Supporting Papers

Wed 24 May 2023, 08:00 - 16:00

Agenda

1. Item 3.1: Integrated Medium Term Plan 2023-26: Update

3.1 b IMTP Ministerial Priorities. Updated May 2023.pdf (77 pages)

2. Item 3.3 Primary Care Provision

Branch Surgery Closure Process
Vacant Practice Policy

3.3.1 b Branch Surgery Closure Process.pdf (15 pages)
3.3.2 b Vacant Practice Policy.pdf (18 pages)

3. Item 3.5 Regional Cataract Business Case

3.5 b FINAL Regional Cataracts Business Case 12 May 23.pdf (151 pages)

4. Item 3.8: Velindre Cancer Centre Business Case

3.8 b nVCC FBC.pdf (42 pages)

5. Item 4.7: An overview of Joint Committee Activity

a) WHSSC
Appendix 1 - Updated Standing Orders
Appendix 2 - Updated Memorandum of Understanding and Hosting Agreement
Appendix 3a - Updated Financial Scheme of Delegation
Appendiz 3b - Updated Financial Authorisation Matrix

4.7 a 3 Appendix 1 - Updated Standing Orders Feb 2023.pdf (57 pages)
4.7 a 4 Appendix 2 - WHSSC MoA Feb 2023 with Annex 1-5 (003).pdf (66 pages)
4.7 a 5 Appendix 3a - Scheme of Delegation New Proposed.pdf (8 pages)
4.7 a 6 Appendix 3b - Copy of Authorisation Matrix.pdf (1 pages)

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

MAY 2023 VERSION

Aneurin Bevan University Health Board

Ministerial Priorities 2023/26

Contents

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES –

Ministerial priorities:

- **Delayed transfers of care**

Regular monthly reporting of 'Pathways of Care' (DTOC) to be introduced for 2023-24 and reduction in backlog of delayed transfers through early joint discharge planning and coordination

- **Primary care access to services**

Improved access to GP and Community Services
Increased access to dental services
Improved use of community pharmacy
Improved use of optometry services

- **Urgent & Emergency care**

Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales to support improved access and GMS sustainability
Implementation of Same Day Emergency Care services that complies with the following: • Is open 5 days a week moving to 7 days a week 12 hours a day by end of Q2 • Is accessible at key times evidenced by the emergency care demand profile in of each hospital site • Is direct access and bypasses Emergency depts • Delivers a service for at least medical and surgical same day care • Is accessible to by WAST clinicians as set out in their clinician referral policy to support reduction in handover as set out in the six goals handbook. • Demonstrate utilisation of allocated resources by WG and measures impact as set out by the national programme
Health boards must honour commitments that have been made to reduce handover waits

- **Planned Care, Recovery, Diagnostics and Pathways of Care**

52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by 30 June 2023 and maintained throughout 2023/24 moving to 36 weeks RTT standards by March 2024
Address the capacity gaps within specific specialities to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025 (This must include transforming outpatients follow up care, reducing follow up by 25% against 2019/20 levels by October 2023 and repurposing that capacity)
Implement regional diagnostic hubs, to reduce secondary care waiting times and meet waiting time ambition in spring 2024
Implement pathway redesign – adopting 'straight to test model' and onward referral as necessary

- **Cancer recovery**

Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion.
Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026,

- **Mental health and CAMHS**

Recover waiting time performance to performance framework standards for all age LPMHSS assessment and intervention and Specialist CAMHS.
Implement 111 press 2 on a 24/7 basis for urgent mental health issue

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES (SUMMARY OF CHANGES)

Ministerial Priority	ABUHB Plan Summary	ABUHB Commitment for submission May 31st
Delayed Transfers of Care (Pathways of Care)	Integrated Discharge Programme Board has commenced with Discharge Hub set up and NHH pull model established. The initial improvement work and updated actions have informed the trajectory, this will be reviewed in Q1	**TEMPLATE UPDATED** • AB will reduce the backlog of Pathways of Care delays • through early joint discharge planning • Improvement Trajectory included shows a 20% improvement
Improve access to Primary Care Services	There has been a worsening position in terms of performance and risk regarding access and sustainable services which includes significant workforce challenges. The work of the Sustainability Programme will support future improvement but are assessed as unlikely to make an impact during this reporting period. There will be no change to baseline	**TEMPLATE NOT UPDATED MATERIALLY** • Commitment to sustain the baseline position- due to service sustainability risks, including contract returns, impact of national contracts, changes in approach of national pharmacy providers.
Cancer Recovery	Operational, workforce and finance plans have been aligned to achieve the reduction in line with the set trajectory. Profiles from improvement and operational priority weighted to achieve implementation. However significant risk sits with delivery due to workforce fragility and tertiary service capacity (30%)	**TEMPLATE UPDATED** • Commitment to reduce the backlog of those waiting 62 days • <250 patients waiting by March 2024 • Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026 • Commitment to implementing 5 pathways this year and to meeting the national target (75% by Q4)
Mental Health and CAMHS Recover waiting time performance to performance framework standards **Mental Health – 111 press 2 24/7**	There is risk with these profiles due to the ongoing issues with WICCIS, additional support to be provided and review at Q1	**TEMPLATE NOT UPDATED** • Waiting time performance and plans profiled to be achieved by March 2024 • The service plans for delivery of the 111 service to be achieved from Q1

Ministerial Priority	ABUHB Plan Summary	ABUHB Commitment for submission May 31st
Urgent and Emergency Care	Urgent Primary Care model is already established for the Health Board and work has moved into aligning to place based care plans	**TEMPLATES UPDATED** Implementation of a 24/7 urgent care service accessible via 111 and sustain the current UPCC model with further development of placed based care meeting the Ministerial Priority
	As at March 2023 the following SDEC services (either by definition or by proxy measures) are delivered by the Health Board: SDEC at GUH (Surgical) SDEC at GUH (Medicine/Other) SDEC at YYF (Medicine) Respiratory Ambulatory Care Unit (RACU) Medicine at RGH 1x Medical Assessment Unit at GUH 1x Surgical Assessment Unit at GUH 3x Medical Assessment at eLGH sites (RGH, NHH, YYF)	*Currently open 5 days a week moving to 7 days a week 12 hours a day by end of Q2* • **ABUHB SDEC is open 5 days week additionally SAU, MAU and eLGH services are open 7 days a week which provide considerable amount of same day care. A 7-day plan for SDEC at GUH would require additional investment and at this stage is not seen as cost effective or affordable** *Is accessible at key times evidenced by the emergency care demand profile in of each hospital site* • **Opening hours match profile throughout the day** *Pathways are direct access and bypasses emergency depts* • **Currently meets both requirements** *Delivers a service for at least medical and surgical same day care* • **Meets the requirements across the sites** *Is accessible by WAST clinicians as set out in their clinician referral policy to support reduction in handover as set out in the six goals handbook* • **Currently in place via Flow Centre**
	Ambulance Handovers New 4-hour handover process introduced from May Identifying true reported position ongoing	**TEMPLATE UPDATED** • Improvement trajectory moved to performance ambition in line with 4 hour red line • From Q2 Zero handovers longer than 4 hours

Ministerial Priority	ABUHB Plan Summary	ABUHB Commitment for submission May 31st

Planned Care (1 of 2)	A review of the RTT trajectories factor in a number of changes since the baseline forecasted position submitted for the IMTP (at Feb 23). These now include the known year end position and cohort sizes for 104 and 52 weeks. The following changes need to be noted:
	
	• There was a worsening position at the end of the year for 52-week stage 1 as the Health Board prioritised those waiting longer than 104 and 156 weeks in Q4. Excellent progress towards completely clearing the longest wait cohorts.
	• Demand increase of 2% (aggregate and included in original forecasts)
	• Known improvements now be factored in, (e.g. Ophthalmology Regional Business Care, Orthopaedics capacity and Urology).
	• Productivity gains have been included based on expected improvements in theatre scheduling. These gains equate to over **1,200** additional procedures in total with significant gains noted for Ophthalmology and Urology (over 400 potential procedures in both specialties).
	• Outpatient Efficiency factored in at DNA rate improvement to 5%
	• Treat in turn has also been prioritised in key areas to support backlog reduction for the longest waiters. The following details the required change in capacity used for the relevant Ministerial priority for the specialties with the longest waiting patients
	
	  • Stage 1 – 52 Weeks, ENT, Ophthalmology, Urology
	  • Stage 1 – 104 Weeks – ENT , T&O , Urology
	  • Stage 4 – 104 Weeks –
	
	These improvements are balanced with the decision to halt all weekend WLI's worsening the Outpatient position by 3,200 and Treatment position by 1,300.
		TEMPLATE UPDATED
		This plan now:
		Ensures all 156 week waits (all stages) are booked, with majority seen by August 23,
		
		Eliminates all 104 week waits (all stages) by March 24,
		Delivers no patients waiting over 52 weeks for outpatients (Stage 1) in all but 4 specialties (ENT, Ophthalmology, Orthopaedics and Urology),
		
		For these 4 specialties, the May submission improves the 52-week outpatient position from previous submission so that numbers of patients waiting are just below March 23 levels ,
		
		Improves delivery on all planned care ministerial priorities, with greatest gains targeted at the longest waiting patients, without compromising prioritising clinically urgent and cancer patients.

Ministerial Priority	ABUHB Plan Summary	ABUHB Commitment for submission May 31st
Planned Care (2 of 2)	**23/24 improvements for Outpatient Transformation Programme** • Straight to Test model and pathway redesign • General Surgery expansion of Lower Gastrointestinal Tract STT pathway • Gastroenterology and Endoscopy direct access scope pathway for diagnostic flexi-sigmoidoscopy and oesophagogastroduodenoscopy (OGD) in place. Implement pathway redesign through adopting calprotectin pathway for inflammatory bowel disease (IBD) patients • Urology expansion of Straight to Test pathway for appropriate prostate-specific antigen (PSA) referrals to all bladder cancer patients. • Respiratory redesigned Straight to Test pathways for lung cancer, sleep, asthma and interstitial lung disease (ILD) implemented. • Cardiology long established Straight to Test pathway in place for echocardiogram or ambulatory monitoring. Implement pathway redesign through adopting STT model for direct to CT pathway.	**TEMPLATE UPDATED** The Health Board has committed to implementing pathway redesign in 5 priority areas 23/24 delivery is focused on Cancer Pathways to meet our Cancer delivery obligations, other pathways will be focused on in the next IMTP period.
	Implement Regional Diagnostic Hubs (Community Diagnostic Centre CDC) Maximum eight week waiting times from referral to report turnaround (requiring six-week maximum imaging time) and improved local access for radiology investigations, with key enabler being submission of business case for second MRI scanner in the Grange University Hospital (GUH) to facilitate establishment of a community diagnostic centre at Ysbyty Ystrad Fawr (YYF).	**TEMPLATE UPDATED** • Health Board commits to regional working and the implementation of the CDC (subject to funding), • This commitment is based on the interdependency of the YYF CDC being enabled by Q3

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITY

Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion.

	Priority area(s)
Key focus should be on delivering	Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion.
Baseline	As of March 23, there were 343 patients in the cancer backlog patients actively waiting over 62 days. This equates to 10.4% of the total cancer waiting list.
Quarter 1:	
Milestones	Backlog < 300
Actions	• Q1 focus will be to reduce breast waiting times through radiological recruitment in line with plan and the commencement of the work plan for optimal pathway manager. • Validation of backlog patients. • Commencement of the role out of Did Not Attend (DNA) reduction pilot schemes. • Continued outsourcing of Pathology to maintain decrease in waiting time
Quarter 2:	
Milestones	Backlog < 250 Achieve 14-day first appointment compliance
Actions	• Optimal pathway work to begin reducing volume of breaching patients through reviewing capacity scheduling with Specialties. • Continued DNA reduction pilots and review.
Quarter 3:	
Milestones	Maintain backlog < 250
Actions	• Review of tertiary pathways, working with tertiary partners to address opportunities in pathways to reduce waits. • Review of alignment to optimal pathway. • Review of progress against recruitment plans required to significantly increase capacity.
Quarter4:	
Milestones	Maintain backlog < 250
Actions	• Commence reactive capacity management to increasing demand. • Using Health pathways, primary care referral support to improve patient awareness and appropriateness of referrals and clarify the appropriate referral pathway.
Risks	**Demand growth –** Demand is forecast to rise by a further 3.6% in 2023. This will require further recruitment plans and reallocation of available capacity.

	Priority area(s)
	Patient engagement – We are increasingly seeing the impact of patient choice on the cancer backlog. Strategies to prevent this are in place but this will continue to impact backlog through the new year **Workforce –** Workforce shortages are still prevalent in tumour site teams. Successful recruitment to these posts is fundamental to reducing backlog and achieving targets. These include Patient Navigators in Endoscopy, Gynae, and Lung, a Consultant Pathologist, and staffing in the colorectal business case. The National Optimal Pathway role, and a supporting role, have been recruited to. Meeting genomics and ICC turnaround time compliance remains a challenge. AB exploring possibilities of providing PDL-1 ICC testing in house to improve treatment turnaround times. **Tertiary dependencies –** 25-30% of treatments are delivered outside of ABUHB services. Efficiencies in these services will impact both on performance and backlog volumes **Theatre access -** The balancing of capacity to prioritise cancer patients and those waiting the longest is a risk to delivery
Outcomes	Improved SCP compliance, improved time to diagnosis and treatment.
Alignment with workforce plans	Aligned with workforce plans
Alignment with Financial plans	The reduction of the backlog in Q1 is dependent on Path outsourcing and continued WLI support
OPTIONAL	
Digital / Technology Opportunities	

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES –

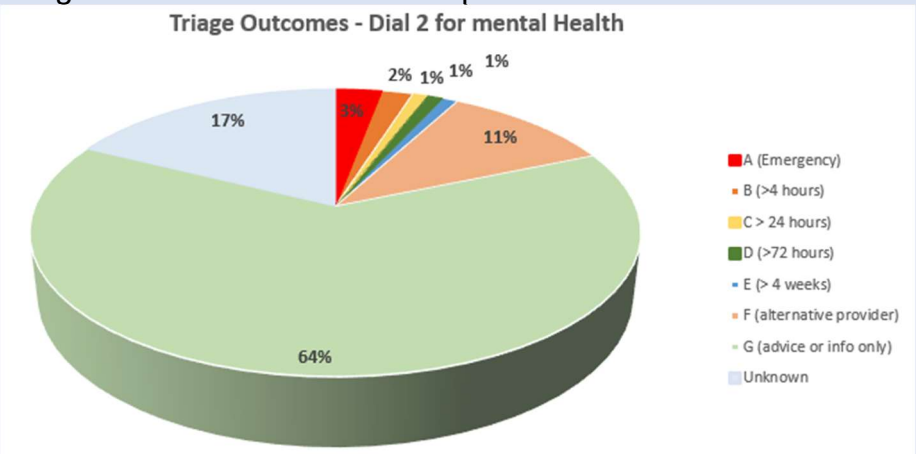
Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026.

	Priority area(s)
Key focus should be on delivering	Implement the agreed national cancer pathways within the national target – demonstrating annual improvement toward achieving target by March 2026
Baseline	March 23 SCP performance = 56% No ABUHB tumour site has fully implemented the national cancer pathway. To date the focus has been on services are aligning the diagnostic pathways with those outlined within the National Optimal Pathways (NOP).
Quarter 1:	
- **Milestones**	**60% performance compliance**
- **Actions**	- Reduced pathology waiting times from outsourcing, compliant against 14 day first outpatient appointment, through continued outsourcing commitment. - Optimal Pathway Manager in post and full implementation strategy completed, initially focussing on Head & Neck and Urology. - Skin and Lung to be NOP compliant. - Improvement in Skin, Gynaecology and Breast performance to increase proportion of patients meeting 62 pathway
Quarter 2:	
- **Milestones**	**65% performance compliance**
- **Actions**	- Head & Neck, Urology and Lower GI to be aligned to NOP. - Waiting times reduced through maximising capacity.
Quarter 3:	
- **Milestones**	**70% performance compliance**
- **Actions**	- Opening of endoscopy suite, endoscopy to be compliant with <14 day wait time**.**
Quarter4:	
- **Milestones**	**>75% performance compliance** Opening of breast unit to enable deliver of optimal pathway
- **Actions**	- Reduction in theatre waiting times across all services by working with specialities. - Reduced pre-operative/anaesthetic assessment waiting times through preop and prehabilitation workstream, currently under development.

	Priority area(s)
Risks	**Pathology –** All NOP's dependent on considerable improvement in pathology turnaround times **Regionalised services** – Regionally commissioned services (delivered by Velindre, C&VUHB, SBUHB) do not all comply with NOPs which will impact on ability to implement. **Tertiary dependencies –** 30% of treatments are delivered outside of ABUHB services. Efficiencies of these services impact on NOP compliance **Demand** – Unexpected spikes in demand, such as colorectal, results in a capacity shortfall **Capacity** – The NOP waiting targets are dependent on considerable additional workforce that are currently being recruited to (detailed below) **Workforce –** Workforce shortages are still prevalent amongst multiple tumour sites. Successful recruitment to these posts is fundamental to reducing backlog and achieving targets. The National Optimal Pathway role, and a supporting role, have been recruited to. These include Patient Navigators in Endoscopy, Gynae, and Lung, a Consultant Pathologist, meting genomics compliance and staffing in the colorectal business case
Outcomes	Improved SCP compliance, improved time to diagnosis and treatment.
Alignment with workforce plans	Aligned with Workforce Plans
OPTIONAL	
Digital / Technology Opportunities	

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITY

Implement 111 press 2 for urgent mental health issues (24/7 basis)

Baseline	Nov-Dec 2022 data: • Average 32 calls answered per day • 33% abandonment rate before reaching the Mental Health 111 telephony queue • Average time to answer calls = 15 seconds • Average out of area calls = 15% Triage scale outcomes over this period are shown below. 
Quarter 1:	
Milestones	• Expand the service to cover a 24/7 period. • Incorporate urgent and crisis assessments into the Mental Health 111 service. • Engage in national advertising campaign. • Maintain compliance with targets - service targets and pathway targets.
Actions	• Recruitment of Band 6 Mental Health Clinicians. • Development of 24/7 rota • Introduction of newly recruited Band 5 Mental Health & Wellbeing Practitioners. • Engagement and consultation with staff regarding the crisis and urgent assessments. • Working group to develop the new model for crisis and urgent assessments. • Implement local comms and engagement in line with national advertising.
Quarter 2:	
Milestones	• Expand the use of the professional line to General Practitioners and other professionals.

	• Move the service into new accommodation. • Implement different ways for people to contact the Mental Health 111 service (explore text/video etc.). • Explore different support that can be offered by the team, i.e. face to face/sanctuary type support. • Maintain compliance with targets - service targets and pathway targets.
Actions	• Ensure the new crisis and urgent assessment model is robust - communicate with GPs to make urgent and crisis referrals via Mental Health 111 Professional Line. • Secure funding for new accommodation. • Working group to look at clinically safe ways of providing the same support to people via different methods. • Map out what further support could be offered by the team and create plan to implement.
Quarter 3:	
Milestones	• Maintain compliance with targets - service targets and pathway targets. • Adapt and develop the service based on evidence.
Actions	• Maintain data reporting and ensure the service meets the necessary targets, making changes to processes where needed.
Quarter4:	
Milestones	• Maintain compliance with targets - service targets and pathway targets. • Adapt and develop the service based on evidence.
Actions	• Maintain data reporting and ensure the service meets the necessary targets, making changes to processes where needed.
Risks	• Recruitment of Band 6 Mental Health Clinicians to 24/7 model. Mitigated by utilising core group of band staff. • Funding may only be available to implement a basic 24/7 service and not allow for development. • National campaign may increase demand to the point where time to answer calls increases above the target. • Continued pressure on 111 may impact Mental Health 111 as callers select option 2 in the hope of being answered quicker. • Continued boundary issues may increase the call demand on ABUHB Mental Health 111 from callers in other health board areas.
Outcomes	• 85% of calls answered in under 1 minute. • 95% of calls answered in under 3 minutes. • Call abandonment rate to be under 5%. • 100% of crisis assessments to take place within 4 hours of referral. • 100% of urgent assessments to take place within 48 hours of referral. • 100% of routine assessments to Community Mental Health Teams to take place within 28 days of referral.

	• 100% of routine assessments to Primary Care Mental Health to take place within 28 days of referral.
Alignment with workforce plans	The Mental Health 111 service has a workforce plan to allow the service to expand to delivering support 24/7. The management structure of the Mental Health 111 service (above team leader level) is being developed in line with the Mental Health and Learning Disabilities Divisional workforce plan.
Alignment with Financial plans	The Mental Health 111 service is aligned with the Mental Health and Learning Disabilities financial plans. Recurrent funding has been allocated to deliver the current model (9am-midnight service). Further funding will be required to expand to a 24/7 model.
Digital / Technology Opportunities	

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITY

Recover waiting time performance to performance framework standards of 18+ LPMHSS assessment and intervention.

Baseline	**July 2022 Baseline:** (latest validated position) Assessments (80% target) - 92% (488 of 528) Intervention (80% target) - 31% (86 of 278) The performance baseline for interventions is in part due to the service focusing on assessment (in line with Welsh Government recovery guidance) to ensure that all those referred receive an initial assessment with a registered mental health practitioner. The rationale to minimise the number of interactions with different practitioners and direct patients to the most appropriate care and support first time.
Quarter 1:	
Milestones	• Covid recovery plan implemented. • Welsh Community Care Information Systems (WCCIS) backlog addressed. • WCCIS fully functional across all Primary Care Mental Health Specialist Services (PCMHSS) Borough areas. • Sufficient clinical space identified and secured for delivery of face-to-face appointments. • Hub based model operating across two NCN areas.
Actions	• Implementation of Covid recovery plan. • Manage and deliver WCCIS backlog plan, recruitment of agency staff and uptake of internal overtime to address current PCMHSS backlog of appointment recording. • Identify and secure/procure clinical space to provide the necessary number of face-to-face appointments to meet demand (including backlog). • Continue work necessary to progress hub-based model.
Quarter 2:	
Milestones	• Funding identified and recruitment of 5(wte) High Intensity Therapists (HIT) complete. (Pending available funding from Welsh Government) • Hub based model operating across four Neighbourhood Care Network (NCN) areas • WCCIS backlog addressed. • Demand and capacity modelling completed to identify commissioned therapy requirements.

Actions	• Strengthen HIT provision to meet demand. This would equate to an additional 5(wte) therapists and is subject to funding availability. • Funding sought and recruitment actions identified. • Further progression of hub-based model.
Quarter 3:	
Milestones	• Implementation of therapy pathways. • Hub based model operating across seven NCN areas.
Actions	• Further progress matched care model • Develop and implementation of therapy pathways
Quarter4:	
Milestones	• Maintenance of compliance with Welsh Government performance targets • Hub-based model fully operational in all ten NCN areas. • Achieve compliance with Welsh Government performance targets by end of March '24
Actions	
Risks	• WCCIS - Operational processes, waiting list management, awaiting system changes external. • External provision - Management of waiting list, Referral To Treatment (RTT), local management/national. • Agency - Still recruiting, monies only up to March'23 risk if backlog goes beyond that. • Internal expertise developed in relation to backlog and progressing, managed via overtime, risk around staff not being able to continue with level of overtime demands. • Ongoing piece of work in collaboration with Older Adult Mental Health around clinical face to face space for Psychology/PCMHSS. Secured temporary space but does cost, again finance stops in March'23, requires ongoing rental if we are to continue. • Performance - Inability to meet targets due to backlog, awareness of actual waiting lists, WCCIS changes required. • Recruitment - No funding at the moment for the additional 5 wte. High Intensity Therapists. Potentially due to backlog and lack of funding predicting 12 month waiting list for HIT. • No funding currently identified for additional agency/internal overtime to address WCCIS Backlog, performance issues with WCCIS have caused significant delays in progression of backlog input. • Currently completing modelling for commissioned therapy not complete, however no funding currently identified for expansion of commissioned therapy provision.
Outcomes	• Assessments – 80% of patients to be assessed within 28 days from referral • Intervention – 80% of initial interventions to commence within 28 days of assessment
Alignment with workforce plans	• Please see below

Alignment with Financial plans	This will be managed within existing budgets and monitored within the monthly PCMHSS Assurance meetings. There are however identified risks around the 5wte posts, accommodation and backlog agency costs whereby the financial funding ends March'23. This will therefore require discussion and planning in relation to what actions need to be taken if additional funding is not identified for these activities. Alternatively, what the service delivery will be if funding is not available and the gap in provision as a result, how this will impact the achievement of the outcomes planned.
Digital / Technology Opportunities	
The ongoing risks regarding WICCIS are being managed but remain identified as high risk for delivery.	

