Joint Committee (Public)

Tue 08 November 2022, 13:30 - 16:30

TEAMS

Agenda

13:30 - 13:30
0 min

1. PRELIMINARY MATTERS

Chair

0.0 JC Public Agenda 8 Nov 2022.pdf (2 pages)

1.1. Welcome and Introductions

Oral *Chair*

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

1.4. Minutes of the Meeting held on 6 Sept 2022 and Matters Arising

Att. *Chair*

1.4 Draft Unconfirmed JC (Public) Minutes 6 September 2022 final.pdf (20 pages)

1.5. Action Log

Att. *Chair*

1.5 JC Action Log v2.pdf (10 pages)

13:30 - 13:30
0 min

2. PRESENTATION

2.1. Draft Integrated Commissioning Plan (ICP) 2023-2025

Att. *Director of Planning*

2.1 Draft Integrated Commissioning Plan 2023-2026.pdf (4 pages)

2.2. Recovery Update (including Progress with Paediatric Surgery)

Presentation *Director of Finance*

13:30 - 13:30
0 min

3. ITEMS FOR CONSIDERATION AND/OR DECISION

3.1. Chair's Report

Att. *Chair*

3.1 Chair's Report.pdf (5 pages)

3.2. Managing Director's Report

Att. *Director of Planning*

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

3.3. Delivering Thrombectomy Capacity in South Wales

Att. *Director of Planning*

- 3.3 Delivering Thrombectomy Capacity in South Wales.pdf (6 pages)
- 3.3.1 Appendix 1 Developing Regional Stroke Services.pdf (13 pages)
- 3.3.2 Appendix 2 WHSSC position statement on the commissioning of mechanical thrombectomy.pdf (6 pages)

3.4. Mental Health Strategy Development

Att. *Director of Mental Health*

- 3.4 Mental Health Strategy Development.pdf (10 pages)
- 3.4.1 Appendix 1 - Summary of Stakeholder feedback.pdf (11 pages)
- 3.4.2 Appendix 2 - Draft MH Strategy Document for Consultation.pdf (84 pages)

3.5. Single Commissioner for Secure Mental Health Proposal

Att. *Director of Mental Health*

- 3.5 Proposal for a Single Commissioner for Secure Mental Health Services in Wales.pdf (7 pages)
- 3.5.1 Appendix 1 - Letter to WHSSC Joint Committee regarding secure services review recommendation (1).pdf (2 pages)
- 3.5.2 Appendix 2 - Options Appraisal Single Comm MH.pdf (4 pages)

3.6. Gender Identity Development Service (GIDS)

Att. *Director of Nursing & Quality*

- 3.6 Gender Identity Development Service (GIDS) Update.pdf (7 pages)
- 3.6.1 Appendix 1 - Gender Identity Services (GIDS) NHS Wales FAQs.pdf (4 pages)

3.7. Individual Patient Funding Request (IPFR) Engagement Update

Att. *Medical Director*

- 3.7 IPFR Process for Engagement.pdf (6 pages)
- 3.7.1 Appendix 1 Proposed WHSSC IPFR Panel ToR v0.6.pdf (3 pages)
- 3.7.2 Appendix 2 Proposed changes to the All Wales IPFR v0.2.pdf (32 pages)
- 3.7.3 Appendix 3 draft engagment letter - IPFR.pdf (2 pages)
- 3.7.4 Appendix 4 Summary of WHSSC IPFR Panel ToR proposed changes (v2).pdf (3 pages)
- 3.7.5 Appendix 5 Stakeholder Engagement Profroma.pdf (2 pages)

13:30 - 13:30
0 min

4. ROUTINE REPORTS AND ITEMS FOR INFORMATION

4.1. COVID-19 Period Activity Report Month 5 2022-2023

Att. *Director of Finance*

- 4.1 COVID-19 Period Activity Report Month 5 2022-2023.pdf (38 pages)
- 4.1.1 COVID-19 Period Activity Report Month 5 2022-2023 - Appendix 1 English data.pdf (14 pages)
- 4.1.2 COVID-19 Period Activity Report Month 5 2022-2023 - Appendix 2 WG measures.pdf (10 pages)

4.2. Financial Performance Report Month 6 2022-2023

Att. *Director of Finance*

- 4.2 Financial Report Month 6 22-23 WHSSC signed.pdf (11 pages)

4.3. Corporate Governance Matters Report

Att. *Committee Secretary*

- 4.3 Corporate Governance Report.pdf (4 pages)
- 4.3.1 WHSSC JC 12 Month Rolling Forward Work Plan.pdf (6 pages)

4.4. Reports from the Joint Sub-Committees

Att. *Joint Sub-Committee Chairs*

i. Management Group Briefings

ii. Quality & Patient Safety Committee (QPSC) (to follow)

iii. Integrated Governance Committee (IGC)

iv. Individual Patient Funding Request (IPFR) Panel

v. Welsh Kidney Network (WKN)

- 4.4.1a 2022-08-25 MG Core Brief v1.0.pdf (4 pages)
- 4.4.1b 2022-09-22 - MG Core Brief v1.0.pdf (3 pages)
- 4.4.1c 2022-10-27 - MG Core Brief v1.0.pdf (5 pages)
- 4.4.2 Quality & Patient Safety Committee Chairs report.pdf (14 pages)
- 4.4.2a Appendix 2 WHSSC Quality Newsletter.pdf (16 pages)
- 4.4.2b Appendix 3 - WHSSC Quality Internal Audit Report.pdf (11 pages)
- 4.4.3 Integrated Governance Committee 11 October 2022.pdf (4 pages)
- 4.4.4 All Wales Individual Patient Funding Chair report - Oct (v3).pdf (2 pages)
- 4.4.5 Chairs Report WKN Oct 2022.pdf (7 pages)

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0 min

5. CONCLUDING BUSINESS

5.1. Any Other Business

Oral *Chair*

5.2. Date of Next Meeting (Scheduled)

Oral *Chair*

17 January 2023 at 9:30hrs

Extraordinary Joint Committee - 10 January 2023 9.00am

5.3. In Committee Resolutions

Oral *Chair*

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 8 November 2022
at 13:30 hrs

Microsoft Teams

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 Meeting held on 6 September 2022 and Matters Arising	Chair	Att.	
1.5	Action Log	Chair	Att.	
2.0	**PRESENTATION**			
2.1	Draft Integrated Commissioning Plan (ICP) 2023-2026	Director of Planning	Att.	13:35 - 13:55
2.2	Recovery Update (incl Progress with Paediatric Surgery)	Director of Finance	Pres.	13:55 - 14:15
3.0	**ITEMS FOR CONSIDERATION AND/OR DECISION**			
3.1	Chair's Report	Chair	Att.	14:15 – 14:20
3.2	Managing Director's Report	Managing Director	Att.	14:20 – 14:25
3.3	Delivering Thrombectomy Capacity in South Wales	Director of Planning	Att.	14:25 – 14:35
3.4	Mental Health Strategy Development	Director of Mental Health	Att.	14:35 - 14:45
3.5	Single Commissioner for Secure Mental Health Services Proposal	Director of Mental Health	Att.	14:45 - 15:05
3.6	Gender Identity Development Service (GIDS)	Director of Nursing & Quality	Att.	15:05 - 15:10
3.7	Individual Patient Funding Request (IPFR) Engagement Update	Medical Director	Att.	15:10 - 15:15

ITEM		LEAD	PAPER / ORAL	TIME
4.0	**ROUTINE REPORTS AND ITEMS FOR INFORMATION**			
4.1	COVID-19 Period Activity Report Month 5 2022-2023	Director of Finance	Att.	15:15 - 15:45
4.2	Financial Performance Report Month 6 2022-2023	Director of Finance	Att.	15:45 - 16:00
4.3	Corporate Governance Matters Report	Committee Secretary	Att.	16:00 - 16:05
4.4	Reports from the Joint Sub-Committees i. Management Group Briefings ii. Quality & Patient Safety Committee (QPSC) iii. Integrated Governance Committee (IGC) iv. Individual Patient Funding Request (IPFR) Panel v. Welsh Kidney Network (WKN)	Joint Sub-Committee Chairs	Att.	16:05 - 16:20
5.0	**CONCLUDING BUSINESS**			
5.1	Any Other Business	Chair	Oral	16:20 - 16:25
5.2	Date of Next Meeting (Scheduled) - 17 January 2023 at 9.30hrs Extraordinary Joint Committee Meeting - 10 January 2023 9.00hrs	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	

Unconfirmed Minutes of the Meeting of the WHSSC Joint Committee Meeting held In Public on Tuesday 6 September 2022 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
Glyn Jones	(GJ)	Interim Chief Executive Officer, Aneurin Bevan UHB
Paul Mears	(PM)	Chief Executive Officer, Cwm Taf Morgannwg UHB
Ceri Phillips	(CP)	Independent Member, Cardiff & Vale UHB
Ian Phillips	(IP)	Chair, Welsh Renal Clinical Network (WRCN), Powys THB
Karen Preece	(KP)	Director of Planning, WHSSC
Carol Shillabeer	(CS)	Chief Executive Officer, Powys THB
Ian Wells	(IW)	Independent Member, Cwm Taf Morgannwg UHB
Jo Whitehead	(JW)	Chief Executive Officer, Betsi Cadwaladr UHB

Deputies:

Lee Davies (for Steve Moore)	(LP)	Executive Director of Strategic Development and Operational Planning, Hywel Dda UHB
Sian Harrop-Griffiths (for Mark Hackett)	(SH-G)	Director of Strategy, Swansea Bay UHB
Meriel Jenney (for Suzanne Rankin)	(MJ)	Medical Director, Cardiff & Vale UHB

Apologies:

Mark Hackett	(MH)	Chief Executive Officer, Swansea Bay UHB
Steve Ham	(SH)	Chief Executive Officer, Velindre University NHS Trust
Steve Moore	(SM)	Chief Executive Officer, Hywel Dda UHB
Suzanne Rankin	(SR)	Chief Executive Officer, Cardiff & Vale UHB

In Attendance:

Andrea Bradley	(AB)	Network Manager, SBUHB
Jacqui Evans	(JE)	Committee Secretary & Head of Corporate Services, WHSSC
Maxine Evans	(ME)	Project Manager, WHSSC
Dinendra Gill	(DG)	Consultant in Emergency Medicine, SBUHB
Claire Harding	(CH)	Assistant Director of Planning, WHSSC
Lorraine Harry	(LH)	Consultant Plastic Surgeon, CVUHB
Nicola Johnson	(NJ)	Assistant Director of Strategy (Commissioning), SBUHB
David Roberts	(DR)	Director for Mental Health and Vulnerable Groups
Nick Wood	(NW)	Deputy Chief Executive NHS Wales, Health & Social Services, Welsh Government

Minutes:
Charles Brain (CNB) Interim Corporate Services Manager, WHSSC

The meeting opened at 09:30hrs

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JC22/102	**1.1 Welcome and Introductions** The Chair welcomed members to the meeting in Welsh and English and reminded everyone that meetings will continue to be held virtually via MS Teams. No objections were raised to the meeting being recorded for administrative purposes. It was noted that a quorum had been achieved. The Chair reminded members that the purpose of the Joint Committee (JC) was to act on behalf of the seven Health Boards (HBs) to ensure equitable access to safe, effective and sustainable specialised services for the people of Wales by working collaboratively on the basis of a shared national approach, where each member worked in the wider interest. The Chair welcomed those from the South Wales Trauma Network team who were attending to deliver a presentation.
JC22/103	**1.2 Apologies for Absence** Apologies for absence were noted as above.
JC22/104	**1.3 Declarations of Interest** The JC noted the standing declarations and that there were no additional declarations of interest relating to the items for discussion on the agenda.
JC22/105	**1.4 Minutes of the meeting held on 12 July 2022 and Matters Arising** The minutes of the JC meeting held on 12 July 2022 were received and approved as a true and accurate record of the meeting. There were no matters arising.
JC22/106	**1.5 Action Log** The action log was received and members **noted** the progress on the actions, noted that all of the 'open' actions were covered under the agenda items during the meeting and noted 'closed' actions.
JC22/107	**2.1 Major Trauma Presentation** Members **received** an informative presentation on the South Wales major trauma network, which was launched in September 2020.

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	Dinendra Gill (DG), Lorraine Harry (LH) and Andrea Bradley (AB) gave an update on the comprehensive evaluation process which was underway to review the effectiveness of the network over the last 18 Months, including: • The two stage evaluation process which included a Peer Review and 1 year evaluation, • The patient flow through the three levels of the Rehabilitation Model and the benefit of the hyper-acute rehabilitation, • A review of the 4,702 Trauma Audit and Research Network (TARN) injuries and outcomes, • The importance of data collection to allow performance measurement and how this needs to be done on a sustainable basis in the future, • Analysis highlights where future resources should be allocated, • The benefits of the Major Trauma Desk as a triage tool, along with updates on secondary transfers and the Emergency Medical Retrieval and Transport Service (EMRTS), • A summary of the Peer Review outcomes which reported no immediate risks and highlighted areas of good practice including the repatriation success, and the communication and support provision, among other areas, • That the Peer Review had raised some "serious concerns" and action plans had been submitted by the four HBs to address the concerns by October 2022. Regular contact between the HBs and SWTN would continue during this period and beyond, • There being further areas of improvement which will be built into the organisational work plans, • The One Year Evaluation which will consider the deliverables of the network against the Benefits Realisation Plan and, following validation, will be published in November 2022, • The success of SWTN to date, along with identified improvements in the core areas which will allow further improvements in the pathways and clinical care; and • The SWTN being on an improvement curve and that a mature trauma network could take five years to develop, therefore it will take time to determine functional outcome benefits and translation into measurable improvements in value for money. DG asked members to positively engage in the recommendations from the peer review and to discuss the concerns identified with their respective trauma clinical and operational leads to ensure they were being addressed. Ian Wells (IW) and Glyn Jones (GJ) queried potential future resource and if the knowledge of the network was embedded across the network, DG advised that through the use of predictive mapping volumes into the Major Trauma Centre (MTC) were expected to stabilise from year 3 onwards and that the One Year Evaluation will include a performance review of the actual and forecasted future

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	flows against those included in the Business Case. Members noted that the SWTN would be producing Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) data in the near future, which will assist in demonstrating the wider socio-economic benefit and the value for money of the network. DG noted that the evaluation, along with the Peer Review, will also identify areas of vulnerability and additional investment requirements such as: • A potential request to increase PTU bed capacity, • Investment in additional resource in major trauma practitioners and the rehabilitation coordinators to provide a more robust provision and ensure patient flow is maintained; and • A regionalised approach to rehabilitation. Sian Harrop-Griffiths (SH-G) advised that she was SRO for the network, thanked DG for the quality and content of his presentation and thanked everyone who had responded to the peer review exercise. Members noted that the resource challenges had been discussed with KP and the NHS Wales Directors of Planning (DoP) group. Karen Preece (KP) advised that the MTN was supported by a programme business into which a resource of £15million had been invested. It will take time for all the benefits to be realised and to demonstrate value for money. As the network matures it will be necessary to ensure future allocation of investment and resources was appropriate. Members noted the benefit it may have for other ODNs which were being developed. Ian Phillips (IP) suggested that the JC receive an update on progress with the network in 12 months' time, and to consider a network wide rehabilitation strategy. **ACTION**– An update on the Major Trauma Centre to be given to the Joint Committee in September 2023, to include consideration of a network wide rehabilitation strategy. Carol Shillabeer (CB) queried equity of access, especially for North Powys, and DG explained that equity of access was one of the parameters in the Benefits Realisation Plan and would be reviewed in the One Year Evaluation. He added that the Trauma Desk and triage process was working well with the issues around secondary transfers for regional providers having been resolved following additional training and education. Members noted that based on the data, which was monitored daily and reviewed on a quarterly basis, there were few incidents where a patient was treated locally, rather than transferred to the MTC, which resulted in a worse outcome.

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	DG advised that LH would be leading the SWTN during his 1 year placement and thanked Members for the opportunity to provide an update and for their continued support. The Chair and KP thanked DG, AB and LH for their presentation. The Joint Committee resolved to: • **Note** the presentation and the progress made.
JC22/108	**2.2 Specialised Services Strategy Presentation and Report** Members **received** a report and a presentation on the planned development of a ten year strategy for specialised services for the residents of Wales, which described the proposed approach to communication and engagement with key stakeholders to support its development. Sian Lewis (SL) advised that as previously agreed at a JC meeting in March 2018, an engagement process would be undertaken to support the development of a strategy using a blended approach of written/electronic feedback via an online survey and general feedback from stakeholder meetings. Members noted that: • The survey responses and general feedback will be used to develop a draft strategy document for consideration by both the JC and Welsh Government (WG), • the timeline for the engagement process will run between 20 September and 22 December 2022 with the aim of a draft strategy being presented to the MG at its February 2023 meeting in preparation for final approval by the JC in May 2023 before being presented to WG and, once approved, formally published; and • Regular updates will be provided to MG during the engagement process on the themes and issues arising from stakeholder feedback to minimise 'surprises' in the drafting of the strategy. Members noted that consultation meetings had been arranged with HBs and Velindre University NHS Trust (VUNT), and asked members to encourage their HB colleagues to complete the stakeholder survey, to ensure it reflected individual HB strategies. Members noted that organisations and bodies representing patient groups had been included in the stakeholder engagement list, but that individual patients had not been included. Paul Mears (PM) advised that HBs had their own clinical service strategies and there was a need to ensure adequate architecture and structure in conjunction with HB planning leads. PM also advised that caution was required when setting expectation levels in relation

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	workforce capacity and financial resource, and suggested focussing on innovative methods through working with the Life Sciences Hub to tap into horizon scanning. SL advised that she recognised the issues raised and that, the survey covered these points. MG members had been fully engaged in developing the survey and approach and will be able to input into the strategy, once drafted, to ensure the areas referenced are included. SH-G advised that it was essential to include a workforce needs assessment as part of the work and queried the time available to WHSSC to compete the work by March 2023. SL responded and advised that the engagement process was to form an overarching strategy and completion of a needs assessment will depend on the individual services identified from the resulting strategy. Members noted the requirement to have additional public health support and that a recruitment process had commenced for an Assistant Director of Public Health to be involved in leading the work. CS queried if the timeline supported HBs in being able to influence their IMTPs. It was clarified that this would inform the 2024/25 IMTPs. SL encouraged everyone to participate in the stakeholder feedback, to ensure it aligned to HB strategies. The Joint Committee resolved to: • **Approve** the overall approach to developing a ten year strategy for specialised services and provided feedback on the key documents presented.
JC22/109	**2.3 Recovery Update Paediatrics – Presentation** The Chair introduced the session and reminded members of the recovery workshop held on the 12 July 2022 and the JC requested a further deep dive on paediatrics for this meeting. Members **received** a presentation providing an update on recovery trajectories for paediatric services across NHS Wales, in particular the differences in patterns of activity for children's services by both provider and HB of residence. KP gave an update and members noted the limitations arising from the available data for the period April 2018 to June 2022 for children under 16 years of age, particularly in relation to waiting lists. In addition, the 'specialist' elements of the surgical specialties were currently not well defined and, consequently, the data for 'WHSSC commissioned' services included some 'non-specialist' activity. It was reported that: • The data showed that there was a significant reduction in

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	activity of paediatric surgery during the pandemic and although activity had increased on the prior year it remained behind 2018-2019 levels, • The data did not suggest any prioritisation of local activity by CVUHB, • Recovery plans had been requested from CVUHB as there were a significant number of children waiting for surgery over 36 weeks and some over two years, • Further investigation should be undertaken on activity that was on the Interventions Not Normally Undertaken (INNU) list, which may provide an opportunity to release some capacity, • Although activity via English providers remained below pre-pandemic levels there was less of a reduction of activity during the pandemic in comparison with Welsh providers and activity was recovering; and • There were no longer any patients waiting for surgery in excess of 52 weeks by English providers and those waiting in excess of 36 weeks had been/were being addressed. KP provided a brief summary of the Getting It Right First Time (GIRFT) Report on Paediatric General Surgery & Urology published in 2021. Meriel Jenney (MJ) reported that Paul Bostock, the new Chief Operating Officer (COO) at CVUHB, was focussed on paediatric surgery waiting lists and was keen to engage in discussions to address the issues. CS thanked the team for compiling the information and suggested focussing on waiting times for children by provider, including comparisons and recovery trajectories, and advised that she could assist in obtaining additional data from English providers if required. Lee Davies (LD) suggested that a long-term plan would be required to resolve the waiting list at the Children's Hospital for Wales (CHfW) as the backlog was unlikely to be resolved by March 2023 through out-sourcing and an increase in activity. Nick Wood (NW) advised that he attended a number of IQPD meetings and that there was a need to bear in mind the focus for patients waiting over 104 weeks by March 2023, recognising the proportion of the child's life this represents. NW asked KP to liaise with Andrew Sallows, National Director – Planned Care Improvement and Recovery of SBUHB, regarding Ministerial measures and recovery trajectories. Members noted that WG were flagging issues with individual HBs and that WG will liaise with CVUHB to discuss the specific issues.

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	NW advised that the data presented a useful examination of the position, and that it was essential that we get this on to a sustainable footing in the next 6 months. KP noted that she had discussed the 'next steps' with Management Group which included: • Reviewing the INNU lists, • Considering out-sourcing options to assist in reducing waiting lists at CHfW. It was noted that the system was in balance before the pandemic so resolving the current back log should restore this position, • Developing and implementing different prioritisation criteria for children so that they are seen in a timely manner, • Retaining paediatric surgery on the agenda to maintain focus, along with reporting progress in the activity reports; and • All HBs implementing the GIRFT recommendations. Stuart Davies (SD) added that capacity levels in both Wales and the England centres were significantly below those prior to the pandemic and that they would need to be reinstated as soon as possible. The Chair suggested that WHSSC work with CVUHB to expedite the work with the new COO. MJ offered to look at INNUs. Members noted that there was also a need to look at outsourcing options, which were discussed during the equity workshop in 2021 and there was a need to re-explore this area. **ACTION:** MJ is to review the INNU lists, including establishing if there were any misallocated or misstated surgical operations. **ACTION:** SD and KP will work with CVUHB on recovery plans and SD will provide members with an update in November. **ACTION:** NJ to provide an update to the November JC on work to develop alternative prioritisation criteria for children **ACTION:** KP will investigate out-sourcing options to address the backlog issue and NJ will provide an update in November. **ACTION:** Following on from the Recovery Trajectories Workshop at the July 2022 meeting SD to coordinate a progress review on recovery trajectories at the 17 January 2023 JC meeting. The Joint Committee resolved to: • **Note** the presentation and report.

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JC22/110	**3.1 Chair's Report** The Chair's report was received and the Chair gave an update on relevant matters undertaken since the previous JC meeting. Members **noted**: • Following the Chair's notification to Members on 27 July they ratified the decision to appoint James Hehir, Independent Member from Cwm Taf Morgannwg University Health Board (CTMUHB), to undertake the role of Interim Chair of the All Wales Individual Patient Funding Request (IPFR) panel for a 6 month period on an unremunerated basis with effect from 27 July 2022, • An update on plans for the recruitment process to fill the two WHSSC IM vacancies, • Attendance at the Integrated Governance Committee (IGC) meeting on 9 August 2022; and • Attendance at key meetings. The Joint Committee resolved to: • **Ratify** the Chairs action to appoint an Interim Chair of the All Wales IPFR panel; and • **Note** the report.
JC22/111	**3.2 Managing Director's Report** The Managing Director's Report was received and the Managing Director gave an update on relevant matters undertaken since the previous JC meeting. Members **noted**: • The Integrated Commissioning Plan (ICP) 2022-2025 being accepted by the Minister for Health & Social Services, • A letter received from WG concerning a review of Secure Services and consideration of a Single Commissioner for Mental Health Services, and that an update report will be presented to the JC in November 2022 outlining potential options. A report would then need to be taken to individual HBs for approval, • The Managing Director of WHSSC being designated as the Senior Responsible Officer (SRO) for an All-Wales Molecular Radiotherapy (MRT) Programme, • That feedback on the Mental Health Specialised Services Strategy for Wales 2022-2028 will be presented to the JC in November 2022, • WHSSC receiving approval through the Value in Healthcare Bid for an Advanced Therapy Medicinal product (ATMP) and for the Welsh Kidney Network (WKN) to provide an all Wales Pre-habilitation Programme to support kidney patients to choose and commence the treatment that offers them the best outcomes,

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	• Work being undertaken to monitor TAVI (Transcatheter aortic valve implantation) activity increases; and • The appointment of an interim Director of Mental Health & Vulnerable Groups. **ACTION:** SD to provide an update on TAVI to the JC in November 2022 and further updates on cardiac surgery at future meetings. The Joint Committee resolved to: • **Note** the report.
JC22/112	**3.3 Neonatal Transport Operational Delivery Network (ODN) – Update report from Delivery Assurance Group (DAG)** The report providing an update from the Delivery Assurance Group (DAG) on the Neonatal Transport ODN was **received.** KP advised that due to the enhanced data reporting and the small number of transfers undertaken there was a risk of being able to identify individual cases therefore a more detailed report will be discussed in the "In Committee" meeting and asked members to note the assurance that had been provided by the DAG. Members noted that a business case was presented to the MG on 28 July 2022 and that members had raised concerns regarding value for money concerning the staffing model, noting that costs were disproportional when benchmarked against other ODNs. This equated to a management fee of £500 per transfer. Therefore, the funding release was not supported and the MG asked the ODN Network Board to reconsider the options and to bring a report back to a future meeting for consideration. The WHSS team are working with SBUHB colleagues to consider the options with the aim of presenting an amended request to the MG in September 2022. **ACTION:** NJ to provide an update to the JC November 2022 following discussion at the Management Group meeting in September. The Joint Committee resolved to: • **Note** the information in the report, • **Note** the update on the progress of the implementation of the Neonatal Transport Operational Delivery Network (ODN); and • **Receive assurance** that the Neonatal Transport service delivery and outcomes is being scrutinised by the Delivery Assurance Group (DAG).
JC22/113	**3.4 Draft Specialised Paediatric Services 5 year Commissioning Strategy** The report providing an update on the Specialised Paediatric Services 5 Year Commissioning Strategy was received.

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	KP advised that the responses to the stakeholder feedback were included in the report and the stakeholder views had been taken into consideration in the proposed final version of the strategy. Members approved the strategy and noted that project will progress to the implementation phase, requiring a full Implementation Board to be established with representation from all seven HBs in Wales, which will develop a detailed plan and timetable. Bi-annual updates will be provided to the JC on progress. The Chair thanked KP and the planning team for developing the strategy. The Joint Committee resolved to: • **Note** the content of the paper, • **Approve** the proposed final version of the strategy; and • **Support** the proposed next steps.
JC22/114	**3.5 Cochlear Implant and Bone Conduction Hearing Implant Hearing Device Service – Engagement Process** The report presented an update on discussions with the Management Group concerning the process and outcome of a recent review of tertiary auditory services and the planned next steps for the South Wales Cochlear Implant and BAHA Hearing Implant Device Service. KP reported that following discussion at the MG meeting on 28 July 2022 the members had supported the preferred commissioning option of a single implantable device hub for Cochlear and BAHA for both children and adults with an outreach support model. Members noted that advice had been sought from the Board of Community Health Councils (CHCs) and that a targeted engagement process with patients, families and affected stakeholders has been supported, along with engagement materials and timelines. The draft Equality Impact Assessment (EQIA) will be finalised, along with an 'easy-read' of the engagement document. Members noted that the CHCs were content with the engagement process outlined and agreed that consultation would only be required if deemed necessary following the engagement process. KP asked members to publish the engagement document on their HB websites and for this to be publicised accordingly. CS and JW queried if publishing the engagement document on HB websites would be sufficient. SL advised that specific interest groups would also be targeted and it was agreed that KP would give further consideration to the communication plan and link in with HB

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	engagement leads on their preferred process to ensure we achieved the right balance on communication and engagement. **ACTION:** KP to link in with HB engagement leads to discuss refining the communication plan with HBs to ensure interested parties will be made aware of the engagement. Members noted that a report would need to be submitted to HB Board meetings in September 2022 to seek support from Boards on engagement with HB residents (each report will include CHC views from the relevant HB area). The Joint Committee resolved to: • **Support** the Management Group recommendation, • **Agree** the process to be followed (as advised by the Board of CHCs), • **Agree** the content of the engagement materials as the basis of targeted engagement, • **Advise** on processes for individual Health Boards; and • **Note** the draft EQIA.

JC22/115	**3.6 Designation of Provider Framework**
	The report seeking approval to adopt the Designation of Provider Framework as the WHSS team methodology for evaluating the appropriateness of Health Care Providers to become a designated provider of Highly Specialised and Specialised Services was received.
	
	Members noted that Designation of a Provider of Specialised Services Framework has been developed to be considered as part of the WHSSC Commissioning Assurance Framework (CAF). It would cover:
	• Highly Specialised and Specialised Services currently commissioned by WHSSC,
	• New or novel services or treatments not currently commissioned; and
	• Existing non-contract services or treatments, which may need to be routinely commissioned on an ongoing basis.
	
	Members noted that:
	• The framework outlined the roles and responsibilities for the specialised commissioning teams and clearly defined the process and criteria for identifying new service providers,
	• The framework supports a two phased approach; an initial screening assessment followed by a full assessment if supported by the evidence following the initial assessment; and
	• The Four key assessment domains identified:
	  • Quality and Patient Safety,
	  • Strategic Fit/equity of access,
	  • Service deliverability/sustainability; and

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	• Value for money/affordability. KP advised that that the framework did not apply to commissioning of secure or specialist Mental Health services or independently provided dialysis services which had their own procurement and commissioning arrangements, or new or novel drugs which had their own assessment process. KP advised that the aim of the framework was to provide a basis for evaluating the appropriateness of health care providers' suitability and readiness to provide a specific specialised service to ensure that services commissioned by WHSSC were safe, effective and sustainable and provided compassionate and person-centred care. It was noted that the framework should not be used if a full tender was required, where advice should be sought from Procurement colleagues. The Joint Committee resolved to: • **Note** the report; and • **Approve** the Designation of Provider Framework as the WHSS team methodology for evaluating the appropriateness of health care providers.
JC22/116	**3.7 Individual Patient Funding Requests (IPFR) Governance Update** The report providing an update regarding discussions with WG and Medical Directors concerning the All Wales Independent Patient Funding Requests (IPFR) Policy, regarding the need to update the terms of reference (ToR) of the WHSSC IPFR Panel and seeking support to undertake an engagement process on updating the ToR and a specific and limited review of the All Wales IPFR policy was received. SL advised that WHSSC had received a letter from WG dated 28 July 2022 confirming the JC's authority to update the WHSSC IPFR Panel ToR, and that an internal IPFR review group has been formed to support a specific and limited review of the IPFR Policy. Members noted that the IPFR review group had considered the risks associated with the existing ToR and had developed a list of principles for consideration which were themed as follows: • The membership, • Urgent cases, • Quoracy, • Meeting frequency; and • Documentation, reporting and monitoring.

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	SL advised that the All Wales IPFR Policy was an NHS Wales policy owned by each of the seven HBs who had statutory responsibilities in relation to IPFR decisions, therefore the outcome of any IPFR process review must therefore be agreed by each of the HBs. Members noted that WHSSC was constituted as a sub-committee of all seven HBs and its JC could delegate certain activities to WHSSC directors as per WHSSC Standing Orders (SOs). On this basis, which was supported by the Chief Medical Officer (CMO), Deputy CMO (DCMO) and Chief Pharmaceutical Officer (CPO), as well as members of the All Wales Medical Directors Group (AWMDG) at a meeting on 1 July 2022, it was agreed that a specific and limited review of the policy could be undertaken with comprehensive stakeholder engagement and it could be led by the WHSSC team. It was also agreed that progress should be reported to the 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. Members noted that WHSSC had sought advice from David Locke QC, the barrister acting on behalf of WHSSC during the judicial review (JR), to support identifying amendments for the All Wales IPFR policy and the WHSSC ToR. This advice will be included within the scope of the specific and limited review of the IPFR policy. Members noted the timeline for the engagement process for the WHSSC IPFR Panel ToR and the specific and limited review of the IPFR policy. CS advised that there was a need to ensure that HBs owned the process in totality and SL advised that there would full and broad engagement with 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. Medical Directors and Directors of Public Health were usually the executive leads within health boards and should ensure engagement with their relevant teams. PM advised that he recognised that there were broader discussions and wanted to make sure that teams within Health Boards were involved, and that he would raise at the next NHS Wales CEO meeting, to ensure everyone was clear on the agreed process to avoid any unintended consequences. Members noted that IPFR Co-ordinators would provide feedback via HB processes. SL thanked everyone for their commented and reiterated that WG had asked for a limited review, and should HBs feel that a broader review was necessary HBs could contact them to discuss. Members agreed that an update be given to the January 2023 meeting.

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	ACTION: SL is to put forward a recommendation for the WHSSC IPFR Panel ToR and the All Wales IPFR Policy at the January 2023 meeting. The Joint Committee resolved to: • **Note** that Welsh Government (WG) had confirmed that as the All Wales Independent Patient Funding Requests (IPFR) Panel was a sub-committee of the WHSSC Joint Committee, it was within its authority to update and approve the terms of reference (ToR), • **Note** that Welsh Government (WG) had confirmed that WHSSC could embark on an engagement process with key stakeholders to update the WHSSC IPFR Panel Terms of Reference (ToR) and to engage on a specific and limited review of the All Wales IPFR Policy, • **Approve** 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 Health Boards (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; and • **Note** that the revised documents will be approved by the Joint Committee prior to referral to the Health Boards for final approval; as requested in the letter of 28th July the revised documents will be shared with Welsh Government.
JC22/117	**3.8 WHSSC Annual Report 2021-2022** A report seeking approval of the WHSSC Annual Report 2021-2022 was received. Jacqui Evans (JE) advised that the Annual Report reflected on WHSSC's performance and its achievements for the 2021-2022 financial year and reflected on what was achieved in collaboration with partner organisations and stakeholders. Members noted that the draft Annual Report 2021-2022 was presented to the Integrated Governance Committee (IGC) on the 9 August 2022 and members were asked to provide any feedback prior to the document being finalised for submission to the JC for approval. Members noted that approval of the annual report was reserved to the JC and that the document had been circulated in advance of the meeting. The Joint Committee resolved to: • **Approve** the WHSSC Annual Report 2021-2022.

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JC22/118	**4.1. Covid-19 Period Activity Report - Month 3 2022-2023** The COVID-19 activity report for month 3 was received and members noted the scale of the decrease in specialist activity delivered for the Welsh population by providers in England, together with the two major supra-regional providers in south Wales. 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: • the data did not reflect performance against the recovery trajectories discussed at the July meeting, which will be presented in November 2022, • the data was yet to show sustained improvement and performance remained below contracted levels by Welsh providers. Waiting lists in some key specialities were deteriorating and Welsh Ministerial measures were not being met; and • activity by English providers has started to increase and was on a trajectory to return to 'normal' activity. There were sufficient funds to cover the increase in activity but this was a potential risk. CS noted the increasing gap in performance of Welsh and English providers and enquired if more up-to-date data could be provided to better understand the performance of Welsh providers. The Chair requested that the performance team look at data activity and split activity and that an update be brought back to the November meeting. **ACTION:** SD to present the recovery position using the latest available data in November, including comparing activity between Welsh and English providers. The Joint Committee resolved to: • **Note** the report.
JC22/119	**4.2 Financial Performance Report Month 4 2022-2023** The financial performance report setting out the financial position for WHSSC for month 4 of 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 by the JC in February 2022. The financial position reported at Month 4 for WHSSC was a year-end outturn forecast under spend of £12.693m. The under spend predominantly relates to releasable reserves from 2021-2022 and declared slippage in development schemes, partially offset by

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	forecast over spends in specialised mental health provision and NHS England contracted providers. The Joint Committee resolved to: • **Note** the current financial position and forecast year-end position.
JC22/120	**4.3 Corporate Governance Matters Report** The Corporate Governance Matters report was received and members noted the update on corporate governance matters that had arisen since the last meeting. The Joint Committee resolved to: • **Note** the report.
JC22/121	**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 meeting held on 22 August 2022. **ii. Management Group Briefing** The JC noted the core briefing document from the meeting held on 28 July 2022. **iii. Quality & Patient Safety Committee (QPSC)** The JC noted the Chair's report from the meeting held on 9 August 2022. In response to JW's question SD noted that the position of the North Wales Adolescent Service (NWAS) remains positive overall but there are occasional pressures in managing complex local authority patients, along with constraints of the unit when managing such a case mix. Carole Bell added that the National Collaborative Commissioning Unit (NCCU) audit all Welsh units on an annual basis and, although the report was awaited, she had been verbally informed that there were no issues raised from the latest audit. **iv. Integrated Governance Committee (IGC)** The JC noted the Chair's report from the meeting held on 9 August 2022. **v. Individual Patient Funding Request (IPFR) Panel** The JC noted the Chair's report from the meeting held on 18 August 2022. It was noted that James Hehir, Independent Member of CTMUHB, had been appointed as the interim Chair from August 2022 on a 6 month

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	basis. Kate Eden had written to thank Dr Ruth Alcolado for fulfilling the Chair role on an interim basis. CB advised that the last meeting was quorate. The Joint Committee resolved to: • **Note** the reports.
5.1 Any Other Business	
JC22/122	**5.1.1 Glyn Jones, Interim Chief Executive Officer, ABUHB** The Chair advised that Glyn Jones (GJ) was stepping down as interim CEO of ABUHB and thanked him for his service to the JC and WHSSC and his input and feedback at meetings. She wished him the very best for the future.
	5.1.2 Karen Preece – Director of Planning, WHSSC The Chair advised that KP was retiring as the Director of Planning at WHSSC and thanked her for her expertise, professionalism and the passion and energy she had brought to the role. The Chair noted that KP would be retained on a part-time basis to undertake project work on behalf of WHSSC, including being the lead executive for the WKN.
	5.1.3 Nicola Johnson – Director of Planning, WHSSC The Chair advised that Nicola Johnson (NJ) has been appointed as Director of Planning at WHSSC and commences her role on 7 September 2022.
	5.1.4 Integrated Commissioning Plan (ICP) The Chair advised that the meeting scheduled for 9.30am on 6 December 2022 for the JC to consider the ICP was no longer required and that an extraordinary JC meeting would be diarised in early January 2023 to sign off the ICP prior to its submission to WG by 31 January 2023.
JC22/123	**5.2 Date and Time of Next Scheduled Meeting** The JC noted that the next scheduled meeting would be at 13.30 on 8 November 2022. There being no other business other than the above the meeting was closed at 12:30 hrs.
JC22/124	**5.3 In Committee Resolution** The Joint Committee resolved: "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: .....

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

JOINT COMMITTEE MEETING
8 November 2022 Action Log

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/004	**JC22/041 3.5 Major Trauma Update** **ACTION:** Dindi Gill from the Major Trauma Network (MTN) to be invited to provide an update presentation to the JC meeting in September 2022.	KP	Sep 2022	**06.09.22** – DG presented to JC under Agenda Item 2.1 on 6 September 2022.	**CLOSED**
10 May 2022					
JC22/006	**JC22/064 Neonatal Transport – Update from the Delivery Assurance Group (DAG)** **ACTION:** An update report on the Neonatal Transport Operational Delivery Network to be presented to the WHSSC Joint Committee at the next meeting.	KP	~~July 2022~~ Sept 2022	**10.05.2022** – Carried forward to September. **06.09.22** – An update was provided to JC under Agenda Item 3.3 on 6 September 2022.	**CLOSED**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/011	**JC22/081 - Recovery Trajectories across NHS Wales – Workshop** KP suggested that insufficient capacity in dermatology services has led to transfers to plastic surgery and a resolution in this area could ease demand on plastic surgery. **ACTION:** KP to liaise with James Barry (JB) on dermatology flows after the meeting to investigate opportunities and to convey good practice to other HBs.	KP	~~Aug 2022~~ Oct 2022	**24.08.22 -** Discussions underway. To be explored further in Management Group Plastic Surgery Workshop on 22 September 2022. **27.10.22** – Skin cancer pathways explored in the Management Group Workshop and a report on a commissioning model to be prepared for the Joint Committee in January 2023. Action Completed.	**CLOSED**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/012	**JC22/081 - Recovery Trajectories across NHS Wales – Workshop** Sian Lewis (SL) advised that WHSSC was very concerned about the Royal College of Surgeons (RCS) prioritisation profile. KP suggested that a regional system review should be undertaken to establish if there had been a change in run rate over the last five years in HB referral thresholds as referrals into the Children's Hospital had increased leading to pressure on the service. KP also advised that waiting times at the Alder Hey Children's Hospital (AHCH), a commissioned provider, were lower leading to inequity concerns. Members agreed it would be useful to see performance data for children's services by both provider and HB of residence. **ACTION:** KP to take forward a review of the paediatric system.	KP	~~Aug 2022~~ Sept 2022	**06.09.22** – A Paediatric Deep Dive presentation was provided to JC under Agenda Item 2.3 on 6 September 2022.	**CLOSED**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/013	**JC22/081 - Recovery Trajectories across NHS Wales – Workshop** SD noted that there were anecdotal concerns that patterns of referrals for paediatric services into CVUHB had increased over the last 5 years and this change was having an adverse impact on the ability of the Children's Hospital for Wales (CHfW) to deliver tertiary care. **ACTION**: KP to include data on referral patterns into paediatric review.	KP	~~Aug 2022~~ Sept 2022	**06.09.22** – A Paediatric Deep Dive presentation was provided to JC under Agenda Item 2.3 on 6 September 2022.	**CLOSED**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/014	**JC22/081 - Recovery Trajectories across NHS Wales – Workshop** Stuart Davies (SD) advised that he would follow up inquiries with both CVUHB and SBUHB on the increase in TAVI (Transcatheter aortic valve implantation) to investigate if this was a one-off issue due to backlogs or whether it was a long-term trend which would have a fundamental impact on being able to achieve contracted volumes. **ACTION:** SD to liaise with CVUHB and SBUHB to establish the rationale for the increase in TAVI and the potential long-term impact in achieving contracted volumes.	SD	~~Aug 2022~~ Sept 2022	**06.09.22** – An update was provided to the JC in the Managing Director's Report under Agenda Item 3.2 on 6 September 2022.	**CLOSED**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/015	**JC22/081 - Recovery Trajectories across NHS Wales – Workshop** SR suggested that KP prioritise the various actions discussed and focus on paediatric referrals first. HE advised that some of the DU data gave global figures presented a challenge on perception and comparison and that there was a need to focus on local and national data to ensure messages were clear. **ACTION:** A deep dive session on Paediatric referrals to be arranged for the JC meeting on 6 September 2022.	KP	Sept 2022	**06.09.22** – A Paediatric Deep Dive presentation was provided to JC under Agenda Item 2.3 on 6 September 2022.	**CLOSED**
6 Sept 2022					
JC22/019	**JC22/107 – Major Trauma Presentation** An update on the Major Trauma Centre to be given to the Joint Committee in September 2023, to include consideration of a network wide rehabilitation strategy.	NJ	Sep 2023	**28.10.22** – an update on Major Trauma was given to the JC meeting on 6 September. As agreed a further update to include consideration of a network wide rehabilitation strategy has been added to the JC forward work plan for September 2023.	**CLOSED**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/020	**JC22/109 - Recovery Update Paediatrics – Presentation** **ACTION:** Meriel Jenney (MJ) is to review the INNU lists, including establishing if there were any misallocated or misstated surgical operations.	MJ	Nov 22	**27.10.22 –** ID contacted MJ and is awaiting a response.	**OPEN**
	ACTION: SD and KP will work with CVUHB on recovery plans and SD will provide members with an update in November.	SD/KP	Nov 22	**27.10.22 -** This is included in the recovery presentation update on the agenda.	**OPEN**
	ACTION: NJ to provide an update to the November JC on work to develop alternative prioritisation criteria for children	NJ	Nov 22	**27.10.22 -** This is included in the recovery presentation update on the agenda.	**OPEN**
	ACTION: KP will investigate out-sourcing options to address the backlog issue and NJ will provide an update in November.	NJ	Nov 22	**27.10.22 -** This is included in the recovery presentation update on the agenda.	**OPEN**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
	ACTION: Following on from the Recovery Trajectories Workshop at the July 2022 meeting, SD to coordinate a progress review on recovery trajectories at the 17 January 2023 JC meeting.	SD/NJ	Jan 2023	**27.10.22 -** This is included in the recovery presentation update on the agenda. Providers have been requested to provide detailed updated recovery trajectories for each key specialty. These will be subject to performance monitoring arrangements	**OPEN**
JC22/020	**JC22/111 Managing Director's Report** **ACTION:** SD to provide an update on TAVI to the JC in November 2022 and further updates on cardiac surgery.	SD	~~Nov 2022~~ Jan 2023	**27.10.22 -** Deferred until January 2023 to enable clarification of the cardiac surgery demand position.	**OPEN**
JC22/021	**JC22/112 Neonatal Transport Operational Delivery Network (ODN) – Update report from Delivery Assurance Group (DAG)** **ACTION:** NJ to provide an update to the JC November 2022 following discussion at the Management Group meeting in September.	NJ	Nov 2022	**27.10.22 –** An update is provided in the MD report. Action completed.	**CLOSED**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/022	**JC22/114 Cochlear Implant and Bone Conduction Hearing Implant Hearing Device Service – Engagement Process** **ACTION:** KP to link in with HB engagement leads to discuss refining the communication plan with HBs to ensure interested parties will be made aware of the engagement.	KP	Nov 2022	**27.10.22 –** Action completed. The engagement is due to commence in early November 2022.	**CLOSED**
JC22/023	**JC22/116 Individual Patient Funding Requests (IPFR) Governance Update** **ACTION:** SL is to put forward a recommendation for the WHSSC IPFR Panel ToR and the All Wales IPFR Policy at the January 2023 meeting.	SL	Jan 2023	**27.10.22 –** IPFR update is on the Agenda. Action completed.	**CLOSED**

Action Ref	Minute Ref and Action	Owner	Due Date	Progress	Status
JC22/024	**JC22/118 Covid-19 Period Activity Report - Month 3 2022-2023** **ACTION:** SD to present the recovery position using the latest available data in November, including comparing activity between Welsh and English providers.	SD	Nov 2022	**27.10.22 -** Activity Report for month 5 on the agenda including a new summary to make comparison easier. Action Completed.	**CLOSED**

Report Title	**Draft Integrated Commissioning Plan (ICP) 2023 – 2026**	**Agenda Item**	**2.1**
Meeting Title	**Joint Committee**	**Meeting Date**	08/11/2022
FOI Status	Public		
Author (Job title)	Assistant Director of Planning		
Executive Lead (Job title)	Director of Planning		

Purpose of the Report	The purpose of this report is to present the draft Integrated Commissioning Plan (ICP) 2023-2026 for consideration and comment prior to final submission to the Joint Committee for approval in January 2023.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☒	ASSURE ☒	INFORM ☒

Recommendation(s):

Members are asked to:

- **Consider** the first draft of the Integrated Commissioning Plan (ICP) 2023-2026,
- **Note** the further work required to finalise the Plan; and
- **Discuss** and provide comment on the proposed financial plan.

DRAFT INTEGRATED COMMISSIONING PLAN (ICP) 2023 – 2026

1.0 SITUATION

The purpose of this report is to present the draft Integrated Commissioning Plan (ICP) 2023-2026 for consideration and comment prior to final submission to the Joint Committee for approval in January 2023.

2.0 BACKGROUND

Each year, Welsh Government issues the *'NHS Wales Planning Framework'* that requires Health Boards (HBs) to develop Integrated Medium Term Plans (IMTPs) which triangulate service, finance and workforce plans. To inform these plans, the Welsh Health Specialist Services Committee develops an Integrated Commissioning Plan (ICP) for consideration and approval by both the Management Group (MG) and the Joint Committee in advance of the completion of Health Board plans.

3.0 ASSESSMENT

3.1 NHS Wales Planning Framework

The Planning Framework has not been issued as yet, and the guidance on the Ministerial Priorities and financial context is still awaited. It has also been signalled by Welsh Government that the deadline for IMTP submission will be pushed back to the end of March 2023. In this context the current timeline for the Joint Committee to approve the WHSSC ICP in early January will be assessed with the MG during November and December and adapted as required. It is still intended to present the Plan for approval in advance of Health Board IMTPs being approved.

3.2 First Draft of the Integrated Commissioning Plan (ICP)

The first draft of the ICP is presented at ***Appendix 1.*** There are a number of caveats to the current draft as outlined below:

- As the planning framework has not yet been issued, requirements arising from it will need to be incorporated when available – with further work required on the Ministerial Priorities, as they apply to WHSSC, when this is issued,
- A Recommissioning for Value Workshop will be held with Management Group on 24 November 2022 as part of the planning process,
- There is more development work to be done to ensure consistency of approach across the sections of the plan, particularly in the areas of; service area context, 'Goals Methods and Outcomes' and the presentation of performance and recovery positions; and
- The detailed Appendices are not yet included – appendix A will be the Ministerial Priorities; appendix B will be the ICP (2021/22) Quarter 3

delivery progress report; appendix C will be the Quarter 3 performance report; appendix D will be the detailed financial chapter which will be further developed as of Month 9; and appendix E will be the national IMTP Minimum Data Set.

3.3 Next Steps

The approval timeline is shown below, subject to the guidance in the Planning Framework as discussed above:

ACTION	TIMESCALE
Draft ICP to November Joint Committee	08/11/22
Discussion at November and December Management Groups as required	24/10/23 15/12/23
Final version of ICP approved at Joint Committee	January/ February– TBC
Submission to Welsh Government	By 31/01/23

4.0 RECOMMENDATIONS

Members are asked to:

- **Consider** the first draft of the Integrated Commissioning Plan (ICP) 2023-2026,
- **Note** the further work required to finalise the Plan; and
- **Discuss** and provide comment on the proposed financial plan.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Yes
Link to Integrated Commissioning Plan	Yes
Health and Care Standards	Safe Care Effective Care Governance, Leadership and Accountability
Principles of Prudent Healthcare	Only do what is needed 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	As identified in the report
Finance/Resource Implications	As identified in the report
Population Health	As highlighted in the report
Legal Implications (including equality & diversity, socio economic duty etc)	As identified in the report
Long Term Implications (incl WBFG Act 2015)	As identified in the report
Report History (Meeting/Date/ Summary of Outcome	**22 September 2022 –** Management Group – Financial presentation
Appendices	Appendix 1 – Draft Integrated Commissioning Plan (ICP) 2023-2026

Report Title	**Chair's Report**	**Agenda Item**	3.1
Meeting Title	**Joint Committee**	**Meeting Date**	08/11/2022
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,
- **Approve** the recommendations to appoint two new WHSCC Independent Members (IMs) from 1 November 2022 for a period of 2 years; and
- **Approve** the recommendation to extend the tenure of the Interim Chair for the Individual Patient Funding Request (IPFR) panel until 31 March 2023.

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 Independent Member Recruitment Update

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 Health Board (HB) Chairs and the Board Secretaries, with eligibility confined to existing HB IMs,
- That the existing arrangements for appointing a CTMUHB 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; and
- To remunerate WHSSC IMs including the requirement for a review following the recruitment process.

In addition, Ian Phillips was appointed as the substantive Chair for the Welsh Renal Clinical Network (WRCN), with effect from the 1 April 2022, and an Independent Member (IM) vacancy arose.

A recruitment exercise commenced in August 2022 to appoint two new WHSSC IMs (generic WHSSC IM and an Audit/Finance Lead IM) in accordance with the IM appointment process agreed by the Joint Committee on the 18 January 2022. The vacancies were advertised through the HB Chairs and the Board Secretaries, with eligibility confined to existing HB IMs.

Ten applications were received and following a series of interviews on 24 October 2022 I am pleased to recommend that Chantal Patel, HDdUHB, is appointed as our new WHSSC IM (Generalist) and that Steve Spill, SBUHB, be appointed as the new WHSSC IM (Finance and Audit). Both roles will be appointed for a 2 year period with effect from 30 November 2022.

In accordance with the Joint Committees decision to transition to a fair and open selection process for appointing all WHSSC IMs through advertising the

vacancies through the HB Chairs and the Board Secretaries, a recruitment process for the third WHSSC IM position will open in early 2023.

I would like to take this opportunity to formally thank Professor Ian Wells from CTMUHB, for all his support since he was appointed as CTMUHB audit lead for WHSSC eighteen months ago. He has been an invaluable member of the team and we are extremely grateful to him for his commitment of time and effort, which is especially notable given his normal HB responsibilities.

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

On the 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.

The engagement process will commence in October 2022, and it is proposed that the interim IPFR chair arrangement is extended until 31 March 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 with a view to undertaking an open and transparent recruitment campaign in early 2023.

3.3 Integrated Governance Committee (IGC) 11 October 2022

I chaired the WHSSC Integrated Governance Committee (IGC) on the 10 October 2022 and, among other items, the Committee considered the quarterly update on delivery of the Integrated Commissioning Plan (ICP), the Corporate Risk and Assurance Framework (CRAF) and an update on internal and external audits.

3.4 Key Meetings

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

- Engagement Workshop – Specialised Services Strategy,
- Regular catch up meetings with WHSSC IMs and WKN Chair
- Regular bi-monthly meetings with the Chair of the QPS Committee,
- Regular NHS Chairs meeting; and
- NHS Wales Chairs Peer Group Meeting.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report; and
- **Approve** the recommendations to appoint two new WHSCC Independent Members (IMs) from 1 November 2022 for a period of 2 years; and
- **Approve** the recommendation to extend the tenure of the Interim Chair for the Individual Patient Funding Request (IPFR) panel until 31 March 2023.

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	-

Report Title	**Managing Director's Report**	**Agenda Item**	3.2
Meeting Title	**Joint Committee**	**Meeting Date**	08/11/2022
FOI Status	Public		
Author (Job title)	Managing Director, Specialised And Tertiary Services Commissioning, NHS Wales		
Executive Lead (Job title)	Managing Director, Specialised And Tertiary Services Commissioning		

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

Recommendation(s):

Members are asked to:

- **Note** the report

MANAGING DIRECTOR'S REPORT

1.0 SITUATION

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

2.0 BACKGROUND

At each Joint Committee meeting, the Managing Director presents a report on key issues 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 Paediatric Radiology Consultant Recruitment

Cardiff and Vale UHB (CVUHB) have reported longstanding challenges in recruiting Consultant Paediatric Radiologists, and have been unable to recruit into 3 new WHSSC funded posts, largely due to national shortages. There is currently no capacity in Wales to increase the number of paediatric radiology training posts because of insufficient volume of work to support training. To address this issue the WHSSC Associate Medical Director (AMD) for Women and Children's services brought colleagues from the Radiology service, Health Education and Improvement Wales (HEIW) and the National Imaging Academy (NIA) together to discuss options for increasing the potential applicant pool for Paediatric Radiology Consultant posts. The outcome of these discussions is that units in NHS England (NHSE) have agreed to host NHS Wales funded paediatric radiology training posts for trainees on the Wales Radiology Training Programme. HEIW colleagues confirmed they are now taking this forward, meaning there will be increased training capacity from February 2023 at the latest.

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 presenting an update on discussions with the Management Group concerning the process and outcome of a recent review of tertiary auditory services and the planned next steps for the South Wales Cochlear Implant and BAHA Hearing Implant Device Service, and which presented the suggested 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 Health Board (HB) Board meeting in September 2022 to seek support from Boards on engagement with HB residents and each HB approved the approach. It was planned that the engagement process would commence on 24 October 2022. Unfortunately this has been delayed and engagement will now commence in early November.

3.3 Evaluation of 4th Thoracic Surgeon activity

As part of commissioning the MTC in 2020, in recognition that there was uncertainty in relation to the nature and extent of what might be required from thoracic surgery to support the MTC, WHSSC agreed to fund a 4th consultant thoracic surgeon at CVUHB on a locum basis. It was agreed that the role would be evaluated once the MTC was fully established. In September, WHSSC received the evaluation report from CVUHB of the thoracic surgical support to the MTC. The report demonstrates that thoracic surgery is an integral part of the service provided by the MTC. In addition to the daily MDT, ward rounds and advice to referrers, there are approximately 50 thoracic operations required each year, the majority being rib fixations which are increasing in number (a finding which aligns with the experience of other longer established MTCs in England). Looking forward, in addition to the requirements to support the MTC, it is expected that Wales will implement screening for lung cancer following the recent positive recommendation from the UK National Screening Committee (a Wales pilot is already being planned to commence in early 2023). This will increase the levels of activity required from the new single thoracic centre and therefore the establishment of thoracic surgeons required to meet patient need. WHSSC therefore is supportive of the 4th consultant surgeon post in CVUHB to provide continued support for the MTC and with a view to the future needs of the service. The Joint Committee is asked to note that due diligence with regard to the evaluation of the 4th consultant thoracic surgeon to support the MTC has been completed.

3.4 Duty of Candour and Duty of Quality

On 3 October 2022 the Corporate Directors Group Board (CDGB) received a briefing from Welsh Government (WG) on the Health & Social Care (Quality & Engagement) (Wales) Act 2022 with a specific focus on the consultation process for the duty of candour and the soon to be launched consultation process on the duty of quality. The session gave an insight into the need to focus on quality-driven decision-making to improve outcomes and the need to demonstrate with evidence how we have complied with the duty. In addition, to the need to comply with the duty of candour in relation to health care provision. It was recognised that we already have good systems and processes in place on which we can build for both the duties.

4.0 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**	08/11/2022
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 on behalf of the 7 Health Boards (HBs) for Wales; services are delivered by two NHS England (NHSE) tertiary centres.

For the population of north Wales, the Mechanical Thrombectomy service is commissioned from the Walton Hospital, this is a 24/7 service. For the south Wales population, the service is commissioned from North Bristol Foundation Trust (NBFT). This is currently an 8am-8pm service, with a 24/7 service planned from December 2022. Patients from Powys have had a greater access, based on their population size to Thrombectomy services with patients accessing services from North Midlands (University Hospitals of Birmingham NHS Foundation Trust (UHBNFT)). This could be attributed to the Powys patients accessing all of their emergency treatment in NHSE.

At the September 2020 Management Group meeting, members 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. This risk has now been resolved. The report also set out a proposal to deliver a long term solution to improve patient outcomes.

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, scoping 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 held in March 2022. The aim of the workshop was to agree a vision for Mechanical Thrombectomy services for the population of Wales.

The workshop highlighted a number of challenges and barriers with the current Mechanical Thrombectomy pathway and an action plan was created which would be monitored and progressed by the Thrombectomy Oversight Group (chaired by the Stroke Implementation Group Chair).

The development of the CVUHB Mechanical Thrombectomy business case is in progress. In the meantime there have been a number of difficulties in patients

accessing the commissioned Mechanical Thrombectomy service, these include only some of the issues:

- Ambulance transport – transferring the patients in a timely manner from Wales to the tertiary Mechanical Thrombectomy Centres,
- Image transfer between Welsh HBs to the tertiary Mechanical Thrombectomy Centres; and
- Sustainability and fragility in all HB services leading to difficulty in supporting the flow of patients through the stroke clinical pathway for those patients meeting the eligibility criteria for a Mechanical Thrombectomy.

A number of these constraints have been resolved or mitigated as detailed in section 3 of the report but there is still one key issue which remains outstanding; the development of the Cardiff and Vale service is currently constrained by a shortage of Interventional Neuroradiologists (there are currently only two Consultants in Cardiff). We are working collaboratively with Health Education and improvement Wales (HEIW) and CVUHB on solutions to this issue.

In addition, with regard to the overall stroke pathway issues, a report was presented to the NHS Wales Health Collaborative Executive Group (NWHCG) in February 2022 which described the vision for stroke services across Wales. It was proposed that a business case is developed to implement a new model of high quality, patient focused stroke service to establish Comprehensive Regional Stroke Centres (CRSCs) and four Stroke Operational Delivery Networks (ODNs) – see ***Appendix 1.***

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. WHSSC has continued to work with CVUHB to progress the Business Case to develop a Mechanical Thrombectomy centre in south Wales and the financial model has been shared and is being worked through. The service will be implemented in a phased approach over four years as outlined in ***Appendix 2***.

The commissioning arrangement with Bristol will continue to ensure 24/7 access to Mechanical Thrombectomy whilst the service is being established in Cardiff.

3.1 WHSSC Position Statement

In the meantime WHSSC has developed a position statement on the commissioning of Mechanical Thrombectomy. The key aspects of the document describes the following (see ***Appendix 2***):

- 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; and
- The steps that have been taken and are being taken to improve flow along the stroke pathway.

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 extrapolated for Wales, would see 500 eligible patients per year when all elements of the stroke pathway are fully embedded. Eligible Welsh patients currently accessing the Mechanical Thrombectomy service is 1.3% (July 2022).

There is a sustained drive to improve door- to- needle time times across Wales but this is hampered by infrastructure and workforce fragility in all the HBs in Wales. There still remains the challenges with the Welsh Ambulance Services Trust (WAST) with 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.

There have been a number of improvements 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 requirement to "pump prime" the Cardiff and Vale Mechanical Thrombectomy centre through the implementation stage. It is proposed that there should be a gateway review after the phase 2 implementation stage to establish whether the operational and financial assumptions are still aligned with the original business case before committing and progressing to further phases.

This is to ensure that the whole stroke clinical pathway is aligned particularly with the development of Comprehensive Regional Stroke centres and Stroke ODN services as there may be opportunities for economies of scale

4.0 RECOMMENDATIONS

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 Health Wales 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	-
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

[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

- Sustainability
- 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 5000 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 from December 2022.

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

With the anticipated demand for Mechanical Thrombectomy in 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 Neuroradiologists (there are currently only two Consultants in Cardiff). WHSSC are 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 anticipated that the service will be developed in a phased approach:

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

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.

It is proposed that after phase 2 implementation, a gateway review should be considered to establish whether the operational and financial

assumptions are still aligned to the original business case, before committing and progressing to phases (3 & 4).

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 neurointerventional robotic solutions.
- 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 by Cardiff at the recent Thrombectomy Oversight Group meeting in September 2022:

- 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.
- 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.

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.

[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/

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

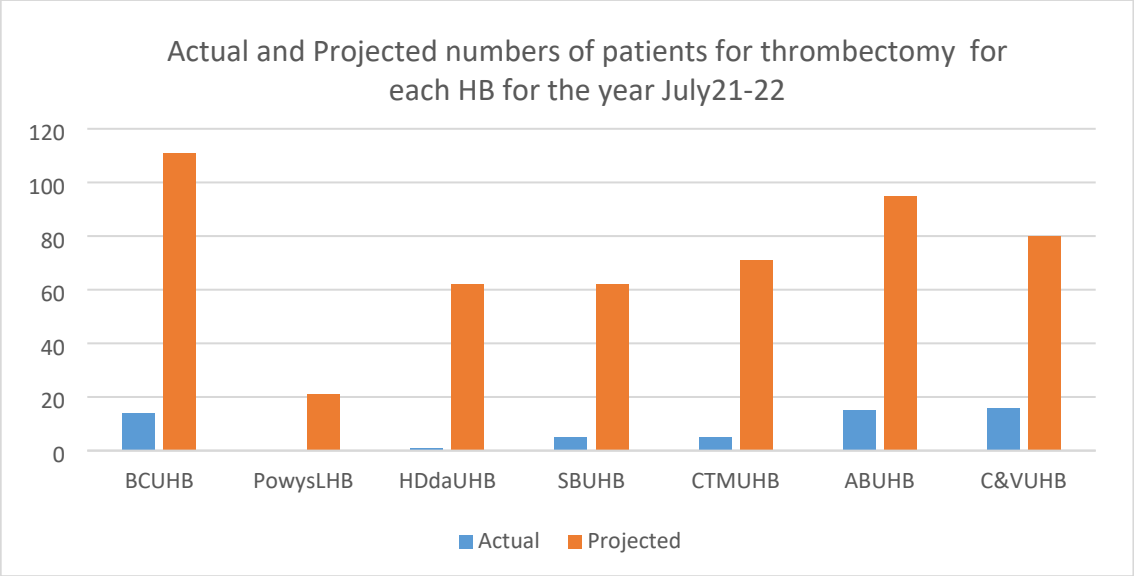


Table 2: shows the volume of patients receiving a Thrombectomy – based on the fact that 10% of stroke patients can benefit from Thrombectomy, there should be over 40 Welsh patients per month receiving Thrombectomy

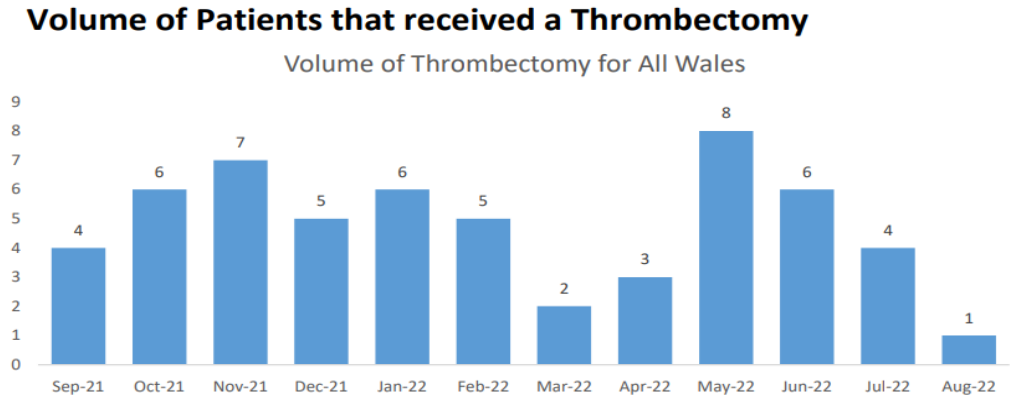
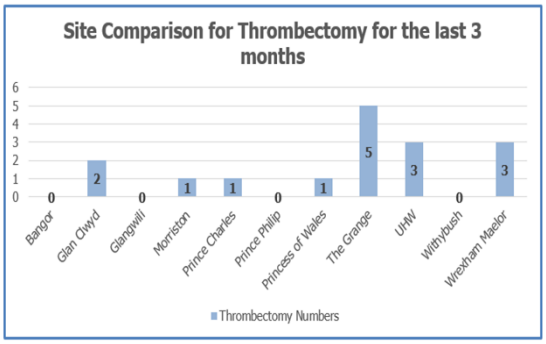
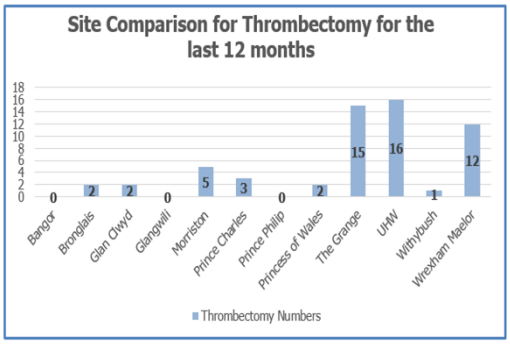


Table 3: illustrates the number of patients receiving a Thrombectomy as at July 2022





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.

A Task and Finish group will be set up to begin the Implementation of this system across Wales.

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.

In Report Title	**Mental Health Strategy Development**	**Agenda Item**	3.4
Meeting Title	**Joint Committee**	**Meeting Date**	8/11/2022
FOI Status	Open		
Author (Job title)	Senior Specialised Services Planning Manager for Mental Health and Vulnerable Groups		
Executive Lead (Job title)	Director of Mental Health and Vulnerable Groups		

Purpose of the Report	The purpose of this report is to advise the Joint Committee of the stakeholder feedback received from the engagement exercise for the Specialised Services Strategy for Mental Health and outline the next steps and proposals to move into implementation of the strategy from April 2023.				
Specific Action Required	RATIFY ☐	APP ROVE ☒	SUPPORT ☐	ASSURE ☐	INFORM ☒

Recommendation(s):

Members are asked to:

- **Note** the stakeholder feedback received from the 12 week engagement exercise on the draft Specialist Mental Health Strategy
- **Approve** the proposals to:
  - Undertake an 8 week consultation process using the draft consultation document,
  - Commission demand and capacity modelling with immediate effect; and
  - Develop a programme approach to implementation of the Strategy following the consultation exercise.

MENTAL HEALTH STRATEGY DEVELOPMENT

1.0 SITUATION

The purpose of this report is to advise the Joint Committee of the stakeholder feedback received from the engagement exercise for the Specialised Services Strategy for Mental Health and outline the next steps and proposals to move into implementation of the strategy from April 2023.

2.0 BACKGROUND

On the 10 May 2022, the Joint Committee received a report presenting the draft Mental Health Specialised Services Strategy for Wales 2022-2028 and endorsed that the draft strategy be circulated through a comprehensive list of stakeholder groups for comment.

2.1 Feedback Received from Stakeholders on the Draft Strategy

The stakeholder feedback generated 21 responses in total to the 43 recommendations with a total of 563 responses to all recommendations. The vast majority of responses agreed "Yes" (89%) or "Partly" (10.5%). There were four responses that answered "No" to the recommendation put forward (0.5%). 2 of these related to the development of an All-Wales Secure Services Board for the male and female secure services (1 "No" for each), 1 to consider the Children and Adolescent Mental Health Services (CAMHS) inpatient referral hub, and 1 to consider funding an electronic records system.

A summary of the responses is presented at ***appendix 1***. Some key headlines from the responses are outlined below:

2.1.1 Transitions

- The development of a patient passport was supported to improve transitions for age and condition related transitions, as was the development of transition workers to support this,
- Only two thirds of responses supported the development of a CAMHS referral hub with a third seeing it as unnecessary.

2.1.2 CAMHS/FACTS

- Supported recommendations included the review of CAMHS estates, development of a comprehensive needs assessment, consideration of staffing models and the stabilisation of the FACTS service,
- The CAMHS Inpatient referral hub was mostly supported with some concerns raised over losing ownership of patients,
- The Electronic records system was largely supported, however many felt that the rollout of WCCIS (Welsh Community Care Information System), would rectify many of the issues. This does need to be further

investigated to establish the timescales associated with the rollout, the number of Health Boards (HBs) who have declined the system and the suitability of the system for use in specialised services.

2.1.3 Eating Disorders

- Consideration should be given to the options available for the provision of Eating Disorders services in Wales. Whilst the establishment of a unit was largely supported, concerns were raised concerning the interim measures to be put in place following the notice given by NHS England (NHSE). The recommendation is therefore to conduct a full options appraisal in the first instance,
- Paediatric support for inpatients in Welsh CAMHS units was fully supported.

2.1.4 Learning Disabilities

- The development of an All-Wales demand and capacity inpatient data dashboard was fully supported,
- The blended patient model was largely supported with caveats including the consideration of national/regional frameworks and effects on HB commissioned low secure services.

2.1.5 Secure Services – Men

- Integrated Secure Services were largely supported with continuity of care, patient flow and expertise cited as supportive reasoning. Clarity on what this would look like, and who would commission was sought including clarity of the role of gatekeepers and care coordinators. It was strongly suggested that these services were inclusive for patients with a learning disability or Autism,
- It should be noted that to integrate the commissioning of low secure services alongside medium and high secure services would result in a large scale change project for the organization,
- The needs assessment for secure services in Wales was wholly supported,
- The proposed secure services board received mixed reactions with support for the ethos, but concerns around ownership and impact on HBs,
- Staff modernisation was supported with emphasis on MDTs and therapeutic interventions, plus the upskilling of staff to be inclusive for patients with a learning disability or Autism.

2.1.6 Secure Services – Women

- The commissioning models, estates, establishment of a community model and workforce development recommendations were all wholly supported,
- Responses to the Forensic Secure Services Board were similar to the feedback received in the Men's section and not wholly supported,
- The development of electronic records continued the same themes as previous sections in terms of the development of WCCIS to support.

2.1.7 Perinatal Mental Health

- The review of the Tonna Hospital provision was wholly supported, along with the development of a long term plan following this review,
- The partnership with NHSE for the provision of 2 beds for North Wales patients was largely supported, with some partly supporting but preference given to a unit within North Wales in the longer term.

2.1.8 Neuropsychiatry

- The recommendations in this section were largely supported with comments received centred on the community provision on discharge and collaboration with major trauma centres,
- The recently approved Clinical Impact Assessment Group (CIAG) scheme addresses these issues and the Strategy should be amended to reflect these changes,
- It was noted that this service only considers patients with acquired brain injury, and a submission from the Stroke Association asked that the service also considered stroke survivors. It is noted that scope of secondary care services be assessed to ensure this cohort of patients is cared for at the appropriate level, as this is outside of the scope of the commissioned specialised services for neuropsychiatry.

2.2 Gaps

There are two main themes emerging from comments received relating to gaps in the strategy:

- Provision for patients with a neurodevelopmental condition such as autism are not currently commissioned by WHSSC; and
- Whole pathway discussions did not form part of the development of this strategy, which focusses on those elements of the pathway commissioned by WHSSC.

3.0 ASSESSMENT

3.1 Outcome of the Engagement Exercise

The Draft Strategy undertook a stakeholder feedback exercise which resulted in very few changes to the document and no strong opposition to the key recommendations meaning that the ethos and fundamentals of the strategy have not changed. The most significant change to the Strategy has been to replace the recommendation for a secure services board for Wales into the development of appropriate governance arrangements to ensure integrated and blended secure service provision in NHS Wales.

The next step in the development of the strategy is a consultation process which will include feedback from our patients, carers and the general public. Given the high degree of consensus observed from the engagement process it is proposed that an 8-week consultation period would be appropriate. The draft consultation documents are presented at ***appendix 2*** for information.

3.2 Implementation of the Strategy

3.2.1 Demand and Capacity Modelling and Outcome Development

Much of the stakeholder feedback supported the inclusion of more robust demand and capacity modelling. Whilst some information and data was available to develop the strategy, it is noted that there are some gaps in the information available to develop full demand and capacity analysis within the current capacity of the organisation. There is also a need to assess the nature of the current demand as service models may have skewed the actual position.

Due to limited capacity at WHSSC and the specialised skills required to conduct robust demand and capacity modelling, we suggest that this work is outsourced to allow a thorough and timely demand and capacity analysis to support the development of needs assessments and service models for the strategy.

This work needs to be expedited as it is a key building block of assessing the optimal service model and will need to feed into any option appraisal. This work will therefore be completed alongside the consultation process.

3.2.2 Service Modelling - Optimal Service Model Options and Option Appraisals

In order to fully meet the needs of the strategy, there are a number of key areas where options need to be scoped and appraised to ensure the recommendations for service development truly meet the needs of the population, and reflect the most effective and appropriate service models for the population of Wales. These key areas include:

- Eating Disorders,
- Perinatal Mental Health,
- Secure Services,
- Learning Disabilities,
- Neuropsychiatry; and
- CAMHS.

For each service it is crucial that there is clinical engagement and input from both within the service in Wales and that where necessary external advice from outside of Wales is sought as well.

Each of these service areas have their own particular issues and complicating factors that need specific and focused reviews and appraisal. It is therefore proposed a formal programme structure will need to be put in place.

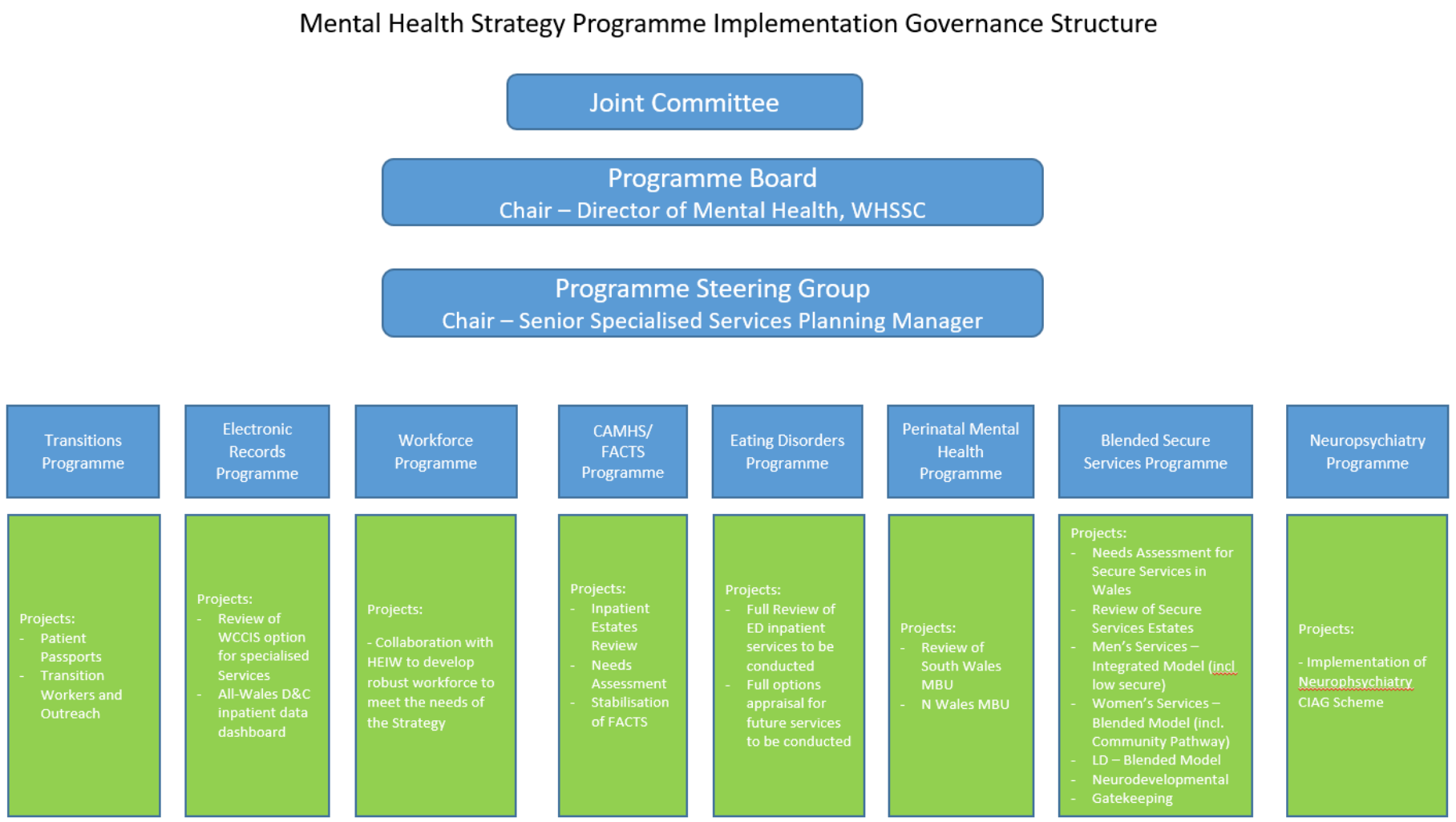
3.2.3 Programme Governance Structure

The implementation of the Specialised Services Strategy for Mental Health requires a robust change management structure to ensure the success of the strategy and continued development of strategic intent going beyond the 5-year scope of the strategy.

This is a large-scale change programme which will impact on services across the whole of the country.

The programme structure outlined in **Figure 1** below demonstrates some of the key programmes to drive these improvements.

Figure 1 – Mental Health Strategy Programme Structure



The timelines set out below incorporate an 8-week consultation period.

