	111	122	139	143	159	164	179	182
Total	**164**	**174**	**214**	**225**	**219**	**237**	**244**	**266**	**275**



47. Percentage of patients waiting less than 26 weeks for treatment (data for all pathways used)

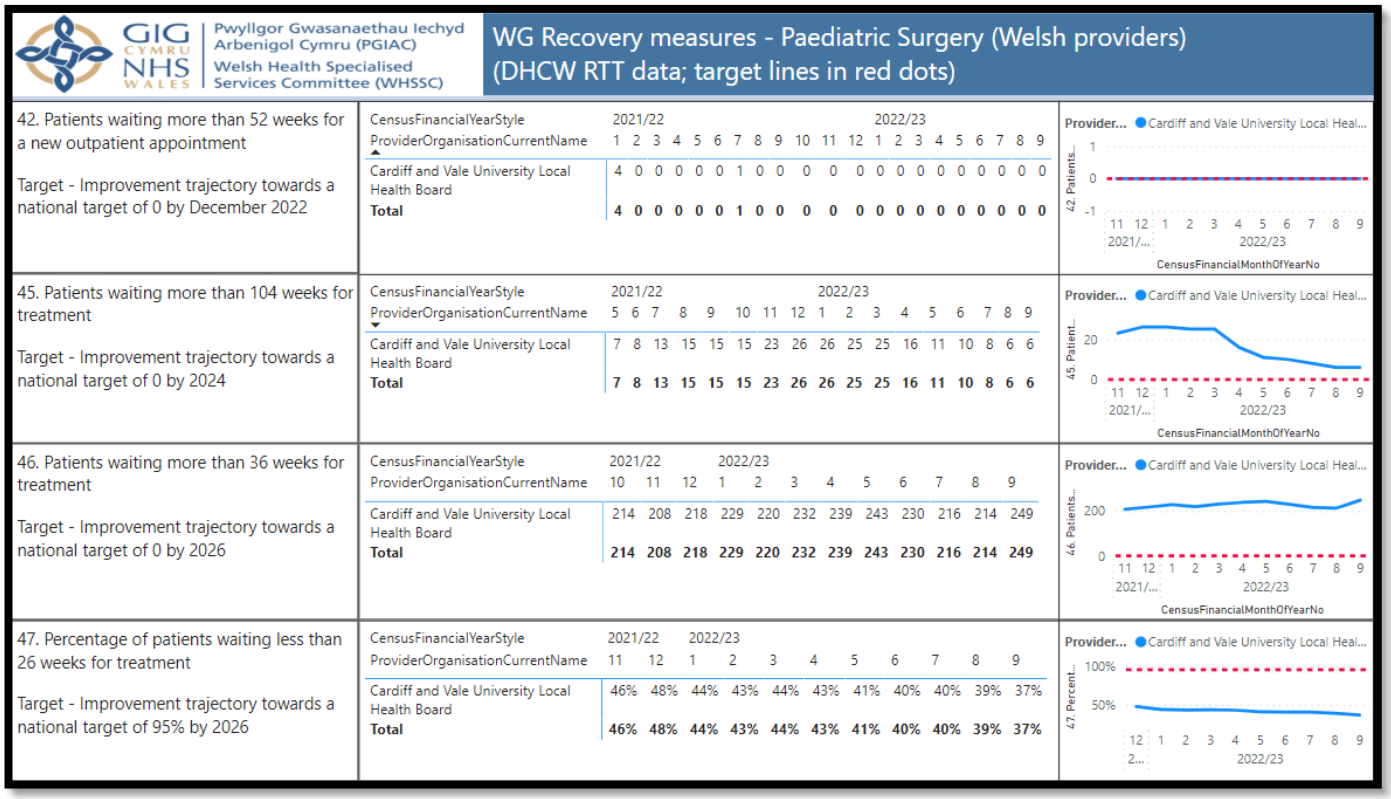
Target - Improvement trajectory towards a national target of 95% by 2026

CensusFinancialYearStyle	2021/22		2022/23						
ProviderOrganisationCurrentName	11	12	1	2	3	4	5	6	7	8
Countess Of Chester Hospital Nhs foundation trus	54%	53%	58%	55%	57%	58%	54%	50%	47%	46%
St Helens And Knowsley Teaching Hospitals nhs tr	68%	68%	64%	64%	62%	64%	60%	61%	63%	63%
Total	**64%**	**63%**	**62%**	**61%**	**60%**	**62%**	**58%**	**58%**	**58%**	**58%**



Note: Countess of Chester activity paid through Betsi Cadwaladr local contract; some months missing in DHCW dataset.

Paediatric Surgery (measures 42, 45-47)



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

WG Recovery measures - Paediatric Surgery (Welsh providers)
(DHCW RTT data; target lines in red dots)

42. Patients waiting more than 52 weeks for a new outpatient appointment

Target - Improvement trajectory towards a national target of 0 by December 2022

CensusFinancialYearStyle	2021/22												2022/23								
ProviderOrganisationCurrentName	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	4	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**4**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

45. Patients waiting more than 104 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2024

CensusFinancialYearStyle	2021/22									2022/23							
ProviderOrganisationCurrentName	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	7	8	13	15	15	15	23	26	26	25	25	16	11	10	8	6	6
Total	**7**	**8**	**13**	**15**	**15**	**15**	**23**	**26**	**26**	**25**	**25**	**16**	**11**	**10**	**8**	**6**	**6**

46. Patients waiting more than 36 weeks for treatment

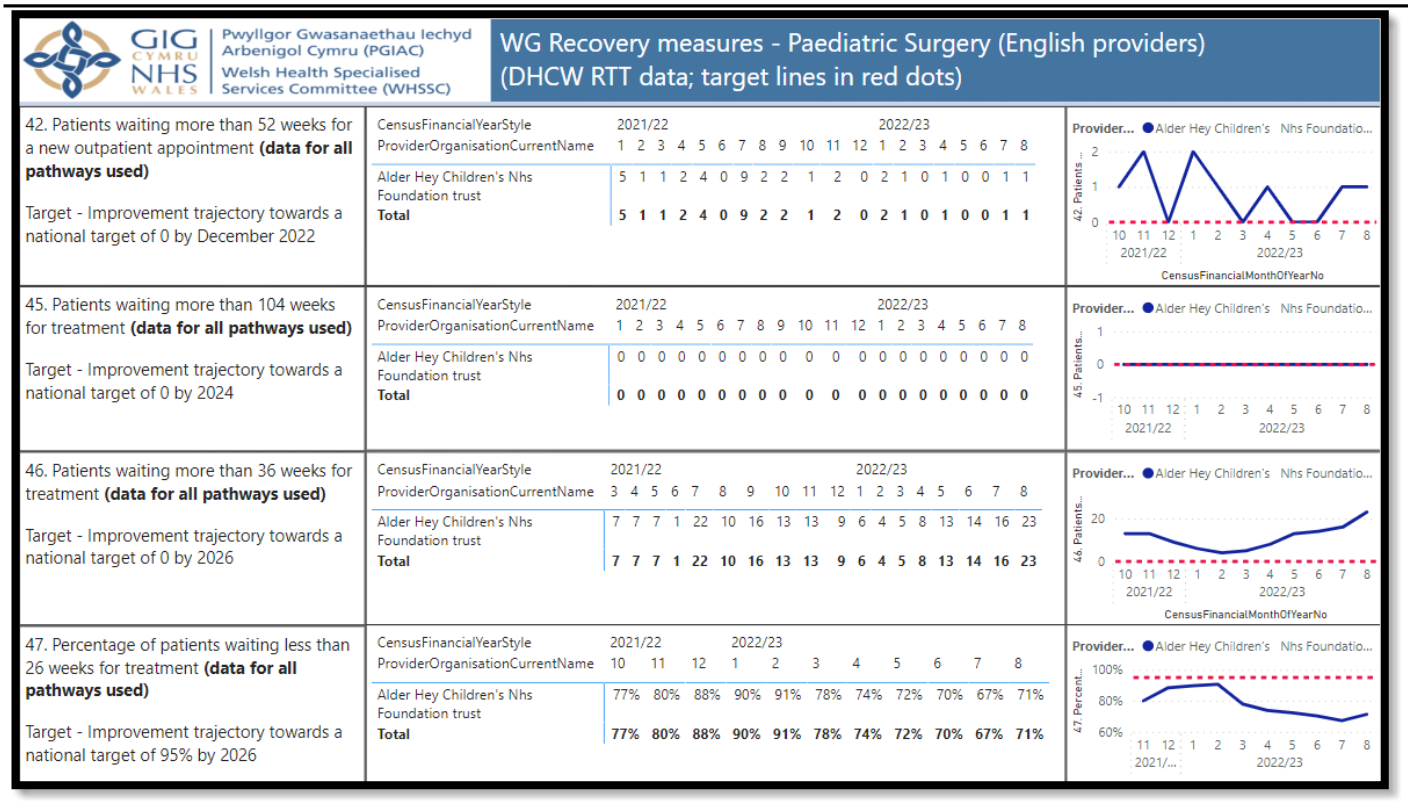
Target - Improvement trajectory towards a national target of 0 by 2026

CensusFinancialYearStyle	2021/22			2022/23								
ProviderOrganisationCurrentName	10	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	214	208	218	229	220	232	239	243	230	216	214	249
Total	**214**	**208**	**218**	**229**	**220**	**232**	**239**	**243**	**230**	**216**	**214**	**249**

47. Percentage of patients waiting less than 26 weeks for treatment

Target - Improvement trajectory towards a national target of 95% by 2026

CensusFinancialYearStyle	2021/22	2022/23									
ProviderOrganisationCurrentName	11	12	1	2	3	4	5	6	7	8	9
Cardiff and Vale University Local Health Board	46%	48%	44%	43%	44%	43%	41%	40%	40%	39%	37%
Total	**46%**	**48%**	**44%**	**43%**	**44%**	**43%**	**41%**	**40%**	**40%**	**39%**	**37%**



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

WG Recovery measures - Paediatric Surgery (English providers)
(DHCW RTT data; target lines in red dots)

42. Patients waiting more than 52 weeks for a new outpatient appointment (data for all pathways used)

Target - Improvement trajectory towards a national target of 0 by December 2022

CensusFinancialYearStyle	2021/22												2022/23								
ProviderOrganisationCurrentName	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	
Alder Hey Children's Nhs Foundation trust	5	1	1	2	4	0	9	2	2	1	2	0	2	1	0	1	0	0	1	1	
Total	**5**	**1**	**1**	**2**	**4**	**0**	**9**	**2**	**2**	**1**	**2**	**0**	**2**	**1**	**0**	**1**	**0**	**0**	**1**	**1**	

45. Patients waiting more than 104 weeks for treatment (data for all pathways used)

Target - Improvement trajectory towards a national target of 0 by 2024

CensusFinancialYearStyle	2021/22												2022/23								
ProviderOrganisationCurrentName	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	
Alder Hey Children's Nhs Foundation trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

46. Patients waiting more than 36 weeks for treatment (data for all pathways used)

Target - Improvement trajectory towards a national target of 0 by 2026

CensusFinancialYearStyle	2021/22												2022/23								
ProviderOrganisationCurrentName	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8			
Alder Hey Children's Nhs Foundation trust	7	7	7	1	22	10	16	13	13	9	6	4	5	8	13	14	16	23			
Total	**7**	**7**	**7**	**1**	**22**	**10**	**16**	**13**	**13**	**9**	**6**	**4**	**5**	**8**	**13**	**14**	**16**	**23**			

47. Percentage of patients waiting less than 26 weeks for treatment (data for all pathways used)

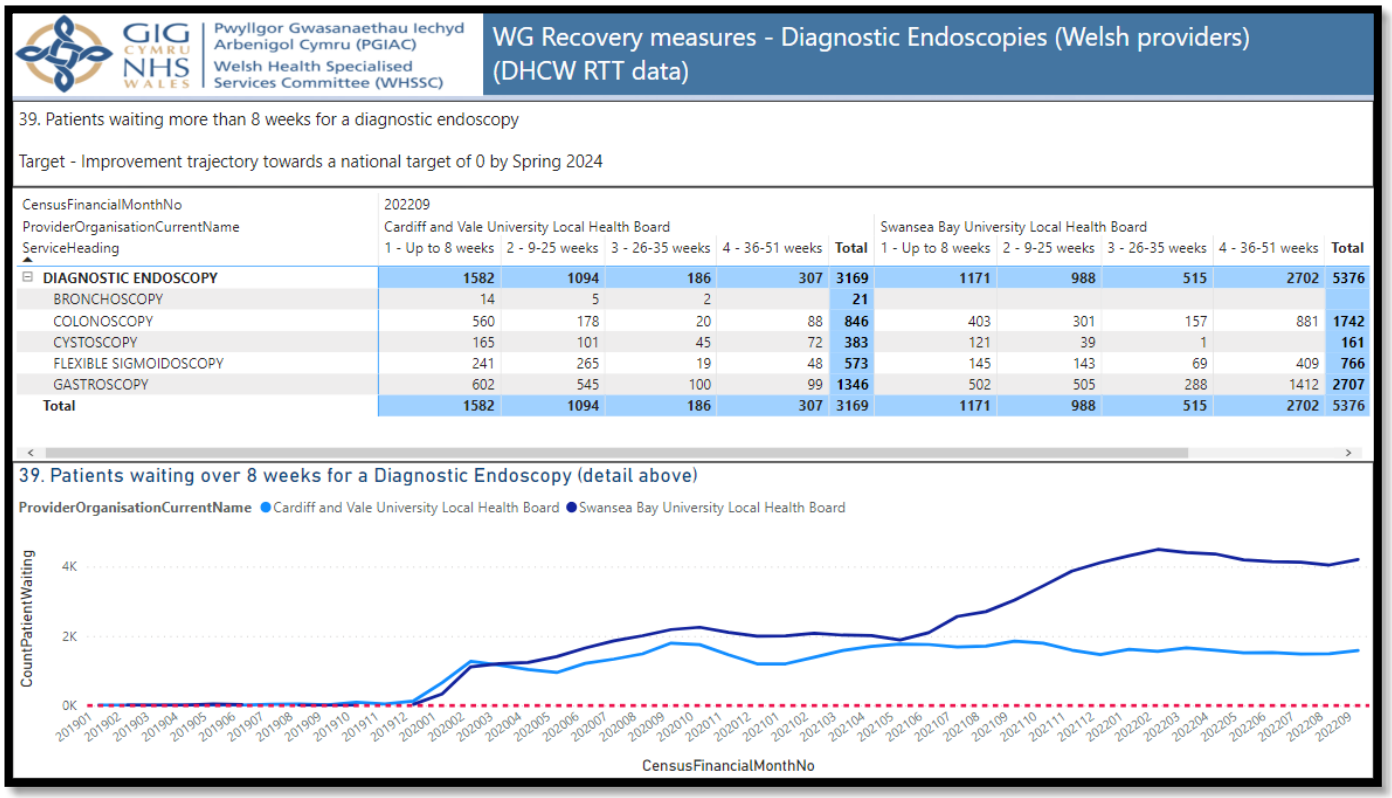
Target - Improvement trajectory towards a national target of 95% by 2026