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITY

Recover waiting time performance to performance framework standards for Specialist CAMHS

Baseline	July 2022 Baseline: (Last Validated position due to Welsh Community Care Information Systems (WCCIS) reporting issues) Referral acceptance to assessment within 28 days RTT 96.5% compliance
Quarter 1:	
Milestones	To maintain over 80% Referral To Treatment (RTT) Target Compliance for New Choice referrals to assessment within 28 days - Core CAMHS and Community Embedded Team (CET) Emergency Department (ED) Teams
Actions	• Clinical Information Hub (CCIH) review and monitor referral demand using data to forecast and inform quarterly job plans • Review Core and CET ED clinician job plans in line with the Clinical and Product Assurance (CAPA) Framework • Ensure that job plans have sufficient capacity to meet CHOICE Demand • Efficient recruitment into vacancies meeting requirements of workforce plans • To monitor room bookings and ensure there is adequate accommodation to meet clinical demand • CCIH to continue to work closely with Gwent wide Single Point of Access for Children's Emotional (SPACE) Wellbeing partners re pre-allocations to ensure timely referrals into CAMHS • CCIH to hold weekly performance meetings to review capacity and demand and expedite potential breachers • Monthly Performance Senior Management Team to continue to review position and propose efficiencies • CCIH to create a CAMHS end of year data performance report for SMT review
Quarter 2:	
Milestones	To maintain over 80% RTT Target Compliance for New Choice referrals to assessment within 28 days - CORE CAMHS and CET ED Teams
Actions	• CCIH review and monitor referral demand using data to forecast and inform quarterly job plans • Review Core and CET ED clinician job plans in line with the CAPA Framework • Ensure that job plans have sufficient capacity to meet CHOICE Demand • Efficient recruitment into vacancies meeting requirements of workforce plans • To monitor room bookings and ensure there is adequate accommodation to meet clinical demand

	• CCIH to continue to work closely with Gwent wide SPACE Wellbeing partners re pre-allocations to ensure timely referrals into CAMHS • Monthly Performance SMT to continue to review position and propose efficiencies • CCIH to hold weekly performance meetings to review capacity and demand and expedite potential breachers
Quarter 3:	
Milestones	To maintain over 80% RTT Target Compliance for New Choice referrals to assessment within 28 days - CORE CAMHS and CET ED Teams
Actions	• CCIH review and monitor referral demand using data to forecast and inform quarterly job plans • Review Core and CET ED clinician job plans in line with the CAPA Framework • Ensure that job plans have sufficient capacity to meet CHOICE Demand • Efficient recruitment into vacancies meeting requirements of workforce plans • To monitor room bookings and ensure there is adequate accommodation to meet clinical demand • CCIH to continue to work closely with Gwent wide SPACE Wellbeing partners re pre-allocations to ensure timely referrals into CAMHS • CCIH to hold weekly performance meetings to review capacity and demand and expedite potential breachers • Monthly Performance SMT to continue to review position and propose efficiencies • CCIH to develop Mid Year Performance Review Report for SMT
Quarter4:	
Milestones	To maintain over 80% RTT Target Compliance for New Choice referrals to assessment within 28 days - CORE CAMHS and CET ED Teams
Actions	• CCIH review and monitor referral demand using data to forecast and inform quarterly job plans • Review Core and CET ED clinician job plans in line with the CAPA Framework • Ensure that job plans have sufficient capacity to meet CHOICE Demand • Efficient recruitment into vacancies meeting requirements of workforce plans • To monitor room bookings and ensure there is adequate accommodation to meet clinical demand • CCIH to continue to work closely with Gwent wide SPACE Wellbeing partners re pre-allocations to ensure timely referrals into CAMHS • CCIH to hold weekly performance meetings to review capacity and demand and expedite potential breachers • Monthly Performance SMT to continue to review position and propose efficiencies

Risks	• Unplanned staff absence • Vacancies • Increase in referrals • Limited accommodation to meet service need • Unexpected external events impacting workforce • Implications of partial implementation of WCCIS, subsequent backlogs and the inability to run performance reports to obtain RTT position, inability to validate and cleanse data, unable to provide accurate data to report RTT
Outcomes	• All CAMHS Core and CET ED New Referrals seen within 28 days from receipt of referral for assessment • Compliance with WG RTT 80% Target
Alignment with workforce plans	CAMHS CORE and CET ED have an established workforce profile that span across all professions and teams - vacancies are reviewed against CHOICE clinicians job plans Neurodevelopmental the whole CAMHS Service demand, capacity and identified priorities.
Alignment with Financial plans	CAMHS Teams who provide CHOICE assessments will continue to be reviewed in alignment with the CAMHS and Family & Therapies IMTP Financial plan.

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITY

Recover waiting time performance to performance framework standards of under 18 LPMHSS assessment and intervention.

Baseline	July 2022 Baseline: Assessments (80% target) - 90% (100 of 111) Intervention (80% target) - 4% (4 of 39)
Quarter 1:	
Milestones	• PCAMHS Initial Assessment Part 1A maintain steady state RTT 80% Target • PCAMHS Initial Intervention Part 1B Recovery- Continued Implementation of recovery plan
Actions	• Recovery Plan for 1B Interventions continues to be implemented, manual collection of unverified data identifies a forecasted Recovery RTT 80% Target in Sept 23 - bringing Initial Interventions to steady state. • Monitor referral rates for 1A Assessments and the impact timeline to 1B and ensure sufficient capacity to support recovery programme. • Complete clinical audit to understand clinical need and complexity in PCAMHS and consider action plan to meet need as a whole service. • Complete conversion audit to better understand referral numbers, destinations and outcomes within PCAMHS and wider system. To review capacity and resource allocated to meet the need. • Use of Clinical and Product Assurance (CAPA) job plan data to understand what tips cases above six sessions. Use of data to inform service planning and improvement. • Weekly PCAMHS Performance meetings to monitor 1A and 1B demand, capacity and activity. To flex resource as needed. • Continue to work through CAMHS Wales Community Care Information System (WCCIS) backlog and monitor issues+ • Efficient recruitment to vacancies to ensure workforce capacity to meet demand. • Planning exercise to consider how in-reach capacity in school holidays can support 1a and 1b if needed. • Monitor use of rooms/accommodation to ensure that physical space is maximised for PCAMHS appointments • Ongoing CAPA job plan reviews and monitoring of six session model within PCAMHS. • Service engagement in quarterly Regional Safeguarding Steering Group (RSSG) to understand local area need and service provision and how this may impact on Part 1a and 1b and develop any needed action plans, e.g. SBC pause referrals etc.

Quarter 2:	
Milestones	• PCAMHS Initial Assessment Part 1A maintain steady state RTT 80% Target • PCAMHS Initial Intervention Part 1B Recovery -Continued Implementation of recovery plan
Actions	• Weekly PCAMHS Performance meetings to monitor 1A and 1B demand, capacity and activity. To flex resource as needed • Performance meeting to monitor referral rates for 1A Assessment and identify impact timeline on 1B to ensure there is sufficient capacity to reach recovery position and maintain steady state • To monitor how WCCIS supports data for Part 1a and 1b • Efficient recruitment to vacancies to ensure workforce capacity to meet demand • Use of in-reach capacity in school holidays to support 1a and 1b as needed • Monitor use of rooms/accommodation to ensure that physical space is maximised for PCAMHS appointments • Monitor annual leave (A/L). Consideration of capacity due to time of increased staff A/L during school holidays. Agree plan with staff to ensure service need is still met • Prepare for 12month review of In-reach service, to measure any impact this has had on Parts 1a and 1b • Ongoing CAPA job plan reviews and monitoring of six session model within PCAMHS • Service engagement in quarterly RSSG to understand local area need and service provision and how this may impact on Part 1a and 1b and develop any needed action plans, e.g. SBC pause referrals etc.
Quarter 3:	
Milestones	• PCAMHS Initial Assessment Part 1A maintain steady state RTT 80% Target • PCAMHS Initial Intervention Part 1B Recovery - Forecasted recovery September 23 (unverified data used)
Actions	• Weekly PCAMHS Performance meetings to monitor 1A and 1B demand, capacity and activity. To flex resource as needed • To monitor how WCCIS supports data for Part 1a and 1b • Efficient recruitment to vacancies to ensure workforce capacity to meet demand • Use of in-reach capacity in school holidays to support 1a and 1b as needed • Monitor use of rooms/accommodation to ensure that physical space is maximised for PCAMHS appointments • Monitor A/L. Consideration of capacity due to time of increased staff A/L during school holidays. Agree plan with staff to ensure service need is still met • Complete 12month review of In-reach service, to measure any impact this has had on Parts 1a and 1b. Action Plan on outcome of this review to support service improvement for 1a and 1b • Ongoing CAPA job plan reviews and monitoring of six session model within PCAMHS

	• Service engagement in quarterly RSSG to understand local area need and service provision and how this may impact on Part 1a and 1b and develop any needed action plans, e.g. SBC pause referrals etc.
Quarter4:	
Milestones	• Maintain Compliance of Part 1 A and 1B RTT targets
Actions	• Weekly PCAMHS Performance meetings to monitor 1A and 1B demand, capacity and activity. To flex resource as needed • To monitor how WCCIS supports data for Part 1a and 1b • Efficient recruitment to vacancies to ensure workforce capacity to meet demand • Use of in-reach capacity in school holidays to support 1a and 1b as needed • Monitor use of rooms/accommodation to ensure that physical space is maximised for PCAMHS appointments • Monitor A/L. Consideration of capacity due to time of increased staff A/L end of financial year. Agree plan with staff to ensure service need is still met • Ongoing CAPA job plan reviews and monitoring of six session model within PCAMHS • Service engagement in quarterly RSSG to understand local area need and service provision and how this may impact on Part 1a and 1b and develop any needed action plans, e.g. SBC pause referrals etc.
Risks	• Unplanned staff absence vacancies • Limited accommodation to meet service need. • Increase in complexity in PCAMHS cases, which may increase number of sessions needed • Unexpected external events impacting workforce • Implications of partial implementation of WCCIS, subsequent backlogs and the inability to run performance reports to obtain RTT position, inability to validate and cleanse data, unable to provide accurate data to report RTT
Outcomes	• Assessments – 80% of patients to be assessed within 28 days from referral • Intervention – 80% of initial interventions to commence within 28 days of assessment
Alignment with workforce plans	PCAMHS have an established workforce profile - vacancies are reviewed against PCAMHS and the whole CAMHS Service demand, capacity and identified priorities.
Alignment with Financial plans	Since moving into CAMHS in February 21, PCAMHS (formally CYP PCMHSS) has received additional investment from the CAMHS financial envelope to sustain the workforce following a period of significant increase in demand. The PCAMHS budget will continue to be reviewed in alignment with the CAMHS and Family & Therapies IMTP Financial plan.

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITY

Implement regional diagnostic hubs, to reduce secondary care waiting times and meet waiting time ambition in spring 2024.

	Priority area(s)
Key focus should be on delivering	Maximum eight week waiting times from referral to report turnaround (requiring six-week maximum imaging time) and improved local access for radiology investigations, with key enabler being submission of business case for second MRI scanner in the Grange University Hospital (GUH) to facilitate establishment of a community diagnostic centre at Ysbyty Ystrad Fawr (YYF). This is proceeding as part of the regional diagnostic programme. There is a clinical consensus acros the region that any service development undertaken must meet the following key criteria: • Delivery is more accessible to residents living in areas of deprivation and able to deliver to more than one health board population in the region • Developments deliver an increase in capacity • Developments will be founded on seeking sustainable solutions to demand backlogs. The regional group has agreed a standard service specification for RDCs and common principles as per above. The delivery model for the RDCs will differ according to local infrastructure, workforce and capacity issues. For CTM, the Llantrisant Health Park development offers regional opportunities for a regional diagnostic hub and, through the SEW collaborative structures, planning is progressing for this to be one of the three planned RDCs. The opening of the Grange Hosptial created opportunities for diagnostics in the eLGHs. The priority for the health board in 2023/24 will be to progress plans for a local diagnostic centre consistent with the strategic vision, utilising an existing site and in-house delivery / provision. Any additional capacity will be made available to enable an optimal regional position in line with the agreed regional principles.
Baseline	As at May 2023, there are 1,500 patients awaiting MRI, 3,000 patients awaiting ultrasound and 1,300 patients awaiting CT scan. Sustained delivery of MRI service and improvements in year currently depend upon a single MRI scanner at GUH.

Quarter 1:	
Milestones	Production of business justification case for second MRI scanner in GUH
Actions	• Completion of all key sections of BJC • Confirmation / agreement of procurement process • Submit BJC to Welsh Government • Planning for liberated MRI capacity in line with RDC model
Quarter 2:	
Milestones	Approval of business justification case and enabling actions
Actions	• Establish project manager / implementation group for the establishment of a community diagnostic centre • Progress all recruitment / training requirements • Produce supporting revenue business cases for workforce / supporting services • Progress MRI / CT procurement / tendering process • Confirm and progress estates enabling actions at GUH
Quarter 3:	
Milestones	Completion of all enabling actions
Actions	• Completion of tendering process and order confirmation • Completion of all recruitment / training requirements • Completion of documentation / standard operational procedures for MRI / CT and diagnostic centre • Completion of estates enabling actions
Quarter4:	
Milestones	Delivery and commissioning of new community diagnostic centre
Actions	• Completion of all recruitment and training • Delivery and commissioning of new scanner • Reconfiguration of MRI / CT service at YYF to align with diagnostic centre requirements
Risks	1. **Capital funding –** delivering this priority on a cost-effective in-house basis requires capital funding availability in-year. 2. **Workforce –** effective operation of the scanner and community diagnostic centre will require additional staff to be recruited and retained. Successful recruitment to these posts is fundamental to reducing backlog and achieving targets. 3. **Interim service resilience –** The existing MRI scanner at GUH represents a single point of failure, and this has been highlighted as a key risk for the health board. Any significant failure of the existing scanner would have a detrimental impact on waiting times and the ability to achieve ambition levels at year end.
Outcomes	• Delivery of key regional planning priority • Improved local access to diagnostic services

	• Delivery of year-end diagnostic waiting time targets as set out in IMTP • Improved MRI service resilience at GUH and across health board
Alignment with workforce plans	Aligned with workforce plans
Alignment with Financial plans	Delivery of the second MRI scanner and new community diagnostic centre is dependent on securing capital funding through the BJC
OPTIONAL	
Digital / Technology Opportunities	

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES –

Implement pathway redesign – adopting 'straight to test model' and onward referral as necessary.

General Surgery Expansion of Lower Gastrointestinal Tract STT pathway **Gastroenterology and Endoscopy** Direct access scope pathway for diagnostic flexi-sigmoidoscopy and oesophagogastroduodenoscopy (OGD) in place. Implement pathway redesign through adopting calprotectin pathway for inflammatory bowel disease (IBD) patients	**Urology** Expansion of STT pathway for appropriate prostate-specific antigen (PSA) referrals to all bladder cancer patients. **Respiratory** Redesigned STT pathways for lung cancer, sleep, asthma and interstitial lung disease (ILD) implemented. **Cardiology** Long established STT pathway in place for echocardiogram or ambulatory monitoring. Implement pathway redesign through adopting STT model for direct to CT pathway.

Baseline	There are a number of Straight To test (STT) pathways in place within ABUHB as detailed below: **General Surgery** The urgent suspected cancer (USC) lower gastrointestinal tract (LGI) STT pathway is accessed by both General Surgery and Gastroenterology patients. Colorectal USC referrals are prioritised by consultants, with suitable patients streamed to STT to facilitate the correct diagnostic intervention; this accounts for around 45% of all referrals. ABUHB currently offers around 245 STT appointments per month to meet the annual demand of 2,977 referrals (Jan 22 – Jan 23); this ensures all demand is met within 3 to 5 days. Pre-pandemic the Health Board received around 400 colorectal USC referrals per month. This has steadily increased with current referrals averaging 650 per month. Cancer Services' forecasting indicates continuing increases with the expectation of 800 referrals per month by July 2023, requiring additional STT capacity of 115 appointments a month. In order to meet this additional demand and, and continue to meet the National Optimal Pathway targets for LGI, the Health Board

	requires an additional 1.5 WTE Band 7 clinical nurse specialist (CNS) support. **Urology** Urology implemented a STT pathway for appropriate PSA referrals in September 2022. The Lead Cancer Urologist produced the clinical criteria for patients suitable to participate in this initiative. Urology currently refers circa 80 PSA patients per month for an MRI, so it is forecast that an average of 5 to 6 patients per day will be identified and referred directly for an MRI. Consultant daily triage of all USC referrals is now in place and an electronic drop-down box allows the referral to be marked STT-PSA. The referral is then forwarded directly to Radiology who contact the patient and arrange an MRI. Once the MRI is undertaken and reported Urology will arrange a face-to-face Consultant led consultation. The revised process should take circa 15 days whereas previously patients waited in excess of 40 days to complete this stage of the USC pathway. The Urology Directorate would like to roll out the above approach for bladder cancers in the near future and has recently submitted a bid to the All-Wales Cancer Network for a STT Navigator (Admin & Clerical post) in order to ensure that robust co-ordination is in place for this cohort of patients and ensure timely consultant-led outpatient consultations once the MRI has been undertaken and reported.  STT Prostate Pathway DRAFT 202 **Respiratory** **Lung Cancer** ABUHB Lung cancer (LC) patients are prioritised by a consultant, and if they do not have a recent CT (referred due to abnormal chest x-ray), all are booked for an USC CT before an outpatient appointment. The LC team have designated 15 slots (due to increase to 20) per week. These are patients whose chest x-ray or GP referral have indicated they have a significant risk of lung cancer (approx. 37% conversation rate). Other patients under suspicion are referred for a CT first slot, in which they are booked by the radiology department within 5 working days, with a lower risk of lung cancer (approx. 10% conversation rate). Those patients whose CT has not identified a risk are discharged and not offered an OP appointment, and those with a CT result where an abnormality has been identified are booked an OP appointment. To meet the demand the LC team are seeking funding from MacMillan for a LC Navigator to micromanage LC patient tests and results. **Sleep**

	Respiratory physiology (sleep) patients are prioritised by consultants and forwarded straight to diagnostic test - pulse oximetry. Patients who have a positive test are either booked for Physiologist or Consultant OP appointment for set up on Continuous Positive Airways Pressure (CPAP). Patients who have a negative test are referred to Sleep Medicine, for further tests and consultant review. **Asthma / ILD patients** Currently patients prioritised by an asthma or ILD consultant are forwarded straight for lung function tests (approximately 40% asthma & ILD referrals) before a consultant OP appointment resulting in the patient having their diagnostic results to be able to adequately diagnose their condition, or requests made to the GP to alter medication until a secondary care appointment is arranged. Processes are currently being reviewed to ensure all Respiratory consultants follow a similar pathway when prioritising patients. We are working towards all patients undertaking continuous lung function tests, until a diagnosis is confirmed, however we need to increase our lung function staffing by 22.5 hours per week. **Gastroenterology and Endoscopy** ABUHB's calprotectin pathway is accessed by Gastroenterology patients that have been triaged to receive an IBD new outpatient appointment. Clinical validation of the new IBD waiting list has been undertaken to highlight patients that are suitable to follow the calprotectin pathway. The attached document outlines the followed algorithm; however, it is worth noting that ABUHB's threshold stands at 80 rather than 100.  York pathway (003).pdf Consultants forward suitable referrals through to CNS so they can assess each patient according to the pathway. **Cardiology** **'Diagnostic Only'** ABUHB's Cardiology STT pathway; 'Diagnostic Only', is a longstanding pathway, it was implemented for patients sent straight to echocardiogram or ambulatory monitoring. Cardiology referrals are prioritised by consultants; with suitable patients streamed to a 'Diagnostic only' pathway to facilitate the correct diagnostic intervention and avoid unnecessary outpatient appointments.

	When patients have had their diagnostic procedure performed, they are either sent for further investigation, followed up in clinic, or discharged, dependant on investigation results. **'Straight to CT'** To further develop the Cardiology services' STT pathways, new additional referral vetting sessions with our GP with a Special Interest (GPwSI) team has identified the need for a potential 'Straight to CT' pathway. Currently patient referrals are vetted, patients are seen in clinic and then referred for CT. The aim of this pathway is to remove the unnecessary step of being seen in an outpatient appointment beforehand. This in turn will then reduce the overall wait and diagnosis time for our patients. We hope to see an improvement in patient outcomes, RTT waiting times and overall clinic capacity for patients who actually need to be seen in an outpatient setting. The pathway design and planning is currently in its infancy and further meetings are to be arranged in the coming months.
Quarter 1:	
Milestones	**General Surgery** agreed funding for additional 1WTE STT CNS and supporting administrative and booking support **Respiratory** Funding to be secured either from MacMillan or development of business case for pre-investment panel to support delivery of sustainable service. **Urology** Funding to be secured either from All Wales Cancer Network or development of business case for pre-investment panel to support delivery of sustainable service.
Actions	**General Surgery** colorectal business case completed and approved by Execs **Respiratory** advertise for MacMillan LC navigator (pending funding) **Urology** advertises for bladder cancer navigator (pending funding)
Quarter 2:	
Milestones	
Actions	**General Surgery** advertise for 1.5 WTE CNS and administrative support roles. Recruit and appoint additional STT staff **Respiratory** appoint and train MacMillan LC navigator (pending funding) **Urology** appoint and train bladder cancer navigator (pending funding)

Quarter 3:	
Milestones	**General Surgery** new staff induction and training, delivery of additional capacity **Respiratory** delivery of additional capacity **Urology** implementation of bladder cancer STT service
Actions	
Quarter4:	
Milestones	
Actions	
Risks	• Funding, Macmillan funding, cancer network funding and local agreement of GS business case • Recruitment • Demand
Outcomes	**General Surgery & Respiratory** STT continues to meet demand within NoP recommended timeframes **Urology** Expansion of STT capacity to all bladder cancer patients
Alignment with workforce plans	
Alignment with Financial plans	

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES Ministerial priorities:

52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by 30 June 2023 and maintained throughout 2023/24 moving to 36 weeks RTT standards by March 2024.

	Priority area(s)
Key focus should be on delivering	**Referral To treatment (RTT) 36 Week Outpatients** **Referral To treatment (RTT) 52 Week Outpatients** **Referral To treatment (RTT) 104 Week Outpatients** **Referral To treatment (RTT) 104 Week Treatments** **Referral To treatment (RTT) 156 Week Treatments**
Baseline (as of April 2023)	Positive progress has been made addressing the longest waiting patients demonstrated by a 55% reduction in two year waits over the past fiscal year. To mitigate the impact of halting weekend WLI the UHB will continue to work on Outpatient Transformation and has recently commenced a Theatre Maximisation Programme. Additionally recent increased focus on treat in turn will be leveraged to ensure capacity is dedicated to the longest waiters once urgent and cancer patients are accommodated.