Revised Strategy Timeline – October 2022 – March 2023 – 8 week consultation

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the stakeholder feedback received from the 12 week engagement exercise on the draft Specialist Mental Health Strategy,
- **Approve** the proposals to:
    - Undertake an 8 week consultation process using the draft consultation document in appendix 1;
    - Commission demand and capacity modelling with immediate effect; and
    - Develop a programme approach to implementation of the strategy following the consultation exercise.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Development of the Plan
Link to Integrated Commissioning Plan	To be included in the 2023/2026 ICP
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
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 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	Quality and Safety is incorporated into the programme structure.
Finance/Resource Implications	Workforce incorporated into the programme structure.
Population Health	-
Legal Implications (including equality & diversity, socio economic duty etc)	Supports compliance with the provisions of the Mental Health Act, The Mental Health (Wales) Measure 2010
Long Term Implications (incl WBFG Act 2015)	Ensuring patients physical and mental well-being is maximised in which choices that will benefit future health.
Report History (Meeting/Date/ Summary of Outcome	**3 October 2022** - Corporate Directors Group Board meeting – Supported **10 May 2022** – Joint Committee
Appendices	**Appendix 1 -** Summary of the Stakeholder feedback from the 12 week engagement exercise on the Draft Specialised Mental Health Services Strategy **Appendix 2 -** Draft consultation document for the Draft Specialised Mental Health Services Strategy

Appendix 1

Summary of the Stakeholder feedback from the 12-week engagement exercise on the Draft Specialised Mental Health Services Strategy

Total number of responses: 21

Transitions

Question	No of Responses	Yes	Partly	No	Key points	Actions for Strategy
1. The development of a patient passport to improve transitions from CAMHS to Adult and Adult to older people's services, and also between levels of service and sub-specialties.	15	14	1	0	**Supported** Patient ownership Care Plans – key document Training needed WCCIS – no requirement if all HBs take up WCCIS Ensure autonomy and relationships remain for N Wales system in place	
2. Transitions between service levels should also be explored for CAMHS Services, with consideration given to transition workers or outreach services to act as an intermediate care service linking inpatient and community services.	15	14	1	0		
3. The development of a CAMHS Referral Hub for the NHS Wales in-patient units would address some of the key issues identified through workstream discussions such as the timeliness of assessments and decision making and agreed national minimum data sets for referrals to ensure inpatient units have all required information for admission.	15	10	5	0	1 x deemed not necessary Others supportive with caveats to ensure some autonomy for units and relationships	
4. Ensure pathways consider the timely transition of patients with a learning disability to the appropriate environment that meets their assessed needs and prioritising transition planning of patients with a learning disability who have a length of stay over five years.	14	14	0	0	LOS of 5 years is too long and unacceptable	
General Comments: - Open up to LD as well as CAMHS for Qs 1-3 - Take into account Royal College of Psychiatry MoU with Responsible clinicians - Person centred transitions based on needs of patient rather than just age e.g. "emerging adult" - Older adult needs based on condition not age - Local authority inclusion in discussions - Mind Cymru research on YPs experience of transitions - No specific acknowledgements of ND conditions (ADHD, Autism, Tourettes)						**Develop ND section of strategy**

CAMHS

Question	No of Responses	Yes	Partly	No	Key points	Actions for Strategy
1. To assess and consider the CAMHS inpatient estate with particular emphasis on the NWAS Site.	12	11	1	0	Agreement to reconsider inpatient estates. Accessibility for those with both physical and learning disabilities including ASD Also consider Ty Llidiard estate	
2. To consider a National CAMHS Inpatient Referral Hub.	12	8	3	1	Mostly supported with concerns over losing ownership, however comments also made supporting impartiality	
3. To consider funding an electronic clinical records system.	13	9	3	1	Mostly supported, however comments regarding roll out of current WCCIS system could rectify most issues. Support for inpatient dashboard	
4. To undertake a comprehensive needs assessment for CAMHS inpatient services.	13	13	0	0	Fully supported	
5. To consider staffing models at both units to meet the needs of the service specification.	13	13	0	0	Support for MDT approach, particularly therapies	Partly addressed through WG funding for 2021/22
6. Stabilisation of the FACTS service and development of a service specification.	11	10	1			
General Comments: - Consideration needed for relationships with local authority partners – particularly for LAC - Service spec to consider emergency access/admission beds - In-reach/Out-reach - ND conditions to be included in strategy						

Eating Disorders

Question	No of Responses	Yes	Partly	No	Key points	Actions for Strategy
1. To establish an Eating Disorders Unit for Wales for both in-patient and Day Service Provision across all ages.	16	13	3	0	Largely supported. Concern for the location suggested 2 units to service North and South Wales would be ideal, however with the acknowledgement that this may not be possible . Day services were strongly suggested to be on a regional basis to allow access to services	
2. Urgent interim measures to be put in place following the notice given for Welsh eating disorder placements contract with NHS England.	15	13	2	0	Concerns raised due to notice served by NHSE.	Interim measures in place at time of writing – medium term options being discussed at WHSSC
3. Full review of ED In-patient services to be conducted by 2023.	16	16	0	0	Fully supported	
4. Expansion of Paediatric Support for inpatients in Welsh NHS Units.	16	16	0	0	Fully supported – NWAS model cited as positive	

Question	No of Responses	Yes	Partly	No	Key points	Actions for Strategy
5. Expansion of HCSW role in adult eating disorder services.	15	13	2	0	Mostly supported	
6. Review of NG Feeding pathways.	16	15	1	0	Strongly supported	
7. Support for strengthening of Community provision.	14	12	2	0	Focus needed on transition to home and relationships with LA	
General Comments: - **The ED Review conducted in 2029 was seen as a key tool for the development of ED services, and the actions to respond to the 22 recommendation were seen as fundamental** - **The "emerging Adult" age range was outlined to give consideration for those 16-25 years olds on the ED pathway – pan-age options were supported for the ED Unit and day services.** - **Investment in workforce needed – AHP roles, Dietetics, MDT, therapies provisions outlined** - **SBUHB expressed interest to provide services** - **Need a whole pathway approach to service delivery for ED**						

Learning Disabilities

Question	No of Responses	Yes	Partly	No	Key points	Actions for Strategy
1. All secure hospital care including low secure to be commissioned by one organisation.	13	9	4	0	Mostly supported with caveats including consideration of national/regional frameworks and effects on HB commissioned low secure units	This needs to be set out more clearly in the final strategy
2. To develop and implement a blended model of care in conjunction with secure service provision in NHS Wales.	13	9	4	0	As above	
3. Ensure regular review of LD patients in placements reinforcing the care co-ordination and gatekeeping role.	13	13	0	0	Fully supported – impact on care co-ordinator role to be considered alongside blended model	
4. Consider the role of the community Learning disabilities team to support forensic requirements.	13	9	4	0	Workforce development requirements	
5. Development of Electronic Records for Learning Disability Patients in NHS Wales.	13	12	1	0	Suggested WCCIS roll out should be all-wales and all-service	
6. Development of an All Wales demand and capacity inpatient data dashboard.	12	12	0	0	Fully supported	
General Comments: - **Commissioning of services by one organisation may lead to lack of local ownership and scrutiny. If such an approach is considered then it needs to ensure there is local arrangements for close monitoring and rapid response where required.** - **It was commented that children with LD were missing from the strategy** - **Underestimated number of prison population with an LD** - **Change working to "Intellectual Disability"** - **Forthcoming changes to MHA may have an impact**						Consideration for children with LD to feature more in strategy

Male Secure

Question	No of Responses	Yes	Partly	No	Key points	Actions for Strategy
1. To develop Integrated Secure Services.	14	12	2	0	General support for integrated services to allow for continuity of care, flow through secure care and expertise. Needs clarity on what this will look like and who will commission/provide – regional/national. Concerns for what this means for gatekeeping and care co-ordination roles and ensuring local relationships remain for discharge/repat Inclusivity for LD and autism patients Concerns re budget and transfer issues	
2. To consider the requirements of the secure services estate in Wales.	14	13	1	0	To be mindful of projects within HBs – particularly those developing low secure units. Capital funding needed to develop estates in line with services Issue with Caswell – CTM estate for SB service	
3. To develop an All Wales Forensic Secure Services Board.	14	9	4	1	Mixed reactions – mostly supportive of the ethos, but concerns around ownership and how this would affect HBs. LA input into secure services board raised	
4. Development of Electronic Records for Secure Services in NHS Wales.	14	12	2	0	Supportive, but feel that WCCIS should provide this function	
5. To undertake a staffing modernisation programme for the two NHS Wales medium secure units.	13	13	0	0	Development of workforce very much supported to include therapies and dietetics, plus the upskilling of staff to consider patients with LD Focus on MDT model of care to include social work	
6. To conduct a needs assessment for secure services in Wales.	14	14	0	0	Fully supported	
General Comments: More clarity is needed – suggest work starts asap to outline the key elements of this project and the resource implications						

Female Secure

Question	No of Responses	Yes	Partly	No	Key points	Actions for Strategy
1. To consider the commissioning arrangements for a regional secure service for both medium and low secure service for women.	14	14	0	0	Comments the same as male secure care	
2. To consider the requirements of the secure services estate in Wales.	14	14	0	0	Issues re Caswell estate being CTM owned and SB ran Seclusion facilities for females to be considered	
3. To consider establishing a robust Community Model Pathway for women.	14	14	0	0	Community based pathways, services and models of care outlined as key for female secure services	
4. To consider the workforce skill mix to adapt to the increasing acuity of female patients in medium secure services.	14	14	0	0	Development of MDT to include therapies and social care	
5. To develop an All Wales Forensic Secure Services Board.	14	9	4	1	Mixed reactions – mostly supportive of the ethos, but concerns around ownership and how this would affect HBs. LA input into secure services board raised Concerns whether this would cause divisions within HBs and whether it is needed if there is a universal plan	
6. Development of Electronic Records for Secure Services in NHS Wales.	14	12	2	0	WCCIS should resolve this	
General Comments: - Neurodiversity and LD must be included in the development of services - A need to modernise inpatient services - A need assessment is required for this service as per the male secure service						

Perinatal

Question	No of Responses	Yes	Partly	No	Key points	Actions for Strategy
1. To review the MBU at Tonna Hospital 12 months post-opening.	12	12	0	0	Review welcomes	
2. To advise following this review the long-term plan for the unit, particularly in relation to the siting of the unit.	12	12	0	0	Location requires green space so not in agreement with Tonna or DGH as preferred site	
3. To work in partnership with NHS England to secure 2 beds for Welsh patients in a new unit scheduled for development within Cheshire and Wirral Partnership Trust.	12	9	3	0	Support closer to home provision for N Wales – agree with interim measure, but consideration should be given to a unit within Wales longer term	

General Comments: - Dietetic resource needed for MBU provision - Need to consider patients with LD, Autism, or those mothers under 18 - Query if capacity at Tonna and projected for N Wales is enough	

Neuropsychiatry

Question	No of Responses	Yes	Partly	No	Key points	Actions for Strategy
1. To address the sustainability of the Welsh Neuropsychiatry Service.	13	13	0	0		
2. To ensure the Welsh Neuropsychiatry Service reaches across the whole of Wales.	13	12	1	0		
3. Improve the flow of patients across the whole patient pathway.	13	12	1	0		
4. Raise awareness and understanding in local areas of the enduring impact of an acquired brain injury on mental health.	13	12	1	0		
General Comments: - Comments centred on the community provision on discharge, particularly physio and AHP roles and pathways back into local services - Collaboration with Major Trauma Centre - Service is for ABI only. Comment received to consider Stroke survivors – need to check service scope for specialised services v secondary care services.						**Strategy to be amended to include the Liaison Model CIAG scheme to address the majority of comments made**

Gaps

- A service for people who use B SL as their first language. There are currently no specialist services for people in North Wales and for them to be referred to those specialist services out of country required weeks and weeks of negotiation with panels of people with no understanding.
- How do specialist services meet the needs of neurodiverse individuals? Autism and ND
- How would having a pan age national Eating Disorders Inpatient unit impact on demand for CAMHS beds and acuity in CAMHS inpatient units?
- Whole pathway discussions
- No mention of patients with a personality disorder
- Reducing restrictive practices
- Alignment to Together for MH
- Links to secondary care e.g. joint tertiary/secondary care posts
- Development of community teams
- ED early interventions
- Working with people with a lived experience

Advice on Implementation of Actions

- Stakeholders to include service users

Examples of different ways of working/ Best Practice/ Case Studies

https://cpmh.csp.org.uk/system/files/documents/2022-06/rcp_ed_sping_conference_2022_developing_a_physiotherapy_led_physical_activity_and_exercise_pathway.pdf

NHS England » Co-production resources

Recovery and Outcomes (rethink.org)

https://www.beateatingdisorders.org.uk/about-beat/policy-work/best-practice in-managing-services-transitions/

Intensive Day-care and home-based treatment https://www.beateatingdisorders.org.uk/about beat/policy-work/family-empowerment/

https://gov.wales/eating-disorders-service-review-2018

Further Comments

- **Nutrition and Dietetics provision to mental health services is inequitable across Wales. As well as Eating Disorder Services and CAMHS more consideration is required to enhance the Dietetic offer to support adults in specialist mental health services, whose main cause for nutritional difficulties is due to their mental health or psychotropic medication.**
- **Has access to substance misuse services and specialist treatment been sufficiently considered for secure services for males and females?**
- **SBUHB welcomes the publication of the MH Specialised Services Strategy. Colleagues within Swansea Bay UHB MHLD Service Group have had an opportunity to contribute to its development through either chairing or participating in the different work streams.**
- **SBUHB supports the overall aim of the strategy which is to ensure the commissioning of high quality MH services for the people of Wales and the principles that the strategy sets out.**
- **The MH Workforce plan developed by HEIW will be key to making the strategy a reality.**
- **Service patterns could more fully acknowledge the rural dimensions and access to receiving culturally sensitive services including the Welsh language**
- **No recognition in the strategy of increasing number of people who self-recognise as non-binary. Transgender and gender-diverse people are three to six times more likely to be diagnosed as autistic.**
- **Transgender and gender-diverse individuals are more likely to be autistic and report higher autistic traits | University of Cambridge**
- **The opportunity to participate in a survey of strategic mental health services' strategy is welcomed by the National Autism Team. The Team is funded by Welsh Government and is managed by WLGA in partnership with Public Health Wales. The Team's current focus is on autism but their remit is expanding and they will be leading on the wider ND agenda.**
- **The following overarching comments are offered :**
    - **1. It is essential the strategy fully recognises the impact of Autism. Autistic people unfortunately are highly vulnerable to experiencing co-occurring mental health conditions with associated high rates of presentation to mental health services. There is emerging recognition of the number of autistic people in specialist mental health services.**
    - **2. Developments need to be examined through the prism of autism as this affects the development of services models, architectural design of units and workforce development. All the areas proposed in the strategy need to be examined in this way and we have provided some sample research evidence within each specialty area.**
    - **3. We have had discussions with the HEIW MH Workforce development team and have highlighted the requirements for enhancing both capacity and competency in Autism and co-occurring disorders. We have emphasised this includes specialist mental health services.**
    - **4. We have suggested that workforce strategies need to promote greater competence of individuals, teams and services to work together to support a person; such an approach would be potentially most efficacious for people with complex mental health needs.**

Other areas of healthcare have benefited from this approach. Mental health services were early adopters of multi-disciplinary approaches so should be receptive to further changes to reflect enhanced knowledge and understanding of mental health conditions.

- **5. The strategy and its implementation would be enriched by overt recognition of the contributions of experts by experience. We are pleased the strategy is attempting to reach out to stakeholders repeatedly , we would be happy to facilitate involvement of autistic people.**
- **6. We have responded from an autistic perspective but would suggest the strategy needs to have due regard to Neurodevelopmental conditions. For example within forensic considerations over 25% of the prison population meet the diagnostic criteria for ADHD.**
- **The impact of ADHD in criminal law - ADHD Institute (adhd-institute.com) Co-occurrence of neurodevelopmental conditions and common conditions should be expected.**
- **7. WG has led internationally in the recognition and support for autism people including a statutory Code of Practice. WG'S recent announcement continues this commitment including a wider remit to include all neurodevelopmental conditions . Written Statement: Improvements in Neurodevelopmental Conditions Services (6 July 2022) | GOV.WALES.**
- **Specialist mental health services have opportunities to provide exemplars of practice and sources of advancing the research evidence base.**

- **In order to achieve the commissioning of high quality specialist mental health services for the people of Wales it is necessary to adopt a holistic, collaborative approach. This approach should include partners such as local authorities and third sector organisations but also other services within the NHS including Primary Care and Local Primary Mental Health Support Services. The development of effective referral pathways between services outside of and within the NHS will lead to improved outcomes for the people of Wales.**
- **In addition, the development of effective care and support provision from early intervention and preventative services will support people to get the help they need when they need it and will lead to reduced numbers of people requiring access to specialist mental health services. The links between this Strategy, the Together for Mental Health Strategy and the joint Health & Social Care Mental Health Workforce Strategy should be intrinsic and meaningful.**
- **In needs-assessing and developing secure and specialist inpatient services it is crucial that culturally diversity is a key consideration, and that services and spaces are developed in a way that meets the social, cultural and spiritual needs of patients. This should be informed by the views and wishes of past and present patients and in recognition of the disproportionate detention of particular groups, including, but not limited to, Black men. Culturally appropriate spaces should be delivered alongside culturally appropriate practices by individual practitioners and services as a whole, for example, providing prayer rooms and access to those spaces as required.**
- **I think it would be beneficial to hold a workshop to gain further clarity regarding the recommendations and understanding the impact / benefits.**
- **There is no mention of joint working practices between learning disability provisions and mental health e.g. forensic services**
- **It is not clear what these recommendations mean for individuals already in low secure provisions**

- **Some of the sections/recommendations are ambiguous and it is not clear what they mean e.g. blended model, secure services commissioned by one organisation**
- **There is a need to be mindful of local service developments already in progress e.g. ABUHB low secure facility**
- **It is not clear as to what the expectations are for MDT provision within these secure settings and what this means to local community teams**
- **The role of the care co-ordinators needs to be better understood**
- **Although this work relates secure services, there is a need for the pathways to fully recognise the transition to community service provision and consideration needs to be given as to what community provision is required to support individuals stepping down e.g. housing, providers, etc**
- **It will be imperative that there is a strong focus on outcomes for individuals within secure services and accountability where outcomes are not being met**
- **On a positive note it is welcoming to see that the needs of people with a learning disability are embedded throughout the document. The recommendations are also succinct and provides a good focus on what needs to be achieved. Furthermore, it is positive to see that there is a recognition of the need to develop the skills of the workforce to meet the needs of people with a learning disability.**
- **The strategy makes little mention of understanding and addressing inequalities in access, uptake or outcomes from services. Only with in the recommendation to undertake a needs assessment for male secure units is ethnic or cultural diversity included.**
- **Improving patient pathways and community-based provision is positive, however to reflect the ambition to develop a whole-system approach consideration should be given of how those pathways might involve voluntary and community sector provision, as well as links with housing and employment support and potentially consider social prescribing-type approaches to enable people to engage with meaningful activities and address key wider determinants which are known to impact on mental health, all in support of their recovery journey.**
- **The quality framework helpfully references patient-centred approaches. It would be helpful to incorporate consideration of how patient empowerment can also be strengthen through service engagement, giving patients more autonomy and control over their care is a central element (or guiding principle) of the UK Governments proposals for reforming the Mental Health Act and thus, whilst health is devolved, this should be considered in Welsh service developments also given the benefit it can have for patient experience and outcomes.**
- **Finally, it is clear to me as a health professional why this strategy only considers some services/mental health conditions as it relates only to "specialised commissioning". However, a clear explanation of what is and isn't included and why that is so would strengthen the strategy and, I think, avoid potential public feedback/criticism on perceived exclusions.**
- **I welcome the proposals to review MH estates and trust this includes looking at the quality of the environments to ensure they are psychologically-informed environments which make people (staff and patients) feel valued and support recovery.**
- **One of the key findings of the 2018 eating disorder service review was major variation across Wales in access to quality eating disorder treatment. This was echoed by the findings of Beat's '…3 Years on' report, published in January 2022. This consultation document**
- **acknowledges that "Some of the key discussions when considering eating disorders are … the different pathways and models each health board holds." (p.45). If this inequity is to be fully addressed, the proposals related to eating disorders put forward in this consultation must be**

integrated into a fully funded early intervention-based service model or framework, that sets clear timelines for health boards to achieve each milestone.

- **In-reach/Out-reach model The Welsh Government and WHSSC should note that the MARSIPAN guidance it cites on pages 42 and 47 of the consultation document has since been superseded by new all-age guidance published by the Royal College of Psychiatrists titled: Medical emergencies in eating disorders (MEED).**
- **Data - The Welsh Government and WHSSC should ensure that data collected on outcomes and experiences of people with mental health conditions can be disaggregated by service type and condition, including eating disorders. Often health boards are unable to extract and report data specific to eating disorders.**
- **Electronic records - We welcome the recommendation to develop an electronic records system that can function across mental health services in Wales to enable appropriate access and sharing of information needed for patient care. However, the ambition should go beyond mental health services to at least include linkage with electronic data systems in use in paediatric/medical care and primary care settings. This could significantly improve coordination of care and the physical health of people with mental health conditions.**

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

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)

MENTAL HEALTH SPECIALISED SERVICES STRATEGY FOR WALES 2023/24-2028/29

DRAFT STRATEGY DOCUMENT NOVEMBER 2022

FOREWARD

Foreword from the Managing Director of Welsh Health Specialised Services Committee (WHSSC)

This Mental Health Specialised Services Strategy 2023-2029 (the Strategy) draft document represents the first step in realising our ambitious whole person approach to commissioning specialised Mental Health services on behalf of the seven HBs for Wales.

We see the development of our strategy as key to our role in supporting the bold agenda set out in A Healthier Wales (2018) that describes a whole system approach to health and social care. It will help ensure we can meet the demands of the Health and Social Care (Quality and Engagement) (Wales) Act (2020), the National Clinical Framework for Wales (2021) and the Quality and Safety Framework (2021). Collectively these set out an aspiration for quality-led health and care services, underpinned by prudent healthcare principles, value-based healthcare and the quadruple aim.

This draft document is the first step in that process and provides the basis for wide stakeholder involvement. We recognise that it has only been possible to develop this document, because of the hard work of a group of clinicians, managers and third sector representatives, who enthusiastically and conscientiously took part in the different work streams. Without them, WHSSC would not have been able to draw together this comprehensive understanding of the services provided to our patients and describe the opportunities for strengthening the quality of care in the future. Their work has provided an essential platform upon which we can take this draft forward and allow those stakeholders, especially patients and their families, who have not contributed so far to have their voice heard. Your input into this draft is therefore essential if we going to be able to develop a strategy, which truly delivers on the ambitions of A Healthier Wales and delivers the best services possible for patients, we look forward to receiving your views.

Sian Lewis, Managing Director

CONTRIBUTORS

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Leads for CAMHS/FACTS Workstream: Shane Mills, Director of Quality & Mental Health/Learning Disabilities, National Collaborative Commissioning Unit and Stuart Davies, Director of Finance, Welsh Health Specialised Services Committee
Leads for Eating Disorders Workstream: Dr Menna Jones, National Eating Disorders Lead, NHS Wales Health Collaborative and Wendy Clarke, Specialist Lead for Eating Disorders, Child and Family Division, Aneurin Bevan University Heath Board
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Lead for Men's Secure Services Workstream: Paul Hanna, Head of Nursing, Regional Specialist Services, Mental Health & Learning Disability Division, Betsi Cadwaladr University Health Board
Lead for Women's Secure Services Workstream: Dr Allyson Witts, Consultant Forensic Psychiatrist, Swansea Bay University Health Board
Lead for Perinatal Mental Health Workstream: Carl Shortland, Senior Planner North Wales, Welsh Health Specialised Services Committee
Leads for Neuropsychiatry Workstream: Joanne Wilson, Directorate Manager (MHSOP), Cardiff and Vale University Health Board and Karen Bonham, Speech Therapist, Cardiff and Vale University Heath Board.

Further contributions have been received from representatives of the following organisations:

Aneurin Bevan University Health Board
Betsi Cadwaladr University Health Board
Cardiff and Vale University Health Board
Cwm Taf Morgannwg University Health Board
Hywel Dda University Health Board
Powys Teaching Health Board
Swansea Bay University Health Board
Ministry of Justice
Improvement Cymru
Community Health Council
Public Health Wales
NHS Wales Collaborative
HM Prison Service

Women in Justice Group
Welsh Neurological Alliance
Diverse Cymru

BEAT Cymru
NHS England Partners

Contents

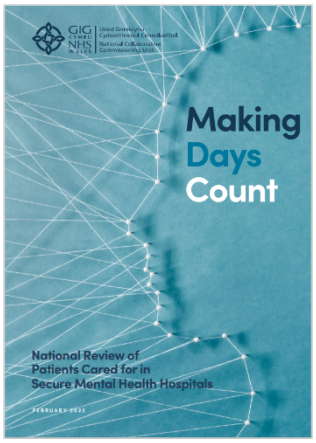
PART 1: STRATEGIC CONTEXT

1.1 Introduction and Strategic Context

The Welsh Health Specialised Services Committee (WHSSC) works on behalf of the seven Health Boards in Wales to ensure the commissioning and provision of high quality, sustainable and equitable specialist services for the Welsh Population. It works through a variety of commissioning teams to plan, secure and evaluate specialist services for the people of Wales. One of the commissioning teams has a focus on Mental Health and Vulnerable Groups.

Services are delivered by Local Health Boards across various NHS sites in Wales and NHS providers in England. The independent sector is also used extensively across mental health in both England and Wales.

Maintaining high quality specialist services which meet the needs of our patients in a rapidly changing environment requires ongoing review and development. The development of this commissioning strategy for specialised mental health services has considered a wide range of key drivers:



External

- A number of Committee inquiries and external reviews influencing Welsh Government policy and recommendations.
- Changes to the commissioning landscape in England and the establishment of NHS England have meant that the previous opportunities for cross border joint planning have reduced and the establishment of Mental Health Provider Collaboratives in England will fundamentally change the delivery model for services in the future.
- A number of reviews into mental health services in Wales have been published of late including Transforming Care, Transforming Lives (2020) with a view on learning disability services, Service Review: NHS Wales Children and Adolescent Mental Health Inpatient Services

(2021), and Making Days Count (2022) which reviews the secure services provision in NHS Wales.

- The Adverse Childhood Experiences (ACE) Support Hub and Traumatic Stress Wales have collaborated on the co-production of a National Trauma Practice Framework for Wales that covers all age groups and all forms of adversity and traumatic events. The aim of the framework is to help people, organisations and systems to prevent adversity and trauma and their associated negative effects. It will facilitate the development of a whole systems approach to supporting the needs of people who have experienced adversity and trauma and seeks to bring consistency and coherence to support that effort and ensure that it meets the needs of those affected by trauma. This document went out to consultation during March 2022.

Internal

- Workforce recruitment issues particularly affecting Child and Adolescent Mental Health Services (CAMHS).
- The Welsh Framework Agreements for accessing non NHS Wales beds is dependent on an adequate supply of beds and provider competition which is currently reducing because of changes to commissioning within NHS England.
- A complex commissioning model for Forensic Adolescent Consultation Treatment Service (FACTS) which is leading to service delivery problems for children with very complex social and health care needs.
- Limited national services for women in secure care.
- Lack of national services for people with a Learning Disability in Wales requiring secure care.

The overall **Aim** is:

To ensure the commissioning of high quality specialist mental health services for the people of Wales

Within this aim, the following principles will need to be considered:

- High quality specialised care provided to patients in the least restrictive environment appropriate for their treatment.
- Providing more care closer to home wherever safe and practicable to do so; primarily in the Welsh NHS but where necessary, and appropriate, with third sector or private sector partners.
- Developing commissioning models which add value and strengthen the whole pathway approach to service delivery supporting the transforming health care agenda within Wales.
- Addressing the challenge of improving outcomes and transitions between different parts of pathway and commissioning organisational boundaries.
- Prioritising investment in areas with demand and capacity constraints and areas with extended waiting times and/or gaps in service.

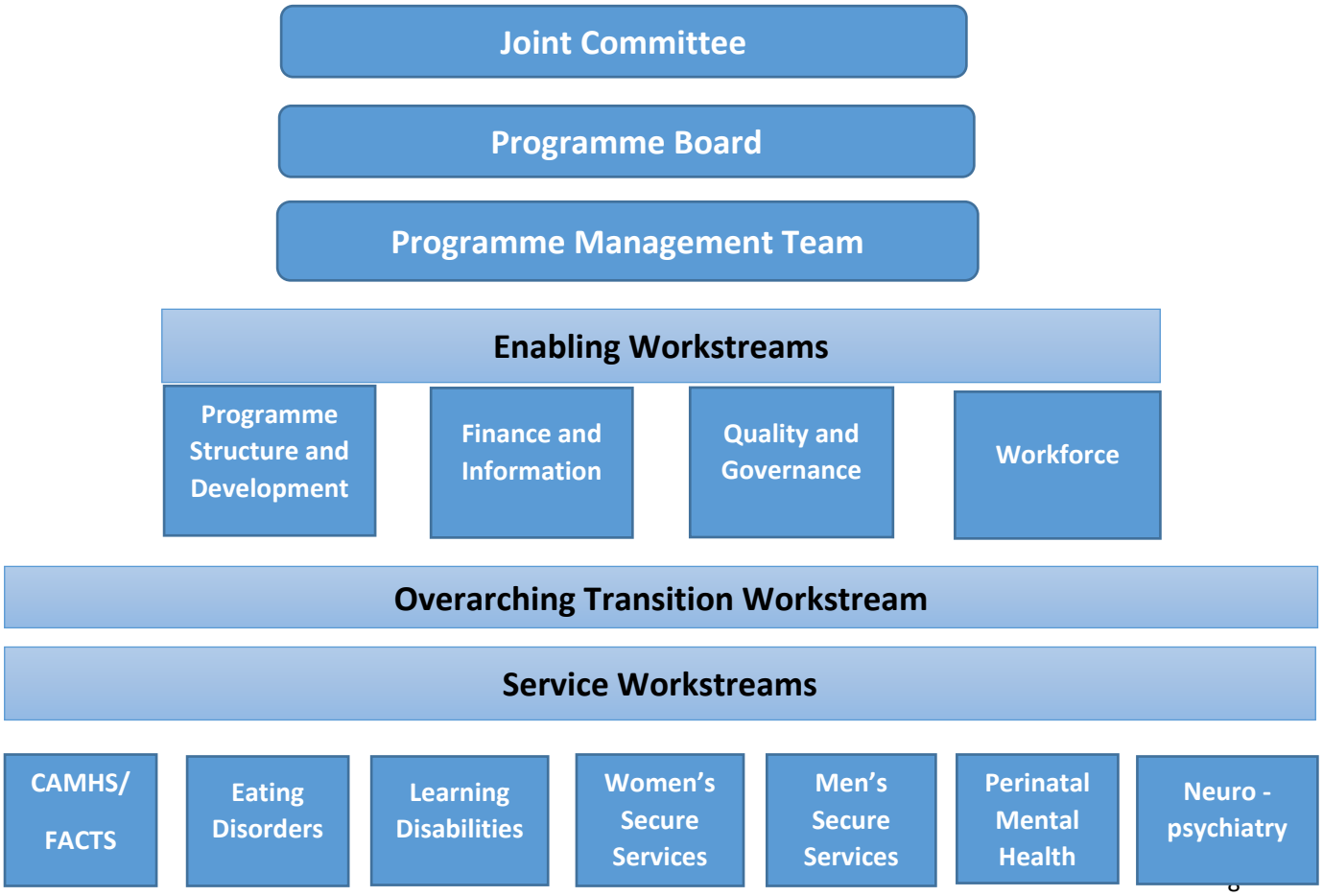
1.2 Methodology and Governance

This strategy was developed using programme management methodology to ensure an appropriate governance structure was applied throughout the process. This governance structure is outlined below with a series of workstreams covering each service area and enabling workstream to provide overall assurance for key overarching themes such as workforce, finance and information, and quality and governance.

These workstreams fed into the Programme Team which was chaired by the WHSSC Assistant Director of Planning with membership from all of the service area and enabling workstream leads. In addition to being a reporting and governance mechanism, this programme team provided a platform upon which to develop discussions to provide a cohesive approach to strategy development and to drive forward discussions around the transition agenda.

The decision making was at Programme Board level, where leads from key partner organisations could consider the development of the strategy and input and advise accordingly. Programme Board was chaired by the WHSSC Director of Planning and reported by exception into the WHSSC Joint Committee.

Mental Health Strategy Programme Governance Structure



1.3 Stakeholder Engagement

A Stakeholder Communication and Engagement Plan has been developed to seek the views and opinions of a range of partners including our service users and their families.

This strategy has been developed subject to the feedback of our stakeholders and will be amended accordingly.

The strategy has been developed in collaboration with many of our stakeholders, and the engagement process provides an opportunity for those stakeholders to see their contribution within the document in its entirety, and to allow those stakeholders who have not contributed so far to have their voice heard.

We welcome your views on this very important strategy for WHSSC.

PART 2: ENABLERS

2.1 Workforce

The development of this strategy has highlighted the need for further strengthening to the mental health workforce across all aspects of the service. Particularly for specialised services, the development of multi-disciplinary teams and roles has been at the forefront of discussions.

Following the Covid-19 pandemic, NHS Wales has seen considerable strains on their workforce and this has resulted in burnout and fatigue amongst staff. Solutions must be sought to ensure staff well-being and development and to consider alternatives to traditional roles where this is appropriate.

In addition to these recent challenges, our specialised mental health services are being delivered using resources identified a number of years ago. This workforce model requires development and consideration in line with the key priorities set out in the Health Education Improvement Wales (HEIW) workforce plan and the ongoing discussions instigated by the development of this strategy.

HEIW have developed a mental health workforce plan which completed consultation stage in March 2022. This plan sets out the intentions of NHS Wales to develop and support the mental health workforce over the coming years and considers a number of key priorities:

- Workforce supply and shape
- An engaged, motivated and healthy workforce
- Attraction and recruitment
- Seamless workforce models
- Building a digitally ready workforce
- Excellent education and learning
- Leadership and succession

This strategy aims to work alongside HEIW to support the achievement of these priorities and associated actions and further strengthen the workforce through its implementation by developing and supporting the workforce, using resources differently and effectively and supporting our workforce and their well-being.

Some of the key discussions through the strategy development have focussed on the need to review the traditional workforce models which are in place. This has focussed on consideration of alternate roles and multi-disciplinary teams, links to other specialties to ensure whole system approaches, development of multi-professional teams to include social care roles as an integral part of the health and care system and encouraging the evolution of professionals from other disciplines with a special interest in mental health.

These can be seen below:

KEY WORKFORCE RECOMMENDATIONS	
CAMHS	To consider staffing models at both units to meet the needs of the service specification.
Eating Disorders	To ensure sufficient training and development opportunities and links to the HEIW MH Workforce Plan to develop staff to enable the establishment of an Eating Disorders Unit for Wales. Development of multi-disciplinary teams (MDTs) to support patients with eating disorders, particularly Paediatric support, and HCSW roles.
Learning Disabilities	Development of workforce in mainstream secure services to ensure the needs of patients with a learning disability are met. Development of workforce to ensure a blended model of care can be delivered.
Secure Services	To undertake a staffing modernisation programme for the two NHS Wales medium secure units. To consider the workforce skill mix to adapt to the increasing acuity of patients in medium secure services, including an increase in those who have experienced significant trauma. To ensure staff are supported and offered regular supervision and dedicated emotional support.
Perinatal Mental Health	The review of the Tonna Mother and Baby Unit (MBU) should ensure the well-being and development of the workforce accordingly. Consideration of the North Wales provision should ensure adequate staffing to meet the requirements of NHS Wales.
Neuropsychiatry	By enhancing staffing establishment in line with British Society of Rehabilitation Medicine (BSRM) standards and investing further in specialist staff to develop and deliver a 'liaison model' of working. Upskilling of non-specialist staff in assessment and management and education/support to staff and family members. Development and roll out of specific neuropsychiatry training programs for clinical teams in order to build on and improve knowledge and skills further.

2.2 Finance and Information

Finance

The development of this strategy has highlighted the need to invest in mental health services both in terms of revenue and capital investment. Some of the key recommendations arising from the workstream discussions include the development of key service provisions which require capital investment to either improve current estate or consider the development of capital projects to provide services in Wales.

The development of Provider Collaboratives in NHS England has further exacerbated this need as we start to see notice given on key contracts with NHS England providers for specialised mental health services. The ending of these contracts force us to consider alternative provision, either through the private sector, provider collaboratives of our own, or the development of new services.

Some of the key capital investment considerations will be scoped in year 1 of this strategy (2022-23), with a view to providing the information required to conduct option appraisals and inform a way forward for NHS Wales' provision of these services.

Some of the key investment requirements are outlined in the table below:

KEY INVESTMENT REQUIREMENTS	
Commissioning	Consideration of commissioning pathway to allow all secure services to be commissioned by a single organisation.
Electronic Records	To develop and implement an electronic records system for mental health services in Wales to include minimum data and a "Patient Passport".
CAMHS	To scope capital investment requirements for North Wales Adolescence Service (NWAS) site development or preferred option to re-site unit to meet the needs of the service specification. To scope capital investment requirements to develop Ty Llidiard site to meet the needs of the service specification. To consider collaborative bidding to allow joint funding for key services such as paediatric input into CAMHS.
Eating Disorders	To scope capital investment to ensure the feasibility of an eating disorders unit for Wales in light of contract changes to NHS England.

	To consider collaborative bidding to allow joint funding for key services such as paediatric input into CAMHS ED Services.
Secure Services	**To consider the requirements of the secure services estate in Wales:** Development and expansion of Caswell Site to improve current facilities and consider requirement for learning disability patients and women's services. To ensure a flexible estate to meet demand, and increased seclusion facilities to better care for those patients requiring additional care and support. Consideration should also be given to the Caswell site as the service is currently run by Swansea Bay University Health Board, but utilises Cwm Taff Morgannwg University Health Board site which can cause barriers and difficulties to developing the estate to meet service need.
Perinatal Mental Health	Capital investment has been secured by NHS England for the development of services for our North Wales patients. A full business case is being developed at the time of writing with an anticipated completion date for the project during Spring 2024. Further financial considerations should be given should this option not progress.
Neuropsychiatry	Service development has been funded via the WHSSC CIAG process for Phase 1 and Phase 2a of the Neuropsychiatry model. The work outlined in this strategy has been submitted as phase 2b of this ongoing work for completion during 2023/24.

In addition to the capital investment, the development and strengthening of the NHS Wales workforce for mental health services is crucial to either support any new or repatriated services, or to enhance current provision to avoid admission to tertiary care. These recommended developments are outlined in the workforce section above.

Information

WHSSC are currently developing a Mental Health information dashboard to include data on the number of patients and associated costs of specialised placements. In addition, information and performance management tools are being developed by our quality team for key service areas.

These developments should contribute towards a more robust information system by which specialised mental health services can be monitored to ensure ongoing service development to meet the needs of our population and assess demand.

The workstreams have also highlighted the need for electronic records and standardised minimum data requirements, and this work is described further in our "Key Themes section".

Demand and Capacity

Demand and capacity information is included in this document in each of the relevant sections. Where further work is needed, this has been highlighted as an action in that section. Where more in depth information is required for specific projects as part of the implementation of this strategy, this will be considered as part of the project plan for that piece of work.

2.3 Quality and Governance

Quality

The quality of care and experience that patients and their families receive, is central to the commissioning of specialised services.

Central to our approach is to develop open and transparent relationships with our providers, to engage and involve the clinical teams and work in partnership with stakeholders. This requires a facilitative and proactive approach where intervention as early as possible is key in order to provide support to services where issues of concern are identified.

Quality in health care supports a system-wide approach which requires an Organisational culture of openness and honesty with continual public engagement in the planning and commissioning of services.

These can be summarised as reflected within the Quality framework

- Safe - avoid harm
- Effective - evidence based and appropriate

- Person-centred - respectful and responsive to individual needs and wishes
- Timely – at the right time
- Efficient - avoid waste
- Equitable – an equal chance of the same outcome regardless of geography, socioeconomic status, etc.

Key enablers

- Ensuring that the patient is at the centre of the services commissioned. Capturing the patient experience alongside quality indicators is key to inform quality improvements. This involves working collaboratively with patients and service users in line with the Welsh Government framework for Assuring Service User Experiences (2018).
- Work in partnership with providers to agree Service specifications.
- Ensuring that the development of quality indicators that are clinically-led and reflect the specialist nature of the service delivered.
- Develop and support tools /mechanisms for analysis and reporting of Quality Indicators.
- Embed a culture whereby quality is seen as everybody's business across the organisation
- Reducing duplication and unwarranted variation.

In addition to the expectation set out in the contracting arrangements with providers, the following sources of internal and external intelligence are used to gain a better understanding from a provider and service perspective. The sources of intelligence builds on quality reporting from the providers, gathers assurance from the regulators and provides an emphasis on the reporting back to the Health Boards for the services that WHSSC commission on their behalf.

Specialised Mental Health Reporting Systems

Reporting for specialised mental health services is currently done using the Commissioning Care Assurance and Performance System (CCAPS) via the Quality Assurance Improvement Services (QAIS). Mental health specialised commissioner meetings also take place with NHS England providers.

In addition, our Gatekeeping, Placement and Case Management for Specialised Mental Health Services policy has been reviewed and was published in summer 2022.

The Once for Wales Concerns Management System (OfWCMS) is a new approach to how NHS organisations in Wales consistently report, record, learn and monitor improvements following incidents, complaints, claims and other adverse events that occur in healthcare. By bringing all this vital data together there is an opportunity for a platform that allows shared

learning and will help to improve patient safety as well as patient experience. Though in early stages there is potential that data captured from OfWCMS can be used by health organisations as part of their routine management information on quality, identifying areas where improvement work is needed and helping with cultural change. We need to harness the information that is available to us across all aspects of quality management systems to measure the quality and outcomes of care

Good experience of care, treatment and support is an essential part of an excellent health and social care service. This, alongside clinical effectiveness and a culture of safety puts the patient first and gives patient experience the highest priority.

These fundamental principles bring the concept of Prudent Healthcare to the forefront and in line with Welsh Government policy direction. Segmenting the individual elements of this definition gives rise to four components:

1. Identification and implementation of standards.
2. Monitoring, evaluating and reporting of performance against standards.
3. Action in response to monitoring; sharing good practice, disseminating and embedding lessons learnt.
4. Evidencing closure of concerns and continuous improvement.

Patient and public engagement are central to understanding service provision and areas for improvement development and of good and excellent practice.

Some of this can be summarised as follows:

- Understand the patient's expectation of a particular service.
- Put things right if the patient experience was not as expected or planned.
- Understand differences in patient experience between locations and types of treatment.
- Make changes where needed and highlight areas where changes have improved care.
- Monitor the outcomes and benefits of treatment in terms of a person's physical, mental and social wellbeing.
- Inform WHSSC how a service or particular treatment is being provided
- Plan future service provision.
- Understand the delivery of a value based health care approach.
- The patient's role in the decision making about their care.

<u>Indirect methods of evaluating services may include</u>

- Undertaking visits to hospitals and specialised units where treatments are funded by WHSSC and speaking to the staff and reviewing the environment.

- Internal reporting of actual and potential issues with a particular service.
- Collating compliments and areas of best practice.
- Keeping updated on current media interests in UK wide patient feedback and NHS developments.
- Requesting clinical updates on patients post treatment.
- Maintaining a website that is easy to use and gain access to important information.
- Undertaking regular audits and reviews of services funded by WHSSC including presentations on Quality Improvement initiatives and development of these.
- Monitoring patient feedback from provider services, through Quality indicators and through data collected on the Once for Wales site.
- Utilising 3rd party surveys.

Feedback may be classified into the following types:

1) **Patient outcomes** – What was the patient's (and family) experience of the service and to what extent were their expectations met or not met.
2) **Process data** – Tells us about the way the services WHSSC funds are delivered
3) **Outcome data** –Demonstrates what difference the service has made to the patient and if this was within a prudent model of care.

Outcome Measures

Outcome measures are currently being considered as part of the strategy development process and will be included in the final version of this document. More detailed outcome measures for specific projects to be implemented as part of this strategy will be included as part of the project plan for that area of focus.

Impact data

Changes in health are important milestones in the lives of patients and we should use Patient Reported Outcome Measures (PROMs) to measure them. This can help us assess and meet patient needs and to understand their experience of care, and to improve services

Patient Reported Outcome measures (PROMS) and Patient Experience Measures (PREMS) are frequently used in the NHS to assess the quality of care delivered. Information about a patient's health and quality of life before they receive treatment and about their health and the effectiveness after they have received treatment can be used to measure and improve the quality of care, evaluate the specific outcomes of treatments and inform future decisions about how care is planned and delivered in the future.

PROMs are a means of collecting information on the effectiveness of services, care and treatment delivered to individuals as perceived by the

individuals themselves. They measure the impact of clinical interventions such as did patient's physical and/or mental condition improve and if so by how much? PROMs examples are Quality of Life, Measurement of symptoms e.g. pain, functional ability, distress.

Patient Reported Experience Measures **(PREMs)** gather a patients' objective experience after treatment and aim to remove the subjectivity around the experience of care by focusing on specific aspects of the process of care e.g. were you seen on time?

Governance

In order to provide robust governance structures to commissioned services, risk registers and escalation processes are in place. Risk is mitigated and managed or escalated at all levels. In addition, oversight is maintained through coordinating regional responses to specialised commissioning issues and ensuring specialised commissioning fits in with the wider quality and governance systems. We manage escalating issues that cannot be managed regionally or require wider support by facilitating improvement through:

- Providing responsive support for issues requiring regional and wider response (e.g. independent providers)
- Sharing benchmarking data, learning and best practice both regionally and nationally
- Reviewing and supporting the mitigation of wider quality risks Specialised Commissioning
- Retaining accountability
- Ensuring that national standards are being maintained

Specific governance recommendations relative to this strategy are outlined below:

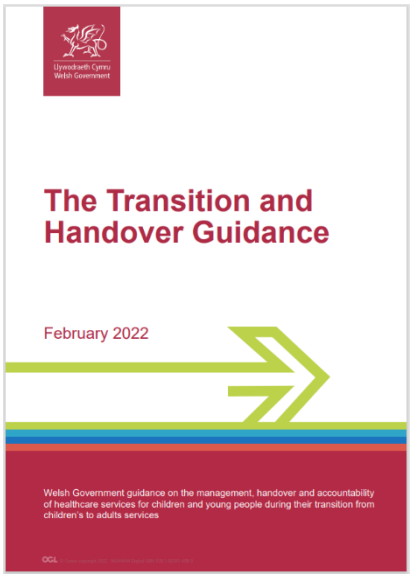
GOVERNANCE	
CAMHS/FACTS	Service specifications to be revised in line with this strategy for CAMHS in-patients and FACTS.
Eating Disorders	Appropriate governance arrangements to ensure robust contracting and service provision for any interim, medium or long term solutions. Review of Naso Gastric (NG) Feeding pathways to be robust and based on clinical evidence.
Learning Disabilities	Commissioning pathway to be considered to ensure appropriate governance for a blended model of care.
Secure Services	Commissioning pathway to be considered to ensure appropriate governance for a blended model of care.

Perinatal Mental Health	The current service review and future service developments should take into account governance processes and develop accordingly. Consideration of the North Wales provision should take into account the needs of the Welsh population including the provision of bi-lingual services where possible.
Neuropsychiatry	Through the development of a liaison model to ensure the service provision in North Wales receives the expertise of the Welsh Neuropsychiatry Services whilst still retaining the ability to provide care close to home for its population. To develop a liaison model that ensures quality of care, prevention and co-ordination and crisis management services.

2.4 Transition

Age Transition

Welsh Government's document "The Transition and Handover Guidance" published in February 2022 highlights the handover of care and accountability from children's to adult's services for children and young people between the ages of 16 and 25 as a key priority.



The overall aim of the document is "To provide a safe and effective transition and handover from children's services to adult's services for all children and young people requiring on-going care and support from health services".

The document outlines the planning for transition should start at age 13-14 years, although does state that this may start later for children in child and adolescent mental health services as in NHS Wales, Mental Health services transition age is 18 years.

For young people entering services at aged 16-17 years, the document states that a clear pathway should be in place for transition and that children and adult teams should work together to achieve continuity and the most effective service for the child or young person.

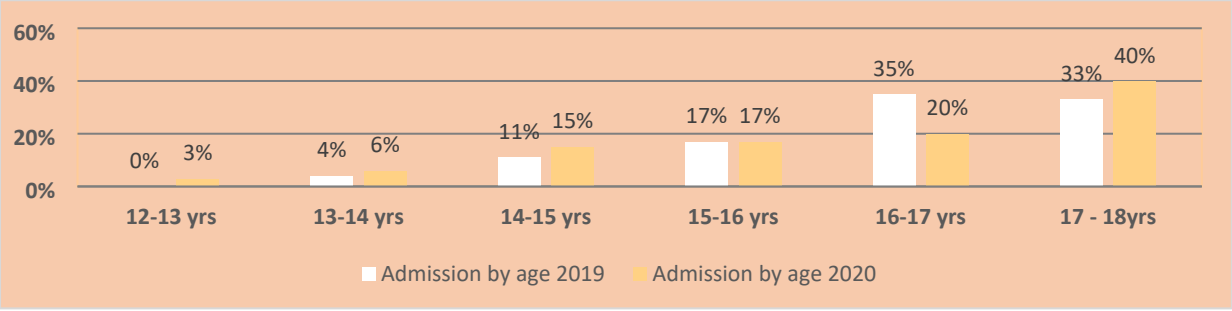
Together for Mental Health (2012) is the Welsh Government's 10 year strategy for mental health services across all age groups and aims to improve mental health services and outcomes.

It states that transfer between services should be based on need and not on artificial age boundaries, however key discussions through the development of this strategy have highlighted a focus on transition at the age of 18 for specialised services provision. This is attributed to the different skills required for CAMHS (Child and Adolescent Mental Health Services) and adult mental health services and also the mix of having adult patients over the age of 18 mixed with young people for this vulnerable cohort of patients.

Together for Mental Health is currently being revised to consider the strategic focus for the upcoming 10 years.

<u>CAMHS to Adult Mental Health Services</u>

In 2020, the numbers of 17-18 year olds seen in CAMHS inpatient services increased and this trend is showing to have increased further into 2021. Transition from CAMHS to adult services should therefore take into account this development and ensure that processes and procedures are in place to ensure the transition is as smooth as possible for those young people reaching adulthood in our services.



This strategy has been developed through a number of key workstreams as outlined in section 1.2 – Methodology and Governance. The workstreams all discussed the issues surrounding the transition for young people from CAMHS to adult services and the importance of these pathways. In particular, the "Patient Passport" was highlighted as, not only an effective tool for referral into different levels of services as outlined elsewhere in this

document, but also to ensure the best transition from CAMHS to adult services.

The secure services workstreams also highlighted the transition between adult and older adult services, particularly for those patients requiring dementia care. It was agreed that the "Patient Passport" would also be a very useful tool for this cohort of patients.

In 2019, Hywel Dda University Health Board and S-CAMHS service submitted a proposal for the recruitment of a dedicated Transition Practitioner. Co-production is an important theme of prudent healthcare and has been pioneered in CAMHS and mental health more generally through the adoption of care and treatment planning which encourages the service user to be fully engaged in the development of their plan. This should be continued during transition, with the young person having access to both CAMHS and adult mental health service named workers, involved in discussions about the transfer of their care.

The National Eating Disorders sub-group has established a pathway into tertiary level adult ED services prior to the 18th birthday in order to ensure continuity and that the patient's needs are still met when they reach their 18th birthday. This work will continue to be implemented as part of the strategy.

Service Level Transition

The workstream discussions also highlighted difficulties and barriers to patients transitioning between different levels of service in Mental Health. These discussions covered a variety of areas where there were issues including:

- Transitions between different levels of secure care, particularly between low and medium secure services.
- Transitions between service levels should also be explored for CAMHS Services, with consideration given to transition workers or outreach services to act as an intermediate care service linking inpatient and community services.
- The development of a CAMHS Referral Hub for the NHS Wales in-patient units would address some of the key issues identified through workstream discussions such as the timeliness of assessments and decision making and agreed national minimum data sets for referrals to ensure inpatient units have all required information for admission.
- The development of a seamless secure care provision would improve the patient pathway and minimise the barriers to accessing appropriate levels of service.
- Timely transition of patients with a learning disability to the appropriate environment that meets their assessed needs.

- Prioritising transition planning of patients with a learning disability who have a length of stay over five years.
- Delayed transfers of Care (DTOC):
    - Prioritising transition of patients in assessment & treatment provision with a length of stay over six months.
    - Prioritising transition of patients in specialist hospital care who have been identified for step down for more than 1 year.

Summary

Through these discussions, it became apparent that the opportunity to commission secure services through one organisation was the preferred option to ensure that the patient was not disadvantaged in their care through any artificial barriers created by the current organisational arrangements. Further benefits to this approach would include providing a seamless approach to care, and strengthening care co-ordination and gatekeeping for this cohort of patients.

Conclusions drawn in the developmental stages of this strategy indicated an appetite to eradicate labelling of patients into categories and to focus more on the needs of the patient.

In addition, the development of electronic records to include a "patient passport" were also felt to be of significant value to the services and the patient journey through the pathways.

Recommendations to support areas of transition have been highlighted as follows:

Transition
The development of a patient passport to improve transitions from CAMHS to Adult and Adult to older people's services, and also between levels of service and sub-specialties.
Transitions between service levels should also be explored for CAMHS Services, with consideration given to transition workers or outreach services to act as an intermediate care service linking inpatient and community services.
The development of a CAMHS Referral Hub for the NHS Wales in-patient units would address some of the key issues identified through workstream discussions such as the timeliness of assessments and decision making and agreed national minimum data sets for referrals to ensure inpatient units have all required information for admission.
Ensure pathways consider the timely transition of patients with a learning disability to the appropriate environment that meets their assessed needs and prioritising transition planning of patients with a learning disability who have a length of stay over five years.

CAMHS/FACTS

KEY RECOMMENDATIONS:

1. **To assess and consider the CAMHS NHS Wales inpatient estate**
2. **To consider a National CAMHS Inpatient Referral Hub**
3. **To consider funding an electronic clinical records system**
4. **To undertake a comprehensive needs assessment for CAMHS inpatient services**
5. **To consider staffing models at both units to meet the needs of the service specification**
6. **Stabilisation of the FACTS service and development of a service specification**

WORKFORCE

To consider staffing models at both units to meet the needs of the service specification.

GOVERNANCE

Service specifications to be revised in line with this strategy for CAMHS in-patients and FACTS.

FINANCE

To scope capital investment requirements for NWAS site development or preferred option to re-site unit to meet the needs of the service specification

To scope capital investment requirements to develop Ty Llidiard site to meet the needs of the service specification.

To consider collaborative bidding to allow joint funding for key services such as paediatric input into CAMHS

3.1 CAMHS/FACTS

3.1.1 Background

In order to provide a focus on the requirements of specialist Child and Adolescent Mental Health Services (CAMHS) across Wales, including the FACTS (Forensic Adolescent Consultation and Treatment Service) Service, the strategy considers the development of services for both CAMHS and FACTS to meet the population need.

One of the key drivers for this area is the "Service Review: NHS Wales Children and Adolescent Metal Health Inpatient Services" published by NCCU in April 2021.

This review considers the care given to inpatients in CAMHS hospitals in NHS Wales sets out key recommendations for Health Boards, commissioners and the Welsh Government.

In order to develop this section of the strategy, a workstream was set up to specifically consider Specialist CAMHS service requirements for the population of Wales to be commissioned by Welsh Health Specialised Services Committee (WHSSC). In addition to this, the workstream considered the relationships and provision of the FACTS service to support forensic CAMHS services in Wales.

The CAMHS/FACTS workstream was jointly chaired by the Director of Quality, NCCU and the Director of Finance at WHSSC, with membership from a range of clinical and service representatives, as well as representatives from NCCU and WHSSC. These professionals came from a range of health boards and statutory organisations to provide a full and unified discussion forum.

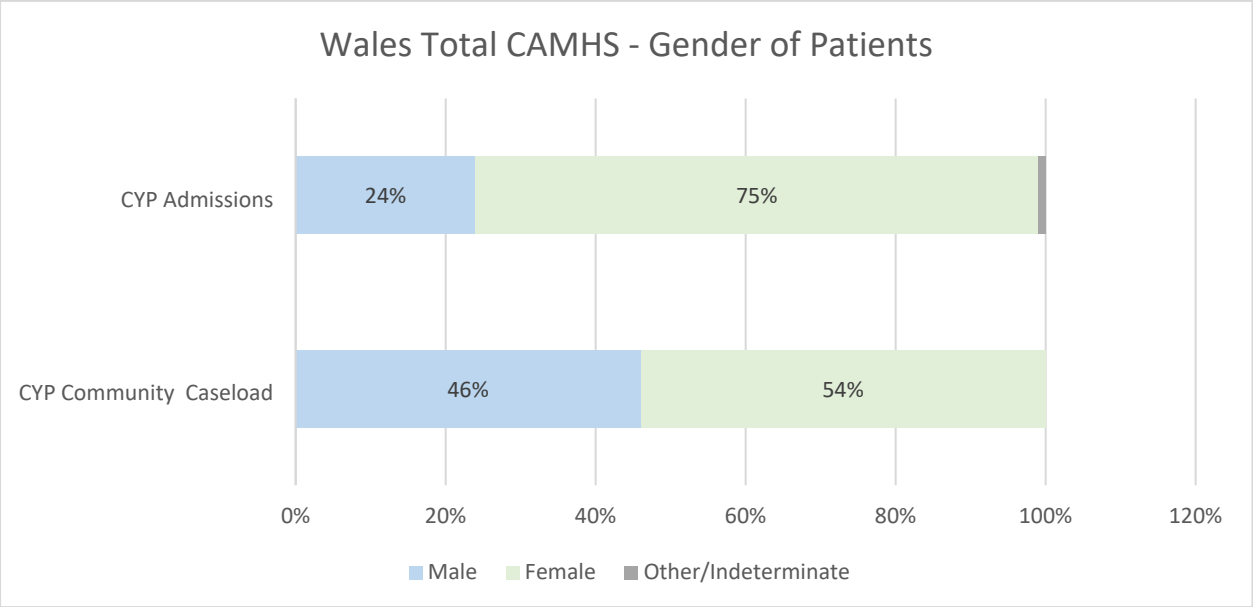
3.1.2 Data and Information

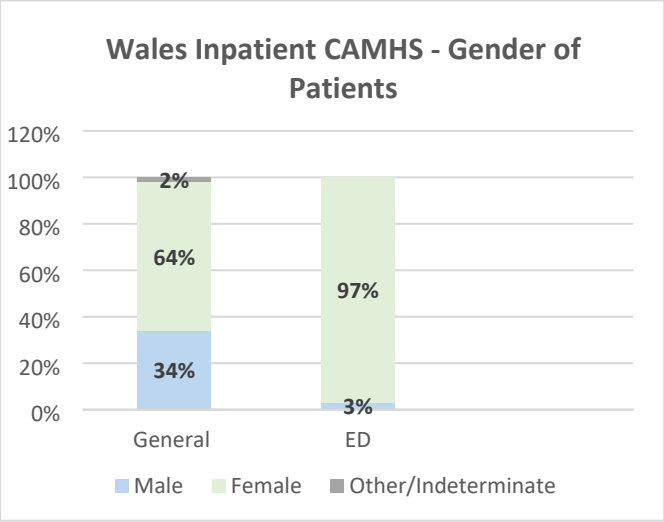
<u>Benchmarking</u>

On 6th December 2021, NHS Benchmarking Network published their 2021 benchmarking findings for CAMHS Services in Wales.

	Occupancy	Length of Stay	Workforce
Inpatient Care	48% bed occupancy (excluding leave) in general admission beds	65 days (excluding leave) in general admission beds	37 WTE per 10 general admission beds

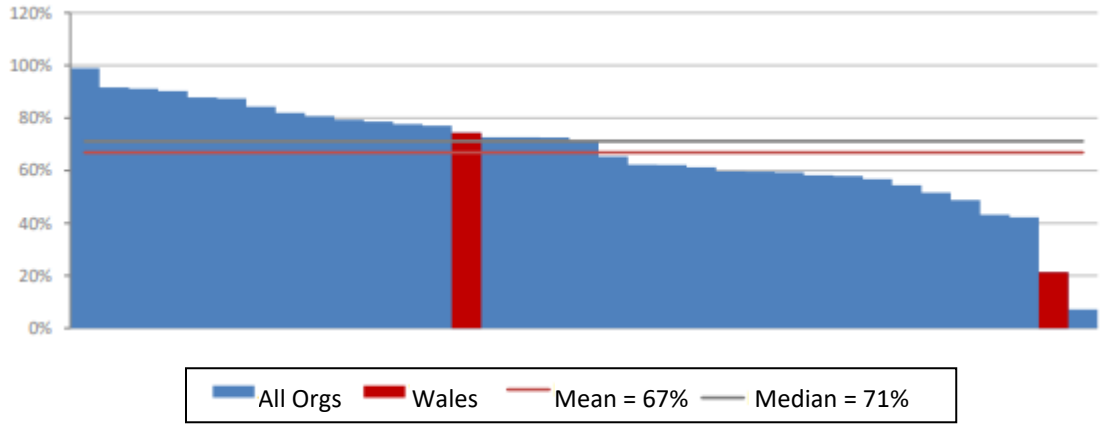
In the inpatient setting, organisations reported that 75% of total CAMHS admissions were female, compared to 70% across the UK. The community caseload gender split was more even at 46% male and 54% female indicating that female community patients were more likely to be admitted for inpatient care.



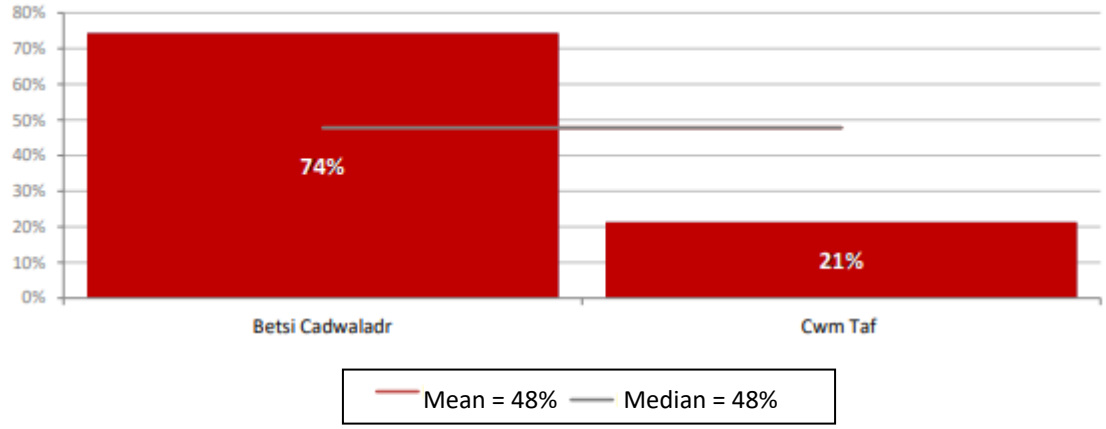


34% of patients admitted to general CAMHS beds were male, in line with the previous year. Welsh Health Boards reported that 97% of patients admitted to Eating Disorder CAMHS beds were female, compared to 89% in the UK overall.

General admission CAMHS: Bed occupancy (excluding leave)

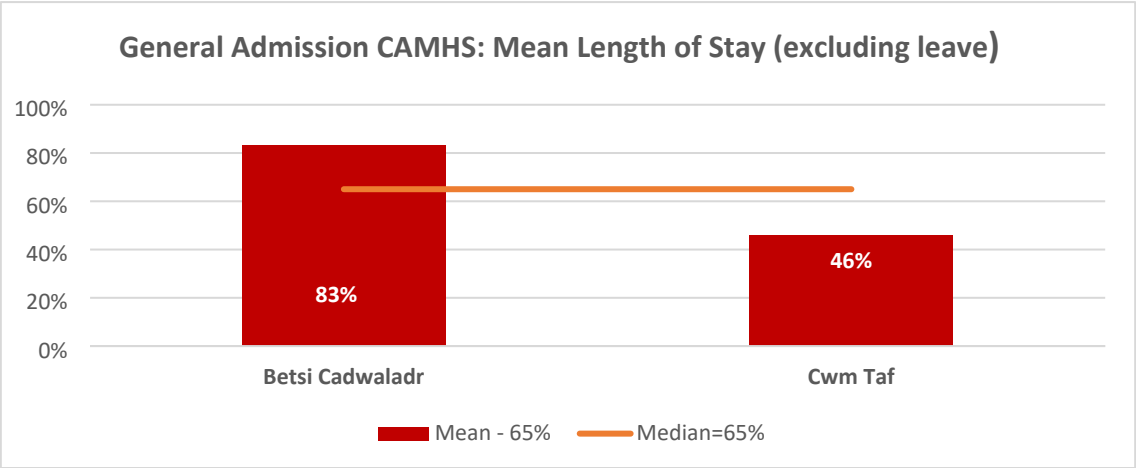


General admission CAMHS: Bed occupancy (excluding leave)



Bed occupancy across CAMHS services decreased at the beginning of the Covid-19 pandemic as patients were discharged from beds in line with national guidance. However, bed occupancy has been slowly increasing with providers reporting in 2020/21, an average bed occupancy of 67% in general admission CAMHS beds. This is marginally higher than reported in 2019/20 (64%).

The two CAMHS inpatient units in Wales average 48% bed occupancy in general admissions. This is below the figure of 56% bed occupancy reported by Wales in 2019/20.



Both Welsh units reported lower lengths of stay than the UK average, resulting in a mean length of stay of 65 days, rising from 45 days in 2019/20, compared to an average of 71 days across the UK.

The number of staff employed in general admission wards was 41 WTE per 10 beds in 2020/21 across the UK, an increase to the figure of 38 WTE reported in 2019/20. The two Welsh units averaged 37 WTE per 10 beds in general admission wards, a decrease from 44 WTE in 2019/20.

Staff vacancies in general admission wards averaged 11% in Wales, compared to 15% across the UK.

Staff turnover in general admission wards averaged 15% across the UK. The two Welsh units reported an average staff turnover of 12%.

3.1.3 Current Provision

CAMHS

The North Wales Adolescent Service Unit (NWAS) is located on a relatively isolated community hospital site, just south of Abergele town in North Wales. As well as the NWAS unit the community hospital site hosts a specialist eye unit, orthopaedic rehabilitation services and some Betsi Cadwaladr University Health Board (BCUHB) administrative functions. There are no other mental health or paediatric services on site. The NWAS unit was opened in 2009, the original business case for the service was for 18 beds split between a 6 bedded acute ward and a 12 bed planned treatment ward but this was adjusted due to revenue constraints. The service was eventually commissioned for 5 acute beds and 11 planned treatment beds although staffing difficulties has limited this to a mixed 12 bedded treatment/acute ward.

The Ty Llidiard Unit is based on the Princess of Wales Hospital site in Bridgend, South Wales. As well as the Ty Llidiard unit, the general hospital

site hosts an emergency department, paediatric services and adult mental health services. The Ty Llidiard Unit was opened in 2011 and although it has capacity for 19 beds, has been commissioned to provide 15 mixed treatment/acute beds.

In December 2021, additional recurring funding was awarded to provide specialised CAMHS services in Wales. This provision will allow the services to strengthen leadership and culture, staff mix and greater therapies input for our inpatient unit therefore developing the multi-disciplinary teams, Tier 4 outreach support, the purchase of additional surge beds, improvements in quality and value, and the opportunity to conduct a rapid review into eating disorder services.

FACTS

FACTS is a highly specialist consultation and treatment service to Tier 3 Forensic Child and Adolescent Mental Health Services (FCAMHS) concerned with the care and treatment of children and young people who, in the context of mental disorder(s) or significant adversity/trauma and related severe psychological difficulties, present a serious risk to others. The service does not provide services directly to patients.
The role of FACTS includes:

- A consultation service to Tier 3 Forensic Child and Adolescent Mental Health Services.
- Facilitating and overseeing the pathway for young people requiring admission to medium secure inpatient services.
- Direct assessment of young people and the family and/or professional systems around the young person may at times be indicated.
- Providing training to other healthcare professionals and multiagency partners.
- Research.

Through the recent development of a draft service specification for FACTS, a number of key performance indicators have been identified that will be reported on a monthly basis going forward, including:

- New Referrals by Health Board
- New Referrals Accepted
- New Referrals Not Accepted
- Number of Professionals Meetings arranged by and attended by FACTS
- Number of Professionals Meetings arranged by partner agency but attended by FACTS
- Number of Written Reports sent out by FACTS
- Number of Professionals Letters written and sent out by FACTS
- Number of cases formally consulted on by FACTS from Tier 2 CAMHS
- Number of cases FACTS has formally consulted on as referred by Tier 3 CAMHS (including cases in the monthly meetings)

- Number of cases formally closed by FACTS with written confirmation sent.

A new service specification outlining 'Core FACTS' has been co-produced by WHSSC and the FACTS Team and the inclusion of prison in reach is being considered. WHSSC are also working with FACTS to develop a service specification for the work they undertake with Youth Offending Teams.

3.1.4 Service Development

CAMHS

In order to ensure that the current in-patient capacity for the Welsh population still meets the needs of our patients, a comprehensive needs assessment should be carried out.

The current service specification describes a High Dependency Unit (HDU) for each site. It has been agreed that this terminology is inaccurate for the needs of the service and misleading. The requirements are for an Extra Care Area "ECA" on each site which would allow de-escalation and segregation where this is appropriate and also allow the provision of out of hours admissions.

Consideration should also be given to the staffing models on each unit to support the ECAs.

Referrals into the units are currently assessed by unit staff and this does not support the ethos of impartial gatekeeping policies. As such, it is recommended that consideration be given to the development of an integrated inpatient/tier 4 community referral hub. This would also provide a single point of access for referring clinicians, and simplify the pathway for patients. Consideration should also be given to developing the service to accommodate 7 day admissions.

In addition, there is a need to develop and strengthen partnership working with community services and consideration given to in-reach, out-reach and transition services.

It was agreed that the traditional "tiers" system in CAMHS services often provided a barrier to care provision for our children and young people and in some cases caused confusion when interacting with other services. It is recommended that the Tier system be reviewed nationally to ensure a seamless pathway for our population.

Betsi Cadwaladr University Health Board are currently developing a programme to improve quality and effectiveness of assessment, inpatient

care and alternative to admission at Tier 4 CAMHS. Links to this strategy are in place in order to inform future developments as a result of this programme, particularly in relation to the Tier 4 NWAS service.

The provision of paediatric support available to the NWAS unit in North Wales was considered a positive addition to service provision and many areas would like to see this replicated. Data would suggest that this input has attributed to admission avoidance, early discharge, and to be of particular support to the avoidance of NG Feeding for children and young people. It is recommended that the option of collaborative bidding be scoped for paediatric input provision to be available across Wales.

Consideration of CAMHS eating disorder services is also considered in the main eating disorders section of this strategy.

In terms of capital developments, the siting of the NWAS unit was raised as a key area of concern due to the separation of this site from other service provision. It is recommended that a review of the NWAS site be undertaken and if appropriate, an options appraisal and scoping exercise undertaken to consider alternative options.

FACTS

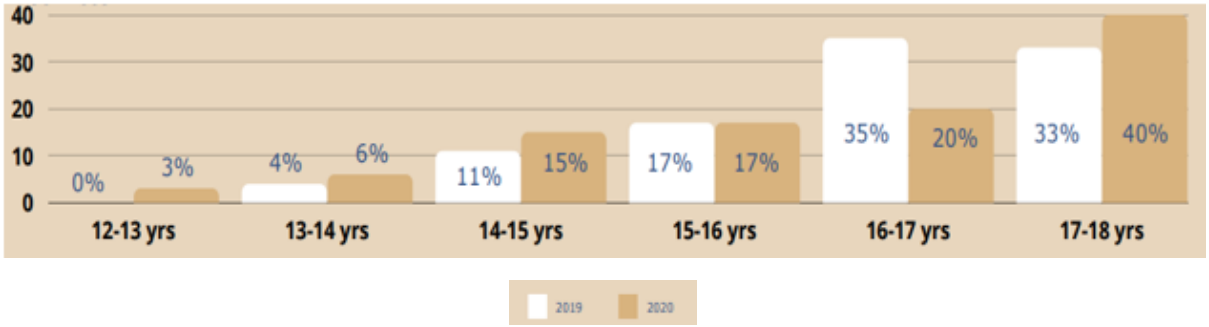
In response to a strategic review in 2019, the following priorities have been identified:

- Stabilisation of the service – addressing recruitment, retention and management issues.
- The development of service specifications and associated resource that set out the services provided to CAMHS, Youth Offending Teams and Parc Prison.
- Review of FACTS interface with CAMHS services as part of the core health (CAMHS) service specification.
- Clarification of FACTS role in Hillside Secure Children's Home.

3.1.5 Transitions

In 2020, the numbers of 17-18 year old seen in CAMHS inpatient services increased and this trend is showing to have increased further into 2021. Transition from CAMHS to adult services should therefore take into account this development and ensure that processes and procedures are in place to ensure the transition is as smooth as possible for those young people reaching adulthood in our services.

Admission by Age



Transitions between service levels should also be explored with consideration given to transition workers or outreach services to act as an intermediate care service linking inpatient and community services.

The development of a CAMHS Referral Hub for the NHS Wales in-patient units would address some of the key issues identified through workstream discussions such as the timeliness of assessments and decision making and agreed national minimum data sets for referrals to ensure inpatient units have all required information for admission.

3.1.6 Recommendations

1. **To assess and consider the CAMHS NHS Wales inpatient estate**

To consider the implications of the remote location of the NWAS unit in its ability to meet the requirements of the service specification. In the short term it may be necessary to consider admission exclusions and initiate corrective actions such as consideration of the secure perimeter fence. In the long term, the re-provision of the service at a more suitable site should be considered.

To ensure estates provision at both units would be able to meet the service specification for an enhanced care area.

2. **To consider a National CAMHS Inpatient Referral Hub**

This hub would provide a set of national standards and templates for the referral of patients for in-patient admission into the 2 welsh units in order to improve and simplify the pathway and strengthen links to gatekeeping and case management.

The hub could also provide the basis upon which to scope the options to extend the current admission hours to allow 7 days admissions onto the units and assist in the timely transition of patients between levels of service provision.

3. **To consider funding an electronic clinical records system**

An electronic clinical records system would allow a much improved provision for patients across the pathway by ensuring information is available to staff to inform patient care and assist in care planning. It is also recommended that these systems be developed to allow a "patient passport" to be developed in order to reduce the amount of times patients need to give the same information and to ensure the quality of information is available through their entire pathway, including any areas of transition, either age or service based.

In addition to these benefits, the system could also provide key information to inform the development of service provision such as readmission rates as an indicator of CAMHS service quality, referral numbers and outcomes on a contemporary basis as an indicator of system pressure and ensure access to modern technological support. This can be further supported through the development and implementation of an agreed set of outcome measures for Tier 4 CAMHS services in Wales.

4. **To undertake a comprehensive needs assessment for CAMHS inpatient services**

This would ensure the establishment of beds to meet the needs of the Welsh population. Any impact other elements of this strategy may have should also be taken into account.

5. **To consider staffing models at both units to meet the needs of the service specification**

To develop and progress the revised staffing model for Ty Llidiard and NWAS in line with the additional funding allocated in December 2021 and any future requirements to meet the needs of the service specification to include therapies and paediatric input and enhance multi-disciplinary teams.

Staffing models should also include provision to support staff well-being and development.

6. **Stabilisation of the FACTS service**

To address recruitment, retention and management issues.

7. **To revise the service specifications to reflect service need**

To develop the CAMHS Inpatient Service Specification to include provision of an Extra Care Area.

The development of the FACTS service specification and associated resource that set out the services provided to CAMHS, Youth Offending

Teams and Parc Prison, including clarification of FACTS role in relation Hillside Secure Children's Home.

To review the FACTS interface with CAMHS services as part of the core health (CAMHS) service specification.

8. **To consider the commissioning contract in light of any service development and changes to the service specification.**

9. **To improve partnership working with partner services**

To establish an intermediate care service linking inpatient and community services through the introduction of transition workers or an outreach service to effect prompt, safe and effective discharge.

EATING DISORDERS

KEY RECOMMENDATIONS:

1. **To establish an Eating Disorders (ED) Unit for Wales for both in-patient and Day Service Provision across all ages**
2. **Urgent interim measures to be put in place following the notice given for Welsh eating disorder placements contract with NHS England**
3. **Full review of ED In-patient services to be conducted by 2023**
4. **Developing our workforce**
5. **Expansion of Paediatric Support for inpatients in Welsh NHS Units**
6. **Expansion of HCSW role in adult eating disorder services**
7. **Review of NG Feeding pathways**
8. **Support for strengthening of Community provision**

   a) Day Services

   b) In-reach/Out-reach Model

   c) National Eating Disorders Team

WORKFORCE

To ensure sufficient training and development opportunities and links to the HEIW MH Workforce Plan to develop staff to enable the establishment of an Eating Disorders Unit for Wales.

Development of MDTs to support patients with eating disorders, particularly Paediatric support and HCSW roles.

GOVERNANCE

Appropriate governance arrangements to ensure robust contracting and service provision for any interim, medium or long term solutions.

Review of NG Feeding pathways to be robust and based on clinical evidence.

FINANCE

To scope capital investment to ensure the feasibility of an eating disorders unit for Wales in light of contract changes to NHS England.

To consider collaborative bidding to allow joint funding for key services such as paediatric input into CAMHS ED Services.

3.2 Eating Disorders

3.2.1 Background

In order to provide a focus on the requirements of specialist Eating Disorders services across Wales, the strategy considers the development of Specialised Eating Disorder services at tertiary level for both CAMHS and Adults to meet the population need.

One of the key drivers for this area is the NHS Benchmarking Demand and Capacity Report commissioned in May 2021. This report provides a rapid review of ED service demand and provision and seeks to identify any trends and considerations for further service development. The review was repeated in November 2021 and the information for both reviews is considered for this section of the strategy.

In order to develop this section of the strategy, a workstream was set up to specifically consider Specialist Eating Disorders service requirements for the population of Wales to be commissioned by Welsh Health Specialised Services Committee (WHSSC).

The Eating Disorders workstream was chaired by the National Eating Disorders Lead for Wales, with membership from a range of clinical and service representatives including psychology, psychiatry, dietetics, paediatrics, nursing, case management, family therapy and service management professionals, as well as representatives from NCCU and WHSSC. These professionals represented both adults and child and adolescent services and came from a range of health boards and statutory organisations to provide a full and unified discussion forum.

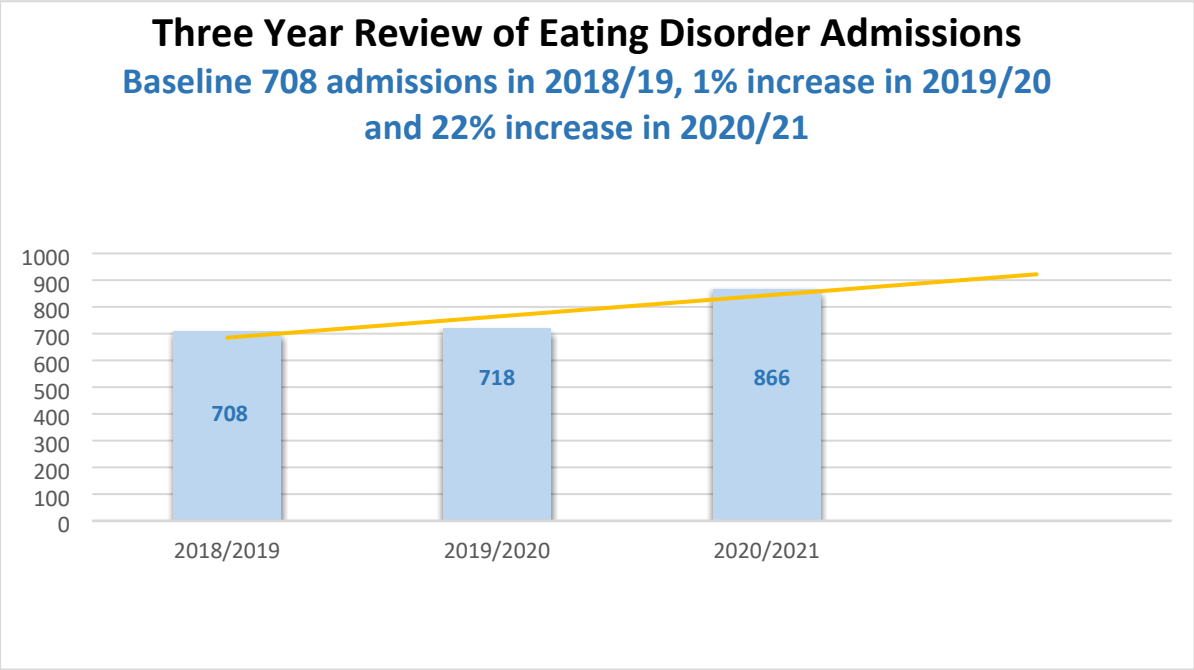
The workstream considered the information and data available, and considered a number of service options as outlined below.