CensusFinancialYearStyle	2021/22			2022/23								
ProviderOrganisationCurrentName	10	11	12	1	2	3	4	5	6	7	8	
Alder Hey Children's Nhs Foundation trust	77%	80%	88%	90%	91%	78%	74%	72%	70%	67%	71%	
Total	**77%**	**80%**	**88%**	**90%**	**91%**	**78%**	**74%**	**72%**	**70%**	**67%**	**71%**	

Patients waiting over 8 weeks for a Diagnostic Endoscopy (measure 39)

This measure is derived from a national DHCW dataset around patients waiting for Diagnostics. Specialties are not separated out, hence the figures below relate to the provider as a whole, and will include patients that are not in a pathway relating to specialist treatments.

Please note that only Cardiff & Vale and Swansea Bay figures are shown, as the largest specialist providers, and that the bulk of this activity relates to non-specialist activity not related to WHSSC.



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

WG Recovery measures - Diagnostic Endoscopies (Welsh providers) (DHCW RTT data)

39. Patients waiting more than 8 weeks for a diagnostic endoscopy

Target - Improvement trajectory towards a national target of 0 by Spring 2024

CensusFinancialMonthNo	202209									
ProviderOrganisationCurrentName	Cardiff and Vale University Local Health Board					Swansea Bay University Local Health Board				
ServiceHeading	1 - Up to 8 weeks	2 - 9-25 weeks	3 - 26-35 weeks	4 - 36-51 weeks	Total	1 - Up to 8 weeks	2 - 9-25 weeks	3 - 26-35 weeks	4 - 36-51 weeks	Total
DIAGNOSTIC ENDOSCOPY	**1582**	**1094**	**186**	**307**	**3169**	**1171**	**988**	**515**	**2702**	**5376**
BRONCHOSCOPY	14	5	2		**21**					
COLONOSCOPY	560	178	20	88	**846**	403	301	157	881	**1742**
CYSTOSCOPY	165	101	45	72	**383**	121	39	1		**161**
FLEXIBLE SIGMOIDOSCOPY	241	265	19	48	**573**	145	143	69	409	**766**
GASTROSCOPY	602	545	100	99	**1346**	502	505	288	1412	**2707**
Total	**1582**	**1094**	**186**	**307**	3169	**1171**	**988**	**515**	**2702**	5376

39. Patients waiting over 8 weeks for a Diagnostic Endoscopy (detail above)

Patients waiting over 8 weeks for Diagnostics (measure 40)

This measure is derived from a national DHCW dataset around patients waiting for Diagnostics. Specialties are not separated out, hence the figures below relate to the provider as a whole, and will include patients that are not in a pathway relating to specialist treatments.

Please note that only Cardiff & Vale and Swansea Bay figures are shown, as the largest specialist providers, and that the bulk of this activity relates to non-specialist activity not related to WHSSC.

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

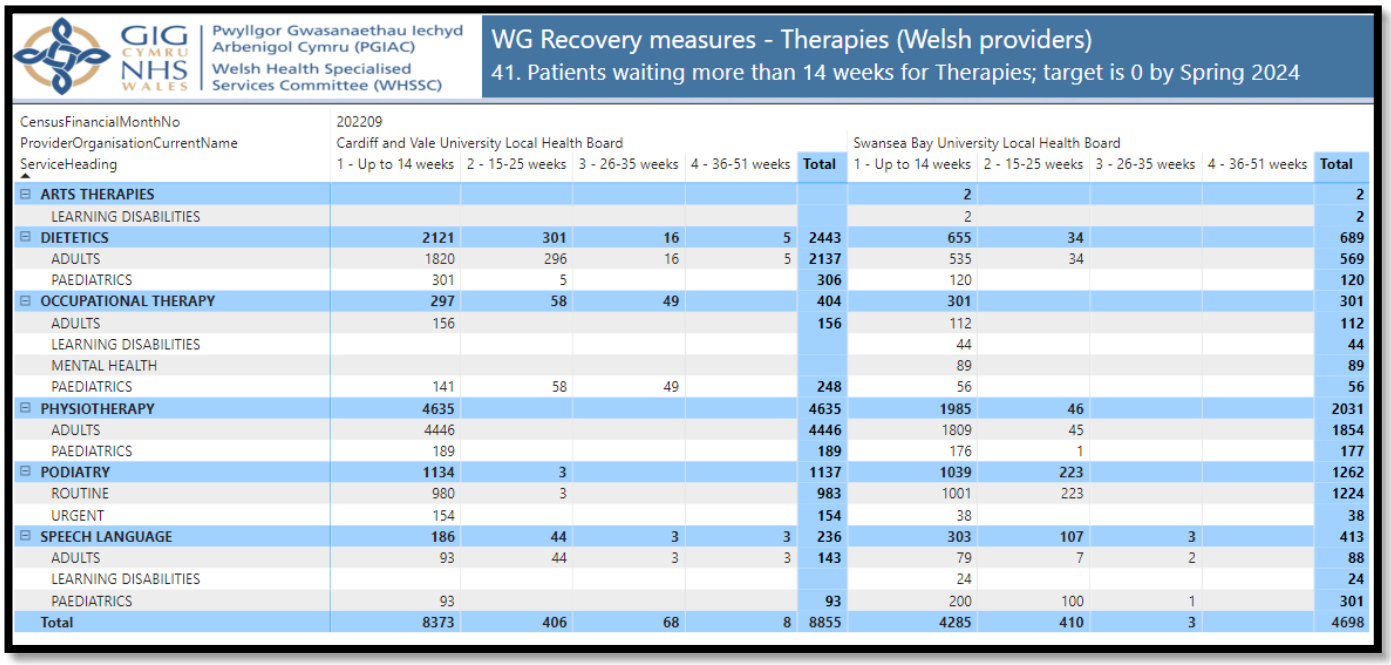
WG Recovery measures - Diagnostics (Welsh providers)
40. Patients waiting more than 8 weeks for Diagnostics; target is 0 by Spring 2024

CensusFinancialMonthNo	202209									
ProviderOrganisationCurrentName	Cardiff and Vale University Local Health Board					Swansea Bay University Local Health Board				
ServiceHeading	1 - Up to 8 weeks	2 - 9-25 weeks	3 - 26-35 weeks	4 - 36-51 weeks	Total	1 - Up to 8 weeks	2 - 9-25 weeks	3 - 26-35 weeks	4 - 36-51 weeks	Total
AUDIOLOGY (ADULT HEARING AIDS)	**522**	**878**	**152**	**16**	**1568**	**347**	**156**			**503**
CONSULTANT	522	878	152	16	**1568**	34	7			**41**
GP						313	149			**462**
CARDIOLOGY	**2214**	**724**	**21**	**62**	**3021**	**2231**	**584**	**38**	**9**	**2862**
BLOOD PRESSURE MONITORING	98	18			**116**	78	6			**84**
CARDIAC COMPUTED TOMOGRAPHY (CARDIAC CT)	94	3			**97**	227	100	3		**330**
CARDIAC MAGNETIC RESONANCE IMAGING (CARDIAC MRI)	111	52	2	2	**167**	82	15			**97**
DIAGNOSTIC ANGIOGRAPHY	33	92	14	10	**149**	6				**6**
DIAGNOSTIC ELECTROPHYSIOLOGY (EP STUDY)	2				**2**					
DOBUTAMINE STRESS ECHOCARDIOGRAM (DSE)	56	40			**96**	17	4	1	1	**23**
ECHO CARDIOGRAM	1171	133			**1304**	1051	333	1	1	**1386**
HEART RHYTHM RECORDING	552	321			**873**	606	25		1	**632**
MYOCARDIAL PERFUSION SCANNING	17	26		50	**93**	61	64	30	4	**159**
STRESS TEST	56	35	5		**96**	97	30			**127**
TRANS OESOPHAGEAL ECHOCARDIOGRAM (TOE)	24	4			**28**	6	7	3	2	**18**
IMAGING	**86**	**1**			**87**	**157**	**16**			**173**
FLUOROSCOPY	86	1			**87**	157	16			**173**
NEUROPHYSIOLOGY	**76**				**76**	**333**	**319**	**68**	**33**	**753**
ELECTROMYOGRAPHY	57				**57**	50	72	9	6	**137**
NERVE CONDUCTION STUDIES	19				**19**	283	247	59	27	**616**
PHYSIOLOGICAL MEASUREMENT	**154**	**83**	**23**	**36**	**296**	**372**	**303**	**86**	**120**	**881**
LIMITED CHANNEL CARDIO-RESPIRATORY SLEEP STUDY						148	211	79	103	**541**
OVERNIGHT PULSE OXIMETRY						117	63	7	17	**204**
URODYNAMIC TESTS	35	83	23	36	**177**					
VASCULAR TECHNOLOGY	119				**119**	107	29			**136**
RADIOLOGY - CONSULTANT REFERRAL	**4264**	**666**	**41**	**23**	**4994**	**3495**	**249**	**28**		**3772**
BARIUM ENEMA						3				**3**
NON CARDIAC COMPUTED TOMOGRAPHY	779	3	1	1	**784**	1028	159			**1187**
NON CARDIAC MAGNETIC RESONANCE IMAGING (MRI)	1848	442	40	22	**2352**	1185	3			**1188**
NON CARDIAC NUCLEAR MEDICINE	134	10			**144**	317	76	28		**421**
NON-OBSTETRIC ULTRASOUND	1503	211			**1714**	962	11			**973**
RADIOLOGY - GP REFERRAL	**3317**	**693**			**4010**	**2086**	**89**			**2175**
NON CARDIAC COMPUTED TOMOGRAPHY	456				**456**	679	72			**751**
NON CARDIAC MAGNETIC RESONANCE IMAGING (MRI)	316	66			**382**	152	2			**154**
NON CARDIAC NUCLEAR MEDICINE	7				**7**	7				**7**
NON-OBSTETRIC ULTRASOUND	2538	627			**3165**	1248	15			**1263**
Total	**10633**	**3045**	**237**	**137**	**14052**	**9021**	**1716**	**220**	**162**	**11119**

Patients waiting over 14 weeks for Therapies (measure 41)

This measure is derived from a national DHCW dataset around patients waiting for Therapies. Specialties are not separated out, hence the figures below relate to the provider as a whole, and will include patients that are not in a pathway relating to specialist treatments.

Please note that only Cardiff & Vale and Swansea Bay figures are shown, as the largest specialist providers, and that the bulk of this activity relates to non-specialist activity not related to WHSSC.