Stage 1 - 36 Weeks

Specialty	Jun-23	Sep-23	Dec-23	Mar-24
ENT	6,040	6,955	7,749	8,371
General Surgery	463	525	766	796
Gynaecology	988	759	541	753
Maxillo-Facial	1,068	1,298	1,415	1,574
Ophthalmology	6,839	6,725	6,469	5,949
Orthopaedics	1,961	1,052	312	87
Urology	1,779	1,926	1,976	1,933
Total	**19,138**	**19,240**	**19,228**	**19,463**

Modelling for 36 and 52 Week Stage 1 demonstrates an improved position in some areas whilst others continue to deteriorate. Focused work is ongoing in ENT which remains the greatest challenge to recovery and progress has been made on the Ophthalmology plan which is forecasted to improve other ministerial targets.

Continued progress is expected in Orthopaedics however the current forecast is limited to the specialty level and is potentially obscuring the spinal position which is unlikely to reduce to meet current projections. Work is ongoing to subspecialise forecasts as inevitably some services are more challenging to recover then others and as backlogs reduce these difficult areas will affect the UHB's ability to forecast.

	Priority area(s)
	The Orthopaedic spinal plan developed in conjunction with Getting It Right First Time (GIRFT) is underway and commencement dates are agreed for two specialty level doctors. On appointment these roles will be targeted at the longest waiting routine patients initially and are expected to make a significant contribution to backlog reduction and crucially long term service sustainability.

Stage 1 - 52 Weeks

Specialty	Jun-23	Sep-23	Dec-23	Mar-24
ENT	3,722	4,076	4,253	4,417
General Surgery	0	0	0	0
Gynaecology	0	0	0	0
Maxillo-Facial	168	209	145	0
Ophthalmology	4,492	4,655	4,392	4,006
Orthopaedics	1,409	894	312	87
Urology	938	1,145	1,209	1,292
Total	**10,729**	**10,979**	**10,311**	**9,802**

The UHB remains determined to continue progress made on two year waits at both Stage 1 & 4 and aims to clear both backlogs in year. Timelines will vary across the stages and there will undoubtably be challenges considering the ENT and Spinal positions particularly, but robust plans have been developed to continue improvement in utilisation, efficiency and treat in turn.

Stage 1 - 104 Weeks

Specialty	Jun-23	Sep-23	Dec-23	Mar-24
ENT	405	284	127	0
General Surgery	0	0	0	0
Gynaecology	0	0	0	0
Maxillo-Facial	0	0	0	0
Ophthalmology	165	0	0	0
Orthopaedics	55	0	0	0
Urology	0	0	0	0
Total	**625**	**284**	**127**	**0**

Balancing treatment breachers whilst efforts are focused on eliminating long waiting outpatients will be a continuing challenge for services over the coming year. There are bulges on the waiting list from successive lockdowns that will be exasperated by the additions from clearing outpatient patient backlogs. These challenges will be compounded by higher acuity and more complex patients which has led to procedure times increasing across the board.

	Priority area(s)

Stage 4 - 104 Weeks

Specialty	Jun-23	Sep-23	Dec-23	Mar-24
ENT	215	126	61	0
General Surgery	0	0	0	0
Gynaecology	0	0	0	0
Maxillo-Facial	0	0	0	0
Ophthalmology	0	0	0	0
Orthopaedics	1,045	777	367	0
Urology	0	0	0	0
Total	**1,260**	**903**	**428**	**0**

The 156 Week Stage 1 backlog was cleared last year and efforts continue to clear the remaining three year waits at Stage 4. Whilst these extensive waits are limited to several specialties only two will have breachers going into Quarter 2 and all will be cleared by the end of the fiscal year. This remains a key priority for the UHB and consequently strict performance management will be maintained to ensure this milestone is delivered.

Stage 4 - 156 Weeks

Specialty	Jun-23	Sep-23	Dec-23	Mar-24
ENT	71	46	0	0
General Surgery	0	0	0	0
Gynaecology	0	0	0	0
Maxillo-Facial	0	0	0	0
Ophthalmology	0	0	0	0
Orthopaedics	235	67	0	0
Urology	0	0	0	0
Total	**306**	**113**	**0**	**0**

Quarter 1:	
Milestones	**Quarterly forecast**
Actions	The following actions will be completed in Q1 to improve the position and maintain:

All specialties

- Continuation of validation
- Targeted scheduling support to increase activity
- Enhanced performance management framework to provide greater challenge and support
- RTT will be monitored over the Q1 with a view to reviewing the forecasted position.

	Priority area(s)
	• Planned Care Academy Launch - As part of the Planned Care Academy scope training requirements for administrative staff involved in outpatient waiting list management.
	Ophthalmology • Utilisation of Vanguard for Cataract Patients • Extension and appointment of locum consultants to support backlog recovery • Targeting list scheduling to improve activity levels by 20%
	ENT • Continuation of focused ENT recovery project • Review long waiting ENT patients with potential for other services to support; Audiology and Dermatology • TeleENT virtual reviews to be piloted
	Orthopaedics • Ongoing GIRFT and National Clinical Strategy for Orthopaedic Surgery (NCSOS) action plans • Two spinal specialty doctors appointed expected start dates in Q1 • Advertise for three specialist doctor roles to support sustainable capacity and recovery • Advertise for additional spinal Extended Scope Physiotherapists (ESPs) (pending funding) • Short stay hip pilot to commence at Orthopaedic Surgical Unit • Advertise for hand therapists to support WG Carpel Tunnel pathway and increase capacity (pending funding)
	General Surgery • Additional Specialist Registrar (SpR) follow up outpatient capacity for 50% of consultant clinics (UGI) allowing for an additional 8 follow up outpatient appointment (FOA) slots per clinic • Work continues to improve SoS and PiFU pathways to free up FOA, but is limited within general surgery due to standard practice of operate and discharge as default
	Oral Surgery • TeleMax virtual reviews to commence • Junior job plan expected to yield additional clinic per week
	Urology • Additional cystoscopy capacity commencing to support backlog recovery • Targeting Did Not Attend (DNA) rate and list utilisation and scheduling changes • Focus work through patient reminder service

<table>
<tr><td></td><td colspan="2">Priority area(s)</td></tr>
<tr><td>Quarter 2:</td><td colspan="2"></td></tr>
<tr><td>Milestones</td><td colspan="2">Address Capacity gaps</td></tr>
<tr><td>Actions</td><td colspan="2"><table>
<tr><td>All specialties
Review targeted scheduling changes
Phase 2 subspecialty improvement opportunities and planning for specific areas of improvement</td><td>General Surgery
Appointment and onboarding of trainee pelvic floor specialist practitioner to provide additional capacity
Recruitment of 2 Colorectal Physician Associates (Pas) to provide additional FOA capacity</td></tr>
<tr><td>Urology
New substantive consultant planned start</td><td>Orthopaedics
Advertise for additional substantive shoulder consultant
Commencement of additional spinal Erector Spinae Plane Block (pending funding)</td></tr>
</table></td></tr>
<tr><td>Quarter 3:</td><td colspan="2"></td></tr>
<tr><td>Milestones</td><td colspan="2">Reduce follow up waiting list</td></tr>
<tr><td>Actions</td><td colspan="2"><table>
<tr><td colspan="2">All specialties
Monitoring of RTT to work towards 36 week waits and maintaining forecasted position
Continue to assess sub specialities
Continue with virtual work
Health Pathway review for key pathways and reduction of referrals</td></tr>
<tr><td>Orthopaedics
Potential commencement of hand therapy posts (pending funding</td><td>ENT
Locum consultant appointment</td></tr>
<tr><td>Oral Surgery
Re-job planning of juniors with potential for additional capacity</td><td>General Surgery
Appointment, onboarding and training of 2 Colorectal PAs to undertake first OPA</td></tr>
</table></td></tr>
<tr><td>Quarter4:</td><td colspan="2"></td></tr>
<tr><td>Milestones</td><td colspan="2">No patients waiting over 36 weeks</td></tr>
<tr><td>Actions</td><td colspan="2"><table>
<tr><td colspan="2">All specialties
Monitoring of RTT to work towards 36 week waits and maintaining forecasted position</td></tr>
<tr><td>Orthopaedics</td><td>General Surgery</td></tr>
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	Priority area(s)	
	Commencement of additional substantive shoulder consultant	All additional capacity sustainably established ensuring no patients wait longer than 36 weeks for FOA
Risks	• Funding, clarity to support demand and capacity planning • Recruitment, where funding is secured • Capacity to meet urgent and cancer demand whilst addressing backlogs • Workforce, including ongoing and potential expansion of strike action • Physical clinical capacity; infrastructure including outpatient consultation rooms, theatres, beds etc • Skill mix including subspecialty concerns	
Outcomes	• Maintaining sufficient capacity to treat the current urgency profile • Maintained focus and balance of capacity to treat the longest waiting patients • Continued progression towards giving patients more control and understanding about how and when they access care • Reduction in DNA's • Improved utilisation • Improved communication and understanding about the appropriate referral and treatment pathways	
Alignment with workforce plans	Aligned with current capacity gaps and workforce profile	
Alignment with Financial plans	In line with financial and savings plans and the current financial context for the Health Board	

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES

Address the capacity gaps within specific specialities to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025. (This must include transforming outpatients follow up care, reducing follow up by 25% against 2019/20 levels by October 2023 and repurposing that capacity)

	Priority area(s)
Key focus should be on delivering	*Replicate each specific priority area featured above.* **Referral To Treatment (RTT) 104 weeks OP** **Referral To Treatment (RTT) 52 weeks OP** **Referral To Treatment (RTT) 36 weeks OP**
Baseline	Positive progress has been made addressing the longest waiting patients demonstrated by a 55% reduction in two year waits over the past fiscal year. However due to financial pressures a difficult decision has been taken to halt weekend WLI which will inevitably affect progress and impact more severely in some specialties. To mitigate the impact of halting weekend WLI the UHB will continue to work on Outpatient Transformation which has already made significant progress in a variety of areas over the past year.

Stage 1 - 36 Weeks

Specialty	Jun-23	Sep-23	Dec-23	Mar-24
ENT	6,040	6,955	7,749	8,371
General Surgery	463	525	766	796
Gynaecology	988	759	541	753
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Continued progress is expected in Orthopaedics however the current forecast is limited to the specialty level and is potentially obscuring the spinal position which is unlikely to reduce to meet current projections. Work is ongoing to subspecialise forecasts as inevitably some services

	Priority area(s)
	are more challenging to recover then others and as backlogs reduce these difficult areas will affect the UHB's ability to forecast. The Orthopaedic spinal plan developed in conjunction with Getting It Right First Time (GIRFT) is underway and commencement dates are agreed for two specialty level doctors. On appointment these roles will be targeted at the longest waiting routine patients initially and are expected to make a significant contribution to backlog reduction and crucially long term service sustainability.

Stage 1 - 52 Weeks

Specialty	Jun-23	Sep-23	Dec-23	Mar-24
ENT	3,722	4,076	4,253	4,417
General Surgery	0	0	0	0
Gynaecology	0	0	0	0
Maxillo-Facial	168	209	145	0
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Urology	938	1,145	1,209	1,292
Total	**10,729**	**10,979**	**10,311**	**9,802**

The UHB remains determined to continue progress made on two year waits at both Stage 1 & 4 and aims to clear both backlogs in year. Timelines will vary across the stages and there will undoubtably be challenges considering the ENT and Spinal positions particularly, but robust plans have been developed to continue improvement in utilisation, efficiency and treat in turn.

Stage 1 - 104 Weeks

Specialty	Jun-23	Sep-23	Dec-23	Mar-24
ENT	405	284	127	0
General Surgery	0	0	0	0
Gynaecology	0	0	0	0
Maxillo-Facial	0	0	0	0
Ophthalmology	165	0	0	0
Orthopaedics	55	0	0	0
Urology	0	0	0	0
Total	**625**	**284**	**127**	**0**

Balancing treatment breachers whilst efforts are focused on eliminating long waiting outpatients will be a continuing challenge for services over the coming year. There are bulges on the waiting list from successive lockdowns that will be exasperated by the additions from clearing

	Priority area(s)
	outpatient patient backlogs. These challenges will be compounded by higher acuity and more complex patients which has led to procedure times increasing across the board. The 156 Week Stage 1 backlog was cleared last year and the UHB is continuing this progress by clearing two waits in year along with one year waits in most specialties.
Quarter 1:	

Milestones	• Maintain 52 and 104 week positions
	• Compliance audits completed for
	  ○ Interventions Not Normally Undertaken (INNU) Policy previously re-issued to clinicians/directorates, along with activity information.
	  ○ Following the review of Hospital Cancellations, complete compliance review against the approval of annual leave and study leave under six weeks.
	• Complete business case for Outpatient Booking System. Business case to include ability to capture start and finish times within clinics. Aim to increase use of capacity and assist with reducing waiting times and waiting list numbers
	• Planned Care Academy Launch as part of the Planned Care Academy scope training requirements for administrative staff involved in outpatient waiting list management.
	• Recruitment Plan by Specialty

Actions	• Deliver recommendations for hospital cancellations following review completion • Weekly clinic utilisation meetings held with Outpatient Department (OPD) Sisters and OPD Team, to decrease vacant sessions by a further 10%. • Increase non-face-to-face follow-up outpatient and new outpatients. Target 50% for follow-up (FU) and 35% for new. Continue use of Attend Anywhere and review use of non-face to face consultations within other HBs to identify further opportunities. • Complete Value Base review of the one stop Outpatient Treatment Unit at RGH. Outcome to assist with development of a business case for recurring funding (WG part funding of Unit for two -year period only) • Increase use of See on System (SoS) and Patient Initiated Follow-up (PiFU) (Target 20%). 15 new pathways identified in quarter 2/ 3 - 22/23; further pathways to be identified, along with establishing impact on waiting lists. Review All Wales Website to identify further opportunities. Work with clinical leads

	Priority area(s)
	to identify further opportunities. Share Welsh Government (WG) information in terms of compliance/pathways from other HBs. • Increase use of advice only. Current hybrid system delivering 5%. Electronic advice to be implemented in quarter 4 22/23. Aim to increase overall to percentage to 15% by end of 23/24. Develop communication strategy for General Practitioners (GPs) and secondary care clinicians. • Continue patient contact and validation monthly programme to determine if patients still require their outpatient appointments. • Complete financial analysis of Speciality Outpatient Plans to determine both activity impact and financial output. • Continued review progress of plans to reduce the follow-up outpatients against 2019/20 levels by 25% by October 2023 • Continue Implementation of Did not attend (DNA) action Plan. 5% target. Plan also linked in with Cancer Services DNA improvement plans.

Specialty	DNA Rate
Gynaecology	7.77%
Ear Nose & Throat	6.57%
Maxillo-Facial	4.65%
Ophthalmology	5.66%
Trauma & Orthopaedic	6.13%
Urology	3.44%
General Surgery	5.83%
UHB Total	6.99%

- Update Speciality Specific Outpatient Transformation Plans and identify further opportunities to improve waiting list positions. Plans to be linked to any further opportunities arising from the Clinically Led OPD guidance – GIRFT report.

Specialty Actions

Ophthalmology	• Recruitment for principal Optometrist • Recruitment of a further Glaucoma Consultant
General Surgery	• Recruitment of a further band 7 trainee specialist pelvic floor practitioner to deliver additional

	Priority area(s)	
		Follow-up outpatient activity (FOA) for clinic capacity (7 patients currently breaching due to shortage of capacity in this service) • Recruitment of a further 2 Straight to Test Colorectal Nurses to undertake FOAs • Recruitment of 2 Physicians Associates to undertake Colorectal FOAs • Additional Specialist Registrat (SpR) FOP capacity for 50% of consultant clinics (UGI) allowing for an additional 8 FOA slots per clinic • Work continues to improve SoS and PifU pathways to free up FOA, but is limited within General Surgery due to standard practice of operate and discharge as default
Quarter 2:		
Milestones	• Reduction of cancelations • Reduction of vacant space by 10% • Increase advice only to 9%.	
Actions	• Continue to Implement DNA action Plan - 5%. Q1 and 2 focus and support for Urology • Monitor actions by divisions to reduce under 6 -week Hospital cancellations (7.5% of attendances) • Weekly clinic utilisation meetings to decrease vacant clinic space. Further reduction by 10%. • Increase advice only to 9%. Review processes with Divisions/Directorates. Work with clinical leads to identify further opportunities. • Reduction of Total Follow-up waiting list linked to speciality outpatient plans, based on baseline without backlog • Reduce 100% past target follow-up patients linked to speciality outpatient plans. • Report outcome of financial analysis of OPD Plans to Outpatient Steering Group and agree next steps. • Agree next steps re Training Gap Analysis • Increase use of SoS and PiFU (Target 20%). Monitor outcomes of new pathways. Plus, review discharge rates alongside SoS/PiFU target. • Phase 2 of Communication Plan, promotion of SoS/PiFU for patients and also within GP practices in Q2/3.	

	Priority area(s)
	Ongoing actions • Continue monitoring of outpatient targets through shared dashboard and monthly directorate managers/outpatient transformation managers meetings. • Continue patient contact and validation programme. • Complete business case for Outpatient Treatment Unit continued funding (WG part funding for two years only) • Agree and monitor outcomes of updated Speciality Action plans and Clinically Led OPD guidance - GIRFT
Quarter 3:	
Milestones	• Increase advice only by 12% from baseline • Business Case presentation Outpatient Treatment Unit and Booking System
Actions	• Deliver Follow Up reduction by 25% against 2019/20 levels by October 23 • Continue to Implement DNA action Plan – 5% • Hospital Cancellations, target to have been met, review gaps and agree action on any continued areas of concern with the Division/Speciality. • Weekly clinic utilisation meetings and reduce by a further 10% from Q2 • Increase advice only to 12%. Work with clinical leads and Primary care. • Present business case for Outpatient Treatment Unit and identify potential funding stream. • Present business case for Booking System and identify potential funding stream. **Ongoing actions** • SoS and PiFU (Target 20%). Monitor target compliance and agree any necessary actions. • Continue monitoring of outpatient targets. • Continue patient contact and validation programme.
Quarter4:	
Milestones	
Actions	• Continue to Implement DNA action Plan – 5% • Hospital Cancellations – 6% reduction. • Meet target of 20% SoS/Pifu. Ensure all new pathways loaded onto Website. • Increase advice only to 15% • Continue monitoring of outpatient targets. • Continue patient contact and validation programme.
Risks	• Not able to meet WG targets • Some targets need further clarification from WG in terms of baseline and dates of delivery

	Priority area(s)
	• Divisions unable to deliver agreed Outpatient Transformation Plans • Impact of emergency pressures on delivery of targets/schemes • Outpatient Transformation needs to continue as a high priority in terms of delivery • Financial support for business cases • IT/Informatics ability to support schemes • Delivery of PSA Patient Platform affecting follow up demand • Demands on divisional/directorate time
Outcomes	• Reducing anxiety, stress and potential harm to patients • Reduction in overall waiting times • Reduction in overall waiting list numbers • Increased activity and capacity • Maximising use of resources • Decreasing un-necessary waste
Alignment with workforce plans	The Outpatient Transformation Programme via the Outpatient Steering Group aligns to the workforce plans both in terms of its own plans and the IMTP/demand and capacity plans
Alignment with Financial plans	The Outpatient Transformation Programme via the Outpatient Steering Group aligns to the financials plans both in terms of its own plans and the IMTP/demand and capacity plans.
Digital / Technology Opportunities	

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITY

Improved use of community pharmacy

Baseline

The Health Board has 131 community pharmacies within its area and commissions a range of national and local additional clinical services. **Table 1** highlights the number of pharmacies commissioned to provide these services:

Table 1 - Additional Services	No pharmacies commissioned to provide service @ Jan 2023
Clinical Community Pharmacy Services (CCPS)	131
Smoking Cessation Level 2	129
Waste Reduction	121
Supervised Admin	113
Medication Administration Scheme (MAR Charts)	110
Smoking Cessation Level 3	95
Out of Hours Rota	49
CCPS-Sore Throat Test and Treat	48
Independent Prescribing	21
Needle Exchange	19
Access to Pall Care Drugs	16
Pall Care Out of Hours Rota	10
Access to Fragmin	7
Access to Tamiflu	4
Care Home	1

This year the Health Board has seen a significant increase in the number of suspensions of pharmaceutical service which includes full day and partial closures. These closures are due to lack of locums, fewer pharmacists working in pharmacies and staff sickness due to COVID. Since April 2022 to Jan 23, the Health Board has received 267 suspension of pharmaceutical service closures which has resulted in 76 breach notices being issued to community pharmacies. The lack of pharmacists and locums, high sickness levels, COVID, increased number of closures and increases in prescription items has had an impact on the delivery of some of the clinical and additional services.

Table 2 shows the consultation activity from April to December 2022 compared the same period in the financial year 2021/22 for some of the services:

Table 2 Comparison of activity 2021/2 to 2022/3

Service	Activity in 2021/22	Activity in 2022/23	Difference
CAS	13,883	25,716	↑ 85.23%
EC	3,311	2,694	↓ 18.63%
Smoking Cess Level 2	2,574	2,090	↓ 18.80%
Smoking Cess Level 3	2,745	2,261	↓ 17.63%
Flu Vaccination	28,834	24,163	↓ 16.18%
Emergency Supply	13,374	20,051	↑ 49.93%
Discharge Meds Review	1,718	1,418	↓ 17.46%

The Health Board currently has 21 community pharmacies who have an independent prescribing pharmacist. Since April to December 2022, 3213 consultations have been conducted.

In November 2022, the Health Board commissioned the Sore Throat Test and Treat (STTT) service as part of the Common Ailment service.
In Jan 2023, the Health Board currently has 48 community pharmacies that will be delivering STTT service.

The Health Board intends to commission the Bridging Contraception service which is part of the Emergency Contraception service and the national Inhaler Review service from the 1st April 2023.

The Discharge Medicine Review service (DMRs) shows a decrease of 17.5% compared to same period in the last budget year. ABUHB does not use Medicines Transcribing and E-discharge (MTeD). Currently there is no ability to send electronic discharge summaries to community pharmacies. A local solution is to use Clinical Workstation (CWS), but issues with the firewall prevent this from happening. To enable this to happen, Digital Health and Care Wales (DHCW) needs to give permission to each pharmacy to access Clinical Work Space (CWS) via the internet. Currently this is not a priority for DHCW.

There is still a high dispensing capacity and the move to extended prescription intervals identified in Welsh Health Circular 2022/2025 requires implementation. In addition, the current sustainability issues have resulted in some contractors seeing increases of up to 50% in prescription workload due to breaches in service by other contractors. Both issues impact on the ability to deliver the clinical and additional services.