3.2.2 Data and Information

A presentation was given to vice-chairs in September 2021 outlining the results of an analysis of data for NHS Wales relating to demand for eating disorders care and related provision of specialist eating disorder services. The project was commissioned by the NHS Wales National Collaborative

Commissioning Unit and the work took place between June and August 2021.

The project explored both historic data and also undertook a point prevalence census exercise to quantify and profile the demand for services on a specified date. The point prevalence study in inpatient care was paralleled by an assessment of specialist community eating disorder services provided by Health Boards. The results are detailed below.



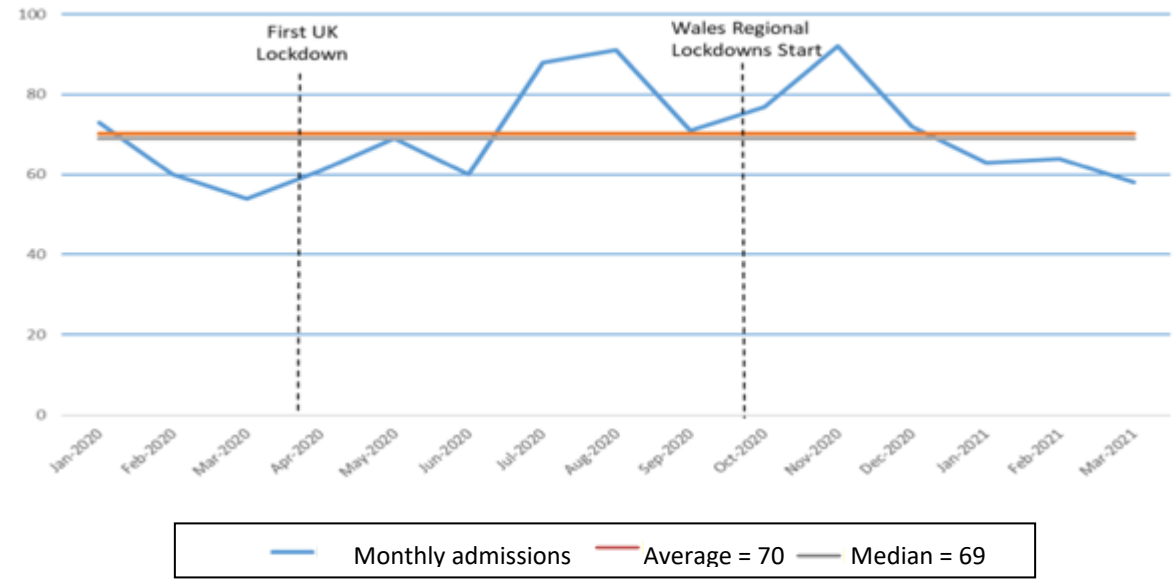
The trends in inpatient admissions between 2018/19 and 2020/21 show that admissions for Eating Disorders have increased by 22% between the financial years of 2018/19 and 2020/21.

There was a slight increase (1%) in admissions when comparing 2019/20 with 2018/19 and a larger increase of 148 admissions (21%) between 2019/20 and 2020/21.

Actual admission volumes for each year were; 2018/19 = 708, 2019/20 = 718, 2020/21 = 866.

Three year review of eating disorder admissions

Increase in demand in 2020/2021 occurred during summer 2020 after first lockdown



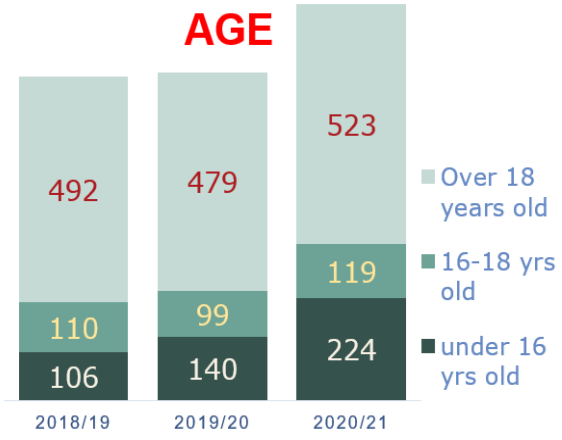
On average there were 70 Eating Disorders admissions per month between January 2020 and March 2021.

There was an initial peak in admissions in July and August 2021 followed by a second peak in admissions in November 2020.

The monthly average admissions were higher in 2020/21 compared to 2018/19 when there were 59 admissions per month and 2019/20 when there were an average of 60 admissions per month.

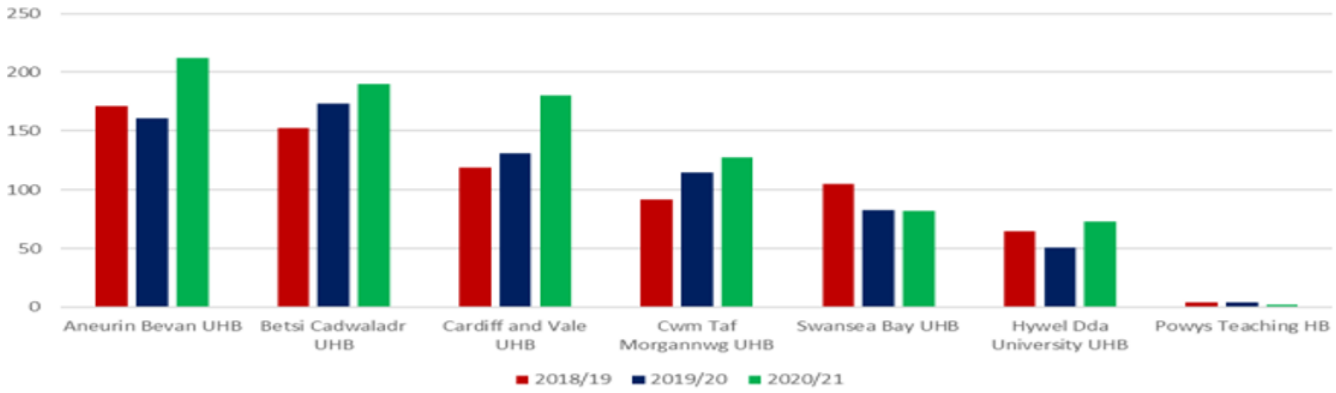
Three year review of Eating Disorders Admissions

- Demographics
- **Age:** (See graph to right) under 16 age group has seen the biggest increase and is the only age group with a year on year increase.
- **Gender**: 92% admissions were female in 2018/19, dropping to 89% in 2019/20, then returning to 92% in 2020/21.
- **Health Boards:** (See graph below) 5/7 HBs have seen increase in 2020/21, 3/7 have seen year on year increase.



This data confirms incremental growth in demand for eating disorder inpatient care over the last 3 years.

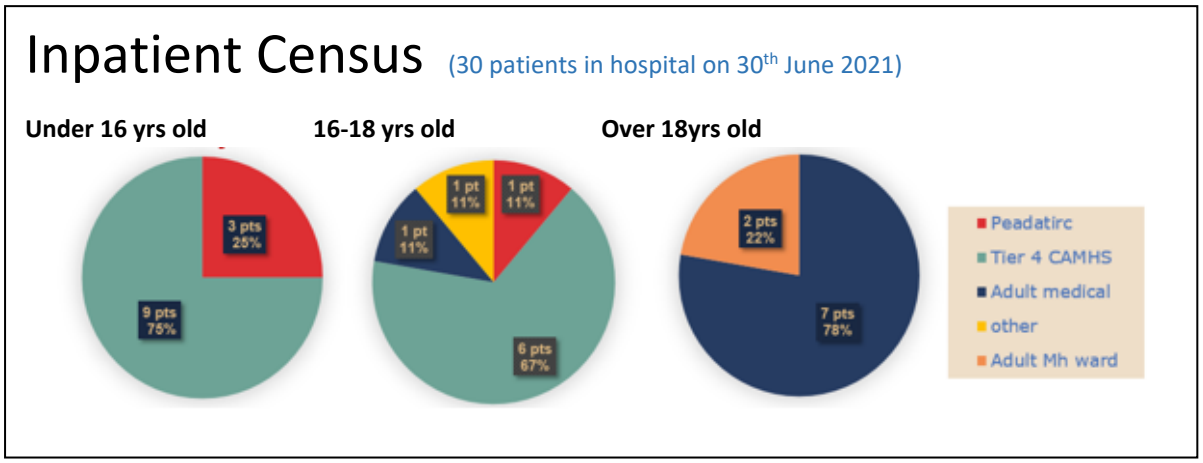
Health Board Demand



A review of the admissions by age band shows the largest increase is in the under 16 age group. Admissions increased for this age group by 32% (34 admissions) in 2019/20 when compared to 2018/19 and by 79% (84 admissions) in 2020/21 compared to 2018/19.

A review of admissions by gender highlights that over 90% of admissions for Eating Disorders in Wales were for female patients. Admissions for female patients increased by 22% when comparing 2020/21 with 2018/19. Admissions for male patients also increased by 40% during the period.

A review by Health Board shows that Aneurin Bevan had the highest levels of admissions. Aneurin Bevin, Betsi Cadwaladr, Cardiff and Vale, Cwm Taf Morgannwg and Hywel Dda University Health Boards all show an increase in admissions when comparing 2020/21 with 2018/19. There has been a reduction in admissions at Swansea Bay University Health Board. Powys University Health Board reported relatively low admissions with 10 admissions in the three year period.



The trends in community services show that caseloads and referrals have been relatively stable over the four year period between 2016/17 and 2019/20 and during 2019/20 the average caseload was 39 patients per health board. This increased to an average of 46 in the census of June 2021.

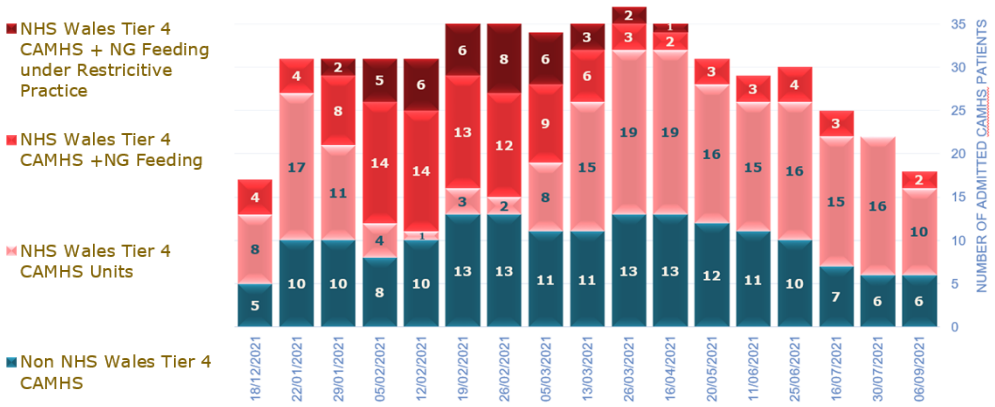
The inpatient census on 30th June 2021 found 30 patients in beds on the census day, 11 of the patients (37% of the total) were housed in private provider beds. Cwm Taf Morgannwg was the health board with the largest number of eating disorder patients at eight, which was over a quarter of the total number of patients identified by the census.

The majority (93%) of patients were female, the largest group by age band was 0-15, with 37% of the cohort being female and aged 0-15. The one male patient was also in the 0-15 age band with the one indeterminate / other gendered patient in the 16-18 age band.

83% of patients were white, the only ethnicity to be specifically identified.

Eating Disorder admissions to CAMHS with Nasogastric Tube Feeding Requirements

Significant increase in NG tube feeding during first months of 2020/21, now returning to 'normal'



The results on tube feeding showed that 50% of the cohort had had not been tube fed within the current admission. Seven of the patients (23%) were currently being tube fed, with two of these patients being restrained to be fed, three patients were not currently restrained but had been in the past and two patients were not restrained to be fed.

<u>Inpatient Census on 10th November 2021</u>

Further to the above, the rapid review was repeated in November 2021, the results of which are summarised below:

- There were 34 patients in an in-patient bed on the census day, an increase of 4 patients since the June census.

- The majority (94%) of patients were female, the largest group by age band was 0-15, with 41% of the cohort being female and aged 0-15.
- 62% of admissions had a diagnosis of anorexia nervosa, an increase compared to the position in June 2021 when 40% of patients had this diagnosis on admission. This increase in diagnosis is seen across all age groups.
- 38% of the cohort had been tube fed within the admission, this was a decrease on the 50% reported in June.
- 15 patients in the cohort were currently subject to Mental Health Act detention, a slight reduction on the position in June.

Conclusions from Data

The CAMHS data indicated that more patients were being seen in CAMHS services and this resulted in longer waiting times. It was also noted that almost half of CAMHS admissions were related to eating disorders.

The census also indicated a national shortage of beds for Adult ED services, and these were also far from home for patients.

Inpatient admissions in total for adults were fairly consistent. This was less than 5% variation across the previous two years, whereas the data pertaining to under 16s shows the most significant amount of increase in the need for inpatient admissions.

3.2.3 Options

Commissioning of Specialist Placements

On 31st January 2022, Welsh Health Specialised Services Committee received notice from the current main provider of specialised services placements for eating disorder patients that the current contract would cease on 31st August 2022.

As a result, a number of options for alternatives to these provisions have been discussed. These discussions have resulted in the ultimate aim of having and Eating Disorders Unit for Wales. It is thought that this option could be scoped during years 1 and 2 of this strategy to determine feasibility and consideration of capital funding to support, and should also consider the provision of eating disorder services for CAMHS patients within the scope of the unit. A full options appraisal of these options will be considered as part of this strategy.

Eating Disorders Unit for Wales

- Capital investment needed

- Workforce challenges for this specialised service in Wales where there is currently no provision
- Numbers of patients to support business case
- Consideration of an all-age facility for CAMHS through to adults
- Day hospital provision can be attached or provide satellite services
- Build time to be considered – out of the 5 year scope of this strategy

Medium Term Considerations

There are a number of interim measures that can be taken whilst consideration is made regarding the Eating Disorders Unit. These measures are required regardless of the feasibility of the unit and have stand-alone benefits to consider as the medium term solution or to develop into a longer term solution should the Unit not be agreed for capital investment.

Building our workforce

- During the timeframe of this strategy, regardless of whether the ED hospital progresses, workforce development is crucial for our Welsh patients
- Skill mix and specialist qualified and experienced staff to be developed within the Welsh workforce
- MDT provision to be developed.

Independent Sector

- Interim arrangement with independent sector to ensure ongoing inpatient provision – England and Wales
- Longer term arrangement option with independent sector to provide in-patient provision within Wales should no capital investment be available within NHS Wales.

Paediatric Support for inpatients in Welsh NHS Units

The number of children placed in NWAS with Eating Disorders is substantially lower than those in Ty Llidiard. This difference has been partly attributed to the availability of Paediatric medical support in BCUHB which gives the community services more support and confidence to treat and support young people with an eating disorder in the community. With Ty Llidiard taking inpatients from a large number of health boards, this arrangement is not yet in place and the proportion of young people placed in Ty Llidiard with an eating disorder has been consistently higher and continues to increase.

It is proposed that Paediatric input is available for all Health Boards to support eating disorder community services for young people in order to avoid hospital admission where this is appropriate.

Health Care Support Worker Support

In 2018 Aneurin Bevan University Health Board received additional funding to support the medical monitoring of Tier 3 adult eating disorder patients and provide support to those requiring a medical admission for refeeding. The funding was used to employ 2 full time Band 4 Health Care Support Workers (HCSW). These HCSWs provide support from 8am – 6pm, this includes meal support, supporting patient pre and post meals and liaising with medical, nursing and dietetic staff on the ward. The service also provides intensive community meal support (1 meal a day, 5 days a week) with the aim of preventing admission or supporting patients on discharge from hospital.

Data shows a substantial decrease in medical admissions from 16 in 2017 to 3 in 2021, a decrease in mental health admissions from 8 to 0 and Tier 4 admissions from 8 to 3 for the same time period.

It is proposed that HCSW input is available for all Health Boards to support eating disorder community services for adults in order to avoid hospital admission where this is appropriate.

Nasogastric (NG) Tube Feeding

WHSSC are currently conducting a preparatory piece of work to understand the prevalence of NG Feeding in Wales. This work is due for conclusion in quarter 1 of 2022/23 and aims to inform any developments in this area, with the ultimate goal of prevention of NG Feeding where possible and appropriate.

It is anticipated that further work will be required during 2022/23 to ensure the findings of this study are addressed and any developments to the NG Feeding pathways, policies and protocols are considered as appropriate. National Guidance and Standards will also be considered alongside this work.

Support for strengthening of Community Provision

- **Day Services**

The National Eating Disorders Sub-group is undertaking an options appraisal regarding developing a national strategy for eating disorder day services to reduce demand on inpatient services.

This scoping work will take place during the tenure of this strategy and will form part of the Year 1 implementation plan.

- **In-reach/Out-reach Model**

In North Wales, funding has been agreed to address the current deficits in Eating Disorder service provision, specifically at early intervention and treatment and tertiary level. Staff recruited to the newly developing early intervention and treatment service will provide NICE (2017) compliant interventions and develop a MARSIPAN (Management of Really Sick Patients with Anorexia Nervosa, Royal College of Physicians, 2014) `team' that is able to provide 1:1 support to Eating Disorder patients when local admissions are required (medical ward or psychiatric unit).

The initial phase would focus on the development of adult early intervention and treatment eating disorder provision through the recruitment of additional staff. The remit of these staff would be to work in accordance with Nice (2017) guidelines in helping to provide early identification, specialist assessment and treatment of ED. All staff recruits will be trained in the delivery of ED interventions within secondary care as well as undergoing MARSIPAN training. It is anticipated these changes will improve prognosis as well as reduce the morbidity and mortality associated with ED as highlighted in the 2018 Review. It is also expected these developments will meet the six underlying principles as highlighted in the ED Report (2018) of early detection and intervention, inclusivity, person centred approach, relationship based, recovery focused, trauma informed.

The second phase would be to develop a MARSIPAN `Team' from the existing Early intervention and treatment staff, that provides 1:1 support to eating disorder patients undergoing admissions to either local medical wards or psychiatric units, such as meal planning, support and supervision. This will improve the length of stay and effectiveness of admissions and minimise the need for out of area Specialist Eating Disorder Units. When a patient requires a local admission, the staff will facilitate and lead this process, including NG tube feeding, as well as providing care on the unit, thereby helping to provide continuity of care.

The Early intervention and treatment service and `MARSIPAN' team will sit alongside the existing community service (CAEDS). Once the Early intervention and treatment service has developed and is established, both services will amalgamate to form a true Community Adult Eating Disorder Service.

It is recommended through this strategy that this work is monitored to establish whether this service could be rolled out across Wales in order to support admission avoidance where possible into tertiary level services with the potential to develop joint working to develop a national business case.

- **National Eating Disorders Team**

The Eating Disorders Outreach Service (EDOS) was established to provide assessment and consultation, specialised Eating Disorders Training and group programmes to support the community eating disorders services for young people. In addition, the service received further funding in 2017 to support the development of transition services.

Consideration should be given through the scoping work described in this strategy to the support the EDOS Team could give to further enhance service provision.

- **Disordered Eating**

To date both CAMHS and Adult Eating Disorder Services have seen a substantial increase in the number of patients presenting with disordered eating, and not specifically an eating disorder. There has also been a significant increase in the complexity of these presentations and high risk (e.g. low BMI's). In Adult services this is often within the context of an Emotionally Unstable Personality Disorder (EUPD), and needs to be treated accordingly, i.e. the eating difficulties are seen as part of the wider EUPD context and therefore is not the sole focus of the treatment. If the eating difficulties *are* focused on and treated as an eating disorder, they are likely to worsen.

Disordered eating cases are presenting in various different services including but not limited to community dietetics, Perinatal, Primary and Secondary care, and also into tertiary level services.

In North Wales the Tier 3 Adult Eating Disorder Service (CAEDS) is working collaboratively with local services such as community dietetics to develop a protocol for adults who present with disordered eating. This is likely to include:

- Guidance on what clinical presentations to expect
- A brief overview of EUPD if appropriate and guidance on language to use Structured Clinical Management, Bateman and Dialectical Behaviour Therapy).
- A guide on the number of sessions to be offered and by whom e.g. 2 sessions from a community dietitian.

3.2.4 Transitions

- **Age Transition**

In their Making Sense report 2016, young people who had used Specialist CAMHS (sCAMHS) reported that they were 'deeply concerned about the

transition point' to Adult Mental Health Services. 38% of sCAMHS users said flexibility over the age young people move to adult mental health services was the most important way to improve the transition. The need to reorganise the transition to adult mental health services was highlighted as a key priority area for improvement.

Following this the Welsh Government T4CYP developed in consultation with young people and professionals the following:

- Good Transition Guidance: A seamless transition from child and adolescent to adult mental health services.
- Young Persons Transition Passport which comes from a strengths based perspective. It is owned by the young person and intended to be dynamic, evolving with them as they grow and their needs and aspirations change.

In 2019, Hywel Dda University Health Board and S-CAMHS service submitted a proposal for the recruitment of a dedicated Transition Practitioner. Co-production is an important theme of prudent healthcare and has been pioneered in CAMHS and mental health more generally through the adoption of care and treatment planning which encourages the service user to be fully engaged in the development of their plan. This should be continued during transition, with the young person having access to both CAMHS and adult mental health service named workers, involved in discussions about the transfer of their care.

The National Eating Disorders sub-group has established a pathway into tertiary level adult ED services prior to the 18th birthday in order to ensure continuity and that the patient's needs are still met when they reach their 18th birthday. This work will continue to be implemented as part of the strategy.

The following case study highlights the importance of a robust transition pathway from CAMHS to Adult Eating Disorders services and a collaborative working model between services:

A new patient was seen by the CAMHS crisis team two months prior to their 18th birthday, and admitted to paediatric bed in the local hospital for urgent medical stabilisation. The local eating disorders team were contacted and a referral was received. Within 7 days, the eating disorders team completed their assessment on the paediatric ward and in discussion with the Specialist CAMHS consultant psychiatrist and Specialist CAMHS Care Coordinator agreed that the patient needed psychiatric inpatient care. It was recognised at this point that inpatient treatment was likely to extend beyond the patient's 18th birthday and to ensure continuity of care, the patient was referred to an adult specialist eating disorder unit. This placement was able to accepted patients prior to their 18th birthday and a

WHSSC review of existing contract terms and conditions indicated that an additional funding application was not required. Community eating disorder clinicians and the specialist eating disorder unit provider had previously agreed to prioritise transition cases.

Following medical stabilisation, due to the unavailability of a bed, the patient was briefly admitted to a specialist CAMHS inpatient bed, but was then transferred to the Adult specialist eating disorders unit. The patent was aware of the planned admission to the specialist eating disorder unit, and was admitted to the placement 4 weeks prior to their 18th birthday. The patient has since been discharged home, their weight restored, remains stable and is engaging with their local eating disorders team.

Although ideally the transfer from paediatrics would have been direct to the adult placement, this was not possible due to bed availability. The patient, however, was aware of treatment plans throughout their care and through the collaborative working of all the teams and agencies involved in their care, a patient transfer to a local generic psychiatric bed or home part way through treatment was therefore avoided.

3.2.5 Summary

Following receipt by WHSSC of the notice period given by NHS England to cease the current contracted provision for specialist inpatient eating disorder placements, an urgent piece of work is required to ensure ongoing service provision for our patients. This is likely to be formed through partnership working with the independent sector in both Wales and England for this interim period.

Longer term, a number of options require consideration, and it is recommended that discussions with Welsh Government take place to consider the feasibility of providing inpatient eating disorder services with NHS Wales, including discussions on the availability of capital funding to support this option and workforce development. It is recommended that an in-depth options appraisal is conducted to thoroughly investigate how best to develop future specialist eating disorder services for Wales.

Some of the key discussions when considering eating disorders are silo working and the different pathways and models each health board holds. Consideration of the data suggested that some health board areas had less referrals to tertiary care and this was partly attributed to resources such as paediatric input and health care support worker roles which correlated with less referrals to specialised services and in particular, less patients with NG feeding requirements. These discussions highlighted the benefits of more robust collaborative working and provided the recommendation that

collaborative funding bids would ensure a more cohesive service across health board areas.

3.2.6 Recommendations

1. To establish an Eating Disorders Unit for Wales for both in-patient and Day Service Provision across all ages

Initial scoping exercise to establish appetite for an eating disorders unit in Wales. Full options appraisal to be delivered in order to scope feasible options for future specialist eating disorder services in Wales and to consider the feasibility of an all-age service for both inpatient and day service provision.

2. Urgent interim measures to be put in place following the notice given for Welsh eating disorder placements contract with NHS England

Work with NCCU to establish feasible options to alterative contracts on an interim basis, for example with independent contractors.

3. Full review of ED In-patient services to be conducted by 2023

Recommendation from ED Review 2018 - a detailed comprehensive review of inpatient provision for eating disorders is required.

4. Developing our workforce

Development of MDTs and strengthening of skills specific to eating disorders to ensure skill mix and capability is available for service provision.

5. Expansion of Paediatric Support for inpatients in Welsh NHS Units

Paediatric input to be available for all Health Boards to support community services and avoid CAMHS admissions for eating disorder patients where this is appropriate.

6. Review of NG Feeding pathways

To consider the prevalence of NG Feeding in Wales and to develop National guidelines and standards for NG Feeding and community refeeding including consideration of the HCSW role.

7. Support the strengthening of Community provision

a) Day Services

Day service model – to be included to reflect the work being carried out by the ED sub-group Task and Finish Group.

b) In-reach/Out-reach Model

MARSIPAN model to be monitored to establish whether this service could be rolled out across Wales in order to support admission avoidance where possible into tertiary level services and collaborative working across health boards to develop and provide a cohesive eating disorders service across Wales, including the provision for joint collaborative bidding for funding where appropriate.

c) National Eating Disorders Team

To develop and strengthen the National Eating Disorders Team to deliver services to support admission avoidance and facilitate timely discharge.

8. To revise "Specialised Services Policy: Tertiary Level Specialised Eating Disorder Services" in line with this strategy.

LEARNING DISABILITIES

KEY RECOMMENDATIONS:

1. **All secure hospital care including low secure to be commissioned by one organisation**
2. **To develop and implement a blended model of care in conjunction with secure service provision in NHS Wales**
3. **Ensure regular review of Learning Disability (LD) patients in placements reinforcing the care co-ordination and gatekeeping role**
4. **Consider a the role of the community Learning disabilities team to support forensic requirements**
5. **Development of Electronic Records for LD Patients in NHS Wales**
6. **Development of an All Wales demand and capacity inpatient data dashboard**

WORKFORCE

Development of workforce in mainstream secure services to ensure the needs of patients with a learning disability are met.

Development of workforce to ensure a blended model of care can be delivered.

GOVERNANCE

Commissioning pathway to be considered to ensure appropriate governance for a blended model of care.

FINANCE

Consideration of commissioning pathway to allow all secure services to be commissioned by one organisation.

3.3 Learning Disability/Intellectual Disability

3.3.1 Background

In order to provide a focus on the requirements of specialist learning disability services across Wales, the strategy considers the development of services for both CAMHS and Adults to meet the population need.

One of the key drivers for this area is "Improving Care, Improving Lives" review published in February 2020.

This review considers the care given to inpatients in learning disability hospitals and sets out 72 recommendations for providers, commissioners and the Welsh Government.

In order to develop this section of the strategy, a workstream was set up to specifically consider Specialist Learning Disability service requirements for the population of Wales to be commissioned by Welsh Health Specialised Services Committee (WHSSC).

The Learning Disability workstream was chaired by the Medical Director for Mental Health and Learning Disability, Betsi Cadwaladr University Health Board, with membership from a range of clinical and service representatives, as well as representatives from Improvement Cymru and WHSSC. These professionals represented both adults and child and adolescent services, and came from a range of health boards and statutory organisations to provide a full and unified discussion forum.

Methodology

The methodology for the workstream was agreed from the start. The main pillars of the methodology are summarised as:

1. The best evidence based practice was sought. It was agreed that the group would actively seek advice and models of care that offered the best standards. External speakers were invited to give presentations to better understand these areas of good practice.
2. The stakeholders should include a variety of people from statutory services, service users and independent sectors representatives.
3. The approach was systemic and not just limited to the small number of patients currently funded by WHSSC. There was a recognition that community provision and secure care at every level are interlinked and recommendations need to reflect this scenario.
4. Interdependencies were explored and taken into consideration, including regulatory bodies such as Health Inspectorate Wales.

Overlaps and dependencies with other workstreams

There are significant overlaps with other workstreams within the programme, particularly the secure services and women's services workstreams. Workstream leads have been working collaboratively to ensure these overlaps are highlighted and addressed as a whole.

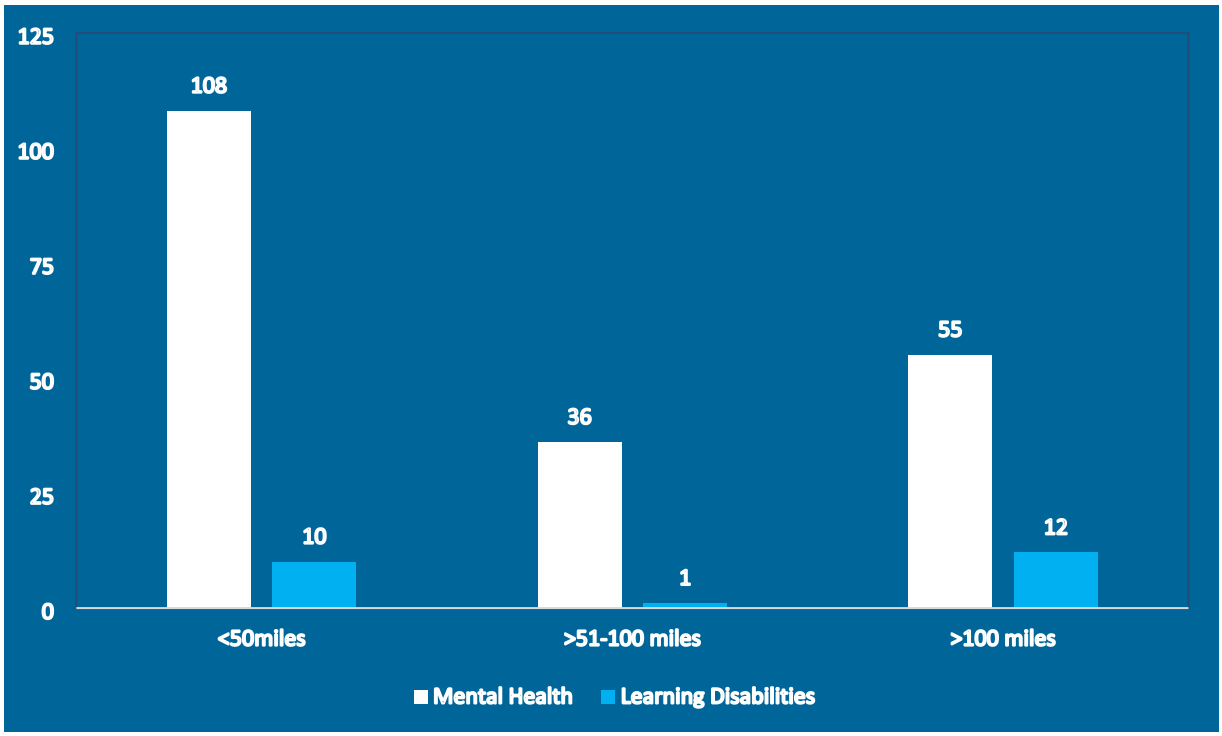
3.3.2 Data and Information

The Learning Disabilities workstream considered the information and data available, and considered a number of service options as outlined below.

Learning Disability and Mental Health Distribution

As at 31st March 2021, 18% of patients receiving assurance under the Adult Hospital Framework were cared for in learning disability hospitals. This figure as remained consistently between 17% and 20% since 2016.

With 50% of admissions to learning disability hospitals more than 100 miles from their home and local communities' people with a learning disability are disproportionately further away from home than people without a learning disability.



3.3.3 Current Provision

1 High Secure Patients

9 Medium Secure Patients

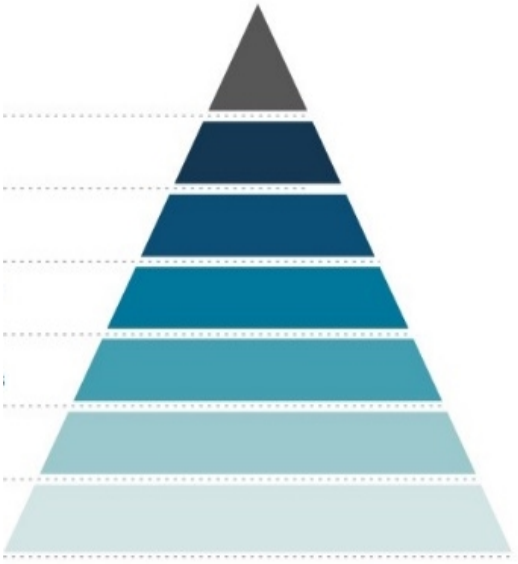
28 Low Secure Patients

30 Controlled Egress Patients

21 Assessment and Treatment Patients

6 Uncontrolled Egress Patients

74 Continuing Care Patients



These types of providers were not part of this National Care Review

Residential Care
Supported Accommodation
Community Teams
Primary Care

Data taken from the Improving Care, Improving Lives Review demonstrated the majority of patients is secure services were in low secure units. There was only 1 patient in high secure and 9 in medium secure.

Best Practice

Quality Network for Learning Disability Services (QNLD) Standards for Inpatient Learning Disability Services (2021) RCPsych Fourth Edition

These standards are designed to be applicable to inpatient learning disability services for working age adults and can be used by professionals to assess the quality of the team. Since inpatient learning disability units differ widely in their configuration and the models used, these standards focus on the function of a team in order to make them as widely accessible as possible.

The standards cover the follow topics:
- Admission and assessment
- Care Planning & Treatment
- Referral, Transfer & Discharge
- Patient & Carer Experience
- Environment & Facilities

- Staffing & Training
- Governance

Key principles of the standards include the introduction of four key principles that run throughout the standards, which are crucial to providing high quality care.

	All information provided to patients and carers must be in an **accessible format**. In line with royal College of Speech & language Therapists '5 Good Communication Standards' & NHS Accessible Information Standard.
	If patients lack capacity, decisions are made in their **best interests** as per the Mental Capacity Act 2005.
	When information is given to patients on the unit, staff **check their understanding** of the information and this is recorded.
	**Reasonable adjustments** are made in line with Equality Act 2010.

Memorandum of Understanding (MOU) between NHS Health Boards in Wales for the Transfer of Care of Adults with Intellectual Disabilities (2018), RCPsych Wales

The purpose of the Memorandum of Understanding (MoU) is to set out a framework to support the working relationship between Healthcare Inspectorate Wales (HIW) and the Medicines and Healthcare products Regulatory Agency.

This working relationship is part of the maintenance of an effective regulatory system for health and adult social care in England and Wales which promotes patient safety and high quality care.

The MoU relates only to the regulation of healthcare in Wales. It does not override the statutory responsibilities and functions of HIW and the Agency and does not create legally binding rights or obligations; its purpose is to define the joint agreement between the two organisations and to indicate a common line of action.

3.3.4 Service Development

Patient demographics should be taken into account with a higher prevalence of male learning disability patients that female (69% male, 31% female) and an ageing population, in addition to special needs and co-morbidities, e.g. deaf, autism, dementia, mental illness.

Staff skill mix and therapeutic interventions should be considered for specialised services to ensure the community first ethos is at the forefront of care.

The following options have been considered by the workstream:

1. Do nothing – status quo
   - The current situation is not sustainable and would carry high risks for service provision.
2. Develop a new national specialist LD MSU for male & female patients
   - Accessing capital funding for this option will be challenging. In addition the numbers of patients requiring the service would not be large enough to support a business case.
3. Blended model:
   - Utilise existing Medium Secure Unit with reasonable adjustments for a provision that blends medium and low secure care.
   - It is useful to have medium and low secure service on the same site, as this would enable a concentration of expertise, particularly important for psychology, to enable treatment programmes (e.g. thinking skills groups, DBT, offender groups).
   - Combine services with autism secure care to concentrate expertise.

<u>Preferred Option - Blended Model</u>

All secure hospital care including low secure to be commissioned through one organisation. This would:

a. Support a blended model
b. Facilitate gatekeeping
c. Ensure close working relationships with local provider and Community Learning Disability Teams

3.3.5 Transitions

Transitions were a key area of focus for the learning disabilities discussions and covered the following areas:

- Timely transition of patients to the appropriate environment that meets their assessed needs.
- Prioritising transition planning of patients who have a length of stay over five years.
- Transition from CAMHS LD to Adult LD Services.
- Delayed transfers of Care (DTOC):
  - Prioritising transition of patients in assessment & treatment provision with a length of stay over six months
  - Prioritising transition of patients in specialist hospital care who have been identified for step down for more than 1 year.

Through these discussions, it became apparent that the opportunity to commission secure services through one organisation was the preferred option to ensure that the patient was not disadvantaged in their care due to the artificial barriers in place in the current system. Commissioning for "Secure Care" was outlined as providing a seamless approach to care and provided strong and more in-depth care co-ordination and gatekeeping for this cohort of patients.

3.3.6 Summary

Learning Disability Specialised Services in Wales provide care for a small number of patients, however placements can be very expensive, particularly bespoke placements.

This strategy aims to consider the needs of those patients first and to provide care as close to home as possible for those patients in our specialised services.

The key message from the Learning Disabilities Workstream to consider is to provide care through a blended model, utilising and maximising current service provision within the NHS in Wales.

The recommendations from both the Improving Care, Improving Lives review published in February 2020, and the Secure Services Review published in April 2022 indicate the need for services to evolve and develop into a more blended model, eradicating barriers along the pathway and improve patient care.

As such, it is the key recommendation of this strategy that a blended model is scoped for consideration, alongside work arising from this strategy for both men's and women's secure services as a coalition to improve secure services for the whole population, including those with learning disabilities.

3.3.7 Recommendations

1. **All secure hospital care including low secure to be commissioned by one organisation**

This would facilitate the development of a blended model and other functions, such as the gatekeeping role and the centralisation of expertise.

Ensuring close working with local provider and Community Learning Disability Teams is crucial to move the patients according to their needs and clinical presentations.

2. **To develop and implement a blended model of care in conjunction with secure service provision in NHS Wales**

Utilise existing Medium Secure Unit with reasonable adjustments for a provision that blends medium and low secure care.

MDT Development - It is useful to have medium and low secure service on the same site, as this would enable a concentration of expertise, particularly important for psychology, to enable treatment programmes (e.g. thinking skills groups, DBT, offender groups). This review is not in the position of advising on estate and finances, but a more comprehensive and agile financial management is advised. This is currently fragmented and in silos, creating artificial barriers in moving patients quickly from secure care to community.

3. **Ensure regular review of LD patients in placements reinforcing the care co-ordination and gatekeeping role**

The current coordination of patients in secure care needs to expand to have strong clinical leadership and input into the treatment plans offered by the secure care. There is also a need to implement a robust Delayed Transfers of Care reporting and explore barriers to step down. The gatekeeping role should be strengthened to support the patient.

4. **Consider the role of the community learning disabilities team to support forensic requirements**

It emerged that there is little specialist expertise to deal with this group of patients. Welsh expertise can be developed to advise on such cases, to avoid total reliance on private providers either through upskilling the current teams, or through the development of an all-Wales liaison model to provide forensic expertise as required.

5. **Development of Electronic Records for Learning Disability Patients in NHS Wales**

The requirement for electronic record has been raised through a number of the service workstreams and has been highlighted as one of the key recommendations in this strategy.

6. **Development of an All Wales demand and capacity inpatient data dashboard**

The development of electronic records would enable the development of a dashboard to continuously monitor demand and capacity for this cohort of patients.

SECURE SERVICES

KEY RECOMMENDATIONS:

Male Secure Services:

1. **To develop Integrated Secure Services**
2. **To consider the requirements of the secure services estate in Wales**
3. **To develop appropriate governance arrangements for Integrated and blended secure service provision in NHS Wales**
4. **Development of Electronic Records for Secure Services in NHS Wales**
5. **To undertake a staffing modernisation programme for the two NHS Wales medium secure units.**
6. **To conduct a needs assessment for secure services in Wales**

Female Secure Services:

1. **To consider the commissioning arrangements for a regional secure service for both medium and low secure service for women**
2. **To consider the requirements of the secure services estate in Wales**
3. **To consider establishing a robust Community Model Pathway for women**
4. **To consider the workforce skill mix to adapt to the increasing acuity of female patients in medium secure services**
7. **To develop**
8. **To develop appropriate governance arrangements for Integrated and blended secure service provision in NHS Wales**
5. **Development of Electronic Records for Secure Services in NHS Wales**

WORKFORCE

To undertake a staffing modernisation programme for the two NHS Wales medium secure units.

To consider the workforce skill mix to adapt to the increasing acuity of patients in medium secure services, including an increase in those who have experienced significant trauma.

To ensure staff are supported and offered regular supervision and dedicated emotional support.

GOVERNANCE

Commissioning pathway to be considered to ensure appropriate governance for a blended model of care.

FINANCE

To ensure a flexible estate to meet demand and increased seclusion facilities to better care for those patients requiring additional care and support.

Consideration of commissioning pathway to allow all secure services to be commissioned by one organisation.

3.4 Secure Services

3.4.1 Background

The purpose of this section is to consider the development of tertiary services for Secure Settings in Wales to meet the population need whilst meeting the requirements of the Service Review of Secure Services "Making Days Count – National Review of Patients Cared for in Secure Mental Health Hospitals" conducted by NCCU published in April 2022.

The review was commissioned to achieve greater understanding of the issues relating to secure mental health hospital care.

3.4.2 Data and Information

In Wales high secure hospitals are commissioned from NHS England by the Welsh Health Specialised Services Committee (WHSSC) through a national contract. Medium secure hospitals are commissioned by WHSSC, either directly from two NHS Units in Wales, or from NHS England or the independent sector through the NHS Wales National Collaborative Framework. Low secure services are provided directly by some Health Boards and/or commissioned from the independent sector, normally through the NHS Wales National Collaborative Framework. Health Boards in Wales are the current commissioner of low secure services. The table below shows the commissioning arrangements and the number of hospitals, units and patients across each type of secure setting.

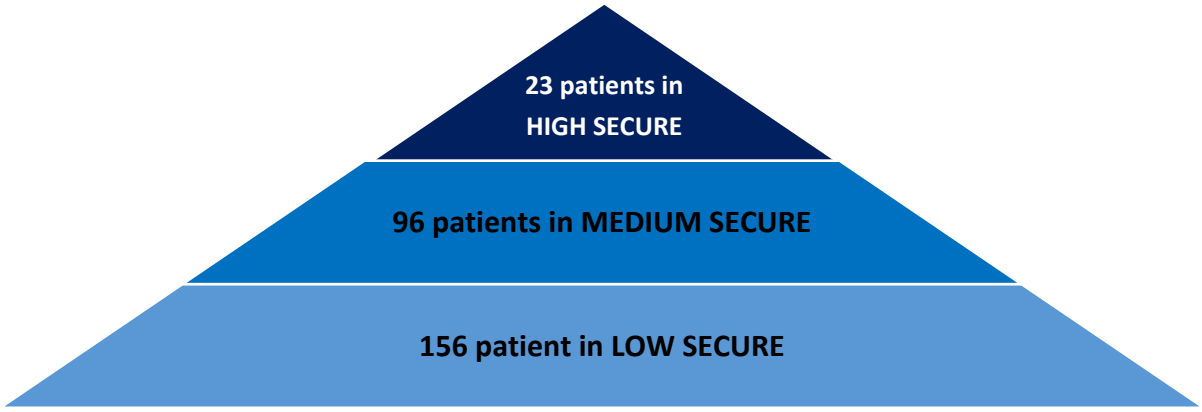
Type of Secure Hospital	Number of Patients	Number of units where the patients were placed at the time of audit	Number of hospitals where the patients were placed at the time of audit	Commissioner of these hospitals	Providers of these hospitals
High Secure	23	4	1	WHSSC	NHS England
Medium Secure	96	16	6	WHSSC	NHS Wales/Independent Sector
Low Secure	156	20	15	Health Boards	NHS Wales/Independent Sector

In line with the policy direction for Wales of caring for people as close to their community as possible, 7 in 10 patients are cared for in Wales.

The approximate cost of secure care for NHS Wales is £80 million per year.

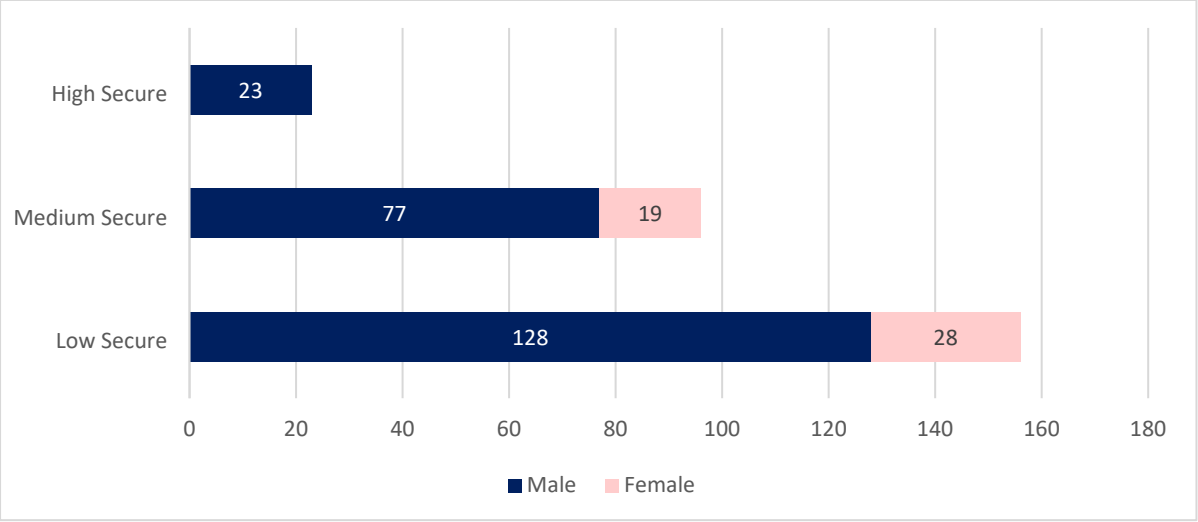
At the time the audits for the National Review were undertaken there were 312 patients of NHS Wales cared for in secure hospitals and the information below relates to 88% (275) of these patients. For the 37 patients excluded,

5 were under 18 years old and 32 were not subject to an on-site audit due to the disruption caused by the Covid-19 pandemic. For the 275 patients, 8.4% (23) were being treated in high secure hospitals, 34.9% (96) were being treated in medium secure and 56.7% (156) were being treated in low secure.



Equality and Diversity

The chart below highlights the gender of patients by type of secure hospital and shows the total number of patients for the National Review, based on gender, is 82.9% (228) male patients and 17.1% (47) female patients.



Gender, Transgender and Non Binary People

Sex refers to the different biological and physiological characteristics of males and females, whilst gender refers to the socially constructed characteristics of women and men. When individuals do not 'fit' established gender norms they often face stigma, discriminatory practices or social exclusion.

'Transgender' is an umbrella term used to describe people whose identification with, or expression of gender, is different from the sex assigned at birth. Transgender people can express their identity is many different ways. People whose gender is not male or female use many different terms to describe themselves, the most commonly used is 'non-binary'.

All healthcare providers must uphold the requirements of the Equality Act [2010], the Human Rights Act [1998] and the Gender Recognition Act [2004] when treating transgender patients. It is also important that the associated risks for a transgender person, as well as other patients, is considered before their admission to single-sex wards in secure hospitals.

It is estimated that between 0.3 and 0.7% of the United Kingdom population are transgender. In this National Review, it was found that 2.2% (6) of patients, being cared for in secure hospitals, identified as transgender.

Ethnicity

0.6% of the secure service population is made up of patients from black and ethnic diverse origins. This makes up 1% of the ethnically diverse population in Wales.

It is of note that within the workforce in secure services in Wales there is not much cultural diversity. The staffing complement within private sector hospitals in England is very ethnically diverse.

Religious Beliefs

Most patients in secure services identify as Christian. 3.6 % of patients in secure services in Wales identify as Islamic. This accounts for 1.5% of the Welsh population.

3.4.3 Current Provision

Male Secure Services

Ty Llewellyn
Tŷ Llewelyn is a 25 bedded purpose-built Medium Secure Unit commissioned by WHSSC for male patients on the Bryn y Neuadd Hospital site, Llanfairfechan.

The North Wales Forensic Psychiatric Service is primarily concerned with the assessment, treatment, rehabilitation and aftercare of patients who suffer from a mental disorder and who have offended or are considered likely to offend and require a secure environment to safely provide the

assessment and treatment required. The unit comprises of three wards Gwion Ward (5 bed Admission/Extra care) Pwyll Ward (10 bed Admission/Assessment) and Branwen Ward (10 bed Rehabilitation).

Referrals are taken from a variety of sources including the generic Mental Health Services, Criminal Justice System, General Practitioners, Prison Services, Special Hospitals and Social Services.

Caswell Clinic

Caswell Clinic is commissioned centrally by Welsh Health Specialist Services Commissioners on behalf of the Welsh Health Boards that it serves.

The clinic provides forensic psychiatric inpatient care to patients with serious mental illnesses who have offended or at risk of offending and pose a risk to the public. The service provides a broad range of evidence-based treatments and therapies delivered via a multi-disciplinary team with a focus on addressing, reducing and managing risk, through collaborative working with the patient to support them during their treatment and road to recovery.

There are 61 beds in the clinic in total (50 male and 11 female).

Cross-sectional Provision

Through discussions across the workstreams during the development of this strategy, it emerged that provision for patients with learning disabilities was very limited in the current secure services provision. It is a recommendation within this strategy, that patients with a learning disability should be able to access mainstream services where their learning disability is not the primary reason for a placement. Models of care, pathways and staffing models should be developed with this consideration.

Estates and Infrastructure

Current estates for the NHS Wales secure services provision require a modernisation agenda. This should support the development of integrated secure services as described above, allow provision for more robust services for our female population, and provide a basis for flexibility and further development to meet the needs of our population now and in the future. This should include the provision of en-suite facilities and the development of sufficient seclusion suites for each unit, with a separate women's seclusion suite.

Recognising that access to capital funding in Wales is limited consideration should be given to developing a provider collaborative approach between

the NHS and independent sector to ensure our population have access to services in a timely manner.

Information systems also require modernisation with paper records still in use and the lack of a system to record and share records. This should include the development of a set of minimum information standards and a patient passport in order to facilitate the transfer of patients into and out of our secure services beds and units.

3.4.4 MALE SECURE SERVICES

3.4.4.1 Service Development

The workstream discussions centred on the need to consider secure services as a whole, and similar to discussions at the Learning Disabilities and Women's workstream, an integrated secure services model was discussed as the preferred option for secure services going forward.

In terms of secure services for our male patients, it was noted that those with a learning disability could be placed in mainstream secure services if appropriate workforce development was undertaken to meet the additional needs this cohort of patients.

The barriers of the current commissioning arrangements for low and medium secure services by different organisations were discussed and a model of secure care in its entirety was considered the most beneficial for patients, staff and organisations alike. These cross-organisational discussions and agreements were seen as detrimental to service provision and caused delays in patient care.

The current pathways were considered complex and confusing and a regional approach would ensure national standards and a cohesive approach to care.

In addition, the changes to the commissioning arrangements in NHS England may also impact the need for a more robust Welsh provision, and the development of the Welsh estate should also be considered to ensure a flexible estate to meet demand and increased seclusion facilities to better care for those patients requiring additional care and support.

The impact of the prison population should also not be underestimated. The establishment of HMP Berwyn in North Wales has seen a significant impact on the services provided by Ty Llewellyn with 60% of referrals into the unit originating from the prison, and all but one admission in the last year. The impact of having no low secure provision in North Wales also has an impact on flow.

It was agreed that the priority for this strategy would be to scope the possibility of a single organisation to commission secure services for Welsh patients to ensure care closer to home and serve the needs of the majority of our Welsh patients in Wakes where this was appropriate to do so. The consideration of working with the independent sector to achieve this was also discussed and should form part of this initial scoping work.

3.4.4.2 Recommendations

1. To develop Integrated Secure Services

To consider a regional secure service for both medium and low secure services for men in Wales in order to commission patient pathways to allow for the model of care to reflect patient need.

It is useful to have medium and low secure service on the same site, as it would enable a concentration of expertise, particularly important for psychology, to enable treatment programmes. A more comprehensive and agile financial management is advised. This is currently fragmented and in silos, creating artificial barriers in moving patients quickly from secure care to community.

Provision should also include provision of physical health service requirements.

2. To consider the requirements of the secure services estate in Wales

To ensure a flexible estate to meet demand, and increased seclusion facilities to better care for those patients requiring additional care and support.

Consideration should also be given to the Caswell site as the service is currently run by Swansea Bay University Health Board but utilises Cwm Taff Morgannwg University Health Board site, which can cause barriers and difficulties to developing the estate to meet service need.

3. To develop appropriate governance arrangements for Integrated and blended secure service provision in NHS Wales

To provide standardisation and cohesion of services, referral pathways and a single point of access on a national or regional basis to include quality assurance.

4. **Development of Electronic Records for Secure Services in NHS Wales**

The requirement for electronic record has been raised through a number of the service workstreams and has been highlighted as one of the key recommendations in this strategy.

5. **To undertake a staffing modernisation programme for the two NHS Wales medium secure units.**

To consider the workforce skill mix to adapt to the increasing acuity of patients in medium secure services, including an increase in those who have experienced significant trauma.

To ensure staff are supported and offered regular supervision and dedicated emotional support.

6. **To conduct a needs assessment for secure services in Wales**

To include consideration of inequality due to ethnic or cultural diversity

3.4.5 FEMALE SECURE SERVICES

3.4.5.1 Service Development

Similarly to the learning disability and men's secure services workstream, the women's secure services workstream had a focus on eradicating labelling and barriers and providing a blended model of care for females in secure services in Wales.

The workstream researched various models of care in NHS England and considered a blended model of care the preferred option. This model considers the secure care pathway for women in secure services and as the majority of women in secure services have a lived experience of trauma, provides a particular focus on trauma informed care.

The blended model should encompass the importance of stability, relationships, connections to family and home life, and include purposeful engagement to develop the model to be most effective and deliver outcomes to support personalised recovery.

Links to the Women in Justice Service would further improve the support available to our women in the criminal justice system benefitting from:

- A Psychologically-led, gender and trauma informed model

- A multi-agency gender-informed training package
- Development of an Information Passport
- Gender-informed housing solution model for women who are in or at risk of entering the CJS
- MoJ Residential Women's Centre to be piloted in South Wales

3.4.5.2 Recommendations

1. To consider the commissioning arrangements for a regional secure service for both medium and low secure service for women

To consider the development of secure service provision for females in Wales to increase bed capacity allowing repatriation from out of area placements.

To include the development of a robust pathway to meet the needs of women in North Wales.

To consider a regional secure service for both medium and low secure services for women in Wales in order to commission patient pathways to allow for the model of care to truly reflect patient need.

2. To consider the requirements of the secure services estate in Wales

It is useful to have medium and low secure service on the same site, as this would enable a concentration of expertise, particularly important for psychology, to enable treatment programmes. A more comprehensive and agile financial management is advised. This is currently fragmented and in silos, creating artificial barriers in moving patients quickly from secure care to community.

Provision should also include provision of physical health service requirements.

To ensure a flexible estate to meet demand, and increased seclusion facilities to better care for those patients requiring additional care and support.

Consideration should also be given to the Caswell site as the service is currently run by Swansea Bay University Health Board but utilises Cwm Taff Morgannwg University Health Board site, which can cause barriers and difficulties to developing the estate to meet service need.

2. To consider establishing a robust Community Model Pathway for women

To include partnership working with Women in Justice and establish a focus on trauma informed care with a whole pathway approach for women.

3. To consider the workforce skill mix to adapt to the increasing acuity of female patients in medium secure services

Including a focus for those who have experienced significant trauma.

4. To develop appropriate governance arrangements for Integrated and blended secure service provision in NHS Wales

To provide standardisation and cohesion of services and referral pathways and a single point of access on a national or regional basis to include quality assurance.

5. Development of Electronic Records for Secure Services in NHS Wales

The requirement for electronic record has been raised through a number of the service workstreams and has been highlighted as one of the key recommendations in this strategy.

3.4.6 Transitions

As with the Learning Disability and CAMHS/FACTS sections, transitions were a key discussion point in the secure care workstreams.

Age transition was outlined as an issue, not just from CAMHS to adult services, but also for the older population where older adult mental health services such as dementia care were highlighted. Work should progress as part of this strategy to include considerations for those age transitions form CAMHS to Adult and Adult to older adult services in line with the ethos of seamless care provision.

It was agreed that service level and cross service transition issues would be largely addressed through the recommendations of this strategy towards a blended or integrated approach to secure services as a while entity.

PERINATAL MENTAL HEALTH

KEY RECOMMENDATIONS:

1. **To consider the 12 month review of the MBU at Tonna Hospital to be conducted in Quarter 1 of 2022-23**
2. **To advise following this review the long-term plan for the unit, particularly in relation to the siting of the unit**
3. **To work in partnership with NHS England to secure 2 beds for Welsh patients in a new unit scheduled for development within Cheshire and Wirral Partnership Trust**

WORKFORCE

The review of the Tonna MBU should ensure the well-being and development of the workforce accordingly.

Consideration of the North Wales provision should ensure adequate staffing to meet the requirements of NHS Wales.

GOVERNANCE

The current service review and future service developments should take into account governance processes and develop accordingly.

Consideration of the North Wales provision should take into account the needs of the Welsh population including the provision of bi-lingual services where possible.

FINANCE

Capital investment is being sought by NHS England for the development of services for our North Wales patients.

Further financial considerations should be given should this option not progress.

3.5 Perinatal Mental Health

3.5.1 Background

This section of the strategy aims to consider the development of tertiary services for Perinatal Mental Health to meet the population need to include a review of the Mother and Baby unit (MBU) hosted by Swansea Bay University Health Board which opened in April 2021, and consideration of options for North Wales residents.

3.5.2 Data and Information

Since the opening of the MBU in Tonna in April 2021, the unit has been consistently at capacity and for the most part has resulted in very few out of area placements. Recent data has shown that the unit remains at capacity and that the number of out of area placements has increased.

Data to inform provision for North Wales' patients demonstrates a need for 2 beds for this population at any one time.

3.5.3 Current Provision

Tonna Hospital provides a 6 bedded MBU which opened in April 2021. Provision for North Wales' patients is currently either at Tonna Hospital, or with NHS England as this would be nearer home.

3.5.4 Service Development

In order to ensure ongoing MBU provision for our patients, a review of the MBU at Tonna Hospital will take place during quarter 1 of 2022/23. This review should provide the information required to make a decision on the future site of the unit, and any action plan to support this.

Recent out of area placements have increased and the unit remains at capacity, so the review should also establish whether this increase is due to the success of the unit, referral pathways and service provision in this area to inform future service provision.

There are ongoing discussions with NHS England to ensure a 2-bed provision for our North Wales patients. At present, there is agreement to proceed with Chester and Wirral Partnership Trust, subject to capital approval from NHS England. The unit will be based on the Countess of Chester Health Park and will consist of 6 beds in total, 2 of which will be secured for Welsh patients.

The business case led by NHS England is scheduled to be signed off by late summer 2022 subject to capital approval, with the service operational 18 months following this.

The Trust have committed to proving literature & signage in dual language and will try to recruit some Welsh speaking staff if this is feasible.

The BCUHB Perinatal Team are fully engaged in the process and have indicated their support for location following discussions with service users. The Trust will establish a service users and carers sub group to support development of the business case. Welsh representation will be included and welcomed by Trust.

3.5.5 Recommendations

1. **To consider the 12 month review of the MBU at Tonna Hospital to be conducted in Quarter 1 of 2022-23.**

2. **To advise following this review the long-term plan for the unit, particularly in relation to the location of the unit.**

3. **To work in partnership with NHS England to secure 2 beds for Welsh patients in a new unit scheduled for development within Cheshire and Wirral Partnership Trust.**

NEUROPSYCHIATRY

KEY RECOMMENDATIONS:

1. **To address the sustainability of the Welsh Neuropsychiatry Service**
2. **To ensure the Welsh Neuropsychiatry Service reaches across the whole of Wales**
3. **Improve the flow of patients across the whole patient pathway**
4. **Raise awareness and understanding in local areas of the enduring impact of an acquired brain injury on mental health**

WORKFORCE

By enhancing staffing establishment in line with BSRM standards and investing further in specialist staff to develop and deliver a liaison model of working.

Upskilling of non-specialist staff in assessment and management and education/support to staff and family members.

Development and roll out of specific neuropsychiatry training programs for clinical teams in order to build on and improve knowledge and skills further.

GOVERNANCE

Though the development of a Liaison Model to ensure the service provision in North Wales receives the expertise of the Welsh Neuropsychiatry Services whilst still retaining the ability to provide care close to home for its population.

To develop a liaison model that ensures quality of care, prevention and co-ordination and crisis management services.

FINANCE

Service development has been funded via the WHSSC CIAG prioritisation process for Phase 1 and Phase 2a of the Neuropsychiatry model. The work outlined in this strategy is intended to be submitted as phase 2b of this ongoing work.

3.6 Neuropsychiatry

3.6.1 Background

In order to provide a focus on the requirements of Neuropsychiatry services across Wales, the strategy considers the development of services for Acquired Brian Injury to meet the population need.

To develop this section of the strategy, a workstream was set up to specifically consider Specialist Neuropsychiatry service requirements for the population of Wales to be commissioned by Welsh Health Specialised Services Committee (WHSSC).

The Neuropsychiatry workstream was chaired by the Directorate Manager, MHSOP at Cardiff and Vale University Health Board, with membership from a range of clinical and service representatives, as well as representatives from WHSSC. These professionals came from a range of health boards and statutory organisations to provide a full and unified discussion forum.

3.6.2 Data and Information

Audit data over past years indicates the service has consistently received around 150 referrals per year for neuropsychiatric opinion. Referrals are for:

- Inpatient assessment
- Day Unit assessment leading to individual interventions and group rehabilitation programmes.
- Out Patient Neuropsychiatric opinion and management advice

		Actual Referrals by Financial Year			Referrals per 100,000 population		
Referrals from (Health Board)	Population (ONS mid 2019)aged 18+	2017/18	2018/19	2019/20	2017/18	2018/19	2019/20
Cardiff & Vale	397,948	49	71	52	12	18	13
Aneurin Bevan	470,481	43	42	32	9	9	7
Abertawe Bro Morgannwg/ Swansea Bay	315,259	7	20	21	2	6	7
Cwm Taf	356,309	22	15	30	6	4	8
Hywel Dda	313,704	10	15	10	3	5	3
Powys	108,508	6	6	6	6	6	6
Betsi Cadwaladr	560,731	1	1	0	0	0	-
TOTAL	**2,522,940**	**138**	**170**	**151**	**39**	**48**	**44**

Patients are complex with Patient Categorisation Tool (PCAT) scores > 30 even on discharge. This can lead to discharge planning delays because

finding appropriate specialist placements in patients' local areas to meet their ongoing complex needs is challenging with few providers having the necessary skills and knowledge. Earlier working with Health Board teams and staff within specialist placements should reduce some of the discharge delays, and reduce the need for unnecessary re-admissions. There have been 2 re-admissions within 90 days to Ash Ward over the last 4 years.
Given the enduring nature of patient complexity, the service provides post discharge follow up and support to ensure sustainability of the place of discharge. The requirement to conduct follow up /home visits by the appropriate discipline of staff and to provide training to support staff in the discharge setting is an additional pressure which cannot be robustly met within the current establishments.

Impact of Covid 19

The brain injury charity Headway (Tyerman, July 2020) has conducted a study into "*The impact of COVID-19 and the associated lockdown on people who are affected by brain injury*". The Headway survey, on over 1000 ABI survivors, indicated that 65% of their ABI respondents reported feeling isolated as a result of lockdown and 60% reported that it had a negative impact on their mental health (including 64% reporting an increase in anxiety and 53% a worsening of depression). This finding is replicated among neuropsychiatry service users with service users demonstrating an increase in psychiatric symptomology, requiring urgent review and re-referral of patients previously discharged now returning for access via part three of the Mental Health Measure (which gives all adults who are discharged from secondary mental health services the right to refer themselves back to those services), for further intervention.

3.6.3 Current Provision

The Welsh Neuropsychiatry Service is a specialist tertiary service for individuals who have suffered a serious acquired brain injury presenting with neuropsychiatric sequelae and neurobehavioral presentations and who require neuropsychiatric management and neuro-rehabilitation.

Patients seen in this service represent the most complex in behavioural, emotional and psychiatric need and require expert clinician in the field of neuropsychiatry. A full complement of specialist skilled and knowledgeable staff would include Medical, Nursing, Psychology, Speech and Language Therapy, Physiotherapy and Occupational Therapy providing assessment, neuropsychiatric interventions, management and rehabilitation.

Referrals are accepted from across Wales for inpatient care. For Day Services referrals are mainly received from South and Mid Wales.

The Service is based at Hafan y Coed, University Hospital Llandough and has:

- An inpatient ward of 10 Inpatient beds.
- A Day Service operating from the same site offering day attendance for assessment and rehabilitation.
- Community based rehabilitation and support in a patient's home locality.
- Consultant and Psychology outpatient appointments are offered in Cardiff. Consultant Psychiatry clinics also operate at Haverfordwest quarterly as needed in Llandrindod Wells.

There is currently no provision in North Wales. When referrals have been received from North Wales, Llandrindod Wells CMHT have provided a clinic facility for the Service on an ad hoc basis. For logistic reasons, from the patient perspective and the staffing capacity within this service, referral rates are low from North Wales but Consultant to Consultant advice has been a component of collaborative working between North Wales and this service.

For admission into the Inpatient Service, patients are received from across Wales. The criteria for admission is linked to the Patient Categorisation Tool (PCAT) and requirement for a highly specialised service able to support patients with severe neuro-behavioural presentations. The pathway for admission is invariably through UHW, Major Trauma Network, Neurosurgery ward, Rookwood Unit (UHL) and Neath and Port Talbot Neurorehabilitation Units and other DGHs.

For patients requiring assessment for inpatient admission, the distribution across Health Boards, excluding Betsi Cadwaladr, is equitable. For North Wales, families have understandably favoured admission to more local units such as Liverpool and the Midlands where there is a greater ease of access for them to visit.

The service should work with providers in North Wales to ensure that any service model changes in both Health Boards are equitable and do not adversely affect patient care. Collaboration and connection with neuropsychiatry developments in North Wales would be a priority to ensure a good interface with all relevant services across the Welsh network.

3.6.4 Service Development

Neuropsychiatry is a specialism that spans both Neurology and Psychiatry and after discharge from Neuropsychiatry and back to their local areas, patients continue to present with lifelong psychiatric difficulties. Local teams are not sufficiently acquainted with psychiatric presentations after

ABI and supporting local Mental Health Services is paramount, by case by case liaison and ongoing training.

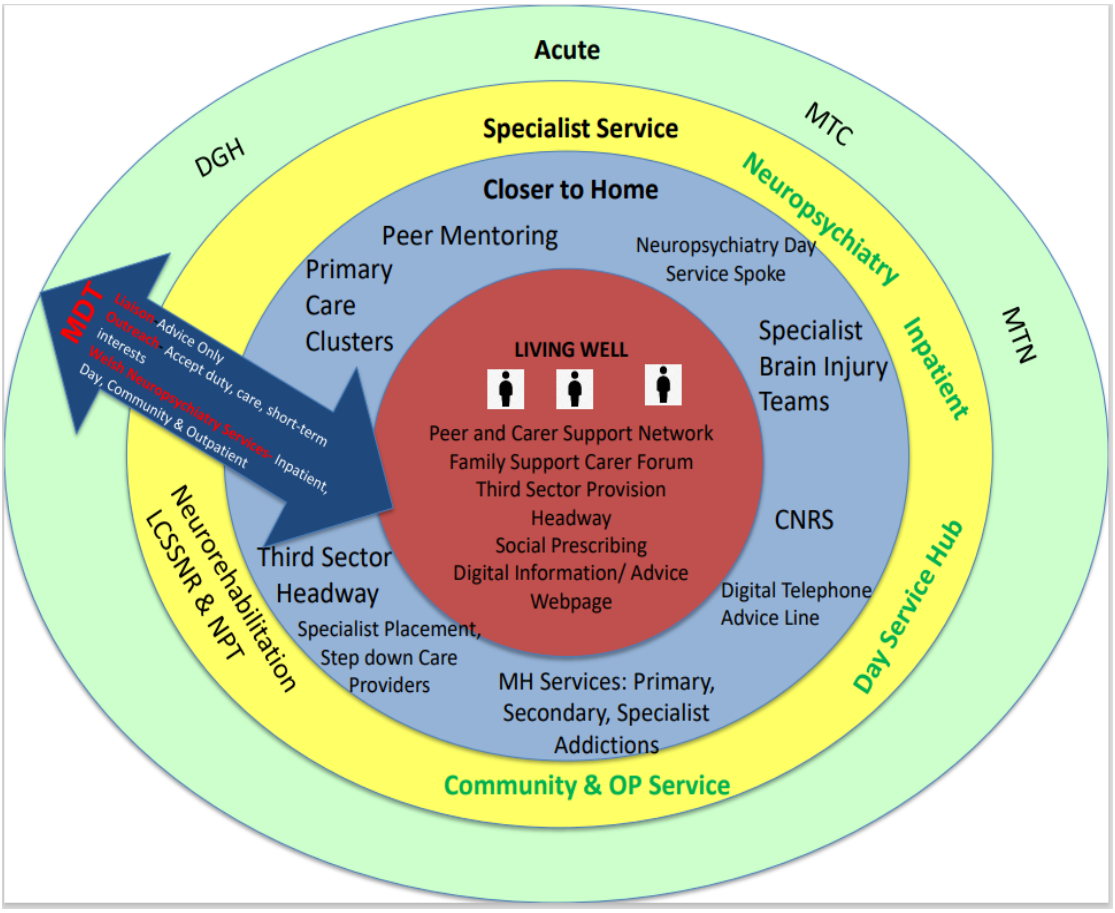
Inequity of access may occur if no bed were immediately available when required as inpatients can typically require lengthy stays and discharge planning can be complex.

With an enhanced multi professional team the service will be able to increase the current in-reach and outreach activity to support services at the front end of the pathway (UHW, Rookwood Unit (UHL) and Neath and Port Talbot etc.). Patients will then be referred from the community in a more efficient and effective way, working closely with teams, reducing admissions and supporting patient management when no bed is immediately available. This enhanced service provision will become a flexible Liaison Service responding to other services' pressures.

It is anticipated that an additional Consultant will ensure the delivery of outreach clinics in other Health Boards, but this will have a corresponding effect on the rest of the Welsh Neuropsychiatry Service demand.

In line with Welsh Government Standards, patients will often require input closer to their home from specialist therapy, psychology or specialist nurses as an alternative to medical outpatient clinics.

By developing the MDT Liaison model as phase two of the Welsh Neuropsychiatry Business case, the service will naturally expand to provide support and training across Wales and within UHB Neuro rehabilitation services, which in turn will inevitably increase demand and generate increased referrals into the service.



3.6.5 Recommendations

1. To address the sustainability of the Welsh Neuropsychiatry Service

By enhancing staffing establishment in line with BSRM standards and investing further in specialist staff to develop and deliver a liaison model of working.

Upskilling of non-specialist staff in assessment and management and education/support to staff and family members.

Development and roll out of specific neuropsychiatry training programs for clinical teams in order to build on and improve knowledge and skills further.

2. To ensure the Welsh Neuropsychiatry Service reaches across the whole of Wales

Though the development of a liaison model to ensure the service provision in North Wales receives the expertise of the Welsh Neuropsychiatry

Services whilst still retaining the ability to provide care close to home for its population.

To develop a liaison model that ensures quality of care, prevention and co-ordination and crisis management services.

3. Improve the flow of patients across the whole patient pathway

Facilitating the movement of patients into and out of the service as their treatment progresses with step down to local area services including a flexible working model.

Providing more consistent and intensive rehabilitation, increasing multidisciplinary input into discharge planning and supporting ongoing rehabilitation at discharge destination in order to reduce patient length of stay.

Support joint and partnership working to enable multi-organisational processes.

Support patients to step down to local facilities; working earlier with care providers to develop intervention and care plans with patients and their families, to support discharge from hospital.

Identify opportunities to develop a tiered model of care and /or further step down placement opportunities closer to patient's homes.

Develop support pathways and networks with the UHB neurorehabilitation team and other health board teams, to provide joined up care and support plans around the needs of patients and their families across Wales

4. Raise awareness and understanding in local areas of the enduring impact of an acquired brain injury on mental health

To work collaboratively with local mental health teams, neurology and neuro-rehabilitation networks.

PART 4: KEY THEMES

The development of this strategy has seen the emergence of a number of key themes. These themes have arisen in each of the workstreams and are supported at Programme Team and Programme Board level.

4.1 A Blended Approach to Service Development

Throughout the development of this strategy, the barriers of having different levels of care and "labelling" given to services has been seen as a key issue in service delivery. It was clear from discussions that a seamless approach was favoured, and a patient centred approach developed to ensure this is delivered.

In order to achieve this, the following recommendations have come through strongly:

The commissioning of secure care services be consolidated and commissioned by one organisation for low, medium and high secure care for both men and women. Also for commissioning to be inclusive of those with a learning disability where secure requirements are relevant and it is appropriate to do so.

- Commissioning and funding streams to be examined and redesigned if necessary
- Funding to be ring-fenced for secure services.
- Consideration of the provider collaborative model.
- Ensure care closer to home where this is possible and appropriate and serves the needs of the Welsh patients in Wales.
- Ensure the Welsh public spending goes back into the Welsh economy (Spending the Welsh £ in Wales).

Links to community services be strengthened to ensure seamless transition between levels of services and between age thresholds.

- Investment in community complex case teams.

To develop appropriate governance arrangements for Integrated and blended secure service provision in NHS Wales to provide quality assurance, care co-ordination and gatekeeping provision for secure services.

- To ensure appropriate gatekeeping and care co-ordination throughout the patient journey in secure services.
- To provide quality assurance for patient care.
- To ensure regular case reviews are in place for patients.

4.2 Electronic Records

The lack of standardised electronic records for mental health services in Wales currently provides a barrier to achieving the seamless approach to care. Many records are still in paper format, and where these are electronic, systems are basic and relevant to the single provider. They do not currently link to other areas of the service and this could result in the providers of care not receiving all the information required.

The following recommendations are made:

An electronic records system be developed in partnership with Digital Health and Care Wales (DHCW) and implemented to cover mental health services across NHS Wales.

- This should include minimum data sets for patient records and to aid referrals and transitions between service levels, and a standard electronic pre-admission form for tertiary level services.
- An all-Wales agreement on information sharing across mental health service provision should be in place urgently.
- A single record for inpatient and outpatient activity to be available on the point of admission via a "Patient Passport".
- CAMHS inpatient services in Wales should have a standard referral pathway and unified electronic records to support this.
- Investment in business intelligence is required to ensure ongoing development and improvement to meet changing needs for patients.

4.3 Estates

Current estates provision for mental health services in Wales are not fit for purpose to provide the appropriate care for our patients. Service need has developed and may elements of the estate to not meet the needs of our patients. Examples of this are the lack of dedicated seclusion facilities for women in out medium secure provision, en-suite provision in care settings, and the CAMHS estate, having been developed for a different demographic not suitable for the current demographic of patients.

The following recommendations are made:

A modernisation agenda for the development of estates to be considered for capital funding in order to achieve optimum service provision, effectiveness of care and efficiency of use of public funds.

- Infrastructure and estates are not robust enough or fit for purpose. Investment in the development of current estates to ensure sufficient capacity and suitable accommodation to include an increase in en-suite and seclusion facilities is necessary to provide the best care for our patients. Seclusion suites should include a separate provision for women
- CAMHS units to be reviewed to identify areas of development, for example the remote location of NWAS to be considered, and developments to Ty Llidiard to meet the needs of patients
- Consideration given to the estates implications of the development of services for eating disorder patients.

4.4 Response to the Impact of Provider Collaborative on Welsh Patients

NHS England have recently agreed a significant change to their commissioning arrangements for services including mental health services.

These changes have seen the development of Provider Collaboratives. This development will have an impact on the availability of service provision for Welsh patients and we have seen notice services on current NHS England contracts for services. It is essential that this strategy considers these impacts and an appropriate response through the development of our services to meet the needs of our patients.

The following recommendations are made:

Urgent and longer term consideration for eating disorder services to ensure continuity of provision for our patients following the notice served on our current contract with NHS England.

- Short term solution of seeking alternative provision amongst the independent sector underway.
- Interim solution of the development of a similar provider collaborative to ensure provision in Wales where this is possible.
- Long term solution of an eating disorders unit for Wales to be considered as described in this strategy with a requirement for capital funding.

Urgent impact analysis required to assess other contracts which may be served notice from NHS England and alternative solutions as outlined for eating disorder services above.

- Impact analysis to be developed and carried out within year 1 of this strategy.
- Outcomes of this impact assessment to inform amendments to this strategy over its tenure.

PART 5: SUMMARY AND RECOMMENDATIONS

This strategy aims to take a holistic view of specialised mental health services for Wales and has considered key service areas to develop themes and recommendations for future development.

Investment will be needed if the ambition for specialised mental health services to ensure the highest quality care and service provision for our patients, is to be realised. Also our current commissioning and service model will need to be restructured to ensure we can deliver a seamless approach to care.

A summary of the recommendations from this strategy is outlined in the table below. Timeframes are set as:

Year 0 – Work is already underway prior to the publication of this strategy
Year 1 – October 2022-March 2023
Year 2 – April 2023-March 2024
Year 3 – April 2024 – March 2025
Year 4 – April 2025 – March 2026
Year 5 – April 2026 – March 2027

KEY THEMES
Recommendation
The commissioning of secure care services to be consolidated and commissioned by one organisation for low, medium and high secure care for men and women, to be inclusive of those with a learning disability where secure requirements are relevant and it is appropriate to do so.
To develop appropriate governance arrangements for Integrated and blended secure service provision in NHS Wales to provide quality assurance, care co-ordination and gatekeeping provision for secure services.
An electronic records system be developed in partnership with Digital Health and Care Wales (DHCW) and implemented to cover mental health services across NHS Wales.
A modernisation agenda for the development of estates to be considered for capital funding in order to achieve optimum service provision, effectiveness of care and efficient use of public funds.
Urgent consideration for eating disorder services to ensure continuity of provision for our patients following the notice served on our current contract with NHS England.
Urgent impact analysis required to assess other contracts which may be served notice from NHS England and alternative solutions as outlined for eating disorder services above.