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

WG Recovery measures - Therapies (Welsh providers)
41. Patients waiting more than 14 weeks for Therapies; target is 0 by Spring 2024

CensusFinancialMonthNo	202209									
ProviderOrganisationCurrentName	Cardiff and Vale University Local Health Board					Swansea Bay University Local Health Board				
ServiceHeading	1 - Up to 14 weeks	2 - 15-25 weeks	3 - 26-35 weeks	4 - 36-51 weeks	Total	1 - Up to 14 weeks	2 - 15-25 weeks	3 - 26-35 weeks	4 - 36-51 weeks	Total
ARTS THERAPIES						2				2
LEARNING DISABILITIES						2				2
DIETETICS	2121	301	16	5	2443	655	34			689
ADULTS	1820	296	16	5	2137	535	34			569
PAEDIATRICS	301	5			306	120				120
OCCUPATIONAL THERAPY	297	58	49		404	301				301
ADULTS	156				156	112				112
LEARNING DISABILITIES						44				44
MENTAL HEALTH						89				89
PAEDIATRICS	141	58	49		248	56				56
PHYSIOTHERAPY	4635				4635	1985	46			2031
ADULTS	4446				4446	1809	45			1854
PAEDIATRICS	189				189	176	1			177
PODIATRY	1134	3			1137	1039	223			1262
ROUTINE	980	3			983	1001	223			1224
URGENT	154				154	38				38
SPEECH LANGUAGE	186	44	3	3	236	303	107	3		413
ADULTS	93	44	3	3	143	79	7	2		88
LEARNING DISABILITIES						24				24
PAEDIATRICS	93				93	200	100	1		301
Total	8373	406	68	8	8855	4285	410	3		4698

Report Title	**Financial Performance Report – Month 10 2022-2023**	**Agenda Item**	4.2
Meeting Title	**Management Group**	**Meeting Date**	14/03/2023
FOI Status	Open/Public		
Author (Job title)	Assistant Director of Finance		
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 10th month of 2022-2023. The financial position is reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC Integrated Commissioning Plan by the Joint Committee in February 2022.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☐	INFORM ☒

Recommendation(s)

Members are asked to:

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

WHSSC FINANCIAL PERFORMANCE REPORT
MONTH 10 2022-2023

1.0 SITUATION

The purpose of this report is to provide the year to date and forecast yearend financial position of WHSSC for the 2022-2023 financial year.

This report will be shared with WHSSC Management Group on 23 February 2023 and the February report will go to Joint Committee on 14 March 2023.

2.0 BACKGROUND

The financial position is reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC Integrated Commissioning Plan the Joint Committee in February 2022.

3.0 ASSESSMENT

The financial position reported at Month 10 for WHSSC is a year-end outturn forecast under spend of (£14.353m).

The under spend predominantly relates to releasable reserves of (£18m) arising from 2021-2022 as a result of WHSSC assisting Health Boards manage resources over financial years on a planned basis, as HBs could not absorb underspends above their own forecasts and to ensure the most effective use of system resources.

Despite the material reported forecast underspend in 2022-23, there are number of underlying cost pressures absorbed within the position such as TAVI activity £4.4m, English provider activity £5.3m, mental health out of area placements for medium secure £2.6m and eating disorders patients £2.1m.

These pressures are further mitigated by non-recurrent recruitment slippage against plan in the first half of the year and COVID related slippage against growth provisions that will reach saturation in early 2023/24.

In development of the 2023/24 WHSSC ICP the baseline assessment has derived that the underlying deficit carried forward above the current funded baseline is £16.2m.

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.
NHS Delivery Framework Quadruple Aim	People in Wales have improved health and well-being with better prevention and self-management Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcome 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 10

1.0 PURPOSE OF REPORT

The purpose of this report is to set out the financial position for WHSSC for the 9th month of 2022-2023 together with any corrective action required.

The narrative of this report excludes the financial position for EASC, which includes WAST & EMRTS provider contracts, EASC and the NCCU team running costs, which are covered in separate Finance Report that is tabled at the EAS Committee. For information purposes, the consolidated position is summarised in the table below:

Table 1 - WHSSC / EASC split

	Annual Budget	Budgeted to Date	Actual to Date	Variance to Date	Movement in Var to date	Current EOYF	Movement in EOYF position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
WHSSC	778,250	648,542	636,590	(11,952)	(592)	(14,353)	126
EASC (WAST, EMRTS, NCCU)	238,313	198,594	198,578	(16)	(354)	(19)	(251)
Total as per Risk-share tables	1,016,563	847,136	835,169	(11,968)	(782)	(14,371)	(125)

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 Welsh Government is a nil variance.

2.0 BACKGROUND/INTRODUCTION

The financial position is reported against the 2022-2023 baselines following approval of the 2022-2023 ICP by the Joint Committee in February 2022. 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 10 is a year to date underspend of £11,952k and a forecast outturn underspend of £14,031k.

NHS England is reported on contract baselines agreed within the post pandemic NHSE framework of 'aligned payments and incentives'. These are reported against the current IMTP provision. 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 2022-2023 ICP, including the full year effects of 2021-2022 approved plan developments. Inflation framework agreements have been allocated within this position. The agreed ICP sets the baseline for all the 2022-2023 contract values.

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.

Due to COVID and block contracting arrangements the current utilisation shares are based on a 2 year average of 2018/19 and 2019/20 activity. It was agreed by the Finance Sub group that to update utilisation for 2020/21 and 2021/22 activity would be too volatile given the downturn in activity.

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	272,253	226,877	227,123	246	291	740	772
Swansea Bay University Health Board	116,841	97,367	98,674	1,307	1,108	1,737	1,304
Cwm Taf Morgannwg University Health Board	11,084	9,237	10,137	900	767	1,080	767
Aneurin Bevan Health Board	9,851	8,209	8,642	433	395	528	395
Hywel Dda Health Board	1,735	1,446	1,446	0	0	0	0
Betsi Cadwaladr Univ Health Board Provider	45,963	38,302	38,303	1	(77)	1	(77)
Velindre NHS Trust	54,292	45,243	45,843	600	317	764	969
Sub-total NHS Wales	**512,018**	**426,682**	**430,169**	**3,487**	**2,800**	**4,850**	**4,130**
Non Welsh SLAs	124,723	103,935	108,074	4,139	3,992	5,304	5,225
IPFR	59,639	49,699	50,348	649	356	15	(369)
IVF	5,020	4,183	4,325	142	210	251	335
Mental Health	36,533	30,444	32,798	2,355	2,335	2,793	2,649
Renal	4,959	4,133	3,781	(352)	(464)	(337)	(453)
Prior Year developments	1,928	1,607	3,542	1,935	1,862	2,322	2,482
2020/21 Plan Developments	27,186	22,655	13,291	(9,363)	(9,533)	(11,350)	(11,127)
Direct Running Costs	6,245	5,204	5,294	89	79	(159)	(23)
Reserves Releases 2021/22	0	0	(15,033)	(15,033)	(12,996)	(18,040)	(17,328)
Total Expenditure	**778,250**	**648,542**	**636,590**	**(11,952)**	**(11,360)**	**(14,352)**	**(14,478)**

The reported position is based on the following:

- NHS Wales activity – provider contract monitoring against the DOF framework principles which includes a 10% tolerance for underperformance and enhanced marginal rates for overperformance.
- NHS England activity – provider contract monitoring against agreed baselines based on the NHSE 'aligned payment and incentives' baselines with actual variances for drugs and devices applied.
- Mental Health & IPFR – live patient data as at the end of the month, plus current funding approvals and block bed capacity.
- Developments – variety of bases, including agreed phasing of funding.

5.0 FINANCIAL POSITION DETAIL - PROVIDERS

Provider positions can be summarised as follows for month 10:

5.1 NHS Wales Providers Summary

2022-23		Variance To Date			EOYF Variance		
	Annual Budget £'000	Mth 10 £'000	Mth 9 £'000	Movement £'000	Mth 10 £'000	Mth 9 £'000	Movement £'000
NHS Wales Providers							
Cardiff & Vale University Health Board	272,253	246	291	(46)	740	772	(33)
Swansea Bay University Health Board	116,841	1,307	1,108	199	1,737	1,304	432
Cwm Taf Morgannwg University Health Board	11,084	900	767	133	1,080	767	313
Aneurin Bevan Health Board	9,851	433	395	39	528	395	133
Hywel Dda Health Board	1,735	-	-	-	-	-	-
Betsi Cadwaladr University Health Board Provider	45,963	1	(77)	78	1	(77)	78
Velindre NHS Trust	54,292	600	317	283	764	969	(205)
Sub-total NHS Wales	**512,018**	**3,487**	**2,800**	**687**	**4,850**	**4,130**	**719**

A number of welsh provider services increased activity through December impacting on the yearend forecasts by £719k, the main forecast movements are as follows:

- Swansea Bay – Plastics £160k
- Cwm Taf Morgannwg – Cardiology (ICDs) £313k
- Aneurin Bevan – Cardiology (PCIs) £254k

There is a risk that current performance trajectories will not be maintained through the last quarter of the year due to winter operational pressures.

5.2 NHS England Providers

YTD M10 position £4,139k, Forecast YE position £5,304k.

NHS England SLA position reflects the agreed baselines based on the NHSE 'aligned payments and incentives' framework with pass through costs for drugs and devices and an uplift for the revised net cost uplift factor of 3.6% inflation.

There is a small forecast movement of £79k across English SLAs mainly reflecting increases in drugs and device expenditure non the UH Bristol and UH Birmingham contracts.

A further £175k release of the planned English Recovery Fund was actioned in month 10 with £325k retained to cover any pressures arising between M10 and year end.

5.3 Individual Patient Commissioning & Non Contract Activity

YTD M10 position £649k, Forecast YE position £15k.

There were increases in Proton Beam and ECMO activity delivered by the NHSE centres resulting in a forecast movement of £383k.

5.4 Specialised Mental Health

YTD M10 position £2,355k, Forecast YE position £2,793k.

The Mental Health forecast position has declined by £144k, this is due to reflecting NHSE gender activity costs and the additional mobilisation costs NHSE has requested from the devolved nations for the re-configuration of surgery services.

5.5 Renal

YTD M10 position (£352k), Forecast YE position (£337k).

The forecast underspend is reduced by £116k as confirmation of a number of renal development schemes have now implemented after recruitment delays.

5.6 Developments and Strategic Priorities

YTD M10 position (£7,428k), Forecast YE position (£9,027k).

The developments forecast has improved by (£382k). This is in part due to the 22/23 CIAG budget phasing adjustment being removed and the reported position against 22/23 schemes increasing by (£216k)

5.7 WHSSC Running Costs

YTD M10 position £89k, Forecast YE position (£159k)

The core DRC forecast position has improved due to confirmation of WRP coverage for a legal settlement. There are a number of vacancies and running cost efficiencies that have offset increased cost pressures from excess energy and insurance.

A number of cost reduction schemes have been identified in development of the Integrated Commissioning Plan and a target 5% saving (£175k) has been applied to the running cost budget for 2023/24.

5.8 Reserves

YTD M10 position (£15,033k), Forecast YE position (£18,040k).

There is a £712k increase in the reserves as the final balance sheet clearance is actioned in preparation for year end and residual reserves are deemed unlikely to materialise.

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 £'000	Cardiff and Vale £'000	SB £'000	Cwm Taf Morgannwg £'000	Aneurin Bevan £'000	Hywel Dda £'000	Powys £'000	Betsi Cadwaladr £'000
Variance M10	(11,952)	(2,308)	(1,236)	(1,241)	(2,127)	(1,471)	(222)	(3,348)
Variance M9	(11,360)	(2,222)	(1,097)	(1,280)	(2,051)	(1,332)	(183)	(3,195)
Movement	(593)	(86)	(139)	39	(75)	(139)	(39)	(153)

Table 4 – End of Year Forecast by LHB

	Allocation of Variance							
	Total £'000	Cardiff and Vale £'000	SB £'000	Cwm Taf Morgannwg £'000	Aneurin Bevan £'000	Hywel Dda £'000	Powys £'000	Betsi Cadwaladr £'000
EOY forecast M10	(14,353)	(2,786)	(1,483)	(1,352)	(2,524)	(1,690)	(204)	(4,314)
EOY forecast M9	(14,479)	(2,735)	(1,508)	(1,631)	(2,584)	(1,674)	(170)	(4,178)
EOY movement	126	(51)	25	279	60	(17)	(33)	(136)

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.

Please note that income for WHSSC & EASC elements are disaggregated, although both entities cash flows are technically managed through the same bank account. The below table uses the total income to allow reconciliation to the MMR returns; please refer to the income tables in the monthly risk-sharing file to for a detailed breakdown of commissioner income.

Table 5 – 2022/23 Commissioner Income Expected and Received to Date

	2022/23 Planned Commissioner Income £'000	Income Expected to Date £'000	Actual Income Received to Date £'000	Accrued Income - WHSSC £'000	Total Income Accounted to Date £'000	EOY Comm'er Position £'000
SB	123,883	103,236	101,727	1,483	103,236	(1,411)
Aneurin Bevan	191,903	159,919	156,964	2,913	159,920	(2,847)
Betsi Cadwaladr	222,566	185,472	185,211	196	185,472	(4,314)
Cardiff and Vale	165,075	137,562	134,439	3,093	137,562	(2,703)
Cwm Taf Morgannwg	144,958	120,798	118,286	2,479	120,798	(1,281)
Hywel Dda	119,499	99,582	98,317	1,231	99,583	(1,624)
Powys	48,680	40,566	40,312	236	40,566	(192)
Public Health Wales					0	
Velindre					0	
WAST					0	
Total	1,016,563	847,136	835,256	11,631	847,136	(14,371)

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

Provider forecasts have been volatile in respect to pass through elements such as drugs, blood products and devices. There are a risk that this could adversely swing the position in Q4.

9.0 PUBLIC SECTOR PAYMENT COMPLIANCE Q3

As at the end of Q3 WHSSC has achieved 99.5% compliance for NHS invoices paid within 30 days by value and 94.5% by number.

For non NHS invoices WHSSC has achieved 94.8% in value for invoices paid within 30 days and 98.2% by number.

This data is updated on a quarterly basis.
WHSSC has undertaken a self-audit of the PSPP results as provided by NWSSP and are content that they are accurate.

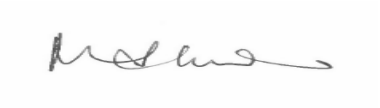
10. RESPONSES TO ACTION NOTES FROM WG MMR RESPONSES

No action points raised from the month 9 financial report and monitoring returns

11. SLA 2021-2022 STATUS UPDATE

All Welsh SLAs were agreed and signed by the end of June 2022.