Quarter 1:	
Milestones	1. Implement the Bridging Contraception Service (change) 2. Implement the Inhaler Review service (change and improvement) 3. Increase uptake of the Smoking Cessation service (improvement) 4. Implement the All-Wales Guidance for Prescribing Intervals (change) 5. To scope access for community pharmacies to receive electronic discharge information to complete DMRs (improvement) 6. Work with contractors who have sustainability issues to reduce the number of temporary closures (improvement)

	7. Implement Pharmacy Professional Collaboratives across all 11 Neighbourhood Care Networks (NCNs)
Actions	1. Issue the Bridging Contraception PGD from the 1st April 2023. Bridging contraception is a new service and a mandatory component of the National Clinical Community Pharmacy Service. It intends to improve patient access to NHS funded contraception by enabling pharmacies to provide an initial three-month supply of oral contraception. To measure uptake by patients, service activity (supplies made) will be monitored monthly on an ongoing basis pending availability of data from DHCW/NWSSP. Pharmacy uptake will be measured from data obtained from the All-Wales Pharmacy Database and NWSSP. 2. Commission the Inhaler Review service from the 1st April 2023. This is a reintroduction of a service suspended during covid. The national service specification has been redeveloped to take account of new All Wales guidance and recommendations for lowering the carbon footprint of inhaled therapies. Pharmacy uptake will be measured by commissioning levels. Patient uptake will be measured monthly on an ongoing basis pending availability of data from NWSSP. 3. Promote community pharmacies that are providing the smoking cessation services and increase availability of the "level 3" service to improve the use and availability of the services. Work with the public health team on signposting patients to the pharmacy services via Help Me Quit campaign. Engage with pharmacy contractors to increase numbers of pharmacy technicians and non-registered staff accredited to deliver the service so as to increase service capacity. Improvement in patient access will be measured quarterly using activity data of treated smokers from NWSSP. Service availability will be measured by monitoring the number of pharmacies commissioned providing the service. 4. Develop an engagement plan to implement the guidance and improve the number of prescriptions issued for treatment periods greater than 28 days which will include the following: ➢ Community Pharmacy cluster leads to engage with GP practices and community pharmacies ➢ Support community pharmacies and GP practice via the medicines management team-supporting local processes ➢ Community pharmacies to identify suitable patients and collaborate with local GP practices ➢ Engage with LMC ➢ Develop patient message 5. Liaise with Digital Health and Care Wales and the Health Board IT department to find a solution in providing community pharmacies access to electronic discharge summaries via the Clinical Workstation. The clinical hospital system within ABUHB does not support communication with the DHCW "choose pharmacy" application. DMRs are currently supported by a paper referral letter system. An option to allow Community Pharmacy access to the ABUHB clinical system has been scoped, but faces technical and resource challenges. Work will continue to facilitate access. Improvement will be measured by successful access to the system by one community pharmacy contractor.

	6. Support contractors who are having sustainability issues by working with them to change opening hours or reduce hours for an agreed period to provide a more reliable service. Provision for change will be made using the existing NHS pharmaceutical services regulations. Activity will be measured on an ongoing basis by recording the number of "HN1" forms submitted or temporary opening hour applications received and granted. 7. Finalise appointment to all Pharmacy Professional Collaborative Leads (x11) and implement local collaborative processes aligned to NCN Planning / Accelerated Cluster Development Programme
Quarter 2:	
Milestones	1. Expand the IP service and improve uptake (Improvement) 2. Review and Expand the STTT service (Improvement)
Actions	1. <u>Expand the IP service and improve uptake:</u> • Ensure that the Health Board funding allocation for pharmacists is utilised. • Provide funding to pay DSPs to mentor the pharmacists undertaking the training. • Promote the pharmacies that are commissioned to provide the IP service to improve the use of the service. The pipeline of new pharmacist IPs is affected by factors outside of the control of the Health Board. Availability of the service will be expanded as new IPs qualify to improve access. Availability will be measured using commissioning data from AWPD and NWSSP. Patient activity will be measured using consultation data provided by DHCW and NWSSP. 2. <u>Review and Expand the STTT Service:</u> • Monitor activity and the number of community pharmacies providing the STTT service • Monitor uptake of the pharmacies providing STTT service • Engage with contractors that are not providing the STTT to encourage pharmacist accreditation and commissioning • Promote pharmacies that are providing the service to improve the use of the service. • Improved access and availability will be measured by ongoing monitoring for increased commissioning levels utilising data from AWPD. • Improved patient take up will be monitored monthly on an ongoing basis using information provided by DHCW and NWSSP
Quarter 3:	
Milestones	1. Review the uptake of the NHS Flu Vaccination Service 2. Pharmacy Professional Collaboratives respond to Population Needs Analysis
Actions	**1. <u>Review the uptake of the NHS Flu Vaccination Service</u>** • Ensure plans for the Winter respiratory vaccination programme has input from Primary Care Cluster Community Pharmacy Leads. • Issue the Flu PGD for the 1st September 2023 • Monitor activity and promote the service to improve the use of the service

	• Activity will be measured by recording the number of vaccines provided at each pharmacy using data from DHCW and NWSSP • Review commissioning for offsite vaccination of Care Home Staff and third sector carers. **2. <u>Pharmacy Professional Collaboratives respond to Population Needs Analysis</u>** • NCN Pharmacy Professional Collaboratives collectively review and respond to Population Needs Analysis to inform development of NCN, ISPB and RPB plans / priorities for 2024/25
Quarter4:	
Milestones	1. Ongoing Monitoring and Promotion of Services
Actions	➢ Review uptake of service ➢ Review promotion material ➢ Measures as above.
Risks	Implementation and promotion of new services could lead to further pressures on community pharmacy staff if current prescription volume does not decrease as a result of not implementing extended prescription intervals. Current workforce shortages.
Outcomes	Increase use of services will improve patient health outcomes, allow more appropriate access and reduce pressure on other areas of unscheduled care.
Alignment with workforce plans	HEIW due to consult on Pharmacy Workforce Plan by March 2023.
Alignment with Financial plans	Within community pharmacy contract allocation.

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES

Increase access to dental services.

<table>
<tr><td>Baseline</td><td>Health Board are working to support and maintain access to Dental Services whilst also reducing the treatments backlog.

<table>
<tr><th>2021/22</th><th>2022/23 Forecast</th></tr>
<tr><td>154,807 patients seen in General Dentistry Services (GDS)
410,048 Units of Dental Activity delivered
77,066 new patients accessing NHS Dental Care
17,112 new Community Dental Services (CDS) patients / first appointments (needs validating)
36,835 patients attended CDS clinic</td><td>226,538 patients seen in GDS
371,108 Units of Dental Activity delivered
36,487 new patients accessing NHS Dental Care
17,308 new CDS patients / first appointments (needs validating)
34,717 patients attended CDS clinic</td></tr>
</table>

• 5,500 patients awaiting orthodontic treatment
• 384 patients awaiting oral surgery
• 60 annual appointment capacity for refugees
• 15,000 urgent dental care appointments

CDS developments that have been established include:
• Bariatric Dental Care pathway in place to enable access to safe dental care.
• Asylum Seekers support for access in place to provide information of oral health care provision.
• CDS provision of sedation for children using specialists, Community Dentists and Dental Therapists, alongside enhanced sedation techniques for more complex patients.
• Appointment of Dental Nurse to provide virtual consultations on oral health care and healthy diet with parents of children referred to Dental Therapist.
• Renewal of GDS dental domiciliary care contract, to triage referrals centrally and send to either CDS or GDS.
• Ongoing work by the SE Wales Managed Clinical Network for Special Care Dentistry into oral health care pathways for vulnerable adults.
• Utilising a clinical skill mix of 1/3 Dental Therapists to maintain access to specialist Special Care Dentistry and Paediatric Dentistry Services.</td></tr>
</table>

	
Quarter 1:	
Milestones	• 9,122 new patients accessed NHS Dental Care (25% of FY forecast) • 92,777 Units of Dental Activity (UDAs) delivered 25% of FY forecast) • 4,327 new patients accessing Community Dental Services (25% of FY forecast) • 8,679 patients attending CDS (25% of FY forecast) • Continue to monitor and manage contract delivery, including orthodontic delivery, oral surgery (OS) (sedation), sedation, Domiciliary (DOMs), asylum seekers • Continue to monitor, manage and maintain urgent access • Review and monitor delivery against CR metrics and Units of dental activity (UDA)
Actions	• Appoint Dental Director to provide clinical leadership for dental developments across Gwent • Re-establish Integrated Oral Health Group and develop integrated plan and priorities for next 3 years • Implement 23/24 contract changes • Re-commission OS (sedation), DOMs dental services following a robust procurement exercise • Where necessary, recommission dental services as a result of contract variations and/or resignations
Quarter 2:	
Milestones	• 18,244 new patients accessed NHS Dental Care (50% of FY forecast) • 185,554 UDAs delivered (50% of FY forecast) • 8,679 new patients accessing Community Dental Services (50% of FY forecast) • 17,358 patients attending CDS (50% of FY forecast) • Continue to monitor and manage contract delivery, including orthodontic delivery, oral surgery (sedation), sedation, DOMs, asylum seekers • Continue to monitor, manage and maintain urgent access • Review and monitor delivery against CR metrics and UDA
Actions	• Re-commission Prison dental services following a robust procurement exercise • Where necessary, recommission dental services as a result of contract variations and/or resignations

	• Recruitment to Dental Therapist post to provide access to vulnerable children in the north of ABUHB.
Quarter 3:	
Milestones	• 27,365 new patients accessed NHS Dental Care (75% of FY forecast) • 278,331 UDAs delivered (75% of FY forecast) • 12,981 new patients accessing Community Dental Services (75% of FY forecast) • 26,037 patients attending CDS (75% of FY forecast) • Continue to monitor and manage contract delivery, including orthodontic delivery • Continue to monitor, manage and maintain urgent access • Review and monitor delivery against CR metrics and UDA
Actions	• Implement new dental contract as part of Tredegar Development • Where necessary, recommission dental services as a result of contract variations and/or resignations
Quarter4:	
Milestones	• 36,487 new patients accessed NHS Dental Care (100% of FY forecast) • 371,108 UDAs delivered (100% of FY forecast) • 17,308 new patients accessing Community Dental Services (100% of FY forecast) • 34,717 patients attending CDS (100% of FY forecast) • Continue to monitor and manage contract delivery, including orthodontic delivery, oral surgery (sedation), sedation, DOMs, asylum seekers • Continue to monitor, manage and maintain urgent access • Review and monitor delivery against CR metrics and UDA
Actions	• Support the roll out of Wales National Workforce and Reporting System (WNWRS) • Implement 24/25 contract changes • Where necessary, recommission dental services as a result of contract variations and/or resignations • Roll out of WNWRS for dental
	•
Risks	1. Access is unlikely to increase, without additional funding 2. Patient Charge Revenue (PCR) risk – PCR income has reduced since Covid-19 3. Contract variations and/or resignations 4. Financial contract recovery which could result in the destabilisation of dental practices/services 5. Practice recruitment and retention issues, highlighted to Welsh Government (WG) and Health Education and Improvement Wales (HEIW), impacting on practice capacity to see patients 6. Increased wait times for referral-based services
Outcomes	1. Continue to maintain 2022/23 dental access in to 2023/24 – new Contract Variation issued for 23/24. Dental practices have yet to confirm whether they will opt-in to contract reform from April 2023 or revert back UDAs. 2. Continue to engage with stakeholders and meeting groups; Integrated Oral Health Group, Dental Quality & Patient Safety, Welsh Government/Public Health Wales meeting forums

	3. Continue to review/monitor activity levels and wait times
Alignment with workforce plans	National discussions ongoing to scope re-introduction of Dental Nurse Trainee schemes. Development of Primary Care Academy locally to include additional dental nurse training – business case in development.
Alignment with Financial plans	Continue to review and monitor activity levels/referral-based service wait times/lists to inform the GDS financial plan, identifying where additional investment is required. Continue to liaise with Finance colleagues on a monthly basis and contribute to the ongoing refinement of the Primary and Community Care Divisions IMTP.

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITY

Improved access to GP and Community Services

Baseline	Despite widespread implementation of a multidisciplinary skill mix model in GMS, services have an estimated vacancy factor of 67 FTE GPs (excluding locums) in November 2022. This has increased from 51 FTE in the 6 months since March 2022. The greatest staffing deficits are impacting services in areas of highest demand and where social deprivation is most prevalent. 5 of Gwent's 71 practices are currently being managed by the Health Board. In 2022/23 the Health Board has overseen the termination of 4 contracts, 2 branch surgery closures, 1 list dispersal and received 3 sustainability applications. Local intelligence estimates that GPs and extended scope practitioners are conducting circa 41,500 patient encounters every week. However, demand continues to outstrip capacity on a regular basis. Welsh Government funding for additional capacity has enabled practices to increase clinical sessions over the winter period. Community Services in Gwent – consisting District Nursing, Community Resource Teams and others – are equally experiencing challenging staffing deficits. District Nursing Teams have managing average caseloads of 6,127 patients throughout 2022/23 and undertaken an estimated 41,781 contacts per month. Rapid Response Services (excluding Monmouthshire) have managed an average caseload of 107 and accepted an average of 350 referrals per month. As a consequence of limited community capacity, patients are becoming increasingly delayed when ready to leave hospital. Throughout 2022/23 the HB's complex list estimates that on average each day 35 people await Occupational Therapy (OT) or Physiotherapy assessment in hospital and 26 people await discharge with Reablement. Welsh Government issued Access to In-Hours GMS Services Standards for all GP practices in 2019. For 2022/23 all GP practices need to achieve all Phase 1 standards by September 2022 and complete Phase 2 by the end of March 2023. As at January 2023, all practices have achieved phase 1 and are moving on the reflective element in Phase 2. For 2023/24, the pre-qualifier access standards (previously known as Phase 1) will be mandated through the contract as of 1st April 2023 and will form part of Unified Services.

	The current Phase 2 Standards will remain in QAIF (100 points) for the 2023/24 cycle to allow for evaluation of achievement and impact during 2023. The Quality Improvement (QI) project moved into the contract from October 2022 and the collection and sharing of activity/appointment data will be mandated through the contract. The Urgent Primary Care service provides mobile home visit capacity, historically covered by salaried/sessional GPs, however experience challenges in filling some GP base and triage shifts.
Quarter 1:	
Milestones	• Expansion of Rapid Response Service 8am-8pm in line with GP referral patterns • Submit Business Case for Primary Care Academy, featuring training cohorts for ANPs, Clinical Pharmacists, Pharmacy Technicians, Physician Assistants and GP Nurses • Introduction of MSK Hub, including self-care resources and Gwent-wide self-referral and assessment service • Activity/Appointment data is recorded and shared through the reporting tool. • Quality Assurance and Improvement Framework (QAIF) reporting of elements relating to access are in place. • GMS services are meeting the requirement of the changes to the contract as set out in 2022/23. • Changes by practices in relation to contract resignations, boundary change, branch closures and sustainability applications acted on in a timely manner. • Quarterly reporting via Primary Care Information Portal in respect of achievement against Access Standards • Increase end of life care capacity in the community (this is subject to confirmation of funding and will be clarified in February 2023 by Welsh Government) (National Community Nursing Specification) • Clear supervision offer to District Nurses, Specialist Nurses and General Practice Nurses in Health Board Managed practices, of a minimum of one restorative supervision session every six months (National Community Nursing Specification)
Actions	• Commence implementation of Managed Practice Recovery Plan, consisting of cross-practice standardisation of processes, alignment of back-office functions, floating clinical teams, portfolio GP roles • Commence reinvigoration of Primary Care Operational Support Team – recruitment to Clinical Lead roles or distribution of funding to 3 regions of Gwent for local solutions • Ongoing communication and engagement to increase public awareness of services - the importance of accessing the right place, first time • Develop proposal for use of Regional Partnership Board (RPB) funding on behalf of the region – including strategic planning,

	organisational development and programme of feasibility studies and utilisation monitoring to ensure best use of existing estate • Develop implementation plan and commence delivery to ensure alignment of AB community services to the National Community Nursing Specification • Evaluate urgent responsive care at home pilot (overnight) • Scope feasibility of integrating primary care and secondary care data to embedding a population health management / segmentation approach within HB managed practices. Use as a proof of concept (supported by NCN Data Analyst, Corporate Information and Public Health Teams) and aligned with Proactive Frailty, Compassionate Communities and Adult Weight Management Programmes prior to further engagement with independent contractors. • Appoint Clinical Editors to commence Health Pathways training and commence pathway development and publication (pending business case approval) • Phase 1 standards are being met. Continue to review quarterly submissions via PCIP. • Review activity/appointment data each quarter • QAIF requirements that relate to access are reviewed and addressed as required • Processes applied to practices requesting contractual changes (contract resignation (etc)) • Promote ongoing use / maximisation of Welsh Government Additional Capacity funding and delivery of additional clinical sessions LES to maintain effective capacity • Appointment of 2 WTE mobile Nurse Practitioners within Urgent Primary Care to replace one mobile GP shift per evening (Mon-Fri) and one Saturday and Sunday shift. • Plans for Urgent Primary Care (UPC) adaptations dependent on conclusions of Working Group established in January 2023
Quarter 2:	
Milestones	• Implement streamlined hot clinic pathway for frail / elderly patients • Activity/Appointment data is recorded and shared through the reporting tool. • QAIF reporting of elements relating to access are in place. • GMS services are meeting the requirement of the changes to the contract as set out in 2022/23. • Changes by practices in relation to contract resignations, boundary change, branch closures and sustainability applications acted on in a timely manner. • Quarterly reporting via Primary Care Information Portal in respect of achievement against Access Standards • Implementation of a two-hour, 72 hour and 10 working day response to referrals, by District Nursing Teams and Community Specialist Nursing Teams (National Community Nursing Specification) • Direct referrals to District Nursing Services out of hours from Urgent Care Services including Out of Hours (OOH) GP, 111 and Welsh Ambulance Service Trish (WAST) Clinical Support Desk

	clinicians and Paramedics where direct referral pathways exist, are in place (National Community Nursing Specification) • Implementation of a frailty score across all community nursing services (National Community Nursing Specification)
Actions	• Implement targeted programme to support GP practices to act as tier 2 sponsors for medics seeking to settle in the UK (seeking support from NWSSP to assist with processes) • Showcasing roles in GP Practices - video profiles to raise awareness of different roles (e.g., Advanced Nurse Practitioner (ANP), Health Care Support Worker (HCSW), Pharmacist) and increase public confidence when booking appointments. The video will also be used in recruitment. • Implement local bolt-on training for care navigators to improve appropriate signposting to Minor Injury Unit (MIU), Emergency Department (ED), community services and self-care resources • Deliver area specific campaigns to address needs at a local level • Scope options for a pilot site to implement a Comprehensive Care Home Service (a single integrated team on an NCN, locality or even Gwent wide basis) to provide full clinical care to care home residents • Review activity/appointment data each quarter • QAIF requirements that relate to access are reviewed and addressed as required • Processes applied to practices requesting contractual changes (contract resignation (etc) • Monitor Access submission via Primary Care Improvement Plan (PCIP) • Promote ongoing use / maximisation of Welsh Government Additional Capacity funding and delivery of additional clinical sessions LES to maintain effective capacity
Quarter 3:	
Milestones	• Implement Health Pathways Platform to improve adherence to appropriate pathways and utilisation of range of services (pending business case approval) • Intake for latest cohort of staff into Primary Care Academy (pending business case approval) • Activity/Appointment data is recorded and shared through the reporting tool. • QAIF reporting of elements relating to access are in place. • GMS services are meeting the requirement of the changes to the contract as set out in 2022/23. • Changes by practices in relation to contract resignations, boundary change, branch closures and sustainability applications acted on in a timely manner. • Quarterly reporting via Primary Care Information Portal in respect of achievement against Access Standards • District Nursing (DN) capacity on Saturday and Sunday daytime is at a minimum of 60% of the usual weekday DN capacity (National Community Nursing Specification)

Actions	• Promote ongoing use / maximisation of Welsh Government Additional Capacity funding and delivery of additional clinical sessions LES to maintain effective capacity during winter period • Update GMS workforce modelling with November 2023 validated data and undertake Sustainability Workshops with all NCNs to inform NCN / ISPB plans for 2024/25 • Redesign referral pathways / single point of access to define access routes for Community Resource Teams (CRTs), Community Services and Secondary Care, aligning resources to streamline processes for GPs • Expansion of Multidisciplinary Team (MDT) roles within Urgent Primary Care, including Advance Practice Paramedics, Clinical Pharmacists and extended scope nurse practitioners to reduce reliance on sessional medical workforce • Monitor activity/appointment data each quarter • QAIF requirements that relate to access are reviewed and addressed as required • Processes applied to practices requesting contractual changes (contract resignation (etc) • Monitor Access submission via PCIP • Nursing and AHP Professional Collaboratives respond to Population Needs Analysis to inform development of NCN, ISPB and RPB planning cycle for 2024/25
Quarter4:	
Milestones	• Refresh NCN and ISPB plans including local analysis of demand / capacity and priorities for investment • Activity/Appointment data is recorded and shared through the reporting tool. • QAIF reporting of elements relating to access are in place. • GMS services are meeting the requirement of the changes to the contract as set out in 2022/23. • Changes by practices in relation to contract resignations, boundary change, branch closures and sustainability applications acted on in a timely manner. • Quarterly reporting via Primary Care Information Portal in respect of achievement against Access Standards
Actions	• Two-way conversations between GP Practices with Urgent Care Teams, Frailty Consultants, Allied Health professionals, Nursing Teams and other services - creation of information resources / service directories • Development of band 4 assistant practitioner model in District Nursing, thereby increasing clinical capacity through modification of skill mix • Monitor activity/appointment data each quarter • QAIF requirements that relate to access are reviewed and poor performance is acted on. • Processes applied to practices requesting contractual changes (contract resignation (etc) • Confirm year end achievement against Access Standards via PCIP

	• Promote ongoing use / maximisation of Welsh Government Additional Capacity funding and delivery of additional clinical sessions LES to maintain effective capacity
Risks	➢ Wide spread reliance on MDT staff not currently trained to the scale required (i.e. ANPs, Clinical Pharmacists, etc.) to offset all medical deficits. ➢ Reliance on short-term investment to bolster primary care and community services means a) difficulties recruiting / retaining staff and b) potential risk of significant service deficit should funding cease to recur or need to be re-prioritised. ➢ Fatigue among primary care workforce has potential to result in higher-than-normal leavers from the sector in the coming year, potentially increasing staffing deficit and requiring greater training numbers than currently forecast. ➢ Significant challenges in GMS services, including but not limited to increasing demands and patient expectations, reluctance to become a GP partner, lack of GPs and other clinical staff, pension constraints. The accumulation of these concerns is resulting in higher than usual contractual changes. In particular, any process where patients are reassigned results in disquiet for patients who have been with a practice, often for many years.
Outcomes	➢ Increased DN capacity through modified skill mix (90:10 to 70:30) allowing for a greater headcount with same resources and reduction in vacancies through reduced reliance on registered nurses. ➢ Reduction in patients referred by GPs to ED/Assessment Units, especially between 4pm and 8pm. ➢ Reduction in GPs vacancy factor within 2-3 years. Academy will take up to 2 years to produce newly trained staff. ➢ Improved navigation of the system and utilisation of services (i.e. hot clinics, rapid response, Same Day Emergency Care (SDEC)) as alternative to hospital admission. GP time saved by streamlining processes and providing pathway/service clarity. ➢ Improved public perception/awareness of service availability and positive messaging regarding. ➢ Utilising a MDT approach within Urgent Primary Care, reducing the demand for GPs for mobile shifts, and in turn re-aligning the existing GP workforce to support base or triage gaps within the service.
Alignment with workforce plans	These actions underpin and enable our workforce plans to, over the course of the IMTP, deliver a more sustainable primary care workforce model
Alignment with Financial plans	Aligned with Divisional financial forecasts

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITIES

Improved use of optometry services

<table>
<tr><td>Baseline</td><td>
<table>
<tr><th>2021/22</th><th>2022/23 Forecast</th></tr>
<tr><td>59 practices providing Clinical Community Optometry Service
15 Optometry Inpatient (IP) Services
139,860 patients accessed NHS Optometry Services
1,203 referrals to secondary care for Wet Age-related Macular Degeneration (AMD)</td><td>56 practices providing Clinical Community Optometry Service
15 Optometry IP Services
141,984 patients accessed NHS Optometry Services
916 referrals to secondary care for Wet AMD</td></tr>
</table>

Limited capacity to forecast future activity due to impending implementation of new national contract, service specification and clinical pathways.
</td></tr>
<tr><td colspan="2">Quarter 1:</td></tr>
<tr><td>Milestones</td><td>

35,496 new patients accessed NHS Optometry Services (25% of FY forecast)
Implementation of new and revised clinical pathways
Introduction of Open Eyes digital record

</td></tr>
<tr><td>Actions</td><td>

Appoint to critical vacant posts, including Clinical Director for Ophthalmology, Clinical Advisor Optometry and Ophthalmology Directorate Manager
Re-establish Eye Care Pathway Collaborative Group and develop integrated plan and priorities for next 3-year period
Finalise appointment to all Optometry Professional Collaborative Leads and implement local collaborative processes aligned to Neighbourhood Care Network (NCN) Planning / Accelerated Cluster Development Programme
Consider contractual requirements for Wet AMD Service Level Agreement (SLA) / lease agreement
Implement Ophthalmic Diagnostic Treatment Centres (ODTC)/Medical Retina clinical pathways – existing ODTC contract may require further extension until national position is clear
Implement Independent Optometry Prescribing Service (IPOS) via clinical pathway
Identify training/service gaps and liaise with Health Education and Improvement Wales (HEIW) and Secondary Care
Await further information from WG regarding Continued Professional Development CPD requirements
Manage service change and/or practice closures as and when required

</td></tr>
</table>

	• Implement Occupational Health Service (£75k contract value) • Support the roll out of Open Eyes
Quarter 2:	
Milestones	• 70,992 new patients accessed NHS Optometry Services (50% of FY forecast) • Roll out of Wales National Workforce Reporting System (WNWRS) for optometry
Actions	• Support the roll out of WNWRS • Manage service change and/or practice closures as and when required
Quarter 3:	
Milestones	• 106,488 new patients accessed NHS Optometry Services (75% of FY forecast)
Actions	• Manage service change and/or practice closures as and when required • NCN Optometry Professional Collaboratives respond to Population Needs Analysis to inform development of NCN, Integrated Services Partnership Board (ISPB) and Regional Partnership Board (RPB) plans / priorities for 2024/25
Quarter4:	
Milestones	• 141,984 new patients accessed NHS Optometry Services (100% of FY forecast)
Actions	• Support the ongoing implementation of the contract requirements for Wales General Ophthalmic Services (WGOS) in 2024/25 • Implement activities subject to national contract implementation plans for 2024/25 • Manage service change and/or practice closures as and when required
Risks	1. Financial pressure regarding ongoing commissioning of ODTC and existing providers continuing 2. Consideration to the procurement of Optical Coherence Tomographys (OCTs) to enable better imaging and easier virtual review of patients – possible financial implications
Outcomes	1. The implementation of pathways will enable collaborative working between primary and secondary care services ensuring patients are seen in timely manner and Making Every Contact Count (MECC) 2. Establishing an occupational health service will ensure equitable access for optometric professionals 3. Undertaking a training needs analysis will identify service gaps and support discussions to encourage the optometry workforce to upskill allowing more patients to be seen in the community 4. Implementing Open Eyes will enable primary and secondary colleagues to share records encouraging shared care for patients 5. The Health Board does not hold workforce data for the profession, therefore having access to this data will support future planning of services

	6. Contribute to discussions as part of the Eyecare Collaborative meeting group
Alignment with workforce plans	Implementation of Optometry Professional Collaborative Groups (NCN Development Programme) will ensure local requirements are identified and used to inform All Wales continuous profession development programme for Optometry, led by HEIW.
Alignment with Financial plans	There is currently no budget for Optometry and therefore current service provision is a cost pressure

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITY

Health Boards must honour commitments that have been made to reduce handover waits.