1. CAMHS/FACTS			
No.	**Recommendation**	**Timeframe**	**Investment Requirements**
1.1	To assess and consider the CAMHS inpatient estate with particular emphasis on the NWAS Site	Years 0-5	Capital
1.2	To consider a National CAMHS Inpatient Referral Hub	Years 1 - 2	Resource
1.3	To consider funding an electronic clinical records system	Years 2-3	IT Infrastructure
1.4	To undertake a comprehensive needs assessment for CAMHS inpatient services	Year 2	Resource
1.5	To consider staffing models at both units to meet the needs of the service specification	Year 0	Resource
1.6	Stabilisation of the FACTS service and development of a service specification	Years 0-2	Resource
2. EATING DISORDERS			
2.1	To establish an Eating Disorders Unit for Wales for both in-patient and Day Service Provision across all ages.	Years 2-5	Capital and resource
2.2	Urgent interim measures to be put in place following the notice given for Welsh eating disorder placements contract with NHS England.	Year 0	
2.3	Full review of ED In-patient services to be conducted by 2023.	Year 2	Resource
2.4	Developing our workforce.	Years 0-3	Resource
2.5	Expansion of Paediatric Support for inpatients in Welsh NHS Units.	Year 2	Resource
2.6	Expansion of HCSW role in adult eating disorder services.	Year 2	Resource
2.7	Review of NG Feeding pathways.	Year 0	Resource
2.8	Support for strengthening of Community provision.	Years 1-2	Resource
3. LEARNING DISABILITY			
3.1	All secure hospital care including low secure to be commissioned by one organisation.	Years 2-4	Resource

3.2	To develop and implement a blended model of care in conjunction with secure service provision in NHS Wales.	Years 2-4	Resource
3.3	Ensure regular review of LD patients in placements reinforcing the care co-ordination and gatekeeping role.	Year 2	Resource
3.4	Consider the role of the community Learning disabilities team to support forensic requirements.	Years 3-4	
3.5	Development of Electronic Records for Learning Disability Patients in NHS Wales.	Years 2-3	IT Infrastructure
3.6	Development of an All Wales demand and capacity inpatient data dashboard.	Years 2-3	IT Infrastructure
4. MALE SECURE SERVICES			
4.1	To develop Integrated Secure Services.	Years 2-5	Resource
4.2	To consider the requirements of the secure services estate in Wales.	Years 2-5	Capital
4.3	To develop appropriate governance arrangements for Integrated and blended secure service provision in NHS Wales	Years 1-2	Resource
4.4	Development of Electronic Records for Secure Services in NHS Wales.	Years 2-3	IT Infrastructure
4.5	To undertake a staffing modernisation programme for the two NHS Wales medium secure units.	Years 0-2	Resource
4.6	To conduct a needs assessment for secure services in Wales.	Year 2	Resource
5. FEMALE SECURE SERVICES			
5.1	To consider the commissioning arrangements for a regional secure service for both medium and low secure service for women.	Years 2-5	Resource
5.2	To consider the requirements of the secure services estate in Wales.	Years 2-5	Capital
5.3	To consider establishing a robust Community Model Pathway for women.	Years 2-3	Resource
5.4	To consider the workforce skill mix to adapt to the increasing acuity of	Years 2-3	Resource

	female patients in medium secure services.		
5.5	To develop appropriate governance arrangements for Integrated and blended secure service provision in NHS Wales	Years 1-2	Resource
5.6	Development of Electronic Records for Secure Services in NHS Wales.	Years 0-3	IT Infrastructure
6. PERINATAL MENTAL HEALTH			
6.1	To consider the 12 month review of the MBU at Tonna Hospital to be conducted in Quarter 1 of 2022-23	Year 0-1	Resource
6.2	To advise following this review the long-term plan for the unit, particularly in relation to the location of the unit.	Years 2-3	Resource and Potential Capital
6.3	To work in partnership with NHS England to secure 2 beds for Welsh patients in a new unit scheduled for development within Cheshire and Wirral Partnership Trust.	Years 0-3	Commissioning
7. NEUROPSYCHIATRY			
7.1	To address the sustainability of the Welsh Neuropsychiatry Service.	Years 1-2	Resource
7.2	To ensure the Welsh Neuropsychiatry Service reaches across the whole of Wales.	Years 1-2	Resource
7.3	Improve the flow of patients across the whole patient pathway.	Years 1-2	Resource
7.4	Raise awareness and understanding in local areas of the enduring impact of an acquired brain injury on mental health.	Years 1-2	Resource

Glossary

WHSSC	Welsh Health Specialised Services Committee
NWASU	North Wales Adolescent Service Unit
NCCU	National Collaborative Commissioning Unit
HEIW	Health Education and Improvement Wales
MH	Mental Health
CAMHS	Children adults Mental Health Service
FACTS	Forensic Adolescent Consultation and Treatment Service
ED	Eating Disorder
LD	Learning Disabilities
HIW	Health Inspectorate Wales
CCAPS	Commissioning Care Assurance and Performance System
HSE	Health Safety Executive
CHC	Community Health Council
SUI	Serious Untoward Incident
QSIS	Quality Surveillance Information System
QST	Quality Surveillance Team
OfWCMS	The Once for Wales Concerns Management System
PROMs	Patient Reported Outcome Measures
PREMS	Patient Experience Measures
HDU	High Dependency Unit
ECA	Extra Care Area
MDT	Multi-Disciplinary Team
HCSW	Health Care Support Workers
NG	Nasogastric (NG) Tube Feeding
NICE	National Institute of Clinical Excellence
MARSIPAN	Management of Really Sick Patients with Anorexia Nervosa
CAEDS	Community Adult Eating Disorder Service
EUPD	Emotionally Unstable Personality Disorder
QNLD	Quality Network for Learning Disability Services
MOU	Memorandum of Understanding
DTOC	Delayed Transfers of Care
PCAT	Patient Categorisation Tool
BSRM	British Society of Rehabilitation Medicine

In Report Title	**Options Appraisal for A Single Commissioner for Secure Mental Health Services in Wales**	**Agenda Item**	3.5
Meeting Title	**Joint Committee**	**Meeting Date**	8/11/2022
FOI Status	Open		
Author (Job title)	Specialised Planner for Mental Health		
Executive Lead (Job title)	Director of Mental Health and Vulnerable Groups		

Purpose of the Report	The purpose of this report is to present the options for a single national organisation to commission integrated secure mental health services for Wales for Health Boards (HBs) to consider. The report has been prepared following a request received from Welsh Government (WG) for the WHSSC Joint Committee to provide the mechanism for the recommendation from the "Making Days Count" review to be considered, and for the Joint Committee to make a recommendation to WG on the preferred option.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☒	ASSURE ☐	INFORM ☒

Recommendation(s):

Members are asked to:

- **Note** the report,
- **Consider** the options for a single national organisation to commission integrated Secure Mental Health Services for Wales; and
- **Note** that the proposal will return to the Joint Committee for decision on 17 January 2023.

OPTIONS APPRAISAL FOR A SINGLE COMMISSIONER FOR SECURE MENTAL HEALTH SERVICES IN WALES

1.0 SITUATION

The purpose of this report is to present the options for a single national organisation to commission integrated secure mental health services for Wales for Health Boards (HBs) to consider. The report has been prepared following a request received from Welsh Government (WG) for the WHSSC Joint Committee to provide the mechanism for the recommendation from the "Making Days Count" review to be considered, and for the Joint Committee to make a recommendation to WG on the preferred option.

2.0 BACKGROUND

2.1 Letter from Welsh Government

On the 3 August 2022, WG issued a letter to HBs to confirm that the recommendations of the Secure Mental Health Services report had been accepted and to ensure that they were aware of Recommendation 3.3 which states: *'Welsh Government, WHSSC and Health Boards should consider the benefits of a single national organisation commissioning integrated secure services'*. The letter is presented at ***Appendix 1*** for information.

The letter suggested that the WHSSC Joint Committee should provide the mechanism for this recommendation to be considered and asked the Managing Director of WHSSC to bring a report outlining the options to the Joint Committee for consideration. Following that consideration, the expectation would be that the WHSSC Joint Committee will make a recommendation to be considered by WG.

The Joint Committee received an update on this request on 6 September 2022. The purpose of this report is to request that Joint Committee members ensure that the options are considered further with their stakeholders and within HBs before a decision is taken at the January meeting. Members are asked to feed their considerations in via the WHSSC Management Group.

2.2 Recommendations of the "Making Days Count" Report

The National Review of patients cared for in secure mental health hospitals, entitled "Making Days Count" report recommended that "Welsh Government, WHSSC and the HBs should consider the benefits of a single national organisation commissioning integrated secure services".

This recommendation was based on "the commissioning organisational infrastructure in NHS Wales differs from the other areas of the UK, as NHS Wales

low secure hospitals, are managed by HBs and not as part of an integrated pathway with medium and high secure hospitals. This fragmented approach also applies to the commissioning of placements external to NHS Wales, which is split nationally and locally dependent on the level of security. The report went on to say "the amalgamation of commissioning responsibilities within a single organisation may remove a significant impediment to the effective use of resources and improve, and possibly expedite, the patient's journey through secure care". Detailed evidence is outlined under section 3.1 below.

2.3 WHSSC Mental Health Strategy

The Draft Secure Services Strategy for Mental Health was circulated for stakeholder feedback during May and June of 2022. One of the recommendations of the strategy is "The commissioning of secure care services to be consolidated and commissioned by one organisation for low, medium and high secure care for men and women, to be inclusive of those with a learning disability where secure requirements are relevant and it is appropriate to do so." This recommendation was supported through stakeholder feedback with the caveat of thorough consideration to ensure local relationships remain.

3.0 ASSESSMENT

3.1 Evidence for the Need to Transition to One Single Commissioner

It is important that the single commissioner system delivers improvements to the patients by improving flow through levels of security; ensuring patients' needs are met by the right level of security, reducing delays in transfer, removing perverse incentives for change, taking a more strategic view of capacity across the secure services system.

The Secure Services Review demonstrated that whilst there are some differences between medium and low secure, there are many areas, such as patient presentations, environment, interventions and staffing models in which the differences are marginal. There are new models of care emerging for certain groups, such as female patients, which combine medium and low secure provision, and which aim to improve patient outcomes and experience and different commissioning responsibilities may be an impediment to this. Studies have stated that secure care needs to be commissioned 'from end to end', rather than each part of the pathway being contracted separately ((Centre for Mental Health. (2013). Briefing Note: Secure Care Services))

Separate development of medium and low services hospitals and their separate commissioning arrangements have led to challenges as to their effectiveness (Dix, R. (2005). Psychiatric Intensive Care and Low Secure Units Past, Present and Future — Introducing the Journal of Psychiatric Intensive Care. Journal of Psychiatric Intensive Care, 1(1), 1-2)

New models of commissioning in NHS England bring NHS and independent sector secure hospitals, within a defined geographical area, into 'Provider Collaboratives' which aim to improve quality of care and outcomes, improve pathway cohesion and reduce transition, length of stay and out of area placements ((NHS England. (2021). Working Together at Scale: guidance on Provider Collaboratives))

A recent report in Scotland recognised that, as each health body in Scotland is responsible for medium and low secure services, this had led to 'disparity' of provision, 'inequality of access' and that services have become a 'collection of distinct services' rather than 'one integrated system where a system wide view of services, standards and resourcing can be achieved (Independent Review into the Delivery of Forensic Mental Health Services. (2021). https://www.gov.scot/publications/independent-forensic-mental-health-review-final-report)

A previous report in Wales recommended that an 'Integrated Commissioning Framework' should be established for secure care and that this 'would be more likely to develop step down facilities' and 'remove current incentives to place and retain patients at higher levels of security than required (National Public Health Service For Wales. (2006). Needs Assessment On Medium Secure Units For Mentally Disordered Offenders. https://www2.nphs.wales.nhs.uk/VulnerableAdultsDocs.nsf/($All)/436C57E37F2904308025727900475EED/$File/medium%20 secure%20final.pdf?OpenElement)

3.2 Options Appraisal

The following options are put forward for consideration:

	OPTION
A	Status Quo
B	WHSSC to become the Single Commissioner
C	National Collaborative Commissioning Unit (NCCU) to become the Single Commissioner
D	NHS Wales Health Collaborative (NWHC) to become the Single Commissioner
E	A newly formed Secure Services network to become the Single Commissioner
F	One of the seven HBs to become the Single Commissioner

The NHS Wales Health Collaborative (NWHC) and a Secure Services Network do not possess the necessary governance framework experience or skills to commission NHS services, and as such should be excluded from the more detailed analysis. Whilst the NCCU is managed as part of the organisational arrangements of EASC, they do not report directly to the EASC Joint Committee and therefore it was deemed that the Unit would also be excluded at the long list stage.

The shortlisted options are for the single commissioner be WHSSC or, for one of the seven HBs in Wales to undertake the role. The option for the status quo to persist, has also been considered. This allows a comparator for the benefits and disadvantages of the Single Commissioner Model. The three options discussed below, are as follows:

- Status quo,
- WHSSC to become the single commissioner;
- One of the seven HBs to become the single commissioner.

The advantage and disadvantages of each of the options are presented at ***Appendix 2*** for consideration.

3.3 Conclusion

The disadvantages of the status quo would suggest that a move to one commissioner is appropriate given the evidence identified in "Making Days Count", relating to ineffective use of resources, a negative impact upon the patient journey and the opportunity to use the least restrictive option.

The advantages of the single commissioner being WHSSC or one of the HBs are broadly similar, other than the purpose of WHSSC is being the specialist commissioner for Wales and it not having the other strategic and operational priorities that the HBs have to focus on.

The transition from Low Secure services being commissioned by the seven HBs to one commissioner will be a detailed and complicated process that will need to take place with stakeholders across Wales.

Therefore, members are asked to consider the following recommendations:

- The secure services system in Wales should be commissioned by one organization,
- On the basis that WHSSC is the body that has been set up to be the specialist services commissioner for Wales and it will be able to treat the commissioning of these services as one of its priorities then WHSSC should become the single commissioner; and
- A national project including WG, WHSSC and all the seven HBs should be set up to manage the transfer of the commissioning of low secure services.

Given the complexity of issues that need to be addressed, this should not occur before April 2024 at the earliest.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report,
- **Consider** the options for a single national organisation to commission integrated Secure Mental Health Services for Wales; and,
- **Note** that the proposal will return to the Joint Committee for decision on 17 January 2023.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Development of the Plan Choose an item.
Link to Integrated Commissioning Plan	Yes
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 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 National Review "Making Days Count" was commissioned to achieve greater understanding of the issues relating to secure mental health hospital care.
Finance/Resource Implications	Financial assessments will be considered for each option to include resource requirements and the possible efficiency savings. It also identifies a need to renegotiate contracts.
Population Health	-
Legal Implications (including equality & diversity, socio economic duty etc)	Supports compliance with the provisions of the Mental Health Act, The Mental Health (Wales) Measure 2010.
Long Term Implications (incl WBFG Act 2015)	Ensuring patients physical and mental well-being is maximised in which choices that will benefit future health.
Report History (Meeting/Date/ Summary of Outcome	**20 October 2022** - Corporate Directors Group Board meeting – Supported **27 October 2022** – Management Group
Appendices	**Appendix 1 –** Letter from WG to WHSSC Single Commissioner for Secure MH Services, **Appendix 2 –** Options Appraisal for Single Commissioner for Secure Mental Health Services

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

To: Health Board Chief Executives.

Cc: Dr Sian Lewis, Managing Director, WHSSC
Matt Downton and Sally Thompson, Welsh Government.

Eich Cyf/Your Ref:
Ein Cyf/Our Ref:

3 August 2022

Dear Colleague

The Welsh Government commissioned the National Collaborative Commissioning Unit to undertake a review of secure services in 2021 and the final report was submitted to the Welsh Government in March 2022 (attached at Annex A). The review was commissioned to achieve a greater understanding of the issues relating to secure mental health hospital care and made several recommendations to providers, commissioners, the Welsh Government and health boards.

The review informed a number of proposals that have been included in the Welsh Health Specialised Services Mental Health Strategy that has recently been out for a period of stakeholder feedback and on which there will be formal engagement later in 2022. The NCCU secure services review recommendations have also informed the allocation of the 2022-23 Mental Health Service Improvement Funding.

Amongst the recommendations to be considered nationally the secure services review highlighted the current fragmented approach to commissioning, with NHS Wales low secure hospitals managed by individual health boards (HBs) as opposed to being part of an integrated pathway with medium and high secure hospitals. This also applies to commissioning placements external to NHS Wales, which is split national and locally dependent on the level of security.

As the recommendations of the secure services review have been accepted by Welsh Government, the purpose of this letter is to ensure that all health boards are aware of recommendation 3.3 in the Review and to specifically request that your organisations agree a preferred commissioning model for all secure services. For ease of reference, recommendation 3.3 states: '*Welsh Government, WHSSC and Health Boards should*

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

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consider the benefits of a single national organisation commissioning integrated secure services'

It is suggested that the WHSSC Joint Committee should provide the mechanism for this recommendation to be considered and we have asked Dr Sian Lewis Managing Director of WHSSC to bring a paper outlining the options to a meeting of the Committee in the Autumn. Following that consideration, the expectation would be that the WHSSC Joint Committee will make a recommendation to be considered by Welsh Government.

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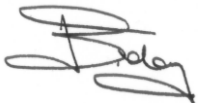
Yours sincerely



Tracey Breheny
Deputy Director of Mental Health, Substance Misuse and Vulnerable Groups

Appendix 2

Options for a Single National Organisation to Commission

Integrated Secure Mental Health Services for Wales

	Option	Advantages	Disadvantages
A	**Status Quo**	• The current system has been in place for fourteen years and is well understood by all organisations • The current system is stable and each Health Board understands the low secure services that it commissions • Health Boards have been able to develop a local approach to match local needs • Established infrastructure within Health Boards to manage Low Secure services • Medium secure services being managed by WHSSC allows risk share approach for high cost patients • Very high cost and low numbers mean, high secure services will remain with WHSSC and aligns with WHSSC commissioning medium secure services	• A different arrangement to that in the remainder of the UK • Has been identified as providing an ineffective use of resources • Can have a negative impact upon the patient journey and their care. • Financial disincentives to managing patients in least restrictive environments • System barriers to managing patients in least restrictive environment • Variation in low secure capacity in Health Boards, utilisation of medium secure beds, and inequity of access • The current low secure framework can cause significant financial risks in individual Health Boards • There is a lack of a system view and outcomes for patients, a variation of availability of care close to home, and duplication of management resources in Health Boards • Low secure services have not always been a priority for capital investment • Fragmented commissioning means it is more difficult to respond to the increasingly challenging market for private provider capacity in England

	Option	Advantages	Disadvantages
B	**WHSSC to become the Single Commissioner**	• Is set up as the specialist services commissioner for Wales and if low secure services are deemed to be specialist then it is the natural home for providing such a function • Has a track record of strong leadership and experience in commissioning secure services • Will deliver a more efficient use of resources • Will deliver an improved patient journey and better care • Will be able to take a national approach to service commissioning and respond better to the increasingly challenging market for private provider capacity in England • WHSSC are already developing a Mental Health strategy, into which this service could fit • Will provide a better view of the secure services system with an opportunity to improve patient outcomes • Increases the opportunities to deliver the objectives of "A healthier Wales" with regards to providing care closer to home • Less duplication of management resources	• A considerable amount of work will be required over an eighteen month period to understand and untangle the commissioning responsibility from the seven Health Boards to WHSSC • There will be risks to service and financial stability during the transition period • The transition period may be unsettling for staff, both those working in the services and in the commissioning functions currently • The untangling of the financial resources from the Health Boards will be complicated • The untangling of the systems in place to manage low secure placements external to NHS Wales from each of the Health Boards will be complex • A national approach will be less sensitive to local requirements and may be less responsive • The Mental Health Directorate in WHSSC is currently small and will need enhancing with the right leadership and skills to work nationally • The interface problems will simply move from between medium and low secure services to low secure and locked rehabilitation services
C	**NCCU to become the Single Commissioner**	• **The NCCU does not possess the necessary governance framework, specifically it does not report routinely into a Joint Committee, neither does it have the experience or skills, to undertake all the functions within**	

	Option	Advantages	Disadvantages
		the commissioning cycle, required for NHS services and as such should be excluded from the more detailed analysis.	
D	**NHS Collaborative to become the Single Commissioner**	• **The NHS Collaborative does not possess the necessary governance framework, experience or skills to commission NHS services, and as such should be excluded from the more detailed analysis.**	
E	**A newly formed Secure Services network to become the Single Commissioner**	• **The Secure Services Network would not possess the necessary governance framework, experience or skills to commission NHS services, and as such should be excluded from the more detailed analysis.**	
F	**One of the seven Health Boards to become the Single Commissioner**	• Would currently provide extensive commissioning of services • Has strong leadership and experience in commissioning • Will deliver a more efficient use of resources • Will deliver an improved patient journey and better care • Will be able to take a national approach to service commissioning and respond better to the increasingly challenging market for private provider capacity in England • Increases the opportunities to deliver the objectives of "A healthier Wales" with regards to providing care closer to home	• Currently the governance framework of HBs is not established for national commissioning and managing potential conflicts of interest • There will be a duplication of national commissioning resource with WHSSC • HBs may not have the capacity to undertake these responsibilities • Challenges related to the Covid-19 pandemic mean that secure services commissioning may not represent a priority for Health Boards • A considerable amount of work will be required over an eighteen month period to understand and untangle the commissioning responsibility from the other the seven Health Boards to the chosen Health Board • There will be risks to service and financial stability during the transition period • The transition period may be unsettling for staff, both those

	Option	Advantages	Disadvantages
			working in the services and in the commissioning functions currently • The untangling of the financial resources from the Health Boards will be complicated • The untangling of the systems in place to manage low secure placements external to NHS Wales from each of the Health Boards will be complex • A national approach will be less sensitive to local requirements and may be less responsive • The interface problems will simply move from between medium and low secure services to low secure and locked rehabilitation services

Report Title	Gender Identity Development Service (GIDS) for Children and Young People Update	**Agenda Item**	3.6
Meeting Title	**Joint Committee**	**Meeting Date**	08/11/2022
FOI Status	Open/Public		
Author (Job title)	Specialised Planning Manager for Vulnerable Groups		
Executive Lead (Job title)	Director of Nursing and Quality		

Purpose of the Report	The purpose of this report is to update members about the Gender Identity Development Service (GIDS) for Children and Young People including what the changes mean for children and young people in Wales and next steps.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☐	INFORM ☒

Recommendation(s):

Members are asked to:

- **Note** the information presented within the report; and
- **Note** the information presented at Appendix 1 regarding the decommissioning of the Tavistock and Portman NHS Foundation Trust (TPNFT) and the NHS England (NHSE) transformation programme.

GENDER IDENTITY DEVELOPMENT SERVICE (GIDS) FOR CHILDREN AND YOUNG PEOPLE UPDATE

1.0 SITUATION

The purpose of this report is to update members about the Gender Identity Development Service (GIDS) for Children and Young People including what the changes mean for children and young people in Wales and next steps.

2.0 BACKGROUND

WHSSC currently commissions a service for children and young people through NHS England's (NHSEs) GIDS provided by the Tavistock & Portman NHS Foundation Trust (TPNFT). There are around 300 young people from Wales on the GIDS waiting list and 50 open cases, accounting for 3.9% of the UK total, which is representative of the population.

2.1 The Cass Review

The Cass Review Interim Report (published in February 2022) emphasised the need to move away from the current model of a sole provider towards the establishment of regional services that work to a new clinical model that can better meet the holistic needs of a vulnerable group of children and young people. The report also described the need for these new services to work as networked centres that connected with other local services including children and young people's mental health services and primary care to support all a patient's clinical needs.

2.2 Implementing the Advice from the Cass Review

In July 2022, in response to the recommendations, NHSE took the decision to de-commission the TPNFT and introduce two early adopter providers from spring 2023.

The need to make these changes is based on the rapid increase in demand and pressure on this service which is unable to be met by a single highly specialist national service. It is crucial that gender diverse children and young people can access care and support in a timely fashion and with a joined-up system of support. The proposals being put forward to create a network of regional centres are designed, once fully operational, to increase capacity and improve access to care.

The Cass Review interim report also made clear that having a single national provider would no longer be a viable or sustainable way to meet the increasing demand for children and young people's gender services. Dr Cass has now delivered further advice that in the future, specialist services for children with gender dysphoria should be delivered in specialist children's hospitals, and that they should work to a new clinical model that is better equipped to consider and

meet the holistic needs of children and young people experiencing gender incongruence and gender dysphoria. As a first step towards establishing a regionally led service, NHSE are taking immediate steps to set up two Early Adopter services led by specialist children's hospitals in the North and South of England.

2.3 What this means for children and young people in Wales

2.3.1 Referral & Waiting Lists

Young people from Wales will continue to access the service through Children & Adolescent Mental Health Services (CAMHS) in the interim, access either one of the early adopter providers. In parallel to this, NHSE will work with the Cass Review Team and stakeholders through a series of work streams to define the future clinical model and a new service specification. This will involve engagement with stakeholders and full public consultation, leading to the establishment of around six additional regional providers from 2023.

Once the Early Adopters are established, new referrals and patients on the waiting list for GIDS will be held by a National Referral Centre and directed to the most appropriate Early Adopter services.

In order to address the waiting list a piece of modelling work will need to be undertaken involving the Welsh Gender Service (WGS) (Adult pathway) to consider a process of repatriating 17 year olds currently on the GIDS waiting list back onto the current adult waiting list as they will effectively 'time-out' and not get seen by GIDS before they reach 18 years. In parallel a system for accepting new referrals from the age of 17 years will also need to be agreed. Currently patients can be referred to the Welsh Gender Service (WGS) from 17.5 years but this will need to be reduced to 17 years as the current waiting times for the adult service are 2 years plus.

2.3.2 Waiting Times

By increasing both the number of providers and clinical capacity within the service, there is an expectation that waiting lists and waiting times will reduce over time once the Early Adopter services are fully up and running by spring 2023. These are the first steps of a major transformation programme that will ultimately result in a network of specialist centres of expertise being established in every region of England and eventually in Wales, which will further increase capacity and bring down wait times over the coming years.

2.3.3 Access to Puberty Blockers

Patients will continue to be able to be considered for puberty blockers under existing NHS protocols. Referrals into endocrine services will continue under current arrangements, which includes the need for assurance by the Multi-Professional Review Group (MPRG) in regard to children under 16.

2.3.4 Research Programme

Through the Cass Review, welsh patients will have be part of a research programme and infrastructure that will contribute to the international evidence base, supported by the extensive governance framework that NHSE is proposing, this work has already started and an initial literature is due to be published by the end of October 2022.

2.3.5 Governance

NHS Wales, represented by WHSSC, will play an active part in the assurance and decision making functions linked to the Cass Review and implementation of the recommendations. WHSSC are a member of the NHSE Programme Board for Gender Dysphoria Services that oversees the current commissioning of Gender Dysphoria services for children and young people, which includes the de-commissioning of the GIDS and the development of a new service specification and clinical model through a national transformation programme.

The NHSE Children's Gender Dysphoria Work Programme is a national transformation programme being established to oversee a smooth and seamless transition for young people to the new Early Adopter services, including bringing the GIDS contract to a managed close because of these changes. WHSSC will be on the following work streams to ensure the needs of young people in Wales are reflected:

- Clinical Design,
- Learning Healthcare System,
- Waiting List Management,
- Workforce Planning,
- Operational Delivery,
- Finance and Contracting,
- Patient and Public Engagement and Communication; and
- Tavistock GIDS Operational Model

Communication and engagement is central to the success of the programme and NHS Wales will engage and consult extensively to ensure that the voice of welsh patients are considered throughout. A specific communication strategy will be required to ensure that the information and progress at each stage is relayed to families and clinicians alike.

2.3.6 Commissioning Position

At present there are no proposed changes to the way that Welsh Health Specialised Services commissions the service through NHSE. There is however the opportunity in the future to explore the development of a regional provider and potentially deliver a service based in Wales, led by the Children's Hospital for Wales (CHW) as part of a network to mitigate the issues associated with having a sole provider of a national service.

3.0 ASSESSMENT

The approach to align with the Cass Review, research programme and NHSE Children's Gender Dysphoria Work Programme was supported by the Health Minister and policy leads in Welsh Government at a meeting on the 12 September 2022.

Next steps
The next steps are:

- to fully engage with the national transformation programme and develop any associated work plans for Wales including a communications plan, to ensure the timely and relevant cascade of information to patients, families and key stakeholders,
- to agree a plan with the WGS to ensure all Welsh patients age 18 and over under the care of GIDS are transferred to the adult service within a set timescale,
- Undertake modelling with Arden & GEM who are responsible for the management of the waiting list to agree he transfer of Young People onto the adult waiting list within the Welsh Gender Service as appropriate; and
- write to GPs and CAMHS to advise them to refer 17 year olds to the adult Welsh Gender Service so they can be added to the waiting list but not seen before their 18th birthday (this will require a change to the adult service specification, allowing them to take referrals from 17 years instead of 17.5 years

By aligning with the Cass Review, research programme and national transformation programme any issues relating to quality, governance or risk will be addressed. Any issues or risks relating to Welsh residents only will be reported to and managed through the WHSSC governance process.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the information presented within the report; and
- **Note** the information presented at Appendix 1 regarding the decommissioning of the Tavistock and Portman NHS Foundation Trust (TPNFT) and the NHS England (NHSE) transformation programme.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	Not applicable - this is already a commissioned service
Health and Care Standards	Safe Care Effective Care Timely Care
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production 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 proposed changes will improve the quality, safety and patient experience of young people as recommended by the Cass Review Interim Report (February 2022) https://cass.independent-review.uk/publications/interim-report/
Finance/Resource Implications	Any financial implications will be identified through the transformation programme 'Finance and Contracting' workstream. The WHSSC finance team will be represented and financial implications reported at a future date. Financial implications of developing a service in Wales will need to be agreed.
Population Health	Not applicable
Legal Implications (including equality & diversity, socio economic duty etc)	NHS England have robust governance surrounding the transformation programme. An EQIA has been produced by NHS England alongside the development of an interim service specification.
Long Term Implications (incl WBFG Act 2015)	This is a very specialised service affecting a relatively small number of the population. Therefore it is proposed that WHSSC continue to commission this service through the NHS England Network with the aim of developing a provider for Wales over time that can join the existing network.
Report History (Meeting/Date/	**3 October 2022 - Corporate Directors Group Board (CDGB)**

Summary of Outcome	• **Supported** the recommendation to align ongoing work with the Cass Review Research Programme and the NHS England Children's Gender Dysphoria Work Programme • **Supported** the recommendation to continue to commission a service for children and young people through the NHS England commissioning network • **Supported** the recommendation to explore the development of a regional provider for Wales as part of the NHS England commissioning network, potentially led by the Children's Hospital for Wales • **Supported amendment** to CP182a and b (Adult Gender Service Non –Surgical Policy and Specification) to reduce age of referral to the adult service waiting list from 17.5 to 17 years and thereby close referral of 17 years olds to GIDS • **Approved** the Frequently Asked Questions attached at Appendix 1 **27 October 2022 –** Management Group – for information.
Appendices	Appendix 1 – GIDS: NHS Wales Frequently Asked Questions

NHS Wales GIDS FAQ's

Appendix 1

How is the service commissioned in Wales?

Welsh Health Specialised Services commissions the gender identity development service for children and young people in Wales through NHS England, provided by the Tavistock and Portman NHS Foundation Trust.

Why are NHS England making these changes to GIDS?

NHS England is making these changes based on the rapid increase in demand and pressure on this service which is unable to be met by a single highly specialist national service. It is crucial that gender diverse children and young people can access care and support in a timely fashion and with a joined-up system of support. The proposals being put forward to create a network of regional centres are designed, once fully operational, to increase capacity and improve access to care.

The Cass Review interim report also made clear that having a single national provider was no longer viable or sustainable in a way to meet the increasing demand for children and young people's gender services. Dr Cass has now delivered further advice that in the future, specialist services for children with gender dysphoria should be delivered in specialist children's hospitals, and that they should work to a new clinical model that is better equipped to consider and meet the holistic needs of children and young people experiencing gender incongruence and gender dysphoria. As a first step towards establishing a regionally led service, NHS England are taking immediate steps to set up two Early Adopter services led by specialist children's hospitals.

Will there be any stakeholder engagement and public consultation on the changes?

Yes. The new Early Adopter services will be commissioned against an interim service specification which will be published in draft imminently for the purposes of engagement and consultation. NHS England will continue to work with the Cass Review and stakeholders to publish a final service specification that will describe the new clinical model, for adoption by the regional services in 2023/24, There will be full consultation and engagement prior to the implementation of the final service specification.

Why are NHS England closing the GIDS at Tavistock?

There is an urgent need to rapidly expand and evolve this service. NHS England are doing this in a way that is consistent with Dr Cass' advice that this service should be led by providers of specialist paediatric services.

What change will this mean for current patients or the GIDS or endocrine services?

There will be no immediate changes or interruption to patient's current care. NHS England are aiming to establish the new Early Adopter services by Spring 2023 and all parties are committed to achieving a smooth and seamless transfer for all patients minimising any disruption.

How will the new service differ from the existing GIDS service?

The Early Adopter services will have a multi-disciplinary team (MDT) of specialist clinicians so that assessment and care planning is delivered in an integrated way. These MDTs will include gender specialists, specialists in paediatric medicine, mental health, autism and neuro-disability so that a young person's overall health needs are met holistically. There will also be more support offered to local services so that children and young people can receive care more locally where this is clinically appropriate.

Who are the Early Adopter Services?

As a first step, NHS England are establishing two new Early Adopter Services- one in London and one in the North West- which will be led by specialist children's hospitals. The aim is to have these services operational by Spring 2023. Once operational, these services will take over clinical responsibility for GIDS patients and for those on the waiting list, with the current GIDS contract being brought to a managed close.

The London-based service will be formed as a partnership between Great Ormond Street Hospital for Children and Evelina London Children's Hospital, with specialist CYP mental health support provided by South London and Maudsley NHS Foundation Trust.

The North West-based service will be formed as partnership between Alder Hey Children's NHS Foundation Trust and Royal Manchester Children's Hospital who both provide specialist CYP mental health services.

Will this change reduce waiting times / how quickly?

By increasing both the number of providers and clinical capacity within the service, it is expected that waiting lists and waiting times will reduce over time once the Early Adopter services are fully up and running by Spring 2023. These are just the first steps of a major transformation programme that will ultimately result in a network of specialist centres of expertise being established in every region of the country which will further increase capacity and bring down wait times over the coming years.

How quickly will the new services be mobilised?

The aim is for the Early Adopter services to become fully operational by the Spring of 2023. NHS England work as quickly as possible but at a pace that appreciates the complexity of the change and the imperative to minimise disruption and any additional anxiety for patients.

Will patients currently under the care of the Tavistock still be able to access puberty blockers?

Yes. Patients will continue to be able to be considered for puberty blockers under existing NHS protocols. In time, the use of puberty blockers in children under 16

will be brought under a formal research protocol in line with Dr Cass's advice. This will:

- provide a major international contribution to the evidence base in this area.
- ensure there is greater transparency for children and their parents / carers around the uncertain clinical benefits and longer-term health impacts surrounding their use.
- further strengthen the consent and information sharing process to support informed decision making by young people.

Will I need to wait for a research protocol to start hormone blockers?

The research proposal is likely to take some time to design and implement. In the meantime, referrals into endocrine services can continue under current arrangements, which includes the need for assurance by the Multi-Professional Review Group (MPRG) in regard to children under 16.

Will I be able to opt out of the research protocol for hormone intervention?

Once the research protocol is established, access to endocrine treatment will be dependent on participation in the research.

Are you disbanding the Multi Professional Review Group that reviews referrals for puberty blockers?

Until the research protocol is operational the MPRG will continue to review the process followed by GIDS and by the Early Adopters once operational. This will still only apply to patients under the age of 16.

I am / my child is on the waiting list for GIDS; what will happen to my / their referral?

Once established, the new Early Adopter services will take a share of the national waiting list currently held by GIDS. The new services will then begin to review the waiting list to determine what the most appropriate care pathway is for each young person at that point.

What does that mean for my place on the waiting list?

Current waiting list positions will be honoured by the new services.

How do Welsh patients get referred into this new children's gender service?

There are no proposed changes to the referral pathway for welsh patients which is and will continue to be through Children & Adolescent Mental Health Services (CAMHS)

I am 17 years old and too young to be put on the waiting list for the adult gender identity service but know I will not be seen by the time I am 18 by GIDS, what do I do?

NHS Wales GIDS FAQ's

WHSSC is putting a plan in place to work with the Welsh Gender Service so that 17 year olds can be added to the waiting list but will not seen before their 18th birthday. The current age referrals can be accepted onto the waiting list is 17 years and 6 months but this will be reduced to 17 years. GP's and CAMHS will be notified when this change has been made so they can make the appropriate referral.

How will the Early Adopters operate differently to GIDS?

The Early Adopter services will have a multi-disciplinary team of specialist clinicians to work alongside the gender dysphoria specialists so that assessment and care planning is delivered in a more integrated way. The MDT will include specialists in paediatric medicine, mental health, autism and neuro-disability so that a child / young person's overall health needs are met holistically.

Will we ever have a service in Wales?

The current priority is to ensure continuity for individuals under the care of the Tavistock and a smooth transfer of individuals from Wales across to the Early Adopter services by Spring 2023.

Welsh Health Specialised Services will continue to commission the service through NHS England for the foreseeable future but will explore through the programme, the feasibility of either developing a welsh based service or working with future provider sites in England to access care as close to home as possible.

How will future changes/developments be communicated?

The main places to watch for updates from NHS England are:
https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/

And here for updates for patients / referrers to the current GID service:
https://gids.nhs.uk/

WHSSC is developing a communications plan to ensure any changes are cascaded through CAMHS and a network of support organisations as we appreciate the above links are not specific to Wales. Updates will also be posted on the WHSSC website: https://whssc.nhs.wales/commissioning/commissioned-services/

Report Title	**Engagement on the Proposed WHSSC IPFR Panel ToR and the Specific and Limited Review of the All Wales IPFR Policy**	**Agenda Item**	3.7
Meeting Title	**Joint Committee**	**Meeting Date**	08/11/2022
FOI Status	Open		
Author (Job title)	Senior Project Manager		
Executive Lead (Job title)	Medical Director		

Purpose of the Report	The purpose of this report is to seek support for the proposed engagement process for the WHSSC Individual Patient Funding Request (IPFR) panel Terms of Reference (ToR) and 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; and
- **Support** the proposed process for engagement for the WHSSC Individual Patient Funding Request (IPFR) panel Terms of Reference (ToR) and the specific and limited review of the all Wales IPFR policy.

ENGAGEMENT ON THE PROPOSED WHSSC IPFR PANEL ToR AND THE SPECIFIC AND LIMITED REVIEW OF THE ALL WALES IPFR POLICY

1.0 SITUATION

The purpose of this report is to seek support for the proposed engagement process for 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

On 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 (QAG), the Medical Directors and the Board Secretaries of each of the Health Boards (HBs) 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.

3.0 ASSESSMENT

3.1 Methodology for Engagement

Following JC approval further consideration has been given to the most appropriate process for the targeted engagement.

It is proposed that a similar process to the one adopted to engage on the WHSSC policy and service specification consultation is followed. A number of documents to support the process have been developed including:

- **Appendix 1** – Proposed Updated Terms of Reference (ToR) for the WHSSC IPFR Panel (approved for engagement by JC),
- **Appendix 2**- Proposed changes to the All Wales IPFR Policy,
- **Appendix 3** – Draft letter to stakeholders setting out the background to the engagement and the process for review and to request feedback on the documentation,
- **Appendix 4** – Updated Summary of WHSSC IPFR Panel ToR proposed changes; and
- **Appendix 5** – Proforma for response to the engagement

The process adheres to the specific request from Welsh Government (WG) for the engagement for the IPFR panel ToR and the specific and limited review of the All Wales IPFR Policy.

The JC are requested to give further consideration the scope of the specific and limited review, taking note of the advice received from David Locke QC in

identifying amendments for the All Wales IPFR policy following the judgment handed down in the judicial review "Maria Wallpott –v- WHSSC & ABUHB" in December 2021.

In addition to the above and due to the complexities of the suggested changes to the All Wales IPFR Policy, it is proposed that David Locke QC presents the rationale for the changes to the HB Board Secretaries and other key stakeholders

3.2 Timeline for Engagement

The proposed timeline for the engagement is as follows:

Date	Task
10 November 2022	Issue email to key stakeholders, including the AWTTC, the IPFR QAG, the Medical Directors and the Board Secretaries of each of the Health HBs and VUNT with a response deadline of 22 December 2022.
2 December 2022	Committee Secretary to update Board Secretaries peer group meeting on the engagement.
TBC	WHSSC Medical Director to update Medical Directors on engagement.
TBC	WHSSC Medical Director to update AWTTC on engagement.
TBC	IPFR Team/Director of Nursing to Update IPFR Policy implementation group (PIG) and IPFR QAG on engagement.
TBC	WHSCC Chair and Committee Secretary to discuss potential remuneration with WG.
22 December 2022	Closing date.
3 January 2023	Review responses and take a report to CDGB.
17 January 2023	Take a report with the findings of the engagement to Joint Committee.
18 January 2023	Send report to HB's and WG for inclusion on January board meeting agendas.
14 March 2022	Final update to JC and begin arrangements to comply with updated ToR.

Documentation would need to be circulated to key stakeholders on the 10 November 2022 for a period of 6 weeks.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report; and
- **Support** the proposed process for engagement for the WHSSC Individual Patient Funding Request (IPFR) panel Terms of Reference (ToR) and the specific and limited review of the all Wales IPFR policy.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	-
Health and Care Standards	Governance, Leadership and Accountability Choose an item. Choose an item.
Principles of Prudent Healthcare	Choose an item. Choose an item. 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	A national IPFR quality function is in place to support the IPFR panel to ensure quality and consistency. The quality function provides quality assurance around the decision-making of panels and promotes consistency across Wales. Currently the IPFR Panel ToR do not meet the needs of the organisation in providing the best
Finance/Resource Implications	No financial resources have been identified.
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	**6 September 2022 –** Joint Committee
Appendices	**Appendix 1** – Proposed Updated Terms of Reference (ToR) for the WHSSC IPFR Panel (approved for engagement by JC), **Appendix 2**- Proposed changes to the All Wales IPFR Policy, **Appendix 3** – Draft letter to stakeholders setting out the background to the engagement and the process for review and to request feedback on the documentation, **Appendix 4** – Summary of WHSSC IPFR Panel ToR proposed changes; and **Appendix 5** – Proforma for response to the engagement

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

DRAFT TERMS OF REFERENCE – WHSSC IPFR PANEL v 0.6

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.

1.1 Panel Authority

The 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 or ratification.

The financial authorisation limit is set a £300,000 for one off 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 and the relevant Health Board for authorisation.

2. MEMBERSHIP

The 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

In attendance from WHSSC:

- IPFR Manager/co-ordinator
- Corporate Governance Manager
- Other WHSSC staff as and when required

A further two panel members from the NHS in Wales may be appointed at the discretion of the Chair of the Panel, for example a member of an ethics Committee.

The Chair of the panel will review the membership as necessary.

For particularly complex cases the 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 panel will be quorate if 4 of the 7 Health Boards representative, 1 WHSSC clinical director or deputy plus the Chair and a lay person are present;

3.2 Meeting Frequency

The IPFR panel will normally be held twice per month 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 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.

Urgent cases will be reported at the next 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 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.

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 database of all cases will be maintained.

4. TRAINING FOR IPFR PANEL MEMBERS

All Panel members will receive an 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 will be expected 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 annually.

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

Reference Number	Policy Reference (as per individual Health Board)	**Version Number**	FINAL June 2017 Amended October 2022 for review
Linked Documents	Health Board Policies on Interventions Not Normally Undertaken (INNU)		

Classification of Document: Clinical Policy

Area for Circulation: Local Health Boards and Primary Care providers across Wales
Public Health Wales (PHW)
Welsh Health Specialised Services Committee (WHSSC)
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Author: Ann-Marie Matthews, Lead for Clinical Commissioning/IPFR, Aneurin Bevan University Health Board

Development Group: All Wales IPFR Network

Consultation: Legal Advice from NHS Wales Shared Services Partnership – Legal and Risk Services, May 2017
NHS Wales Medical Directors Clinical Networks
Patient Groups / Patient representatives
Stakeholder groups

Approved: Health Board IPFR Panel Chairs

Date of Publication: June 2017 [Amended January 2022]

Lead Health Board Contact: Contact details as per individual Health Board

Classification: This document supersedes the previous IPFR policy document published in May 2016

KEY TO PROPOSED CHANGES IN THE POLICY DOCUMENT

Purple – Additional wording

Blue – Changes to existing wording

Green – Changes to wording to address issues arising from the judicial review

Table of Contents

1 INTRODUCTION

1.1 Background

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

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

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

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

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

1.1.6 **Amendments were made in January 2022 to clarify the meaning of parts of this Policy, to clarify the issues for panels making decisions under this Policy and to provide a consistent set of definitions for terms used in the Policy (now in Appendix 4).**

Commented [AR(U-WHSS1]: Comments from the QC to explain the changes made in the policy

2 THE PURPOSE OF THIS POLICY

2.1 Continuing advances in technology, changing populations, better information and increasing public and professional expectations all mean that NHS Health Boards have to agree their service priorities for the application of their financial and human resources. Agreeing these priorities is a complex activity based on sound research evidence where available, sometimes coupled with value judgments. It is important for the NHS in Wales to be open and clear about which healthcare interventions are routinely funded for NHS patients and which interventions are not routinely

funded for NHS patients. It is also important that patients understand decisions are made both about the contents of standard commissioning policies and on how funding may be approved outside standard commissioning policies.

2.2 A wide range of NHS healthcare services are routinely funded for patients locally by primary care services and hospitals across Wales under commissioning policies adopted by each Health Board ("**HB**"). In addition, the Welsh Health Specialised Services Committee ("**WHSSC**"), working on behalf of all the Health Boards throughout Wales, commissions a number of specialist services for Welsh NHS patients. WHSSC carries out its functions on behalf of the patient's Health Board. NHS clinicians are entitled to seek NHS funding for one or more interventions which are outside the range of treatments that can be provided under either Health Board commissioning policies or under WHSSC policies. These applications are called Individual Patient Funding Requests ("**IPFRs**"). This Policy sets out how the IPFR process operates and how decisions are made on IPFRs.

2.3 **Each Health Board in Wales has a range of commissioning policies that define which interventions for NHS patients for whom it has commissioning responsibility will be routinely commissioned. In reaching policy decisions, Health Boards will have regard to guidance from a range of bodies including NICE. However, save in the case of Technology Appraisal Guidance by NICE, Health Boards are entitled to adopt policies which depart from NICE Guidance or depart from policies which operate in other parts of the NHS.**

Commented [AR(U-WHSS2]: The QC has asked specifically for comments on this section

2.4 **The Health Boards have also worked together to develop a list of interventions that are not routinely commissioned as NHS funded care for people in Wales. This policy is called 'Interventions Not Normally Undertaken' ("INNU"). An intervention will normally be included in the INNU because:**

- The intervention has been reviewed by the National Institute for Health and Care Excellence ("**NICE**") or by the All Wales Medicines Strategy Group ("**AWMSG**") and a decision has been taken that there is currently insufficient evidence that the intervention is either clinical effective or there is currently insufficient evidence that the intervention is cost effective; and/or
- The intervention has not yet been reviewed by NICE or AWMSG and the intervention has been included pending such a review; and/or
- The intervention is considered to be of a low priority for funding and thus is not routinely an appropriate use of NHS resources.

2.5 The challenge for all Health Boards is to make the best use of NHS resources so as to deliver the maximum level of clinically effective and cost effective healthcare possible within the available budget. Health Boards seek to deliver on this aim by striking the right balance between providing NHS

services that meet the health needs of the majority of the population in the geographical area for which the Health Board has responsibility and enabling exceptions to commissioning policies to be made where this is justifiable and necessary to meet a person's individual needs.

2.6 **Each Health Board has a range of commissioning policies which define the services that the Health Board is prepared to fund where clinically appropriate to meet the needs of its local population. However, Health Boards recognise there may be individual cases where it is appropriate to make an exception to the constraints imposed by commissioning policies or where there is no policy governing an intervention for particular patients. Demand for NHS services is always likely to exceed the resources available to meet that demand and, as a result, making decisions as to whether to fund a treatment for individual patient which is not available to other patients with a like condition results in some of the most difficult a Health Board has to make.**

Commented [AR(U-WHSS3]: Minor change from QC

2.7 **In order to improve transparency and consistent decision making, the NHS in Wales has introduced this Policy to guide decision making for IPFR's. It describes both the principles underpinning how decisions are made and the processes to be followed when making such decisions.**

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

2.9 **It is not the role of the IPFR panel to make decisions to change the terms of commissioning policies adopted by Health Boards in Wales and panels have no authority to do so. An IPFR panel can only make an individual funding decision on the particular case before it. It is only entitled to make a decision to enable an intervention to be funded where the tests under this policy are met, based on the individual clinical facts of a case.**

Commented [AR(U-WHSS4]: Added by QC for clarity

2.10 IPFRs should not be confused with requests for packages of care for patients with complex continuing healthcare needs. Such packages of care are covered by NHS Continuing Healthcare ("CHC") arrangements. **A requested intervention which is part of a CHC arrangement could be the subject of an IPFR application if funding could not otherwise be approved for that intervention. Further information can be obtained from the Health Board's Nursing Department.**

Commented [AR(U-WHSS5]: Added by QC for clarity

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

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

3 MAKING AN INDIVIDUAL PATIENT FUNDING REQUEST

3.1 The vast majority of care for NHS patients in Wales arises as a result of decisions made by clinicians and patients working together to make choices from the range of treatments that the NHS has agreed to fund for patients with a particular disease or other medical condition as set out in the relevant commissioning policy. In such cases, decisions are made by clinicians and patients without the need for the clinician to seek additional authority before providing the treatment.

3.2 **IPFRs are requests by clinicians for funding for an individual patient to meet the costs of a specific intervention where the clinician does not have the authority to approve the intervention as part of NHS funded care. Applications will be needed to be made before funding can be approved where (a) the requested intervention is listed in the INNU policy or (b) the requested intervention is sought for a patient who is outside the clinical criteria listed in a commissioning policy which define the patients who can be routinely provided with the requested intervention or (c) the clinician seeks funding for an intervention which has not been included in a commissioning policy or in INNU.**

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

- a patient and NHS clinician have agreed together that they would like a treatment that is either new, novel, developing or unproven and is not within the Health Board's routine schedule of services and treatments (for example, a request to use a cancer drug that has yet to be approved by the Health Board for use in that particular condition);
- a patient and NHS clinician have agreed together that they would like a treatment that is provided by the Health Board in certain clinical circumstances but is not eligible in accordance with the clinical policy criteria for that treatment (for example, a request for treatment for varicose veins for cosmetic reasons alone);
- a patient has a rare or specialist condition that falls within the service remit of the WHSSC but is not eligible in accordance with the clinical policy criteria for treatment (for example, a request for plastic surgery where the indication is personal preference rather than medical need).

3.4 The requesting clinician must sign the application form to indicate that the patient is aware and agrees with the submission of the request. In doing

Commented [AR(U-WHSS6]: The QC has commented that better to start with an explanation as to what an IPFR is rather than starting with what it is not. The key point being that the clinician does not have delegated authority to approve the intervention for one of the three stated reasons.

Commented [AR(U-WHSS7]: The QC has stated that he is unsure if this section 93.3) is really needed in the policy

so, the clinician is providing confirmation that the patient has been fully informed of the treatment request and all its associated implications.

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

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

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

3.8 IPFR applications should be made before any intervention is provided or administered. Save in genuinely exceptional circumstances, requests will not be considered for retrospective funding.

3.9 The panel is likely to be assisted by evidence from the referring clinician in the following areas:

- Relevant NICE, AWMSG or Scottish Medicines Consortium recommendations or advice.
- Relevant Public Health Wales advice.
- Relevant peer reviewed clinical journal publications.
- What information does the locally produced evidence summary provide.
- Is there evidence from clinical practice or local clinical consensus.

3.10 Whilst the panels acknowledge the clinical expertise of the referring clinician in his or her area of speciality, statements of opinion, belief or expectation from the referring clinician which are not supported by objective clinical evidence are unlikely to be accepted by a panel as amounting to evidence to support a case. The referring clinician is required to use his or her sector expertise to provide the panel with clinical evidence to support any statement which is made in support of the above tests, with the source of the evidence explained in the application.

3.11 The panel may also seek advice from its own advisors or seek external advice on any aspects of the evidence.

3.12 The referring clinician is required to provide evidence of the cost to the NHS of the requested intervention and details of any savings

Commented [AR(U-WHSS8]: The QC suggests this paragraph to make it clear that un- evidenced statements will not usually constitute evidence

Commented [AR(U-WHSS9]: The QC suggests this is included to make it clearer the panel can be informed by other evidence from its advisors

Commented [AR(U-WHSS10]: Suggested by QC to pick up the point in case about the extent of savings on other treatments

that the NHS may or is likely to make in the current year or in future years as a result of treatment that would otherwise be provided to the patient but which may or is likely not to be needed if funding is provided for the requested intervention.

3.13 The referring clinician is also encouraged to provide any evidence on the cost effectiveness of the proposed intervention.

4 HOW DECISIONS ARE MADE ON IPFR APPLICATIONS.

4.1 Stage 1 Actions following the receipt of an IPFR

4.1.1 The IPFR application form must be completed in full to enable the IPFR Panel to reach a fully informed decision. Should the IPFR Co-ordinator receive an application form which has not been completed sufficiently enough to determine whether or not the request can be screened out or taken to the IPFR Panel, or the incorrect form is completed, the form should be returned to the requesting clinician **within three working days**.

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

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

4.2 Stage 2 Screening of the IPFR

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

(a) **the IPFR Senior Officer considers that there is no reasonable basis upon which a panel could conclude that the tests under the policy may be met based on the evidence presented in the application;**

(b) the request meets pre-agreed criteria for a service already commissioned/provided and can be automatically funded;

(c) **this is a second or subsequent request for funding for the same or a similar intervention and there is no reasonable case made that meets the tests under this policy for a second or subsequent request;**

(d) **the request matches previous cases where an application has been turned down and the IPFR Senior Officer considers there is no reasonable basis for considering that a different decision would be made by a panel;**

(e) **an alternative and satisfactory clinical solution is available which means that there is no reasonable need for the requested intervention;**

Commented [AR(U-WHSS11]: QC suggests adding this because it is the basis on which screening is actually carried out. It is effectively ruling out applications where the evidence does not merit the attention of the panel.

Commented [AR(U-WHSS12]: QC suggests adding this as will allow subsequent applications to be screened out

Commented [AR(U-WHSS13]: The QC has changed this to remove the word "precedent" which has unfortunate legal consequences. Is the test really "whether there is any reasonable chance that a panel will make a different decision". If so, the case should go forward to panel; if not the panel's time should not be wasted.

Commented [AR(U-WHSS14]: The QC has amended - The original wording was "*an alternative and satisfactory clinical solution has been found".* It is unclear as what it means as it begs the question "found by whom"? It thus raises the danger of substituting the roles of the treating clinician and the WHSSC staff. QC suggests either omitting this entirely or changing the wording to the suggested words

(f) *the request represents a service development which needs to be passed to the relevant Division or Director for their action;*

(g) *the request raises a policy issue where more detailed work is required.*

4.2.2 **If the application is refused at the screening stage, the IPFR Senior Officer should then communicate the outcome of the screening stage to the requesting clinician by letter or email within five working days of the decision being made. This letter will set out the reasons for the decision.**

4.3 Stage 3 Considerations by the IPFR Panel

4.3.1 Requests that are not screened out at Stage 2 will be considered at a meeting of the IPFR Panel. The IPFR Co-ordinator will ensure that the panel has all the information needed to make a decision and will ensure that it is anonymised before each meeting.

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

4.3.3 Applications will be considered by the IPFR panel based on the clinical evidence provided at the date of the application. The onus is on the clinician to provide the panel with evidence to meet the tests set out at paragraph 4.4 of the policy.

4.3.4 **In the case of decisions made by a panel on behalf of an Health Board, the IPFR Senior Officer shall advise the panel whether the requested decision is within the delegated financial authority of the panel, in which case the panel shall act as a decision maker, or whether it exceeds the delegated financial authority of the panel, in which case the panel's authority is limited to making recommendations to the Health Board about the funding of the intervention. The approach taken by the panel shall be the same in both cases, save that where the panel does not have delegated authority, its "decision" shall be a decision to make a recommendation.**

4.4 The tests to be applied by an IPFR Panel.

Commented [AR(U-WHSS15]: The QC suggests omitting this. If the evidence does not support a case that the individual patient meets tests 1 and 2, the application should be screened out under the first test. If the evidence supports a case that the individual patient meets tests 1 and 2, the case should proceed to panel even if it could also be classified as a request for a service development.

Commented [AR(U-WHSS16]: The QC suggests this is also omitted for the reasons above

Commented [AR(U-WHSS17]: Changed to make it clear that decision letters are only required to be sent where the application has been rejected. A letter can be sent saying that the matter is proceeding to panel but that does not need to be in the policy.

Commented [AR(U-WHSS18]: QC added this in to be consistent with Appendix one to cover a case where the panel are limited to making a recommendation.

A: If a relevant commissioning policy applies which covers the requested intervention, the following tests must be met:

I. The panel must be satisfied that the clinician has demonstrated that the patient's clinical circumstances are significantly different to the general population of patients for whom the recommendation is not to use the intervention.

II. The panel must be satisfied that the clinician has demonstrated that the patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients for whom the recommendation is not to use the intervention, and

III. The panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.

B: If there is no relevant commissioning policy which applies to the requested intervention:

I. The panel must be satisfied that the clinician has demonstrated that the patient is likely to gain significant clinical benefit from the requested intervention,

II. **The panel is satisfied that the requested intervention does not constitute a service development where decisions about funding the intervention should be made through the relevant service development process, and**

III. The panel must be satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.

Commented [AR(U-WHSS19]: QC is of the view that the existing policy does not explicitly prevent the IPFR process being used to bring in service developments by the back door. Where there are potentially service developments, funding applications ought to proceed by the service development process, but the policy needs to say so. It also needs to deal with the potential problem of a service development for an exceptional patient – i.e. one where the individual tests are met. Thus it is proposed that this should be brought in via this third test.

4.4.1 An IPFR panel is required to decide whether the application is a Part A application or a Part B application and then consider each application against the relevant criteria. A panel may only approve applications which meet all of the relevant applicable tests (A&B above)

Commented [AR(U-WHSS20]: QC Highly recommended additions to address the issues raised in the Judicial Review (section 4.4.1 to 4.9.2)

4.4.2 It is the responsibility of the requesting clinician to demonstrate the clinical case for the individual patient with respect to the first and second tests for a Part A application or the first test for a Part B application.

4.5 The required approach where there is a relevant commissioning policy related to the requested intervention

4.5.1 The first test under a Part A application applies where a commissioning policy is in place which provides that the requested intervention will not be routinely funded for patients by the Health Board (**or WHSSC)** or will not be routinely funded for patients with the requesting patient's clinical circumstances. In such a case this test requires the panel to consider whether the **patient for whom the request is made** (requesting patient)'s clinical circumstances are significantly different to "*the general population of patients for whom the recommendation is not to use the intervention*". The "*recommendation*" referred to in this test is the recommendation in the commissioning policy not to fund the intervention generally or for classes of patients. That test requires the panel to make a comparison between the requesting patient's clinical circumstances and the clinical circumstances of other patients who are denied funding for the requested intervention by the relevant commissioning policy.

4.5.2 That process will usually require a comparison between the requesting patient and other patients with the same medical condition who, but for the commissioning policy, could have been provided with the requested intervention. Patients whose clinical circumstances mean that they would not be clinically suitable for the intervention are not part of the comparison group because the treatment options for those patients would not have been affected by the relevant recommendation. The test for the panel for a Part A application is whether the referring clinician has demonstrated that there is a significant difference between the clinical circumstances of the requesting patient and the clinical circumstances of this comparison group of patients.

4.5.3 The second test for a Part A application is whether the panel is satisfied that the referring clinician can demonstrate that the requesting patient is likely to gain significantly more clinical benefit from the intervention than would normally be expected from patients for whom the recommendation is not to use the intervention. The comparison group is the same set of patients as under the first test.

4.5.4 This test requires the panel to compare the likely clinical benefits for the requesting patient if the intervention were to be funded for that patient with the likely clinical benefits for patients in the comparison group if the intervention were to be made available for patients in the comparison group.

4.5.5 There are cases where the same clinical circumstances are relied upon by

the referring clinician to support a case that the requesting patient meets both tests. In such a case, the panel will consider those clinical circumstances separately in relation to each of the tests. The panel will then consider the value for money test, as described below.

4.6 The required approach where there is no relevant commissioning policy related to the requested intervention

4.6.1 Where there is no relevant commissioning policy related to the requested intervention, the case will be considered under Part B above. In such a case, the first test is whether the referring clinician has provided evidence which leads the panel to conclude that the patient is likely to gain significant clinical benefit from the requested intervention.

4.6.2 The second test requires the panel to consider whether the request for funding for the intervention constitutes a service development where decisions about funding the intervention should be made through the relevant service development process. If there are a significant number of other patients who are or are likely to be in the same clinical circumstances as the requesting patient, funding for a new intervention to treat such patients should normally be considered through the process of developing commissioning policies and not through an IPFR application.

4.6.3 However, even if the request constitutes a potential service development, it may be appropriate to grant the application if the requesting patient's individual circumstances are significantly different to other patients who could benefit from the same intervention. Panels will normally refer applications for funding for interventions which amount to service developments to the service development process unless the first and second tests in Part A are met. In considering those tests, the comparison group is patients who could also benefit from the requested intervention.

4.7 The required approach in considering if the requested intervention provides value for money.

4.7.1 If the panel is satisfied that the first and second tests are met for either a Part A application or a Part B application, funding can be approved if, but only if the panel is satisfied that the value for money of the intervention for that particular patient is likely to be reasonable.

4.7.2 The panel should make an assessment of the overall likely overall net cost to the NHS of the requested intervention. The overall net cost to the NHS of the intervention will usually be the cost of the intervention less the cost of other NHS treatments which would be likely to be provided to the patient but which are likely to be avoided in the current or future financial years if the requested intervention is funded.

4.7.3 The assessment as to whether the intervention provides "value for money" is a matter of judgement for the panel. In coming to this decision the panel

will consider whether it is possible to ascribe an estimated incremental cost effectiveness ratio ("ICER") and quality- adjusted life year (QALY) to the intervention for patients generally and in the case of the requesting patient. In doing so, the panel will seek to use the same definitions as NICE, adjusted as far as appropriate to the case of an individual patient.

4.7.4 The panel will consider, so far as appropriate, whether the ICER for the requested intervention is likely to be above or below £30,000. An ICER of below £30,000 is likely to result in the intervention representing value for money. An ICER of above £30,000 is unlikely to be considered to result in the intervention representing value for money, but may do so where there are compelling reasons arising from an individual case.

4.7.5 The estimated ICER figure of £30,000 may be revised at any time by WHSSC without the need to review the remaining terms of this policy and, where revised, the new ICER figure shall apply.

4.7.6 Where it is not possible for the panel to reach an estimated ICER, the panel will reach a decision exercising its broad discretion to decide whether the value for money of the intervention for that particular patient is likely to be reasonable.

4.8 Record keeping.

4.8.1 The IPFR Co-ordinator or Senior Officer will complete a record of the panel's discussion on each IPFR, including the decision and an explanation for the reasons for that decision including decisions made as to whether it is a Part A or Part B application and what the panel concluded in respect of each of the tests. Where the panel have been able to reach a decision on the likely ICER for the intervention for the particular patient, this should be stated in the reasons.

4.9 Communicating the decision.

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

4.9.2 The aim will be to send a decision letter **within five working days** of the panel's decision. The letter will set out the reasons the panel reached the decision and, where practicable, may contain a copy of the notes made at the panel meeting. The letter will also include information on how to request a review of the process where a decision has been made to decline the request.

4.10 The consequences of making a decision under this Policy.

4.10.1 **Once a decision has been made on an IPFR application the Health**

Commented [AR(U-WHSS21]: QC suggests suggest putting in these paragraphs to divert patients away from being able to issue judicial review proceedings in line with the principles set out by the Court of Appeal in *Cowl v Plymouth and comments that* it would be far more cost effective for the NHS in Wales to review IPFR decisions under the complaints process (and if needed get the decisions taken again) as opposed to allowing patients to issue judicial review proceedings and hence (a) taking decision making outside the NHS and (b) exposing the NHS to considerable costs.

Board will have made a decision whether to grant funding for the requested intervention or to decline funding. If the patient or the referring clinician remain dissatisfied with that decision an application can be made for a review. If the patient or the referring clinician remains dissatisfied following a review, the patient or the referring clinician is entitled to make a formal complaint under the "Putting Things Right" policy.

4.10.2 **The NHS in Wales acknowledges that complaints about an unsuccessful IPFR application may have a degree of urgency due to the need to make timely decisions about the patient's treatment. Where appropriate, the complaints process can operate to provide a prompt consideration of concerns that a patient may have about an IPFR decision.**

4.11 Further or additional requests in relation to the same patient and/or for the same or similar treatment.

4.11.1 The IPFR panel process involves a detailed consideration of an individual case. Once a decision is made, it will be rarely justifiable for the same or a similar application to be reconsidered by the panel outside of the review process. However, if **following an initial application (which was either granted or refused), (a) the clinical circumstances for the specific individual patient have changed significantly or (b) there is significant further information about the likely benefit to the patient of the intervention, a further IPFR application can be submitted. The change in clinical circumstances can arise for any reason including where a patient funds a treatment themselves or as a result of third party funding and their clinician believes the outcome of this non-NHS funded treatment means that the referring clinician can demonstrate that the patient has gained significantly more clinical benefit from the intervention than would normally be expected for that treatment, an IPFR can be submitted for consideration.**

Commented [AR(U-WHSS22]: QC comments that the policy needs to define threshold conditions for a second application. The existing para is limited to a change in clinical circumstances but that is probably too narrow because new evidence of clinical effectiveness should also be permissible and suggests the test is twofold namely whether there is "*significant further information about the likely benefit to the patient of the intervention*".

4.11.2 In such a case, the first issue for the panel will be whether the panel is satisfied either (a) that there has been a significant change in the patient's clinical circumstances since the previous IPFR was considered or (b) that the referring clinician has provided significant further information about the likely benefit to the patient of the requested intervention.

4.11.3 If the panel is satisfied on either ground, the panel will proceed to consider the application by applying the relevant tests set out above. If the panel is not satisfied that either (a) that there has been a significant change in the patient's clinical circumstances or (b) that the referring clinician has provided significant further information about the likely benefit to the patient of the, the application shall be refused.

4.12 How will IPFR Panels make decisions?

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

4.12.2 **Panels are entitled to meet in person or by way of a telephone or e-meeting in the discretion of the chair.**

Commented [AR(U-WHSS23]: QC added for clarity

4.12.3 **The panel will seek to achieve decisions by consensus. However, if after discussion there is a disagreement between panel members, a decision will be taken after a vote of panel members, with the Chair having a casting vote in the event of a tie.** In such an event, the reasons for the grant or refusal of the application shall be reasons agreed between those members in the majority.

Commented [AR(U-WHSS24]: QC added for clarity

4.13 Clinically urgent cases.

4.13.1 **Genuinely clinically urgent cases can be considered outside of the normal screening and panel processes. A decision whether a case requires an urgent decision can be taken by the IPFR Senior Officer or by the Chair or Vice Chair of the IPFR panel, based on the information provided by the referring clinician.**

Commented [AR(U-WHSS25]: QC amended this to make it clear that the decision as to whether an application is urgent of not is for the IPFR Senior Officer and not the referring clinician.

4.13.2 **Where an application is accepted as being clinically urgent, the Chair or Vice Chair of the IPFR panel is authorised to make a decision outside of a full meeting of the panel or may convene a panel urgently to consider the application. Any such decisions will be made in line with the principles of this policy, taking into account the clinical urgency of the request outlined in the application form by the clinician.**

4.13.3 **Applications which are accepted by the IPFR Senior Officer or by the Chair or Vice Chair of the IPFR panel as being urgent will be sought to be considered within 24-48 hours of an urgency decision being made.**

4.14 Can patients and clinicians attend the IPFR Panel?

4.14.1 **Patients are not permitted to attend IPFR Panels. The principal reasons is that it would make the process less fair, because it would draw to the attention of panel** members characteristics of the individual patient that should not influence their decision-making, such as age and gender. The IPFR Panel will normally reach its decision on the basis of all of the written evidence which is provided, including the IPFR application form and other documentary evidence which is provided in support. Patients and clinicians are able to supply any written statements they feel should be considered by the Panel. Any information provided which relates to non-clinical factors will not be considered. Community Health Councils

are able to support patients in making such statements if required.

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

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

4.15 Holding IPFR Information

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

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

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

5 THE LEGAL, EVIDENTAL AND ETHICAL CONTEXTS FOR THIS POLICY

5.1 The legal context.

5.1.1 **Health Boards exercise functions delegated to them by the Welsh Ministers under various statutes and in particular under the National Health Service (Wales) Act 2006 and under secondary legislation made under that Act.**

Commented [AR(U-WHSS26]: QC clarifying the legal context

5.1.2 **In addition to specific statutory obligations, Health Boards are public bodies which are required to comply with their legal obligations to act in accordance with the rights of individuals under the European Convention of Human Rights as defined in the Human Rights Act 1998 and under common law.**

5.1.3 **It is lawful for a Health Board to adopt commissioning policies about which treatments will, and which will not, be routinely funded as part of NHS funded care. It is also lawful for a Health**

Board to adopt this policy to define the circumstances in which a decision can be made to fund an intervention for a patient where other patients are lawfully denied funding for the same intervention as a result of general commissioning policies or as a result of an absence of a policy approving funding for the intervention.

5.1.4 **In making decisions under this policy, panels are required to assume that any general commissioning policy under which it has been decided that an intervention should not be routinely funded is a lawful commissioning policy by the Health Board.**

5.1.5 **Where patients or their relatives disagree with a decision made by a panel under this policy, the appropriate route to raise any concern will be to seek a review or, if they remain dissatisfied, by making an NHS complaint. Unless a case has exceptional urgency, patients are encouraged to use the NHS complaints process as this will provide a more appropriate means of challenging a decision than seeking to challenge a decision by way of Judicial Review before the High Court. Where a case has clinical urgency, the complaints process can be expedited so as to reflect the need to take an urgent decision**.

5.2 The evidential context.

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

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

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

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

have to be able to justify, defend and corporately "live with" such decisions.

5.3 The ethical context.

5.3.1 Health Boards are faced with the ethical challenge of meeting the medical needs of a large number of individuals within the resources available. They also need to allocate resources fairly between patients, accepting that it is impossible to fund every potentially beneficial intervention for every patient for whom the Health Board has responsibility.

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

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

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

5.3.4 Panels and WHSSC officers will have regard to those ethical principles when making decisions under this policy.

5.4 Economic Considerations

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

Commented [AR(U-WHSS27]: QC has addressed this in section 4.7 therefore this could be removed

6 HOW TO REQUEST A REVIEW OF THE PROCESS

6.1 If an IPFR is declined by the panel, a patient and/or their NHS clinician has the right to request information about how the decision was reached or the reasons giving for declining the request. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy or inadequate reasons have been given, a review can be requested on one of the grounds set our below.

6.2 The 'review period'

6.2.1 A review can be requested up to 25 working days from the date of the decision letter. The letter from the Health Board that accompanies the original decision should state the deadline for any review request. In calculating the deadline, Saturdays, Sundays and public holidays in Wales will not be counted.

6.3 Who can request a review?

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

6.4 The grounds for seeking a review.

6.4.1 A review does not constitute a reconsideration of the merits of the original decision. The review panel is entitled to uphold a request for a review for one or more of three grounds set out below. A review request on any other ground will not be considered.

6.4.2 The 3 grounds for a review are:

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

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

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

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

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

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

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

Commented [AR(U-WHSS28]: The QC suggests omitting this

6.5 How is a review request lodged?

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

- **The ground relied upon to seek the review.**
- **The reasons why the ground is said to apply on the facts of the case.**

Commented [AR(U-WHSS29]: QC slight change

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

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

6.6 Initial scrutiny of the review application by the IPFR Senior Officer

6.6.1 The review documents lodged will be scrutinised by the IPFR Senior Officer who will look to see that they contain the necessary information. If the review request does not contain the necessary information or if the review does not appear to the IPFR Senior officer to fall under any one or more

grounds of review, the IPFR Senior Officer will contact the referrer (patient or their clinician) to request further information or clarification.

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

6.6.3 The Chair of the review panel shall be entitled to take the decision that the application should be refused because a case is not made out that falls under one or more of the grounds upon which the review panel can consider the review or that the review has no realistic chance of success.

6.7 The timescale for a review being considered.

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

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

6.8 Can new evidence be submitted to the review panel?

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

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

6.9 Can patients attend review panel hearings?

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

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

retire at the end of the review panel discussion in order for the panel to make their decision.

6.10 The decision of the review panel hearing

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

6.10.2 The review panel can either:

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

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

6.11 After the review hearing

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

6.12 How will WHSSC undertake a review?

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

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

7 MAKING A COMPLAINT.

7.1 Making an IPFR does not conflict with a patient's ability to make a complaint

to the Health Board or, if a person is dissatisfied with the response, a further complaint can be made to the Public Services Ombudsman for Wales. Further information is available on the Ombudsman's website www.ombudsman- wales.org.uk.

APPENDIX ONE

Commented [AR(U-WHSS30]: May need revision by the HB

TERMS OF REFERENCE – Health Board IPFR PANEL

PURPOSE

1. To act as a Committee of the Health Board for the purpose of making decisions on behalf of the Health Board on IPFR applications.

2. An IPFR panel shall have delegated authority up to a financial limit set by each Health Board to consider and make decisions on behalf of the Health Board where requests are made to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide under its own commissioning policies.

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

4. The Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue. The Panel may also request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

SCHEME OF DELEGATION REPORTING	**MEMBERSHIP AND ATTENDANCE**
The IPFR Panel cannot make policy decisions for a Health Board. Any policy proposals arising from their considerations and decision will ultimately be reported to the Health Board Quality & Safety Committee for consideration by the Health Board. Financial authorisation is as follows: - The Panel's authorisation limit will be set at the delegated financial limit as per the individual Health Board	• Executive Public Health Director or deputy • Executive Medical Director or deputy • Executive Director of Therapies and Health Science or deputy • Director of Pharmacy and/or Chief Pharmacist or deputy • Executive Director of Nursing or deputy • Two Lay Representatives A further two panel members may be appointed at the discretion of the panel Chair, for example a member of the Ethics Committee, Primary Care Director or

structure. - Any application which, if approved, would result in a financial cost in excess of the level of the panel's delegated must be considered and a provisional recommendation shall be made to the Health Board Chief Executive for further consideration by the Health Board under its own procedures.	Director of Planning. In Attendance in order to provide advice to the panel (but not as members of the panel): • IPFR Senior Officer • IPFR Co-ordinator • Finance Advisor (if required) • Senior Pharmacist (if required)

PROCEDURAL ARRANGEMENTS

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

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

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

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

APPENDIX TWO

Commented [AR(U-WHSS31]: Under review

TERMS OF REFERENCE – WHSSC IPFR PANEL

PURPOSE

1. To act as a Sub Committee of the Welsh Health Specialised Services Committee (the Joint Committee) and hold delegated Joint Committee authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

2. The Panel will act at all times in accordance with the All Wales IPFR Policy taking into account the appropriate funding policies agreed by WHSSC.

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

4. The Panel may, at its discretion, request the attendance of any clinician to provide clarification on any issue or request independent expert clinical advice for consideration by the Panel at a further date. The provision of appropriate evidence to the Panel will be entirely at the Panel Chair's discretion.

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

PROCEDURAL ARRANGEMENTS

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

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

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

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

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

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

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

APPENDIX THREE

TERMS OF REFERENCE – REVIEW PANEL

PURPOSE

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

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

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

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

PROCEDURAL ARRANGEMENTS

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

Meetings: As required.

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

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

APPENDIX FOUR

EXPLANATION OF THE TERMS USED IN THIS POLICY – LIST OF RECOMMENDATIONS

Commissioning policy	A policy developed by a Health Board which defines which interventions appropriate clinicians delivering NHS care in Wales are entitled to provide to a patient as part of NHS funded health care without seeking prior authority. Commissioning policies will usually defined the categories of patients to whom the policy applies. Where a patient comes within the terms of a commissioning policy, the patient and the appropriate clinician can decide between them to provide that treatment to the patient as part of NHS funded care.
A relevant commissioning policy	A commissioning policy adopted by the patient's Health Board or WHSSC which refers to the requested intervention.
Health Board	A Welsh Health Board.
Routinely commissioned	An intervention is "routinely commissioned" if the intervention comes within the terms of a commissioning policy for a patient. The word "routinely" means that the decision as to whether an intervention should be provided to a particular patient is taken by the clinician (applying the terms of a commissioning policy) as opposed to being authorised by any other NHS management process.
Intervention	In medical terms this could be a drug treatment, surgical procedure, diagnostic test or psychological therapy. Examples of

	public health interventions could include action to help someone to be physically active or to eat a more healthy diet. Examples of social care interventions could include safeguarding or support for carers (Taken from the NICE Glossary)
WHSSC	The Welsh Health Specialised Services Committee
IPFR	Individual Patient Funding Request.
Putting Things Right	The Policy published by the NHS in Wales for considering and adjudicating on complaints under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
ICER	The incremental cost-effectiveness ratio, is the difference in the change in mean costs in the population of interest divided by the difference in the change in mean outcomes in the population of interest.
NICE	The National Institute for Health and Care Excellence
AWMSG	All Wales Medicines Strategy Group

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

Your ref/eich cyf:
Our ref/ein cyf:
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Tel/ffôn: 01443 443443 ext
Fax/ffacs: 029 2080 7854
Email/ebost: @wales.nhs.uk

Dear Colleague

Re: Stakeholder engagement on the proposed changes to the WHSSC IPFR Panel TOR and limited review of the All Wales IPFR Policy

As you will be aware from previous discussions, WHSSC have requested a review of the current WHSSC IPFR Panel ToR due to both longstanding issues and risks arising from the COVID-19 pandemic related to the terms of reference (ToR) of the WHSSC IPFR Panel.

Separate to the ToR issues, on the 3 December 2021 a request for a judicial review in the case of Maria Rose Wallpott (MW) – v- (1) WHSSC & (2) Aneurin Bevan UHB (ABUHB) was allowed and the decision of the WHSSC IPFR panel to refuse funding for treatment was quashed by the court. The basis of this decision was the court's interpretation of the existing NHS Wales Policy Making Decisions on Individual Funding Requests (IPFR's), and legal advice from a Queen's Counsel (QC) Barrister, which indicated that the policy would need to be updated if its original and intended meaning was to be reinstated.

In July 2022, Welsh Government confirmed as the All Wales IPFR Panel is a sub-committee of the WHSSC Joint Committee, it is within its authority to update and approve the terms of reference and that WHSSC could embark on an engagement process with key stakeholders to update the WHSSC IPFR Panel Terms of Reference (ToR) and to engage on a specific and limited review of the All Wales IPFR Policy.

Subsequently, in September 2022 the Joint Committee approved the proposal for WHSSC to embark on the engagement process with key stakeholders, including the All Wales Therapeutics and Toxicology Centre, 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).

Welsh Health Specialised Services Committee
Unit G1, Main Avenue
Treforest
Pontypridd
CF37 5YL

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Uned G1, Main Avenue,
Trefforest
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Chair/Cadeirydd: *Kate Eden*
Managing Director of Specialised and Tertiary Services Commissioning/Rheolwr Gyfarwyddwr Comisiynu Gwasanaethau Arbenigol a Thrydyddol: *Dr Sian Lewis*

I am now writing to ask you to review and comment on the proposed changes to both the WHSSC IPFR Panel ToR and the specific and limited review of the All Wales IPFR Policy. A proforma has been enclosed for your use. Please use a separate proforma for each document review.

To aid review of the draft ToR, I have also included a summary table of the proposed changes against the current ToR.

The proposed changes to All Wales IPFR Policy have been colour coded to aid review.

Please could you return the completed proforma by **insert time** on **insert date** to the following email address:

Andrea.Richards2@wales.nhs.uk

Yours sincerely

Dr Sian Lewis
Managing Director of Specialised and Tertiary Services

Stakeholder engagement Distribution List:

Health Board Medical Directors
Health Board Board Secretaries
Velindre University NHS Trust Board Secretary
All Wales Therapeutic and Toxicology Centre IPFR Quality Assurance Group
IPFR Policy Implementation Group
WHSSC IPFR Panel Chair and members
Andrew Evans, Chief Pharmaceutical Officer, Welsh Government

Welsh Health Specialised Services Committee
Unit G1, Main Avenue
Treforest
Pontypridd
CF37 5YL

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Uned G1, Main Avenue,
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Chair/Cadeirydd: *Kate Eden*
Managing Director of Specialised and Tertiary Services Commissioning/Rheolwr Gyfarwyddwr Comisiynu Gwasanaethau Arbenigol a Thrydyddol: D*r Sian Lewis*

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

Proposed changes to the WHSSC IPFR Panel ToR

The table below summarises the key changes proposed in the revised WHSSC IPFR Panel ToR.