12. CONFIRMATION OF POSITION REPORT BY THE MD AND DOF



Sian Lewis,
Managing Director, WHSSC

Stuart Davies,
Director of Finance, WHSSC

Report Title	**South Wales Neonatal Transport Delivery Assurance Group Report (July-November 2022)**	**Agenda Item**	4.3
Meeting Title	**Joint Committee**	**Meeting Date**	14/03/2023
FOI Status	Open		
Author (Job title)	Senior Project Manager		
Executive Lead (Job title)	Director of Planning		

Purpose of the Report	To provide a summary of South Wales Neonatal Transport Delivery Assurance Group (DAG) Report for July-November 2022.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☒	INFORM ☒

Recommendation(s):

Members are asked to:

- **Note** the information in the report; and
- **Receive** assurance that the Neonatal Transport service delivery and outcomes is being scrutinised by the Delivery Assurance Group (DAG).

SOUTH WALES NEONATAL TRANSPORT DELIVERY ASSURANCE GROUP REPORT (July to November 2022)

1.0 SITUATION

The purpose of this report is to provide a summary of South Wales Neonatal Transport Delivery Assurance Group (DAG) Report for July to November 2022.

2.0 BACKGROUND

The DAG was established in January 2022, is chaired by the WHSSC Director of Planning and comprises of representation from all commissioning Health Boards (HB's) covered by the transport service and the three provider HB's at a clinical and managerial level.

The purpose of the group is to provide commissioner assurance on the performance of the service and to address any concerns from commissioners. The group meet bi-monthly and report directly to the Joint Committee (JC).

From April 2023 it has been agreed that the DAG will meet quarterly (rather than bi-monthly) and the reporting schedule to Joint Committee will reflect this change.

3.0 ASSESSMENT

The WHSSC team continue to work closely with the neonatal transport providers in developing a robust reporting tool for presentation to the JC to provide sufficient assurance on the delivery of the service**.**

Due to the enhanced data reporting and the small number of transfers undertaken there is a risk of being able to identify individual cases. Therefore the full report will be presented to the Joint Committee in committee meeting only.

3.1 Highlights from the report

- A total of 189 transfers were undertaken in the period, of which 26 were undertaken at night and 4 transfers facilitated by EMRTS.
- In comparison to last year there has been a 10% increase in total activity.
- CHANTS have constantly achieved the < 1 hour response time and maintained 100% compliance against the NTG immediate dispatch standard.
- Month on month activity undertaken by each provider varies but appears to equal out over the year.
- CHANTS perform well when benchmarked against other national transport services, in particular, temperature management of extreme preterm babies and the rate of normal blood gases.

- CHANTS transferred 100% of all uplift referrals; during this period there were 10 occasions then the team did not arrive within the 3.5 hour time period. On all but 3 occasions this was due to the team being busy with another sick baby. The remaining 3 occasions were due to a flight delay waiting for EMRTs availability, long distance travel as EMRTS unavailable and a time required to create an ITU cot.
- There have been no gaps in service during the reporting period

3.2 Incidents and shared learning

The report highlights the submission of 8 Datix incidents during the period 6 from Chants and 2 from HB's), and are broken down into the following categories below in Table 1:

Table 1.

Category	Number of incidents	Severity	Action/Outcomes
Equipment	3	Low, No harm, No harm	2 x closed 1 remains open with further investigation ongoing
Operational	4	Moderate x 2 No harm x 2	Transport Sub group learning and closed
Clinical	1	No harm	Closed and to be discussed at the next Transport Sub group

3.3 Issues and Risks

- The interim night service has a restricted criteria for night transfers and capacity transfers should only be undertaken when there is no ITU capacity in the Network. However, the demand for capacity transfers is reflected in the current cot availability and staffing pressures. Going forward, to ensure equity of service, a review of the night transfer criteria is required before the permanent 24hr model is in place. The new ODN will need to consider this.
- SBUHB identified a risk to the delivery of the ODN due to a £54k gap in funding to deliver their preferred delivery model. A further funding release is to be presented to the Joint Committee for approval in March seeking the additional funding to support operationalising the ODN.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the information in the report; and
- **Receive** assurance that the Neonatal Transport service delivery and outcomes is being scrutinised by the Delivery Assurance Group (DAG)

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	Neonatal Transport service and the establishment of the DAG were included in the ICP
Health and Care Standards	Safe Care Timely Care Individual Care
Principles of Prudent Healthcare	Reduce inappropriate variation Choose an item. Choose an item.
NHS Delivery Framework Quadruple Aim	People in Wales have improved health and well-being with better prevention and self-management Choose an item. Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	The DAG is providing scrutiny on the service
Finance/Resource Implications	The financial implications of the ODN are still being established.
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 to any of the issues outlined within this report
Long Term Implications (incl WBFG Act 2015)	None identified
Report History (Meeting/Date/ Summary of Outcome	CDGB on 16/02/2023 supported the recommendations
Appendices	

Report Title	**Corporate Governance Report**	**Agenda Item**	4.4
Meeting Title	**Joint Committee**	**Meeting Date**	14/03/2023
FOI Status	Open		
Author (Job title)	Corporate Governance Manager		
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 REPORT

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 that 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 Independent Member (IM) Recruitment

On 18 January 2022, the Joint Committee agreed to:

- transition to a fair and open selection process for appointing WHSSC Independent members (IMs) through advertising the vacancies through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs,
- 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; and
- remunerate WHSSC IMs including the requirement for a review following the recruitment process.

Professor Ceri Phillips' first two-year term as a WHSSC IM will end on 31 May 2023. It was agreed that at the end of his first term a recruitment exercise would be undertaken given the now remunerated nature of the role. Therefore, a recruitment process for this IM position will commence in April 2023.

3.2 Matters Considered In-Committee

In accordance with the WHSSC Standing Orders, the Joint Committee is required to report any decisions made in private "In-Committee" session, to the next available public meeting of the Joint Committee. An "In-Committee" meeting was held on 8 November 2022 and 17 January 2023 and the following updates were received:

- Minutes of the In Committee Meeting held on 6 September 2022
- Minutes of the In Committee Meeting held on 8 November 2022
- Tier 4 CAMHS – Ty Llidiard Update
- Welsh Kidney Network (WKN) SBUHB Procurement Update

3.3 Welsh Health Circulars (WHCs)

Welsh Government (WG) issue Welsh Health Circulars (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:

2022

- WHC/2022/026 Approach for Respiratory Viruses – Technical Guidance for Healthcare Planning
- WHC/2022/027 – Urgent Polio Catch Up Programme for children under 5 years old
- WHC/2022/028 – More Than Just Words Welsh Language awareness course
- WHC/2022/029 – Follow Up advice on the Polio Catch Up Programme for children under 5 years old
- WHC/2022/031 - Reimbursable vaccines and eligible cohorts for the 2023 to 2024 NHS seasonal influenza (flu) vaccination programme
- WHC/2022/035 – Influenza (flu) vaccination programme deployment 'mop up' 2022 to 2023.

2023

- WHC/2023/02 – Faecal immunochemical testing (FIT) in symptomatic colorectal cancer referral
- WHC/2023/001 Eliminating hepatitis (B and C) as a public health threat: actions for 2022 to 2023 and 2023 to 2024

3.4 Sub-Committee Terms of Reference

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. The sub-committees ToR are in the process of being discussed and reviewed in readiness for presentation to the sub-committees during March and April. Following this initial review and opportunity for members to comment the proposed changes will be presented to the Joint Committee meeting on 16 May 2023 for final approval.

3.5 Annual Committee Effectiveness Survey 2022-2023

For the 2021-2022 assessment, a survey was issued via e-mail utilising MS forms to enable an efficient yet effective reflection on committee effectiveness and which offered a consistent approach for all committees. The survey closed on the 11 April 2022.

Overall, the survey received a positive response, and the findings and feedback were shared with the relevant Chairs prior to developing an action plan to address any areas that require development. A comprehensive report was submitted to the IGC meeting on 7 June 2022 outlining the responses.

Members of the IGC are in the process of considering the approach for the 2022-2023 Committee Effectiveness exercise and the preferred approach.

3.6 Forward Work Plan

The Forward Work Plan is presented at ***Appendix 1*** for information.

3.7 Virtual Committee Arrangements

Further to the Committee effectiveness exercise for 2021-2022 undertaken in April 2022, the feedback from individual members indicated that the majority of members would prefer to continue with the virtual meeting arrangements adopted during the COVID-19 pandemic and the recovery phase. Therefore, all Joint Committee and sub-committee meetings will continue to be held virtually for the foreseeable future, and face to face meetings will be considered for any key decision making requirements as deemed appropriate by the Chair.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance
Link to Integrated Commissioning Plan	Approval process
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production
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 Integrated Governance 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.)	There are no direct legal implications. There are no adverse equality and diversity implications.
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	14 February 2023 – IGC
Appendices	Appendix 1 – Joint Committee Forward Work plan

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

WHSSC JOINT COMMITTEE – 12 MONTH ROLLING FORWARD WORK PLAN 2023-2024

MEETING	STANDING ITEMS	FOR APPROVAL / ACTION	ROUTINE REPORTS	INFORMATION
14 March 2023	Chair's Report Managing Director's Report Declarations of Interest Minutes Action Log Forward Work Plan	Neonatal Operational Delivery Network Funding Release Neonatal Cot Configuration Project WHSSC Governance & Accountability Framework – SOs and SFIs IPFR Engagement Update – ToR and All Wales Policy	COVID-19 Period Activity Report Month 9 Financial Performance Report Month 10 Corporate Governance Matters Report Neonatal Delivery Assurance Group (DAG) Update Reports from the Joint Sub-Committees - CTMUHB Audit & Risk Committee - Management Group Briefings - Quality & Patient Safety Committee - Integrated Governance Committee - Individual Patient Funding Request	Eating Disorder In-Patient Provision for Adults Thrombectomy Capacity in South Wales

WHSSC JOINT COMMITTEE – 12 MONTH ROLLING FORWARD WORK PLAN 2023-2024

			Panel - Welsh Kidney Network	
MEETING	**STANDING ITEMS**	**FOR APPROVAL / ACTION**	**ROUTINE REPORTS**	**INFORMATION**
16 May 2023	Chair's Report Managing Director's Report Declarations of Interest Minutes Action Log Forward Work Plan	WHSSC Specialised Services Strategy Haematology Review Performance Management Framework Paediatric Strategy Improvement Board Welsh Kidney Network Future Model IPFR All Wales Policy Review Annual Governance Statement	COVID-19 Period Activity Report Financial Performance Report Financial Assurance Report Corporate Governance Matters Report Report from the Chair of the CTMUHB Audit & Risk Committee Reports from the Joint Sub-Committees - Management Group Briefings - Quality & Patient Safety Committee	Sub – Committee Annual Reports 2022-2023 Cochlear and Baha results of engagement process Audit Wales – Final Report

WHSSC JOINT COMMITTEE – 12 MONTH ROLLING FORWARD WORK PLAN 2023-2024

		Risk Management Strategy (incl. Risk Appetite) Annual Review of Committee Effectiveness 2022-2023 Joint Committee Assurance Framework (JAF)	- Integrated Governance Committee - Individual Patient Funding Request Panel - Welsh Kidney Network	
MEETING	**STANDING ITEMS**	**FOR APPROVAL / ACTION**	**ROUTINE REPORTS**	**INFORMATION**
18 July 2023	Chair's Report Managing Director's Report Declarations of Interest Minutes Action Log Forward Work Plan	Corporate Risk Assurance Framework	COVID-19 Period Activity Report Financial Performance Report Corporate Governance Matters Report Report from the Chair of the CTMUHB Audit & Risk Committee	NHSE funding growth approach – discussion on the variation and impact of investment between Scotland, England and Wales. Review of the potential impacts on providers in Wales on strategic reinvestment, disinvestment and

WHSSC JOINT COMMITTEE – 12 MONTH ROLLING FORWARD WORK PLAN 2023-2024

			Reports from the Joint Sub-Committees - Management Group Briefings - Quality & Patient Safety Committee - Integrated Governance Committee - Individual Patient Funding Request Panel - WRCN	any subsequent reconfiguration Ty Llidiard Update
MEETING	**STANDING ITEMS**	**FOR APPROVAL / ACTION**	**ROUTINE REPORTS**	**INFORMATION**
19 September 2023	Chair's Report Managing Director's Report Declarations of Interest Minutes Action Log	WHSSC Annual Report 2022-2023	COVID-19 Period Activity Report Financial Performance Report Corporate Governance Matters Report Report from the Chair of the CTMUHB Audit & Risk Committee	

WHSSC JOINT COMMITTEE – 12 MONTH ROLLING FORWARD WORK PLAN 2023-2024

	Forward Work Plan		Reports from the Joint Sub-Committees - Management Group Briefings - Quality & Patient Safety Committee - Integrated Governance Committee - Individual Patient Funding Request Panel - WRCN	
MEETING	**STANDING ITEMS**	**FOR APPROVAL / ACTION**	**ROUTINE REPORTS**	**INFORMATION**
21 November 2023	Chair's Report Managing Director's Report Declarations of Interest Minutes Action Log		COVID-19 Period Activity Report Financial Performance Report Corporate Governance Matters Report Reports from the Joint Sub-Committees	Specialised Paediatric Services 5 year Commissioning Strategy (Bi-annual update)