Baseline

The below outlines the most recent reported handover performance submitted for the period November 2022:

Measure	Report period	National Target	Current Performance	Previous period performance	In month trend
No ambulance handovers < 60 mins	Feb 23	0	1179	1343	↓

The above reported month demonstrates an improvement in handover over 1 hour. However, it is anticipated that the December performance will be challenged due to a number of factors widely reported. These include factors such as higher levels of respiratory infections (flu, Covid-19, Strep A) in circulation combined with areas of staff shortages and strike action all affecting demand and subsequent ability to manage that demand.

Broadly however, the Six Goals for Urgent and Emergency Care Programme is already established and aims to generate system wide improvement that will result in improved flow and subsequently improved ambulance handover times.

Within the Six Goals plan there are a number of key projects and initiatives that should deliver incremental improvement over a shorter period of time whilst the longer-term strategy develops in parallel.

Quarter 1:	
Milestones	• Introduce the Safety Flow System at ED GUH to commence implementation of 4 hour handover wait reduction • GUH – move SAU into ward A1 & move AMU to existing SAU/ reception footprint; increase in acute medicine SDEC activity • An APP at the Flow centre to improve patient flow and reduce conveyance. This is to test and strengthen the workforce model, senior decision-making function and provide additional advanced clinical assessment skills. • Work in partnership with WAST to understand the shared strategy in relation to Physician Response Unit (PRU) • Recruit dedicated Front Door Therapies staff to ED GUH • Pilot of Elderly frail assessment service at GUH front door

Actions	• Multidisciplinary & cross-Divisional meetings with key Clinicians, Executives & Managerial staff to agree processes, escalation points & commencement date • Reconfigure the SAU & AMU areas • Review Q4 APP pilot and whether permanent roll out beneficial or justifiable • Implement outcome of PRU winter service activity & develop business case for substantive implementation of PRU • Complete recruitment process and on-board remaining therapy practitioners, OT and Physio • Identify and recruit Care of the elderly (COTE) locum for duration of the pilot
Quarter 2:	
Milestones	• 0 > 4 hour ambulance handovers form Q2 and sustain for all following quarters • System Flow Improvement, movements out of Emergency Department (ED) every 2 hours • Increase in PRU interventions preventing GUH or eLGH attendance • Elderly Frailty Assessment Service at GUH • Exploration of Integrated assessment model • Launch of Goal 5 Optimal Discharge Framework
Actions	• System wide engagement on risk stratification and subsequent effect of regular patient flow from ED utilizing eLGH and community sites • Recruitment of locum resilience to enable Frailty assessment • Feasibility assessment of GP resilience to eLGH and GUH front door, possibly utilizing SDEC space
Quarter 3:	
Milestones	• Sustain 0 > 4 hour ambulance handovers • Implementation of e-Triage • ED referral to speciality improvement
Actions	• Procure e-Triage solution and focus on the long lead time aspect (relating to technical integration with Welsh Patient Administration System (WPAS)) • Agree mechanism to be used (i.e. CWS watchlist) and risk management approach for a pilot of a new ED referral process
Quarter4:	
Milestones	• Sustain 0 > 4 hour ambulance handovers form Q2 and sustain for all following quarters • Preparations to commence in development of front door pathways utilizing e-Triage and ED expansion due in 2024 • Continue to monitor progress against plan
Actions	• Utilize lessons learned from Same Day Emergency Care (SDEC), Integrated Assessment Centre (IAC) and early e-Triage experience to shape new ways of working

	• Continuous Data and PREM Review
Risks	• Adoption and sustainment of new ways of working • Footprint to enable flow, increasingly fewer safe locations for boarding etc • Public behavioural response to new introductions such as IAC/SDEC • COTE staffing availability • Financial risk associated with subsequent years e-Triage costs
Outcomes	• Improved ambulance handover delays • Improved discharge profile • Risk stratification of walk-in patients to ED • Improved visibility to clinical risk within the waiting room • Better matching of patient acuity to appropriate clinician early in the process
Alignment with workforce plans	• Modelling exercise in progress to align ED staffing resource with patient demand, analysing the number of patients attending ED per hour, per day, by time spent in the department, by time spent with each grade of clinician and map the optimal deployment of staffing resource against demand • Reduction in utilization of agency staff due to variable pay and knowledge of the system
Alignment with Financial plans	• E-Triage is funded via National Six Goals programme for year 1 pilot • Funding agreed for ED Extension • Longer term funding required for PRU

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITY

Reduction in backlog of delayed transfers of care (Pathways of Care)

<table>
<tr><td>Baseline</td><td>Describe the baseline as of April 2023 from which you will be working
Pathways of Care figures for the last three months

February – 266
March – 275
April – 250
Established Integrated Discharge Board – Chaired by Executive Director of Nursing
Executive Committee updated on discharge improvement programme</td></tr>
<tr><td colspan="2">Quarter 1:</td></tr>
<tr><td>Milestones</td><td>< 249 number of Pathway of Care Delays

• Key metrics signed off and reported at the end of the quarter
• Implement the realignment of Six Goals programme management arrangements</td></tr>
<tr><td>Actions</td><td>• Continue to monitor and support the RGH discharge pilot/NHH pull model.
• Scope options and funding for capturing Board Round data digitally, explore use of digital white boards, Red to Green, D2RA.
• Develop discharge digital dashboard to enhance reporting and monitoring of patients delaying

<table>
<tr><td>Discharge Improvement Board
• Draft terms of reference
• Confirm membership – local authority/third sector/housing
• Develop work plan and documentation</td><td>Digital Solutions
• Scope digital options for in house solutions with Informatics colleagues
• Visit other Health Boards as part of an awareness raising exercise to consider further options
• Explore funding options</td></tr>
<tr><td>RGH/NHH Pilot
• Dedicated health and social care professional focus discharging medically fit patients
• Monitor the impact of the pilot
• Assess the benefits and impact on discharge
Metrics</td><td>Optimising Patient Flow Framework
• Develop education and training programme – focus on RGH, improve knowledge and skills
• Red to Green day refresher training
• SAFER – embed MDT approach in Board Rounds
• Establish discharge ‘champion’ team at RGH -</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td colspan="2">Integrated Discharge Board to sign off metrics</td><td>medic/nurse/OT/physio/local authority</td></tr>
<tr><td colspan="4">Quarter 2:</td></tr>
<tr><td>Milestones</td><td colspan="3"><232 number of Pathway of Care Delays
Education programme roll out at NHH/YYF/community hospitals
Implementation of the digital solution following scoping – short term solution,</td></tr>
<tr><td>Actions</td><td colspan="3">Integrated Discharge Board meetings – held monthly
Continue to monitor and support the RGH discharge pilot/NHH pull model.
Continue to review and refine the dashboard measures
Continue to scope long term digital solution
Six Goals Programme Board – deep dive on discharge
<table>
<tr><td>Discharge Improvement Board
Monthly meeting held, system wide membership, update of all discharge improvement projects, metrics and benefits</td><td>Digital Solutions
Progress with preferred solution, either in house or external solution</td></tr>
<tr><td>RGH Pilot/NHH Pull Model
Dedicated health and social care professional focus discharging medically fit patients
Monitor the impact of the pilot
Access the benefits and impact on discharge</td><td rowspan="2">Optimising Patient Flow Framework
Develop education and training programme – focus on NHH/YYF/community hospitals, improve knowledge and skills
Red to Green day refresher training
SAFER – embed MDT approach in Board Rounds
Establish discharge ‘champion’ team at NHH/YYF/community hospitals - medic/nurse/OT/physio/local authority
Continue to monitor and review roll out at RGH</td></tr>
<tr><td>Metrics
Ongoing review of measures to ensure they are fit for purpose
Quarterly reporting of metrics to Clinical Futures Programme Board</td></tr>
</table></td></tr>
<tr><td colspan="4">Quarter 3:</td></tr>
<tr><td>Milestones</td><td colspan="3"><217 number of Pathway of Care Delays
Ward audits completed across all sites to monitor the roll out of the framework</td></tr>
<tr><td>Actions</td><td colspan="3">
<table>
<tr><td>Discharge Improvement Board
Monthly meeting held, system wide membership, update of all discharge improvement projects, metrics and benefits</td><td>Digital Solutions
Progress with preferred solution, either in house or external solution
Continue to review long term digital solution</td></tr>
<tr><td>Metrics
Ongoing review of measures to ensure they are fit for purpose
Quarterly reporting of metrics to Clinical Futures Programme Board</td><td>Optimising Patient Flow Framework
Continue to monitor and review roll out across all sites
Undertake ward audits across all sites
Subject to the ward audits, consider refresher training on targeted wards</td></tr>
</table></td></tr>
<tr><td colspan="4">Quarter4:</td></tr>
</table>

<table>
<tr><td>Milestones</td><td>

<203 number of Pathway of Care Delays
Implement digital solution following scoping

</td></tr>
<tr><td>Actions</td><td>
<table>
<tr><td>Discharge Improvement Board
Monthly meeting held, system wide membership, update of all discharge improvement projects, metrics and benefits</td><td>Digital Solutions
Progress with preferred solution, either in house or external solution</td></tr>
<tr><td>Metrics
Ongoing review of measures to ensure they are fit for purpose
Quarterly reporting of metrics to Clinical Futures Programme Board</td><td>Optimising Patient Flow Framework
Continue to monitor and review roll out across all sites
Undertake ward audits across all sites
Subject to the ward audits, consider refresher training on targeted wards</td></tr>
</table>
</td></tr>
<tr><td>Risks</td><td>Workforce challenges - support implementation of the framework across all sites
Education and training - across a large number of staff and sites
Lack of digital solution at ward level to collect data to support the roll out of the framework
Complex system working across five local authorities
Funding to deliver digital solution</td></tr>
<tr><td>Outcomes</td><td>Better patient outcomes
Fewer delayed discharges
Shorter lengths of stay
Reduced hospital readmissions
Proactive approach to managing risk across the system
Prevention of deconditioning</td></tr>
<tr><td>Alignment with workforce plans</td><td>Local authority staff supporting RGH discharge hub and NHH pull model</td></tr>
<tr><td>Alignment with Financial plans</td><td>Aligned with the Programme and Divisional Plans</td></tr>
</table>

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITY

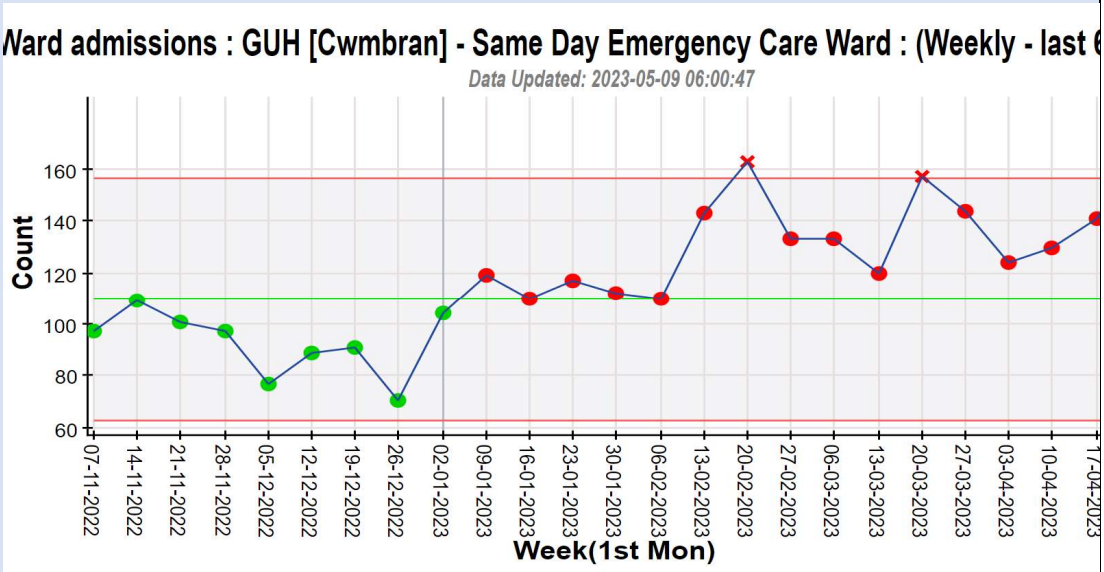
Implementation of Same Day Emergency Care services that: -

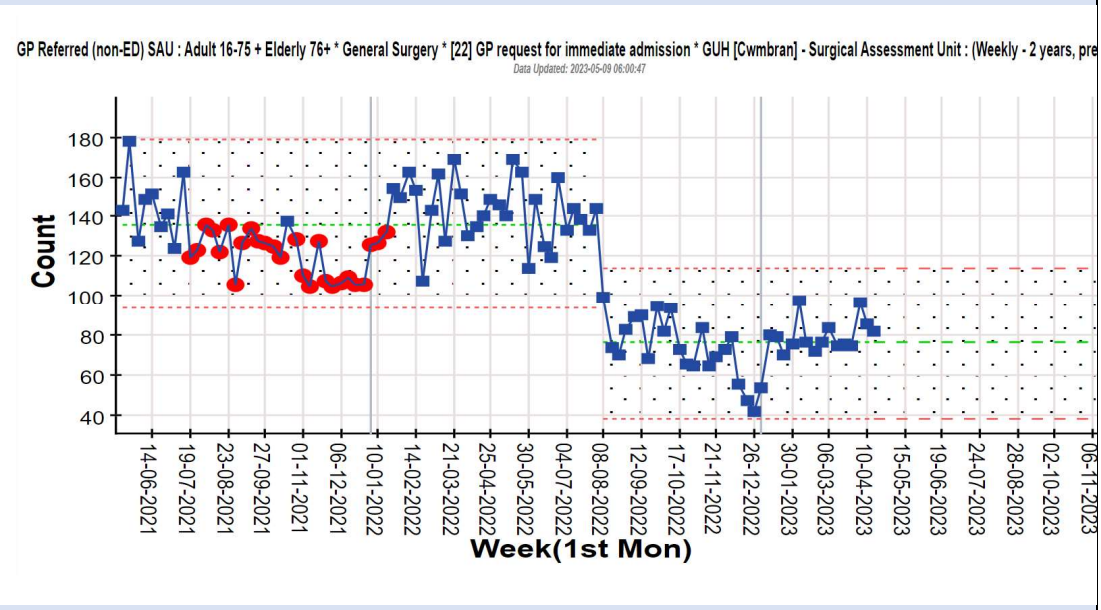
- Is open 5 days a week moving to 7 days a week 12 hours a day by end of Quarter 2
- Is accessible at key times evidenced by the emergency care demand profile in of each hospital site
- Is direct access and bypasses emergency depts
- Delivers a service for at least medical and surgical same day care
- Is accessible by WAST clinicians as set out in their clinician referral policy to support reduction in handover as set out in the six goals handbook.

Baseline	As at March 2023 the following SDEC services (either by definition or by proxy measures) are delivered by the Health Board: SDEC at GUH (Surgical) SDEC at GUH (Medicine/Other) SDEC at YYF (Medicine) Respiratory Ambulatory Care Unit (RACU) Medicine at RGH Gastro Ambulatory Care Unity (GACU) at RGH 1x Medical Assessment Unit at GUH 1x Surgical Assessment Unit at GUH 3x Medical Assessment at eLGH sites (RGH, NHH, YYF) ABUHB prior to 2022 had **established same day medical assessment services in the 3x eLGH sites in Ystrad Mynach, Abergavenny and Newport**. In **2022, the SDEC unit at the Grange University Hospital** (GUH) was opened. SDEC GUH opening following capital (and revenue) investment in August 2022. The graphics below illustrates the key SDEC metrics for both the GUH since opening and then progress since opening. **The MAUs across all sites are accessed 24/7** for medical patients via the flow centre referred via WAST and GPs. This averages 150 patients per day across the 3x sites, avoiding ED attendance at the GUH. The **GUH SDEC** provides an alternative location for same day assessment and treatment of patients who **either self-present to ED or on initial diagnosis are required for referral to ED** but then deemed suitable for same day speciality management and not admission Prior to GUH SDEC, for patients requiring same day surgical assessment the only option was surgical admission via ED at GUH. This is due to the surgical 'take' being centralised at GUH for the Health Board following the opening of the GUH in November 2020. In its initial phase therefore the SDEC has prioritised the surgical patient flow through the unit to complement the medical same day access via the eLGH sites. As we move through Q1 23/24 work is ongoing to develop the acute

medicine service in all sites but also SDEC GUH to complement the surgical service.

SDEC GUH seen over 4300 patients and has been incredibly impactful upon patient flow and patient experience at GUH, most notably for General Surgery. SDEC receives roughly 40% of the overall Emergency General Surgery take. Prior to SDEC all patients would have been seen through the Surgical Assessment Unit (SAU). Since January 2023, weekly attendances to SDEC have increased from 110 – 140.





The median time on SDEC is just under 4 hours and has remained fairly consistent over the last 6 months. This includes all patient activity including assessment and minor procedures. In addition, data demonstrates that General Surgery patients are more likley to spend less time in hospital since SDEC opening. There is an 8% increase in patients spending less than 12 hours within General Surgery post SDEC. SDEC has changed the flow of patients through GUH, higher acuity patients now go to SAU and lower acuity patients go to SDEC. This means there are fewer patients waiting in the SAU

waiting area and corridor, therfore less congestion. This has enabled 10 chairs to be removed from the SAU corridor improving patient and staff experience .

Additionally, In early 2022, plans were developed to transform a former pathology lab within Ysbyty Ystrad Fawr (YYF) into a Medical SDEC providing extra capacity for an already over capacity MAU. The capital element was funded and completed by the Health Board. The revenue element was successfully approved by the Regional Integration fund (RIF) to support an interim service from October 2022 to March 2023. The SDEC YYF opened on 31st October 2022. An initial evaluation of SDEC YYF produced similar findings to that of the GUH evaluation in terms of patient reported experience and length of stay measures. Extension of SDEC YYF is subject to approval of funding through RIF which should be determined in May 2023

The introduction of the three mentioned services (SDEC GUH, SDEC YYF and RACU) have been extremely positive both in terms of releasing system capacity, admission avoidance and ultimately patient experience.

Current average weekly Patient throughput by Service is summarised below:

SDEC Service	Weekly Patient throughput (Approx)
SDEC GUH (General Surgery)	120
SDEC GUH (Medicine)	25
SDEC GUH (Other Speciality)	20
SDEC YYF	25
RACU	25
SAU GUH (Includes Weekend)	66* (40% of SAU GUH Attendances)
MAU GUH (Includes Weekend)	47* (29% of MAU GUH Attendances)
MAU eLGH (Included Weekend)	230* (51% of eLGH MAU Attendances)
Total	568

*Less than 12 hour LOS used as a proxy measure

The primary referral source into all above services is General Practice via the flow centre. However referrals can also be made through the ED, WAST and Minor Injury Units

The strategy for SDEC is to continue developing existing services and review applicability and feasibility of other specialities. There is a particular focus on Acute medicine in terms of model development limited by current vacancies, however the goal remains to have an SDEC approach in enhanced Local General Hospitals (eLGH) for ‘care closer to home’ with a default position of discharge, but step up / admit facility available if necessary to the MAU at GUH.

	Currently there are no resourced plans (finance and workforce) to expand the GUH SDEC facility to 7 days a week. A business case to support service expansion is being developed as part of the 6 Goals Programme and will also consider the implications of widening access.
Quarter 1:	
Milestones	• Delivery of SDEC i.e. non admitting assessment space to all eLGH sites (sustaining YYF and adding NHH and RGH) • Sustaining YYF SDEC capacity • Sustaining Respiratory Ambulatory Care Unit (RACU) capacity • Integration of T&O into SDEC GUH provision • Integration of Acute Oncology into SDEC GUH provision
Actions	• Securing funding for YYF SDEC continuation • Securing funding for RACU continuation • Reidentifying trolley assessment spaces at NHH and RGH as Same Day Emergency Care (medical patients direct from WAST via Flow Centre as per current MAU model) • Agree criteria for SDEC with T&O and Acute Oncology • Reconfigure Level 1 GUH to enhance navigation to SDEC from ED, SAU, MAU
Quarter 2:	
Milestones	• Increase Acute Medicine SDEC volume • Increase overall weekly patient volume to 150 • Implement direct from triage referral to SDEC (Gen Surgery) • Integrate ENT pathway
Actions	• Identify Clinical sessions to enable SDEC GUH • Recruit additional locum resilience to Support • Develop criteria for ‘direct referrals from ED triage’
Quarter 3:	
Milestones	• Build a resourcing plan for 7 day per week SDEC coverage (GUH) • Develop programme around Flow Centre pathway improvement
Actions	• Feasibility assessment of Surgical, Medical and Nursing staffing rota resilience • Establish T&F working group following workshop • Complete costing profile
Quarter4:	
Milestones	• Further development of speciality model of SDEC • Continue to Monitor progress against plan
Actions	• Continuous Data and PREM Review
Risks	• Financial risk to YYF SDEC additional capacity as currently fixed term funded through RIF • Acute Medicine workforce availability (5 day and 7 day) • Recruitment and retention of nursing and support staff
Outcomes	• Reduced ED congestion, • Fewer under 24hr admissions to hospital sites freeing up assessment and admission beds for those who require them
Alignment with	• A continued focus required on the recruitment and retention of both substantive and locum Consultant Acute Physicians where there is significant deficit currently

workforce plans	• Recruit additional Registered Nurse at MAU to support triage and existing deficits • Recruit remaining SAS Doctor to bring SDEC to full complement of Surgeons • Retain existing ANP and PAs within assessment areas
Alignment with Financial plans	• Forecast of SDEC for 23/24 spend is within WG Six Goals allocation

NHS WALES PLANNING FRAMEWORK - MINISTERIAL PRIORITY

Implementation of a 24/7 urgent primary care service, accessible via NHS 111 Wales to support improved access and GMS sustainability.