ToR Issue	Current	Proposed
Membership	• Independent Chair (who will be from existing members of the NHS organisations Boards) • Two Lay representatives • Nomination at Director level from each of the LHBs A named representative from each of the seven Health Boards who should be a Director or Deputy/Assistant Director, or named deputies of appropriate seniority and experience who can operate in the capacity of the primary representative. The intention will be to secure an appropriate balance of processional disciplines to secure an informed multi-disciplinary decision. A further two panel members may be appointed at the discretion of the Chair of the panel, for example a member of the Ethics Committee or a Senior Pharmacist. These members should come from outside the 7 Health	• Independent chair from open recruitment or existing members of the NHS organisation Boards • 2 Lay representatives** • Health Board (HB) IPFR Panel Chairs from each of the 7 HB's 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 In attendance from WHSSC: • IPFR Manager/co-ordinator • Corporate Governance Manager • Other WHSSC staff as and when required A further two panel members from the NHS in Wales may be appointed at the discretion of the Chair of the Panel, for example a member of an ethics committee.

ToR Issue	Current	Proposed
	Boards and one of which would be nominated as the Vice Chair. The Chair of the panel will review the membership as necessary. In attendance from WHSSC • Medical Director or Deputy • Director of Nursing or Deputy • IPFR Co-ordinator • Finance Advisor (if required) • Other WHSSC staff as and when required.	
Urgent cases	It is recognised that provision must be made for occasions where decisions may need to be made urgently. In these circumstances, the Chair of the IPFR Panel is authorised to make a decision outside of a full meeting of the Panel, within their delegated financial limits.	Provision will be made for occasions when a decision may be required urgently. Where possible a video conference 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 Service 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. Urgent cases will be reported at the next IPFR panel.
Quoracy	The Chair or Vice-Chair and representation from five of the seven Health Boards, three of which must be clinical representatives	The panel will be quorate if 4 of the 7 Health Boards representative, plus the Chair or vice chair, 1 WHSSC clinical director and a lay person are present.

ToR Issue	Current	Proposed
Meeting frequency	At least once a month with additional meetings held as required and agreed with the Panel Chair. Video conferencing facilities will be available for all meetings.	The IPFR panel will normally be held twice per month via video conferencing, face to face or a combination of both. The Panel will run for no more than 4 hours with adequate breaks
Documentation, reporting and monitoring	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.	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 database of all cases will be maintained.

**** Definition: Not currently registered as a healthcare professional, both lay (not currently a healthcare worker) and lay plus (healthcare experience ever) (Health Research Authority (HRA) 2004) will be eligible).**

To further strengthen the ToR, the review group have proposed 3 additions:

- Declaration of Members' interest during the meeting,
- situations where the panel cannot reach a consensus,
- training for IPFR Panel members,
- Consideration of time commitment and remuneration of the Chair of the Panel (not included in the ToR)

WHSSC Specialised Services engagement

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

Stakeholder Response Proforma

Document Title	WHSSC IPFR Panel Terms of Reference/ All Wales IPFR Policy (please indicate the relevant document)
Policy Reference Number	N/A
Deadline for comments	Please complete and return your completed form by e-mail to Andrea.Richards2@wales.nhs.uk by **17:00** on xxxx

Respondent's Name	
Respondent's Job Title	
Replying on behalf of organisation?	Yes / No
Name of Respondent's organisation	

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

Stakeholder Response Proforma

Comment Number	Page Number	Line Number	Section	**Comment** [Insert each comment in a new row]
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Insert extra rows as needed

Instructions for submitting comments

- Include page, line and section number of the text each comment is referring to.
- If you wish to make a comment on the whole document please insert 'general' in the page number and section column.
- Submit this template as a Word document (not a PDF).
- Combine all comments from your organisation into one response. We cannot accept more than one response from each organisation.
- Spell out any abbreviations you use.
- We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Commented [AR(U-WHSS1]: Ive amended this section slightly but ay need to change further

Report Title	**COVID-19 Period Activity Report Month 5 2022-2023**	**Agenda Item**	4.1
Meeting Title	**Joint Committee**	**Meeting Date**	27/10/2022
FOI Status	Open/Public		
Author (Job title)	Head of Information		
Executive Lead (Job title)	Director of Finance		

Purpose of the Report	The purpose of this report is to highlight the scale of the decrease in activity levels during the peak COVID-19 period, and whether there are any signs of recovery in specialised services activity. These activity decreases are shown in the context of the potential risk re patient harms and of the loss of value from nationally agreed financial block contract arrangements.				
Specific Action Required	RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☐	INFORM ☒

Recommendation(s)

Members are asked to:

- **Note** the report

COVID-19 PERIOD ACTIVITY REPORT

MONTH 5 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 (previously known as NWIS) together with monthly contract monitoring information to inform this report. Members are asked to note that the DHCW data for Admitted Patient Care and Patients Waiting includes all Welsh activity at providers with a WHSSC contract, and also includes some non-specialist activity that may be included in local Health Board contracts. The DHCW data used in this report was refreshed on August 30th 2022.

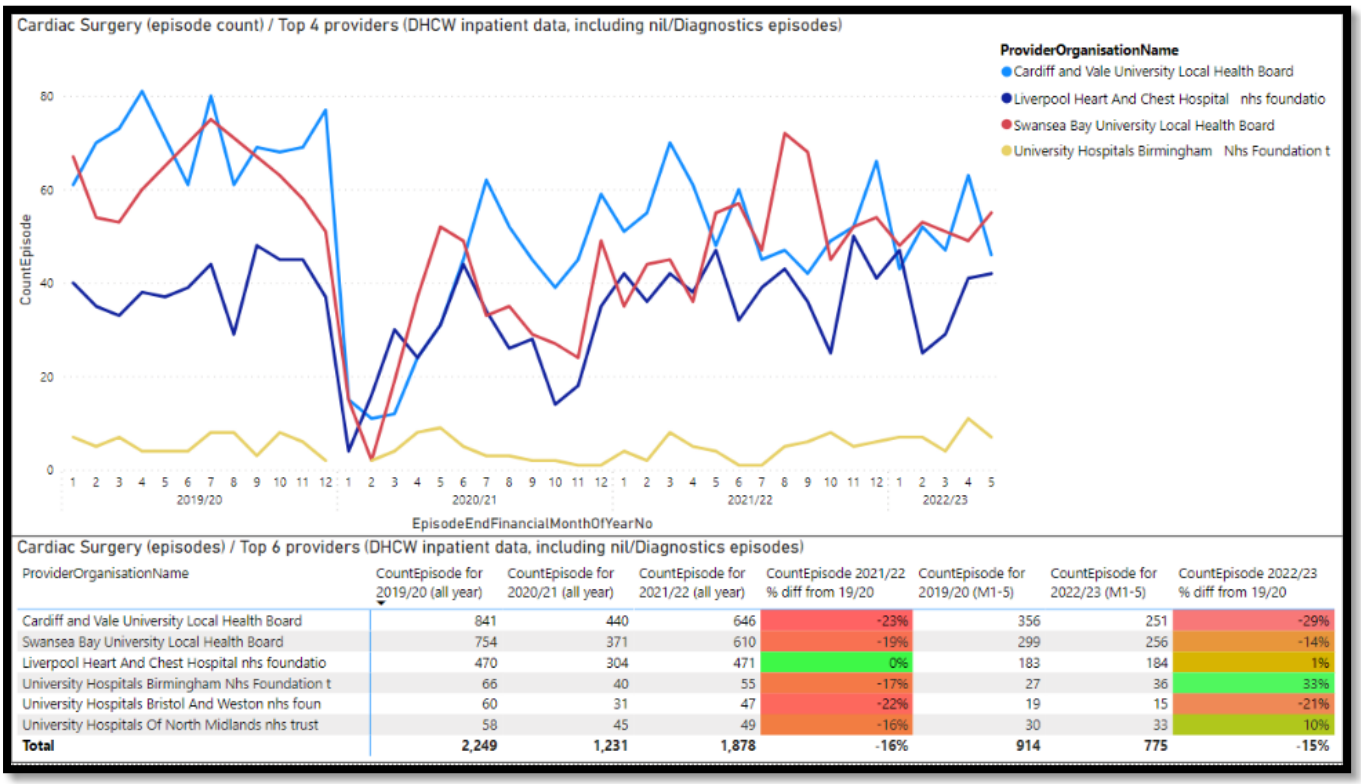
3.0 ASSESSMENT

Specialties/areas covered in this report include:

- Cardiac Surgery
- Thoracic Surgery
- Neurosurgery
- Plastic Surgery
- Paediatric Cardiac Surgery
- Paediatric Surgery
- English provider activity (all specialist and non-specialist)
- Annex A – 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)

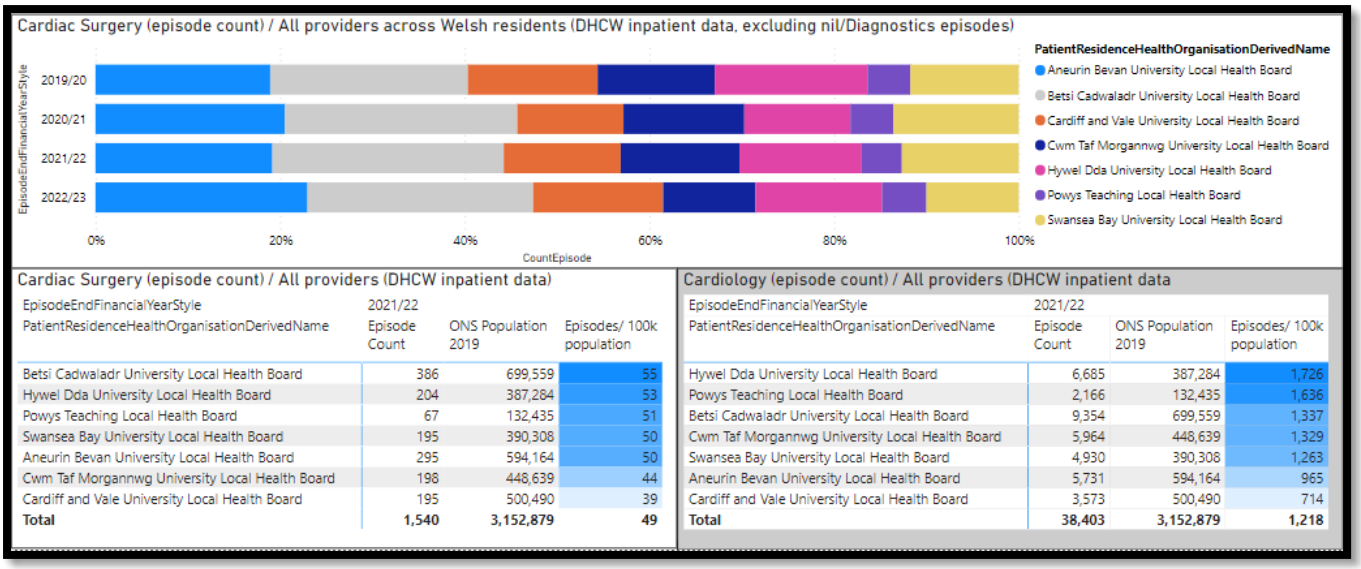
ProviderOrganisationName	CountEpisode for 2019/20 (all year)	CountEpisode for 2020/21 (all year)	CountEpisode for 2021/22 (all year)	CountEpisode 2021/22 % diff from 19/20	CountEpisode for 2019/20 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
Cardiff and Vale University Local Health Board	841	440	646	-23%	356	251	-29%
Swansea Bay University Local Health Board	754	371	610	-19%	299	256	-14%
Liverpool Heart And Chest Hospital nhs foundatio	470	304	471	0%	183	184	1%
University Hospitals Birmingham Nhs Foundation t	66	40	55	-17%	27	36	33%
University Hospitals Bristol And Weston nhs foun	60	31	47	-22%	19	15	-21%
University Hospitals Of North Midlands nhs trust	58	45	49	-16%	30	33	10%
Total	**2,249**	**1,231**	**1,878**	**-16%**	**914**	**775**	**-15%**

Data source: DHCW central data warehouse; **Note: inpatient activity includes the nil/diagnostics procedure episodes as there is currently significant missing procedure coding for Swansea (all months) and LHCH for Month 5**

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% less in 2021/22 (excludes non-procedure/diagnostics episodes). Using all activity to date this year (Month 5 of 2022/23), activity is still 15% 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 (Trans catheter Aortic Valve Implant) procedures for selected sub groups of patients, but numbers are not material.



Data source: DHCW central data warehouse; **Note: inpatient activity excl. non-procedure/diagnostic episodes**

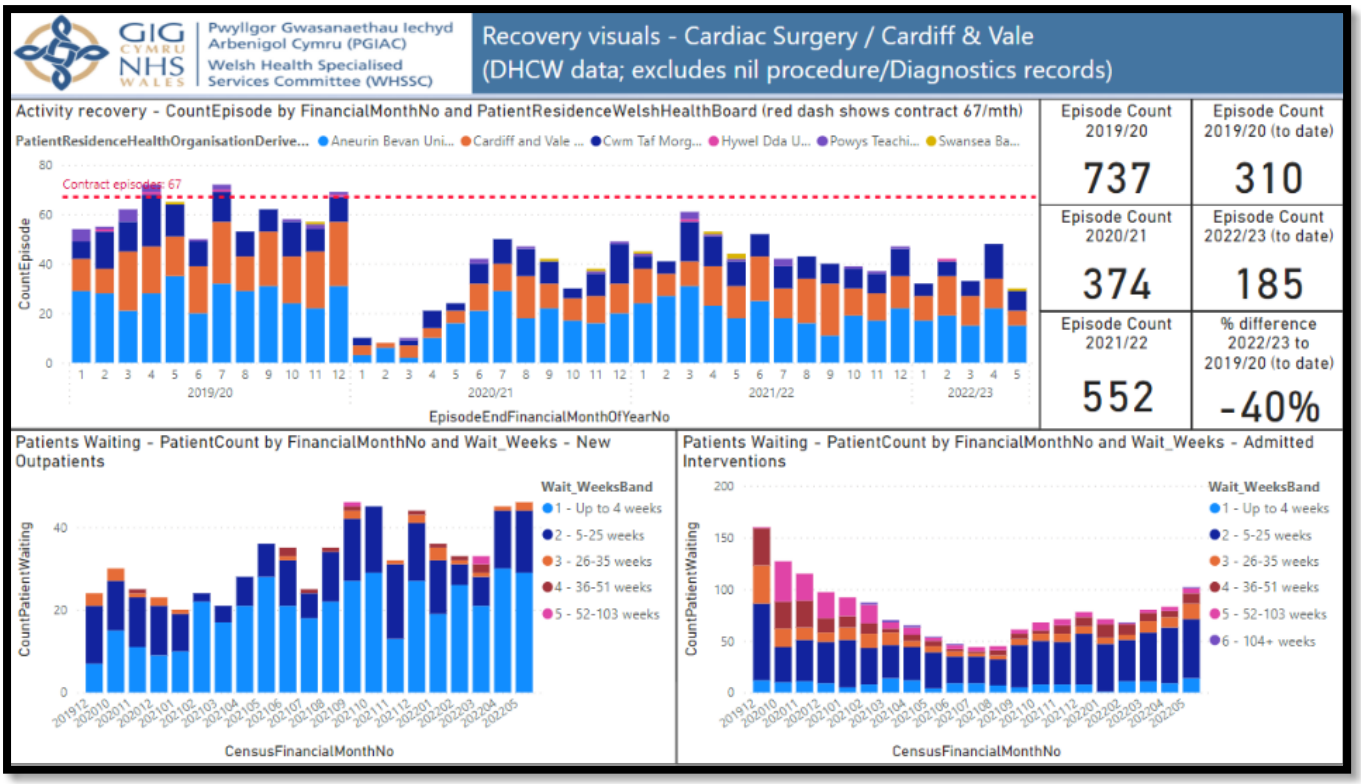
Access rates across the Health Boards varied the most during the initial COVID-19 wave, but have stabilised in recent months to almost the same split of the available activity as 2019/20. However, Betsi Cadwaladr is reflecting an increased share of the activity, due to the good recovery at Liverpool Heart & Chest.

Inpatient episodes per 100k population varies overall across the Health Board areas, from 39 to 55 in 2021/22 as per the small table above to the left. The 2022/23 figures will be inserted once the episode coding for Swansea Bay has been completed.

Interestingly, the access rates vary to those of Cardiology (mostly non-specialist), which is shown in the small table above to the right. This data is shown for information only as a related specialty, as this is not WHSSC-commissioned, except for some specific devices/interventions.

3.1.2 Cardiac Surgery – Recovery and Waiting Lists

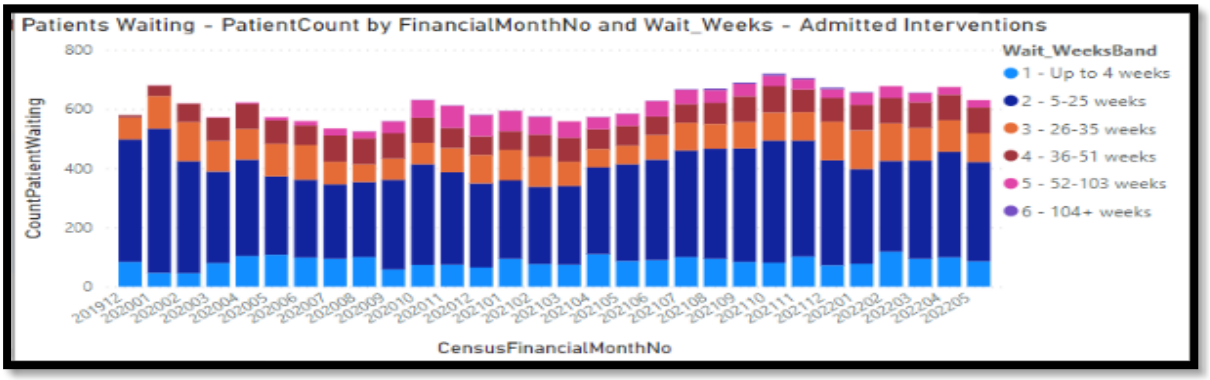
Cardiff & Vale UHB



Data source: DHCW central data warehouse; **Note: inpatient activity excl. non-procedure/diagnostic episodes**
Please use caution as there appears to be a significant amount of uncoded Cardiac activity in 2022/23, which should be updated later with procedure codes. Contract monitoring is showing about 10% more episodes than the DHCW extracts.

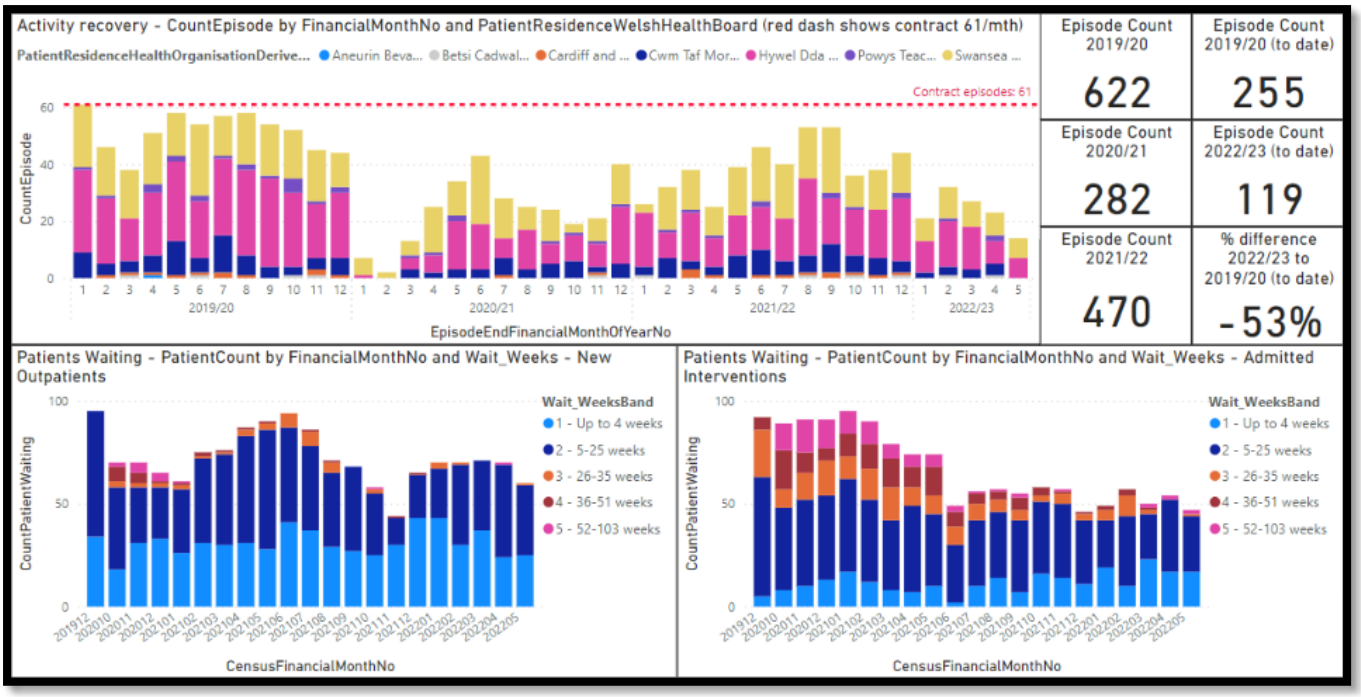
The tables above show a summary of the position at Cardiff & Vale in relation to Cardiac Surgery. Whilst the chart showing New Outpatients shows a small increase in new referrals (those between 0-4 weeks) again, elective activity had kept pace to the point that the waiting list for admissions had reduced to almost a third of pre-COVID-19 demand, with few patients now waiting over 26 weeks, although this waiting list has been growing slightly over the past few months.

It is worth noting that patients waiting for admissions for Cardiology treatments have increased marginally at Cardiff, in contrast to Cardiac Surgery.6



Data source: DHCW central data warehouse; all Cardiology patients waiting at Cardiff – admitted interventions (specialist and non-specialist).

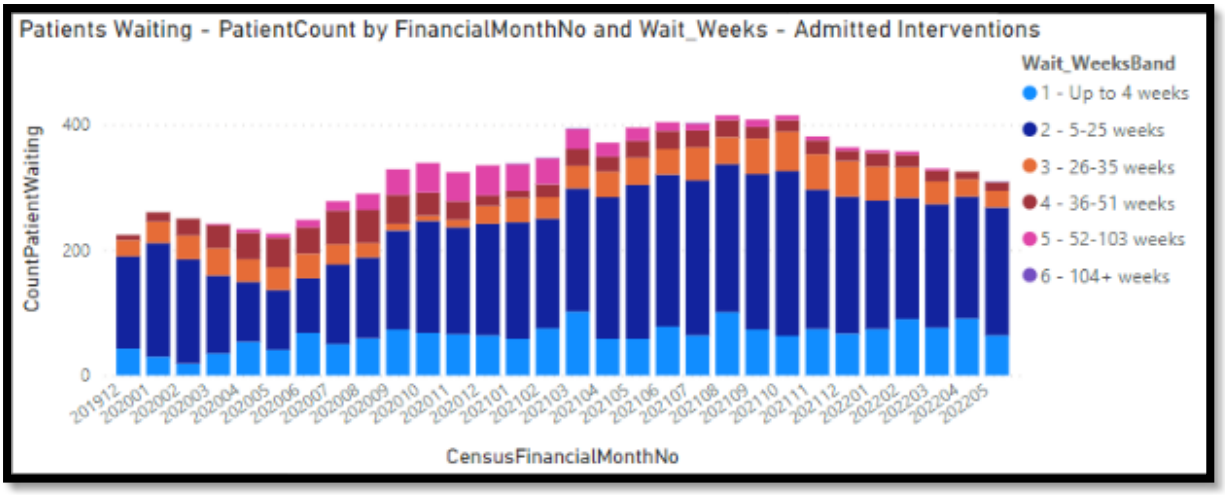
Swansea Bay UHB



Data source: DHCW central data warehouse; **Note: inpatient activity excl. non-procedure/diagnostic episodes**
Please use caution as there appears to be a large amount of uncoded Cardiac activity for all months at Swansea so far this financial year, which should later be updated. Contract monitoring is showing about 46% more episodes than the DHCW extracts (174 to M5), which would show a reduction of 32% compared to 2019/20

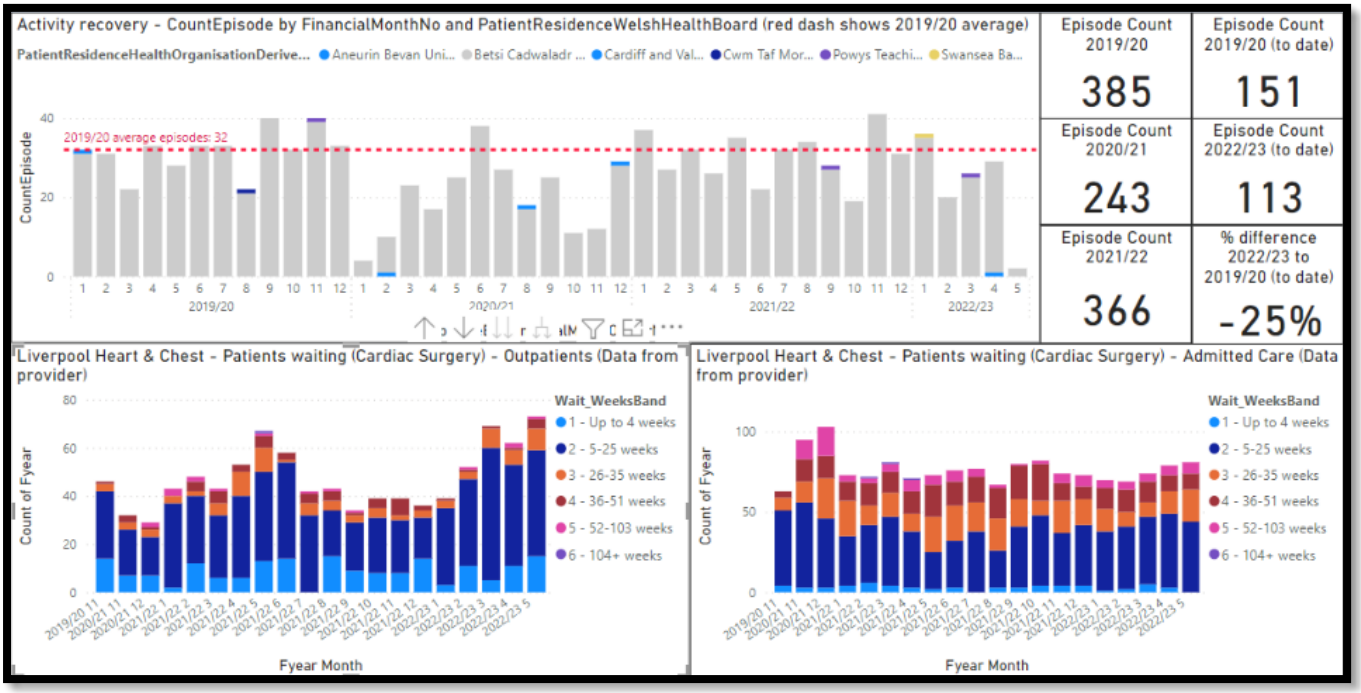
The tables above show a summary of the position at Swansea Bay in relation to Cardiac Surgery. Whilst the chart showing New Outpatients shows a growing increase in new referrals (those between 0-4 weeks) again to Pre-COVID-19 levels, elective activity has kept pace to the point that the waiting list for admissions has reduced to about half of Pre-COVID-19 demand, with 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



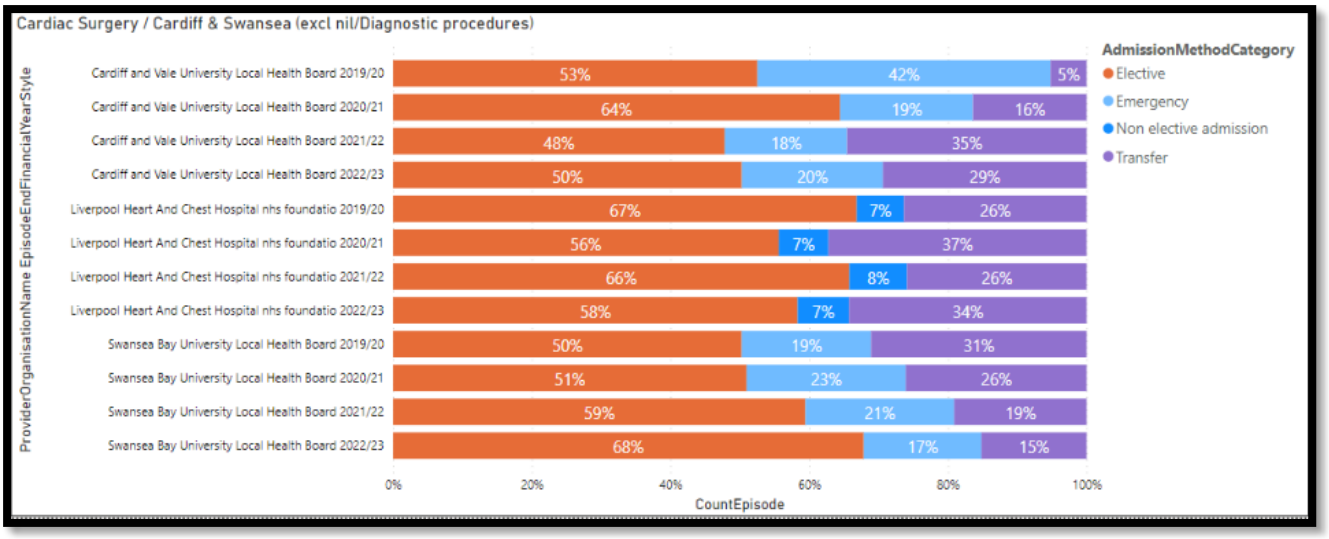
Data source: Inpatient activity from DHCW central data warehouse; **Note: inpatient activity excl. non-procedure/diagnostic episodes.** Please use caution as there appears to be a large amount of uncoded Cardiac activity for M5, which should later be updated. Waiting list data from provider direct.

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 almost 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.



Data source: DHCW central data warehouse; all inpatient activity excl. non-procedure/diagnostic episodes

Specialised Planner comments:

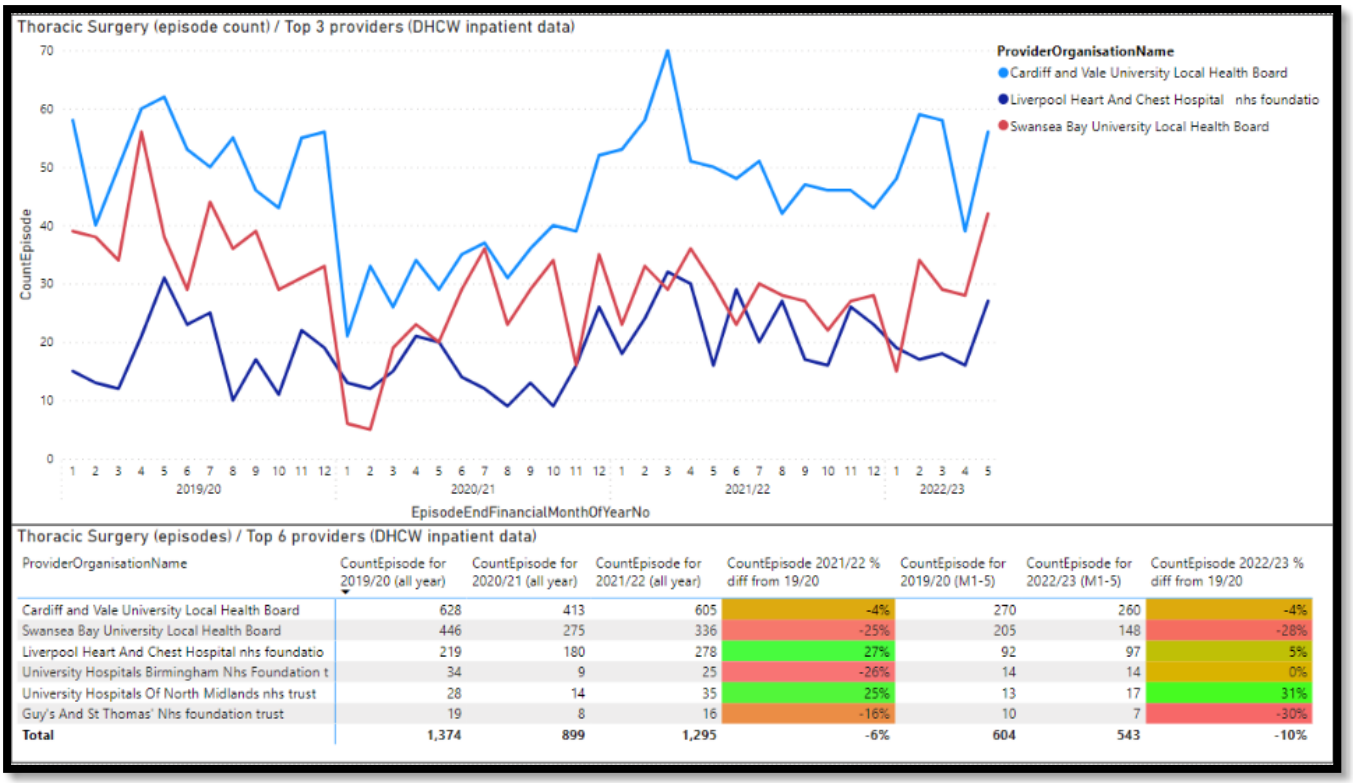
An increase in new outpatients in both Cardiff and Vale University Health Board and Liverpool Heart and Chest Hospital is evident; activity levels remain high and there has not yet been any significant growth in in-patient waiting lists. In Swansea Bay University Health Board, the number of patients waiting (admitted interventions) is continuing to trend gently downwards, with a notable decrease in the number of long waiters (52-103 weeks and 104+ weeks) evident over the course of the last 12-18 months.

Previous iterations of this report have noted 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. This risk remains to be realised, despite Health Boards working proactively to address their diagnostic backlogs. The report has previously highlighted the possibility that the anticipated increases may not be as significant as feared; this risk has been discussed by the Cardiac Commissioning Team, with the result that it has been deescalated and, should the mooted increases not manifest, it will be removed from the risk register.

The last version of this report highlighted the work planned 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. This has proceeded apace via the agreement of a number of actions for WHSSC colleagues, an update to Management Group, and a planned meeting with health boards (estimated end September).

3.2 Thoracic Surgery

3.2.1 Thoracic Surgery – Activity and Access Rate Summary



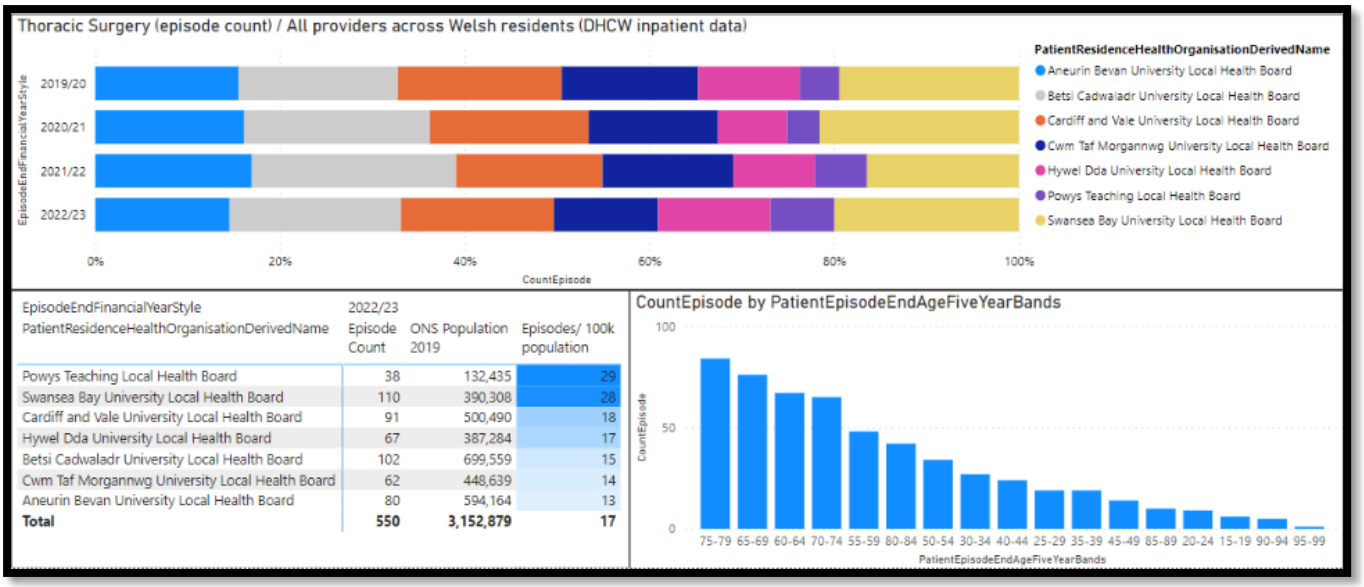
Thoracic Surgery (episodes) / Top 6 providers (DHCW inpatient data)

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 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
Cardiff and Vale University Local Health Board	628	413	605	-4%	270	260	-4%
Swansea Bay University Local Health Board	446	275	336	-25%	205	148	-28%
Liverpool Heart And Chest Hospital nhs foundatio	219	180	278	27%	92	97	5%
University Hospitals Birmingham Nhs Foundation t	34	9	25	-26%	14	14	0%
University Hospitals Of North Midlands nhs trust	28	14	35	25%	13	17	31%
Guy's And St Thomas' Nhs foundation trust	19	8	16	-16%	10	7	-30%
Total	**1,374**	**899**	**1,295**	**-6%**	**604**	**543**	**-10%**

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 5% higher so far this year (2022/23). Cardiff & Vale is showing similar activity to 2019/20 to the same month this year. However, Swansea Bay is showing a 28% 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 5), activity is 10% less than 2019/20.



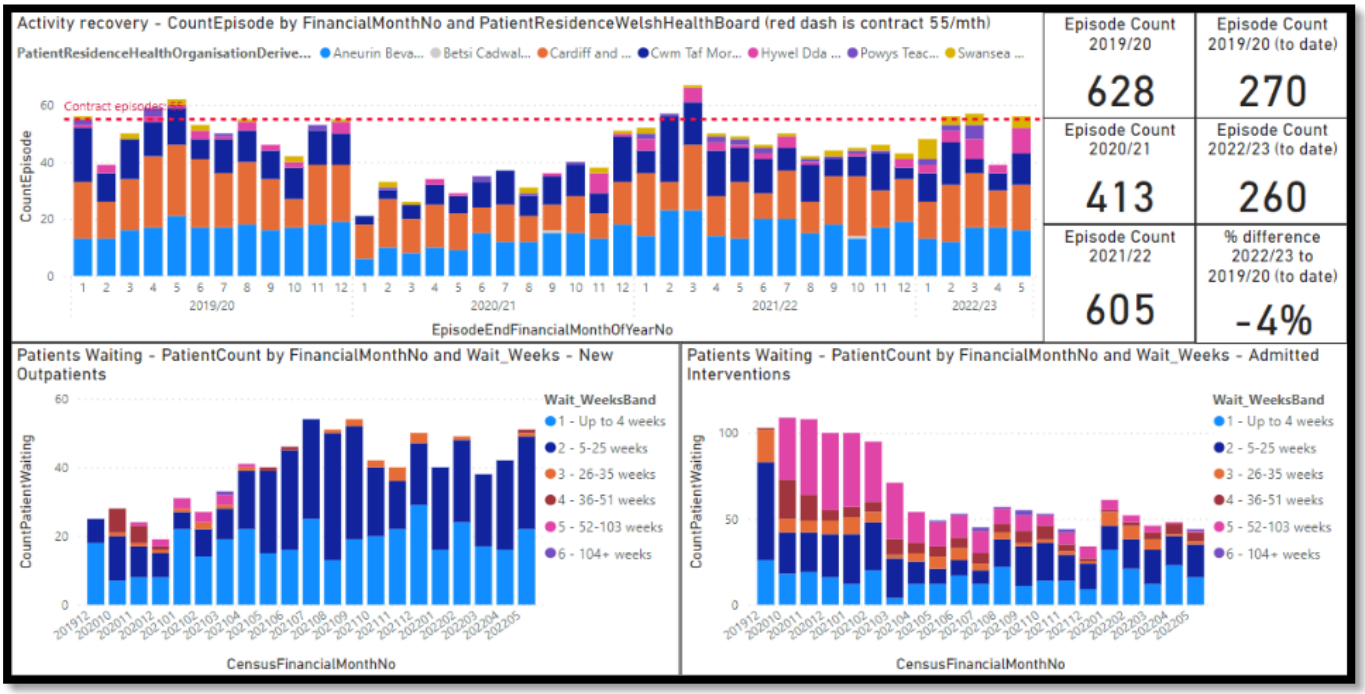
Data source: DHCW central data warehouse; all inpatient activity

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 73/month), but should still be monitored.

Inpatient episodes per 100k population varies significantly overall across the Health Board areas, from 13 to 29 as per the small table above for 2022/23.

3.2. Thoracic Surgery – Recovery and Waiting Lists

Cardiff and Vale UHB

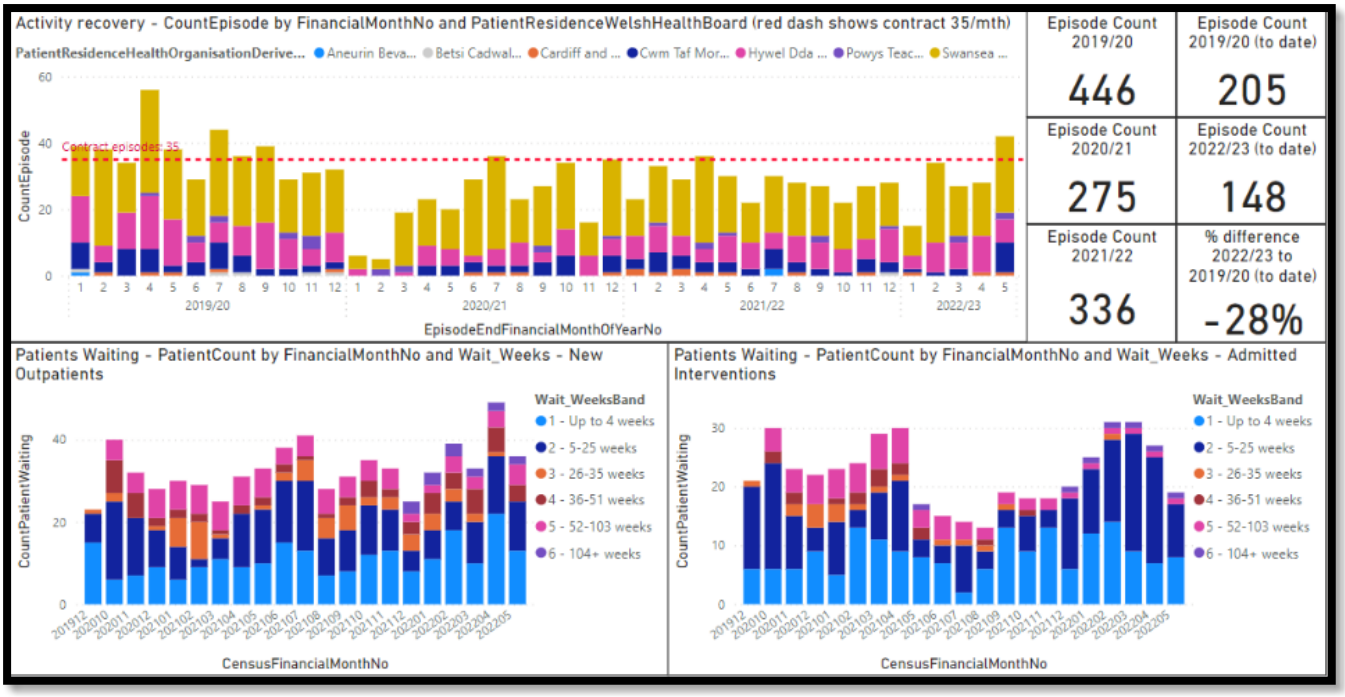


Data source: DHCW central data warehouse; all patients waiting with an open pathway

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 growing increase in 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 have 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.

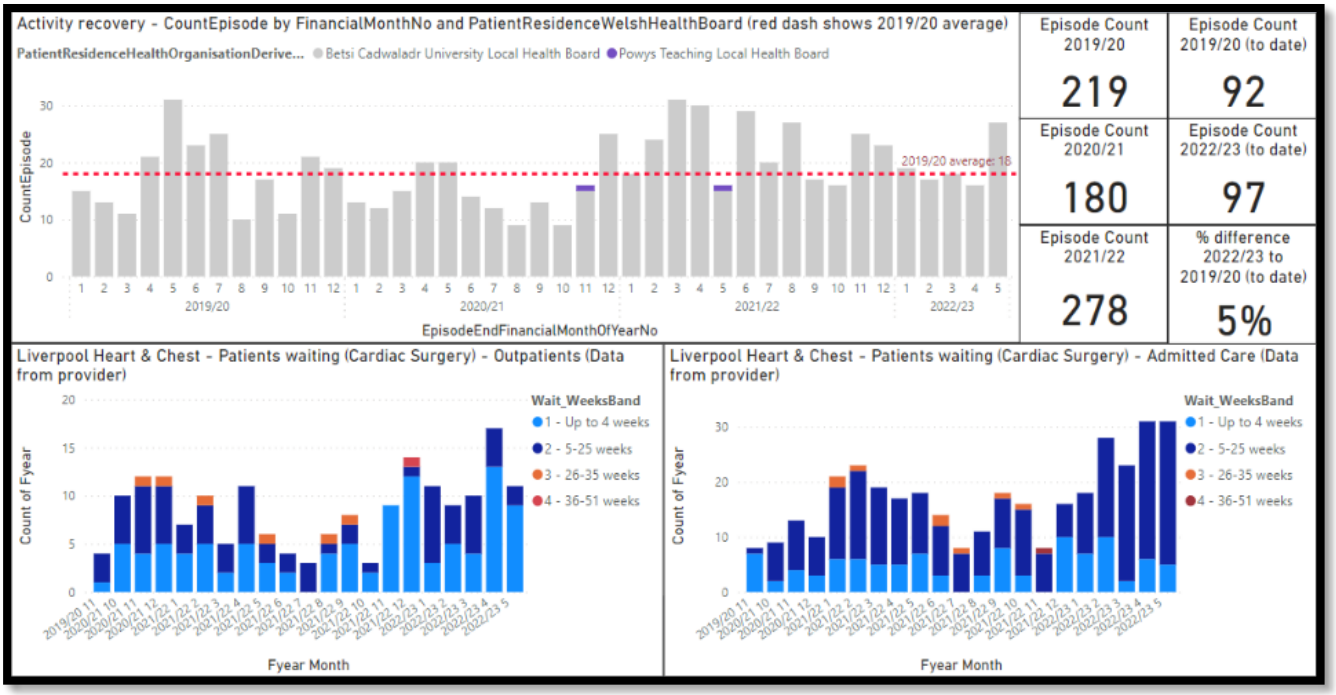
Swansea Bay UHB



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 5% this year compared to 2019/20. Despite this, the patients waiting for admission have increased from pre-Covid levels, although these are not material numbers and are easily skewed month-on-month.

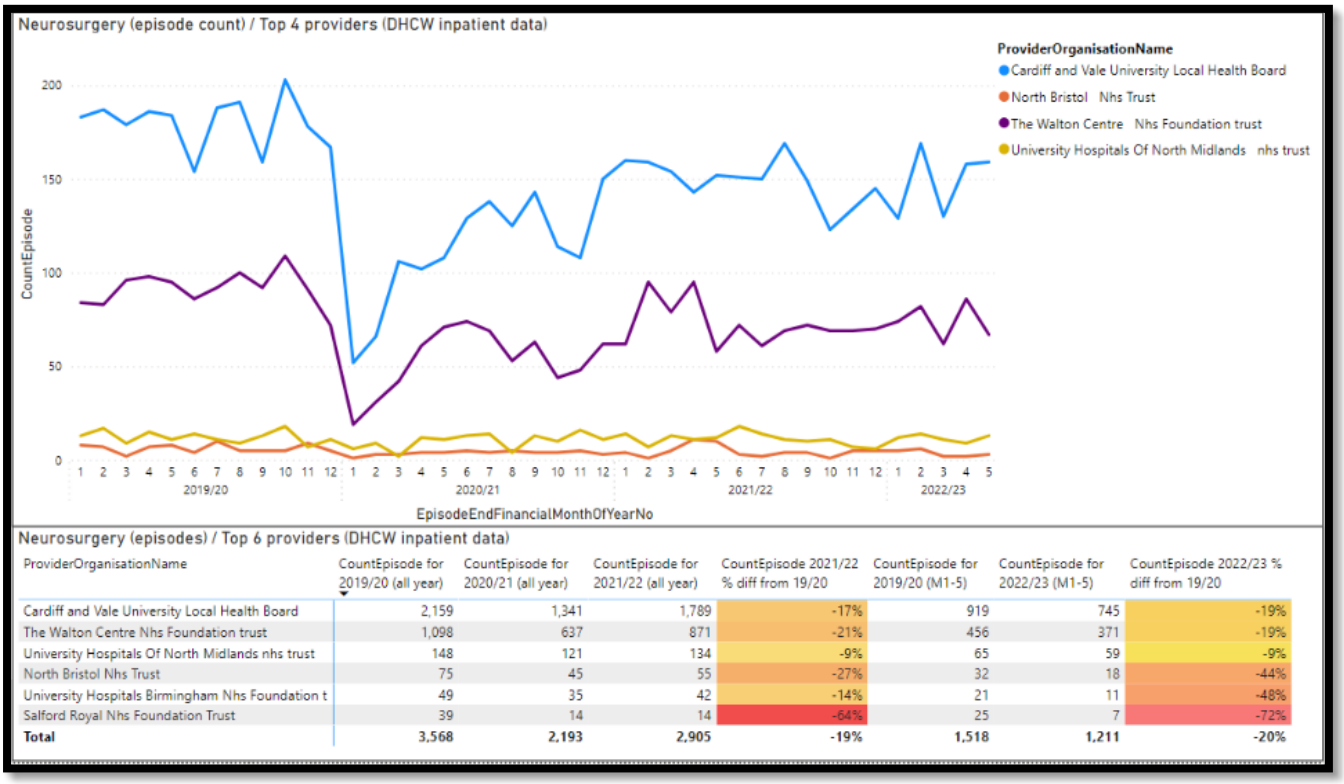
Specialised Planner comments:

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



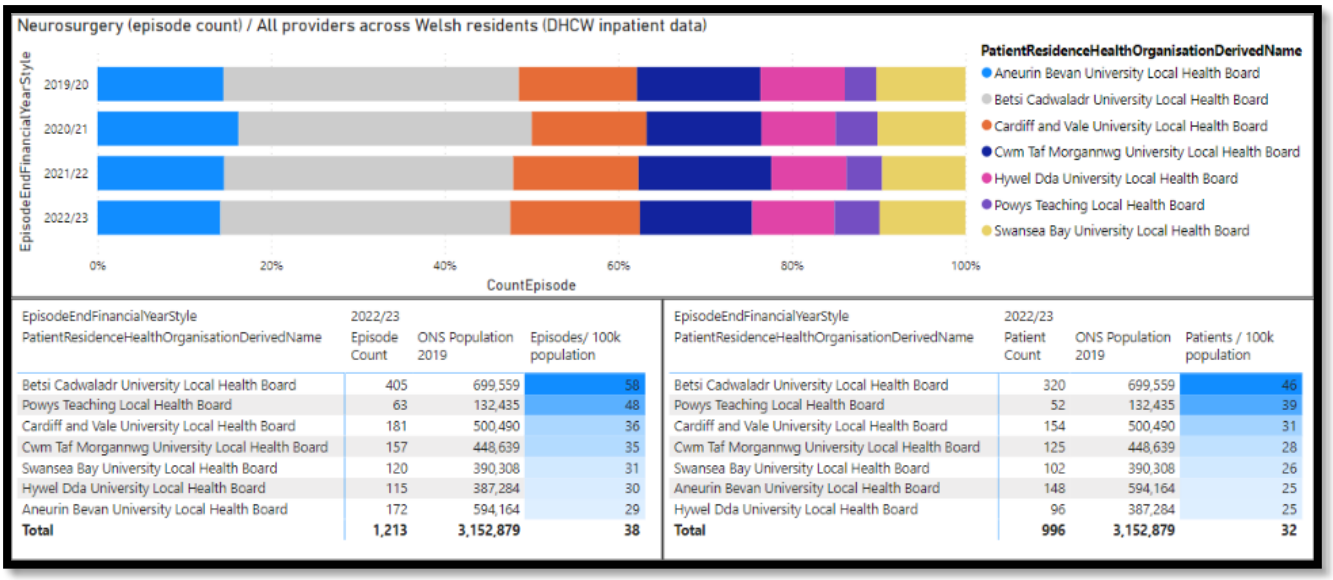
Neurosurgery (episodes) / Top 6 providers (DHCW inpatient data)

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 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
Cardiff and Vale University Local Health Board	2,159	1,341	1,789	-17%	919	745	-19%
The Walton Centre Nhs Foundation trust	1,098	637	871	-21%	456	371	-19%
University Hospitals Of North Midlands nhs trust	148	121	134	-9%	65	59	-9%
North Bristol Nhs Trust	75	45	55	-27%	32	18	-44%
University Hospitals Birmingham Nhs Foundation t	49	35	42	-14%	21	11	-48%
Salford Royal Nhs Foundation Trust	39	14	14	-64%	25	7	-72%
Total	**3,568**	**2,193**	**2,905**	**-19%**	**1,518**	**1,211**	**-20%**

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 19% and 19% 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 20% less so far in 2022/23.

Please note the UH North Midlands activity above primarily relates to North Wales residents, which is paid for through a local contract and not WHSSC.



EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2022/23 Episode Count	ONS Population 2019	Episodes/ 100k population
Betsi Cadwaladr University Local Health Board	405	699,559	58
Powys Teaching Local Health Board	63	132,435	48
Cardiff and Vale University Local Health Board	181	500,490	36
Cwm Taf Morgannwg University Local Health Board	157	448,639	35
Swansea Bay University Local Health Board	120	390,308	31
Hywel Dda University Local Health Board	115	387,284	30
Aneurin Bevan University Local Health Board	172	594,164	29
Total	**1,213**	**3,152,879**	**38**

EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2022/23 Patient Count	ONS Population 2019	Patients / 100k population
Betsi Cadwaladr University Local Health Board	320	699,559	46
Powys Teaching Local Health Board	52	132,435	39
Cardiff and Vale University Local Health Board	154	500,490	31
Cwm Taf Morgannwg University Local Health Board	125	448,639	28
Swansea Bay University Local Health Board	102	390,308	26
Aneurin Bevan University Local Health Board	148	594,164	25
Hywel Dda University Local Health Board	96	387,284	25
Total	**996**	**3,152,879**	**32**

Data source: DHCW central data warehouse; all inpatient activity

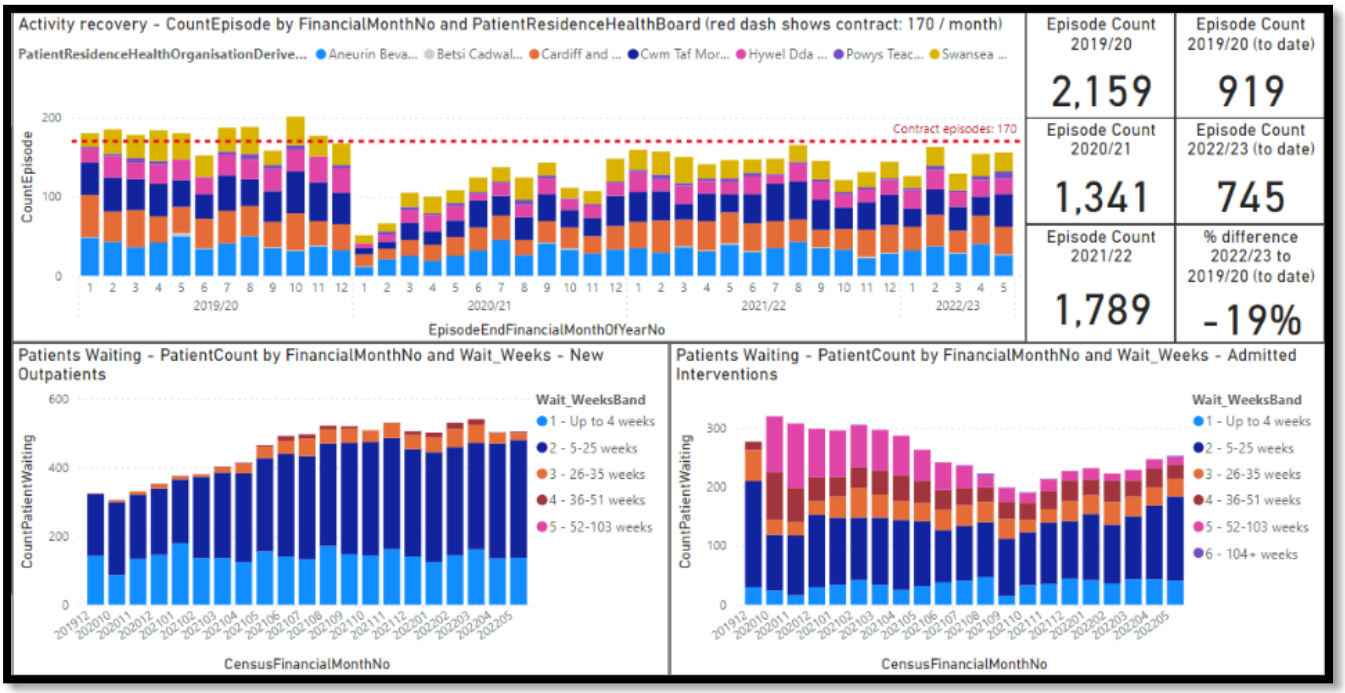
Access rates across the Health Boards have not varied much across the past four years, as shown in the charts above. Inpatient episodes per 100k population in 2022/23 so far vary from 29 to 58 across Health Boards in the bottom left chart, with North Wales having the highest access.

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

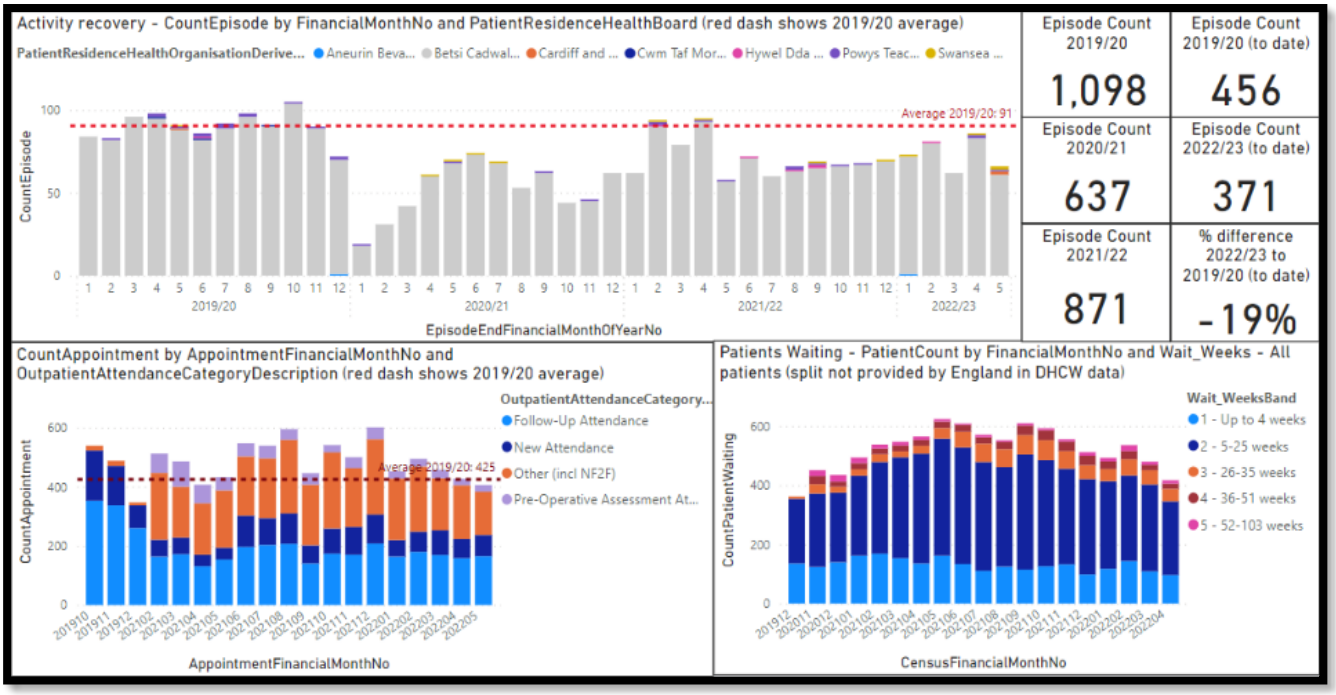
Cardiff & Vale UHB



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 growing. While admitted activity increased from the initial reduction, it has 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 19% 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 will hopefully continue.

One point to note is the bottom left chart, which shows the movement across types of Outpatient appointment since March 2020. New attendances in person are starting to increase again, and it is notable 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 at the end of July 2022 at the regular Performance meeting.

The Cardiff service advised that the service had undergone significant changes during and subsequent to the Covid pandemic, including:

- Service had delivered only emergency procedures during the acute phase of pandemic, noting initially poor outcomes for patients who contracted Covid following their procedures
- Daily 08:00 handover meetings had been scaled back in size (to c.10); service has aspiration to restore them to their pre-Covid form

- Cardiac surgery service had been aligned to the Protected Elective Surgery (PESU) model, comprising green and amber pathways and necessitating a massive change to longstanding working practices
- Moved to prioritising patients with RCS codes and took a more flexible approach to the management of lists
- Launched a pre-elective clerking model ('one stop shop')
- Utilised Teams to improve attendance at MDTs
- Widespread use of Attend Anywhere, including for wound reviews and low grade glioma clinic, with the result that benefiting patients were able to avoid long journeys
- Neuro oncology service received Tessa Jowell Award, in part the result of investment from WHSSC, and due to the approach taken by surgeons to the treatment of neuro oncology
- Pain relief clinics for SBUHB resident patients now delivered in Swansea Bay by CVUHB staff.

It was also confirmed that the service would be moving away from streamed theatre capacity in July 2022, with no limitations on equipment (including microscopes), and that it would be returning to its dedicated neurosurgery theatres (T12 and T14) in September 2022. In the short-term, the provision of two additional theatre lists will be secured as a result of extended days, something which had been common practice pre-Covid and which had contributed to the reduction in waiting lists.

Elective Inpatients – although a dip in December is anticipated (arising from different operation of theatres), service is forecasting that it will meet commissioned levels of elective activity by year end; forecasting that this will result in a gradual reduction in the inpatient waiting list and that, by March, there will be no patients waiting over 52 weeks.

DSAs stopped at the beginning of the pandemic, resulting in a significant increase in waits; from July (weekend of 30/31), Interventional Radiologists will be running a weekend list to significant reduce waiting lists.

The Walton

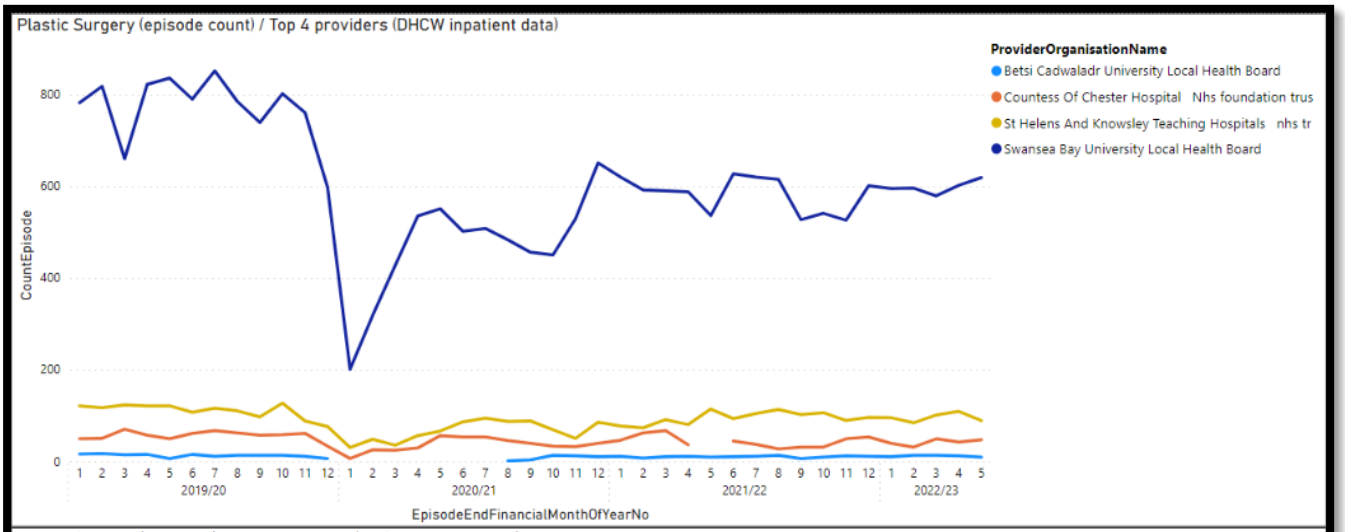
In a recent contract meeting, the Walton Centre have confirmed that Spinal patients will be cleared by the summer 2022. The 52-week wait patients are on track to be cleared by the end of this calendar year – December 2022.

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 later in 2022.

3.4 Plastic Surgery (excl. Burns)

3.4.1 Plastic Surgery (excl. Burns) – Activity and Access Rate Summary



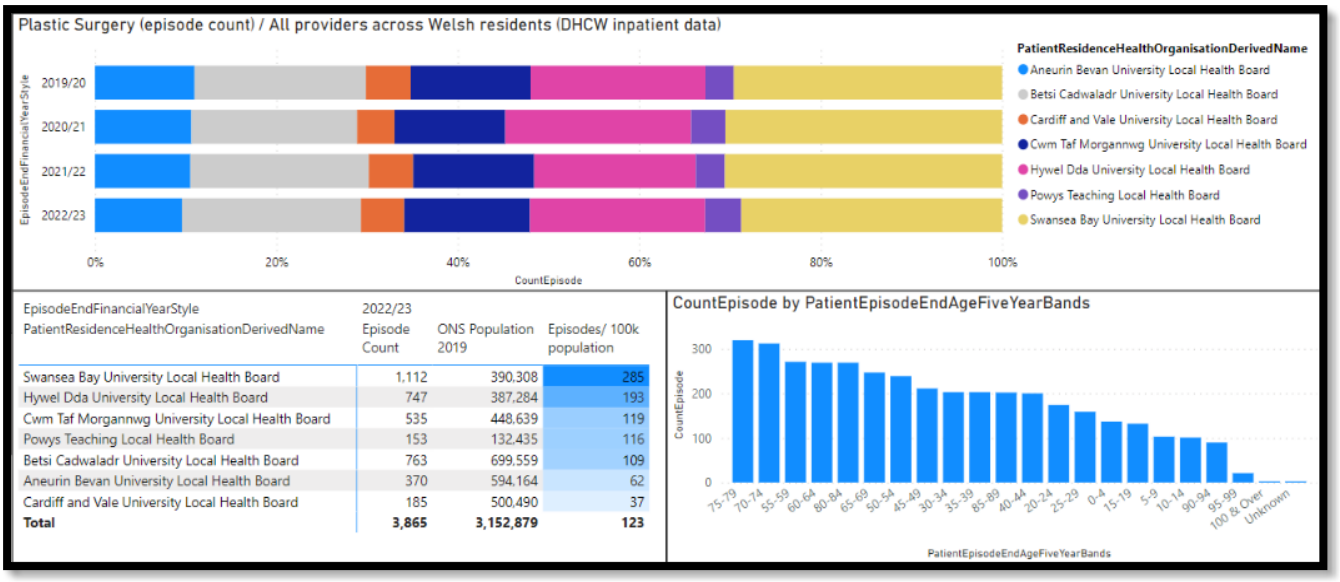
Plastic Surgery (episodes) / Top 6 providers (DHCW inpatient data)

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 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
Swansea Bay University Local Health Board	9,245	5,611	6,983	-24%	3,918	2,991	-24%
St Helens And Knowsley Teaching Hospitals nhs tr	1,324	794	1,138	-14%	603	478	-21%
Countess Of Chester Hospital Nhs foundation trus	674	434	483	-28%	275	208	-24%
Betsi Cadwaladr University Local Health Board	150	39	120	-20%	68	57	-16%
Wye Valley Nhs Trust	52	81	87	67%	26	51	96%
North Bristol Nhs Trust	42	45	31	-26%	25	25	0%
Total	**11,487**	**7,004**	**8,842**	**-23%**	**4,915**	**3,810**	**-22%**

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 22% 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.



EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2022/23 Episode Count	ONS Population 2019	Episodes/ 100k population
Swansea Bay University Local Health Board	1,112	390,308	285
Hywel Dda University Local Health Board	747	387,284	193
Cwm Taf Morgannwg University Local Health Board	535	448,639	119
Powys Teaching Local Health Board	153	132,435	116
Betsi Cadwaladr University Local Health Board	763	699,559	109
Aneurin Bevan University Local Health Board	370	594,164	62
Cardiff and Vale University Local Health Board	185	500,490	37
Total	**3,865**	**3,152,879**	**123**

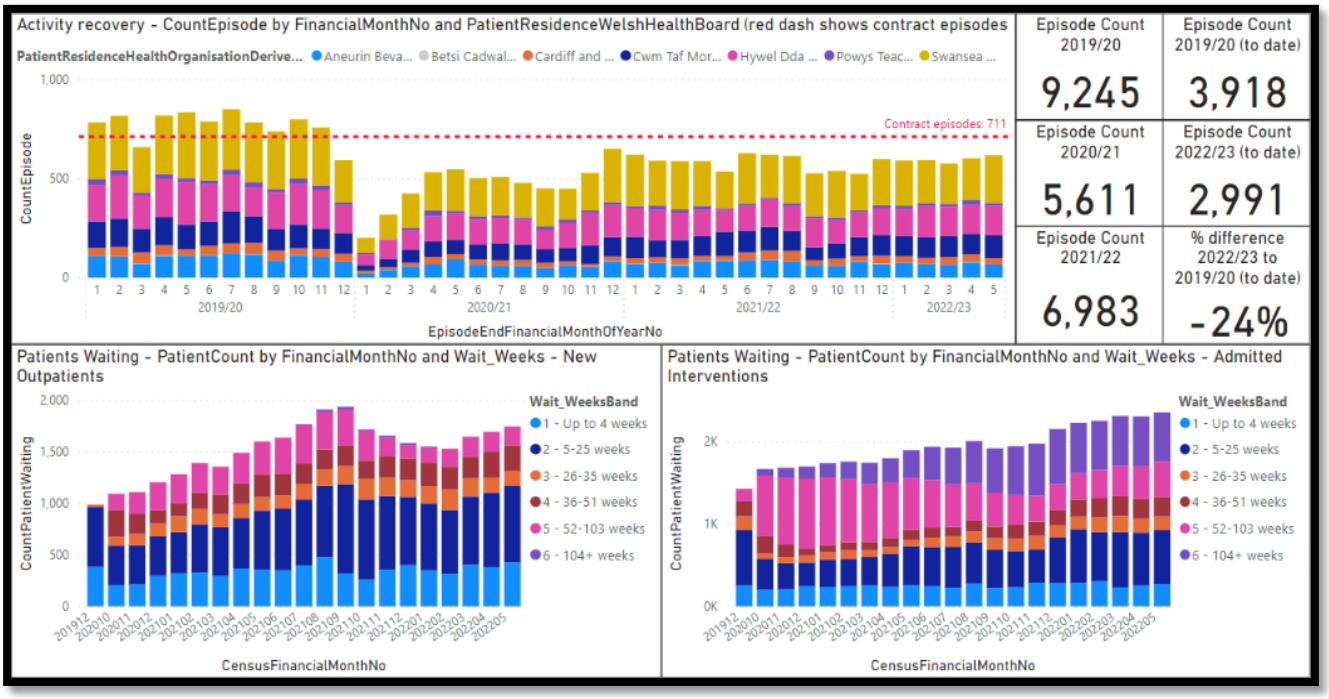
Data source: DHCW central data warehouse; all inpatient activity

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 37 to 285 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, and is being discussed internally, with a wider workshop with Management Group members held in September. Non-specialist activity for other Health Boards is reported under non-WHSSC areas/specialties.

3.4.2 Plastic Surgery (excl. Burns) – Recovery and Waiting lists

Swansea Bay UHB

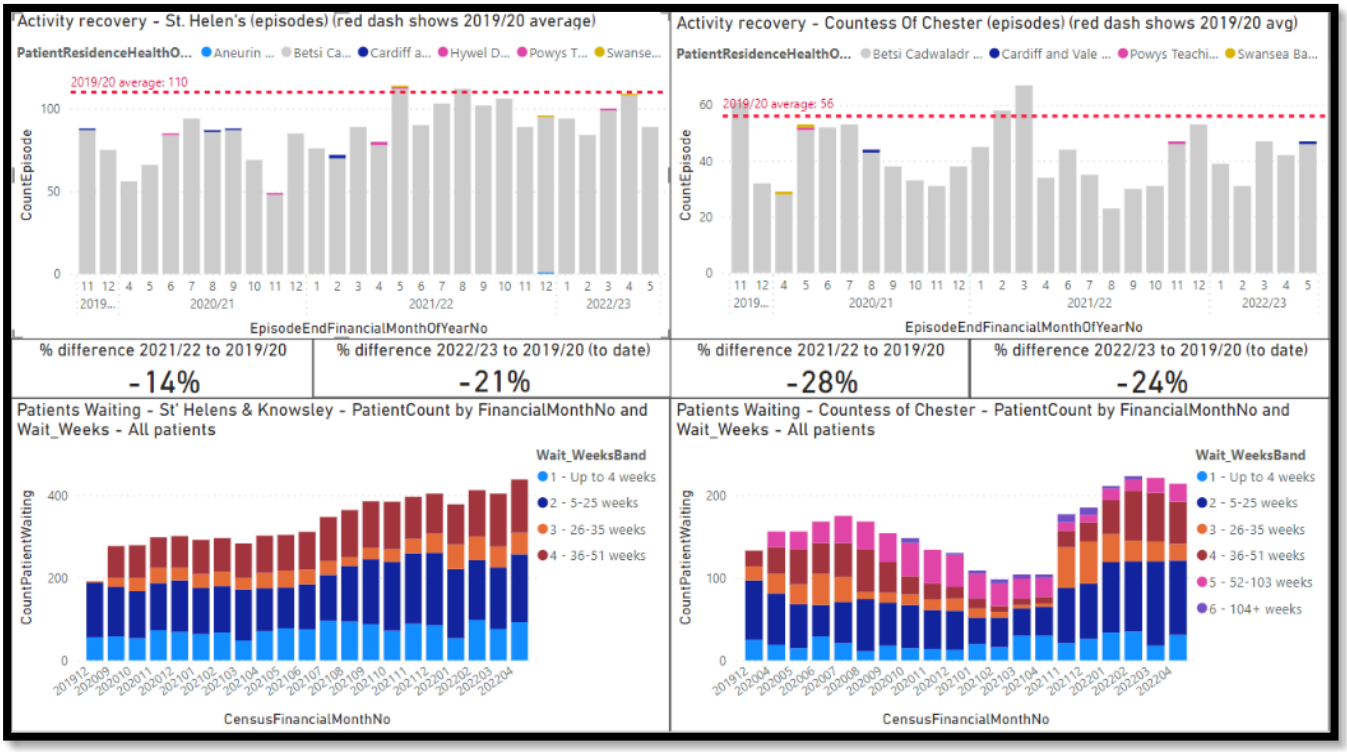


Data source: DHCW central data warehouse; all patients waiting with an open pathway

The tables above show a summary of the position at Swansea Bay in relation to Plastic Surgery. Whilst activity is now 24% 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. However, it is concerning that those waiting for admissions have increased by around 35% and the total is still steadily rising; currently 595 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



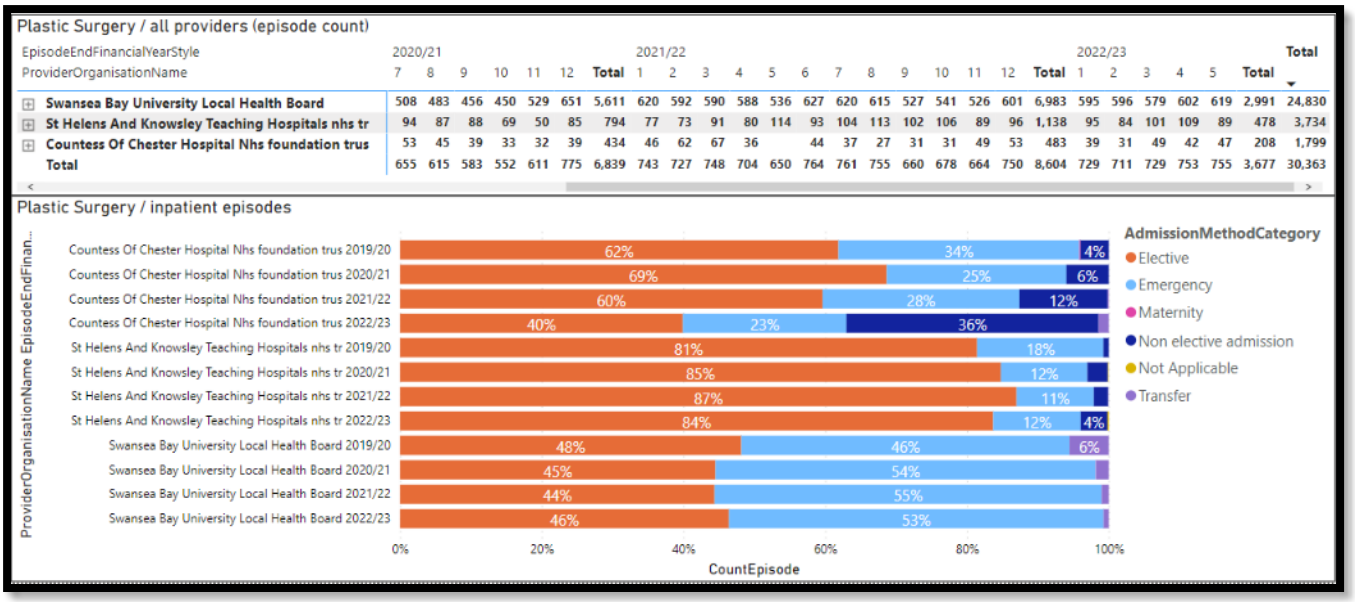
Data source: DHCW central data warehouse; all patients waiting with an open pathway

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 3 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.