WHSSC JOINT COMMITTEE – 12 MONTH ROLLING FORWARD WORK PLAN 2023-2024

	Forward Work Plan		- CTMUHB Audit & Risk Committee - Management Group Briefings - Quality & Patient Safety Committee - Integrated Governance Committee - Individual Patient Funding Request Panel	
MEETING	**STANDING ITEMS**	**FOR APPROVAL / ACTION**	**ROUTINE REPORTS**	**INFORMATION**
16 January 2024	Chair's Report Managing Director's Report Declarations of Interest Minutes Action Log Forward Work Plan		COVID-19 Period Activity Report Financial Performance Report Corporate Governance Matters Report Report from the Chair of the CTMUHB Audit & Risk Committee	

WHSSC JOINT COMMITTEE – 12 MONTH ROLLING FORWARD WORK PLAN 2023-2024

			Reports from the Joint Sub-Committees - Management Group Briefings - Quality & Patient Safety Committee - Integrated Governance Committee - Individual Patient Funding Request Panel - WRCN	
MEETING	**STANDING ITEMS**	**FOR APPROVAL / ACTION**	**ROUTINE REPORTS**	**INFORMATION**
19 March 2024	Chair's Report Managing Director's Report Declarations of Interest Minutes Action Log		COVID-19 Period Activity Report Financial Performance Report Corporate Governance Matters Report Report from the Chair of the CTMUHB Audit & Risk Committee	

WHSSC JOINT COMMITTEE – 12 MONTH ROLLING FORWARD WORK PLAN 2023-2024

	Forward Work Plan		Reports from the Joint Sub-Committees - Management Group Briefings - Quality & Patient Safety Committee - Integrated Governance Committee - Individual Patient Funding Request Panel - WRCN	

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

WHSSC Joint Committee
14 March 2023
Agenda Item 4.5.1

CTMUHB Audit and Risk Committee – Part 2
Assurance Report

Reporting Committee	**CTMUHB Audit and Risk Committee - Hosted Bodies**
Chaired by	**Patsy Roseblade, CTMUHB Independent Member and Chair of the Audit & Risk Committee**
In attendance for WHSSC	**Helen Harris, Financial Accountant, WHSSC** **Helen Tyler, Head of Corporate Governance**
Date of Meetings	**13 February 2023**
Report Author	**Corporate Governance Manager**

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 (JC) of the effectiveness of its arrangements for handling reservations and delegations. The Memorandum of Agreement (MoA) states that the Audit Lead will provide reports to the JC following the Host Audit & Risk Committee meetings. This assurance report sets out the key areas of discussion and decision.

24 October 2022 – Audit & Risk Committee CTM Hosted Bodies – Part 2

1.Emergency Ambulance Services Committee (EASC)/National Collaborative Commissioning Unit (NCCU) Update

Gwenan Roberts (GR) EASC Committee Secretary/Assistant Director Corporate and Stephen Harrhy (SH) Chief Ambulance Services Commissioner (CASC), gave an update on the following:

- EASC Risk Register,
- EASC Assurance Framework,
- NCCU Risk Register, and
- EASC Action Plan.

SH reported that December 2022 had been the worst performing month on record in terms of the unprecedented levels of ambulance handover lost hours and how these posed a real and significant challenge to the delivery of timely, safe and effective emergency ambulance provision. SH provided an outline of the data from December 2022 and explained that there remained continued challenges regarding red and amber performance. There remained significant challenge in relation to call volumes and answer times.

In addition, the extreme pressures across the whole of the urgent and emergency care system resulted in ambulances not responding to a significant number of patients. Assurance was provided that these patients would have received advice on the alternative pathways for care available to them.

Whilst the January 2023 data had not yet been published, SH advised members that he expected to see an improvement across the board especially with the numbers of handover delays resulting in hours lost. The 100 WTE additional staff were now operational and this will help with performance levels.

SH presented the EASC action plan which captured all key activities in one document with a RAG rating and provided some updates on key activities being undertaken. The actions were allocated to the Welsh Ambulance Service NHS Trust (WAST), Health Boards (HBs) and combined HBs and WAST Actions.

SH and GR outlined the meetings that regularly take place between EASC, Health Boards and WAST.

GR presented the EASC and NCCU Risk Registers and highlighted some of the new risks. The EASC risk register had been reviewed and comprehensively updated during January 2023 and was presented at the EASC meeting on 17 January 2023.

The Committee **noted** the report.

2. National Imaging Academy
The National Imaging Academy risk register was deferred until the April 2023 ARC meeting.

3. WHSSC Corporate Risk Assurance Framework (CRAF)
Helen Tyler (HT), Head of Corporate Governance at WHSSC, provided an update on the Corporate Risk and Assurance Framework (CRAF), which had been approved by the Joint Committee on 17 January 2023. Members noted that as at 31 December 2022 there were 17 risks comprising of 11 commissioning risks and 6 organisational risks.

1 new commissioning risk, Risk 42 – Mental Health Referrals for adults with an eating disorder was added to the CRAF. 3 commissioning risks were also escalated. No red risks were de-escalated and no red risks were closed during the period.

In December 2022, the Corporate Directors Group Board (CDGB) reviewed the Welsh Kidney Network (WKN) Risk Register and approved two risks for addition to the CRAF.

One new organisational risk related to the financial climate was approved. In addition the workforce and capacity risk was re-escalated having previously been de-escalated in May 2022.

Members noted that a risk management workshop had taken place on 20 September 2022 and a Risk Scrutiny Group meeting took place on 30 January 2023 and the Mental Health and vulnerable groups team presented their commissioning risk register. Currently 5 of the 11 commissioning risks on the CRAF were mental health/vulnerable groups. There was a significant amount of activity around mental health following the JC recommending to Welsh Government that WHSSC become the single commissioner for Mental Health. In addition the Mental Health strategy was in the process of being finalised.

HT highlighted that the Risk Appetite Statement had been approved by the Joint Committee on 17 January 2023 and was aligned to the CTMUHB approach.

In response to a query on the renal capacity risk, Helen Harris (HH) provided assurance that the JC had recently approved a funding release to enable Swansea Bay University Health Board to proceed with the procurement of the new Dialysis Unit and this would address the capacity issues as described in the risk. The risk score should now be reduced.

In response to a query raised by Patsy Roseblade (PR) as to what the WHSSC JC members raised when reviewing the CRAF, HT explained that there had been some comments on the level of red risks. HT had explained that the risks below 15 which were amber and yellow were managed within the Directorates and Commissioning teams and were not reported to JC and its sub-committees.

PR drew attention to the target scores for some of the risks and suggested that they were reviewed or rationale added as to how the impact of the risk changed in the target risk score assessment.

HT explained that this had been noted and the Risk Management Strategy was due to be updated and taken to the JC for approval in May 2023. The plan was to roll out risk management training across the organisation and to provide specific examples around scoring to ensure a more consistent approach following JC in May.

The Committee **noted** the report.

4. WHSSC Internal and External Audit Recommendations Tracker

HH, Financial Accountant, gave a progress report on the implementation of internal audit recommendations and members noted:

- Two recommendations regarding the Positron Emission Tomography (PET) Scanner service were past their planned due dates (see separate update below),
- Two recommendations were outstanding in relation to the report on Risk Management. However, two of these had revised due dates; and
- There was one recommendation outstanding for the Neurosciences and Long Term conditions report, and this had been re-assessed and moved to March 2023.

Members also noted the positive progress made against the seven external audit recommendations outlined in the Audit Wales report "WHSSC Committee Governance Arrangements".

In relation to the WHSSC recommendations, the majority of actions had been completed and there were only two areas of partial compliance on the actions relating to:

- the Integrated Commissioning Plan (ICP); and
- the Specialised Services Strategy. An engagement process had commenced and the Managing Director, WHSSC was providing briefing sessions to HB board development sessions as part of the engagement process.
- There continued to be some delay with the AMD post for Public Health and this was down to the need to update the Job description which was being progressed. It is anticipated that this position will be advertised in March 2023.

In relation to the Welsh Government (WG) recommendations:

- On the 22 August 2022 WHSSC were advised that the Director General for Health and Social Services/NHS Wales Chief Executive (DGHSS/NWCEO) had written to Mark Isherwood, Chair of the PAPAC regarding Welsh Government recommendations 6 and 7 of the Audit Wales report into WHSSC Governance arrangements,
- The letters described the work in progress, and suggested that the recommendations from the Audit Wales report were completed,
- A Discussion with WG on the 31 August 2022 confirmed that the recommendations could be categorised as completed;
- However, on the 27 September 2022 WHSSC received a further update from WG advising that Audit Wales had written to the DGHSS/NWCEO to express the view that, at this stage, it was premature to consider the recommendations as closed and that they would like to keep them open and receive an update from WG in six months' time.

The Chair suggested that future reports capture only open recommendations or those proposed for closure.

The Committee **noted** the report.

5. PET scanner Progress Report

HT presented a comprehensive update on progress to implement the recommendations from the Internal Audit report on the Positron Emmission Tomorgrophy (PET) Scanner Programme. Following the significant progress made the two remaining actions would be closed as they would be managed as part of the programme function.

The Committee **noted** the report.

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

CORE BRIEF TO MANAGEMENT GROUP MEMBERS

MEETING HELD ON 23 FEBRUARY 2023

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, following on from the COVID-19 pandemic, meetings continued to be held via MS Teams.

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:

- **WG Review of National Commissioning Functions -** When Welsh Government (WG) published the "a Healthier Wales" report in 2018 in which they made a commitment to review the National Commissioning Functions across NHS Wales alongside the establishment of the new NHS Executive. The Minister for Health and Social Services has agreed that this review should now commence. A facilitated discussion will be undertaken with both the Joint Committees of EASC and WHSSC in March 2023,
- **Paediatric Rehabilitation Services -** The Women and Children's Commissioning Team are working with stakeholders to develop a model where all specialist paediatric rehabilitation services are commissioned as one, in order to ensure an efficient and sustainable service model that meets the needs of the paediatric population regardless of their initial diagnosis. A number of workshops have been held with clinical teams from across NHS Wales and NHS England to discuss potential models of delivery and access Criteria; and
- **Paediatric radiology training posts –** WHSSC have been informed that WG are now in a position to fund the higher radiology paediatric training post via HEIW and WHSCC funding will not be required. The first Welsh trainee will go to Bristol in April 2023.

Members **noted** the report.

4. Review of specialised commissioning in haematology: Acute Myeloid Leukaemia (AML), Acute Lymphoblastic Leukaemia (ALL) and High Risk Myelodysplasia (HRM)

Members received a report outline the main findings and proposals of the report on Acute Myeloid Leukaemia, Acute Lymphoblastic Leukaemia and High Risk Myelodysplasia from the review of specialised commissioning in haematology.

Members (1) **Noted** the findings of the specialised haematology review in relation to the opportunities, risks and challenges for the AML, ALL and HRM service in Wales, (2) **Considered** the options proposed for how specialised commissioning under WHSSC could address the opportunities, risks and challenges in the AML, ALL and HRM service to provide an equitable, high quality and sustainable service for patients in Wales; and (3) **Confirmed** that option 4, the phased implementation of option 1 (all Wales MDT) and option 3 (network service model for Wales) can be supported in principle as the preferred option; and (4) Noted that subject to confirmation that option 4 can be supported, to bring the report back to Management Group in March for formal approval prior to submission to Joint Committee.

5. Review of specialised commissioning in haematology: Allogenic Haematopoietic Stem Cell Transplantation, Salvage therapy in Non-Hodgkin's Lymphoma and Secondary Immunodeficiency

Members received a report outlining the main findings and proposals of the review of specialised commissioning in haematology for Allogenic Haematopoietic Stem Cell Transplantation (AHSCT), salvage therapy for high grade Non-Hodgkin's Lymphoma (HG NHL) and Secondary Immunodeficiency in haematology patients.

Members (1) **Noted** the findings of the specialised haematology review in relation to the management of AHSCT, salvage therapy for HG NHL and treatment for secondary immunodeficiency in haematology patients, (2) **Noted** the options proposed for how specialised commissioning under WHSSC may address the opportunities, risks and challenges in these services; and (3) **Supported** the following specific recommendations:

- Management of AHSCT:
    - Commissioning responsibility for long-term follow up (post 100 days) by the specialist AHSCT team is transferred from health boards to WHSSC,
- Salvage therapy for HG NHL:
    - Current commissioning arrangements are retained,
    - The role of central commissioning is re-evaluated once an agreed national pathway for HG NHL is in place,
- Secondary immunodeficiency:
    - Current commissioning arrangements are retained; and
    - Consideration is given to undertaking work at an all Wales level to evaluate the feasibility of a national sub-cutaneous immunoglobulin therapy service for patients with secondary immunodeficiency.

6. Review of specialised commissioning in haematology: Thrombotic Thrombocytopenic Purpura

Members received a report outlining the main findings and proposals of the review of specialised commissioning in haematology for Thrombotic Thrombocytopenic Purpura (TTP).

Members (1) **Noted** the current model of service delivery for TTP across Wales and the risks to equitable access to best treatment, (2) **Supported** the transfer of commissioning responsibility for TTP from health boards to WHSSC; and (3) **Supported** the proposed preferred option to commission TTP for the population of south Wales from a designated comprehensive TTP centre in NHS England.