Development of Urgent Primary Care Centres, Referrals from 111, Re-directions from MIU and ED, contact first, WAST stack, support of in hours GMS practices in escalation and managed practices.

Baseline	Aneurin Bevan University Health board (ABUHB) submitted a bid in order to take part in the Welsh Government (WG) pathfinder to deliver Urgent Primary Care 24/7 within Wales. ABUHB adopted a model in line with the Welsh Government policy in supporting patients to access treatment by the right person, at the right time and in the right place, as close to home as possible (A Healthier Wales; Health and Social Care, 2018). Linking more recently to the six goals for urgent and emergency care. Within the ABUHB Urgent Primary Care 24/7 pathfinder it was determined that the pathfinder aligned to the existing Urgent Primary Care Service in place. The Urgent Primary Care service already supported the population of Gwent with an Urgent Primary Care need within ABUHB from 6.30pm to 8am weekdays and 24/7 during weekends and bank holidays. This service is integrated with the 111 service. Professional calls are routed directly through the ABUHB call handling function. Within the model in ABUHB it was considered key to ensure that access to the Urgent Primary Care Pathfinder was consistent across all Health board clusters and practices. Therefore, the pathways available are accessible by all patients shown opposite, with Figure 1 showing the area covered by AB's pathfinder. It is acknowledged that the pathfinder delivered within ABUHB for phase 1 was delivered at pace and within a short period matured into a stable model. The UPCCs within RGH and NHH were set up quickly after the pathfinders' inception and quickly integrated into the wider Health board system,

Map key	HB	Practices	Clusters	Population	Comments
2	ABUHB	73*	11	615,949	* 72 practices from 01.05.21

Figure 1

	through the process of re-directions from minor injury departments and the Emergency Department at The Grange University Hospital (GUH). It was acknowledged that the model needed to develop within phase 2 rollout, particularly in respect of engagement with the re-direction pathway from GUH ED. This was achieved via an admin pilot within GUH, in addition to staff engagement sessions. Links with the Single Point of Access Mental Health pilot have continued as the uplift from phase 1 and 2 and the medical lead is heavily involved in this development. In addition to the mental health pathway, it was initially deemed necessary to develop the physiotherapist role within UPCC, through engagement with the physiotherapy service within ABUHB and joint working and consultation, it was deemed this resource would be more appropriately accessed via the MSK transformation within the health board. This would ensure sustainability of physiotherapy services within ABUHB, ensuring that the resource is best used to meet the need of our patients. As the MSK posts are filled, pathways will be made available to the UPCC service, continuing the whole system integration. Our UPCCs within RGH and NHH are more fully integrated within the front doors of the eLGHs, something that we wanted to progress from phase 1 to phase 2 and this has had a positive impact on whole system integration within acute urgent care and Urgent Primary Care, supporting the work around the six goals for Urgent and Emergency Care. Demand and capacity work has been ongoing throughout phase 1 and 2 and will continue, in addition to the performance matrix, linking with colleagues from the programme manager's group and DCHW in line with progressing the national reporting matrix. Closer links have been made with the flow centre and the C3 WAST stack work, supporting patients awaiting ambulances within the community, with the ABUHB pilot starting in April 2022.
Quarter 1:	
Milestones	• Development of UPCC in NHH to provide mobile support to practices in escalation, WAST stack and frailty model. • Review and dissemination of process for GMS practices in escalation to provide equitable support for urgent primary care services, for practices with highest need. • Support of benchmarking and shared learning of national models
Actions	• Staff consultations to support change of remit within role. • UPC management presentations and presentations at health board wide practice manager forums, in order to promote support available from urgent primary care service. • Shared learning with Cardiff and Vale in enhancing GMS support within AB and health board model within Cardiff and Vale.
Quarter 2:	
Milestones	• Linkage with frailty hot clinics within Blaenau Gwent as pilot, holistic support to maintain supporting people to remain at home.

	• Development of pathways into MSK transformation programme, to support high level MSK conditions • Continue to support DHCW in development of national performance matrix
Actions	• Availability of clinic area alongside frailty hot clinics in Ysbyty Aneurin Bevan (YAB) • Attendance at national forums to participate in informing developments of performance matrix
Quarter 3:	
Milestones	• Demand and capacity review of model to ensure appropriate resourcing of pathways on a 24/7 basis • Roll out of patient satisfaction survey
Actions	• Undertake demand and capacity review of urgent primary care 24/7
Quarter4:	
Milestones	• Evaluation of matured model • Continue to monitor progress of model against national performance measures.
Actions	• Evaluation of matured model • Continuous data monitoring
Risks	• Recruitment and retention of GPs • Recruitment and retention of wider MDT • Funding to support the contact first workstream within the pathway
Outcomes	• Reduced UPC presentations at ED/MIUs • Support for sustainability of GMS services • 24/7 support for the 111 model for appropriate patients with an urgent primary care need • Signposting of patients through the contact first pathway to ensure patients are seen in the right place first time.
Alignment with workforce plans	• Linked with urgent primary care 24/7 workforce plan • Development of wider MDT working as discussed in national peer review
Alignment with Financial plans	• Forecast of Urgent Primary Care spend for 23/24 spend is within WG Six goals allocation

Aneurin Bevan University Health Board

General Medical Services Branch Surgery Closure Policy

1.0 DEFINITION OF A BRANCH SURGERY

A subsidiary practice utilising the resources and staff of the parent practice. Usually attended only at specified, limited hours, with the opportunity for a patient to go to the parent practice in an emergency.

2.0 BACKGROUND

This document sets out a draft process for the management of branch surgery closure applications.

A branch surgery can be closed subject to agreement between the Health Board and the providing practice. Whilst there is limited guidance in this regard, the Primary Care Contract Quality Standards relating to "branch / split – site surgeries" (paragraphs 4.53 – 4.59) outlines a process under paragraph 4.56;

"A branch surgery can be closed subject to agreement between the PCO and providing practice. In the event there is no agreement the practice can give notice that it wishes to close its branch surgery. There will be a given period in which the PCO can issue a counter- notice, to allow for any required consultation, requiring the surgery to remain open until the issue is resolved. Normal appeal procedures will apply, or where both the practice and PCO agree that the surgery should remain open, then the PCO is required to continue supporting it with the necessary funding."

The PCO in this instance will be the Health Board.

The Health Board is required to put arrangements in place to consider branch surgery applications. This document describes a process and links to formal NHS appeals mechanism.

All arrangements for considering branch surgery closure applications will be managed by the Primary Care and Community Division.

The Health Board is aware that Aneurin Bevan Community Health Council, as a statutory organisation, could consider a Branch Surgery Closure to be a significant loss of service to the patients accessing services in this venue. The views of the Community Health Council will be presented to the Board independently as part of the decision making process.

3.0 PROCESS FOR CONSIDERING BRANCH SURGERY CLOSURE APPLICATIONS

The rationale for developing this process is to ensure that all interested parties work collaboratively to ensure that the delivery of patient care is paramount in all considerations.

All arrangements for considering branch surgery closure applications will be managed by the Primary Care and Community Division

3.1 A Branch Practice review Panel will be established by the Primary Care and Community Division. This group will be responsible for the decision process, the end result of which will be a recommendation to proceed with the appropriate option for the branch practice.

Proposed membership of the Branch Practice review Panel is:

- ABUHB Divisional Director Primary Care & Networks / General Manager
- ABUHB Deputy Medical Director (General Practice) / Primary Care Clinical Director
- ABUHB Head of Primary Care / Deputy Head of Primary Care
- Senior Primary Care Manager
- Neighbourhood Care Network Lead / Head of Service
- Local Medical Committee (LMC) representative (voting rights)
- Aneurin Bevan Community Health Council (ABCHC) representative (Non-voting)
- Other Primary Care colleagues involved in the process
- Additional representatives may be invited as per local agreement and decision.

4.0 NOTIFICATION AND MANAGEMENT OF REQUEST TO CLOSE BRANCH PRACTICE

The practice formally writes to the Health Board with their request to close a branch surgery, detailing:

- Reasons for the proposed closure request including an up to date sustainability report (the income streams information is not required for the purposes of this process)
- Detail on any estate issues
- Opening times and surgery times of the branch and main surgeries
- Current access rates
- The list size of the practice
- Number of patients accessing the surgery services in the last three years, broken down by month
- Number of patients that have accessed services at the branch site alone in the last three years, broken down by month. Where the Practice is unable to identify patients who use the Branch Surgery,

then all patients registered with the practice will need to be consulted with

- Services that are currently being provided from the branch surgery
- Impact the closure will have on patients and services at the main site
- Proposals for how the information will be communicated to patients if the closure application is approved
- Details of the timing of the closure if approved, i.e. a phased closure.
- Details of any engagement already undertaken with key stakeholders including NCNs and neighbouring practices
- Impact on patients including consideration to vulnerable groups.

The Primary Care Team will:

1. Acknowledge the request for closure in writing within 5 working days of receipt and inform Aneurin Bevan Community Health Council and the Local Medical Committee that this has been received, asking for their views on the application.

   The Primary Care Team, in conjunction with the Practice will also identify the following:
   - Premises infrastructure concerns, i.e. costs to meet DDA compliance, statutory regulations compliance
   - Any other purpose for which the branch surgery is used
   - Details of the nearest GP practices and pharmacies. This should be presented on a map
   - Any proposed changes to services at the main practice
   - Details of public transport links from the branch site to the main practice site
   - Conduct and review the outcomes of an Equality Impact Assessment
   - Practice patient distribution map plus boundary maps of neighbouring practices.

2. Escalate the notification internally and establish the timeline for decision making, Branch Surgery Closure process and implementation of the outcome.

3. Issue confidential communication notice to WG, LMC and ABCHC.

4. Inform in confidence, AM/MPs and local councillors, issue patient letters and questionnaires, advising of consultation process.

5. The Primary Care Team will co-ordinate and agree the consultation process with Aneurin Bevan Community Health Council, identifying key stakeholders which may include:

- NCN Leads
- Local Medical Committee
- Aneurin Bevan Community Health Council
- Community Pharmacists in the area
- Other relevant Community Health Councils (outside the Health Board area)
- Other practices in the area which may be impacted upon from the closure
- Local politicians
- Patient Participation Group representation

A patient consultation process will take place, in conjunction with engagement with Local Politicians, using an approved questionnaire and other relevant forms, which will also be available in Welsh. All patients accessing the Branch Surgery will be consulted with. If the practice is unable to identify those patients, then the total practice population will be subject to the patient consultation.

Local drop in sessions for patient consultation may be considered by the Primary Care Team and advertised within the practice, details will also be included on the patient letters.

Consultation should last a minimum of four weeks (extended if this coincides with holiday periods) or the Community Health Council deems a longer period necessary. This will be agreed with the Community Health Council.

The Health Board and practices may choose to progress further patient consultation in addition to the questionnaire, for example attendance at patient forum and/or community group.

The Primary Care Team will progress an Equality Impact Assessment.

The Health Board will inform neighbouring Local Health Boards, of the request, that may be affected by the closure.

Once the consultation is completed the Primary Care Team will collate and review the responses to the questionnaire. A further review will be conducted on the additional information provided by the practice and Primary Care Team.

6. Arrange a Branch Practice Review Panel meeting. A Panel will be convened to consider the application from the Practice, the outcome of the patient consultation, views of Aneurin Bevan Community Health Council and Local Medical Committee, and the Equality Impact Assessment, to make a decision. The Primary Care Team will prepare the information packs and issue these seven days before the panel meeting will take place. The Practice will be offered the opportunity to present their case in the form of a 15 minute presentation during the

course of the meeting so that the panel are briefed and able to ask questions.

7. The Panel will consider the request from the Practice, the outcome of the patient consultation, views of Aneurin Bevan Community Health Council, Local Medical Committee and other interested parties and the recommendation from the Branch Practice Review Panel.

8. Representatives from Aneurin Bevan Community Health Council and Gwent Local Medical Committee (voting rights) will be in attendance to observe the process, ABCHC will not have voting rights.

9. If there is a change to service there will be a requirement that following the approval of the recommendation by the Executive Team, this decision is then considered by the Aneurin Bevan Community Health Council Executive Committee. The timeframe for this will be discussed and agreed accordingly.

10. The decision of the Board or Committee will be notified to all listed stakeholders which will include the practice and interested parties and patients.

    Where the closure application is approved, a clear communication plan will be agreed to ensure all registered patients are informed of the closure and how they will access services from the Practice.

    Practices should ensure a minimum of 3 months' notice following the Board approval to close, unless agreed otherwise with the Health Board.

    Where the closure application is approved it is the responsibility of the practice to meet all associated costs with closing the surgery including redundancy and practice information costs.

    Where an Improvement Grant has been provided to upgrade the premises which are being closed, the Health Board will assess whether this warrants a recovery, advise practice of same and implement a recovery plan.

    Where the closure application is not supported by the Board or Committee, the Primary Care Team will discuss with the Practice the sustainability implications of this decision.

11. Further correspondence to be issued to all stakeholders following the Branch practice review panel including the outcome of the patient consultation.

Each Branch practice review will need to be considered on its individual merits and the local context:

- Health Board Strategic Plan: this will be based on proactive planning from the cluster and sustainability framework
- Local population health needs including distance from other services, demography, local provider assets and other commissioned contractor services.

5.0 APPEALS

Any appeal against the decision of the Board in relation to Branch Surgery Closure applications will be resolved through the contractual appeals process "Contract Dispute Resolution – Part 7 of Schedule 6 to the National Health Service (General Medical Services Contracts) (Wales) Regulations 2004("The Regulations").

The decision of the appeal will be made in consultation with the Community Health Council and the Executive Board.

The decision of the Board or Committee will be notified to all listed stakeholders which will include the practice and interested parties and patients.

OBJECTION FROM ANEURIN BEVAN COMMUNITY HEALTH COUNCIL

The Community Health Council has a right to undertake an independent consultation, should they not consider the Health Board's consultation to be a robust process.

If the Community Health Council objects to the Health Board's decision they have a right of appeal to the Minister for Health and Social Services (as per the Welsh Government Guidance for Engagement and consultation on changes to Health Services).

QUORACY

Review Panel will be quorate when the following are in attendance:
1 Clinical Representative
1 Head/Deputy Head of Primary Care/Senior Primary Care Manager
1 Divisional Director/General Manager
1 Independent Representative LMC/ABCHC

Annex1

PROCESS FOR CONSIDERATION OF BRANCH SURGERY CLOSURE APPLICATION

The practice formally writes to the Health Board with their request to close a branch surgery and provides additional information on access, opening times, impact on patients etc.

↓

The Primary Care Team will:

- Acknowledge the application **within 5** working days.
- Progress further information in conjunction with the practice.
- Inform the Local Medical Committee, Community Health Council and neighbouring Local Health Boards (if required).
- The Health Board will establish a Branch Practice Review Group.

↓

The Primary Care Team will co-ordinate the engagement process. Key stakeholders to include; Patients, Local Medical Committee, Community Health Council, Local Community Groups, Local politicians and Patient Participation Group representation.

↓

The Primary Care Team will implement the engagement process to include Patient Questionnaire and other forms of engagement as required - **Minimum of 4 weeks.**

↓

The Primary Care Team will conduct a Equality Impact Assessment to support the process.

The Primary Care Team will collate and review the responses to the questionnaire.

- The Branch Practice Review Panel will convene to review the application and information provided from patient consultations, Sustainability framework application, Equality Impact Assessment, LMC and CHC views.
- The panel will decide whether or not to support the closure application and make a recommendation for consideration by the Board. The practice will be offered the opportunity to present their case in the form of a 15 minute presentation at the beginning of the meeting.
- Each member of the panel will receive an information pack **7 days** before the date of the panel.

Recommendation from the Branch Surgery Review Panel, with the views of the LMC and Community Health Council(s) will be presented to the Board, who will make the final decision.

The decision of the Board will be notified to the Practice, Patients, Community Health Council(s), Local Medical Committee and neighbouring practices within **1 week.**

Appeal Process if required.

Annex 2

1 Reasons for the proposed closure, including an update on the practice's sustainability status plus any issues relating to your primary care estate i.e. costs to meet DDA compliance, statutory regulations compliance.

2 What are the current opening times of your main surgery and your branch surgery?

3 Practice current list size.

4 Number of patients accessing the **main** surgery services over the last three years, broken down by month.

Services	Year 1	Year 2	Year 3

5 Number of patients that have accessed services at the **branch** site alone in the last three years, broken down by month (if unable to identify these specific patients then all patients will need to be consulted with).

Services	Year 1	Year 2	Year 3

6 Detail on services currently being provided from the branch surgery including a timetable of clinics/services. Please also any other purpose for which the branch surgery is used.

7 What impact will the closure have on patients including vulnerable groups and how it will affect services at the main site?

8 Detail on how this proposal will be communicated to patients if application to close is approved by the Health Board.

9 Detail of any engagement already undertaken with cluster networks and neighbouring practices.

10 Detail of the timing of the closure i.e. will this be a phased closure?

11 Any other relevant information.

Annex 3

Time Frames

Detail of workflow	**Days**	**Timescale**	
Acknowledgement of formal request received from practice including further information if required.	**5 days**	**Within 5 working days**	**Within 5 working days**
Consultation with stakeholders	**4 or 8 weeks**	**By week 5**	**By Week 9**
PC Team to collate and review responses and complete EIA	**5 days**	**By week 11**	**By Week 15**
Panel meeting - documents issued prior to panel	**5 days**	**By week 12**	**By Week 16**
Panel meeting	**1 day**	**By week 13**	**By Week 17**
Inform stakeholders/IP's of recommendation		**By week 13/14**	**By Week 17/18**
Paper to be prepared for Executive Board	**1 day (following Monday after panel)**	**By week 14**	**By Week 18**
Paper to be presented to Executive Board	**1 day**	**By week 14/15**	**By Week 17/18**
Practice and all IPs notified of decision	**1 day (within 5 days of Exec decision)**	**By week 14/15/16**	**By Week 17/18/19**
Patients notified	**1 day**	**By week 14/15/16**	**By Week 17/18/19**

Annex 3

Revised Sustainability Framework Risk Matrix (including guidance notes)

The framework involves applying a Red/Amber/Green (RAG) weighted score against the risk matrix criteria. The following weighting has been applied:

- High/Red -10
- Medium/Amber – 5
- Low/Green - 1

The outcome of the risk assessment matrix score has been set as follows:

- High risk of unsustainability > or = 80
- Medium risk of unsustainability >55 -79
- Low risk of unsustainability <55

Practice:

Area	Indicator	Ranking	Ranking	
Demographics: STAGE 1	Open/closed list	Open	Low	
		Application submitted (formal/informal)	Medium	
		Closed	High	
	Welsh index of multiple deprivation (WIMD % of patients living in the two most deprived fifths)	<10%	Low	
		10 -20%	Medium	
		>20%	High	
	Practice population age spread %	<30% over 65	Low	
		30% - 50% over 65	Medium	
		>50% over 65	High	
Premises: STAGE 1	Number of sites/branch surgeries (to include both open and temporarily closed branch surgeries)	1 site	Low	
		>1 site	Medium	
		>3 sites	High	
	Condition of premises; (practices with more than 1 site will be ranked against a judgement of the total estate condition)	adequate/new or approved funding	Low	
		Poor, but working towards improving	Medium	
		Poor quality	High	
	Capacity of premises	Adequate for current needs only	Low	
		Inadequate to accommodate	High	

		current service needs		
Workforce – General Practitioner: STAGE 1	Partnership/singlehanded	Partnership	Low	
		Singlehanded	High	
	Patients 000's per WTE GP (WTE assumed as 8 sessions)	<2000 patients	Low	
		>2000 patients	Medium	
		>2500	High	
	Age profile (individual GP ages will be used to give an overall rank for age profile. To include all substantive GPs including principles and salaried posts.)	<50 years	Low	
		50-55 years	Medium	
		>55 years	High	
	Current vacancies Linked to % of WTE	<10%	Low	
		10 – 20%	Medium	
		>20%	High	
	Length of vacancies	< 6 months	Low	
		6 months	Medium	
		>6 months	High	
	Reliance on locums (sessions per average week)	<3 sessions	Low	
		3-5 sessions	Medium	
		>5 sessions	High	
Workforce General: STAGE 1	Patient 000's per WTE senior clinician (GP, Advanced Practitioner, Pharmacist etc.)	<2000	Low	
		>2000	Medium	
		>2500	High	
	No of unfilled clinical sessions per week	0	Low	
		<3	Medium	
		>3	High	
Income Streams: STAGE 1	Income loss arising after MPIG redistribution (as a % of GSE)	<10%	Low	
		10%-15%	Medium	
		>15%	High	
Access to Services: STAGE 1	Opening hours (per site) - recent changes (Relating to a reduction in hours only)	No	Low	
		Yes	High	
	Total			

High Risk	>70
Medium Risk	50-70
Low Risk	<50

Aneurin Bevan University Health Board

General Medical Services Vacant Practice Policy

Issue 3 – January 2020
Approved by Access Group
Review Date - tbc

GENERAL STATEMENT OF POLICY

Welsh Health Circular (2006) 063 General Medical Services Practice Vacancies – A Guide to Good Practice, provides advice to Local Health Boards (LHBs) on the recruitment of General Practitioners and reminds Local Health Boards of the steps they should follow when considering the future of vacant practices. The overriding concern is to ensure that primary medical services are delivered to a consistently high standard across the whole of Wales.

The WHC (2006) 063 details the process to be followed. This suggests a Vacant Practice Panel is developed to manage the process. The guidance relating to membership of this panel suggests that as many stakeholders as possible are involved, whilst recognising that it is for the Health Board to determine this. The recommendation from the panel will need to be agreed by the Board.

1.0 PROPOSED PROCESS FOR TAKING DECISIONS ON VACANT PRACTICES

A Vacant Practice Panel will be established by the Primary Care & Community Services Division. This group will be responsible for the decision process, the end result of which will be a recommendation to proceed with the appropriate option for the future vacant practice. The group will, upon notification of a confirmed or potential practice vacancy, be responsible for preparing a generic specification collating the necessary information to recommend to the Executive Team the appropriate stage to commence the recruitment process.

Proposed membership of the Vacant Practice Panel is:

- ABUHB Divisional Director Primary Care & Networks/ General Manager
- ABUHB Deputy Medical Director (General Practice) / Primary Care Clinical Director
- ABUHB Head of Primary Care/Deputy Head of Primary Care
- Senior Primary Care Manager
- LMC representative
- CHC representative
- Additional representatives may be invited as per local agreement and decision

1.2 TIMEFRAMES

Timeframe for replacement of services: this may impact on the decision making and initial outcome:

1.2.1 Contractual notice from a Partnership contract – a minimum of 6 months' notice must be given unless a shorter period is mutually agreed locally.

1.2.2 Contractual notice from a Single Handed Practitioner – a minimum of 3 months' notice must be given unless a shorter period is mutually agreed locally.