Data source: DHCW central data warehouse; all inpatient activity

Specialised Planner comments:

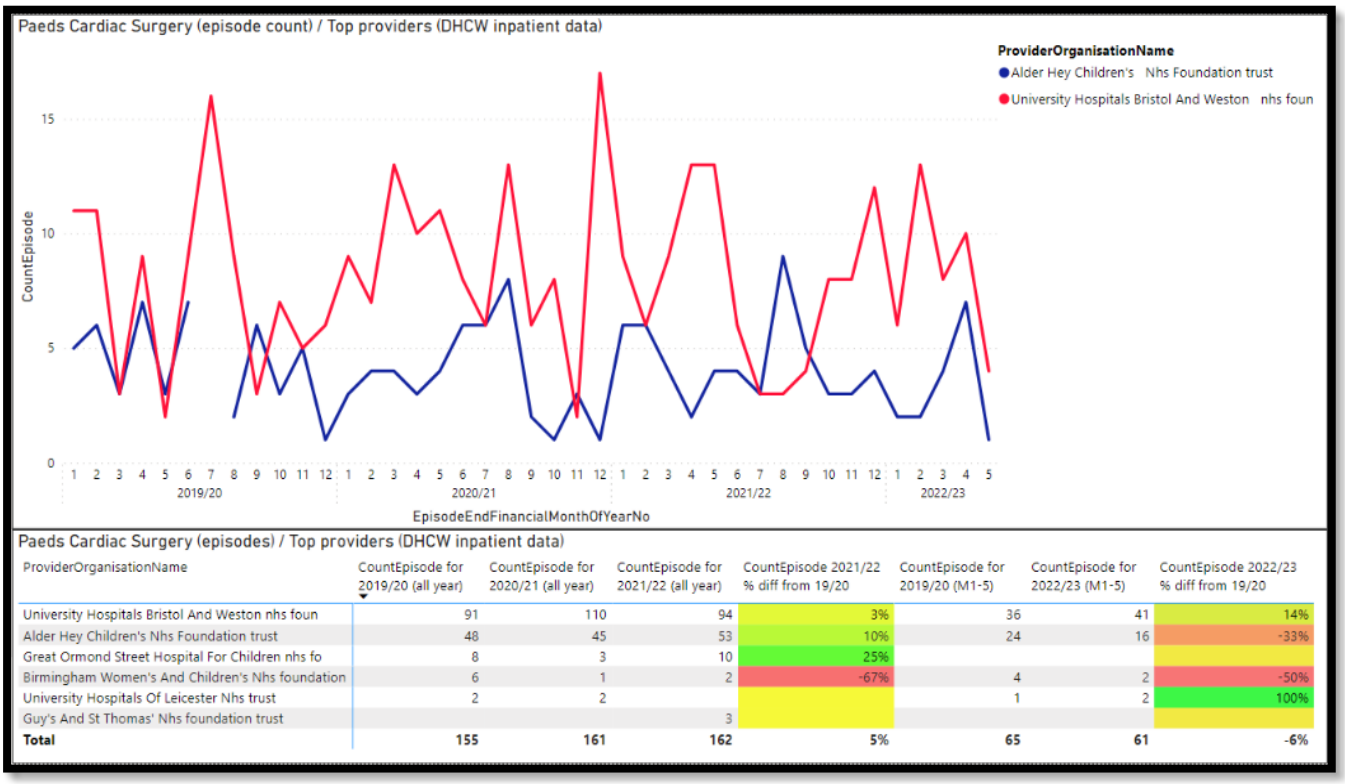
As noted in the comments above, variation across heath boards in utilisation of plastic surgery does not necessarily reflect variation in access to appropriate treatment, since many procedures (the majority of activity) provided by plastic surgery are also provided by other specialties. Whether a particular 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 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
University Hospitals Bristol And Weston nhs foun	91	110	94	3%	36	41	14%
Alder Hey Children's Nhs Foundation trust	48	45	53	10%	24	16	-33%
Great Ormond Street Hospital For Children nhs fo	8	3	10	25%			
Birmingham Women's And Children's Nhs foundation	6	1	2	-67%	4	2	-50%
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%**	**65**	**61**	**-6%**

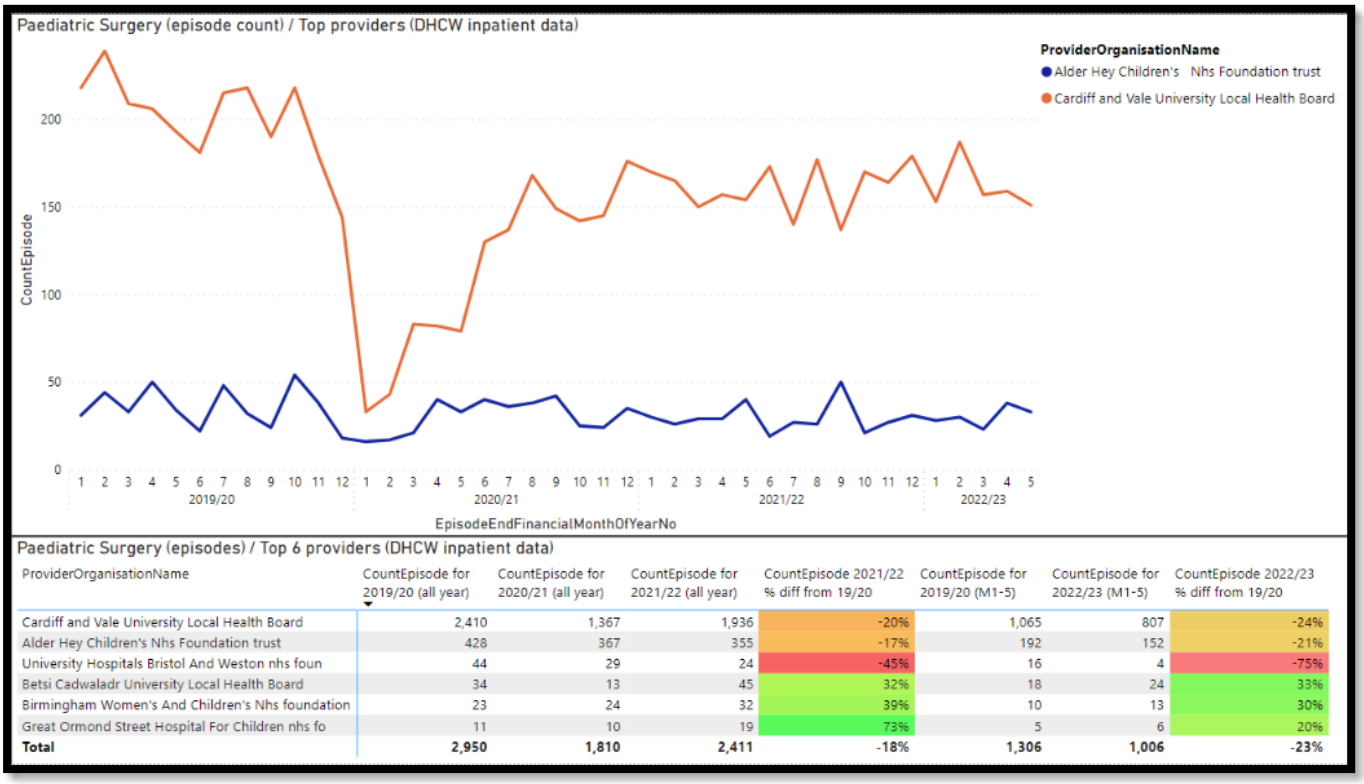
Data source: DHCW central data warehouse; all inpatient activity

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)

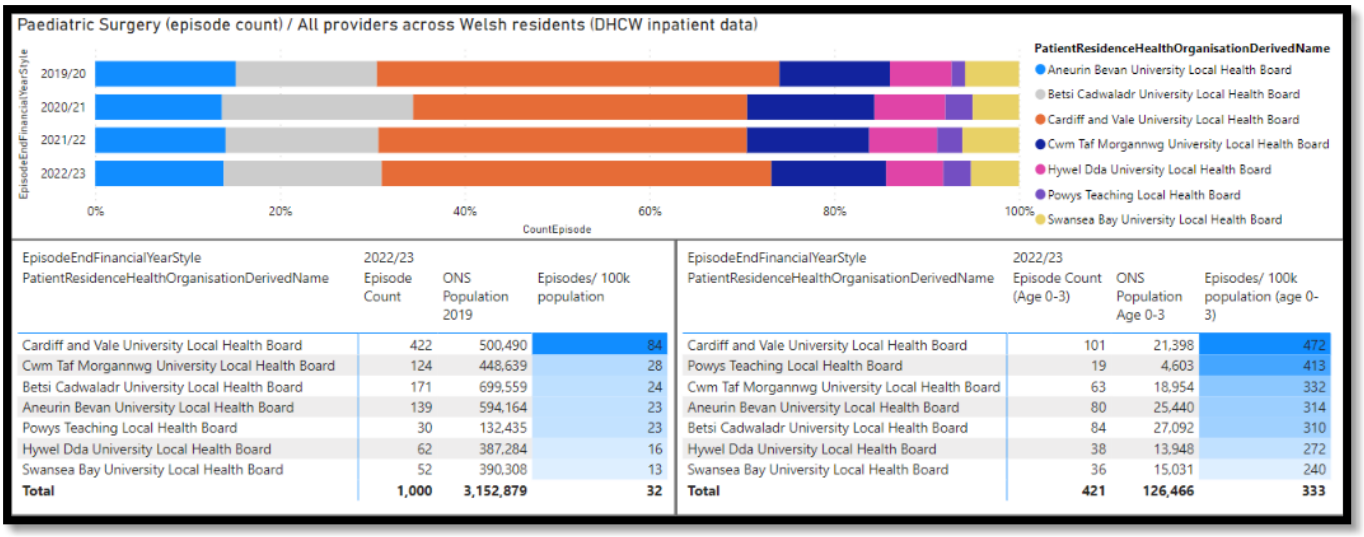
ProviderOrganisationName	CountEpisode for 2019/20 (all year)	CountEpisode for 2020/21 (all year)	CountEpisode for 2021/22 (all year)	CountEpisode 2021/22 % diff from 19/20	CountEpisode for 2019/20 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
Cardiff and Vale University Local Health Board	2,410	1,367	1,936	-20%	1,065	807	-24%
Alder Hey Children's Nhs Foundation trust	428	367	355	-17%	192	152	-21%
University Hospitals Bristol And Weston nhs foun	44	29	24	-45%	16	4	-75%
Betsi Cadwaladr University Local Health Board	34	13	45	32%	18	24	33%
Birmingham Women's And Children's Nhs foundation	23	24	32	39%	10	13	30%
Great Ormond Street Hospital For Children nhs fo	11	10	19	73%	5	6	20%
Total	**2,950**	**1,810**	**2,411**	**-18%**	**1,306**	**1,006**	**-23%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Paediatric Surgery inpatient recovery across the main specialist providers, with Alder Hey initially showing the highest and quicker recovery, although the main providers (Alder Hey and Cardiff) are now both around the same percentage decrease. 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 23% less than 2019/20, with the 2 main providers being roughly the same.



EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2022/23 Episode Count	ONS Population 2019	Episodes/ 100k population
Cardiff and Vale University Local Health Board	422	500,490	84
Cwm Taf Morgannwg University Local Health Board	124	448,639	28
Betsi Cadwaladr University Local Health Board	171	699,559	24
Aneurin Bevan University Local Health Board	139	594,164	23
Powys Teaching Local Health Board	30	132,435	23
Hywel Dda University Local Health Board	62	387,284	16
Swansea Bay University Local Health Board	52	390,308	13
Total	**1,000**	**3,152,879**	**32**

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	101	21,398	472
Powys Teaching Local Health Board	19	4,603	413
Cwm Taf Morgannwg University Local Health Board	63	18,954	332
Aneurin Bevan University Local Health Board	80	25,440	314
Betsi Cadwaladr University Local Health Board	84	27,092	310
Hywel Dda University Local Health Board	38	13,948	272
Swansea Bay University Local Health Board	36	15,031	240
Total	**421**	**126,466**	**333**

Data source: DHCW central data warehouse; all inpatient activity

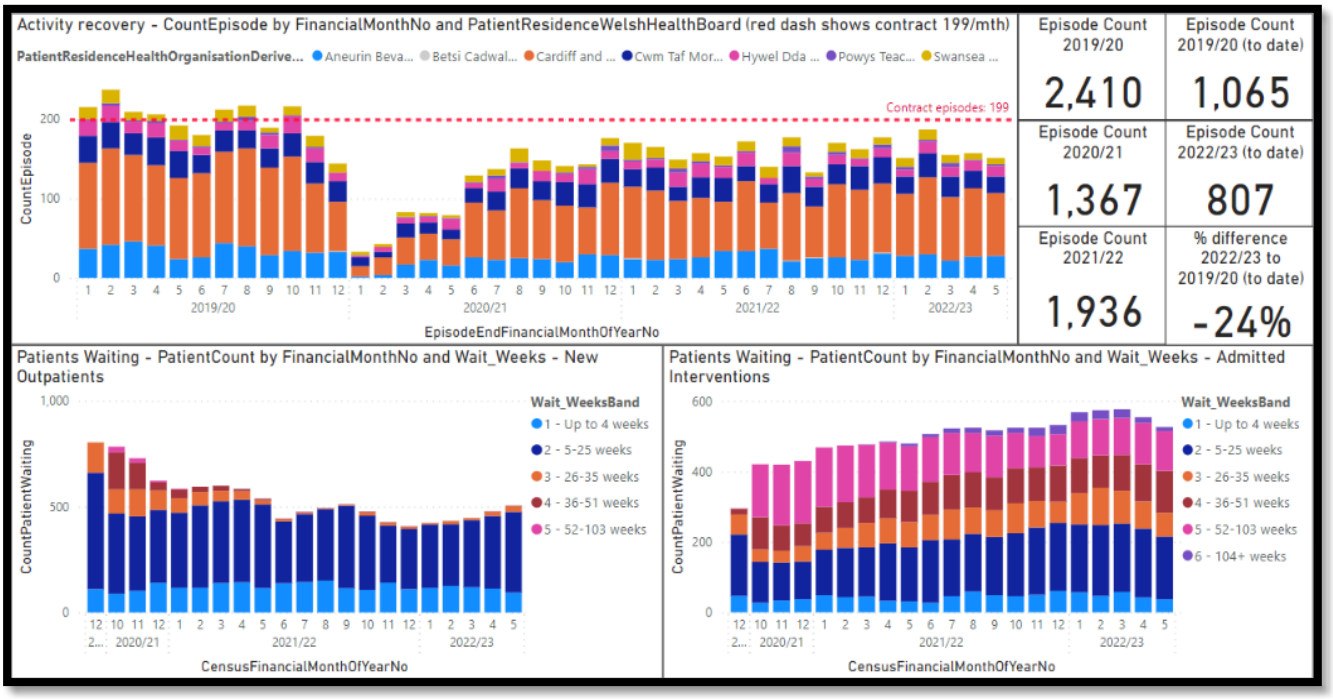
Access rates across the Health Boards varied as the pandemic initially hit, but have now stabilised to roughly the same split as before the pandemic.

However, inpatient episodes per 100k population varies significantly overall across the Health Board areas, from 13 to 84 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

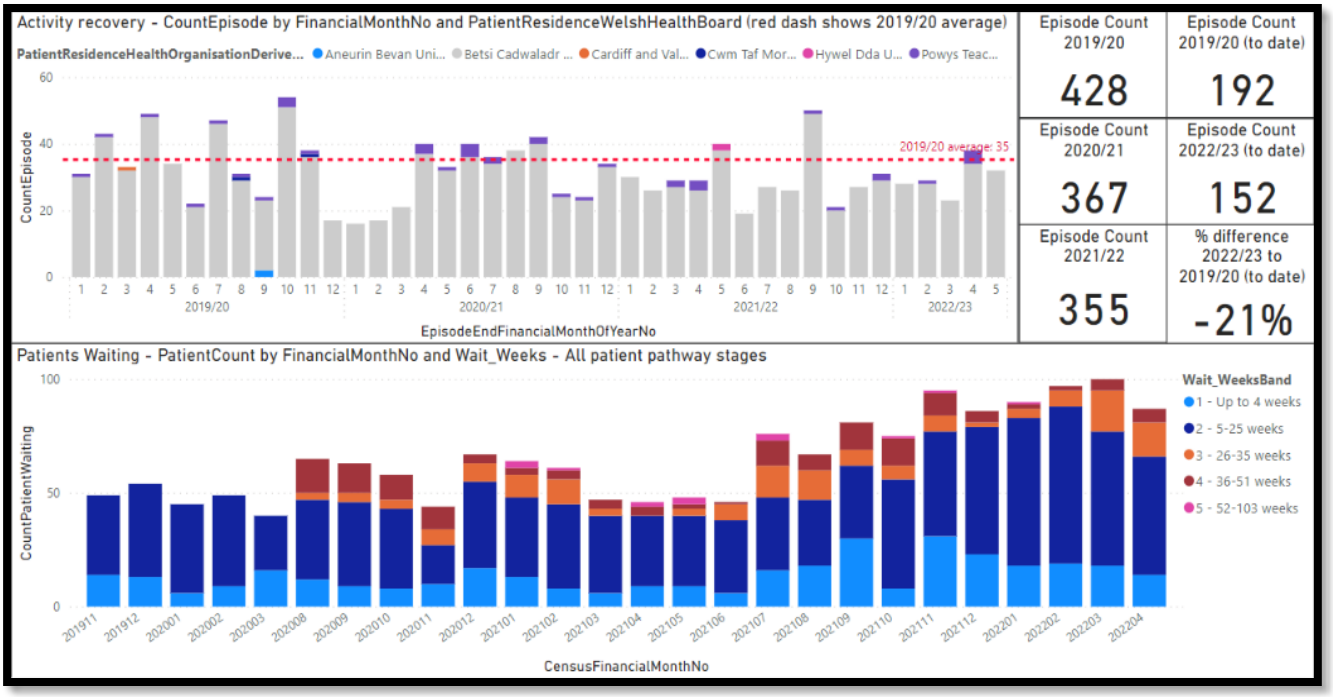


Data source: DHCW central data warehouse; all patients waiting with an open pathway

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 21% lower than last year (14% less in 2020/21 compared to 2019/20 in total, and 17% less to date in 2021/22 compared to 2019/20), but the low numbers are easily skewed with only five months data at this point. 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 are reporting a significant number of patients waiting over 52 weeks. It was noted there are currently 22 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 plan in place to utilise the support of Anaesthetists from SBUHB to increase capacity.

The HB confirmed that the clinical teams were reviewing patient notes and in some instances face to face reviews were taking place. It is only with a face to

face appointment would a clinic letter be communicated with local paediatricians and GP's.

3.7 NHS England Providers – Organisations with WHSSC Contracts

The key summaries and analysis relating to English providers are set out in Appendix A.

3.7.1 Analysis summary

Tables 1 to 3 of Appendix A detail the trend in admitted patient care activity levels since the 2019/20 financial year. Table 2 analyses the activity by resident Health Board, and Table 3 analyses the activity by Specialty. In summary, 2020/21 English provider activity (using providers with WHSSC contracts) dropped by 34% in comparison to 2019/20, and in the inverse pattern to the COVID-19 waves, as expected. 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 by only 10% in total 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 (M1-5)	CountEpisode for 2020/21 (M1-5)	CountEpisode for 2021/22 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
⊞	4,213	2,529	3,495	1,494	11,731	1,891	895	1,455	1,494	-21%
⊞ Major North Wales provider	14,810	9,783	12,727	5,579	42,899	6,254	3,293	5,149	5,579	-11%
⊞ Major Powys provider	17,649	11,590	15,701	6,768	51,708	7,191	3,642	6,704	6,768	-6%
Total	36,672	23,902	31,923	13,841	106,338	15,336	7,830	13,308	13,841	-10%

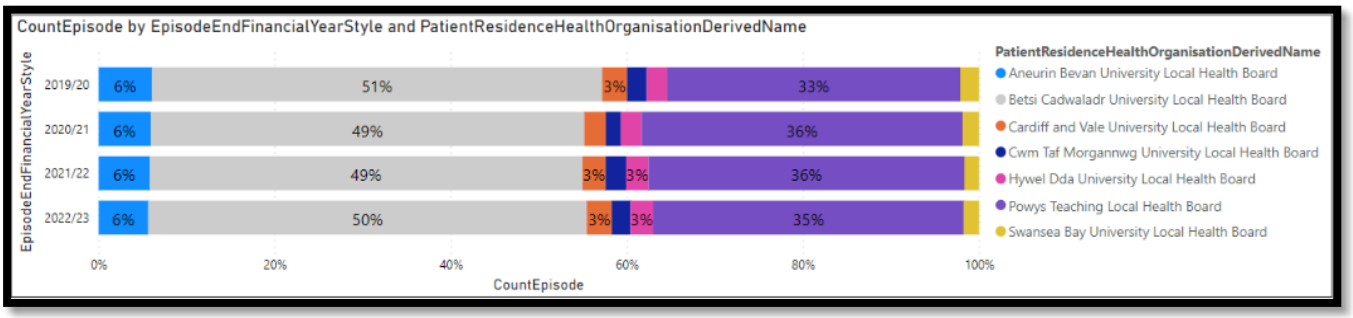
Episodes by provider - full years except 2022/23 (data: DHCW)

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	2022/23	TreatmentSpecialtyDescription	CountEpisode for 2019/20 (M1-5)	CountEpisode for 2020/21 (M1-5)	CountEpisode for 2021/22 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
⊞ Accident & Emergency	384	194	298	108	⊞ Accident & Emergency	173	82	147	108	-38%
⊞ Paediatric Trauma and Orthopaedics	143	95	131	84	⊞ Paediatric Trauma and Orthopaedics	70	20	62	84	20%
⊞ Trauma & Orthopaedics	5,429	2,170	4,089	1,765	⊞ Trauma & Orthopaedics	2,133	555	1,657	1,765	-17%
Total	5,956	2,459	4,518	1,957	Total	2,376	657	1,866	1,957	-18%

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.



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 15% to date this financial year, compared to 2019/20, this has not translated into higher waiting lists due to lower demand for inpatient admissions. Cardiff's waiting list for admissions has actually reduced to about two thirds of pre-COVID-19 levels (about 100 patients), and Swansea Bay's has reduced to just over half (about 50 patients), although Liverpool's list has increased slightly (about 70 patients).

However, referrals for New outpatient appointments is now growing again after an initial lull as COVID-19 hit Wales, and the Welsh centres historically have a much higher percentage than Liverpool of emergency admissions compared to elective admissions. Therefore the good progress must be maintained, especially considering the link to Cardiology and that patients may move to Cardiac Surgery lists at short notice.

It is also 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 600 in March 2020), but a larger increase at Swansea Bay to around 300 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 10% 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 5%, and their waiting list for admissions is around 30 patients, although this is an increase. Swansea Bay's activity is 28% lower than 2019/20 so far this year, but their waiting list is similar as pre-Covid with about 20 patients. Cardiff are currently 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 20% in 2022/23 compared to 2019/20, with both Cardiff and the Walton showing similar recovery rates. However, Cardiff's waiting list for admissions has reduced a little (about 250 patients), although some of those have been waiting for over a year, while the Walton's waiting list for admissions has increased from about 350 patients in March 2020 to about 400 in June 2022.

New outpatient referrals appear to be consistent, but both centres now have a growing waiting list for new appointments, which could translate into pressure on the waiting list for admissions.

Cardiff have confirmed they are intending to be back to pre-Covid theatre capacity by September.

Plastic Surgery (pages 17-21) – Inpatient activity is still 22% 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 over 2,200 in August 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 400 in July 2022, although none have waited over a year.

It is noteworthy that Swansea Bay shows a far higher percentage of emergency activity (54% to date in 2022/23) than St Helen's (16% 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 23% 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 (which has seen steadily growing referrals again since April 2020), the waiting list for admissions has been progressively growing from about 300 patients in March 2020 to about 530 in August 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 the list is now growing again.

NHS England providers (page 27, Appendix 1) – Overall, the English Trusts that WHSSC commission have performed by 12% 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 22% in total, and A&E by 37% in 2022/23. Appendix A lists all the specialties in order, and also shows the position by Health Board.

Other notes

Cardiff & Vale - throughout the LHB are issues with regards to staffing, due to COVID infections, and at UHW there are COVID cases on some wards. The front door performance is poor at present, and there are also social care issues that are impacting their ability to discharge patients. All this is having an effect upon elective cases in all speciality levels. The LHB have also had to make temporary changes to wards with some green wards moving to amber and some amber wards moving to red.

5.0 RECOMMENDATIONS

Members are asked to:

- **Note** the report.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Implementation of the Plan Choose an item. Choose an item.
Link to Integrated Commissioning Plan	This report provides assurance on delivery of the ICP.
Health and Care Standards	Choose an item. Choose an item. Choose an item.
Principles of Prudent Healthcare	Choose an item. Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Choose an item. Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	
Finance/Resource Implications	
Population Health	
Legal Implications (including equality & diversity, socio economic duty etc)	
Long Term Implications (incl WBFG Act 2015)	
Report History (Meeting/Date/ Summary of Outcome	
Appendices	**Annex A** – Recovery summary of main specialties/providers **Annex B** – contract monitoring return activity CVUHB **Annex 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

ANNEX 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 (M1-5)	CountEpisode for 2020/21 (M1-5)	CountEpisode for 2021/22 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
Cardiac Surgery	**892**	**364**	**748**	**760**	**-15%**
Cardiff and Vale University Local Health Board	356	93	285	251	-29%
Liverpool Heart And Chest Hospital nhs foundatio	181	105	203	184	2%
Swansea Bay University Local Health Board	298	125	214	256	-14%
University Hospitals Birmingham Nhs Foundation t	27	23	23	36	33%
University Hospitals Of North Midlands nhs trust	30	18	23	33	10%
Neurosurgery	**1,440**	**698**	**1,214**	**1,175**	**-18%**
Cardiff and Vale University Local Health Board	919	434	768	745	-19%
The Walton Centre Nhs Foundation trust	456	224	389	371	-19%
University Hospitals Of North Midlands nhs trust	65	40	57	59	-9%
Paediatric Surgery	**1,257**	**447**	**950**	**959**	**-24%**
Alder Hey Children's Nhs Foundation trust	192	127	154	152	-21%
Cardiff and Vale University Local Health Board	1,065	320	796	807	-24%
Plastic Surgery	**4,796**	**2,407**	**3,572**	**3,677**	**-23%**
Countess Of Chester Hospital Nhs foundation trus	275	140	211	208	-24%
St Helens And Knowsley Teaching Hospitals nhs tr	603	235	435	478	-21%
Swansea Bay University Local Health Board	3,918	2,032	2,926	2,991	-24%
Thoracic Surgery	**594**	**306**	**569**	**536**	**-10%**
Cardiff and Vale University Local Health Board	270	143	282	260	-4%
Liverpool Heart And Chest Hospital nhs foundatio	92	81	120	97	5%
Swansea Bay University Local Health Board	205	73	151	148	-28%
University Hospitals Birmingham Nhs Foundation t	14	1	8	14	0%
University Hospitals Of North Midlands nhs trust	13	8	8	17	31%
Total Specialty	**8,979**	**4,222**	**7,053**	**7,107**	**-21%**

Current Waiting List totals (DHCW data)

202204 Admitted diagnostic intervention	FUP OP appointment	New OP appointment	Unknown	**Total**
137	**54**	**115**	**173**	**479**
83	30	45		**158**
			158	**158**
54	24	70		**148**
			11	**11**
			4	**4**
247	**206**	**502**	**436**	**1,391**
247	206	502		**955**
			417	**417**
			19	**19**
554	**97**	**478**	**87**	**1,216**
			87	**87**
554	97	478		**1,129**
2,305	**124**	**1,695**	**652**	**4,776**
			214	**214**
			438	**438**
2,305	124	1,695		**4,124**
75	**81**	**91**	**54**	**301**
48	73	42		**163**
			48	**48**
27	8	49		**84**
			5	**5**
			1	**1**
3,318	**562**	**2,881**	**1,402**	**8,163**

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

ANNEX 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, which are not reflected in the charts in the main body of the report, to be consistent with other providers.**

	Financial (£)							Activity								
	20/21 Avg	21/22 Avg	April	May	June	July	August	February	March	20/21 Avg	21/22 Avg	April	May	June	July	August
CARDIOTHORACIC																
Cardiology - Specialist	890,234	1,030,201	999,585	1,073,683	1,092,218	1,331,502	1,103,030	194	146	149	162	149	148	143	164	168
Cardiology - Aneurin Bevan	161,312	111,442	143,343	7,238	57,826	86,206	402,452	37	47	44	35	27	29	20	33	17
Cardiology - Cwm Taf	29,836	28,021	23,426	13,510	33,343	111,053	30,458	7	8	2	2	3	2	1	8	2
Cardiology - Swansea Bay	3,307	6,516	3,445	3,445	3,445	20,311	3,445	3	2	0	1	1	0	1	0	0
Transcatheter Aortic Valve Implantation (TAVI)	263,010	291,136	289,410	722,014	367,564	415,690	386,316	12	20	15	14	15	31	18	20	18
Mitral Valves (PMVLR)		-	55,940	55,940	55,940	55,940	(120,181)					0	0	3	0	0
Adult Congenital Heart Disease (ACHD)	64,857	105,022	108,778	108,778	108,778	108,778	108,778	61	63	56	62	72	77	85	73	85
Cardiac Surgery	1,103,661	1,175,724	1,140,349	1,218,366	1,159,504	1,219,707	1,168,443	62	82	37	54	44	52	45	64	46
OP	-	-						106	119	66	97	83	105	104	75	103
Thoracic Surgery	230,345	326,761	363,846	416,603	404,091	384,832	384,864	53	61	35	51	48	59	58	39	55
OP	-	-						111	102	94	126	143	146	135	106	148
TOTAL	***2,746,563***	***3,074,824***	***3,128,122***	***3,619,578***	***3,282,709***	***3,734,018***	***3,467,605***	***646***	***650***	***496***	***603***	***585***	***649***	***613***	***582***	***642***
NEUROSCIENCES / ALAS	-	-								0	0					
Neurosurgery	1,467,583	1,548,500	1,562,415	1,627,787	1,572,281	1,598,002	1,593,021	190	192	120	162	129	166	129	157	156
OP	-	-						516	396	381	427	374	404	425	415	408
Spinal Implants	40,960	132,156	138,206	119,536	86,418	195,593	58,876	4	12	3	10	8	12	9	16	8
OP	-	-						63	38	0	0					
Intrathecal Pump Transfer from ABMU/SBU	14,025	14,306	14,706	(14,706)	-	1	2			0	0					
ISAT	138,768	159,432	105,049	165,685	67,228	145,621	161,889	18	13	14	15	12	14	9	11	9
Excess costs of INR outsourcing	10,118	6,158	-	-	-	-	-	4	0	0	0					
Epilepsy Surgery	5,231	(1)	1,919	63,909	32,914	(1)	(1)	1	1	0	0	0	2	1	0	0
PDOC	-	23,833	24,501	24,501	24,501	24,501	24,501			0	0					
Neuro-Oncology		4,333	42,833	42,833	42,833	42,833	42,833				0					
Spinal Injuries	278,062	288,168	309,494	323,435	323,294	328,645	327,941	615	556	512	540	546	645	644	682	677
OP	-	-						63	38	52	66	53	77	67	54	58
Neuro Rehab	282,238	277,061	303,334	303,716	312,752	307,152	306,738	537	782	479	345	457	460	531	571	553
OP	-	-						16	9	9	32	24	26	28	36	17
Relocation of Specialist Rehabilitation		6,800	42,833	42,833	42,833	42,833	42,833				0					
ALAS incl. AAC	1,269,732	1,429,258	1,546,961	1,547,003	1,547,004	1,546,836	1,547,136			0	0					
ALAS - Exceptional Circumstances (Treforest Ind. Estate)	-	-	-	-	-	-	-			0	0					
TOTAL	***3,506,717***	***3,890,005***	***4,092,251***	***4,246,531***	***4,052,058***	***4,232,017***	***4,105,770***	***2,027***	***2,037***	***1,570***	***1,597***	***1,603***	***1,806***	***1,843***	***1,942***	***1,886***

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	Financial (£)							Activity								
	20/21 Avg	21/22 Avg	April	May	June	July	August	February	March	20/21 Avg	21/22 Avg	April	May	June	July	August
RENAL	-	-								0	0					
Renal Surgery	277,873	308,694	338,099	388,232	342,681	377,601	332,553	75	69	51	72	76	93	81	97	68
OP	-	-						394	347	259	350	307	353	366	315	391
Nephrology	519,762	543,670	555,329	548,863	539,164	548,863	563,412	154	118	100	116	109	86	106	103	129
OP	-	-						736	557	536	683	439	525	469	628	824
Home Renal Dialysis	125,181	125,963	129,488	127,562	129,965	145,421	144,537	583	650	662	627	644	624	649	718	782
Renal CAPD (Dialysis)	128,186	129,572	128,813	129,970	128,284	133,615	132,013	1,723	1,872	1,883	1,814	1,644	1,691	1,636	1,735	1,645
Hospital Renal Dialysis	1,105,891	1,138,061	1,241,309	1,235,502	1,280,881	1,188,665	1,262,369	6,900	6,900	6,831	6,992	7,281	7,283	7,574	6,952	7,487
Renal Transplants	449,974	487,534	521,308	573,623	562,281	523,168	495,583	9	2	5	8	10	12	12	10	8
TOTAL	***2,606,867***	***2,733,495***	***2,914,345***	***3,003,751***	***2,983,257***	***2,917,333***	***2,930,467***	***10,574***	***10,515***	***10,326***	***10,661***	***10,510***	***10,667***	***10,893***	***10,558***	***11,334***
HAEMATOLOGY	-	-								0	0					
Haemophilia	336,642	433,932	448,436	479,466	426,136	507,624	761,737	1,600,796	2,223,126	1,419,378	1,712,428	1,374,003	1,402,611	1,756,043	1,506,823	2,063,128
IBD Transfer	122,914	154,764	159,097	159,097	159,097	159,097	159,097			0	0					
Haemophilia Reference Centre	6,122	6,245	6,419	6,419	6,419	6,419	6,419			0	0					
Blood and Marrow Transplantation (BMT)	644,365	741,006	739,972	765,336	854,475	637,533	808,277	8	7	7	10	11	13	12	9	12
ATMP - CAR-T	231,419	213,477	342,308	340,136	86,613	86,613	1,102,468	0	1	1	1	1	1	0	0	4
All Wales Lymphoma Panel	78,672	108,708	127,370	132,305	111,918	127,154	124,099	114	103	74	183	207	228	141	206	193
Clinical Immunology	786,206	741,531	675,785	891,994	807,137	721,865	940,516	234	254	248	217	135	223	224	235	228
Herediatry Anaemia	7,917	30,770	31,632	31,632	31,632	31,632	31,632			0	0					
TOTAL	***2,214,257***	***2,430,432***	***2,531,018***	***2,806,386***	***2,483,427***	***2,277,937***	***3,934,245***	***1,601,152***	***2,223,491***	***1,419,707***	***1,712,839***	***1,374,357***	***1,403,076***	***1,756,420***	***1,507,273***	***2,063,565***
PAEDIATRICS / NEONATAL	-	-								0	0					
Paediatric Surgery	498,489	542,662	566,155	592,537	565,352	569,176	561,612	178	139	113	159	153	188	152	157	147
OP	-	-						280	276	210	279	236	281	235	174	178
Paediatric Renal	121,909	135,112	146,742	161,679	170,941	144,163	142,835	62	62	48	55	47	59	46	40	45
OP	-	-						131	134	133	152	148	168	129	162	147
Paediatric Oncology	758,417	860,093	945,745	964,767	900,347	944,574	944,050	278	232	232	202	228	205	170	221	226
OP	-	-						493	464	366	488	224	452	461	689	465
Paediatric Neurology	192,661	221,280	250,226	257,867	250,355	253,076	262,468	22	25	17	19	19	24	19	18	22
OP	-	-						120	121	108	113	118	106	139	45	129
Paediatric Ketogenic Diet	3,958	8,313	8,546	8,546	8,546	8,546	8,546			0	0					
Paediatric Rheumatology Service	22,199	41,852	61,129	54,592	57,861	57,861	57,861			0	0					
Paeds Neuro Rehab	21,829	22,266	22,889	22,889	22,889	22,889	22,889			0	0					
Paediatric Gastroenterology	88,449	108,014	163,788	136,769	158,342	154,845	171,005	40	45	48	59	66	57	77	61	66
OP	-	-						30	60	82	100	72	84	86	55	79
Paediatric ENT	105,832	113,514	123,498	125,633	124,533	124,795	127,835	55	23	19	30	34	37	33	37	45
OP	-	-						257	187	64	126	108	183	144	133	224
Paediatric Cardiology	214,877	241,910	250,466	256,477	280,342	250,648	214,577	14	9	14	19	17	18	21	18	12
OP	-	-						261	220	256	198	171	224	224	186	183
Fetal Cardiology	20,873	22,190	22,135	22,135	22,135	22,135	22,135	24	17	25	38	42	64	59	38	37
Paediatric Cystic Fibrosis	38,645	43,323	48,442	45,397	46,550	44,012	47,040			0	0					
Paeds Respiratory Equipment / CNS	22,676	30,005	21,364	29,369	73,051	26,793	69,309			0	0					
Paediatric Radiology		12,646	51,400	23,600	37,500	37,500	37,500				0					
Paediatric Endocrinology	59,075	60,257	61,944	61,944	61,944	61,944	61,944			0	0					
Foetal Medicine	25,925	26,444	27,184	27,184	27,184	27,184	27,184			0	0					
Children's Hospital for Wales	104,770	106,866	109,858	109,858	109,858	109,858	109,858			0	0					

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	Financial (£)							Activity								
	20/21 Avg	21/22 Avg	April	May	June	July	August	February	March	20/21 Avg	21/22 Avg	April	May	June	July	August
PICU BH	356,408	386,341	409,420	420,061	512,561	392,789	338,871	113	153	63	88	86	115	133	99	81
NICU BH	796,630	814,717	825,486	849,448	802,903	855,001	877,805	898	864	814	872	741	704	837	934	803
Perinatal Pathology	23,509	23,979	24,650	24,650	24,650	24,650	24,650			0	0					
Paedatric MRI Investment & IMD	14,152	37,876	39,609	39,609	39,609	39,609	39,609			0	0					
Syndrome without a Name (SWAN)		17,917	36,837	(36,837)	-	143,333	35,833				0					
TOTAL	***3,491,285***	***3,877,576***	***4,217,513***	***4,198,176***	***4,297,452***	***4,315,383***	***4,205,415***	***3,256***	***3,031***	***2,610***	***2,996***	***2,510***	***2,969***	***2,965***	***3,067***	***2,889***
ADULT CRITICAL CARE	-	-								0	0					
Adult ICU	484,917	547,583	596,342	541,128	234,185	457,218	640,842	309	340	230	271	284	309	410	307	285
Adult HDU	42,758	51,727	55,913	48,093	75,463	74,681	80,936	42	12	17	28	22	14	48	47	55
LTV Consultant Sessions	3,184	3,247	3,338	3,338	3,338	3,338	3,338			0	0					
LTV Unit Development	69,167	71,961	73,976	73,976	73,976	73,976	73,976			0	0					
TOTAL	***600,025***	***674,518***	***729,569***	***666,535***	***386,962***	***609,213***	***799,093***	***351***	***352***	***247***	***300***	***306***	***323***	***458***	***354***	***340***
GENETICS / LTC	-	-								0	0					
Medical Genetics	1,088,985	1,133,724	1,338,061	947,263	1,244,538	1,198,465	1,182,424	186	162	67	45	6	23	20	32	20
Lynch Syndrome - (Genetics)	24,837	25,334	26,043	26,043	26,043	26,043	26,043			0	0					
Genetic Counsellor 8a - £24,420 HD & £36,630 ABMU	5,293	5,399	5,550	5,550	5,550	5,550	5,550			0	0					
Enzyme Replacement Therapy	38,879	72,973	75,017	75,017	75,017	75,017	75,017			0	0					
Cystic Fibrosis	509,631	531,401	549,042	542,692	536,765	550,209	512,982			0	0					
Home TPN	104,063	187,166	277,621	202,333	213,171	292,073	350,379	172	104	170	288	325	218	224	360	455
TPN Exceptional Costs	32,188	30,178	-	-	-	-	-	106	117	115	112	0				
BAHAs & Cochlears	386,167	395,868	422,054	422,054	422,054	580,046	461,552			0	0					
TOTAL	***2,190,044***	***2,382,043***	***2,693,389***	***2,220,952***	***2,523,139***	***2,727,403***	***2,613,948***	***464***	***383***	***351***	***445***	***331***	***241***	***244***	***392***	***475***
OTHER	-	-								0	0					
Liver Surgery	87,559	85,384	107,958	107,958	83,738	81,774	91,083	10	11	10	10	13	12	10	4	10
Major Trauma Centre	881,583	935,184	1,000,557	1,000,557	1,000,557	1,000,557	1,000,557			0	0					
Gender Service	47,964	73,207	116,647	116,647	116,647	116,647	116,647			0	0					
Radiofrequency Ablation (RFA)	12,862	25,374	26,178	26,178	32,779	46,982	25,339			0	0					
Hepatology	21,865	22,302	22,927	22,927	22,927	22,927	22,927			0	0					
HCC MDT		-	793	57,460	29,127	29,127	29,127									
Neuropsychiatry	225,738	235,047	252,818	256,324	255,645	252,001	255,042	425	351	301	351	311	334	329	306	326
Regional Pharmaceutical Service	61,851	63,088	64,854	64,854	64,854	64,854	64,854			0	0					
Pay Award	441,050	485,065	718,034	718,034	718,034	718,034	718,034			0	0					
NICE / High Cost Drugs	78,317	55,292	104,691	60,879	113,998	51,183	103,091			0	0					
Interstitial Lung Disease	12,719	12,973	13,336	13,336	13,336	13,336	13,336			0	0					
Neuroendocrine Tumours	47,993	63,403	65,178	65,178	65,178	65,178	65,178			0	0					
Rebasing Difference / Roundings	-	-	-	-	-	-	-			0	0					
TOTAL	***1,919,502***	***2,056,320***	***2,493,972***	***2,510,332***	***2,516,819***	***2,462,600***	***2,505,215***	***435***	***362***	***311***	***360***	***324***	***346***	***339***	***310***	***336***
	-	-								0	0					
Total	19,275,259	21,119,212	22,800,179	23,272,241	22,525,824	23,275,904	24,561,759	1,618,905	2,240,821	1,435,619	1,729,800	1,390,526	1,420,077	1,773,775	1,524,478	2,081,467

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.
2. Swansea's contract monitoring is usually in spells for admissions, whereas all the charts in the main report use episode data from DHCW for consistency with other providers

	Financial (£)								Activity									
	March	20/21 Avg	21/22 Avg	April	May	June	July	August	February	March	20/21 Avg	21/22 Avg	April	May	June	July	August	
ICC			0	25,015	25,015	25,015	25,015	25,015				0	0	0	0	0	0	
Total	***2,394,760***	***2,281,788***	***2,520,337***	***2,762,563***	***2,778,608***	***2,739,989***	***2,458,950***	***2,825,122***	***266***	***187***	***206***	***272***	***257***	***251***	***256***	***182***	***337***	
PAEDS / NEONATAL												0						
CLP	85,937	112,170	123,851	115,139	125,131	115,395	148,147	128,419	19	2	5	9	4	7	4	14	8	
NICU	434,980	448,083	455,324	478,150	469,820	400,394	447,343	481,290	592	534	540	536	475	427	461	465	561	
BAHA	5,091	5,193	5,270	5,418	5,418	5,418	5,418	5,418			0	0						BLOCK
Paeds Onc	11,611	11,844	12,080	12,419	12,419	12,419	12,419	12,419			0	0						BLOCK
Total	***537,620***	***577,290***	***596,526***	***611,125***	***612,787***	***533,625***	***613,326***	***627,545***	***611***	***536***	***544***	***545***	***479***	***434***	***465***	***479***	***569***	
CANCER & BLOOD												***0***						
Plastics	1,326,215	1,055,137	1,269,290	1,552,784	1,532,747	1,523,606	1,561,446	1,475,400	695	620	434	564	657	642	624	659	708	
OP		0	0						582	534	264	1,243	1,842	2,152	1,896	1,898	2,141	OP and OPP
Burns	410,743	420,748	435,868	429,154	415,367	485,221	480,165	514,173	166	126	130	145	85	55	207	196	270	
Thoracic	217,228	149,015	208,882	180,291	241,622	229,707	253,272	335,838	27	30	19	27	14	31	25	27	44	
OP		0	0						68	34	42	92	65	99	93	88	122	
SNB	9,221	9,405	9,593	0	0	0	0	0			0	0						BLOCK
Haemophilia	63,931	64,730	91,625	75,113	117,253	84,261	59,604	141,659			0	0						Product Issue
Sarcoma	103,167	75,287	83,829	83,886	110,875	92,018	101,782	97,688	15	27	13	21	11	26	23	17	21	
Clinical Genetics	5,177	5,177	5,386	5,537	5,537	5,537	5,537	5,537			0	0						BLOCK
Total	***2,135,681***	***1,779,499***	***2,104,473***	***2,326,765***	***2,423,402***	***2,420,350***	***2,461,806***	***2,570,295***	***1,553***	***1,371***	***902***	***2,091***	***2,674***	***3,005***	***2,868***	***2,885***	***3,306***	
NEUROSCIENCES												***0***						
ALAC	155,174	158,277	161,443	194,435	194,435	194,435	194,435	194,435			0	0						BLOCK
Rehab	158,763	150,653	162,248	178,797	181,966	174,539	168,102	178,599	295	314	263	345	330	362	287	222	328	
OP		0	0						28	25	13	14	25	24	13	41	6	
Total	***313,937***	***308,930***	***323,691***	***373,232***	***376,402***	***368,974***	***362,537***	***373,034***	***323***	***339***	***276***	***359***	***355***	***386***	***300***	***263***	***334***	
OTHER												***0***						
NICE	42,825	49,204	51,305	8,707	19,455	25,936	20,619	97,454			0	0						DRUGS
East Forensics	1,174,502	1,197,992	1,221,952	1,256,167	1,256,167	1,256,167	1,256,167	1,256,167			0	0						BLOCK
Devices	-32,838	0	0								0	0						BLOCK
Academic Fee	10,629	10,841	11,058	11,368	11,368	11,368	11,368	11,368			0	0						BLOCK
IVF	238,959	123,533	192,861	270,435	259,041	268,562	329,982	296,899	179	153	129	160	170	160	91	264	179	
EMRTS	260,563	312,690	318,944	385,356	385,356	1,208,157	659,623	659,623			0	0						BLOCK
Air Am	63,833	65,110	66,412	0	0	0	0	0			0	0						BLOCK
Pay award 20/21	132,167	193,060	196,921	202,435	202,435	202,435	202,435	202,435			0	0						BLOCK
Major Trauma Plastics			0	79,516	79,516	79,516	79,516	79,516				0	0	0	0	0	0	
Major Trauma ODN			0	44,389	44,389	44,389	44,389	44,389				0	0	0	0	0	0	
Perinatal			0	127,472	127,472	127,472	127,472	127,472				0	0	0	0	0	0	
Total	***1,890,639***	***1,952,431***	***2,059,454***	***2,385,845***	***2,385,198***	***3,224,002***	***2,731,571***	***2,775,323***	***179***	***153***	***129***	***160***	***170***	***160***	***91***	***264***	***179***	
												0						
Total	8,827,651	8,424,006	9,164,960	10,185,085	10,261,649	10,803,492	10,226,593	10,756,042	9,131	8,474	8,082	9,798	10,276	10,731	10,479	10,412	11,386	

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 (M1-5)	CountEpisode for 2020/21 (M1-5)	CountEpisode for 2021/22 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
	4,213	**2,529**	**3,495**	**1,494**	**11,731**	**1,891**	**895**	**1,455**	**1,494**	**-21%**
Cambridge University Hospitals Nhs Foundation tr	80	27	44	37	**188**	35	11	19	37	6%
Great Ormond Street Hospital For Children nhs fo	326	193	354	118	**991**	149	73	145	118	-21%
Guy's And St Thomas' Nhs foundation trust	446	182	326	148	**1,102**	204	72	133	148	-27%
Imperial College Healthcare Nhs Trust	302	131	239	140	**812**	151	33	89	140	-7%
King's College Hospital Nhs Foundation trust	130	61	93	38	**322**	56	27	30	38	-32%
Leeds Teaching Hospitals Nhs Trust	80	24	56	16	**176**	43	17	26	16	-63%
Royal Free London Nhs Foundation trust	193	121	170	79	**563**	84	47	78	79	-6%
Royal Papworth Hospital Nhs Foundation trust	105	32	63	29	**229**	45	7	20	29	-36%
The Newcastle Upon Tyne Hospitals nhs foundation	132	103	60	32	**327**	72	37	29	32	-56%
The Royal Marsden Nhs Foundation trust	52	54	57	32	**195**	20	23	27	32	60%
The Royal Orthopaedic Hospital Nhs foundation tr	159	98	145	51	**453**	63	29	60	51	-19%
University College London Hospitals Nhs foundati	357	216	350	182	**1,105**	164	60	138	182	11%
University Hospitals Bristol And Weston nhs foun	1,851	1,287	1,538	592	**5,268**	805	459	661	592	-26%
Major North Wales provider	**14,810**	**9,783**	**12,727**	**5,579**	**42,899**	**6,254**	**3,293**	**5,149**	**5,579**	**-11%**
Alder Hey Children's Nhs Foundation trust	3,669	2,816	3,197	1,479	**11,161**	1,594	1,014	1,313	1,479	-7%
Liverpool Heart And Chest Hospital nhs foundatio	1,400	1,129	1,542	608	**4,679**	540	372	661	608	13%
Liverpool University Hospitals Nhs Foundation tr	2,572	1,454	2,104	950	**7,080**	1,097	464	854	950	-13%
Manchester University Nhs Foundation Trust	1,106	571	973	379	**3,029**	430	164	381	379	-12%
Salford Royal Nhs Foundation Trust	301	109	166	85	**661**	120	63	63	85	-29%
Sheffield Teaching Hospitals Nhs Foundation trus	221	155	196	103	**675**	91	46	82	103	13%
St Helens And Knowsley Teaching Hospitals nhs tr	1,655	1,010	1,371	567	**4,603**	697	288	543	567	-19%
The Christie Nhs Foundation Trust	620	542	486	220	**1,868**	256	199	190	220	-14%
The Clatterbridge Cancer Centre Nhs foundation t	351	212	302	77	**942**	199	81	121	77	-61%
The Walton Centre Nhs Foundation trust	1,895	1,170	1,651	715	**5,431**	761	379	718	715	-6%
Wirral University Teaching Hospital Nhs foundati	1,020	615	739	396	**2,770**	469	223	223	396	-16%
Major Powys provider	**17,649**	**11,590**	**15,701**	**6,768**	**51,708**	**7,191**	**3,642**	**6,704**	**6,768**	**-6%**
Birmingham Women's And Children's Nhs foundation	413	313	403	141	**1,270**	169	108	172	141	-17%
The Robert Jones And Agnes Hunt Orthopaedic hospit	5,188	2,192	3,913	1,693	**12,986**	2,022	476	1,646	1,693	-16%
University Hospitals Birmingham Nhs Foundation t	1,154	702	890	402	**3,148**	436	268	324	402	-8%
University Hospitals Of North Midlands nhs trust	903	738	829	415	**2,885**	387	278	365	415	7%
Wye Valley Nhs Trust	9,991	7,645	9,666	4,117	**31,419**	4,177	2,512	4,197	4,117	-1%
Total	**36,672**	**23,902**	**31,923**	**13,841**	**106,338**	**15,336**	**7,830**	**13,308**	**13,841**	**-10%**

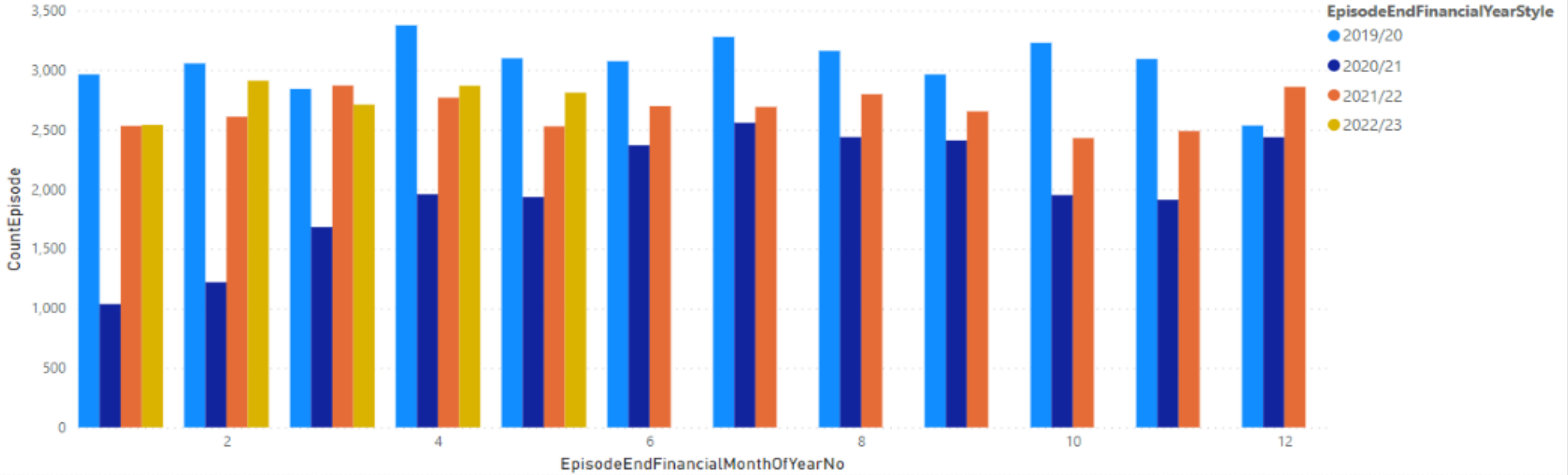
Admitted Patient Care Data for WHSSC English contract providers (DHCW data warehouse – all reported episodes Spec+NonSpc)

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						Total
PatientResidenceHealthOrganisationDerivedName		2	3	4	5	6	7	8	9	10	11	12	Total	1	2	3	4	5	Total	
Aneurin Bevan University Local Health Board	124	179	167	142	138	164	164	157	111	132	146	146	1,770	125	153	174	160	134	746	3,860
Betsi Cadwaladr University Local Health Board	,138	1,244	1,349	1,217	1,174	1,220	1,264	1,372	1,279	1,170	1,197	1,325	14,949	1,202	1,342	1,300	1,349	1,390	6,583	32,704
Cardiff and Vale University Local Health Board	51	53	53	70	75	80	79	78	62	57	62	74	794	94	72	63	70	76	375	1,725
Cwm Taf Morgannwg University Local Health Board	60	40	65	79	60	70	58	61	57	43	38	78	709	81	60	51	51	37	280	1,377
Hywel Dda University Local Health Board	68	48	80	64	48	66	77	47	66	57	67	91	779	75	66	54	69	78	342	1,659
Powys Teaching Local Health Board	920	871	1,004	1,019	867	912	882	927	905	824	833	949	10,913	807	1,042	901	1,015	898	4,663	23,844
Swansea Bay University Local Health Board	42	33	38	49	52	41	50	39	46	26	29	64	509	37	47	51	42	52	229	1,169
Total	**,403**	**2,468**	**2,756**	**2,640**	**2,414**	**2,553**	**2,574**	**2,681**	**2,526**	**2,309**	**2,372**	**2,727**	**30,423**	**2,421**	**2,782**	**2,594**	**2,756**	**2,665**	**13,218**	**66,338**

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	1
Accident & Emergency	384	194	298	108
Adult Cystic Fibrosis Service	69	34	17	3
Adult Mental Illness	2			2
Allergy Service	91	54	137	41
Anaesthetics	20	15	156	72
Blood And Marrow Transplantation	137	83	113	38
Breast Surgery	89	61	84	41
Burns Care	95	77	78	26
Cardiac Surgery	602	376	579	240
Cardiology	1,665	1,330	1,790	784
Cardiothoracic Surgery	72	52	63	37
Cardiothoracic Transplantation	71	29	53	15
Chemical Pathology	3	2		1
Child & Adolescent Psychiatry		2	2	
Clinical Genetics	1		1	
Clinical Haematology	1,055	926	1,008	413
Clinical Immunology	22	6		2
Clinical Immunology And	17	15	46	13
Clinical Microbiology		2		
Clinical Neurophysiology	4		2	2
Clinical Oncology (previously Radiotherapy)	491	406	362	138
Clinical Pharmacology	7	23	20	5
Colorectal Surgery	270	204	242	94
Community Paediatrics				
Congenital Heart Disease	29	28	30	12
Critical Care Medicine	201	116	166	77
Dental Medicine Specialties		1	2	
Dermatology	503	404	401	141
Diabetic Medicine	29	20	29	15
Total	**36,672**	**23,902**	**31,923**	**13,841**

TreatmentSpecialtyDescription	CountEpisode for 2019/20 (M1-5)	CountEpisode for 2020/21 (M1-5)	CountEpisode for 2021/22 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
(Unknown)				1	
Accident & Emergency	173	82	147	108	-38%
Adult Cystic Fibrosis Service	28	15	5	3	-89%
Adult Mental Illness	1			2	100%
Allergy Service	26	5	50	41	58%
Anaesthetics	16	3	69	72	350%
Blood And Marrow Transplantation	47	34	59	38	-19%
Breast Surgery	38	16	32	41	8%
Burns Care	29	19	32	26	-10%
Cardiac Surgery	226	143	248	240	6%
Cardiology	671	414	739	784	17%
Cardiothoracic Surgery	37	24	27	37	0%
Cardiothoracic Transplantation	45	15	21	15	-67%
Chemical Pathology	2	1		1	-50%
Child & Adolescent Psychiatry			1		
Clinical Genetics	1		1		
Clinical Haematology	442	319	445	413	-7%
Clinical Immunology	6	1		2	-67%
Clinical Immunology And	4	1	21	13	225%
Clinical Microbiology		2			
Clinical Neurophysiology	2		2	2	0%
Clinical Oncology (previously Radiotherapy)	259	147	154	138	-47%
Clinical Pharmacology	3	5	10	5	67%
Colorectal Surgery	105	40	115	94	-10%
Community Paediatrics					
Congenital Heart Disease	6	9	14	12	100%
Critical Care Medicine	80	34	66	77	-4%
Dental Medicine Specialties			2		
Dermatology	177	129	164	141	-20%
Diabetic Medicine	17	5	5	15	-12%
Total	**15,336**	**7,830**	**13,308**	**13,841**	**-10%**

Episodes by provider - full years except 2022/23 (data: DHCW)

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	2022/23
Diagnostic Imaging	199	186	216	104
Endocrinology	91	72	109	52
ENT	322	127	222	81
Gastroenterology	1,695	1,343	1,852	777
General Medicine	3,018	2,431	2,562	922
General Surgery	1,799	1,101	1,445	697
Geriatric Medicine	376	367	441	228
Gynaecological Oncology	9	17	12	6
Gynaecology	448	238	364	186
Haemophilia Service		3	4	3
Hepatobiliary & Pancreatic Surgery	297	188	233	123
Hepatology	216	194	207	62
Infectious Diseases	38	17	28	8
Intermediate Care			2	
Interventional Radiology	138	103	161	66
Maxillo-Facial Surgery	110	29	34	17
Medical Oncology	474	266	380	159
Midwifery Service	15	10	7	3
Neonatology	77	74	92	46
Nephrology	425	303	385	207
Neurology	962	652	925	369
Neurosurgery	1,376	830	1,103	468
Nuclear Medicine	9	6	15	15
Obstetrics Hospital Bed	343	366	419	171
Ophthalmology	1,530	689	1,119	499
Oral Surgery	198	101	112	48
Orthoptics	1			
Orthotics			1	
Paediatric Audiological		1		
Paediatric Burns Care	58	53	41	9
Total	**36,672**	**23,902**	**31,923**	**13,841**

TreatmentSpecialtyDescription	CountEpisode for 2019/20 (M1-5)	CountEpisode for 2020/21 (M1-5)	CountEpisode for 2021/22 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
Diagnostic Imaging	93	64	94	104	12%
Endocrinology	39	26	30	52	33%
ENT	141	51	91	81	-43%
Gastroenterology	720	342	718	777	8%
General Medicine	1,304	877	1,196	922	-29%
General Surgery	801	355	578	697	-13%
Geriatric Medicine	155	156	182	228	47%
Gynaecological Oncology	4	5	4	6	50%
Gynaecology	178	68	167	186	4%
Haemophilia Service		1	1	3	
Hepatobiliary & Pancreatic Surgery	111	72	94	123	11%
Hepatology	98	57	97	62	-37%
Infectious Diseases	10	6	20	8	-20%
Intermediate Care			2		
Interventional Radiology	53	28	66	66	25%
Maxillo-Facial Surgery	39	9	12	17	-56%
Medical Oncology	215	110	146	159	-26%
Midwifery Service	3	3	2	3	0%
Neonatology	29	24	31	46	59%
Nephrology	207	144	134	207	0%
Neurology	371	218	380	369	-1%
Neurosurgery	586	298	481	468	-20%
Nuclear Medicine	6	2	3	15	150%
Obstetrics Hospital Bed	149	123	157	171	15%
Ophthalmology	588	227	472	499	-15%
Oral Surgery	85	19	45	48	-44%
Orthoptics					
Orthotics					
Paediatric Audiological					
Paediatric Burns Care	25	28	20	9	-64%
Total	**15,336**	**7,830**	**13,308**	**13,841**	**-10%**

Episodes by provider - full years except 2022/23 (data: DHCW)

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	2022/23
Paediatric Cardiac Surgery	153	159	162	59
Paediatric Cardiology	355	267	325	136
Paediatric Clinical Haematology	354	162	227	88
Paediatric Clinical Immunology And Allergy Service	47	18	22	19
Paediatric Dentistry	52	28	35	10
Paediatric Dermatology	31	18	38	14
Paediatric Diabetic Medicine		3	1	
Paediatric Ear Nose and Throat	205	107	148	46
Paediatric Endocrinology	122	78	101	34
Paediatric Epilepsy	24	11	12	4
Paediatric Gastroenterology	221	217	342	155
Paediatric Infectious Diseases	1			
Paediatric Intensive Care	158	132	185	51
Paediatric Interventional Radiology	26	12	20	6
Paediatric Maxillo-Facial	2	1	6	4
Paediatric Medical Oncology	679	553	448	282
Paediatric Metabolic Disease	17	17	19	13
Paediatric Nephrology	367	267	318	107
Paediatric Neuro-Disability		2	1	
Paediatric Neurology	151	99	120	40
Paediatric Neurosurgery	193	141	180	72
Paediatric Ophthalmology	95	94	109	42
Paediatric Pain Management			1	
Paediatric Plastic Surgery	187	141	164	92
Paediatric Respiratory Medicine	158	100	125	43
Paediatric Rheumatology	103	95	91	54
Paediatric Surgery	513	440	439	176
Paediatric Thoracic Surgery	6	2	5	1
Paediatric Transplantation Surgery	10	2	9	3
Total	**36,672**	**23,902**	**31,923**	**13,841**

TreatmentSpecialtyDescription	CountEpisode for 2019/20 (M1-5)	CountEpisode for 2020/21 (M1-5)	CountEpisode for 2021/22 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
Paediatric Cardiac Surgery	64	68	81	59	-8%
Paediatric Cardiology	173	102	114	136	-21%
Paediatric Clinical Haematology	148	55	108	88	-41%
Paediatric Clinical Immunology And Allergy Service	17	2	5	19	12%
Paediatric Dentistry	29	15	17	10	-66%
Paediatric Dermatology	18	8	16	14	-22%
Paediatric Diabetic Medicine					
Paediatric Ear Nose and Throat	93	32	59	46	-51%
Paediatric Endocrinology	58	24	44	34	-41%
Paediatric Epilepsy	12	5	8	4	-67%
Paediatric Gastroenterology	106	71	123	155	46%
Paediatric Infectious Diseases					
Paediatric Intensive Care	71	59	75	51	-28%
Paediatric Interventional Radiology	16	5	11	6	-63%
Paediatric Maxillo-Facial Surgery	2		4	4	100%
Paediatric Medical Oncology	230	246	159	282	23%
Paediatric Metabolic Disease	5	5	12	13	160%
Paediatric Nephrology	182	101	143	107	-41%
Paediatric Neuro-Disability		1	1		
Paediatric Neurology	72	41	46	40	-44%
Paediatric Neurosurgery	84	50	64	72	-14%
Paediatric Ophthalmology	36	31	55	42	17%
Paediatric Pain Management			1		
Paediatric Plastic Surgery	84	52	74	92	10%
Paediatric Respiratory Medicine	56	22	44	43	-23%
Paediatric Rheumatology	44	32	34	54	23%
Paediatric Surgery	225	154	190	176	-22%
Paediatric Thoracic Surgery	1		3	1	0%
Paediatric Transplantation Surgery	5		3	3	-40%
Total	**15,336**	**7,830**	**13,308**	**13,841**	**-10%**

Episodes by provider - full years except 2022/23 (data: DHCW)

TreatmentSpecialtyDesc	2019/20	2020/21	2021/22	2022/23
Paediatric Respiratory Medicine	158	100	125	43
Paediatric Rheumatology	103	95	91	54
Paediatric Surgery	513	440	439	176
Paediatric Thoracic Surgery	6	2	5	1
Paediatric Transplantation Surgery	10	2	9	3
Paediatric Trauma and Orthopaedics	143	95	131	84
Paediatric Urology	331	235	325	158
Paediatrics	708	361	413	235
Pain Management	126	75	52	18
Palliative Medicine	1	5	4	
Physiotherapy				
Plastic Surgery	1,490	939	1,316	577
Podiatric Surgery	109	22	78	34
Rehabilitation Service	46	37	32	12
Respiratory Medicine	875	510	665	350
Respiratory Physiology	4	3	4	4
Restorative Dentistry	2	3	1	
Rheumatology	728	550	902	437
Spinal Injuries	235	84	96	63
Spinal Surgery Service	27	39	35	37
Stroke Medicine	157	171	166	68
Thoracic Surgery	309	210	344	134
Transient Ischaemic Attack				1
Transplantation Surgery	242	158	163	89
Trauma & Orthopaedics	5,429	2,170	4,089	1,765
Tropical Medicine	2		2	
Upper Gastrointestinal Surgery	87	46	72	38
Urology	1,103	718	1,107	493
Vascular Surgery	113	64	79	39
Well Babies	22	14	22	7
Total	**36,672**	**23,902**	**31,923**	**13,841**

TreatmentSpecialtyDescription	CountEpisode for 2019/20 (M1-5)	CountEpisode for 2020/21 (M1-5)	CountEpisode for 2021/22 (M1-5)	CountEpisode for 2022/23 (M1-5)	CountEpisode 2022/23 % diff from 19/20
Paediatric Respiratory Medicine	56	22	44	43	-23%
Paediatric Rheumatology	44	32	34	54	23%
Paediatric Surgery	225	154	190	176	-22%
Paediatric Thoracic Surgery	1		3	1	0%
Paediatric Transplantation Surgery	5		3	3	-40%
Paediatric Trauma and Orthopaedics	70	20	62	84	20%
Paediatric Urology	127	68	161	158	24%
Paediatrics	245	123	171	235	-4%
Pain Management	58	7	17	18	-69%
Palliative Medicine	1	1	2		
Physiotherapy					
Plastic Surgery	666	296	500	577	-13%
Podiatric Surgery	52		35	34	-35%
Rehabilitation Service	14	12	8	12	-14%
Respiratory Medicine	384	180	291	350	-9%
Respiratory Physiology	1	1	1	4	300%
Restorative Dentistry	1	1	1		
Rheumatology	281	128	391	437	56%
Spinal Injuries	113	14	57	63	-44%
Spinal Surgery Service	9	14	16	37	311%
Stroke Medicine	72	65	79	68	-6%
Thoracic Surgery	130	90	138	134	3%
Transient Ischaemic Attack				1	
Transplantation Surgery	93	53	67	89	-4%
Trauma & Orthopaedics	2,133	555	1,657	1,765	-17%
Tropical Medicine	2				
Upper Gastrointestinal Surgery	40	19	24	38	-5%
Urology	513	210	442	493	-4%
Vascular Surgery	43	13	30	39	-9%
Well Babies	6	3	12	7	17%
Total	**15,336**	**7,830**	**13,308**	**13,841**	**-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:

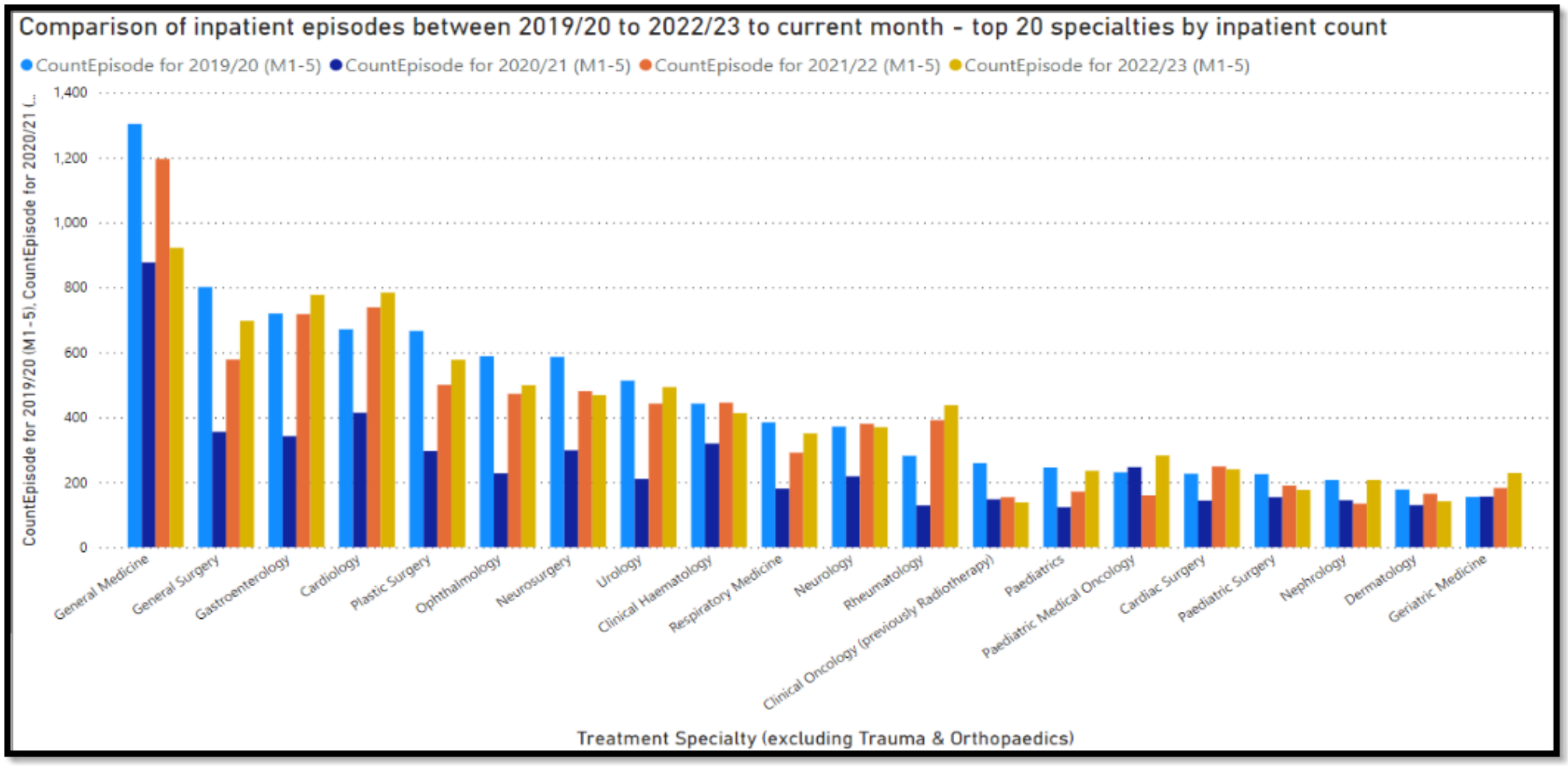


Table 4.2 – Aneurin Bevan UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23

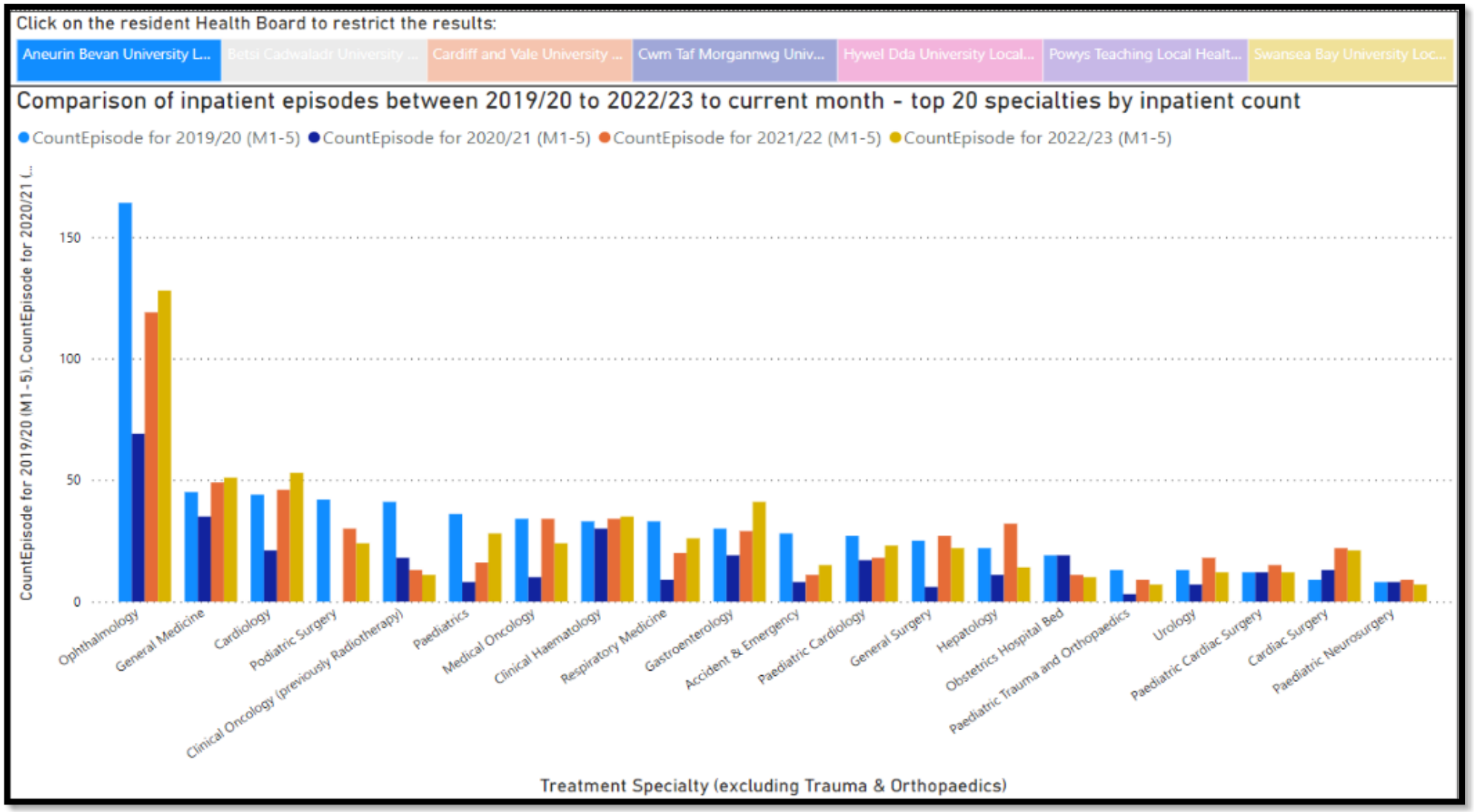


Table 4.3 – Betsi Cadwaladr UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23

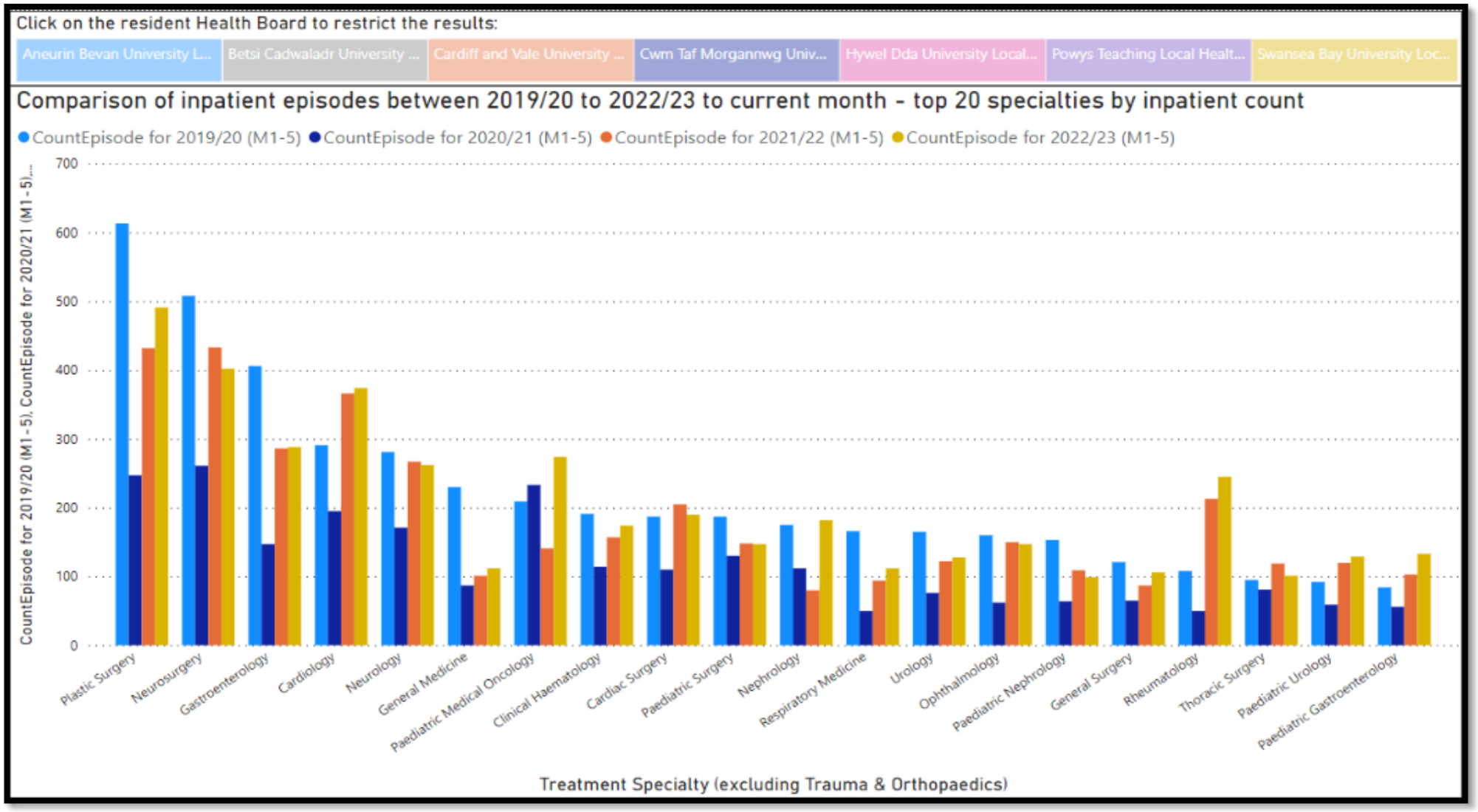


Table 4.4 – Cardiff & Vale UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23