7. Specialised Mesothelioma MDT Update

Members received a report providing an update on the work carried out to date in relation to commissioning a specialist mesothelioma multi-disciplinary team, to seek support for the proposed referral pathways in north, mid and south Wales respectively, and to note that the Cancer and Blood commissioning team intend to carry out a process of provider designation.

Members (1) **Noted** note the work carried out to date in relation to commissioning a specialist mesothelioma multi-disciplinary team, (2) **Supported** the proposed pathways for patients in north, mid and south Wales; and (3) **Noted** the intention to carry out a process of provider designation for a health board to host the WHSSC commissioned mesothelioma MDT in Wales.

8. Paediatric Pathology – Funding Release

Members received a report requesting support for the release of funding to enable the implementation of the 2022/25 Integrated Commissioning Plan (ICP) scheme to stabilise the Paediatric Pathology Service.

Members (1) **Supported** the release of funding to enable the implementation of the 2022/25 ICP scheme to stabilise the Paediatric Pathology Service; and (2) **Noted** that the requested funding is within the provision made for paediatric pathology within the 2022/25 ICP.

9. Final report on the Neonatal Cot Reconfiguration and Review of Tariff

Members received a report outlining the outcomes of the Neonatal Cot Capacity Review project, the proposed preferred option as recommended by the Project Board for the configuration of cots across the Network and the required long-term next steps.

Members (1) **Noted** the background within the report, (2) **Noted** the outcomes of the Project, (3) **Noted** the financial assessment, (3) **Noted** the preferred option of the Project Board, (4) **Supported** the recommended preferred option and the release of funding in line with the provision within the 2022/2025 ICP as an interim measure; and

(5) **Supported** the recommendation to Joint Committee for a phase 2 programme of works to be undertaken.

10. Commissioning and Contracting for BCUHB population with North West NHS England Providers

Members received a report providing an update on contractual and commissioning issues in relation to North West NHS England contracts, and which proposed that WHSSC and BCUHB colleagues work together to develop a Memorandum of Understanding for managing NHS England contracts where contractual and commissioning responsibilities are held across organisations.

Members **noted** the report.

11. Specialised Services Strategy Update

Members received a report providing an update on the development of a ten year strategy for specialised services and to advise on next steps.

Members **noted** the current position of the development of the specialised services strategy.

12. COVID-19 Activity Report for Month 9 2022-2023

Members received a report highlighting the scale of the 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 that the activity decreases were shown in the context of the potential risk regarding patient harms and of the loss of value from nationally agreed financial block contract arrangements.

Members noted that recovery rates, access comparisons across HBs and waiting lists were also considered, along with the relevant new performance measures set out by WG.

Members **noted** the report.

13. Financial Performance Report - Month 10 2022-2023

Members received the Financial Performance Report for Month 10, which set out the financial position for WHSSC for the ninth month of 2022-2023.

The financial position was reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC ICP by the JC in February 2022.

Members noted that the financial position reported at Month 10 for WHSSC is a year-end outturn forecast under spend of (£14.353m).

The under spend predominantly relates to releasable reserves of (£18m) arising from 2021-2022 as a result of WHSSC assisting Health Boards

manage resources over financial years on a planned basis, as HBs could not absorb underspends above their own forecasts and to ensure the most effective use of system resources.

Members **noted** the current financial position and forecast year-end position.

14. Policy Group Report

Members received a report providing an update on activity and output from the WHSSC Policy Group during the period July 2022 – January 2023, which included an updated overview of all WHSSC policies and service specifications published during the current financial year and the rationale for their development.

Members **noted** the information presented within the report.

15. Forward Work Plan

Members **noted** the forward work plan.

16. Any Other Business

Members **noted** the following items of additional business:

- **Parliamentary Health Service Ombudsman - University Hospitals Birmingham Foundation Trust (UHBFT)** – Clare Lines (CL) alerted members to the unprecedented warning the Parliamentary Health Service Ombudsman had issued over patient safety, culture and leadership at University Hospitals Birmingham Foundation Trust (UHBFT), which has triggered an investigation by NHS England. Members noted that each HB would have patients flowing through the Trust, and that it was important to continue to monitor adherence to set standards.
- **Plastic Surgery Outreach Clinics in BCUHB: Update on Quality Concerns –** SL advised that further to the MG workshop on plastic surgery in September 2022, St Helens and Knowlsey Teaching Hospital NHS Trust (SHKTHNT) had raised additional serious safety concerns regarding the service and the lack of progress made to address the issues identified at a recent SLA meeting with WHSSC. They reported that further SUIs had occurred and there was a lack of engagement from the UHB regarding their concerns and therefore they were considering withdrawing the service. WHSSC had discussed the issues with colleagues in WG and it has been agreed that given that the issues do not lie directly within the WHSSC commissioning responsibility that WG will lead on the escalation process whilst maintaining close liaison with WHSSC. Members noted that it was a complex escalation issue to manage.
- **Organ utilisation & Transplantation** – SD advised that over the last 18 Months WHSSC had been undertaking intensive work with the transplant organisations within the NHS organ utilisation and transplantation. Members noted that the Department for Health & Social Care had published a report on 21 February 2023 "Honouring the Gift of Donation: Utilising Organs for Transplant". The report outlined recommendations from the Organ Utilisation Group (OUG)

on how to maximise the potential for organ transplantation from living and deceased donors, through making the best use of available resources, driving improvements to the infrastructure and supporting innovation. Members noted that the significant changes propose to increase transplant levels over the next 5-0 years. SD agreed to share the report for information.

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

CORE BRIEF TO MANAGEMENT GROUP MEMBERS

MEETING HELD ON 26 JANUARY 2023

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, following on from the COVID-19 pandemic, meetings continued to be held via MS Teams.

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:

- **Single Commissioner for Secure Mental Health Proposal -** The options assessment report for the single commissioner for the provision of secure mental health services has been shared with Health Boards (HBs) and the responses have been collated and were presented to the Joint Committee on 10 January 2023 to inform a recommendation from the Joint Committee to Welsh Government (WG). The Joint Committee supported that the following recommendations be put forward:
    - That secure mental health services in Wales should be commissioned by WHSSC,
    - That a national programme of work, including representatives from WG, WHSSC and all of the seven HBs should be set up to manage the transfer of the commissioning of low secure services; and
    - That more detailed work needs be done to define the appropriate timescales but that the programme of work is unlikely to be completed before April 2024 at the earliest.

Members **noted** the report.

4. Options Appraisal for Eating Disorder Provision assessment

Members received a report providing an outline of the medium term options for consideration following the end of the contract for eating disorder services between WHSSC and Oxford Health NHS Trust (OHNT) to follow the interim measures currently in place.

Members **supported** the following recommendations for approval by the Joint Committee:

- To progress tendering and procurement options with the independent sector in line with service need for Welsh patients requiring specialist eating disorder services.

5. Comparison Between NG Feeding in South Wales to North Wales CAMHS Services

Members received a report outlining the findings of the exploration of the difference in Children & Adolescent Mental Health Services (CAMHS) patients requiring Nasogastric Tube (NG) feeding admitted to the Ty Llidiard in-patient unit in Bridgend and the North Wales Adolescent Service (NWAS).

Members **noted** the report.

6. All Wales Positron Emission Tomography (PET) Programme Update

Members received a report which provided a copy of the All Wales Positron Emission Tomography (PET) Programme Update report that was presented to the Joint Committee on 17 January 2023 for information.

Members **noted** the report.

7. National Skin Camouflage Pilot Service

Members received a report concerning the commissioning of a National Skin Camouflage Pilot Service for NHS Wales and to assess the impact on HBs.

Members (1) **Noted** the information in the report and next steps,
(2) **Noted** the request for a response from Health Boards as set out in the report; and **agreed** to that each Health Board would assess the impact on services, put forward a nominated contact for the scheme, complete the response form and return to WHSSC by 17 February 2023; and
(3) **Received assurance** that WHSSC is considering robust procurement options.

8. COVID-19 Activity Report for Month 8 2022-2023

Members received a report highlighting the scale of the 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 that the activity decreases were shown in the context of the potential risk regarding patient harms and of the loss of value from nationally agreed financial block contract arrangements.

Members noted that recovery rates, access comparisons across HBs and waiting lists were also considered, along with the relevant new performance measures set out by WG.

Members **noted** the report.

9. Financial Performance Report - Month 9 2022-2023
Members received the Financial Performance Report for Month 9, which set out the financial position for WHSSC for the ninth month of 2022-2023.

The financial position was reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC ICP by the JC in February 2022.

Members noted that the financial position reported at Month 9 for WHSSC was a year-end outturn forecast under spend of (£14.2m).

The under spend predominantly related to releasable reserves of £17m arising from 2021-2022 as a result of WHSSC assisting HBs manage resources over financial years on a planned basis, as HBs could not absorb underspends above their own forecasts and to ensure the most effective use of system resources.

Members **noted** the current financial position and forecast year-end position.

10. Forward Work Plan
Members **noted** the forward work plan.

11. Any Other Business

- **Paediatric radiotherapy, north Wales: Transfer of service from Clatterbridge Cancer Centre NHSFT to the Christie NHSFT** - The conventional paediatric radiotherapy service at Clatterbridge, Wirral, which provides radiotherapy for children under the care of Alder Hey, will be closing and the service transferring to Christie in Manchester. This affects circa 6 patients and families per annum from north Wales and north Powys. The decision to close the Clatterbridge service has been taken because the number of referrals has fallen to a level too small to sustain a safe service. The fall in referrals for conventional radiotherapy is a direct result of the increasing use of proton beam therapy in children due to the reduced risk of long term side effects. NHS England has approved Christie's business case to expand its conventional paediatric radiotherapy service to accommodate the patients treated at Clatterbridge. The Christie is currently recruiting staff with the aim of commencing the new service by end of March 2023. It is anticipated that the go live date will be confirmed by the end of January.

Agenda Item 4.5.3
Joint Committee
14 March 2023

Reporting Committee	**All Wales Individual Patient Funding Request (IPFR) Panel**
Chaired by	**James Hehir**
Lead Executive Director	**Director of Nursing and Quality Assurance**
Date of last meeting	**WHSSC IPFR Panel meeting 16/02/2023 (meeting twice monthly)**

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

The AW IPFR Panel on 5 January was not quorate for this meeting as there was only representation from four of the seven local Health Boards. Quoracy was expected but certain members gave apologies at the last minute i.e. at the time of the meeting was due to start.

The quoracy requirements for the AW IPFR Panel are set out in WHSSC IPFR Terms of Reference (ToR) which stipulate that the Chair or Vice Chair and five out of the seven Health Boards (3 of which need to be clinical representatives) must be present to convene the meeting.

It was agreed that, in line with the ToR, that the meeting must be stood down and urgent requests would be considered as Chairs Actions.

The Chair reminded members of the importance of confirming their attendance on a regular basis and re-confirming this when reminder emails are sent out by the IPFR Coordinator.

The Chair extended his apologies to members for the time they had used preparing for and attending the meeting unnecessarily.

The following table demonstrates the number of requests considered at the Chair's Action Panel meetings and All Wales IPFR Panel meetings during January and February 2023.

	Number of Requests discussed as Chair's Actions	Number of Requests discussed by WHSSC IPFR Panel
January	7	9
February	2	12

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

All Wales Panel Terms of Reference (ToR) and All Wales Policy
The stakeholder engagement on the proposed changes to the All Wales Panel ToR concluded on the 22nd December 2022, with feedback received from all Health Boards and other key stakeholders. The WHSS team has completed the review of the feedback in relation to the All Wales Panel ToR and a revised proposal will be presented to the Joint Committee in March.

The team are currently reviewing the comments received in regards to the All Wales IPFR Policy.

Individual Patient Funding Request (IPFR) Quality Assurance (QA) Group Audit Report – October to December 2022
One of the roles of this group is to consider an anonymised random sample of IPFR reports (one from each IPFR panel in Wales) in relation to their completeness, timeliness and efficiency of communication in line with the NHS Wales IPFR policy process.

The report highlighted that the minutes did not capture the discussions of the panel in sufficient detail, most particularly those relating to the economic considerations. Additionally, the letter to the clinician did not give sufficient explanation as to why the panel considered the intervention would not provide value for money in this case.

There was an intention to write to the Chair of the QA Group to ask for guidance on the detail required when discussing and documenting cost-effectiveness. However, the IPFR Workshop scheduled for 28 February has a session covering: *Making value based assessments - Dr Sophie Hughes, Health Technology Wales.*

The Panel were informed of the QA report at the meeting held on 16 February and the Chair asked that the Panel particularly discuss and determine if a treatment is value for money or not and the rationale for that decision.

IPFR Workshop - Tuesday 28 February 2023 Ricoh Suite, Cardiff City Stadium CF11 8AZ Chair: Professor James Coulson
Dr Sian Lewis, Managing Director, WHSSC and Professor Coulson will be presenting an interactive sessions looking at IPFR in light of quality assurance, the judicial review as well as providing IPFR policy updates and the next steps.

The workshop will also include a clinician's view of the IPFR process. The afternoon session will involve delegates forming panels to consider examples of IPFR cases and decide whether funding is 'approved' or 'not' and the rationale for that decision.

WHSSC will have a stand at the Event.