1.2.3 Immediate or significantly shorter notice period may be inevitable where a Single Handed Practitioner has died or become seriously unwell, where there is a serious breach of contract or the Partnership has dissolved.

2.0 NOTIFICATION OF CONTRACT RESIGNATION

On receipt of a contact resignation from a GMS Contractor, the Primary Care Contracting (PCC) Team will:

1. Acknowledge receipt of the resignation from the Contractor. Meet with the contractor to clarify their expectations, responsibility for closing down the contract and to outline their future plans and options under the Vacant Practice process

2. Escalate the notification internally and establish the timeline for decision making, Vacant Practice process and implementation of the outcome

3. Issue confidential communication notice to WG, LMC and ABUHB CHC.

4. Arrange a meeting with practice staff to advise of the process

5. Inform AM/MPs and local councillors

6. Notify Shared Services Partnership and NWIS

7. Issue patient letters (if required at this stage)

8. Arrange a meeting with the NCN/neighbouring practices (optional). This may be required to discuss the options, consider the impact and assess sustainability across the NCN to inform decision making process. Discussions may take place regarding the "preferred option" however, this will not determine the final decision until the the Vacant Practice Panel provides a recommendation to the Executive Team, which is subsequently approved

9. Arrange a Vacant Practice Panel meeting. Decision making needs to be informed and timely, it is expected that the timeline between Contractual Notice being served and a ratified decision being made would be no more than 6 weeks. Where an immediate or shorter notice period (1.2.3) is enacted, a rapid decision making process will be required that should take no more than 2 weeks.

   There will be a requirement that following the approval of the recommendation by the Executive Team, this decision is then considered by the Aneurin Bevan Community Health Council Executive Committee. The timeframe for this will be discussed and agreed accordingly.

10. Further correspondence to be issued to all stakeholders following Vacant Practice Panel including patient engagement.

Each Vacant Practice will need to be considered on its individual merits and the local context:

- LHB Strategic Plan: this will be based on proactive planning from the cluster and sustainability framework.

- Local population health needs including distance from other services, demography, local provider assets and other commissioned contractor services

The PCC Team will prepare the generic specification which will reflect and be influenced by the following key issues:

- Strategic Context of the LHB and the NCN/Cluster
- Practice list size
- Workforce model required to deliver the services and available local assets
- Sustainability within the LHB and Cluster, where the Vacant Practice is on a Cluster or LHB border, the neighbouring LHBs and Clusters should be consulted
- Demography of the registered practice population
- Number and location of neighbouring practices and sustainability of these
- Geography of the Practice area including where patients are registered, the practice boundaries and access to transport, location of neighbouring practices
- Financial impact of each option including an assessment of value for money
- Practice income/future viability
- The number and range of services provided
- Clinical governance and quality issues
- Premises – ownership/potential lease arrangements

An assessment of any shortfalls which may need to be addressed before the final outcome.

Feedback received from neighbouring contractors, services and key stakeholders

Recommendation and justification which of the six options outlined in section 3 below is preferred.

Proposed implementation plan including timeline of the recommended option.

Consider management arrangements/action plan for the next steps for the process.

3.0 VACANT PRACTICE PANEL

When a Practice becomes vacant, the Health Board will want to determine the most appropriate, sustainable option for the delivery of services to the registered population.

At the Vacant Practice Panel meeting, the options for the future of the practice where a vacancy is declared are discussed and a recommendation reached. The options are listed below (options 1-6 do not have to be considered in sequencial order, and/or each one implemented before considering the next option. Option 1,2 and 3 maybe considered together):

Option 1: Aim to fill vacancy through local interest under a GMS Contract, (the practice could be passed completely over to another practice in the borough under GMS Contract arrangements (through inviting local expressions of interest)).

Option 2: Aim to fill vacancy through national interest under a GMS Contract, (the whole practice would be advertised nationally as a vacancy under current GMS Contract arrangements).

Option 3: Managed list dispersal with existing neighbouring practices (through inviting local expressions of interest). Practices to consider taking on a proportion of the list.

Option 4: If vacancy not filled, the LHB take on the management and delivery of GMS services, in accordance with GMS Regulations.

Option 5: Dispersal of practice list (the LHB decide to disperse the practice list).

Option 6: Fill the vacancy through interest from existing/remaining partners (where clauses 525-529 of the GMS contract do not apply (existing partners agree to the transfer of the existing contract to one or more of the existing partners following dissolution)) aim to fill the vacancy through interest from existing partners.

The Health Board will be required to undertake a procurement exercise in relation to options 1-3. This process is detailed in Appendix 1. Practices may be required to attend for interview at a later stage.

** Options 1, 2, 4 and 6 maybe subject to Policy for the Reassignment of Patients whose Address is outside the Catchment Area of their Registered GP & Application Process.

4.0 RECOMMENDATION

The Vacant Practice Panel prepares a recommendation on preferred option(s) to commence recruitment process for the Health Board Executive Team to consider.

Should the decision be made to advertise the practice (may apply to options 1, 2 and 3), a Vacant Practice Interview Panel would convene to undertake this task.

The Interview Panel will consider and interview candidates (options 1, 2 and 3).

The interview panel will make a recommendation to the Executive Team to appoint to the vacant practice or to progress to another stage of the agreed process.

This recommendation if supported by the Executive Team will be reported to the Board.

The Vacant Practice Panel Interview Panel to consist of:

- Independent Board Member (optional)
- Divisional Director Primary Care & Networks/General Manager (Chair)
- Deputy Medical Director General Practice / Primary Care Clinical Director
- ABUHB Head of Primary Care/Deputy Head of Primary Care
- Senior Primary Care Manager
- Business Partner Accountant
- LMC representative
- CHC representative
- Neighbourhood Care Network Lead
- Head of Service
- Additional representatives may be invited as per local agreement and decision

Appendix 2 provides details for the complete timeline for the process outlined above.

5.0 ENGAGEMENT

The Health Board should develop a clear and comprehensive communication plan whenever a change of contract is implemented and this should provide for open and ongoing sharing of information and management of feedback. This should include communication with the following stakeholders:

- Current Contract Provider
- Neighbouring Practices
- Registered patients of the practice
- Local community groups
- Local Politicians/Councillors
- Community Health Council
- Local Medical Committee
- Local NCN service providers
- NCN Lead/Head of Service
- Health Board departments where there may be a service impact e.g. communications, patient support, medical records etc.
- Welsh Government Primary Care leads

5.1 Communication should clearly articulate the change, the expected impact and the timeline for change.

5.2 Patients should have access to advice where they have concerns or queries, the mechanism for accessing this should be clearly shared. Local “drop in” sessions at the practice may be required in order to inform patients of the process/outcome.

5.3 LHBs should consider using letters, posters, leaflets, newsletters, social and print media for the dissemination of information.

5.4 Where public meetings are arranged, they should be scheduled to provide information, where this is not possible due to shortened timescale for change alternative mechanisms should be considered such as identifying local champions and groups to share information.

Quoracy

VPP group will be quorate when the following are in attendance:
1 Clinical Representative
1 Head of Primary Care/Senior Primary Care Manager
1 Divisional Director/General Manager
1 Independent Rep LMC/ABCHC

Appendix 1

PROCUREMENT PROCESS

FIRST STAGE EXPRESSION OF INTEREST (OPTIONAL)*

An advert is circulated to GP Practices (locally/nationally) in the Health Board area and advertised in the BMJ (nationally). The advert invites a simple expression of interest by a certain date.

Where an expression of interest is received and considered by the Health Board to be above the line (considered by the Deputy Medical Director, Head of Primary Care and other senior managers), the interested applicant is invited to proceed to the second stage.

**There may be circumstances when it is appropriate to omit Stage 1 Expressions of Interest and proceed directly to Stage 2 Submission of Full Business Case. There are occasions when it is a useful part of the process in that it informs with regard to knowing how many bids to expect and it provides a summary that shows the potential provider is interested in and capable of delivering the service.*

THE PROCESS – SECOND STAGE FULL BUSINESS CASE

Successful applicants are requested to produce a full business case detailing the proposal. In order to assist applicants, they are provided with an information pack enclosing all relevant up to date information about the practice, a template for the business case (Annex 1, optional to use) and the scoring criteria used when evaluating the submissions (Annex 2). A deadline is provided to all applicants for the receipt of the completed business case, and provisional details of the interview panel.

Applicants are expected to prepare a 15 minute presentation, followed by a question and answer session related to their submission and presentation. After which the panel evaluate and allocate scores for each of the headings identified in the scoring template.

The decision of the panel is then presented to the Executive Team.

Annex 1

BUSINESS CASE TEMPLATE

FOR APPLICATIONS TO PROVIDE A PERMANENT GMS CONTRACT FOR XXX PATIENTS REGISTERED WITH XXX MEDICAL PRACTICE

Business Case proposals are sought for delivery of services for the whole/part registered list of xxx Medical Practice.

Name of applicant(s)			
Contact Address			
Contact Telephone			
Contact Email			

Signature			

Date of Submission of Business Case	

Please answer ALL questions fully but concisely, please refer to Annex 2, Scoring Template at the end of the document to identify how responses will be scored. (space will expand)

Please return completed templates to XXXXXX by (enter date)

SECTION 1: Workforce (15 points)		**Score** *(LHB use)*
1.1	Please provide a summary of the partnership that is making this application, to include the main qualifications and accreditations.	

1.2	Please provide the details of the partnership and whether there is an existing written and signed partnership agreement. Where there is no existing partnership please state this and advise of the timeframe of establishment. Please enclose the decision making structure to be put in place (or already in place) so that decisions can be made with ease.	
1.3	Please provide a summary of the clinical team, including number of clinical sessions per week that will deliver care to patients including any special interests or enhanced skills. Please include all GPs, qualified nurses or other qualified and registered clinical staff involved in direct patient care.	
1.4	Please provide a summary of the administrative team that will deliver services to the patients to include an organisational structure for the merged practice.	
1.5	Please provide a summary of the systems and processes you will put in place to manage the transition of appropriate staff needed to deliver the contract (to include your management of duplication of roles, inconsistencies in duties, differences in salaries etc.)	

SECTION 2: Premises (15 points)		**Score** ***(LHB use)***
2.1	Please provide a summary of the premises you will use to provide services for the XXX number of patients currently registered at XXX Medical Practice (including information on your long term strategy for use of the premises).	
2.2	Please identify any changes or amendments to the premises or equipment that will be needed to deliver the contract for the XXX number of patients currently registered at XXX Medical Practice.	

SECTION 3: IM&T (5 points)		**Score** ***(LHB use)***
3.1	Please provide a summary of the clinical and telephone system you will use to deliver services to the XXX number of patients currently registered at XXX Medical Practice.	
3.2	Please identify any changes or amendments to the hardware or software needed to deliver the contract for the XXX number of patients currently registered at XXX Medical Practice (consideration needs to be given to the type of system each practice uses, contracts in place, age of the systems and data protection issues).	

SECTION 4: Service Model (30 points)		**Score** *(LHB use)*
4.1	Please describe your proposed model for delivering services for patients between 8am and 6.30pm Monday to Friday. This should include the: • number of sessions per week • the timing of appointments throughout the working day • method for ensuring that the proposed model meets reasonable patient need.	
4.2	Please describe what changes would need to be made to the enhanced services currently offered, this may include stopping, reducing or increasing services offered based on the skills and competencies of available clinicians.	
4.3	Please describe what clinical governance processes you will put in place to minimise any risk of harm to patients during transition periods at the start of the contract.	
4.4	Please describe what processes and systems you will put in place to reassure the registered patients about the changes and respond to any concerns raised (to include ways in which you intend to communicate any proposed merger to your patients).	

SECTION 5: Financial Model (10 points)		**Score** *(LHB use)*
5.1	Please provide a summary of your financial model for delivering the contract, identifying any additional financial support you might require (taking into consideration the financial position of the managed practice).	

SECTION 6: Timetable (0 points)		**Not Scored** *(LHB use)*
6.1	Please provide an overview of the timetable in which you feel that you could reasonably take up the contract, including any interim actions that will need to be resolved.	

SECTION 7: Continuity (5 points)	**Score** *(LHB use)*

7.1	Please identify actions and processes to be put into place to ensure the safe delivery of services to the registered patients and to support the handover of care.	
7.2	Please outline contingency plans that you will put in place to mitigate any other risks identified as part of taking on this new GMS contract.	

SECTION 8: Any other information (0 points)		**Not Scored** ***(LHB use)***
8.1	Please give any other supporting information that you feel is relevant and needs to be taken into consideration as part of the decision making process.	

Annex 2

Weighting For Short-listing of Tenders

Scoring Template

Each question indicates whether it is specifically scored, those with a zero score are for the purpose of clarifying or assurance information.

Where a question is scored it is weighted according to its relative value. Each scored question has specific criteria that qualifies it for a **ZERO**, **LOW** or **HIGH** score. The range within that level will be determined as outlined below:

	Max Score = 5	*Max Score = 10*	*Max score = 15*
Meets specific **HIGH** criteria **AND** Exceeds Expectations – excellent response over and above requirements	5	10	15
Meets specific **HIGH** criteria **AND** Complies - Fully meets requirement and response gives thorough and comprehensive detail	4	7	10
Meets specific **LOW** criteria **AND** Complies - Fully meets requirement and response gives thorough and comprehensive detail	3	5	7
Meets specific **LOW** criteria **AND** Partially Complies – Broad outline provided relevant to the question asked with some ambiguity around details and at least one piece of information missing	2	3	5
Meets specific **LOW** criteria **OR** Very Poor Response – little evidence	1	2	3
Meets specific **ZERO** criteria **OR** Does Not Comply - No evidence	0	0	0

Specific Criteria: the criteria outlined below are intended to provide very clear, specific and objective measures to help guide the panel in their scoring of proposals.

Specific Criteria	Maximum Score	Zero Score	Low Score	High Score
1.1 Please provide a summary of the partnership that is making this application, this needs to include the main qualification and accreditations.				
1.2 Please provide the details of the partnership and whether there is an existing written and signed partnership agreement. Where there is no existing partnership please state this and advise of the timeframe of establishment. Please enclose the decision making structure to be put in place so that decisions can be made with ease.				
1.3 Please provide a summary of the clinical team, including number of clinical sessions per week that will deliver care to patients including any special interests or enhanced skills.	10	1 clinical session per week for more than 225 patients	1 clinical session per week for 200-225 patients	1 clinical session per week for between 175-200 patients
1.4 Please provide a summary of the administrative team that will deliver services to the patients (include an organisational structure for the merged practice).	5	Less than 5 WTE admin staff or no clear plan or staff in place	5 – 7.9 WTE admin staff	More than 8 WTE admin staff
1.5 Please provide a summary of the systems and processes you will put in place to manage the transition of appropriate staff needed to deliver the contract (to include your management of duplication of roles, inconsistencies in duties, differences in salaries etc.)				
2.1 Please provide a summary of the premises you will use to provide services for the XXX patients currently registered at XXX (including information on your long term strategy for use of the premises).	10	3 or less clinical rooms	Minimum 4 clinical rooms to deliver services AND Meets premises minimum standards	Minimum 5 clinical rooms to deliver services AND Meets premises minimum standards
2.2 Please identify any changes or amendments to the premises or equipment that will be needed to deliver the contract for the XXX patients currently registered at XXX.	5	Requires investment from LHB OR Requires no investment from LHB but delay of 4 weeks or more in rooms being available	Requires no additional investment from LHB although may incur investment from contract holder. Premises available within 4 weeks	Requires no additional investment and premises available immediately

Specific Criteria	Maximum Score	Zero Score	Low Score	High Score
3.1 Please provide a summary of the clinical and telephone system you will use to deliver services to the xxx patients currently registered.				
3.2 Please identify any changes or amendments to the hardware or software needed to deliver the contract for the XXX patients currently registered at XXX (consideration needs to be given to the type of system each practice uses, contracts in place, age of the system and data protection issues).	5	Requires investment from LHB OR Requires no investment from LHB but delay of 4 weeks or more in clinical system being available	Requires no additional investment from LHB although may incur investment from contract holder. Clinical system available within 4 weeks	Requires no additional investment and clinical system available immediately
4.1 Please describe your proposed model for delivering services for patients between 8am and 6.30pm Monday to Friday. This should include the: • number of sessions per week • the timing of appointments throughout the working day • method for ensuring that the proposed model meets reasonable patient need.	15	Does not fully meet access standards and HB expectations	Partially meets the access standards, fully meets HB expectations (5A principles) and positive principles for good access	Fully meets the access standards, fully meets HB expectations (5A principles) and positive principles for good access
4.2 Please describe what changes would need to be made to the enhanced services currently offered, this may include stopping, reducing or increasing services offered based on the skills and competencies of available clinicians.	5	2 or more enhanced services to be stopped with no plans for reintroducing services or sharing work with other practices in the area	No more than 2 enhanced services to be temporarily stopped OR Plans in place for sharing work with other practices in the area	All current enhanced services to be maintained
4.3 Please describe what clinical governance processes you will put in place to minimise any risk of harm to patients during transition periods at the start of the contract.	5	No clear or robust plans, limited/no mitigating actions	Reasonable plans in place OR Identified mitigating actions	Robust plans in place with identified mitigation actions

Specific Criteria	Maximum Score	Zero Score	Low Score	High Score
4.4 Please describe what processes and systems you will put in place to reassure the registered patients about the changes and respond to any concerns raised (to include ways in which you intend to communicate any proposed merger to patients).	5	No/limited communication plan	Reasonable communication plan for patients only	Robust communication plan in place for patients and key stakeholders and interested parties
5.1 Please provide summary of your financial model for delivering the contract, identifying any additional financial support you might require to assist you (taking into consideration the financial position of the managed practice).	10	No clear plan in place	Plan in place but limited in clarity, sustainability	Clear and sustainable financial plan that operates within the existing GMS financial envelope
6.1 Please provide an overview of the timetable in which you feel that you could reasonably take up the contract, including any interim actions that will need to be resolved.				
7.1 Please identify actions and processes to be put into place to ensure the safe delivery of services to the registered patients and to support the handover of care.				
7.2 Please outline contingency plans that you will put in place to mitigate any other risks identified as part of taking on this new GMS contract.	5	Limited / no risk assessment or action plan	Some indication of risk assessment with no clear or accountable plan	Clear risk assessment undertake, with mitigating actions, named individuals and a clear accountability structure
8.1 Please give any other supporting information that you feel is relevant and needs to be taken into consideration as part of the decision making process.				

Appendix 2

TIMETABLE – VACANT PRACTICE

Action	Timescale including EOI Partnership	Timescale including EOI Partnership
Initial Notification: • Contractor acknowledgment • Executive Team • LMC, CHC and WG • NWSSP in confidence • NWIS in confidence • PPV in confidence	Week 1 Within 3 days Within 3 days Within 3 days Within 3-7 days Within 3-7 days Within 3-7 days	Week 1 Within 3 days Within 3 days Within 3 days Within 3-7 days Within 3-7 days Within 3-7 days
Meet with partners and meeting with practice staff	By week 3	By week 2/3
Inform: AM/MPS, local councillors in confidence	By week 3	By week 2/3
Issue 1st patient letter (if required)	By week 3	By week 2/3
Arrange meeting with local GP practices, if required	By week 3	By week 2/3
Arrange Vacant Practice Panel	By week 3/4	By week 2/3
Executive Team to consider recommendation	By week 4	By week 3/4
Issue further correspondence to all relevant stakeholders, if needed	By week 4/5	By week 4
Advertisement of Vacant/Managed practices (1st Stage – requesting expression of interest optional)	By week 5	By week 4/5
Patient engagement, if needed	By week 5	By week 5
Closing date expression of advert	By week 11	By week 7

Consider expression of interests received	By week 12	By week 7/8
Additional information to be provided to those applicants submitting a full business case	By week 12	By week 8
Full Business Case to be submitted	By week 14	By week 9
Interview Panel	By week 16	By week 10
Contract Award (subject to Board ratification)	By week 22	By week 10/11
Issue correspondence to IPs and patients	Subject to approval date	Subject to approval date
Patient engagement, if needed	Subject to approval date	Subject to approval date
Proposed Transfer Date	TBC*	TBC*

***Notes:**

1. **It is recommended practice transfers take place immediately at the start or end of any financial year quarter period.**
2. **Normally following the award of a contract there is a 3 month lead in time to the transfer date. However, the UHB accepts a flexible approach may need to be adopted particularly where the vacant/managed practice is to merge with another established practice.**

Offthalmoleg Ardal De-ddwyrain Cymru
South East Wales Regional Ophthalmology

Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg

University Health Boards

Business Case

Title	Regional Cataracts Expansion Business Case		
		Date Last Updated	12/05/2023
Accountable Executive	Chris Dawson Morris, Director of Planning (AB)	**Lead /Project Manager** **Clinical Lead**	Hannah Brayford, Programme Manager Dr Rhianon Reynolds, Dr Siene Ng, Dr Anjana Haridas
Clinical Service		Planned Care, Ophthalmology	

1. Executive Summary

This Business Case seeks to provide a 14 month solution for additional regional capacity for cataract outpatient and inpatient stages to enact a collaborative regional approach to recovery and to maximise the use of our assets across the region.

This additional capacity will provide a service for health board patients from Aneurin Bevan, Cwm Taf Morgannwg and Cardiff and Vale University Health Boards.

Aims

The aims of the regional solution outlined in this business case are

- to enact a collaborative regional approach to recovery
- to provide additional regional capacity for cataract outpatient and inpatient stages
- to demonstrate optimal utilisation of our assets and resources across the region
- to address current waiting list backlogs
- to reduce clinical risk on an equitable basis across the region

The Regional Ophthalmology Programme Board have also agreed a set of regional working principles on which the approach to expanding cataract capacity will be based.

- Treating the longest waiters first, regardless of their 'home' health board
- Using the outsourcing, insourcing, evenings and weekends capacity for less complex patients
- Adopting best practice guidance in all sites
- Adopting shared waiting list (PTL) management arrangements

Each health board is at a different starting point for their waiting list and this is reflected in the trajectories and projections. It is anticipated that as a result of this business case the following trajectories will be met:

- Aneurin Bevan: no patients waiting over 104 weeks for an outpatient appointment by the end of the funding period
- Cwm Taf Morgannwg: no patients waiting over 104 weeks for an outpatient appointment by the end of the funding period
- Cardiff and Vale: no patients waiting over 78 weeks for an outpatient appointment by the end of the funding period

Staged Delivery

The Regional Ophthalmology Programme Board have agreed the following staged approach to delivering sustainable cataracts solutions in the region, whilst balancing the need to activate capacity quickly and reduce the rate that the backlog is growing. This business case represents the first stage.

- Stage 1 – A Business Case for maximising our existing assets and increasing capacity with a focus on recovery activity and reducing waiting lists to run for 14 months.
- Stage 2 – Developing sustainable staffing and clinical models for the region. For cataracts and VR in University Hospital Wales (UHW), Cardiff, and cataracts and VR referral pathways across the region. To include new staffing models, new clinical models and costings, this model will be operational on the conclusion of stage 1.

Demand and Capacity

The region is presented with a sizable challenge for backlog, demand and capacity. Demand continues to outstrip capacity and is forecast to grow year on year.

- The total number of patients waiting for assessment and treatment for cataracts is forecast to reach over 19,000 by the end of March 2023.

- Demand across the region has returned to pre-pandemic levels and is forecast to be 9,960 per year for 23/24
- The projected combined core capacity across the region for 23/24 with no further intervention is 5,940 treatments and assessments per year, broken down as follows
    - Aneurin Bevan UHB – 2,400
    - Cardiff and Vale UHB – 1,440
    - Cwm Taf Morgannwg UHB – 2,100

Eliminating the waiting list backlog in 23/24 would require a capacity of 28,960 in one year, almost five times the projected combined core capacity. With no further intervention the projected waiting list of 19,000 in March 2023 would therefore be over 23,000 by March 2024.