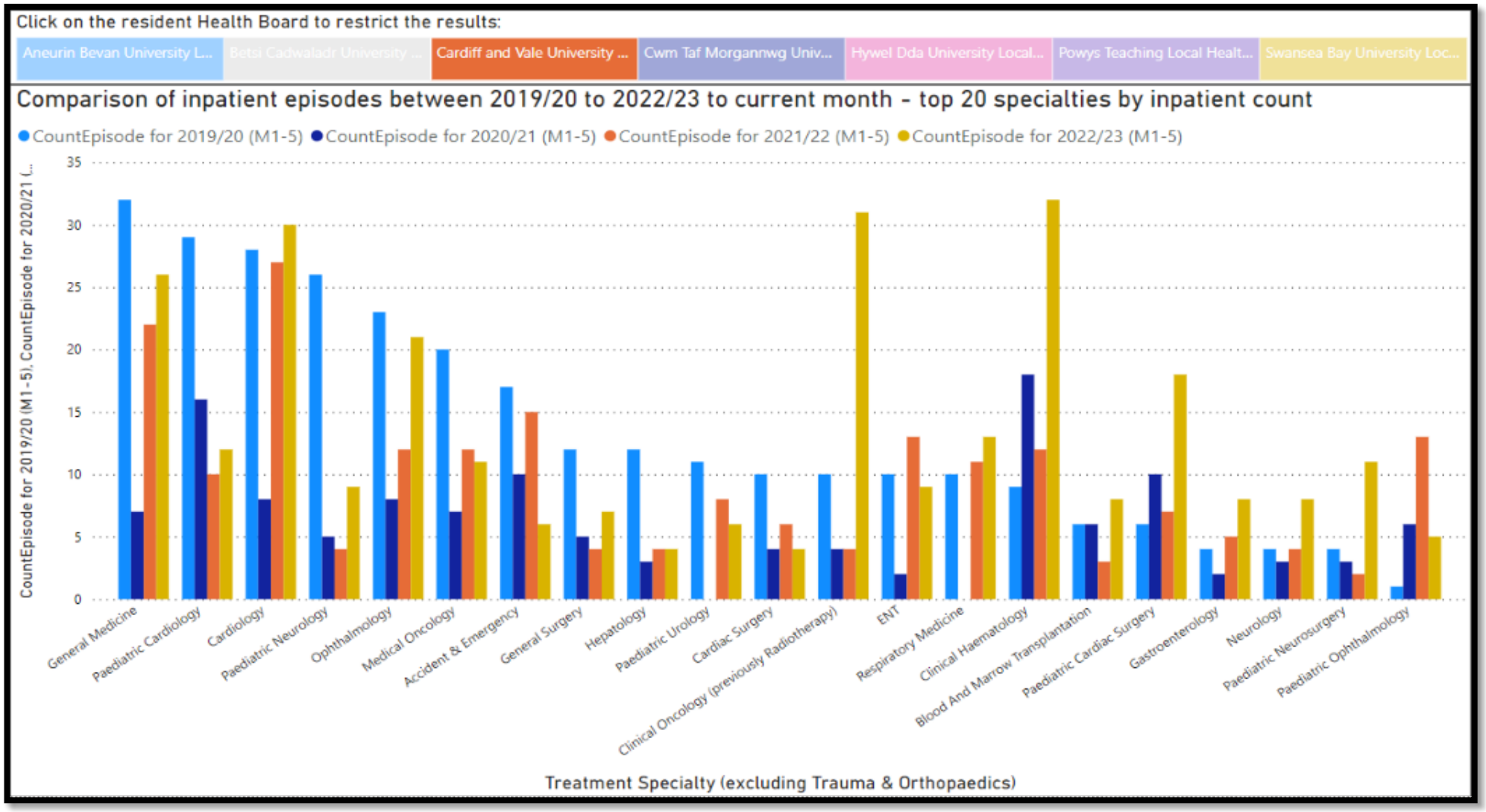


Table 4.5 – Cwm Taf Morgannwg UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23

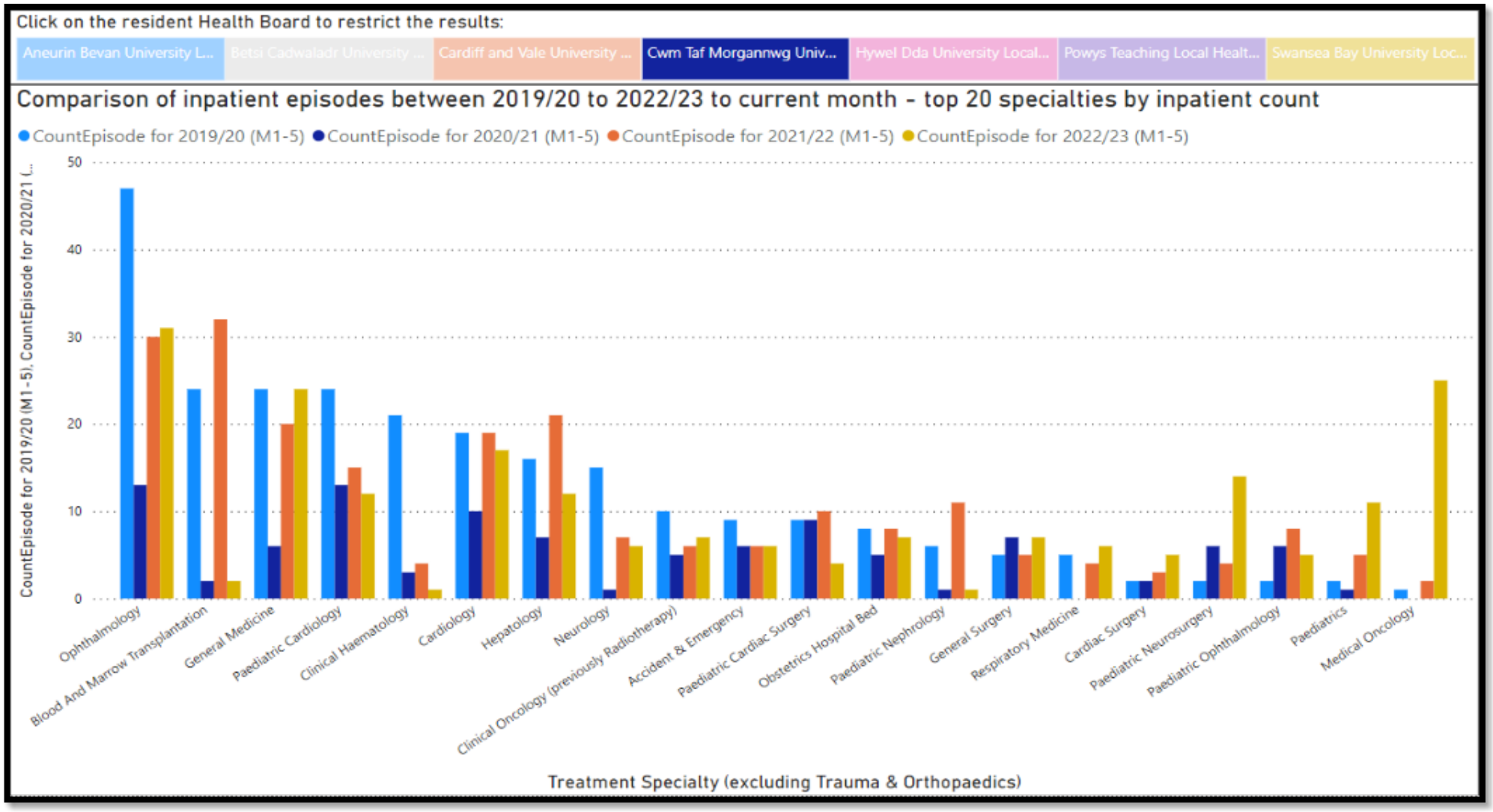


Table 4.6 – Hywel Dda HB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23

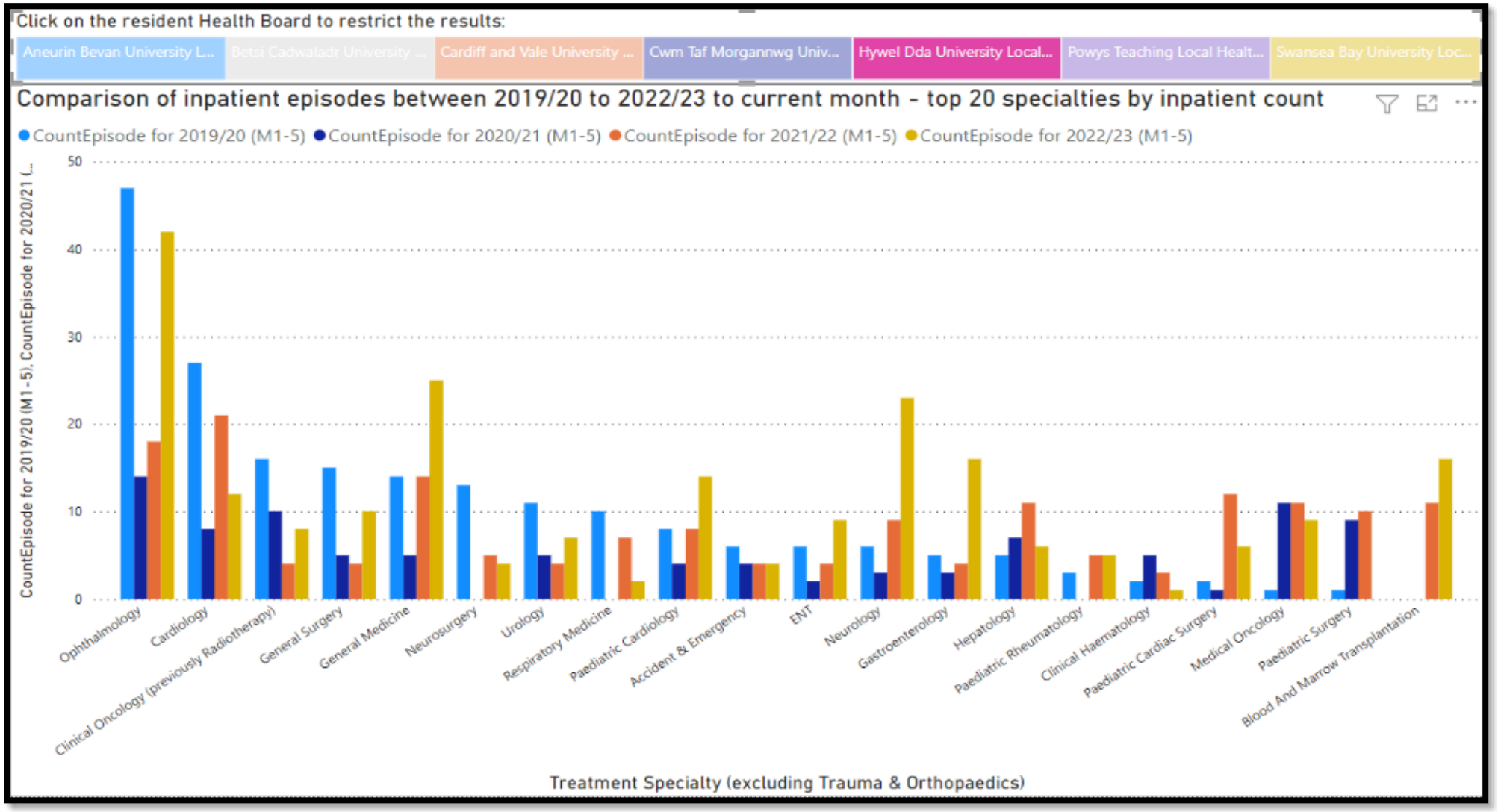


Table 4.7 – Powys THB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23

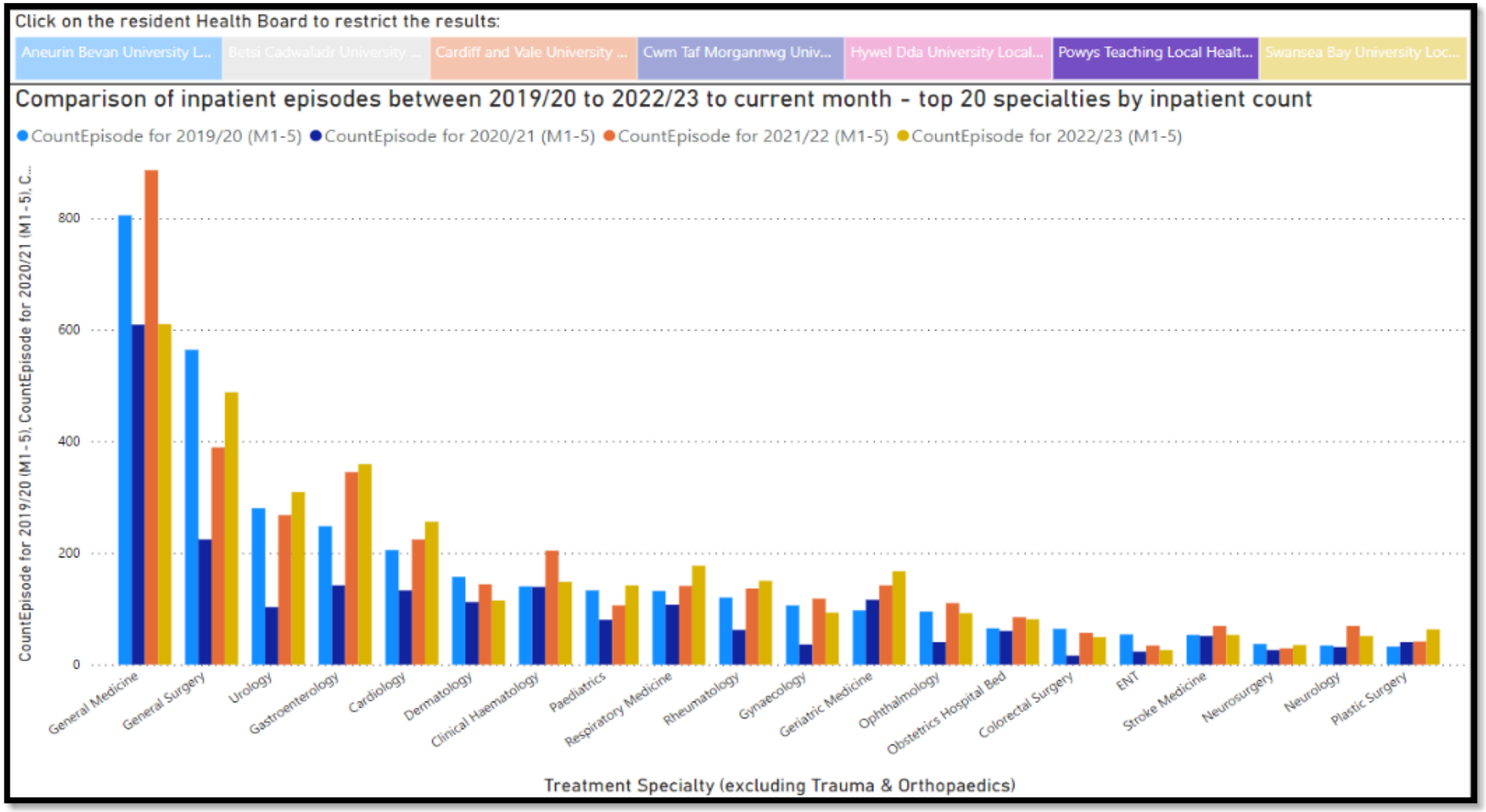
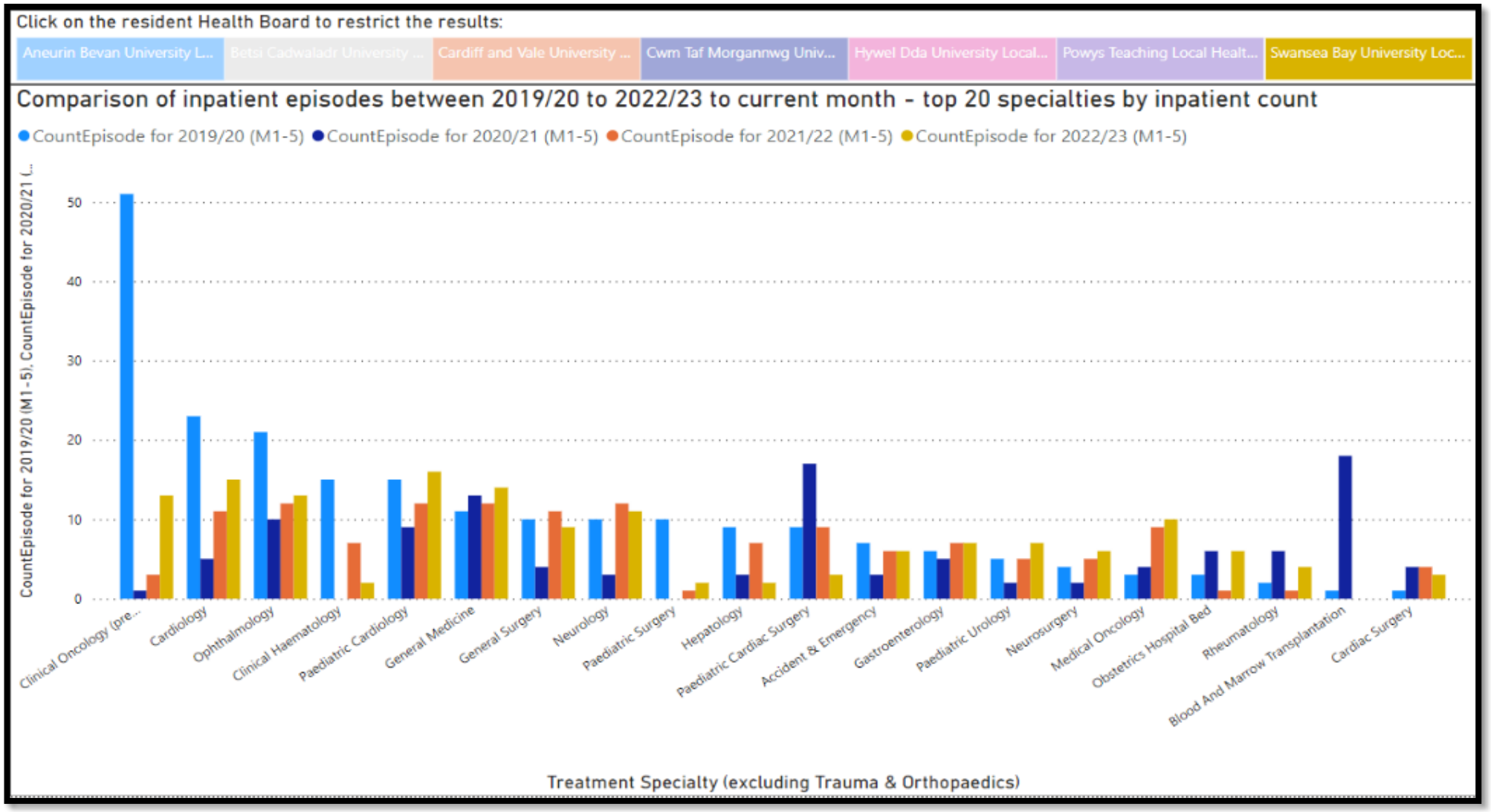


Table 4.8 – Swansea Bay UHB - Analysis by Specialty – Comparison of episodes to current month between 2019/20 and 2022/23



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.			

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)

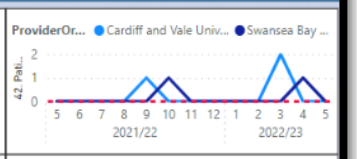
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

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

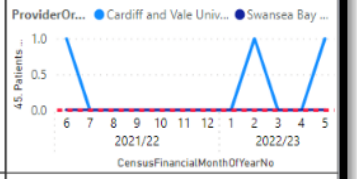
CensusFinancialYearStyle	2021/22												2022/23					
ProviderOrganisationCurrentName	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	
Cardiff and Vale University Local Health Board	0	0	0	0	0	0	0	0	1	0	0	0	0	0	2	0	0	
Swansea Bay University Local Health Board	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	
Total	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**2**	**1**	**0**	



45. Patients waiting more than 104 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2024

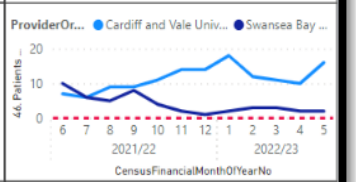
CensusFinancialYearStyle	2021/22												2022/23					
ProviderOrganisationCurrentName	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	
Cardiff and Vale University Local Health Board	0	2	2	2	1	1	0	0	0	0	0	0	0	1	0	0	1	
Swansea Bay University Local Health Board	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total	**0**	**2**	**2**	**2**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	



46. Patients waiting more than 36 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2026

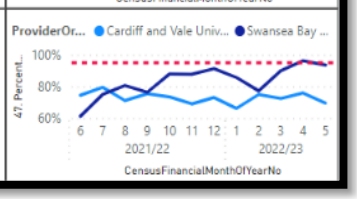
CensusFinancialYearStyle	2021/22								2022/23					
ProviderOrganisationCurrentName	5	6	7	8	9	10	11	12	1	2	3	4	5	
Cardiff and Vale University Local Health Board	9	7	6	9	9	11	14	14	18	12	11	10	16	
Swansea Bay University Local Health Board	20	10	6	5	8	4	2	1	2	3	3	2	2	
Total	**29**	**17**	**12**	**14**	**17**	**15**	**16**	**15**	**20**	**15**	**14**	**12**	**18**	



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	9	10	11	12	1	2	3	4	5
Cardiff and Vale University Local Health Board	75%	74%	69%	73%	66%	75%	73%	76%	70%
Swansea Bay University Local Health Board	76%	88%	88%	91%	86%	77%	90%	96%	94%
Total	**76%**	**80%**	**77%**	**80%**	**74%**	**76%**	**79%**	**84%**	**77%**



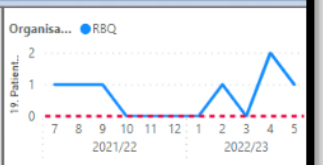
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

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

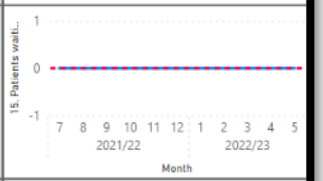
Fyear	2021/22												2022/23					
Organisation Code (Code of Provider)	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	
RBQ	3	2	1	0	2	0	1	1	1	0	0	0	0	1	0	2	1	
Total	**3**	**2**	**1**	**0**	**2**	**0**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**2**	**1**	



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	
RBQ	0	1	1	1	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**	



46. Patients waiting more than 36 weeks for treatment

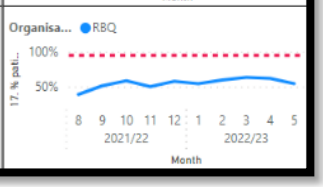
Target - Improvement trajectory towards a national target of 0 by 2026

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	
RBQ	16	18	19	22	26	22	21	21	22	25	17	15	18	19	18	16	17	
Total	**16**	**18**	**19**	**22**	**26**	**22**	**21**	**21**	**22**	**25**	**17**	**15**	**18**	**19**	**18**	**16**	**17**	

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)	6	7	8	9	10	11	12	1	2	3	4	5
RBQ	42%	49%	39%	51%	59%	50%	58%	54%	59%	64%	62%	54%
Total	**42%**	**49%**	**39%**	**51%**	**59%**	**50%**	**58%**	**54%**	**59%**	**64%**	**62%**	**54%**



Thoracic Surgery (measures 42, 45-47)

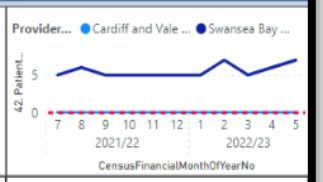
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

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

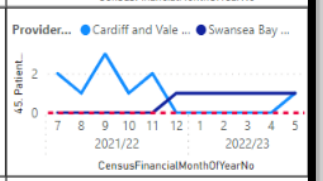
CensusFinancialYearStyle	2021/22												2022/23					
ProviderOrganisationCurrentName	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5		
Cardiff and Vale University Local Health Board	3	4	1	0	0	0	0	0	0	0	0	0	0	0	0	0		
Swansea Bay University Local Health Board	7	7	7	7	4	5	6	5	5	5	5	5	5	7	5	6	7	
Total	**10**	**11**	**8**	**7**	**4**	**5**	**6**	**5**	**5**	**5**	**5**	**5**	**7**	**5**	**6**	**7**		



45. Patients waiting more than 104 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2024

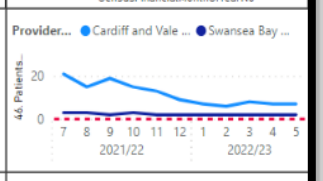
CensusFinancialYearStyle	2021/22												2022/23					
ProviderOrganisationCurrentName	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	
Cardiff and Vale University Local Health Board	0	0	0	0	1	1	2	1	3	1	2	0	0	0	0	0	1	
Swansea Bay University Local Health Board	0	0	0	0	1	0	0	0	0	0	0	1	1	1	1	1	1	
Total	**0**	**0**	**0**	**0**	**2**	**1**	**2**	**1**	**3**	**1**	**2**	**1**	**1**	**1**	**1**	**1**	**2**	



46. Patients waiting more than 36 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2026

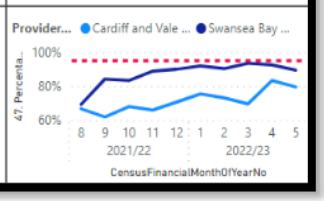
CensusFinancialYearStyle	2021/22												2022/23					
ProviderOrganisationCurrentName	4	5	6	7	8	9	10	11	12	1	2	3	4	5				
Cardiff and Vale University Local Health Board	24	21	20	21	15	19	15	13	9	7	6	8	7	7				
Swansea Bay University Local Health Board	8	6	4	3	3	2	3	2	2	2	2	2	2	2				
Total	**32**	**27**	**24**	**24**	**18**	**21**	**18**	**15**	**11**	**9**	**8**	**10**	**9**	**9**				



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	9	10	11	12	1	2	3	4	5
Cardiff and Vale University Local Health Board	62%	68%	66%	71%	75%	73%	70%	83%	80%
Swansea Bay University Local Health Board	84%	83%	89%	90%	92%	90%	94%	93%	89%
Total	**68%**	**72%**	**73%**	**78%**	**80%**	**80%**	**79%**	**87%**	**83%**



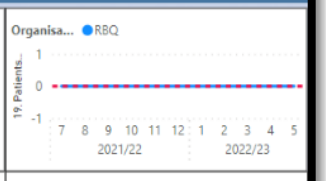
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

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

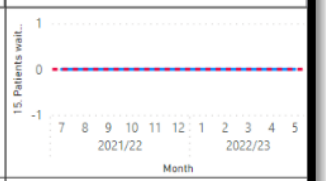
Fyear	2021/22												2022/23					
Organisation Code (Code of Provider)	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	
RBQ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	



45. Patients waiting more than 104 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2024

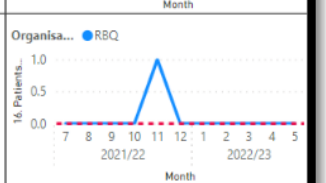
Fyear	2021/22												2022/23					
Organisation Code (Code of Provider)	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	
RBQ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	



46. Patients waiting more than 36 weeks for treatment

Target - Improvement trajectory towards a national target of 0 by 2026

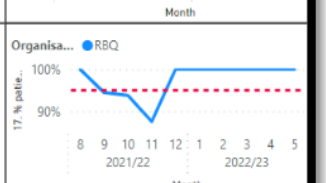
Fyear	2021/22												2022/23					
Organisation Code (Code of Provider)	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	
RBQ	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	



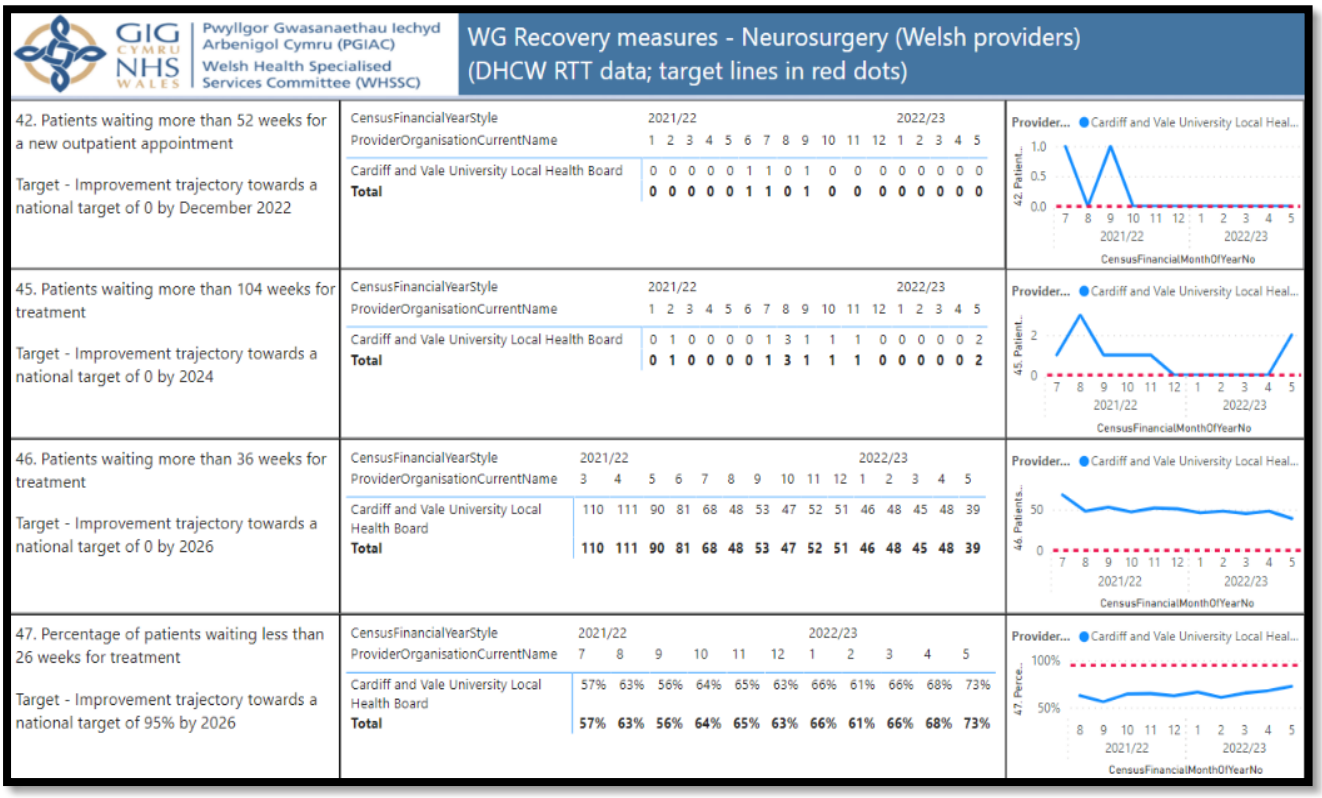
47. Percentage of patients waiting less than 26 weeks for treatment

Target - Improvement trajectory towards a national target of 95% by 2026

Fyear	2021/22					2022/23				
Organisation Code (Code of Provider)	8	9	10	11	12	1	2	3	4	5
RBQ	100%	94%	94%	88%	100%	100%	100%	100%	100%	100%
Total	**100%**	**94%**	**94%**	**88%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**



Neurosurgery (measures 42, 45-47)



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	
Cardiff and Vale University Local Health Board	0	0	0	0	0	1	1	0	1	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**	

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	
Cardiff and Vale University Local Health Board	0	1	0	0	0	0	1	3	1	1	1	0	0	0	0	0	2	
Total	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**3**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**2**	

46. Patients waiting more than 36 weeks for treatment

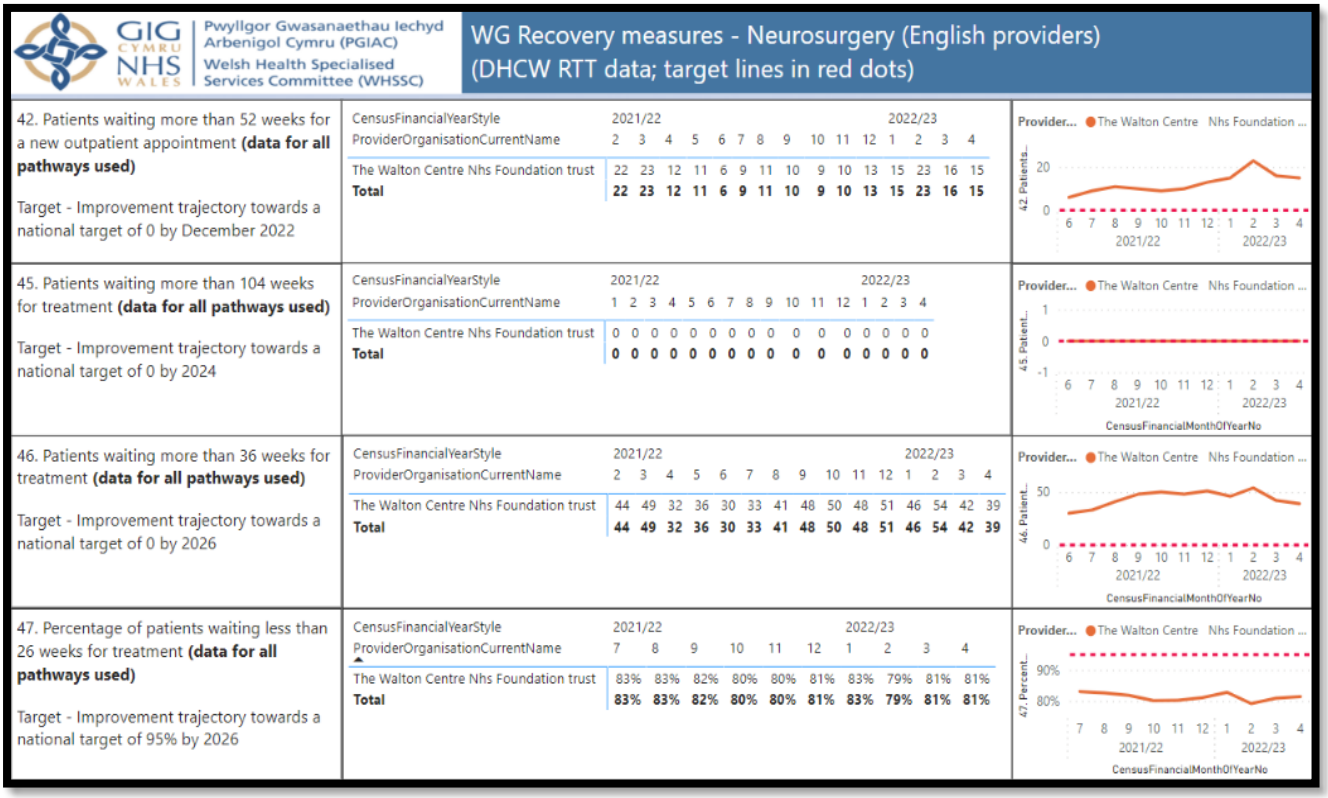
Target - Improvement trajectory towards a national target of 0 by 2026

CensusFinancialYearStyle	2021/22												2022/23					
ProviderOrganisationCurrentName	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5			
Cardiff and Vale University Local Health Board	110	111	90	81	68	48	53	47	52	51	46	48	45	48	39			
Total	**110**	**111**	**90**	**81**	**68**	**48**	**53**	**47**	**52**	**51**	**46**	**48**	**45**	**48**	**39**			

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	7	8	9	10	11	12	1	2	3	4	5
Cardiff and Vale University Local Health Board	57%	63%	56%	64%	65%	63%	66%	61%	66%	68%	73%
Total	**57%**	**63%**	**56%**	**64%**	**65%**	**63%**	**66%**	**61%**	**66%**	**68%**	**73%**



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	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4		
The Walton Centre Nhs Foundation trust	22	23	12	11	6	9	11	10	9	10	13	15	23	16	15		
Total	**22**	**23**	**12**	**11**	**6**	**9**	**11**	**10**	**9**	**10**	**13**	**15**	**23**	**16**	**15**		

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	
The Walton Centre Nhs Foundation trust	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**	

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

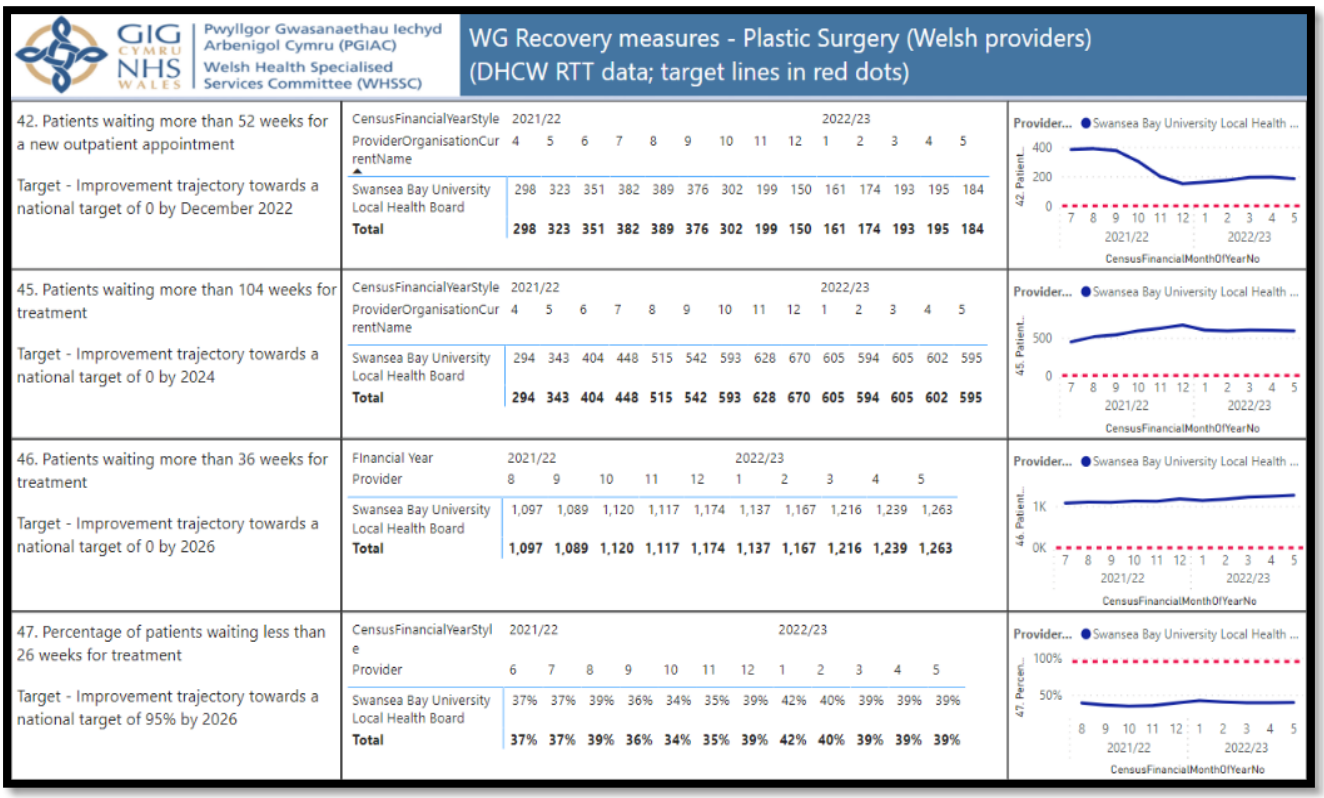
CensusFinancialYearStyle	2021/22												2022/23				
ProviderOrganisationCurrentName	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4		
The Walton Centre Nhs Foundation trust	44	49	32	36	30	33	41	48	50	48	51	46	54	42	39		
Total	**44**	**49**	**32**	**36**	**30**	**33**	**41**	**48**	**50**	**48**	**51**	**46**	**54**	**42**	**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	7	8	9	10	11	12	1	2	3	4
The Walton Centre Nhs Foundation trust	83%	83%	82%	80%	80%	81%	83%	79%	81%	81%
Total	**83%**	**83%**	**82%**	**80%**	**80%**	**81%**	**83%**	**79%**	**81%**	**81%**

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	4	5	6	7	8	9	10	11	12	1	2	3	4	5
Swansea Bay University Local Health Board	298	323	351	382	389	376	302	199	150	161	174	193	195	184
Total	**298**	**323**	**351**	**382**	**389**	**376**	**302**	**199**	**150**	**161**	**174**	**193**	**195**	**184**

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	4	5	6	7	8	9	10	11	12	1	2	3	4	5
Swansea Bay University Local Health Board	294	343	404	448	515	542	593	628	670	605	594	605	602	595
Total	**294**	**343**	**404**	**448**	**515**	**542**	**593**	**628**	**670**	**605**	**594**	**605**	**602**	**595**

46. Patients waiting more than 36 weeks for treatment

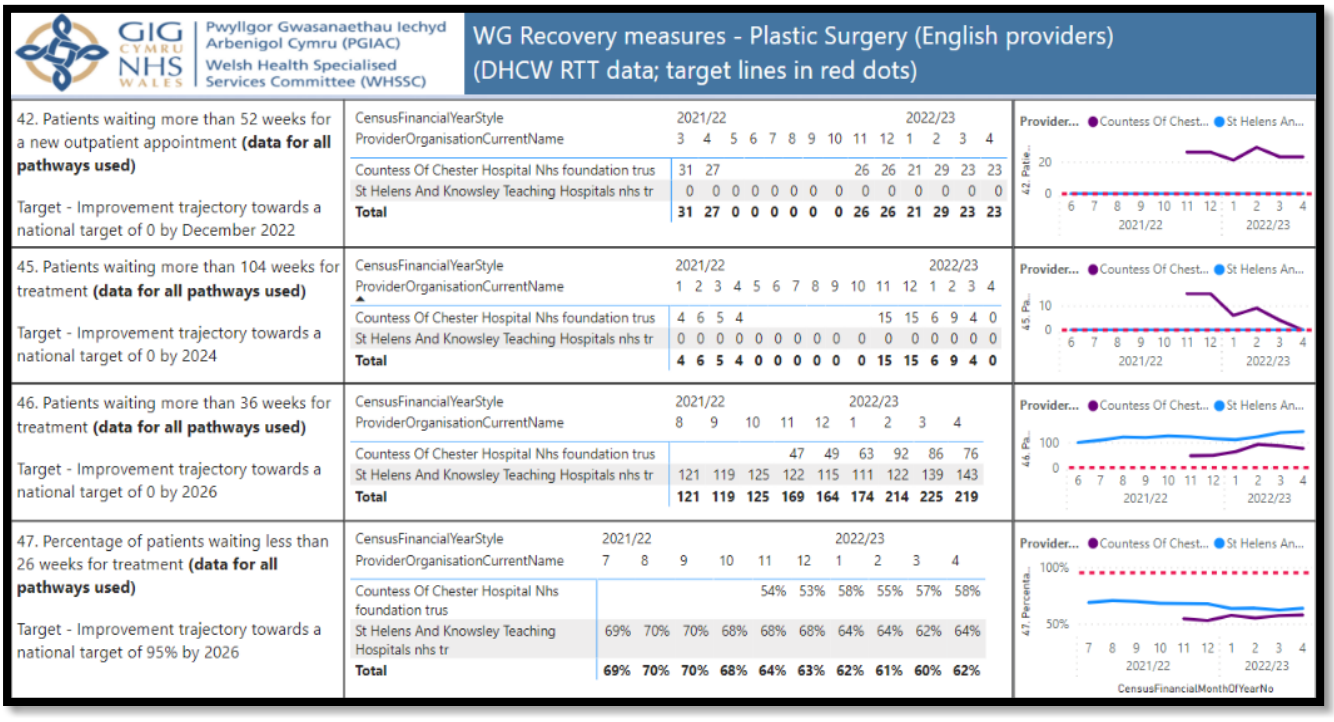
Target - Improvement trajectory towards a national target of 0 by 2026

Financial Year	2021/22					2022/23				
Provider	8	9	10	11	12	1	2	3	4	5
Swansea Bay University Local Health Board	1,097	1,089	1,120	1,117	1,174	1,137	1,167	1,216	1,239	1,263
Total	**1,097**	**1,089**	**1,120**	**1,117**	**1,174**	**1,137**	**1,167**	**1,216**	**1,239**	**1,263**

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	6	7	8	9	10	11	12	1	2	3	4	5
Swansea Bay University Local Health Board	37%	37%	39%	36%	34%	35%	39%	42%	40%	39%	39%	39%
Total	**37%**	**37%**	**39%**	**36%**	**34%**	**35%**	**39%**	**42%**	**40%**	**39%**	**39%**	**39%**



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	3	4	5	6	7	8	9	10	11	12	1	2	3	4
Countess Of Chester Hospital Nhs foundation trus	31	27							26	26	21	29	23	23
St Helens And Knowsley Teaching Hospitals nhs tr	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**31**	**27**	**0**	**0**	**0**	**0**	**0**	**0**	**26**	**26**	**21**	**29**	**23**	**23**

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
Countess Of Chester Hospital Nhs foundation trus	4	6	5	4							15	15	6	9	4	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	**4**	**6**	**5**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**15**	**15**	**6**	**9**	**4**	**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

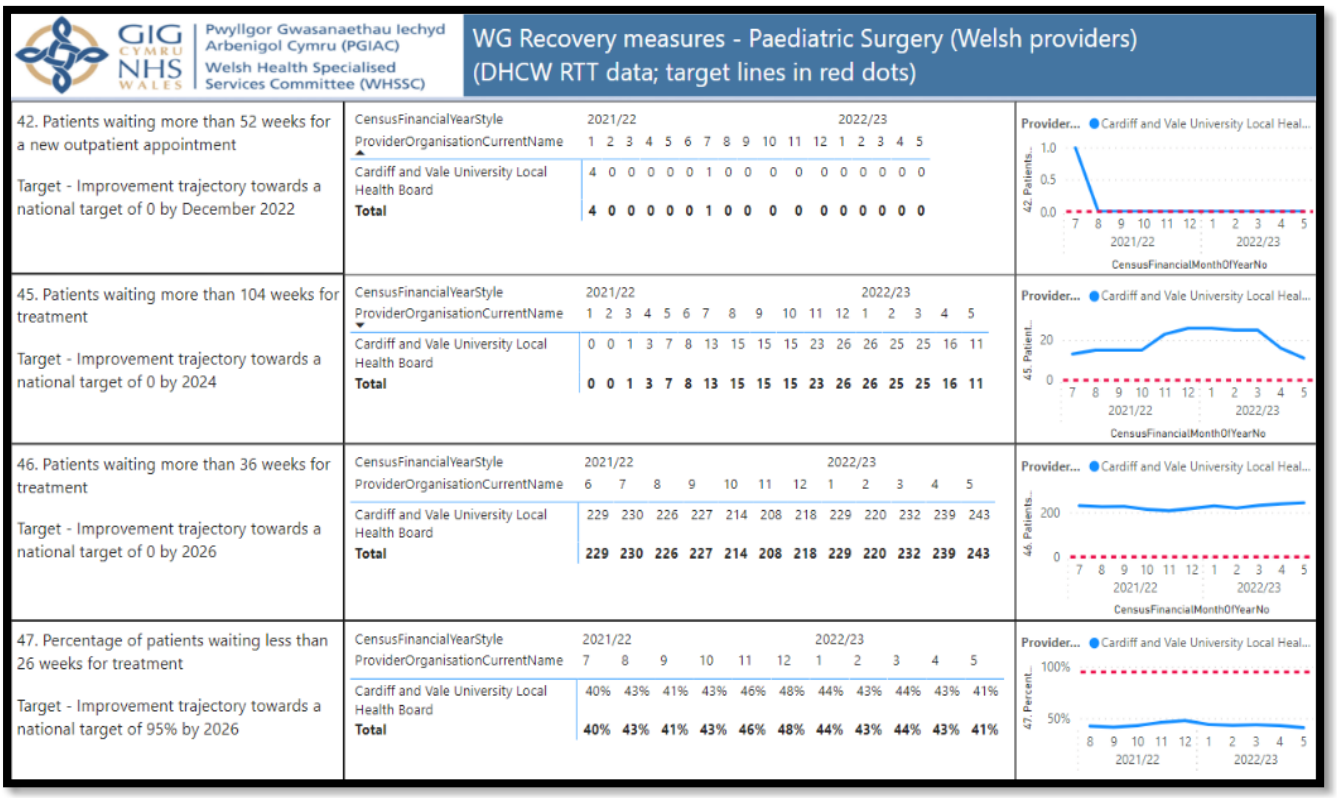
CensusFinancialYearStyle	2021/22						2022/23			
ProviderOrganisationCurrentName	8	9	10	11	12	1	2	3	4	
Countess Of Chester Hospital Nhs foundation trus				47	49	63	92	86	76	
St Helens And Knowsley Teaching Hospitals nhs tr	121	119	125	122	115	111	122	139	143	
Total	**121**	**119**	**125**	**169**	**164**	**174**	**214**	**225**	**219**	

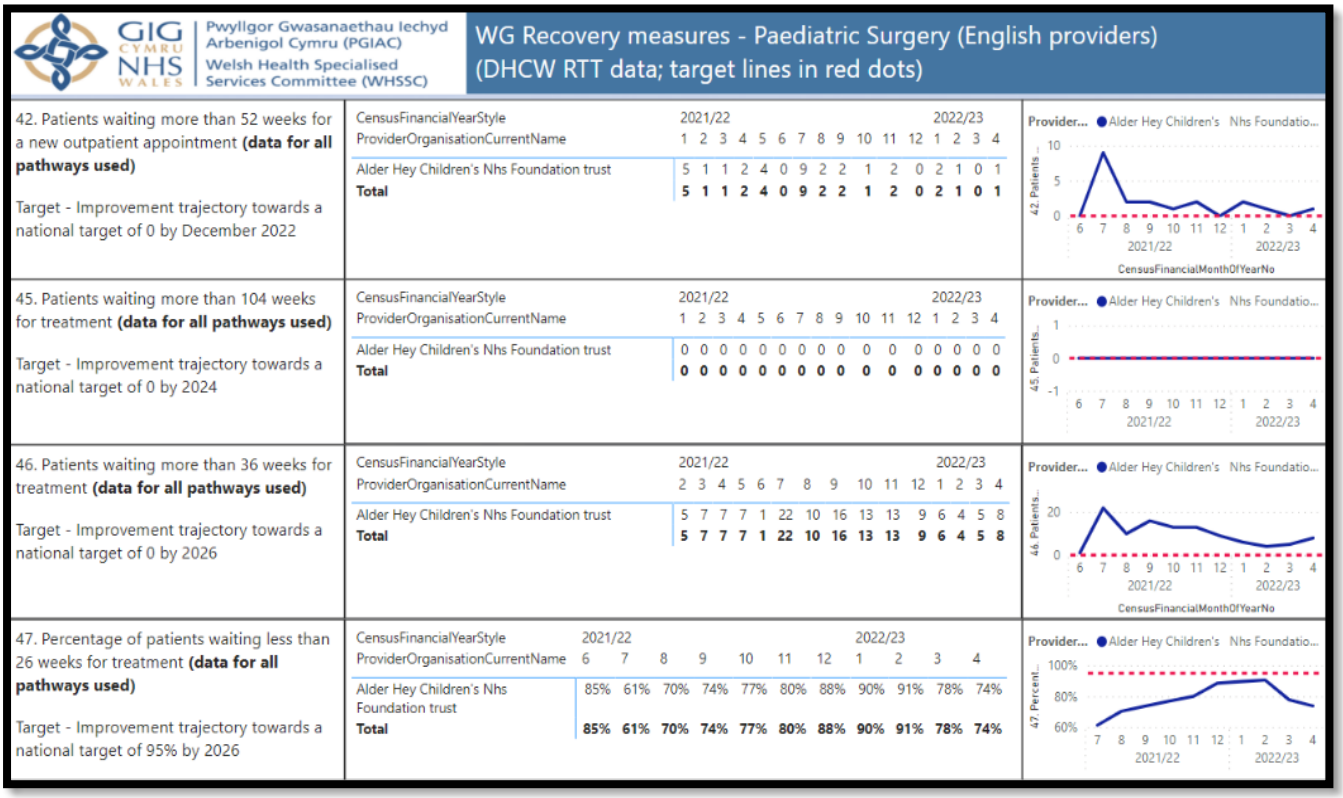
47. Percentage of patients waiting less than 26 weeks for treatment (data for all pathways used)

Target - Improvement trajectory towards a national target of 95% by 2026

CensusFinancialYearStyle	2021/22						2022/23			
ProviderOrganisationCurrentName	7	8	9	10	11	12	1	2	3	4
Countess Of Chester Hospital Nhs foundation trus					54%	53%	58%	55%	57%	58%
St Helens And Knowsley Teaching Hospitals nhs tr	69%	70%	70%	68%	68%	68%	64%	64%	62%	64%
Total	**69%**	**70%**	**70%**	**68%**	**64%**	**63%**	**62%**	**61%**	**60%**	**62%**

Paediatric Surgery (measures 42, 45-47)

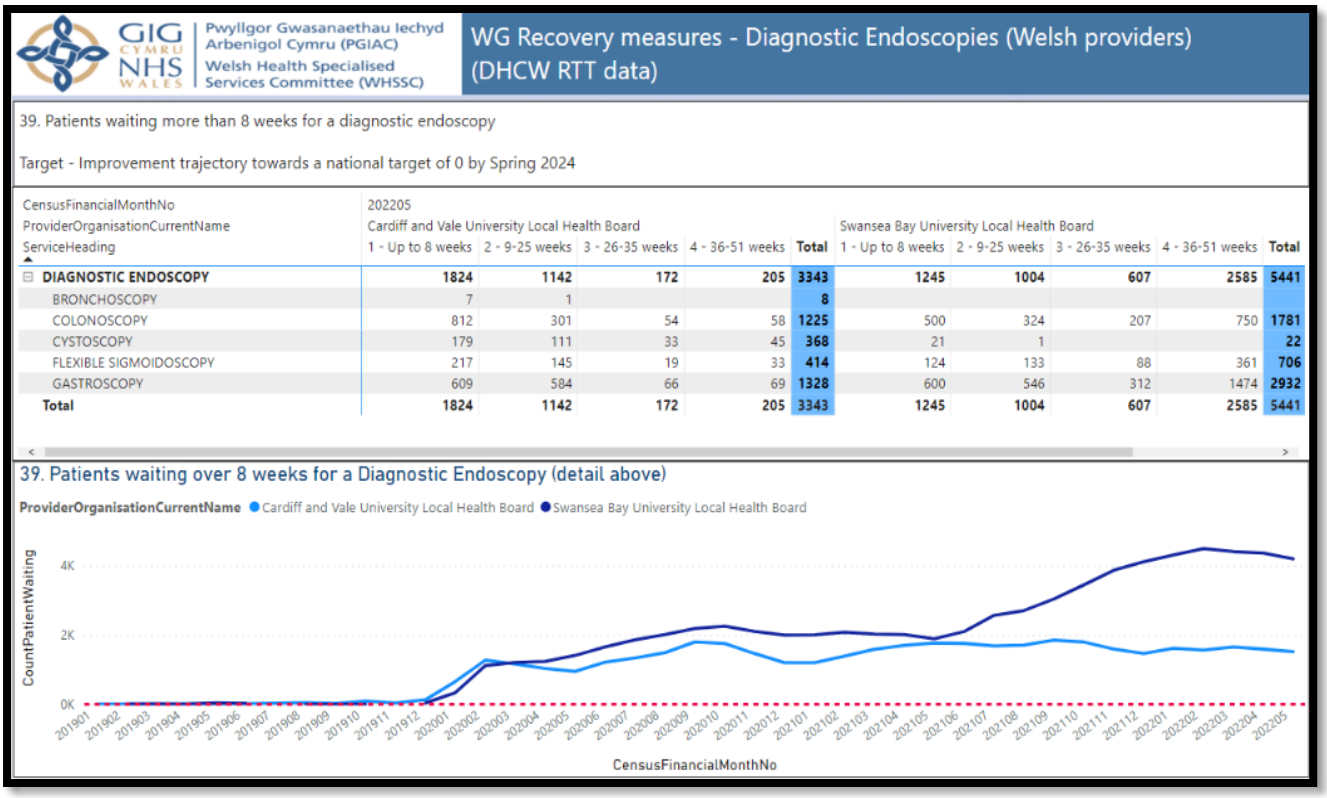




Patients waiting over 8 weeks for a Diagnostic Endoscopy (measure 39)

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.



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)

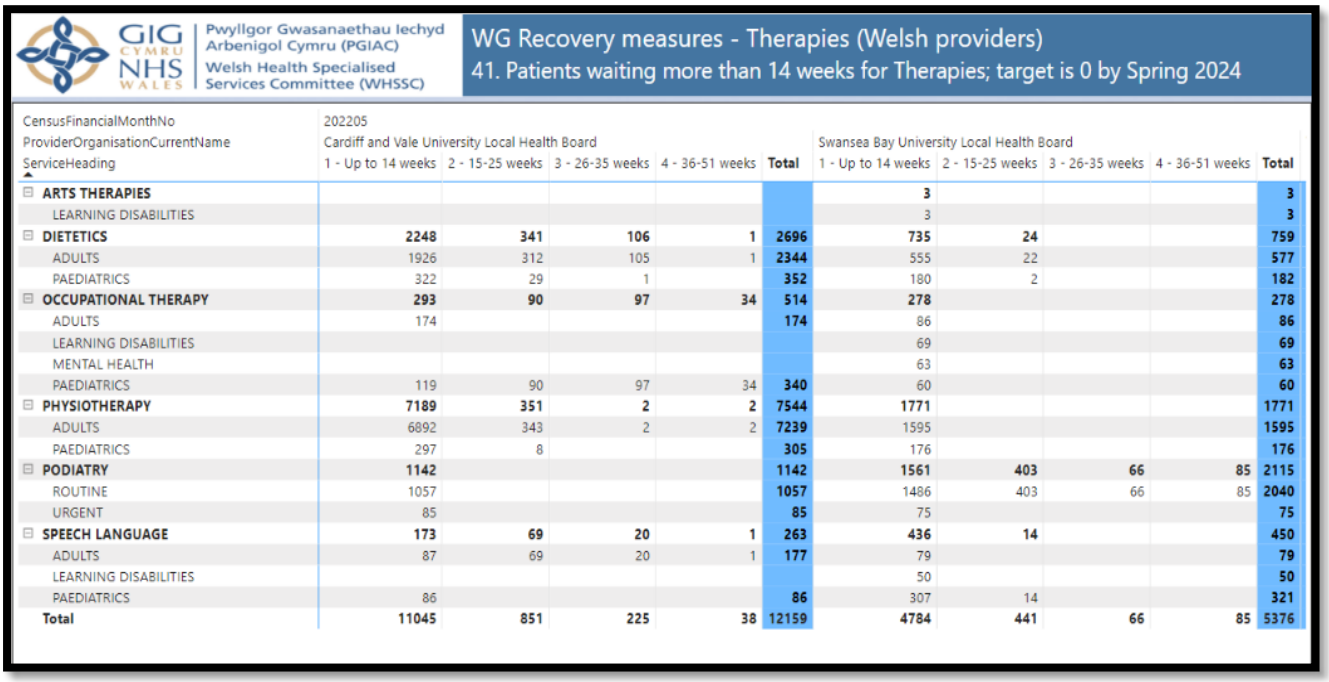
WG Recovery measures - Diagnostics (Welsh providers)
40. Patients waiting more than 8 weeks for Diagnostics; target is 0 by Spring 2024

CensusFinancialMonthNo	202205									
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)	**605**	**513**	**82**	**4**	**1204**	**401**	**50**			**451**
CONSULTANT	605	513	82	4	**1204**	43	6			**49**
GP						358	44			**402**
CARDIOLOGY	**2088**	**429**	**38**	**58**	**2613**	**1841**	**917**	**24**	**22**	**2804**
BLOOD PRESSURE MONITORING	73	2			**75**	49				**49**
CARDIAC COMPUTED TOMOGRAPHY (CARDIAC CT)	46				**46**	174	80	14	19	**287**
CARDIAC MAGNETIC RESONANCE IMAGING (CARDIAC MRI)	66	15		1	**82**	86	12			**98**
DIAGNOSTIC ANGIOGRAPHY	36	73	17	16	**142**	2	2		1	**5**
DIAGNOSTIC ELECTROPHYSIOLOGY (EP STUDY)		1			**1**			1		**1**
DOBUTAMINE STRESS ECHOCARDIOGRAM (DSE)	20	38			**58**	10	9			**19**
ECHO CARDIOGRAM	1256	193			**1449**	1014	728	1		**1743**
HEART RHYTHM RECORDING	501	49			**550**	371	7			**378**
MYOCARDIAL PERFUSION SCANNING	9	22	13	41	**85**	57	76	8		**141**
STRESS TEST	58	28	8		**94**	72	1			**73**
TRANS OESOPHAGEAL ECHOCARDIOGRAM (TOE)	23	8			**31**	6	2		2	**10**
IMAGING	**77**	**5**			**82**	**101**	**5**			**106**
FLUOROSCOPY	77	5			**82**	101	5			**106**
NEUROPHYSIOLOGY	**105**	**5**			**110**	**362**	**318**	**38**		**718**
ELECTROMYOGRAPHY	75	5			**80**	92	51	4		**147**
NERVE CONDUCTION STUDIES	30				**30**	270	267	34		**571**
PHYSIOLOGICAL MEASUREMENT	**132**	**54**	**38**	**67**	**291**	**386**	**185**	**26**	**41**	**638**
LIMITED CHANNEL CARDIO-RESPIRATORY SLEEP STUDY (POLYGRAPHY)						99	140	20	35	**294**
OVERNIGHT PULSE OXIMETRY						161	30	6	6	**203**
URODYNAMIC TESTS	41	54	38	67	**200**					
VASCULAR TECHNOLOGY	91				**91**	126	15			**141**
RADIOLOGY - CONSULTANT REFERRAL	**4072**	**281**	**17**	**13**	**4383**	**2360**	**77**	**2**		**2439**
NON CARDIAC COMPUTED TOMOGRAPHY	1069	3		1	**1073**	423				**423**
NON CARDIAC MAGNETIC RESONANCE IMAGING (MRI)	1546	102	17	12	**1677**	993	3			**996**
NON CARDIAC NUCLEAR MEDICINE	105				**105**	241	72	2		**315**
NON-OBSTETRIC ULTRASOUND	1352	176			**1528**	703	2			**705**
RADIOLOGY - GP REFERRAL	**4076**	**446**	**1**		**4523**	**1335**	**4**			**1339**
NON CARDIAC COMPUTED TOMOGRAPHY	783				**783**	257				**257**
NON CARDIAC MAGNETIC RESONANCE IMAGING (MRI)	363	11			**374**	119				**119**
NON CARDIAC NUCLEAR MEDICINE	5				**5**	6				**6**
NON-OBSTETRIC ULTRASOUND	2925	435	1		**3361**	953	4			**957**
Total	**11155**	**1733**	**176**	**142**	**13206**	**6786**	**1556**	**90**	**63**	**8495**

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	202205									
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						3				3
LEARNING DISABILITIES						3				3
DIETETICS	2248	341	106	1	2696	735	24			759
ADULTS	1926	312	105	1	2344	555	22			577
PAEDIATRICS	322	29	1		352	180	2			182
OCCUPATIONAL THERAPY	293	90	97	34	514	278				278
ADULTS	174				174	86				86
LEARNING DISABILITIES						69				69
MENTAL HEALTH						63				63
PAEDIATRICS	119	90	97	34	340	60				60
PHYSIOTHERAPY	7189	351	2	2	7544	1771				1771
ADULTS	6892	343	2	2	7239	1595				1595
PAEDIATRICS	297	8			305	176				176
PODIATRY	1142				1142	1561	403	66	85	2115
ROUTINE	1057				1057	1486	403	66	85	2040
URGENT	85				85	75				75
SPEECH LANGUAGE	173	69	20	1	263	436	14			450
ADULTS	87	69	20	1	177	79				79
LEARNING DISABILITIES						50				50
PAEDIATRICS	86				86	307	14			321
Total	11045	851	225	38	12159	4784	441	66	85	5376

Report Title	**WHSSC Financial Performance Report – Month 6 2022-2023**	**Agenda Item**	4.2
Meeting Title	**Joint Committee Meeting**	**Meeting Date**	08/11/2022
FOI Status	Open/Public		
Author (Job title)	Finance Manager - Contracting		
Executive Lead (Job title)	Director of Finance		

Purpose of the Report	The purpose of this report is to set out the financial position for WHSSC for the 6th 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 6 2022-2023

1.0 SITUATION

The purpose of this report is to provide the yearend financial position of WHSSC for the 2022-2023 financial year.

This report will be shared with WHSSC Management Group on 27th October and Joint Committee on 8th November.

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 6 for WHSSC is a year-end outturn forecast under spend of £13,711k.

The under spend predominantly relates to releasable reserves from 2021-2022, Welsh provider under performance, Renal underperformance and 22/23 planned development. This is partially offset by forecast over spends in specialised mental health provision, NHS England contracted providers, IPFR and prior year developments.

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 6

1.0 SITUATION / PURPOSE OF REPORT

The purpose of this report is to set out the estimated financial position for WHSSC for the 6th month of 2022-2023 together with any corrective action required.

Table 1 - WHSSC / EASC split

	Annual Budget	Budgeted to Date	Actual to Date	Variance to Date	Movement in Var to date	Current EOYF	Movement in EOYF position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
WHSSC	760,111	380,056	371,197	(8,858)	(1,019)	(13,717)	(35)
EASC (WAST, EMRTS, NCCU)	238,013	119,006	119,010	3	0	6	(0)
Total as per Risk-share tables	998,124	499,062	490,207	(8,855)	(1,018)	(13,711)	(36)

The narrative of this report excludes the financial position for EASC, which includes the WAST contracts, the EASC team costs and the QAT team costs, and have a separate Finance Report. For information purposes, the consolidated position is summarised in the table below.

Please note that as LHB's cover any WHSSC variances, any over/under spends are adjusted back out to LHB's. Therefore, although this document reports on the effective position to date, this value is actually reported through the LHB monthly positions, and the WHSSC position as reported to 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 6 is a year to date underspend of £8,855k and a forecast outturn underspend of £13,711k.

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 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	272,165	136,083	136,170	87	(193)	(537)	(693)
Swansea Bay University Health Board	113,836	56,918	56,926	8	(379)	(865)	(1,305)
Cwm Taf Morgannwg University Health Board	11,084	5,542	5,869	327	200	327	200
Aneurin Bevan Health Board	9,851	4,925	5,207	281	271	281	271
Hywel Dda Health Board	1,735	868	868	0	0	0	0
Betsi Cadwaladr Univ Health Board Provider	45,748	22,874	22,881	7	6	7	6
Velindre NHS Trust	54,292	27,146	27,463	317	261	561	543
Sub-total NHS Wales	**508,712**	**254,356**	**255,384**	**1,028**	**166**	**(226)**	**(978)**
Non Welsh SLAs	124,723	62,361	64,526	2,165	1,400	4,409	3,896
IPFR	43,857	21,928	21,748	(180)	(170)	801	705
IVF	5,020	2,510	2,678	168	148	226	226
Mental Health	36,533	18,266	19,907	1,640	1,224	1,388	2,031
Renal	4,959	2,480	2,130	(350)	(312)	(504)	(552)
Prior Year developments	1,928	964	2,312	1,348	1,079	2,267	1,990
2020/21 Plan Developments	29,436	14,098	7,984	(6,114)	(4,321)	(5,051)	(3,957)
Direct Running Costs	4,944	2,472	2,420	(52)	(75)	(2)	(39)
Reserves Releases 2019/20	0	0	(8,512)	(8,512)	(6,979)	(17,025)	(17,003)
Phasing adjustment for Developments not yet implemented ** see below	0	620	620	0	0	0	0
Total Expenditure	**760,111**	**380,056**	**371,197**	**(8,858)**	**(7,839)**	**(13,717)**	**(13,681)**

The reported position is based on the following:

- NHS Wales activity – provider contract monitoring against the DOF framework principles against baselines based on 19-20 outturn.
- NHS England activity – provider contract monitoring against agreed baselines based on the NHSE 'aligned payment and incentives' baselines with known variances for drugs and devices applied.
- Mental Health & IPFR – live patient data as at the end of the month, plus current funding approvals.
- Developments – variety of bases, including agreed phasing of funding.
- All other areas are reported as 1/12th of IMTP.

** Please note that Income is collected from LHB's in equal 12ths, therefore there is usually an excess budget in Months 1-11 which relates to Developments funding in future months. To keep the Income and Expenditure position equal, the phasing adjustment is shown on a separate line for transparency and is accrued to date to avoid a technical underspend.

5.0 FINANCIAL POSITION DETAIL - PROVIDERS

Provider positions can be summarised as follows for month 6:

5.1 NHS Wales Providers

YTD M6 position £1,028k, Forecast YE position (£226k).

The YTD position comprises overspends in all LHBs apart from Hywel Dda. C&V have performance variations in a number of services this month with movements seen in the following services:

- An increase in the trajectory for TAVI is included in the forecast position.
- Home TPN has seen an increase in activity due to a number of long stay patients currently being treated by the service.
- All the above has been partially off-set by a reduction Mitral Valve Leaflet repair activity and Immunology products.

At SB there is also an upwards trajectory in relation to TAVI, an upturn in thoracic activity and an overall increase in spending on NICE drugs. These increases have been partially offset by a reduction in plastics activity in non-elective procedures. The overspending position in the other Welsh providers remains stable this month with only a small increase in forecast positions.

5.2 NHS England Providers

YTD M6 position £2,165k, Forecast YE position £4,409k.

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 4.1% inflation. The position remains stable this month with relatively small increases in over performance.

The forecast this month also includes:

- There has been continued activity increases on drugs and devices pass through costs at a number of trusts in recent data that has been reflected in this month's position. These trusts include Manchester, The Christie, Bristol and North Midlands.
- This month has also included an ERF claim for Q1 recovery above baseline for Liverpool Heart and Chest.
- These overspends are partially offset by underspending positions in a number of other trusts due to reductions in activity to date.
- It should also be noted that the recovery provision of £2.7m is held back at this point in anticipation of further elective recovery in the second half of the year in line with provider plans.

5.3 Individual Patient Commissioning & Non Contract Activity

YTD M6 position (£180k), Forecast YE position £801k.

There is no material movement in either YTD or forecast positions this month. This position reflects known approvals to date and the impact of ERT high cost

drugs which is the main factor in the position movement this month. The Home Parenteral Nutrition forecast includes the anticipated price inflation that is likely to arise from the proposed contract extension.

5.4 Specialised Mental Health

YTD M6 position £1,640k, Forecast YE position £1,388k.

The Mental Health forecast position has improved by (£0.643m) due to a number of CAMHS OOA placements being discharged in the last 2 months and only a small number of placements continuing into October. There are a number of complex CAMHS patients in high costs placements and a provision of for non-contract eating disorders for when the Oxford contract capacity is withdrawn.

5.5 Renal

YTD M6 position (£350k), Forecast YE position (£504k).

There has been no material movement in the position reported this month. The main reason for the forecast position remains an under spend in the Royal Liverpool and Broadgreen based on the 19-20 block contract.

5.6 Developments and Strategic Priorities

YTD M6 position (£4,766k), Forecast YE position (£2,784k).

This month a new patient has been approved for Asfotase Alpha and there has been an increase in spend on radio labelled therapies which has been more than offset by increased slippage against prior year development schemes and New Specialised Services & Strategic Priorities.

5.7 WHSSC Running Costs

YTD M6 position (£52k), Forecast YE position (£2k).

The forecast under spend position is mainly due to vacancies within the renal network. The core DRC position is breakeven as vacancies will balance off a number of exceptional costs, including excess insurance and energy.

5.8 Reserves

Secured releasable reserves of £17,025k relating to the 2021-22 year end have been identified and will be phased into the position on a monthly basis.

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 M6	(8,858)	(1,669)	(1,236)	(1,558)	(1,523)	(1,278)	(213)	(1,380)
Variance M5	(7,840)	(1,311)	(1,199)	(1,306)	(1,162)	(1,167)	(195)	(1,499)
Movement	(1,019)	(358)	(37)	(252)	(361)	(111)	(18)	118

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 M6	(13,717)	(2,481)	(2,171)	(2,353)	(2,394)	(2,080)	(197)	(2,041)
EOY forecast M5	(13,682)	(2,483)	(2,114)	(2,293)	(2,422)	(2,025)	(155)	(2,190)
EOY movement	(35)	2	(57)	(61)	28	(54)	(42)	149

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 has been separated, although both organisations share one bank account. The below table uses the total income to allow reconciliation to the MMR returns; please refer to the income tab on the monthly risk-sharing file to see further details relating to the commissioner income.

Table 5 – 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	Accrued Income - EASC £'000	Total Income Accounted to Date £'000	EOY Comm'er Position £'000
SB	121,901	60,950	60,746	186	19	60,951	(2,171)
Aneurin Bevan	188,357	94,178	93,711	437	30	94,179	(2,392)
Betsi Cadwaladr	218,000	109,000	108,956	0	44	109,000	(2,041)
Cardiff and Vale	162,120	81,060	80,008	1,029	23	81,060	(2,480)
Cwm Taf Morgannwg	141,944	70,972	70,666	683	(377)	70,972	(2,350)
Hywel Dda	117,687	58,844	58,820	0	23	58,844	(2,080)
Powys	48,116	24,058	23,943	102	13	24,057	(197)
Public Health Wales						0	
Velindre						0	
WAST						0	
Total	**998,124**	**499,062**	**496,851**	**2,437**	**(226)**	**499,062**	**(13,711)**

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

Cardiff University PETIC scanning centre have notified WHSSC of excess energy costs relating to NHS activity forecast at £1m for 2022/23.

9.0 PUBLIC SECTOR PAYMENT COMPLIANCE

As at month 6 WHSSC has achieved 99.7% compliance for NHS invoices paid within 30 days by value and 94.0% by number.

For non NHS invoices WHSSC has achieved 98.1% in value for invoices paid within 30 days and 99.1% by number.

This data is updated on a quarterly basis.

WHSSC has undertaken a self-audit of our PSPP results as provided by NHS WSSP and are content that they are accurate. Therefore we have updated our forecast end of year position.

10. RESPONSES TO ACTION NOTES FROM WG MMR RESPONSES

Action 5.1 – We have reviewed the Employers NI exceptional costs previously reported and materially revised down the reported value of this cost pressure.

Action 5.2 – WHSSC have no requirement for cash assistance at this time.

11. SLA 2021-2022 STATUS UPDATE

All Welsh SLAs were agreed at the end of June.

12. CONFIRMATION OF POSITION REPORT BY THE MD AND DOF

Sian Lewis,
Managing Director, WHSSC

Stuart Davies,
Director of Finance, WHSSC

Report Title	**Corporate Governance Report**	**Agenda Item**	4.3
Meeting Title	**Joint Committee**	**Meeting Date**	8/11/2022
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 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 6 September and the following updates were received:

- Managing Director's Report:
  - An update of the Private Relationship with Eating Disorder Beds
  - High Cost CAMHS Low Secure Placement
- Neonatal Transport Network Update report from Delivery Assurance Group (DAG).

3.2 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:

- WHC/2022/022 – The role of the Community Dental Service
- WHC/2022/023 – Changes to the vaccine for the HPV immunisation programme

3.3 Quality & Patient Safety Committee Development Day

As part of the Joint Committee's development plan the Quality & Patient Safety Committee (QPSC) hold an annual development day to keep members informed and engaged on developments.

On 26 September 2022, the Quality Patient Safety Committee Development Day went ahead and IM representatives from 6 of the 7 Health Boards were in

attendance. The event received positive feedback and formal evaluation form was sent to attendees and the presentations from the day circulated. A detailed update will be presented to the next QPS Committee on the 25 October 2022.

3.4 Welsh Kidney Network (WKN) Governance Review Update

A governance review was recently undertaken on the Welsh Kidney Network (WKN) (previously known as the Welsh Renal Clinical Network (WRCN)) and the findings were considered by the WKN Board on 6 October 2022.

Karen Preece has been appointed as the new executive lead for the WKN and is developing an action plan in response to the recommendations, which will focus on governance, strategy and workforce. An update is provided under the WKN Chairs report and the WKN Board will consider and develop an action plan at its next Board meeting on 23 November 2022.

3.5 Forward Work Plan

The Forward Work Plan is presented at ***Appendix 1*** for information.

3.6 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 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	Approval process
Health and Care Standards	Governance, Leadership and Accountability Choose an item. Choose an item.
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Choose an item. Choose an item.
Institute for HealthCare Improvement Quadruple Aim	Improving Patient Experience (including quality and Satisfaction) Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	Ensuring the 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	11 October 2022 – Integrated Governance Committee
Appendices	**Appendix 1 –** Forward Work Plan

WHSSC JOINT COMMITTEE – 12 MONTH ROLLING FORWARD WORK PLAN

MEETING	STANDING ITEMS	FOR APPROVAL / ACTION	ROUTINE REPORTS	INFORMATION
08 November 2022	Chair's Report Managing Director's Report Declarations of Interest Minutes Action Log Forward Work Plan	Mental Health Specialised Services Strategy Options Appraisal for Single Commissioner for Secure Mental Health Delivering Thrombectomy Capacity in South Wales	COVID-19 Period Activity Report Financial Performance Report Corporate Governance Matters Report Reports from the Joint Sub-Committees - CTMUHB Audit & Risk Committee; including update to Financial Limits - Management Group Briefings - Quality & Patient Safety Committee - Integrated Governance Committee - Individual Patient Funding Request Panel - WKN - Governance	Draft ICP Gender Identity Development Service (GIDS) Recovery update –including progress with Paediatric Surgery Draft Integrated CommissioningPlan 2023-2026 IPFR engagement documents and draft ToR/Policy.

			Report and Procurement Update, along with a General Network Briefing	

MEETING	STANDING ITEMS	FOR APPROVAL / ACTION	ROUTINE REPORTS	INFORMATION
17 January 2023	Chair's Report Managing Director's Report Declarations of Interest Minutes Action Log Forward Work Plan	Corporate Risk Assurance Framework (CRAF) Risk Management Strategy (incl. Risk Appetite) WHSSC Standing Orders & SFI's, including review of Financial Limits and Reporting – Approve the increase in limits WHSSC IPFR Panel ToR and the All Wales IPFR Policy recommendation Integrated Commissioning Plan 2023-2026 – Final Plan Plastic Surgery Proposal	COVID-19 Period Activity Report Financial Performance Report Corporate Governance Matters Report Reports from the Joint Sub-Committees - CTMUHB Audit & Risk Committee - Management Group Briefings - Quality & Patient Safety Committee - Integrated Governance Committee - Individual Patient Funding Request	Haematology Review Paediatric Strategy Improvement Board Tier 4 CAMHS update Ty Llidiard (from JC meeting held on 12 July 2022) Audit tracker COVID-19 Recovery Trajectories Update (following July 2022 presentations) TAVI COVID-19 Preparedness

			Panel - WRCN	

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	Annual Review of Committee Effectiveness 2022-2023 WHSSC Specialised Services Strategy	COVID-19 Period Activity Report Financial Performance Report Corporate Governance Matters Report Reports from the Joint Sub-Committees - CTMUHB Audit & Risk Committee - Management Group Briefings - Quality & Patient Safety Committee - Integrated Governance Committee - Individual Patient Funding Request Panel - WRCN	Specialised Services Strategy – Final Strategy Document Specialsed Paediatric Services 5 year Commissioning Strategy (Bi-annual update)

MEETING	STANDING ITEMS	FOR APPROVAL / ACTION	ROUTINE REPORTS	INFORMATION
09 April 2023	Declarations of Interest Minutes Action Log Forward Work Plan	Chair's Report	COVID-19 Period Activity Report Financial Performance 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 - Integrated Governance Committee - Individual Patient Funding Request Panel - WRCN	

MEETING	STANDING ITEMS	FOR APPROVAL / ACTION	ROUTINE REPORTS	INFORMATION
11 June 2023	Declarations of Interest Minutes Action Log Forward Work Plan			
MEETING	**STANDING ITEMS**	**FOR APPROVAL / ACTION**	**ROUTINE REPORTS**	**INFORMATION**
12 August 2023	Declarations of Interest Minutes Action Log Forward Work Plan			

MEETING	STANDING ITEMS	FOR APPROVAL / ACTION	ROUTINE REPORTS	INFORMATION
12 September 2023	Declarations of Interest Minutes Action Log Forward Work Plan	WHSSC Annual Report 2021-2022	COVID-19 Period Activity Report Financial Performance Report Corporate Governance Matters Report Reports from the Joint Sub-Committees - CTMUHB Audit & Risk Committee - Management Group Briefings - Quality & Patient Safety Committee - Integrated Governance Committee - Individual Patient Funding Request Panel	Specialsed Paediatric Services 5 year Commissioning Strategy (Bi-annual update)

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

CORE BRIEF TO MANAGEMENT GROUP MEMBERS

MEETING HELD ON 25 AUGUST 2022

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 the meeting would be held via MS Teams.

The Chair expressed great sadness at the news of the sudden death of a long standing MG member and asked for condolences from the group to be passed on to family and friends in Powys.

2. Action Log

Members received an update on progress against the action log and **noted** the updates including a verbal update in relation to recruitment for Paediatric Neurology posts.

3. Major Trauma Presentation

Members received an informative presentation providing an update on progress and experience of the first 18 months of the Major Trauma Network since it launched on 14 September 2020. The presentation provided an overview of the outcomes of the first peer review and summarised the 1 year evaluation process which will seek to measure SWTN performance against a set of quality indicator standards. Overall, the establishment of the SWTN had been successful in delivering some early positive outcomes and some areas of excellent practice. A mature trauma network would take up to 5 years to develop and therefore the resultant translation into Value for Money will take time to determine.

Members **noted** the update and thanked the Network for the presentation.