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	**2 March 2023**

Reporting Committee	**Integrated Governance Committee (IGC)**
Chaired by	**WHSSC Chair**
Lead Executive Director	**Committee Secretary**
Date of last meeting	**14 February 2023**

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

The Integrated Governance Committee (IGC) scrutinises evidence and information brought before it in relation to activities and potential risks which impact on the services commissioned by the Welsh Health Specialised Services Committee (WHSSC) and provides assurance to the Joint Committee that effective governance and scrutiny arrangements are in place across the organisation.

Meetings continue to be held via MS Teams.

14 February 2023

1.0 WELSH KIDNEY NETWORK (WKN) GOVERNANCE PLAN

Members received an update on the WKN Governance Action Plan.

Members noted:

- The action plan recommendations had been agreed and would be monitored through the WKN Board.
- The Network had not been reviewed since 2011 and any governance concerns as a result of the review would be addressed,
- Steven Combe had been appointed as the independent governance advisor and the review had looked at the Network's functions and any strengths and weaknesses in governance areas so that they could be improved where needed,
- Ensuring that the Network had Terms of Reference that captured its remit was vital, and subject to some minor queries, these were in the final stages and would be presented to the WKN Board in April 2023 before final approval being requested from the JC in May 2023.
- The importance of working closely with other Networks and WG to ensure alignment was highlighted.
- To fully implement the Welsh Government Quality Statement, further expansion of the Network would be required.
- The future ambition and direction of the WKN would be brought back to the Joint Committee in May 2023.

2.0 PROGRESS UPDATE ON DELIVERING THE INTEGRATED COMMISSIONING PLAN 2022-2023 – QUARTER 3

Members received a Quarter 3 update which highlighted:

- The majority of actions and timeline were revised to Quarter 4. It was noted the scheduling of work in this way was not WHSSC's preference as this caused a lot of work pressure across the organisation but a more balanced workload is included within the ICP for 2023/24.
- Paediatric and Pulmonary Hypertension had been delayed
- FACTS had been formally de-escalated
- Haematology review is to be presented to Management Group (MG) on 23 February 2023
- Procurement exercise in SBUHB had been completed

Members queried the delays and were advised that these were related to business cases progressing through HBs' own internal process.

Members discussed the implications of the financial pressures and received assurance that any risks would be closely monitored.

3.0 AUDIT WALES WHSSC COMMITTEE GOVERNANCE ARRANGEMENTS UPDATE

Members noted that the Audit Wales report into the WHSSC Committee Governance arrangements was published in May 2021. Since then WHSSC have been working in collaboration with Welsh Government to address the 7 recommendations made.

An update was provided to JC on 10 January 2023 with 4 recommendations for WHSSC, 2 being completed, and the final 2 relating to the Specialised Services Strategy and the appointment of an Assistant Medical Director for Public Health. The latter will be going out for advert in March 2023.

Welsh Government (WG) recommendations 6 and 7 were partially complete. Despite their advice informing they should be marked as completed, the auditor felt it was premature to close and instructed WG to provide an update in 6 months' time.

On 25 January 2023 WG informed WHSSC that the Director General Health and Social Services/NHS Wales Chief Executive Health and Social Services Group had written to Audit Wales to provide them with an update on a proposed review of national commissioning functions. Copies of letters issued to NHS Chairs and Chief Executives on 23 January 2023 were included, along with the ToR for an independent review, which had been agreed by the Minister for Health and Social Services. The review commenced week commencing 23 January and will conclude by April 2023. The ToR were discussed at the NHS Wales Leadership Board 24 January 2023 and NHS organisations confirmed their commitment to participate in the review.

An additional update will be given to the JC on 16 May 2023, thereafter an update will be submitted to Audit Wales and to Health Board Audit Committees for assurance in June/July 2023. This will 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 Health Board in Wales.

4.0 CORPORATE RISK ASSURANCE FRAMEWORK (CRAF)

Members received the updated CRAF as at 31 January 2023 which outlined the risks scoring 15 or above on the Commissioning Teams and Directorate risk registers.

The CRAF as at 31 January 2023 currently had 20 open risks, 14 being Commissioning and 6 Organisational risks. It was highlighted that a comprehensive update was shared with JC on 17 January 2023 including the 6-month summary of activity.

The CRAF has since then been updated following a Risk Scrutiny Group (RSG) meeting on 31 January 2023. The updates to the individual risk schedules were outlined in red for completeness. Following the RSG, a request was made to add what Health Board the risks relate to as this information is not currently captured.

Risk Management training for all staff is planned following a review of the Risk Management Strategy in May 2023. The risk management training remains an outstanding recommendation from the internal audit review.

Assurance was provided on the Service Level Agreement (SLA) framework and it was reported that a dashboard had been developed which displays the commissioning risks and these are also discussed in the escalation meetings with provider Health Boards.

The Mental Health and Vulnerable Groups were developing their own Directorate risk register due to their expansion and the Welsh Kidney Network was now reporting their risks the same way and their risks had been transferred over to the CRAF so reporting across the whole of WHSSC was uniform.

5.0 SUMMARY OF SERVICES IN ESCALATION

Members were advised that a number of services had been de-escalated since the last report in October 2022.

As at January 2023, WHSSC had 6 services in escalation but this was reduced to 4 as 2 services come out of escalation in this period. The services that have come out of escalation include FACTS and PETIC. One service has also reduced its level

of escalation and there are no new services in escalation to report.

The aim was to present an updated version of the Escalation Trajectory to QPSC in March 2023.

6.0 SOs and SFIs

Members received a verbal update as the report is currently in draft and will be shared with members once finalised. This report will be presented to the JC on 14 March 2023 for approval.

The revised Governance and Accountability Framework documents, including the SOs and SFIs, for WHSCC were last approved by the Joint Committee on 13 July 2021, and were subsequently taken forward for approval by the seven LHBs for inclusion as schedule 4.1 within their respective LHB SOs.

To ensure effective governance they are in the process of being updated and the main changes will include:

- Scheme of Delegation will be updated to reflect the recommendations of the Welsh Kidney Network
- Welsh Kidney Network executive lead role
- Change of Audit Lead Independent Member
- An updated list of services delegated from LHBs to WHSSC for planning and funding
- Updated SFIs following JC approval on 10 January 2023 which included a financial authorisation matrix
- Updated process for approval of non-contract cases above defined limits

7.0 CORPORATE GOVERNANCE REPORT

Members noted that WHSSC had successfully transitioned to remunerated independent members by advertising the vacancies through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs. It was confirmed that recruitment of the third IM position would begin shortly.

Members noted the following salient points contained within the Corporate Governance report included:

An update on the extension of Chair for the IPFR panel. The engagement process commenced in October 2022, and the interim IPFR chair arrangement was extended until 31 March 2022 following JC approval on 11 November 2022 to enable sufficient time to be given to reviewing the feedback from the engagement process and to reviewing the person specification for the substantive Chair role. It is anticipate that this will require a further extension while this work is finalised.

IGC members received the Internal Audit tracker for assurance. The tracker captures recommendations received from internal and external audits and was presented to the Audit and Risk Committee on 13 February 2023. The Internal Audit Plan was agreed for 2023/2024 and the planned audits were detailed in the report. Members noted that a comprehensive PET update was presented to the Audit and Risk Committee on 13 February 2023.The Committee was content with the progress. The two outstanding PET internal audit recommendations will now be closed. Members were asked to provide suggestions for the annual committee effectiveness process.
Key risks and issues/matters of concern and any mitigating actions
The financial constraints and any impact on the planned delivery of the ICP
Matters requiring Joint Committee level consideration and/or approval
Matters referred to other Committees
None
The confirmed Minutes for IGC meetings are available on request

Date of next meeting	TBC

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**24 January 2023**

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

Presentation – Mental Health Deep Dive

The committee received an informative Mental Health (MH) presentation which covered the following key areas:

- Mental Health Strategy – Consultation Feedback
- Secure Services Review
- Single Commissioner
- CAMHS
- Eating Disorders
- Mother and Baby Unit
- Governance and Incident Reporting

Dai Roberts (DR) explained that the majority of HBs had submitted consultation feedback and from the initial review of responses there was no firm opposition to the key elements of the MH strategy. The consultation responses would be used to inform the development of the final strategy and an implementation plan for the strategy was also under development.

Shane Mills (SM) provided a detailed overview of the Secure Mental Health review which he conducted and highlighted the general differences between High, Medium and Low Secure Services, the average lengths of stay as well as other classifications by gender, sexual orientation etc. for patients in each sector.

DR explained that the Single Commissioner Model had been to the WHSSC Joint Committee on 10 January 2023 and that Secure Mental Health Services in Wales should be commissioned by WHSSC. More detailed work needed be done to define the appropriate timescales, but the programme of work is unlikely to be completed before April 2024 at the earliest.

DR provided an update on the positive progress in relation to CAMHS and the de-escalation of Ty Llidiard to Escalation Level 3. The service had been in Escalation Level 4 for a considerable length of time. There will be a piece of work undertaken on referral management, which will be undertaken by NCCU.

In relation to Eating Disorders, interim arrangements are currently in place with

the Priory to ensure access to Eating Disorder beds for adults. A tender process is underway to secure a medium-term solution for the next 2-3 years. The long-term solution will be considered as part of the Specialised Services Strategy for Mental Health.

Several recommendations were made following the review of Tonna Mother and Baby Unit (MB) and an analysis of a permanent option is being conducted in line with the Mental Health Strategy Work.

Welsh Kidney Network (WKN)
QPS members were provided with an update around the two risks documented as they scored above 15, the first being around the financial element and possible inability to meet demands through the current budget. The second high level risk was around the limited outpatient capacity in Morriston Hospital, where there is a plan to establish two new satellite units around the Swansea area which should be running early 2024. The funding for these dialysis units had been approved by the Joint Committee during January 2023.

Ashraf Mikhail (AM) provided an update on the peer review process and gave details on the Quality Statement that was released by WG in 2022, which summarised the aims and objectives for the WKN.

Commissioning Team and Network Updates
Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

Cancer & Blood
Within the Cancer & portfolio and in relation to the Burns service, WHSSC were notified this week that the Mutual Aid arrangements through the Burns Network had been triggered due to a nurse staffing issue and all the arrangements with the Burns network worked appropriately.

The Corporate Directors Group Board (CDGB) had also agreed to de-escalate the PETIC service.

Neurosciences
There was a performance issue that had been a pre-COVID issue within the Neurosurgery Service, but that had now been de-escalated. Nicola Johnson (NJ) highlighted the good progress that had taken place in terms of access.

The single-handed Consultant within the Neuroendocrine Tumour service (NETS) has taken a leave of absence, but WHSSC have received assurance that contingency arrangements are in place. A Consultant from another accredited Centre is providing support and cover for these clinics.

Within the Neurosciences Commissioning Team, the Cochlear and Baha engagement was launched in December 2022 and this will close on 14 February 2023.

Cardiac
Within the Cardiac surgery services, unfortunately the escalation status has remained at the same level in both C&VUHB and SBUHB.

Following receipt of the Royal College of Surgeons (RCS) Report, it was not considered appropriate to de-escalate the service in SBUHB. WHSSC will be meeting again with the HB at an escalation meeting in February to consider the Action Plan that they have put in place to address the issues highlighted in the report. The position will then be considered again under the Escalation Framework processes.

C&VUHB has reported that hood discussion had taken place around their strategic issues and cultural changes. The provider had expressed the view that the escalation process has helped to maintain the focus of the Health Board on these issues. There will be a further meeting in April 2023.

NJ commented that the RCS Report had been written on the basis of a visit to the HB in March 2022 and the HB had undertaken significant action as a result. WHSSC had written to the HB outlining the areas of concern and the evidence required to provide WHSSC with the necessary assurance. NJ explained that she and Sian Lewis had also met with the Medical Director and Chief Executive of the Health Board and explained the progress that was expected by the next Escalation meeting.

Women & Children
During the winter there had been increased pressure within the paediatric intensive care service. This was anticipated post Covid with a return to children mixing on top of the usual respiratory pressures during the winter months.

AR reminded the Committee that WHSSC continued to attend the Paediatric Intensive Care SitRep meetings. There continues to be high demand for PICU beds.

In response to a query around Paediatric activity levels in C&VUHB, NJ explained that WHSSC had received assurance from the HB that they would be able to deliver the contract for 2022/23, but throughout the year due to pressures of theatre and staffing allocation across other Paediatric surgical disciplines the HB has not been able to deliver the level of planned contract activity. This has remained a focus of the performance meetings with the HB. NJ highlighted that, in conjunction with the JC, WHSSC would be reviewing the contract for next year and the provision for Paediatric Surgery. Outsourcing options remain on the table.

Mental Health & Vulnerable Groups
NJ explained that details around the NWAS and Ty Llidiard Services had been covered within the Mental Health presentation.

Adele Roberts (AR) felt it was important to add to the Mental Health update that WHSSC received a report on 7 November 2022, jointly undertaken by NHS Wales and NHS England, relating to a serious incident, which had led to the death of a patient on 20th April 2022. There were 12 recommendations, which will be considered by the Mental Health and Vulnerable Groups Commissioning Team. The

date of the Inquest has not yet been confirmed. The final report and findings of the inquest will be reported to the Quality and Patient Safety Committee once concluded. An update will be provided to the Joint Committee through the Chair's report.

Intestinal Failure (IF) – Home Parenteral Nutrition
The action on the Intestinal Failure (IF) invoices had been closed and an update has been provided within the report. Some new IF risks will be added onto the CRAF in January 2023 mainly around the financial and contractual arrangements.