4. Managing Director's Report

Members received the Managing Director's Report and noted updates on:

- Approval of the Integrated Commissioning Plan 2022-2025 and the accountability conditions
- Review of Secure Services – Single Commissioner for Mental Health Services
- Molecular Radiotherapy (MRT) and the need for a Welsh strategy
- The appointment of Interim Director of Mental Health (MH) & Vulnerable Groups (VG) – David Roberts

- TAVI (Transcatheter aortic valve implantation) rates

5. Specialised Services Strategy Development and Engagement Process

Members received an update on the Communication and Engagement Plan for the specialised services strategy development which included a summary of the feedback received from Management Group following the July 2022 meeting. Members received an update on the further work to be undertaken and a request to test the survey and provide feedback on the questions developed.

Members previously **supported** the overall approach to developing a ten year strategy for specialised services and **noted** the further update.

6. Paediatric Gastroenterology (North Wales) Funding Release

Members received a report requesting support for the release of funding to enable the implementation of the 2021/22 Integrated Commissioning Plan (ICP) scheme to commission Paediatric Gastroenterology outreach clinics for the paediatric population of north Wales.

Members (1) **supported** the release of funding to enable the implementation of the 2021/22 ICP scheme for paediatric gastroenterology outreach clinics for the north Wales population, and (2) **noted** that the requested funding is within the provision made for paediatric gastroenterology outreach within the ICP 2021-24.

7. Implementing a 12 Week Clinical Pathway for the management and treatment of Aortic Stenosis – Update August 2022

Members received a report providing an update on the implementation of a 12-week clinical pathway for the management and treatment of aortic stenosis. WHSSC's subsequent efforts to secure an implementation plan from each Health Board outlining how the imaging components of the pathway will be met, and to understand the volume of TAVI CT-angiograms undertaken across Welsh Radiology units in 2021/22 have had only limited success.

Members (1) **noted** the challenges that ISEG, the National Imaging Programme and WHSSC have faced when seeking to secure Health Board implementation plans and TAVI CT-angiograms data, (2) **noted** the engagement required by the All Wales Cardiac Network in order that they are in a position to submit the elements for which they have taken responsibility by Tuesday 20 September 2022, and (3) **supported** the request to work within their Health Boards to ensure that the required information is provided at the earliest possible opportunity.

8. Paediatric Deep Dive.

Members received a detailed presentation which provided detailed information on Paediatric Surgery activity delivered by all Health Boards and Cardiff & Value UHB paediatric waiting lists. A detailed analysis was also provided of WHSSC Commissioned services and English providers activity. This information was in addition to the information already

provided in the monthly COVID-19 activity reports. Members provided useful comments and feedback for WHSSC to consider.

Members **noted** the information.

9. WHSSC Policy Group report
Members received a report providing an update on activity and output from the WHSSC Policy Group during the last quarter (May 2022 – July 2022), and which gave an overview of all WHSSC policies and service specifications published during the financial year 2021-22, and the rationale for their development.

Members **noted** the report.

10. Designation of Provider Framework
Members received a report informing members of the WHSS team methodology for evaluating the appropriateness of Health Care Providers to become a designated provider of Highly Specialised and Specialised Services. The report will be presented to Joint Committee in September for approval.

Members **noted** the report.

11. COVID-19 Activity Report for Month 3 2022-2023
Members received a report highlighting the scale of the decrease in activity levels during the peak COVID-19 period, and outlining whether there were any signs of recovery in specialised services activity.

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 Health Board's (HBs) and waiting lists were also considered, along with the relevant new performance measures set out by Welsh Government (WG).

Members **noted** the report.

12. Financial Performance Report - Month 4 2022-2023
Members received the Financial Performance Report for Month 3, which set out the financial position for WHSSC for the third month of 2022-2023.

The financial position was reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC ICP by the Joint Committee in February 2022.

Members noted that the financial position reported at Month 4 for WHSSC was a year-end outturn forecast under spend of £12,693. The under spend predominantly related to releasable reserves from 2021-2022 and declared slippage in development schemes, this is partially offset by

forecast over spends in specialised mental health provision and NHS England contracted providers.

Members **noted** the current financial position and forecast year-end position.

13. Forward Work Plan
Members **noted** the forward work plan.

14. Any Other Business

- **Clinical Impact Assessment Process (CIAG) Update** – members received a verbal update following CIAG.

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

CORE BRIEF TO MANAGEMENT GROUP MEMBERS

MEETING HELD ON 22 SEPTEMBER 2022

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

1. Welcome and Introductions

The Chair welcomed members to the meeting noting that, due to the COVID-19 pandemic, the meeting would be held via MS Teams.

2. Action Log

Members received an update on progress against the action log and **noted** the updates.

3. Prioritisation Panel - Update

Members received a report presenting the final, validated results from the Prioritisation Panel to inform development of the WHSSC Integrated Commissioning Plan (ICP) for 2023-2026.

Members noted that that the horizon scanning process had identified six interventions for consideration, each of which was supported by a comprehensive evidence review.

Members (1) **noted** the update, (2) **endorsed** the process for determining the priority of new treatment interventions, and (3) **supported** the recommendations of the WHSSC Prioritisation panel.

4. Draft Integrated Commissioning Plan (ICP) Financial Plan

Members received an informative presentation outlining the first early forecast for the WHSSC ICP to provide Health Board's (HB's) with an early insight into forecasted expenditure and commissioning priorities.

Members discussed the need to consider opportunities and efficiencies and suggested that a workshop be held to look at future investment and disinvestment in order to make best use of resources and ensure value based healthcare was being delivered.

Members (1) **noted** the presentation; and (2) **agreed** to hold a workshop to consider future investment and disinvestment to coincide with a future meeting.

5. Managing Director's Report

Members received the Managing Director's Report and noted updates on:

- Capacity within the Speech and Language Therapy element of the Welsh Gender Service,
- The Mental Health Specialised Services Strategy for Wales 2022-2028 which will be presented to the November meeting of Joint Committee (JC),
- The Draft Specialised Paediatric Services 5 year Commissioning Strategy which was presented to the JC on the 10 May 2022; and
- The approval received for Value in Healthcare Bids relating to an Advanced Therapy Medicinal Product (ATMP) and the Welsh Kidney Network (WKN).

6. Neonatal Transport Operational Delivery Network (ODN)

Members received a report seeking 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 ICP 2022-2025.

Members discussed the revised proposal and expressed concern that the proposal did not address the issues previously raised by the MG concerning the staffing model, lack of integration with other services and expenditure.

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 £176k), to outline what synergies had been explored to integrate the service within existing teams and the anticipated timeline for delivery. In addition, if this was not possible, whether Emergency Medical Retrieval & Transfer Service (EMRTS) would offer an alternative solution.

Members (1) **did not 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; and (2) **Agreed** that a revised proposal be brought back to the Management Group for consideration in October 2022 to include reduced costs, opportunities for utilising synergies with other teams and a timeline for delivery. Alternatively, for consideration be given to whether EMRTS could provide an alternative solution.

7. COVID-19 Activity Report for Month 4 2022-2023

Members received a report highlighting the scale of the decrease in activity levels during the peak COVID-19 period, and outlining whether there were any signs of recovery in specialised services activity.

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 Health Board's (HBs) and waiting lists were also considered, along with the relevant new performance measures set out by Welsh Government (WG).

Members **noted** the report.

8. Financial Performance Report - Month 5 2022-2023
Members received the Financial Performance Report for Month 5, which set out the financial position for WHSSC for the fifth month of 2022-2023.

The financial position was reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC ICP by the Joint Committee in February 2022.

Members noted that the financial position reported at Month 5 for WHSSC was a year-end outturn forecast under spend of £13,675k. The under spend predominantly related to releasable reserves from 2021-2022, Welsh provider under performance and recruitment slippage in prior years' development schemes, which was partially offset by forecast over spends in specialised mental health provision and NHS England contracted providers.

Members **noted** the current financial position and forecast year-end position.

9. Forward Work Plan
Members **noted** the forward work plan.

10. Any Other Business

- **Plastics Workshop** – members noted that Plastics Workshop was scheduled for 1pm after the meeting and key clinicians had been invited to discuss recovery trajectories; and
- **Date of next meeting** – it was confirmed that the date of the meeting would return to the original date of 27 October 2022.

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

CORE BRIEF TO MANAGEMENT GROUP MEMBERS

MEETING HELD ON 27 OCTOBER 2022

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

1. Welcome and Introductions

The Chair welcomed members to the meeting noting that, due to the COVID-19 pandemic, the meeting would 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:

- The actions taken following the plastic surgery workshop held with Management Group on 22 September 2022 during which quality concerns were raised concerning Plastic Surgery Outreach Clinics in BCUHB, and the Task & Finish Group established by BCUHB to address the issues,
- Discussion with SBUHB on the Neonatal Transport Operational Delivery Network (ODN) Funding Release; and
- WHSSC receiving a briefing form Welsh Government on the Duty of Candour and Duty of Quality recognising that WHSSC already have good systems and processes in place upon which we can build for both the duties.

4. Medicines Optimisation Service

Members received a report outlining the rationale for continuing to invest in a Medicines Optimisation Service and seeking approval for recurring funding to resource the existing and expanding service.

Members discussed the request and agreed to approve the proposal subject to MG receiving quarterly update reports for assurance.

Members (1) **noted** the information presented within the report, (2) **approved** the proposal to fund a team of staff to manage and deliver the Medicines Optimisation Service; to include a Lead Medicines Management Pharmacist, a Deputy Medicines Management Pharmacist and technical support, on a permanent basis to:

- develop and lead on WHSSC Medicines Management strategy,
- improve medicines clinical and financial governance,

- support additional savings falling to commissioners,
- provide expert advice on medicines to both the WHSSC team and the commissioned providers where applicable; and

(3) **supported** the rationale for a permanent WHSSC Medicines Optimisation Service.

5. Draft Integrated Commissioning Plan (ICP) 2023-2026

Members received a report presenting the first draft of the Integrated Commissioning Plan (ICP) 2023-2026 for consideration, comment and support prior to submission to Management Group for approval in November, and to the Joint Committee in January 2023.

Members (1) **considered** the first draft of the Integrated Commissioning Plan for Specialist Services 2023-2026, (2) **noted** the current caveats to the draft document; and (3) **discussed** the proposed financial plan.

6. Options Appraisal for a Single Commissioner for Secure Mental Health Services in Wales

Members received a report presenting a proposal outlining the options for a single national organisation to commission integrated secure mental health services for Wales, following a request received from Welsh Government (WG) for the WHSSC Joint Committee to provide the mechanism for the recommendation from the "Making Days Count" review to be considered, and for the Joint Committee to make a recommendation to WG on the preferred option.

Members discussed the report and felt that they needed additional information on the benefits of the models before being in a position to advise on a preferred commissioning option. Members sought clarification on the engagement process and noted that the report would be updated to include comments from MG and presented to Joint Committee 8 November, it would then be subject to engagement within HBs prior to a final report going back to Joint Committee in January 2023, in order to meet the request from WG.

Members noted that the Joint Committee would also receive an update on the engagement for the Mental Health Strategy on the 8 November which would aid discussion.

Members (1) **noted** the report, (2) **discussed** the options appraisal for a single national organisation to commission integrated secure mental health services for Wales; and (3) **Supported** that a report outlining the benefits of the commissioning options be put forward to the Joint Committee for consideration on the 8 November 2022, prior to an engagement process with HBs before the final report is re-presented to Joint Committee for approval at an agreed time.

7. Artificial Limb and Appliance Service (ALAS) Psychology Services (Betsi Cadwaladr and Swansea Bay University Health Board)

Members received a report requesting support for the release of funding which is fully provided for in the WHSSC Integrated Commissioning Plan (ICP) 2022-2023 to enable the implementation of the 2022-23 ICP scheme for Artificial Limb and Appliance Service (ALAS) Psychology services at Betsi Cadwaladr University Health Board (BCUHB) and Swansea Bay University Health Board (SBUHB).

Members (1) **supported** the request for the release of funding, which is fully provided for in the WHSSC Integrated Commissioning Plan (ICP) 2022-2023 to establish psychology services for the ALAS Prosthetic Service provided by Betsi Cadwaladr University Health Board (BCUHB) and Swansea Bay University Health Board (SBUHB); and (2) **noted** the information presented within the report.

8. Paediatric Plastic Surgery Psychological Support – Funding Release for Implementation of 2022-23 ICP Scheme

Members received a report requesting approval for the release of funding to enable the implementation of the 2022-23 Integrated Commissioning Plan (ICP) scheme for the provision of psychological support in the south Wales paediatric plastic surgery service.

Members (1) **supported** the release of funding for the Integrated Commissioning Plan (ICP) scheme for the provision of psychological support in the paediatric plastic surgery service; and (2) **noted** that the requested funding is within the provision made for plastic surgery within the ICP 2022-23.

9. Paediatric Neurology Update

Members received a report providing an update on the transfer of arrangements for Paediatric Neurology to a pan-south Wales model is due to take effect on the 1 of November 2022. There remains a level of uncertainty surrounding the timeliness of recruitment and therefore WHSSC have considered in collaboration with Cardiff and Vale UHB as lead provider the potential options for mitigation in the short term. The purpose of this report is to provide an update on the mitigating plans and the impact on the timeliness of patient care.

Members (1) **noted** the report, (2) **noted** the mitigating plans; and (3) **noted** the next steps set out in the report.

10. Project Initiation Document (PID) for the Development of a Specialised Services Rehabilitation Strategy

Members received a report initiating the development of a Specialised Rehabilitation Strategy for the population of Wales.

Members (1) **noted** the initiation of this work; and (2) **noted** the Project Initiation Document (PID) to develop a Specialised Rehabilitation Strategy.

11. Paediatric Strategy Implementation Board

Members received a report noting the establishment of the

Implementation Board for the Paediatric Strategy and to note the draft Terms of Reference (ToR).

Members noted that the Joint Committee had approved the paediatric strategy on 6 September 2022.

Members (1) **noted** the establishment of an Implementation Board for the Paediatric Strategy; and (2) **noted** the draft terms of reference.

12. Gender Identity Development Service (GIDS) for Children and Young People Update

Members received a report updating members about the Gender Identity Development Service (GIDS) for Children and Young People including what the changes mean for children and young people in Wales and next steps.

Members **noted** the information presented within the report and Appendix 1 regarding the decommissioning of the Tavistock and Portman NHS Foundation Trust and NHS England transformation programme.

13. COVID-19 Activity Report for Month 5 2022-2023

Members received a report highlighting the scale of the decrease in activity levels during the peak COVID-19 period, and outlining whether there were any signs of recovery in specialised services activity.

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 Health Boards (HBs) and waiting lists were also considered, along with the relevant new performance measures set out by WG.

Members **noted** the report.

14. Financial Performance Report - Month 6 2022-2023

Members received the Financial Performance Report for Month 6, which set out the financial position for WHSSC for the fifth month of 2022-2023.

The financial position was reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC ICP by the Joint Committee in February 2022.

Members noted that the financial position reported at Month 6 for WHSSC was a year-end outturn forecast under spend of £13,711k. The under spend predominantly relates to releasable reserves from 2021-2022, Welsh provider under performance, renal underperformance and 2022-2023 planned development. This is partially offset by forecast over spends in specialised mental health provision, NHS England (NHSE) contracted providers, Individual Patient Funding Requests (IPFR) and prior year developments.

Members **noted** the current financial position and forecast year-end position.

15. Forward Work Plan
Members **noted** the forward work plan.

16. Any Other Business

- **WHSSC Specialised Services Strategy** – members noted that the engagement process concerning the WHSSC 10 Year Specialised Services Strategy had commenced and that an update would be circulated outside of the meeting.

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**25 October 2022**

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

1.0 Patient Story

The committee heard a patient video/story from a couple who had accessed neonatal intensive care for their two children. The family were very complimentary of the service they received both from the tertiary and local unit focusing on the importance of communication and bringing care as close to home as soon as possible. The family were thanked for sharing their story and how the issues they raised can feed into the current work being undertaken re cot configuration.

2.0 Welsh Kidney Network (WKN)

QPS members were advised of 3 high risks on the WKN risk register. One risk referred to the introduction by Welsh Government of a Quality Statement for kidney disease and the capacity of the WKN as currently configured to ensure delivery of all components of the Statement. They noted that further clarity is being sought from Welsh Government regarding the role of the WKN in this regard. Two further high risk relate to vascular access capacity at BCUHB and dialysis capacity at Ysbyty Glan Clwyd. Members were informed of actions being undertaken to mitigate these risks. A Peer Review on vascular access has recently been undertaken at BCUHB. The report and subsequent action plan is in the process of being completed. The actions are intended to address the vascular access capacity issue. With regard to dialysis capacity, members noted that this facility is independent sector provided and discussion are ongoing with the provider and the HB regarding options to increase capacity. Members noted that patients access to dialysis is not being compromised whilst these discussions conclude.

Members were also informed that a governance review of the WKN had recently been completed, an action plan was being developed and this would be brought to the Joint Committee in January 2023. They were also appraised of the recent Annual Audit Day held by the Network which was well attended and an informative learning event.

3.0 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**

The risk register for the commissioning team was presented to the committee. There was one new risk relating to the management of outreach clinics delivered by St Helen's & Knowsley NHS Trust on two sites in Betsi Cadwalader University Health Board. Assurance and progress were provided against the two services that are in escalation and further information is provided in the summary of services in the escalation table, which is attached.

- **Cardiac**

The risk to bariatric services remain unchanged; however conversations with an alternative provider remain ongoing. WHSSC is still awaiting the Royal College of Surgeons' report for Swansea Bay University Health Board. The committee requested that this was escalated if not received shortly.

- **Neurosciences**

A neurosciences update was received by the committee. Members noted that the risk that patients were being prevented access to the Thrombectomy services in North Bristol, due to the current 3D biotronics-imaging platform not meeting the current Welsh Government cyber security credentials was now resolved and had subsequently been closed by the Commissioning team in October 2022. The risk relating to neurosurgery in South Wales had also been lowered, due to an improvement in both theatre and bed capacity and will be monitored over the coming months. The committee was informed that the Community Health Council (CHC) had undertaken a positive visit to the spinal unit in Llandough Hospital and the report would be published shortly. The quality team would follow this up with CVUHB.

- **Women & Children**

The committee was updated re the risks and, in particular, the risk regarding Paediatric surgery and noted the ongoing work being undertaken. Information had been requested from the Health Board and options regarding outsourcing were continuing to be explored and a detailed recovery paper was due to go to Joint Committee on the 8th November 2022.

It was noted that there is now a Commissioning Assurance Group meeting for each specialised paediatric service at CHfW. There is a rolling monthly schedule, to capture every service. Within the Quality agenda, work is currently being undertaken to address how assurance is reported with the aim of creating a dashboard to gain assurance for each specialised service.

The committee received a progress update on Paediatric neurology and pathology, noting an improved position and the work that was ongoing to secure a longer term sustainable position.

- **Mental Health & Vulnerable Groups**

The committee received a report on any Quality and Patient Safety issues for services relating to the Mental Health & Vulnerable Groups Commissioning Team portfolio. This included a summary of the services in escalation which contained a progress update on the work being undertaken in Tŷy Llidiard.

Members were provided with an update regarding service on Eating Disorders. Following the end of the contract with Cotswold House on 31st August 2022, arrangements have been made to secure beds with the Priory Group for Welsh patients. These arrangements are in place until January 2023, in the first instance, with options to extend this arrangement. In the interim, options are being scoped and considered to inform an options appraisal exercise for long term sustainable options for eating disorder services, through the Specialised Services Strategy for Mental Health, and a medium term solution to stabilise services for the next 3-5 years.

In July 2022, in response to the recommendations of the Cass Review Interim Report, NHS England took the decision to de-commission the Tavistock and Portman NHS Foundation Trust and introduce two early adopter providers from Spring 2023. The committee was assured that WHSSC are involved in the NHS England programme work and noted that the interim service specification has been released for a 45-day consultation. An update paper on GIDS has been submitted to Corporate Directors Group Board and Management Group for information.

The committee was pleased to note that NHS England has provisionally allocated £5m capital funding to the North West Mother Baby Unit scheme at Chester. It is expected that the provider, Cheshire & Wirral Partnership Trust, will develop a full business case for submission to NHS England in next 3 months.

The Committee noted the work that the Commissioning Team was undertaking and felt it would be helpful to receive a deep dive and invite the newly appointed Director of Mental Health to present the work at the next meeting. The Secure Services review was also outstanding and would therefore be an opportune time to fully understand how the strands will fit in the Mental Health Strategy going forward.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

A detailed report was received by the committee. Reassurance was received regarding the substantial work that had been undertaken and it was pleasing to note that the risk had reduced since the last report. A query was raised regarding the invoicing position, which would be addressed outside of the meeting and reported in the next report if there were ongoing concerns or had an impact on quality and patient safety issues.

4.0 Other Reports Received

Members received reports on the following:

- **Services in Escalation Summary**

WHSSC currently has seven services in escalation. The status of each service in escalation remains unchanged. However, the Cardiac services are making good progress and it is hoped that WHSSC will be in a position to de-escalate these over the next few months. The North Wales Adolescent Unit is also waiting for the NCCU review and should also be in a position to be de-escalated. The template for reporting would alter from next year in line with the work presented at the Development Day.

- **CRAF Risk Assurance Framework**

Members were provided with an updated positon regarding the WHSSC CRAF and noted the proposed engagement work to support the IPFR risk. Members noted the risk workshop that had taken place on September 20th and the SWOT analysis undertaken on each risk to support the process of review and updating.

- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**

The committee received the report and agreed that any inspections undertaken by the CHC would be included in the future.

- **Incident and Concerns report**

An update report was noted and received by the committee for assurance. There have been 10 new incidents reported to WHSSC over the period July 2022 to end September 2022.

- **Development Day summary report**

A second Development Day was held on the 16th September 2022. Committee members received a summary from each of the sessions and a copy of the presentations. Six out of the seven Health Boards were represented and positive comments were received regarding the content of the day. An evaluation of the day had been circulated and will be used to consider the content for forthcoming days and any improvements that could be made.

- **WHSSC Quality Unit Final Internal Audit Report**

A copy of the Final Internal Audit report, undertaken in June 2022, was received by the Committee. Substantial assurance was received with one matter requiring management attention:

  - There was limited evidence to suggest that Health Boards are submitting the WHSSC Quality and Patient Safety Chair's report to their own quality committee meetings for scrutiny and assurance.

The agreed management plan has been accepted and a discussion was initiated at the Development Day. It was agreed that the report would to be considered by the All Wales Health Board Chairs QPS Committee and future auditing of compliance would be monitored through that group. Assurance was received that Health Boards do already have reporting systems in place to address the issue. A copy of the report is attached.

- **Quality Newsletter**

A copy of the second Quality Newsletter was received by the committee and is an Appendix to this report

5.0 Items for information:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 6 September 2022,
- Welsh Risk Pool and Legal & Risk Services Annual Review
- 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)
WHSSC Quality Unit Final Internal Audit Report (Appendix 2 attached)
Quality Newsletter (Appendix 3 attached)

Matters requiring Committee level consideration and/or approval The committee requested that the findings of the Quality Internal Audit Report were noted and considered by the Health Boards.	
Matters referred to other Committees As above	
Confirmed minutes for the meeting are available upon request	
Date of next scheduled meeting:	23 January 2023 at 13.00hrs

Appendix 1

SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 18.10.2022	Movement from last month
November 2017	North Wales Adolescent Service (NWAS)	BCUHB	2	• Medical workforce and shortages operational capacity • Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of- Area admissions	• QAIS report outlined key areas for development including the recommendation to consider the location of NWAS due to lack of access on site to other health board provision – This is being considered in the Mental Health Specialised Services Strategy. • Bed panel data submitted electronically • NCCU undertook Annual Review on 29th June 2022 report yet to be published. • Escalation status will be considered thereafter.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 18.10.2022	Movement from last month
March 2018 Sept 2020 Aug 2021	Ty Llidiard	CTMUHB	4	• 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 11th October • 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. • Candidate withdrew from Physician Associate post and further advertisement to be progressed. • Psychologist/Family Therapist post interviews scheduled for w/c 17th October • JD under development for Psychology Assistant post with recruitment to progress following the appointment of the Family Therapist • Improved leadership evident via escalation meetings	⟺

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 18.10.2022	Movement from last month
September 2020	FACTS	CTMUHB	3	• Workforce issue	• Last escalation meeting was held on 01/09/22 • Next meeting is on 09/11/22 • Consultant Psychiatrist Interviews are on 1st November and will be followed by Clinical Lead appointment • Recommendation will be made to CDGB on November 7th that service is de-escalated to level 2 if all outstanding issues are addressed at next escalation meeting	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 18.10.2022	Movement from last month
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 has remained in level 3 whilst the impact of these actions is ascertained. • The escalation level was discussed again in October 2022 and significant progress towards the GIRFT benchmarks was noted. • WHSSC is waiting for the final report of the recent Royal College of Surgeons of England (RCS England) Invited Service Review to be submitted, with the Health Board's response, after which the potential for further de-escalation and revised monitoring arrangements will be considered in line with the Escalation Framework.	

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-escalated in April 2022. • The service has now provided both 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 will be discussed at the next escalation meeting. • Level 3 meetings were held in June and July, and a meeting was scheduled for September, but this was postponed due to staff availability. • In view of the following meeting being scheduled for November, an updated action plan was requested	

					(due for submission 11 October 2022)	
Date of Escalation	**Service**	**Provider**	**Level of Escalation**	**Reason for Escalation**	**Current Position 19.10.2022**	**Movement from last month**
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 2002. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model	• Escalation monitoring meetings held on 12th August and 27th September 2022. • The current timeline for completion of the capital works to enablerelocation of burns ITU togeneral ITU at Morriston Hospital is the end of 2023. • The next escalation monitoring meeting is arranged for 1st December 2022.	⟷

February 2022	PETIC	Cardiff University	3	• Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients. • Recent suspension of population of PSMA due a critical quality control issue identified during MHRA inspection. Service slow to address impact on service for patients. • Failure to undertake a timely recruitment exercise leading to isotape production failures. • Failure to produce a business case of sufficient quality in a timely manner for replacement of the scanner.	• PETIC is taking forward the agreed actions with regard to increasing management capacity within the service and clarifying the governance arrangements for the service. • The next escalation monitoring meeting is arranged for 5th December.	

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

Welsh Health Specialised Services Commissioning NEWSLETTER

2nd Edition, Autumn 2022

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

South Wales Neonatal Units

This is the 2nd edition of the Quality newsletter from the Welsh Health Specialised Services team in Wales. Our plan is for these to be published on a quarterly basis to supplement reports and data already provided through different forums into Welsh Health Boards.

This Newsletter is available in Welsh on request. Mae'r Cylchlythyr hwn ar gael yn Gymraeg ar gais.

This gives an overview of some of the work we are involved with, and presents some of the highlights from a commissioning perspective. The services commissioned from Welsh Health Specialised Services Committee (WHSSC) are provided both in Wales and in England this will only provide a snapshot of our work.

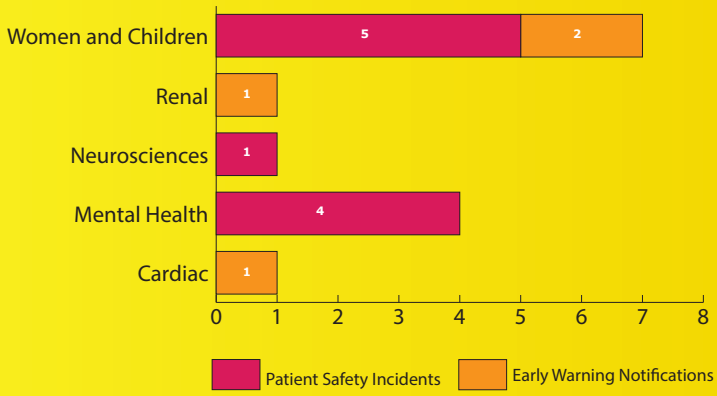
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Contents

Reporting for the Last Quarter

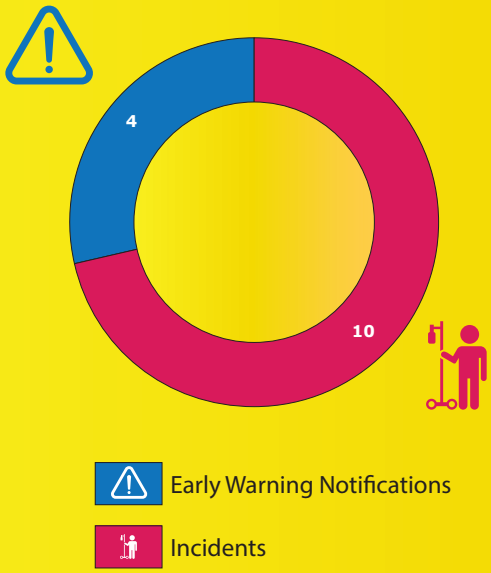
WHSSC do not investigate incidents but are responsible for supporting the investigations into these alongside the monitoring and reporting to the Health Boards. WHSSC are responsible for ensuring the delivery of safe services and ensure that trends or themes arising from concerns have actions plans which are are completed and support learning. WHSSC facilitates the continued monitoring of commissioned services and work with providers when issues arise.

Type by Commissioning Team



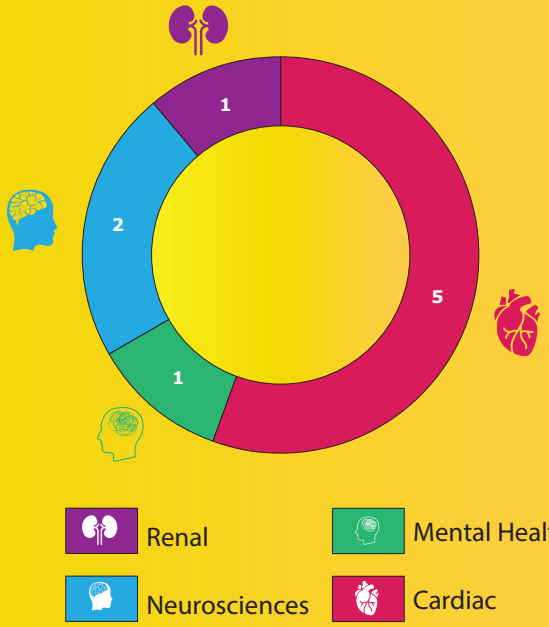
Patient Safety Incidents and Early Warning Notifications

Between March to July 2022, there were **10** Patient Safety Incidents and **4** Early Warning Notifications logged:



Patient Safety Incidents

Between March to July 2022, there were **9** Patient Safety Incidents closed:



Concerns raised with WHSSC may involve a direct response from the organisation or involve a joint response with the commissioning Health Board or WHSSC may need to ask the Health Board to respond directly.

Concerns

Incidents

Putting Things Right

Complaints

Update from the Patient Care Team IPFR (Individual Patient Funding Request)

The Patient Care Team receives and manages individual patient funding requests for healthcare that falls outside of agreed range of services.

An overview of IPFRs processed in Quarter 1 2022-23:

	Number of Requests discussed as Chairs Actions	Number of Requests discussed by All Wales IPFR Panel
April 2022	16	-
May 2022	7	14
June 2022	2	10

Welsh Gender Service

The Welsh Gender Service published their first ever Newsletter in Spring 2022 and a Summer edition is to follow. For now though, please see the Spring edition here:

Welsh Gender Service: Spring Edition Newsletter April 2022

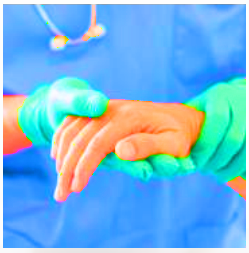
April and June 2022 Patient Safety Updates

Patient Safety Update: 5 April 2022

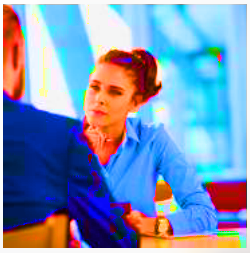
Patient Safety Update: 28 June 2022

Quality and Patient Safety Development Day

WHSSC will be holding a Quality and Patient Safety Development Day on 26th September 2022. Quality Clinical Colleagues and Independent member from across Welsh Health Boards will be in attendance. The day will feature data systems presentations from NHS England, the data team in WHSSC and presentations from the Delivery Unit team and NWSPP. A recap and feedback from the day will be provided in the next newsletter!



Patient Safety Incidents



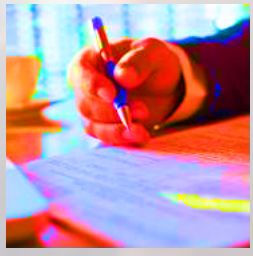
Listening

Never Events

Reassurance

Reporting

Learning



Compliance

Quality

Culture

Assurance

Feedback

Experience

Improving

Developing

Innovation

Ty Llidiard Co-production Event

Ty Llidiard have recently hosted a co-production event that involved young people, their carers and the staff based at Ty Llidiard. The event focused on the four C's: Compassionate, Calm, Confident and Caring.

Through consultation with Staff and the Young People who use Ty Llidiard, Scarlett Design came up with 4 potential design proposals with examples of how we would like to use them to create an internal and external philosophy and identity.

TŶ LLIDIARD
CARING · COMPASSIONATE
CALM · CONFIDENT

The day was split into 3 sessions:-

- ✓ Former service users and their families along with external stakeholders.
- ✓ The young people who were admitted at the time.
- ✓ The Ty Llidiard staff.

Over 70 people attended on the day with another 50 giving feedback electronically and by using the feedback forms and box that was left in the Ty Llidiard foyer for 6 weeks after.

The main themes to come from the young people were reducing boredom through engagement and activities and from the staff it was around communication and support.

Over 100 people voted on the visual identity / logo with nearly 70% voting on this design. The next steps are to use the agreed logo on uniforms, signage and on the exterior of Ty Llidiard. Positive feedback was received from the Director General of Health & Social Services/Chief Executive NHS Wales.

North Wales Adolescent Unit

There are positive developments for Children & Young People (CYP) who are being treated for Eating Disorders (ED) within the service. Over time, there has been a recognition that, the needs of young people admitted to Kestrel ward with an eating disorder have changed. Historically, Kestrel ward had a high proportion of admissions associated with Anorexia Nervosa (AN).

Across North Wales, there has been an increase in young people presenting with complex presentations around eating who require intervention. This is in line with the referrals and presentations seen within the inpatient context.

Kestrel ward have historically followed a weight restoration model for eating disorders, there has been no formal review of the ED pathway completed within the last decade. The recognised change in presentation of CYP has driven the change of pathway from one of weight restoration to a pathway with a stronger focus on Young People engagement. The inpatient ward is committed to developing an Autism friendly environment working alongside the National Autistic Society (NAS). The journey to accreditation with NAS has begun with the first meeting taking place in August 2022. Following a review of the environment, the NAS advisor was able to make suggestions as to what could be developed to ensure that the service could improve meeting the needs of CYP with a diagnoses of Autism Spectrum Disorder. The development of the environment is clinically led by the nursing team and operationally partnered by the broader MDT.

The service has welcomed a new role this year, the Patient Liaison Officer role was developed following a trend in concerns noted by CYP & families that recognised how communication between the service and families was not as effective as it could be.

The liaison officer has taken an active role in enhancing parts of the admission pathway including the information that is distributed to CYP & families pre admission, this includes the development of an North Wales Adolescent Service (NWAS) specific website.

There is a strong emphasis on what the role is and how this can support the CYP & family journey. In addition, the liaison officer is also closely linked to the regional Betsi Cadwaladr University Health Board (BCUHB) Child and Adolescent Mental Health Services (CAMHS) patient experience leads who have developed an action plan for improved patient experience in practice.

The liaison officer supported the children's charter events held by the CAMHS BCUHB patient experience leads, building on the existing principles of CYP engagement and enhancing the focus of patient centred care.

The development of the Advanced Nurse Practitioner (ANP) pathway is now complete, the service currently has 4 ANP trainees with a 5th joining in December, all of which are in the final phase of their academic studies, during their training phase the trainees are undertaking advanced level nursing tasks under supervision to ensure that they able to meet all 4 pillars of their advanced level training.

Ty Llewellyn Medium Secure Unit

A meeting with the quality team in WHSSC took place with Ty Llewellyn Medium Secure Men's Adult Mental Health Unit in July 2022. An update was provided on the progression of the environmental, workforce and quality developments which have been underway to support a more therapeutic environment and clear recognition of physical health monitoring in mental health patients.

These have included the development of a more robust handover, physical health check monitoring, NEWS training and access to medical cover 24 hours 7 days a week and a policy to support individual therapeutic monitoring.

Staff sessions on physical health checks have included further training around sepsis management and the recognition and monitoring of side effects which may occur following the long term use of medications.

A culture of openness and transparency is continuously being encouraged and supported.

Outcome measure training is being facilitated for some of the staff and there are some further developments within the unit to capture patient experience, which will be shared once completed.

Moondance Awards

The Moondance Cancer Awards 2022 held on June 16th to celebrate 'brilliant people across NHS Wales and its partners who maintained, and innovated, cancer services despite the extraordinary circumstances of the last two years'.

Among the lucky shortlist of delegates eagerly awaiting the results were colleagues from the All Wales Positron Emission Tomography (PET) Advisory Group who submitted an application to the 'Achievement: Working Together' category and All Wales Genomics Oncology Group (AWGOG), All Wales Medical Genomics Services (AWMGS) and Velindre Cancer Centre (VCC) who submitted a co-application to the 'Innovation in Treatment' category.

Presiding over judging of the innovation category were an esteemed panel of judges including UK Medical Director of the Telemedicine Clinic, Cancer Clinical Director for Wales Prof Tom Crosby, CEO of Tenovus Judi Rhys MBE and Prof Neil Mortensen, President of the Royal College of Surgeons.

The judges were reportedly *"delighted and humbled by the number and quality of submissions received".*

WHSSC staff enjoying the Moondance Awards, from left to right: Professor Iolo Doull, Dr Andrew Champion and Sarah McAllister. Dr Champion and Sarah McAllister were part of the shortlisted All Wales PET Advisory Group!

Upon declaring the winning result to the AWMGS/AWGOG/VCC application, the judges noted the formidable achievements of each of the following three initiatives commissioned via WHSCC:

1. The DPYD gene testing pilot in collaboration with VCC saw Wales become the first UK nation to routinely offer DPYD pharmacogenetic screening for cancer patients in receipt of certain types of chemotherapy
2. The All Wales Genetics Oncology Group (AWGOG) since its formation has published timely clinical guidance on NTRK gene and FGFR2 gene fusion diagnostic testing for cancer treatment following NICE recommendations
3. Cymru Service for Genomic Oncology Diagnosis (CYSGODI) launched in 2021 offer high-quality oncology precision medicine services using next generation sequencing technology to screen for targeted genes in a tumour and haematological malignancy.

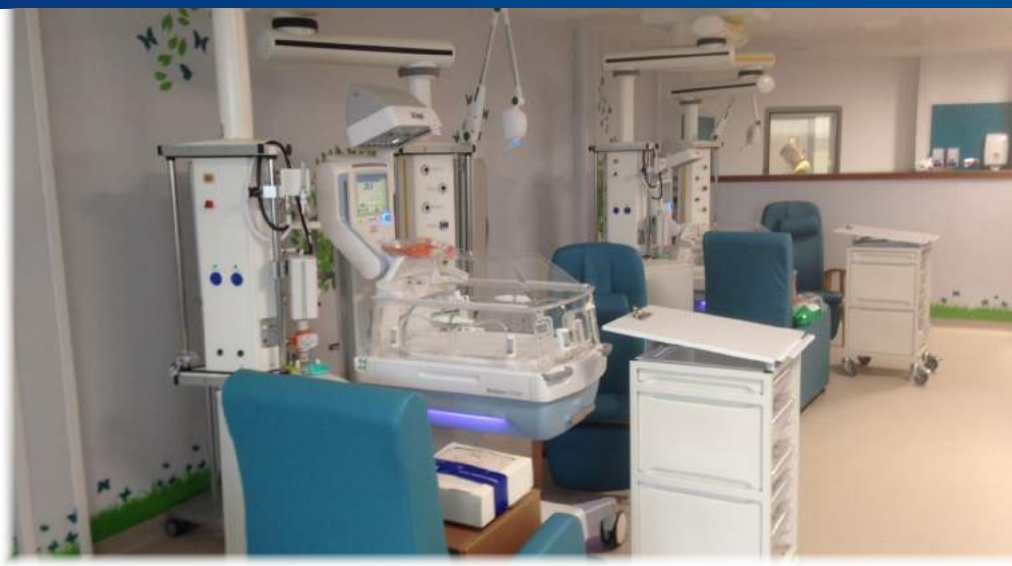
A huge congratulations to The All Wales Genomics Oncology Group for winning the Innovation in Treatment Award and also to The All Wales PET Advisory Group for being shortlisted in the Working Together category!

South Wales Neonatal Units

The WHSSC Quality team are undertaking scheduled neonatal visits within South Wales. The face to face meetings are intended to strengthen relationships and to develop an understanding of the role of the quality team within commissioning. WHSSC are responsible for commissioning the ITU and HDU cots in South Wales.

This is alongside supporting the importance of reporting and data collection in light of publications such as the Independent Maternity Services Oversight Panel (IMSOP) and Ockenden report and an awareness that the services have had a great deal of activity and had a number of workforce pressures. During the visits, the units have been encouraged to share evidence of Quality Improvement, good practice alongside areas of concern including workforce plans and recruitment.

Discussions have also included capturing patient experience and signposting to the Health Board team to support facilitation of this.



During the visits there was evidence of inspiring innovations to benefit patients, families and the staff and we have asked that this be continuously shared with WHSSC.

Alongside some workforce initiatives to utilise some of the current vacancies more successfully into advanced practice role development and Band 4 role development. To date the team have visited Hywel Dda University Health Board (HDUHB), Cwm Taf Morgannwg University Health Board (CTMUHB), Swansea Bay University Health Board (SBUHB) and Cardiff and Vale University Health Board (CVUHB).

HDUHB

HDUHB provided the WHSSC Quality team with the opportunity to visit the new unit and to meet with the neonatal team. It was evident moving into a better environment and managing the care of neonates within the new facility had a positive impact on the team.

CTMUHB

Very positive visit to the team in CTMUHB, it provided the opportunity to understand how the team have worked to address the issues identified by Independent Maternity Safety and Oversight Panel. There was evidence of practice development and support for the clinical team alongside the rotation of staff into different clinical areas and support to work with the regional Centres.

SBUHB

The Team have recently had nurses join them from overseas and are in the process of supporting their development with specific clinical programs. These have included the development of Objective Structured Clinical Examinations to enable a smooth transition into the workforce and to meet the NMC requirements. During the visit alongside meeting the Neonatal Intensive Care Unit (NICU) team the Quality team met with the midwifery team who demonstrated the work which had been undertaken with a Neonatologist and maternity to enable the Transitional care model to be better utilised to support a model of more rapid step down from Special Care Baby Unit (SCBU).

CVUHB

The NICU visit provided the Quality team with an opportunity to understand how the Operational Team are continuously addressing the daily priorities of managing the ever changing clinical picture. This was demonstrated through their facilitation of a twice daily huddle and their reporting to the Clinical Board. The clinical team welcomed an opportunity to share their concerns regarding workforce, repatriation and training issues.

These included the difficulties of sometimes having families who had become dependent on the regional Centres and their concerns about being repatriated back to their local health boards, due to a perceived lack of understanding on how their particular specialist needs would be met. This concern was highlighted form both a family perspective and the clinical teams perspective. The clinical team raised concern around local skill and knowledge in relation to managing some of the more complex surgical cases.

There had been recent recruitment event with some success at external recruitment. A number of nursing vacancies exist within the team and there is a plan to support student streamlining with over recruitment into some of these vacancies.

Maternity and Neonatal Safety Summit

Sue Tranka, Chief Nursing Officer for Wales has launched the Maternity and Neonatal Safety Support Programme to improve safety, experience and outcomes for mothers and babies in Wales. Maternity and neonatal champions will be appointed to every health board in Wales to improve the quality of services and to support the Maternity Five Year Vision.

The Programme aims to create national standards to ensure that all pregnant individuals, babies and their families will experience safe, high quality health care along with influencing their decisions regarding the care they receive.

The Maternity and Neonatal Safety Summit was held in August 2022 and was well attended both in person and remotely. There was engagement from the participants, who were encouraged to submit online questions to the presenting panel. This identified collaborative themes amongst the audience and facilitated an opportunity to network in person.

Welsh Pharmacy **Awards 2022**

The Blueteq High Cost Drugs (HCD) software programme was procured for NHS Wales by the WHSSC and the Welsh Government via the Advanced Therapies Wales Board, to support the implementation of Advanced Therapy Medicinal Products (ATMPs) and other HCDs commissioned by WHSSC. A Blueteq Project Working Group piloted the system in May 2021. In January 2022, the system went live for all WHSSC commissioned HCDs.

This new system allows NHS Wales to audit the initiation of complex HCDs in line with evidence based health technology appraisal recommendations, to support clinical data collection and evaluation and to strengthen financial governance.

A Blueteq form is created for all WHSSC commissioned National Institute for Health and Care Excellence (NICE) Technology Appraisals, Highly Specialised Technologies and All Wales Medicines Strategy Group approved medicines by the WHSSC Medical team in collaboration with Welsh clinical experts.

The implementation of Blueteq ensures equitable and timely access to specialised HCDs for eligible patients across Wales. The Blueteq project has been shortlisted as a finalist in the Welsh Pharmacy Awards 2022, which is a fantastic achievement.

Well done team!

Quick Round up of Commissioning Teams

Mental Health

5 year strategy being developed and well underway with excellent engagement and support from the Welsh Clinical Teams.

Women and Chidren's

Paediatric Strategy is gaining momentum and out for consultation.

Neurosciences and long term condition

All Wales strategy to improve outcomes and experience of patients receiving specialised rehabilitation is underway.

Cancer and Blood

Thoracic and Inherited Bleeding Disorder Service Improvement and Innovation Day to be organised. ENETS won a Patient Experience award and will be hosting a celebration event on 13th October.

Cardiac

Cystic Fibrosis Service Improvement and Innovation Day scheduled for 11th November 2022.

Intestinal Failure

Ongoing work being undertaken with the recently formed Intestinal Failure commissioning team and as a result of the Intestinal Failure review and Service Improvement and Innovation Day.

Recognition of significant events, thank you's and useful links

Adele Roberts, Head of Quality at WHSSC, receives a special parcel from a patient who was supported through the NHS England Gender pathway:

Lieutenant Colonel

On behalf of the whole military in Wales I am very grateful for the enhance patient care the systems providers and for the friendly, flexible and efficient way it is administered by you and Catherine. Patients enjoy fantastic care from the providers in Wales. The options for select-ed individuals to be seen quickly in order to make them fit for duty and progress their care is transformational…….This support to the military in Wales is envied by my colleagues in other parts of the UK

Ministry of Defence (MOD)

A thank you from a Lieutenant Colonel with the MOD was received into WHSSC by the Director of Finance Stuart Davies and Catherine Dew IPFR manager.

Useful Links

- Welsh Health Specialised Services Committee

Public Health Wales - 30 month implementation evaluation for NIPT (Non-invasive Prenatal Testing) evaluation

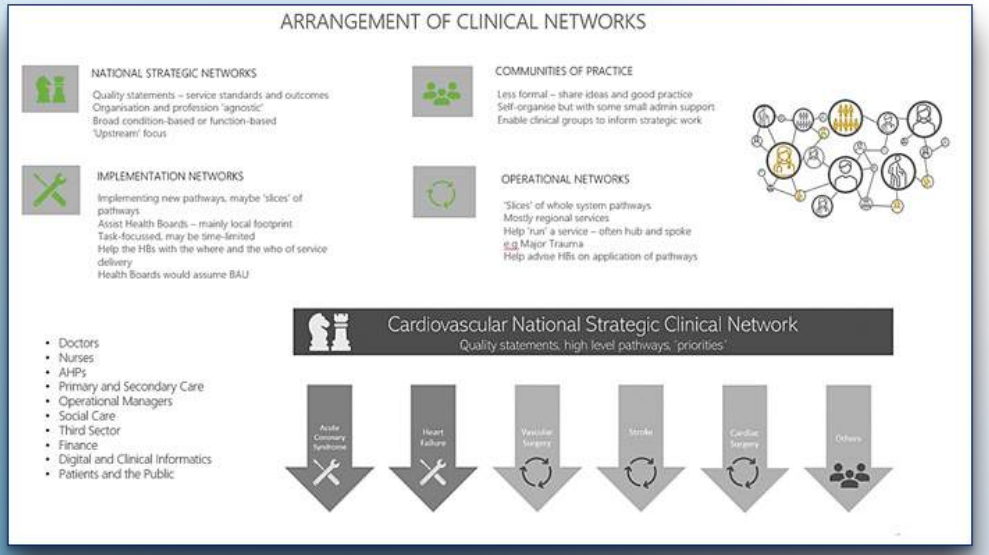
WHSSC commission NIPT and were informed by Public Health Wales of the evaluation findings from the first 30 months following the implementation of this as a contingent test as part of the antenatal Screening programme in Wales were formally published in the May edition of Prenatal Diagnosis, a peer reviewed journal.

Implementation of non-invasive prenatal testing within a national UK antenatal screening programme: Impact on women's choices - Bowden - 2022 - Prenatal Diagnosis - Wiley Online Library

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Clinical Network Programme

As part of the strategy work WHSSC has been working closely with the Clinical Network Programme and whilst the names and arrangements of networks in the diagram below are still under discussion we felt it would be helpful to share as part of the stakeholder engagement that has been undertaken over the past year. The Clinical Networks Programme is part of the National Clinical Framework implementation within the NHS Executive.



NETS

South Wales Neuroendocrine Cancer Service has received a Centre of Excellence Accreditation with ENETS (European Neuroendocrine Tumour Society) – a massive congratulations to Dr Mohid Khan:

ENETSCoE
ASSURING QUALITY SINCE 2009

DR Mohid Khan, Cardiff and Vale University Health Board

A well-done from Dr Sian Lewis, Managing Director for WHSSC the neurosciences commissioning team received substantial assurance form the Audit and Assurance team and to the pharmacy team Eleri Schiavone, Dr Andy Champion and Professor Iolo Doull on reaching the pharmacy finalist awards.

"Well done team we are proud of you!"

PDF

ENETS Audit Checklist/ Report Cardiff

Welsh Health Services Specialised Commissioning

NEWSLETTER

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

whssc.nhs.wales

Autumn 2022

For queries or detail on any aspect within this Newsletter, contact Adele Roberts, Head of Patient Safety and Quality or Leanne Amos, Quality Administration Support Officer.

Email: Adele.Roberts@wales.nhs.uk / Leanne.Amos@wales.nhs.uk

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Designed by NHS Wales Shared Services Partnership Communications

Quality Assurance Reporting
Final Internal Audit Report

October 2022

Welsh Health Specialised Services Committee

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Contents

Review reference:	CTMUHB-2223-32
Report status:	Final
Fieldwork commencement:	13 July 2022
Fieldwork completion:	9 September 2022
Draft report issued:	15 September 2022
Management response received:	4 October 2022
Final report issued:	6 October 2022
Auditors:	Lucy Jugessur, Internal Audit Manager Emma Samways, Deputy Head of Internal Audit
Executive sign-off:	Carole Bell, Director Nursing Quality
Committee:	Audit & Risk Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To evaluate and determine the adequacy of the systems and controls in place within WHSSC in relation to quality assurance reporting.

Overview

We have issued substantial assurance on this area.

There was one matter requiring management attention:

- There was limited evidence to suggest that Health Boards are submitting the WHSSC Quality and Patient Safety Chair's report to their own quality committee meetings for scrutiny and assurance.

Report Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure

Assurance summary[1]

Objectives		Assurance
1	Roles and responsibilities of the Quality and Commissioning teams	Substantial
2	Processes and mechanisms to allow the Quality and Commissioning teams to co-ordinate the quality monitoring	Substantial
3	Effective quality assurance reporting arrangements in place	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Monitoring of WHSSC quality matters in Health Board committee meetings	3	Operation	Medium

1. Introduction

1.1 Our review of quality assurance reporting within the Welsh Health Specialised Services Committee (WHSSC) was completed in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 WHSSC is responsible for the joint planning of specialised services on behalf of the Local Health Boards in Wales. Their strategic aim is to ensure that there is equitable access to safe, effective and sustainable specialised services, as close to patients' home as possible, within available resources. The quality of care and experience that patients and their families receive is central to the commissioning of specialised services. The specialised services commissioned by WHSSC are managed though five programme commissioning teams and include areas such as mental health, cancer & blood and neurosciences.

1.3 In 2014 a WHSSC Quality Framework was developed to provide an infrastructure around quality assurance. The framework has since been revised and renamed the Commissioning Assurance Framework (CAF) to encompass components necessary to provide assurance. A quality team was set up in 2019 to strengthen the focus of quality monitoring, improvement and reporting. The quality team have a pivotal role in the co-ordination of quality monitoring, interventions and reporting across the commissioned services. In turn, relevant quality information is required by health boards from WHSSC so they can meet their responsibilities to deliver high quality, safe healthcare services for all their citizens.

1.4 The risks considered in this review were:

- Serious concerns and performance related issues are not identified meaning remedial action cannot be taken.
- WHSSC is unable to provide assurance to health boards on the quality of care it commissions on their behalf.

1.5 We focussed on the role performed by the Quality function, and not the CAF as a whole.

2. Detailed Audit Findings

Objective 1: The role and responsibilities of the Quality team and the Commissioning service teams in relation to quality monitoring and reporting have been captured.

2.1 The CAF identifies that the Quality team was appointed in 2019 to "strengthen the focus on quality monitoring and improvement". It further details their role in the co-ordination of quality monitoring and interventions within commissioned services.

2.2 The Quality team comprises of a small number of staff, with each providing support to a number of commissioning teams. Their role is integral in the Commissioning teams and they provide quality information from internal and external reports and visits to the service providers, on matters such as infection control, serious untoward incidents (SUIs) and patient experience. Our testing has not identified

any concerns with the current set up of the team, though should the remit of their work expand in the future, the current resource and set up of having a shared quality lead overseeing a few commissioning teams may need to be reviewed.

2.3 The Quality team do not carry out the investigations into complaints and SUIs, this is undertaken by the service provider. However, the team link in with the provider and ensure that investigations are carried out in a timely manner, that responses address the issues of concern, and that lessons learnt are shared and themes are considered. They will also advise the Health Board who are commissioning the service of any complaints or SUIs.

2.4 The Quality team have been involved in re-introducing Service Improvement & Innovation Days (previously called Audit and outcome days). The days are to "support and strengthen the reporting of patient outcomes and experience, sharing of best practice and benchmarking across commissioned services". At the time of our audit, four improvement days had been hosted for Intestinal Failure, Sarcoma, Gender and Traumatic Stress Wales (TSW) Services, and there were key learnings and actions taken from the events.

2.5 The Quality team have recently produced a quarterly Quality Newsletter. The newsletter is to highlight some of the work that the team are involved with from a commissioning perspective and includes an update on the Service Innovation & Improvement Days, data about the number of incidents and complaints and short updates in relation to each of the Commissioning Teams.

Conclusion:

2.6 The roles and responsibilities of the Quality team members within the Commissioning teams is clearly set out. The Quality team have embedded quality monitoring and quality reporting within the commissioning services. The team have progressed since they were established, ensuring that quality and quality monitoring is a key priority in all commissioning teams. We have provided a Substantial assurance rating for this objective.

Objective 2: Processes and mechanisms are in place that allow the Quality and Commissioning teams to co-ordinate the quality monitoring and interventions within commissioning teams to enable reporting.

2.7 There are service specifications and Service Level Agreements (SLAs) in place for each of the services commissioned and these are monitored through SLA meetings with the provider. Prior to the meeting, the quality team review any available data on the services of the provider. During the meetings updates are provided on the services being commissioned and issues are discussed including actions to resolve the issue.

2.8 The WHSCC Quality team also meet with the health boards to discuss the services that WHSSC have commissioned on their behalf. These meetings allow the health boards to feedback concerns they may have, and for WHSSC to update the health boards about the commissioned services.

2.9 Where quality issues are identified with a service provided, an escalation process is in place that allows for enhanced monitoring to ensure issues are resolved as

soon as possible. The Corporate Directors Group Board are responsible for placing services in escalation. The escalation steps are aligned to a tiered approach:

- Level 1 – Enhanced monitoring. This is for any quality or performance concerns that have been identified and will be reviewed by the Commissioning Team.
- Level 2 – Escalated Intervention – For services where Level 1 Enhanced Monitoring identifies the need to further investigation/ intervention.
- Level 3 – Escalated Measures – Evidence that the action plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified.
- Level 4 – Decommissioning / Outsourcing – Services that have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage.

2.10 WHSSC are in the process of enhancing the process by developing an 'Escalation on a page' document. We understand that this will provide greater detail on the escalation status, highlighting a trajectory showing movements within the escalation level, to allow for more granular monitoring.

2.11 We reviewed the quality monitoring arrangements for Adult Gender Services and Cardiac Services, to ensure that there were appropriate processes in place and in line with the CAF. Both services had specifications in place, albeit one was in draft, which detailed the quality indicators and key performance indicators for the provider. There was evidence of meetings with the provider to discuss the services. Both commissioning teams for these services reported into the WHSSC Quality Patient Safety Committee (QPSC) and detailed reviews undertaken by other external functions and services that were in escalation. They also reported actions that had been taken since the previous review and the current position.

Conclusion:

2.12 There are appropriate processes and mechanisms in place that allow the Quality and Commissioning teams to review the providers and services in place. Where there have been issues with a service, an escalation process was in place. We have provided a Substantial assurance rating for this objective.

Objective 3: Effective quality assurance reporting arrangements are in place.

2.13 The CAF details the required quality reporting mechanisms. We confirmed that the QPSC receive consistent update reports from the Commissioning teams including information on services in escalation and any actions taken, quality visits and meetings undertaken, details of serious incidents, safeguarding concerns, complaints and compliments.

2.14 Following each QPSC meeting, a Chair's report is produced. We reviewed the minutes and papers of the WHSS Joint Committee and confirmed the Chair's report of the QPSC was presented at each Joint Committee meeting. A 'Services in Escalation' report was also provided detailing the current position of these services.

2.15 The QPSC Chair's report is also issued to health boards for inclusion on the agenda of their respective quality committees. Our review of a sample of Health Board quality committee meetings identified that for some of the health boards' Chair's report was not always presented to the committee. **(Matter Arising 1)** We acknowledge the Independent Members and officers from health boards sit on the WHSS committees and are therefore made aware of quality matters. However, the regular inclusion of the Chair's report in health board committee papers ensures that the information contained in the reports is available for review and scrutiny by a wider audience, including the public.

2.16 Our review of the minutes and papers from the QPSC identified a number of other quality update reports including:

- Reports that had been undertaken by Health Inspectorate Wales (HIW) and Care Quality Commission (CQC) on the commissioned services.
- An update report and action plan on one of the services within Mental Health & Vulnerable Groups that was at escalation level 4.
- Information in relation to the recent QPSC development day. The day consisted of an update on the CAF and how the Quality team are able to obtain assurance through areas such as SLAs, Service Specifications and performance & escalation.

2.17 We also saw a copy of the QPSC annual report which is provided to health boards. The report provided an update of the areas that were reported to the Joint Committee in the Chair's report, which included updates on the commissioned services.

Conclusion:

2.18 We recognise that there are sufficient quality assurance reporting arrangements on the commissioned services within WHSSC. However, the onward reporting of the quality of commissioned services is not always evident within the health boards. We have provided a Reasonable assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Monitoring of WHSSC quality matters in Health Board committee meetings (Operation)	**Potential Impact**
The Quality and Patient Safety Committee (QPSC) Chair's report provides an update from each of the Commissioning Teams and a summary of services that are in escalation. Chair's reports from each QPSC are presented at the Joint Committee meetings and are forwarded onto the health boards for inclusion within the papers of their respective Quality Committee meetings. We reviewed the papers of the last four quality committees for four health boards and found: • In one health board the Chair's report was an agenda item on three out of four of their quality committee meetings. • In two health boards the Chair's report was an agenda item on only one of their four meetings. • One health board did not appear to have the Chair's report as an agenda item at any of the quality committee meetings that we reviewed.	WHSSC is unable to provide assurance to health boards on the quality of care it commissions on their behalf.

	Recommendation	**Priority**
1.1	We acknowledge that the action of including Chair's reports on health board quality committee agendas is outside of WHSSC's control. However, WHSSC should liaise with health boards to communicate to them the importance of their committees being sighted on this information in order to scrutinise, and gain assurance from it, on behalf of their local population. WHSSC should work with the health board officers and Independent Members who sit on WHSSC committees to facilitate this.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
1.1	Consider the draft report in QPS Development Day.	26/10/2022	Director of Nursing & Quality
	Present Final report and Management Action Plan to WHSSC QPS Committee.	25/12/2022	Director of Nursing & Quality
	Appendix report to QPS Chairs report for submission and consideration by WHSSC Joint Committee.	8/11/2022	Chair WHSSC QPS Committee
	Report to be considered by All Wales Health Board Chairs QPS Committee.	Nov 2022	Chair WHSSC QPS Committee
	Future auditing of compliance to be monitored by the above committee.	Ongoing	All Wales Chairs QPS Committee

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Reporting Committee	**Integrated Governance Committee (IGC)**
Chaired by	**WHSSC Chair**
Lead Executive Director	**Committee Secretary**
Date of last meeting	**11 October 2022**

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.

11 October 2022

1.0 THE INTEGRATED COMMISSIONING PLAN

1.1 Progress update on delivering the Integrated Commissioning Plan 2022-2023 – Quarter 2

Members received a Quarter 2 update which highlighted:

- That a more equally balanced workload needed to be considered for future plans to alleviate some of the pressure on the Planning team and MG at the end of the year.
- That urgent action had been taken to secure another provider for Paediatric Pathology.
- Mitigating actions had been put in place following a detailed report by the commissioning team highlighting that Paediatric Neurology was now considered as high risk. The contingency plans were recently presented to CDGB and it was anticipated that the risk profile would drop following consideration of that paper.

Members also noted that the way accountability issues were being dealt with had been well received at a recent meeting with Welsh Government.

1.2 Progress update on developing the Integrated Commissioning Plan 2023-2025

Members received assurance that the development of the ICP was on track. The draft plan would be going to MG in October 2022 and to JC in November 2022, followed by the final plan for sign-off in early January 2023.

The CIAG scheme and the Clinical Prioritization of the Development Schemes with Services had been completed, and a first cut of the Financial Plan had been presented to MG in October 2022.

A further workshop on value and recommissioning had been scheduled for November 2022 to ensure that WHSSC continued to get the best value out of its core budget.

2.0 CORPORATE RISK ASSURANCE FRAMEWORK (CRAF)

The update report outlined that as at 30 September 2022 there were 17 risks scoring 15 or above, of which 15 were commissioning risks and 2 were corporate risks.

It was noted that there were no changes to the CRAF for the commissioning risks but there would be changes to some of the risks in the next report following review by the commissioning teams:

The 2 corporate risks remained the same in terms of the IPFR governance process.

JC had approved the report on 6 September, agreeing a proposal to engage on the IPFR panel terms of reference on the All Wales policies. Andrea Richards (AR) would lead, and there would be further updates at the next JC and IGC meetings.

The recovery workshop held on 12 July had been well received with a follow up session on Plastic Surgery held on 22 September.

The CRAF report would be going to the CTMUHB ARC on 24 October for assurance and would include verbal updates to some of the commissioning risks for assurance. The CRAF would also be presented to the WHSSC Quality and Patient Safety Committee on 25 October 2022.

The findings from the Risk Workshop of 20 September were being considered by CDGB on 11 October 2022.

WHSSC was also updating and approving a new risk appetite statement as the current statement was now overdue for review.

An update following the Risk Workshop would be presented to JC at their November meeting, with a more comprehensive update being provided in January 2023.

Whilst some positive progress had been made on the IPFR risk, it remained a

challenge as it depended on the engagement process in terms of whether the Health Boards and the AWTTC would engage and be supportive of the suggested changes to the ToR and Policy. However, if progress continued the IPFR risk score could be lowered and JE confirmed that she would be reviewing the IPFR risk.

Another key risk was remuneration for the chair position as it had become a more complex role since the judicial review. The time commitments required to demonstrate the robust discussions and decision-making process had increased significantly. Therefore, the remuneration element for getting a substantive chair was a key issue in terms of sustainability.

3.0 SUMMARY OF SERVICES IN ESCALATION

A verbal update was provided at the meeting and the report would be circulated to IGC members following the October QPSC meeting.

4.0 CORPORATE GOVERNANCE REPORT

Members noted that, following JC approval, 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.

WHSSC had been working with Welsh Government and the Board Secretaries over the past couple of months and had opened the recruitment for the positions of generic WHSSC IM and Audit/Finance Lead IM in August 2022 following agreement to open the audit lead to all HBs, rather than restricting it to CTMUHB IMs.

There had been positive response to both vacancies. Interviews were scheduled for 24 October.

Members noted the following salient points of the Corporate Governance report:

- An update on the matters considered at the In-committee meeting of 6 September 2022.
- An outline of the Welsh Health Circulars which had been issued by WG since the last meeting, and which were now available on the WG website.
- Notification that the engagement process for the IPFR ToR and Policy had commenced and a report outlining the findings would be presented to the Joint Committee in January 2023.
- An update on the QPSC Development Day which had taken place on 26 September and had been well attended with IM representatives from 6 of the 7 Health Boards in attendance.
- Notification that the findings from the Welsh Kidney Network Governance Review were due to be considered by the Welsh Kidney Network Board on 6 October. KP would be leading the discussion on the findings and the action plan, which would be progressed to JC in January 2023.

- Notification that the WHSSC Quality Assurance Report and the WHSSC Neurosurgery Report which were being presented by the audit team on 24 October had both received substantial assurance.
- Sight of the Audit Wales Governance Review tracker for assurance. The tracker captures recommendations received from internal and external audits and was presented to each Audit and Risk Committee as a standing item on the agenda. The next date for discussion would be 24 October 2022.
- Correspondence had been received from Judith Paget following communication with the Auditor General regarding Recommendations 6 and 7. WG were of the view that these could be categorized as complete in terms of the momentum they had received on the NHS executive. Audit Wales had responded that it was premature to consider these recommendations as closed, and would prefer to keep them open until receipt of an update from WG in 6 months' time. Currently WHSSC was waiting to receive copies of the correspondence but, in the meantime, this item would remain green / partially completed on the WG recommendations due to the difference of opinion.
- The Chair referred to correspondence from Judith Paget to the Chair of the Public Accounts Committee with regards to their activity relating to Recommendation 7. JP had advised that she was in the process of setting up a new piece of work to review the national commissioning arrangements in NHS, and that the scope and timescale of this work were currently under consideration.

Key risks and issues/matters of concern and any mitigating actions	
Then IPFR risk continues to be closely monitored as we embark on the engagement process.	
Matters requiring Joint Committee level consideration and/or approval	
N/A	
Matters referred to other Committees	
None	
The confirmed Minutes for IGC meetings are available on request	
Date of next meeting	24 January 2023

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

Agenda Item 4.4.4
Joint Committee
8 November 2022

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 20/10/2022 (meeting twice monthly)**

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

WHSSC IPFR Panel meetings continue to be scheduled twice-monthly during this reporting period. However, the second meeting in October had to be stood down because of lack of availability of panel members. Emails were sent to Panel members prior to the meeting to confirm non-attendance and we were able to cancel the meeting in advance and schedule a Chair's Action meeting instead.

The following table demonstrates the number of requests considered at the Chair's Action Panel meetings and All Wales IPFR Panel meetings during this period.

	Number of Requests discussed as Chair's Actions	Number of Requests discussed by WHSSC IPFR Panel
September 2022	3	10
October 2022	14	9

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

All Wales IPFR Panel Quoracy

WHSSC are still actively addressing the ongoing issues around achieving full Health Board attendance at Panel meetings.

The Patient Care Team continue to try and maximise attendance and ask members to re-confirm their attendance at meetings a week in advance. However, an issue remains in not knowing if the Panel will be quorate sometimes until the last minute. This is despite a great deal of WHSSC administrative time attempting to confirm attendance of members or seek a replacement.

All Health Boards have now nominated representatives to attend the AW IPFR Panel and they have attended the meetings in September and early Ocober however the meeting on 20 October 2022 had to be stood down as 3 of the 7 Health Boards sent appologies less than 36 hours before the meeting was scheduled.

All Wales Panel Terms of Reference

In September,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 Health Boards (HBs) and Velindre University NHS Trust (VUNT), to update the WHSSC IPFR Panel Terms of Reference (ToR) and a specific and limited review of the All Wales IPFR Policy. The WHSS team are currently preparing the documentation to commence the engagement process within the next few weeks.

Individual Patient Funding Request (IPFR) Quality Assurance (QA) Group Audit Report -26 September 2022 covering the period April to June 2022

There were very few issues raised with the application assessed for WHSSC. The group noted that the application had been completed by a specialist physiotherapist, the IPFR Policy states that applications should be made by an NHS clinician. In this case the group consider the applicant was appropriate for the request under consideration and recommend that the wording of the IPFR Policy should be revised to "NHS healthcare professional".

All cases considered in the period April to June 2022 met the urgency stipulated, an increase on the previous quarter when 94% of cases met urgency timelines. In the same period in 2021 85% of cases met urgency timelines.

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	**3 November 2022**

Agenda Item 4.4.5
WHSSC Joint Committee
8 November 2022

Reporting Committee	**Welsh Kidney Network (WKN)**
Chaired by	**Chair, Welsh Kidney Network (WKN)**
Lead Executive Director	**Director of Programmes**
Date of last meeting	**6 October 2022**

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 WRCN 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. Change of Network Name

Following consultation and approval by Joint Committee in August 2022, the Welsh Renal Clinical Network has been operating under the new name of Welsh Kidney Network (the 'WKN'). This change has been in effect since 30th September 2022.

2. Network Board Governance Review

The WKN Board workshop in early 2022 identified issues concerning the complexity of the governance framework for the WKN and the significant changes to the governance environment since the WKN founded in 2009. Consequently, there was agreement that a bespoke review be undertaken on the governance framework in order to strengthen and develop the ToR. The review was been completed over the summer and the recommendations were presented to WKN Board.

It was agreed to enable Board members to further review recommendations and contribute to an implementation action plan that a follow-up workshop is held on 23rd November 2022 as an integral element of the next Board agenda.

It is anticipated that the findings, recommendations and implementation action plan will be presented to the Joint Committee in January 2023.

2. Swansea Bay University Health Board (SBUHB) Procurement Project Update

Sarah Siddell, Directorate Manager Renal Services, SBUHB gave an update on the regional procurement project. Members noted that in October 2020 Welsh Government (WG) approved the procurement programme to re-tender the contracts for existing dialysis units, providing in-hospital dialysis machines and to provide two new additional units to deliver care closer to home. The WKN is the commissioning body and commissions the NHS Wales Shared Services Partnership

(NWSSP) Procurement team at CVUHB to support both the HBs and the WKN in adhering to the procurement regulations. The contract, once awarded will be between SBUHB as the regional centre for dialysis in South West Wales (i.e. including Hywel Dda UHB) and the successful bidder.

There have been a series of delays to the timeline, which have required on-going revisions during a time of significant volatility in the global and national financial landscape. The tender evaluation is now being finalised and the impact of the overall affordability of the procurement and any associated risks are to be outlined to the WKN by the Directorate Manager at the next WKN Board on 23rd November 2022. WHSSC are working closely with SBUHB to progress the tender process and a progress report will be brought to the Joint Committee in December.

3. Quality Statement Kidney Disease.

As an integral element of the National Clinical Framework a quality statement for Kidney Disease in Wales was drafted in collaboration with WKN management team and Quality and Patient Safety Group, Welsh Government and kidney charity partners. This was presented to the Board and was approved to enable final approval by Welsh Government and subsequent publication. Once published, next steps will be the development of a three year rolling implementation plan and refresh of service specifications.

The Quality Statement is appended for Joint Committee information **(Appendix 1)** however, it should be noted that this is essentially a Welsh Government document which encompasses the whole patient pathway. The role of the WKN in taking forward this Quality Statement is still to be clarified however currently the Network core team is established to commission specialised adult kidney care services and any revisions to the role in respect of the Quality Statement will need to be agreed.

4. Finance Report

Helen Harris gave an update on the WKN budget. There has been no additional call on the WHSSC Joint Committee to provide further growth funding for the 2022-2023 financial year. Provider Health Boards are reporting service pressures and as a consequence additional work is being undertaken by the WKN to understand these issues. Activity and financial forecasts are being considered in light of this and return to pre-Covid levels of activity growth. There are strong indications that this will translate into additional growth funding in the 2023/24 ICP.

5. Quality & Patient Safety

The WKN risk register has been reviewed to align with the WHSSC Corporate Risk Assurance Framework (CRAF) template.

Two Standard Operating Procedures were presented and approved by the WKN Board:

- Dialysis Away from Base

- Reimbursement for dialysis transport.

6. Schedule of Network Board Meetings - Ensuring Clinical Representation at WKN Board and associated meetings:
Amendments have been made to the dates and times of meetings to ensure that clinical representation is maximised and a forward plan of meetings dates will be issued.

7.WKN Website
Richard Davies gave an overview of the new website for the WKN launched at the annual WKN Clinical Audit Day on 30th September 2022. Work remains on going to ensure all patient education material is available in Welsh before the website fully publically available. However, clinicians have already been using the content within the clinic environment and report it to be an excellent resource.

8.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
- Lead Nurse Highlight Report
- Home Dialysis Lead Highlight Report
- Transplant and Vascular Access Clinical Lead 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 to resolve this issue and ensure that a sustainable service can be provided.

Matters referred to other Committees

- None

Date of next meeting	**23rd November 2022**

Appendix 1

DRAFT QUALITY STATEMENT: KIDNEY DISEASE

Kidney disease affects approximately 10% of the global population with diabetes and hypertension being amongst the commonest causes. The increasing prevalence of such conditions in our communities suggests we are likely to see more Welsh people with kidney disease requiring therapy, including those with mild disease in the community through to those requiring specialist care with dialysis and transplantation.

Kidney Replacement Therapy (KRT) such as dialysis is provided to around 1,400 adult Welsh residents and around 100 kidney transplants are undertaken each year. There are also almost 1,800 Welsh patients living with a functioning kidney transplant, who require ongoing clinical review, psychosocial support and immunosuppressive drug treatments. All forecasts consistently demonstrate that the need for these services for adults will grow by 4-5% year on year.

The number of children reaching end stage kidney disease per annum is around 2 per million of the total population. In Wales this corresponds to approximately 6 new cases per year. There are approximately 50 children on Kidney Replacement Therapy (KRT) in Wales at any one time, many with a kidney transplant. The need to ensure a smooth transition from children's to adult health services, as outlined in Transition and handover from children's to adult health services guidance, is recognised as an integral element of the pathway.

Building on the work of the **Renal Delivery Plan** (2016-2020) the next five year phase of service development for people with kidney disease must take advantage of the widespread consensus on priority areas, bring programmes to fruition, and maintain the national leadership, local engagement and collaboration with third sector that has been achieved. This will ensure that there is a long-term and consistent approach to improving outcomes as envisaged in the Wellbeing of Future Generations Act and demonstrated by international experience.

The introduction of **quality statements** were signalled in 'A Healthier Wales' and has been described in the National Clinical Framework as the next level of national planning for specific clinical services. Quality statements form part of the enhanced focus on quality and will be integral to the future planning and accountability arrangements for the NHS in Wales.

Kidney services in Wales were significantly impacted by the **COVID-19 pandemic**, and the learning from the need to adapt to the challenges has influenced the approach of this Quality Statement. As a consequence, it includes the immediate, short-term focus on recovery and also consideration of the medium and longer-term potential for transformation.

There is a need to ensure that equity of access is provided for those people who have faced inequality, such as, for example, ethnic minority communities and the LGBQT+ communities and pathways will need incorporate more flexibility to deliver this. The Welsh Government's "More than just words" plan to strengthen Welsh language in health and care services through the 'active offer' principle should become an integral part of service provision. Service providers should build on current best practice and plan, commission and provide care based on this principle.

The vision is to develop a Kidney Integrated Care Pathway (KICP) to provide the overarching framework for the delivery of kidney care from prevention to supporting patients to decide on the form of kidney replacement therapy that is right for them. The KICP will aim to drive system-wide improvement through a reduction in unwarranted variation of care and improved patient outcomes.

This approach aligns with the National Clinical Framework which places specific emphasis on the development of national **clinical pathways** and the Quality Safety Framework which emphasises the importance of systemic local use of the **quality assurance cycle**.

It also enables a focus on **cross-working** with other groups to address areas such as prevention, rehabilitation, organ donation and transplantation, care for those who are critically ill or at end of life as well as **collaboration** with other conditions such as heart conditions, stroke, diabetes and vascular.

Health boards are responsible for the delivery of kidney services in line with professional standards and the quality attributes set out below. Health boards will be directed, supported and enabled to deliver improved services. The Welsh Kidney Network (WKN) will set out a rolling, three-year implementation plan that identifies and prioritises developments based on the quality attributes described below. Detailed service specifications will also be developed to support the commissioning and accountability arrangements including key metrics for delivering high quality and sustainable kidney services that meet the needs of the population. These will be set out in Annex A as they become available.

Quality attributes of services for people with kidney disease in Wales

Equitable
1. National approach led by the Welsh Kidney Network to deliver service improvement through its network board in conjunction with the NHS Executive. 2. A Kidney Integrated Care Pathway will ensure transparency, support equity of access, consistency in standards of care and address unwarranted variation. 3. Services for people with kidney disease will be measured and held accountable using metrics, clinical audit, PROMs and peer review that reflect the quality of patient care and its outcomes.

4. A ‘kidney transplant first’ approach, before a patient needs to consider dialysis is adopted. This will include early identification of all potential patients for transplantation, particularly pre-emptive transplantation and potential living kidney donors.
5. Provision of as much treatment and support as possible close to or in the patient’s home, with home dialysis being a first choice if kidney transplant is not possible.
6. Kidney care workforce is supported and developed, to address staff retention and ensure it is sustainable, equitably distributed, grown to meet increased demand with focus on key areas such as kidney health and wellbeing support and specialist nursing.

Safe

7. A system-level focus on transforming pathways to further build in resilience by adopting the learning that achieved throughout the pandemic.
8. Evidenced patient safety improvement programmes are embedded utilising the all Wales incident reporting system to identify themes and share collective learning points.

Effective

9. Patients at risk of kidney disease or in the early stage of diagnosis are actively supported and involved in the management of their disease, including lifestyle modification support.
10. Children and Young people should be provided with care appropriate to their age and needs with the transition to adult services appropriately supported to ensure a smooth transition of care.
11. A culture where all patient’s needs, not just kidney care are understood ensuring the right support is provided at the right time, utilising a whole system approach including other specialties such as diabetes and services such a peer support provided by third sector.

Efficient

12. A national approach to the kidney informatics system (VitalData) to enable greater integration of care and provide relevant, high quality, standardised data to guide service development and inform commissioning needs.
13. Building on new ways of working by using technology to free up more time to care such as the electronic prescribing and medicines administration (EPMA) programme that enables the safe and efficient management and administration of medication.

Person Centred

14. Patients are supported to self-manage wherever possible using digital communications to facilitate and coproduced care plans.
15. Patients are actively involved in on-going management and decision making processes regarding treatment of their kidney disease. Ensuring that patients are supported to understand the likely trajectory of their disease, including a reasonable estimate of prognosis including information and support about Advanced Care Plans to enable them to record how they would wish to be cared for at the end of life no matter which treatment option they choose.

16. Patients are well-prepared for dialysis (if transplantation not clinically indicated), including commencing on preferred type and place of dialysis, with a permanent vascular access in place.
17. Collaborative approach to person-centred care is culturally embedded and supported by a common approach to diagnosis, treatment and care provided within the community where appropriate.
18. PROMS and PREMs are used to better understand care and service needs to ensure people affected by kidney disease achieve the outcomes that matter to them.
19. Outcomes from the research studies undertaken in Wales and globally are utilised to inform how we model delivery of care and patient education.

Timely
20. Validated mechanisms for identifying people at risk of developing kidney disease and those at the early stages of disease will used to support primary care to ensure timely referral to secondary care. 21. Opportunities to implement new medications proven to reduce the progression of kidney disease and associated cardiovascular disease are explored and implemented.

ANNEX A - Service Specifications

The WKN will develop service specifications for kidney disease pathways to inform accountability discussions and commissioning decisions. These will be added as they become available.