4.0 Other Reports Received
Members received reports on the following:

- **Services in Escalation Summary**
  WHSSC currently has 6 services in escalation to report, although this will be reduced to 4 as 2 services are scheduled to come out of escalation. One service has also reduced its level of escalation and there are no new services in escalation. The table at the end of this paper provides a summary of each of those services.
- **CRAF Risk Assurance Framework**
  Members were provided with an updated position regarding the WHSSC CRAF. Members noted the updated Risk Appetite Statement that had recently been approved by the JC.
- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**
  AR provided a briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period October to December 2022.

It was acknowledged that the structure of the CQC had recently changed and may have had an impact on the structure for producing the reports. However, going forward WHSSC will continue to work closely with the CQC on their action plans and meet with them regularly.

Incident and Concerns report
An update report was noted and received by the Committee for assurance. The Chair asked for the content of the report to be considered with perhaps some additional information added to the next report.

5.0 Items for information:
Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 8 November 2022,
- QPSC Distribution List; and
- QPSC Forward Work Plan.

Key risks and issues/matters of concern and any mitigating actions Key risks are highlighted in the narrative above.	
Summary of services in Escalation (Appendix 1 attached)	
Matters requiring Committee level consideration and/or approval None	
Matters referred to other Committees As above	
Confirmed minutes for the meeting are available upon request	
Date of next scheduled meeting:	21 March 2023 at 13.00hrs

SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
September 2020	FACTS	CTUHB	2	• Workforce issue	• Last escalation meeting was held on 14/12/22 • Assurance was provided for the remaining key requirements • The service was formally de-escalated to level two on 16/12/22 Service will continue to be monitored through an improvement plan for further de-escalation (confirmation of clinical leadership and recruitment of remaining psychology posts)	**To be removed from escalation** 

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
March 2018 Sept 2020 Aug 2021	Ty Llidiard	CTMUHB	3	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11 September	• Escalation meetings held monthly, Exec Lead identified from Health Board. Last escalation meeting 5th December 2022 • Improvement Board established to oversee delivery of an integrated improvement plan • Emergency SOP has been fully implemented • Majority of posts recruited to or start dates agreed. • Improved leadership evident via escalation meetings • Progress against de-escalation action plans, and a favorable report following the latest quality visit provided assurance to support de-escalation of service to Level 3 • Further audit being conducted around the referral processes to enable consideration of further de-escalation.	
July 2021	Cardiac Surgery	SBUHB	3	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	• Continued six weekly meetings in place to receive and monitor against the improvement plan. • The service was de- escalated on delivery of the immediate actions required by the GIRFT recommendations (per March update), but remained in level 3 whilst the impact of these actions is ascertained. • The escalation level was discussed at the most recent	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
					meeting in October 2022 and, although significant progress towards the GIRFT benchmarks was noted, it was agreed that WHSSC would need to review the final report of the Royal College of Surgeons of England (RCS England) Invited Service Review to be prior to any potential further de-escalation. • This report was received in November 2022 and was subsequently reviewed by the Cardiac Commissioning Team. As a result of the report's urgent recommendations to address patient safety risks, and in view of a small number of new concerns identified by the RCS, WHSSC concluded that further assurance was required further assurance before de-escalation could be taken forward, and the service remains in Level 3 escalation.	
July 2021 (original escalation) April 2022 (escalated from 2-3)	Cardiac Surgery	C&VUHB	3	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB had previously agreed a programme of improvement work to address the recommendations set out in the GIRFT report. • In view of a failure to provide the requested GIRFT improvement plan and HEIW report, the service was re-	⟷

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
					escalated in April 2022. • The service has since provided both a GIRFT improvement plan and HEIW report (and action plan), and WHSSC has developed de-escalation criteria based on the GIRFT recommendations and action plans. • The de-escalation criteria were discussed at the November 2022 escalation meeting. It was agreed that there was no expectation that the criteria would need to be delivered in full to facilitate de-escalation, but that the service would need to evidence demonstrable progress as a result of targeted actions • A further escalation meeting has been scheduled for April 2023.	
November 2021	Adult burns	SBUHB	3	• At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2022. The current escalation	• Escalation monitoring meetings held on 12th August, 27th September and 1st December 2022. • The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023. • The capital case remains on target with the planned timeline. • The next escalation monitoring	⟷

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
				concerns the progress of the capital case for the long term solution and sustainability of the interim model.	meeting is arranged for 3rd March 2023.	
February 2022	PETIC	Cardiff University	1	Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients. These concerns include: • Recent suspension of production of PSMA due to critical quality control issue identified during MHRA inspection. Service slow top address impact on service for patients. • Failure to undertake a timely recruitment exercise leading to isotope production failures. • Failure to provide a business case of sufficient quality in a timely manner for replacement of the scanner	PETIC has taken forward the agreed actions with regard to increasing management capacity within the service and clarifying the governance arrangements for the service. PETIC has been de-escalated and therefore removed from the table of services in escalation. WHSSC corporate directors agreed to de-escalate PETIC following confirmation on 5th December 2022 that the actions in the escalation action plan had been completed. The service has returned to routine monitoring.	**To be removed from escalation**

Reporting Committee	**Welsh Kidney Network (WKN)**
Chaired by	**Chair, Welsh Kidney Network (WKN)**
Lead Executive Director	**Director of Programmes**
Date of last meeting	**2nd February 2023**

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

This report provides assurance to the Joint Committee in accordance with the WKN Terms of Reference (ToR) which state that the Chair of the Welsh Kidney Network (the 'WKN') will provide reports to the Joint Committee following WKN meetings outlining the activities of the Network and bringing attention to any significant matters under consideration by the Network. Minutes are available on request from the WKN Coordinator, Jonathan.Matthews@wales.nhs.uk

1. Patient Story

There was a presentation to the Board of complex patient story that required considerable care coordination by a specialist renal social worker.

The key theme related to significant delay in being allocated appropriate housing for a mother who required dialysis whilst supporting her child with multiple health needs. This meant that the patient was not able to utilise home dialysis, which was the preferred option both clinically and from a psychosocial perspective, due to the poor housing situation. The specialist social worker, which is a WKN commissioned service, and the rest of the MDT spent considerable time supporting the woman and her family and eventually the family were rehoused. The social worker described the impact of the significant delays and the impact this had on the patient's health and that of her family and that such delays are not isolated incidents.

Board members acknowledged the need for a more integrated holistic approach across the health and social care economy for meeting the needs of people living with kidney disease. **Board members asked that housing related issues are raised at Joint Committee and requested, through the CEOs at JC, that these issues are raised at Regional Partnership Boards**. It was agreed that the issues would also be raised at All Wales Directors of Planning again to raise at RPBs and the Welsh Government representative suggested raising with the Minister responsible for housing

2. Finance Report

The WKN Finance Manager gave an update on the WKN budget. Block payments based on 2019-2020 activity is expected to gradually wind down during the year ahead. For the purposes of financial forecasting to the end of March, and based on the current information available, it is expected that Swansea Bay and BCU will

continue to receive block payments for the rest of the financial year in line with the overarching LTA agreements with WHSSC. Cardiff will reach and exceed the 2019 dialysis activity levels and could require a further support which is available within the WHSSC growth reserves.

On 17th January 2023, the WHSSC Joint Committee approved an additional £1.4m of funding to support the procurement of satellite dialysis services in West Wales, the commissioning of 2 new satellite units east of Swansea and a dialysis machines replacement contract at Morriston.

Members were informed that the long-term financial outlook into 2023/2024 is included in the WHSSC ICP but it cannot be finalised until the WHSSC Joint Committee confirm support for the plan. Once the outcome of this is known it will be reported to network board.

3. Quality and Patient Safety

The revised version of the WKN Board risk register has become embedded within the quality assurance and risk management process. The risks, as they apply to Health Board operational matters, are sense checked at the quarterly WKN/Regional Renal centre interface meetings.

Any risk scoring 15 and above on any of the sub-committee or directorate registers are automatically considered for inclusion on the WHSSC corporate assurance risk register (CRAF).

BCUHB Board representatives noted that their internal renal risk register is currently suspended as, due to the current operating model, there is no clear governance pathway to enable Health Board oversight and management of risks in the renal service. The suspension could give rise to a renal related risk appearing on the WHSSC corporate register without it formally being reported upon in the BCUHB health board. The BCU representatives confirmed that they are in discussion with the BCUHB Medical Director and are expecting a resolution to this issue. The WKN Board Executive Lead also agreed to discuss this with the BCUHB Medical Director.

4. Value Based Health Care

The WKN have received funding of up to £444,460 in 2022-23, and 23-24 from the Value in Health Programme with the aim of increasing the number of patients receiving a pre-emptive transplant and increasing the number of patients accessing home dialysis.

Since the funding award a range of discussions have taken place with Clinical Directors from each of the three regional renal centres. These discussions confirmed that the aims that the original bid set out to achieve were totally supported. However the clinical teams' at all three centres felt that the suggested methodology in the proposal was not the priority to achieve these aims. They wanted to target resources to the key areas that research had identified would

have the maximum impact in terms of patient support. Each region would focus on strengthening any gaps in their current provision. To that end the costs within the proposal are being reframed. Early discussions with the Value in Health Team have confirmed their support. The reframed proposal will be forwarded to Board members in the first week of March and an implementation plan developed soon after.

5. Welsh Government Update.

The Quality Statement for Kidney Disease in Wales which was developed in collaboration with WKN Management Team and Quality and Patient Safety Group, Welsh Government and kidney charity partners has been published by Welsh Government. This forms part of the National Clinical Framework and is the successor document of the Renal Delivery Plan.

A programme of work to develop the three year rolling implementation plan and updates to the service specifications will now form a significant part of the WKN work plan for 23/24. This will require wide stakeholder consultation across the care pathway inclusive of primary and social care.

Board members were informed on the position with NHS Blood and Transplant (NHSBT) service within NHS England around the funding position for organ donation and transplantation. NHSBT have an on-going discussion with NHS England regarding the recurrent funding for donation after circulatory death (DCD) for heart transplantation and the Abdominal Normothermic Regional Perfusion Service (ANRP). The latter affects the service at Cardiff who have a team of transplantation surgeons who will attend hospitals to retrieve organs and perfuse them prior to taking them to the transplantation centre. NHSBT are concerned that without confirmation of recurrent funding from NHS England they will no longer be able to continue these services which could impact the number of organs available for transplantation. Working with Welsh Government, WHSSC and the WKN have confirmed that funding allocated from Wales will continue to be made available. Discussions continue with the service at Cardiff and with NHSBT and once the final position is known WKN members will be informed.

At the Board meeting Welsh Government noted that they were awaiting confirmation of the date for the publication of the independent report, "Honouring the gift of donation: utilising organs for transplant - summary report of the Organ Utilisation Group" which was commissioned by the Secretary of State for Health and Social Care in England. Since the meeting this report has been published.

6. Swansea Bay University Health Board (SBUHB) Procurement Project Update

Members were informed that the tender evaluation is finalised and the preferred bidder recommended by the Swansea Bay University Health Board at their meeting on 26th January 2023 following support on the revenue from Joint Committee at their meeting on 17th January 2023. A report has now been submitted for onward

approval by Welsh Government and the WKN core team will work with Swansea Bay UHB on an implementation plan

7. Network Board Governance Review and Future of the WKN

The WKN continue to monitor and support progress on the action plan developed from the Governance Review. Members were pleased to receive progress in delivering the actions. The Board have engaged in the development of a new set of terms of reference (TORs) and in setting out their vision for the future of the Network. Both the TORs and the vision for the Network will be finalised at the next WKN Board meeting in April 2023 before bringing to Joint Committee in May for discussion and approval.

As an integral element of the National Clinical Framework, the Quality Statement for Kidney Disease was published by Welsh Government on 30 November 2022. However, the National Clinical Framework Implementation Programme does not currently include the WKN. Discussion with NHS executive have taken place to consider how the WKN aligns or works with the new organisation.

8. UK Kidney Week

Board members were advised that the UK Kidney week is approaching (5th-7th June at the ICC in Newport). This is the first time this prestigious event is being held in Wales. The health minister will be in attendance to give a key note speech on value in healthcare on the first day.

9. Highlight Reports

The following highlight reports were received:

- Lead Pharmacist Highlight Report
- Clinical Information Lead Highlight Report
- South West Wales Highlight Report
- North Wales Highlight Report
- South East Wales Highlight Report
- Home Dialysis Clinical Lead Highlight Report
- Transplant and Vascular Access Clinical Lead Highlight Report
- Health and Wellbeing Professionals Reference Group Highlight Report
- Collaboration of third sector partners highlight report.

Matters requiring Committee level consideration and/or approval

Workforce

There is a recurring theme whereby there are limitations to service delivery and innovation caused by the lack of availability and/or retention of highly skilled members of the kidney care teams.

Clinic Capacity

There are continuing challenges in Cwm Taf Morgannwg UHB (CTMUHB) concerning extended waiting times to see a nephrologist. This potentially leads to delayed diagnoses and missed opportunities to delay or reverse progression of CKD to the point where renal replacement therapy is required. Although this is not

an area of WKN commissioning responsibility support is being provided by the WKN Board Exec Lead to resolve this issue and ensure that a sustainable service can be provided.	
Matters referred to other Committees	
• None	
Date of next meeting	**4th April 2023**