Delivery Assumptions

Shared PTL

To support a regional approach, the three health boards have agreed to pool their patient treatment lists (PTL) and adopt shared waiting list management arrangements for the allocation of the additional regional capacity. This will be supported by a regional booking team who will also manage the shared patient waiting list ensuring that the patients who have been waiting the longest are treated first, regardless of their 'home' health board.

North and South Hubs

The geography of the region lends itself to distributing the capacity is across a North and South Hub model. This model that will keep service delivery closer to home and reduce patient travel as far as possible.

Insourcing and Outsourcing

The capacity across the region can be rapidly increased by utilising the local opportunities for insourcing and outsourcing. These arrangements make the best use of our assets across the region for short-term flexible arrangements that protect our core capacity.

Patient Second Offer and Travel

Patients will be offered the opportunity to travel to receive their assessment and treatment as part of the additional capacity arrangements where thy may be able to be treated sooner. At a maximum travel would be 40 miles and 55 minutes by private car under normal traffic conditions and most of the patient travel will be shorter. Patients unable or unwilling to travel will keep their place on the waiting list and receive treatment from their home health board. A recent survey of 140 patients across the region shows that 71% of patients would be willing to travel.

Allocation by Health Board

The table below shows the numbers of patients waiting and how this is split proportionally across the region. Data relates to August 2022 and includes the total number of patients waiting in each health board.

Patient Waits	Total			Over 52 weeks	
AB	7041	39%		2175	36%
CAV	4066	22%		891	15%
CTM	7103	39%		2939	49%
	18210			6005	

As a proportion of the patients waiting, 39% are from AB. 39% from CTM and 22% from CAV. When this is viewed as patients waiting at the end of the lists the proportions change and it is from this pool of patients that the additional capacity would be targeted.

Of this group of longer waiters 49% are from CTM, 36% from AB and 15% from CAV and this indicates how the additional capacity will be used.

Options

To achieve the stated aims of the business case, the options need to:

- Be mobilised quickly
- Be deliverable with the resources available
- Protect the viability of the core capacity
- Keep patient travel to a minimum

The options are:

- **Option 1: Do nothing**
  - Core capacity 5,940 only

- **Option 2: Maximising the use of NHH and POWH**
  - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: in POWH (3,558, for 1 NHS session and Evenings and Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 8,668 (plus 5,940 core is 14,608 total)
  - One theatre in NHH and twin theatres in POWH

- **Option 3a: Vanguard and NHH**
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)
  - South Hub: in UHW (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 7700 (plus 6,120 core is 13,820 total)
  - One theatre in NHH and twin theatres in Vanguard

- **Option 3b: Vanguard and Maximising NHH**
  - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)
  - South Hub: in UHW (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 9,310 (plus 7,140 core is 16,450 total)
  - One theatre in NHH and twin theatres in Vanguard

- **Option 4: Weekend Insourcing and Outsourcing only**
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: in POWH (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)
  - One theatre in NHH and twin theatres in POWH

- **Option 5: Outsourcing activity to external provider (s)**
  - Outsourcing (5,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)

Options Summary

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH **	Option 4 Weekends	Option 5 Outsourcing
North Hub: NHH Weekdays NHS Staff		1610		1610		
North Hub: NHH Weekends Insourcing		1500	1500	1500	1500	
South Hub: Vanguard Weekdays NHS Staff			2700	2700		
South Hub: Vanguard Weekends Insourcing			1500	1500		
South Hub: POWH Evenings insourcing (+1 NHS session)		2058				
South Hub: POWH Weekends Insourcing		1500			1500	
Outsourcing		2000	2000	2000	2000	5000
Total Additional	0	8668	7700	9310	5000	5000
Plus Core	5940	5940	6120	7140	5940	5940
Total	**5940**	**14608**	**13,820**	**16450**	**10940**	**10940**

*Yellow – Provision on AB site, Blue – provision on CAV site, Green – provision on CTM site

**Option 3b is for 14 months

High level Financials

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Core Capacity	5,940	5,940	6,120	7,140*	5,940	5,940
Additional Regional Capacity	0	8668	7,700	9,310	5,000	5,000
Total Capacity	5,940	14,608	13,820	16,450	10,940	10,940
Total Revenue Costs	£0	£12.4m	£10.5m	£12.9m**	£7.5m	£7m
Total Capital Costs	£0	£0	£2.4m	£2.4m	£0	£0
Total Costs (Capital + Revenue)	£0	£12.4m	£12.9m	£15.3m	£7.5m	£7m
Cost per patient	n/a	£1,436	£1,672	£1,640	£1,504	£1,410

**Option 3b is for 14 months*

***Costing for this option include 5% increase on all pay costs*

Waiting List Changes

The table below shows the impact of each of the options on the total size of the waiting list. The start position for each option is 19,000 patients waiting.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Waiting list project end	23,046	14,352	15,186	14,168	18,483	18,483
Waiting list change from 19,000 baseline	+4,046	-4,648	-3,814	-4,832	-517	-517

Options Appraisal

The six options have been through an options appraisal process. An exercise was undertaken with each health board individually to score and assess each option against the business case aims and the principles of regional working in section 2.1 below and appendix two.

Weighting for the scoring was allocated as follows:

- Quality and Safety: 35%
- Effective use of resources: 10%
- Strategic Fit: 10%
- Sustainability: 15%
- Access: 10%
- Deliverability: 20%

Results of the appraisal process are shown below. All three health boards have selected the same option as the highest scoring option against the criteria. Results are shown below. Scores are out of 5, with the regional total out of 15.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH	Option 4 Weekends	Option 5 Outsourcing
Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Regional Total	5.05	10.75	11.00	12.15	6.30	5.80

Preferred Option

The preferred option in this business case is Option 3b Vanguard and Max NHH

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing

- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

Preferred Option Financials

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs

			2023/24					2024/25			TOTAL ACTIVITY	TOTAL COST
Host Health Board	Delivery	Pre Go Live costs	Patients	Patients	Total Estimated Costs	Cost per Patient	Host Health Board	Delivery	Patients	Patients	Patients	Patients
Provider			Activity	Cost		Cost per case excl capital and pre go live			Activity	Cost	Activity	Cost
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589	Cardiff and Vale	Insource Weekend	410	£651,344	1,500	£2,382,967
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812	Cardiff and Vale	Weekday	675	£547,907	2,700	£2,191,628
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328	Aneurin Bevan	Insource Weekend	500	£664,206	1,500	£2,118,401
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151	Aneurin Bevan	Weekday Capacity	670	£771,366	1,610	£2,017,103
External	Outsource		1,334	1,861,757	£1,861,757	£1,396	External	Outsource	666	£929,483	2,000	£2,791,240
Regional Operational Team		£50,642		£871,566	£922,208		Regional Operational Team			£443,449		£1,365,656
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**		**TOTAL**		**2,921**	**£4,007,754**	**9,310**	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW		**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS		**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the ‘long waiters’ commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as ‘pre go live’. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The ‘regional operational team’ meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

Contents

2. Introduction and Background

2.1 Regional Working

The Regional Portfolio is made up of three main programmes, Orthopaedics, Diagnostics and Ophthalmology. The three University Health Boards in South Eat Wales, Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg have agreed to work together regionally and adopt for following regional working principles

- To reduce unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level.
- To improve resilience.
- To make effective use of capacity and capability in whichever organisation it sits.
- To create critical mass for effective high quality care delivery when and where it makes sense to do so accepting that my not reside in every organisation.
- Take all opportunities to use the evidence base and best practice to improve quality, efficiency, productivity, and use of finite resources.
- To enable clinical leaders, and others, to work together, lead together and learn together.
- Distributed leadership (The SRO maybe from organisation A, clinical lead from org B and delivery of service in B and C.)
- Approach collaboration with benign intent, honesty, transparency, and integrity in order to build trusting and effective relationships.
- To agree approaches to engagement and communications together.
- To avoid leaving anyone behind and learn from the past and progress in an open, honest and humble way.

2.2 Regional Ophthalmology Programme and Clinical Summit

The Regional Ophthalmology Programme has been running for 4 years in South East Wales with a pause for the pandemic and restarted with a renewed focus in summer 2021. The Programme aligns strongly with national priorities and is designed around delivering solutions on a regional basis where this would provide the best care to patients. The three Health Boards in the region are committed to working together, sharing resources and solutions across Ophthalmology, where working together would add value for patients and the workforce. The Programme includes active clinical and management representation from Cwm Taf Morgannwg, Cardiff and Vale and Aneurin Bevan University Health Boards.

A Clinical Summit was held in December 2021 where clinical staff were engaged in discussing and agreeing key issues and priorities for Ophthamology services in South East Wales. It was agreed that a new regional strategy should be developed to inform the future direction of the programme, including agreement regarding the ophthalmic specialties that would benefit from a collaborative regional approach

2.3 Regional Ophthalmology Strategy

A Regional Ophthalmology Strategy has been developed with clinical staff to set out the high level direction for the Regional Programme. The principles set out in the strategy are:

The Strategy has a number of delivery themes that reflect the issues and priorities identified in the Clinical Summit and now inform the future direction for the service on a regional footprint, these are set out below

1. Regional Model: Adoption of a regional model would bring together ophthalmic services under the umbrella described as a Regional Centre of Excellence network model. This will provide additional regional cataracts capacity and will use the network model approach to bring experts together to provide the best care for patients and sector-leading teaching and education expertise.
2. Sustainable Services: There are many services that cannot be sustained on a health-board only level and need to be brought together on a regional footprint. These include Vitreo-Retinal (VR) services, Corneal Cross linking and out of hours and emergency cover as requiring the most urgent attention.
3. Workforce: There is a significant skills shortage across the Ophthalmic disciplines and the strategy will also work to address the training and development of key staff to deliver a regional sustainable workforce with strong succession planning, teaching, training and development.
4. Research, Innovation and Development: Key to attracting workforce and achieving the other aspects of the strategy over the longer term is a Regional Clinical Research Facility allowing delivery of high quality clinical research trials which will increase income and quality of care for patients whilst building links with industry partners with strong consultant support.

Regionalising Services to ensure their sustainability and offer the best services to patients aligns with *A Healthier Wales*, *The National Clinical Framework* and Royal College

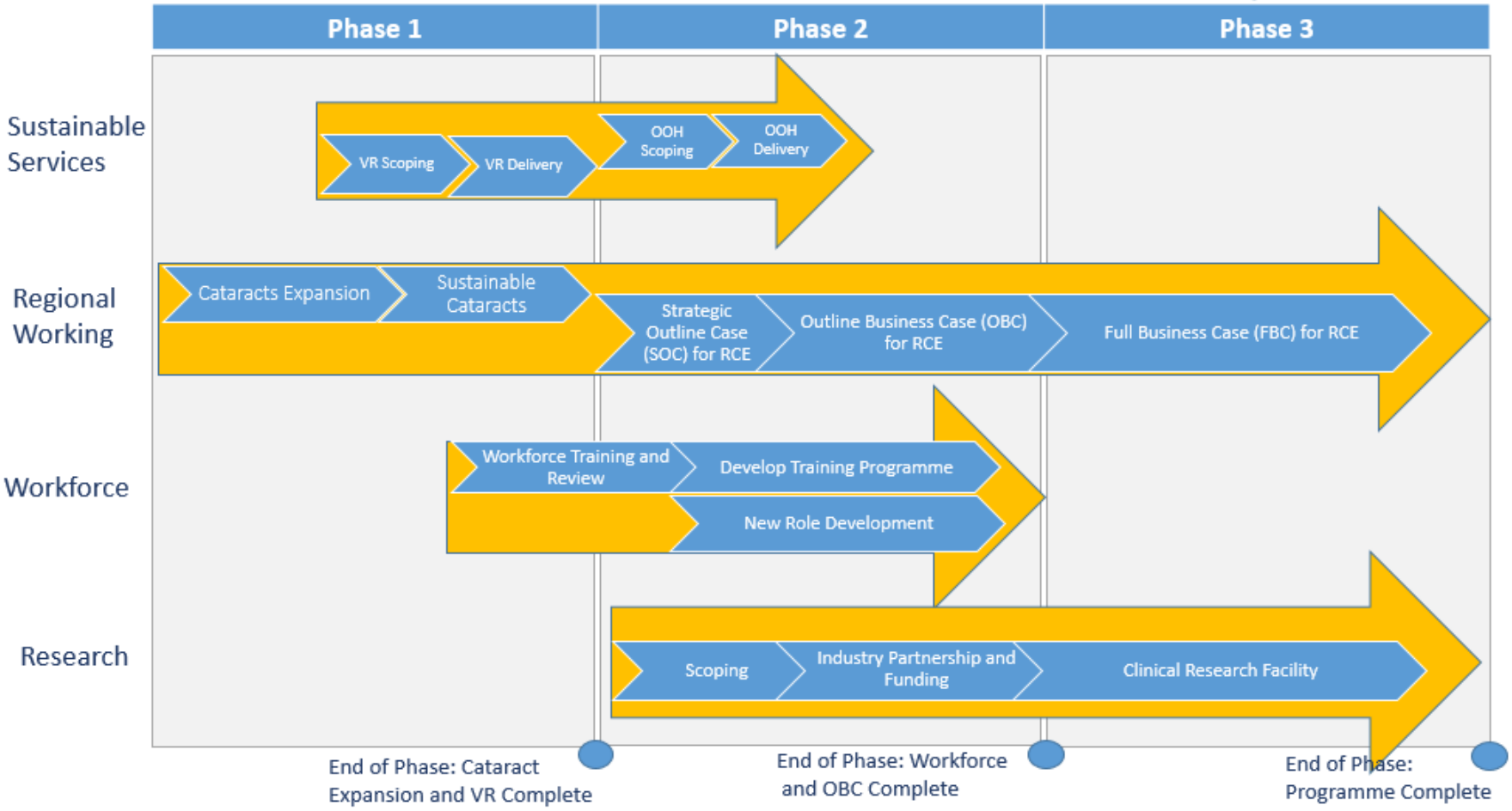
of Ophthalmologists Clinical Guidance and best practice. The long term goal is a South East Wales regional centre of eye care excellence which can co-ordinate and provide the services identified above at a tertiary level. This will enable the region to care for all complex eye care procedures, for specialist clinicians to share and enhance their skills and to reduce the need for patients to travel outside Wales for certain specialist treatment.

2.4 Programme Plans and Phased approach

The diagram below represents the timeframes for the implementation of the strategy through a programme approach. Regional working starts first with the cataracts solution, closely followed by Vitreo Retinal hub and out of hours arrangements. The plans for the Regional Centre of Excellence will be developed through the 3 stage business case process alongside workforce developments and a research and innovation facility.

High Level Programme Plan

Offthalmoleg Ardal De-ddwyrain Cymru South East Wales Regional Ophthalmology



2.5 Cataracts Sustainability Staged Approach

The Regional Ophthalmology Programme Board have agreed the following staged approach to delivering sustainable cataracts solutions in the region, whilst balancing the need to activate capacity quickly and reduce the rate that the backlog is growing. This business case represents the first stage.

- Stage 1 – A Business Case for maximising our existing assets and increasing capacity with a focus on recovery activity and reducing waiting lists to run for 12 months.
- Stage 2 – Developing sustainable staffing and clinical models for the region. For cataracts and VR in University Hospital Wales (UHW), Cardiff, and cataracts and VR referral pathways across the region. To include new staffing models, new clinical models and costings, this model will be operational on the conclusion of stage 1.

3. The Case for Change

3.1 National Drivers for Change

Throughout the United Kingdom ophthalmic services are under considerable pressure. The Way Forward[1] document produced by the Royal College of Ophthalmologists in 2017 indicate

- Cataract surgery alone represents 6% of all surgery carried out in the UK, with an expected growth within 10 years of 25%.
- 35% of patients over the age of 65 have visually significant cataract.
- 10% of all out-patient appointments within the UK (9 million appointments) are for eye clinics, and the demand on our services is expected to increase by 40% over the next 20 years.
- Overall, the economic burden of sight loss in the country was estimated to be £28 billion.
- In 2019 UK wide there was a shortfall of 230 consultants, and 67% of eye units were using locums to fill 127 vacant posts.
- 85% of units depended on waiting list initiatives in out-of-hours sessions to try and meet their demand.
- 22 patients a month were losing vision from hospital-initiated system delays.

All of these statistics pre-date the Covid pandemic, during which things have grown considerably worse (External Review of Eye Care Services in Wales, 2021[2]).

3.2 Planned Care

The Welsh Government April 2022 document “Our programme for transforming and modernising planned care and reducing waiting lists in Wales” states 5 planned care goals

[1] The Way Forward | The Royal College of Ophthalmologists (rcophth.ac.uk)
[2] External Review of Eye Care Services in Wales (rcophth.ac.uk)

And 7 Planned Care priorities to support and influence recovery planning and investment decisions:

- Transformation of outpatients.
- Prioritisation of diagnostic services.
- Focus on early diagnosis and treatment of suspected cancer patients.
- Implementing a fair and equitable approach to patient prioritisation to minimise health inequalities.
- Eliminating long waiters at all stages of the pathway.
- Build sustainable planned care capacity across the care pathway.
- The provision of appropriate information and support to people.

This business case, and the long term proposals that it supports in stage 2 align closely with the Planned Care priorities, in particular the patient prioritisation and the long waiters.

3.3 Getting It Right First Time (GIRFT)

The Ophthalmology GIRFT Programme National Specialty Report 2019[3] also considers the challenging context for Ophthalmic services in the UK with demand for services across primary and secondary care increasing by over 10% in a 5 year period to 2019 and further increases expected. The report notes that workforce has not grown in line with demand and that Ophthalmology departments are cramped with little room for expansion. This review

[3] Ophthalmology (gettingitrightfirsttime.co.uk)

makes some cataract specific recommendations including making optimum use of theatre time

This business case and the longer-term approach planned for cataract provision across the region addresses the points raised in the report.

3.4 Royal College of Ophthalmologists, External Review of Eye Care Services in Wales

An External Review of Eye Care Services in Wales[4] published in 2021 makes ten recommendations for Wales including Data Management, a reduction in patients transferred to England for treatment and more frequent sharing of best practice. Recommendation 8 is about Cataract Service Redesign and increased use of high-volume surgery. This will reduce waiting times and also - but as the report notes - encourage improvements in the end to end process where surgery is just one part.

This business case aims to address this recommendation for South East Wales and provide an increased number of high volume lists. The longer term approach identified in section 2.5 above will then address other areas for improvements.

3.5 Patient Harm

Cataracts can lead to progressive visual loss and if left untreated can lead to almost total vision loss with the sufferer only being able to perceive light and dark. Prior to Covid-19, vision loss of this nature was an unusual occurrence however, in the current climate this is alarmingly becoming more common.

A significant proportion of patients waiting for this surgery have been rendered severely sight impaired because of the delay to the treatment albeit in a reversible manner. Furthermore, the surgical complexity and time taken to perform cataract surgery increases in such cases. This reduces the number of cases that can be completed on a list, but also increases the risk of a serious complication that could lead to a second or third surgery being needed at a specialist centre.

The disability that cataracts cause has a significant impact on the sufferer. Driving is impossible leading to loss of independence. The ability to work or carry out activities of daily living may also be impaired. Poor mental health in people with vision impairment is an all too familiar problem. Furthermore, it has been identified that falls and the resulting injury and morbidity are significantly increased in this vulnerable population, thereby significantly adding to the trauma load and the hospitalisation that inevitably accompanies it.

Evidence suggests sight impairment in older people is associated with increases in the incidence of falls and hip fractures. Compared to the general older population, this group is

[4] External Review of Eye Care Services in Wales (rcophth.ac.uk)

1.7 times more likely to fall, 1.9 times more likely to have multiple falls and 1.3–1.9 times more likely to experience hip fractures. Often the patients may be a carer for their family, and their preventable visual impairment begins to make this impossible, further increasing the burden on social care.

3.6 Service issues and gaps

There are some significant service issues and gaps that further evidence the need for increased capacity of cataracts procedures across the region. These include:

- Demand across the region being greater than the cataract capacity across the region - with no additional capacity the total number of patients waiting by March 2024 will be over 23,000
- Shortage of trained ophthalmology staff at all levels. All health boards have vacancies they cannot fill
- Burn out amongst staff
- Due to long waits, case mix can be more challenging
- Currently limited ability to share resources across the region for cataract surgery
- Patients waiting longer and are at greater risk of coming to additional harm

4. Current Service Provision

This section sets out the current activity and capacity assumptions for cataract surgery across AB, CAV, and CTM UHB's.

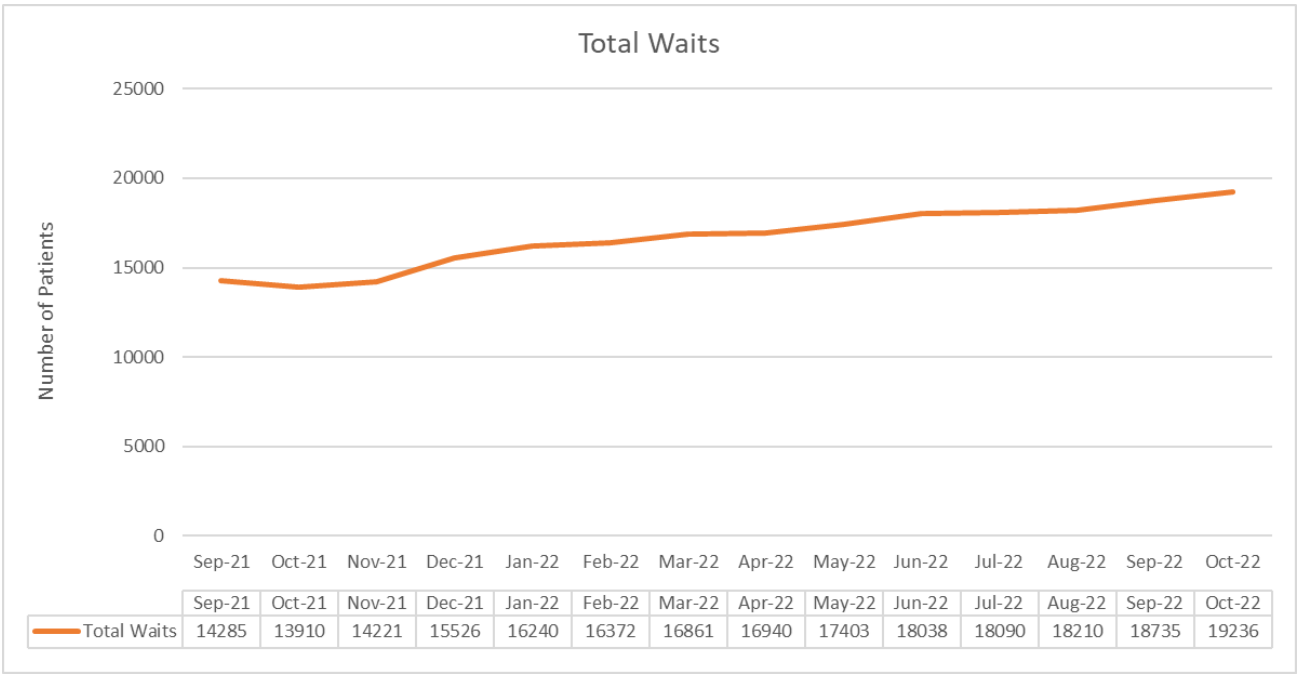
4.1 Current Situation Background

During the covid-19 pandemic, the ability to operate on cataracts patients was reduced significantly. This has resulted in a considerable backlog of patients waiting to be seen for both assessments and surgery. Cataract surgery is the most frequently performed surgery within the NHS. Quality of life gains following successful surgery are amongst the highest of any procedure in Ophthalmology. With an ageing population the demand for the service across the region has steadily grown and demand outstrips the resources available to delivery capacity at current levels.

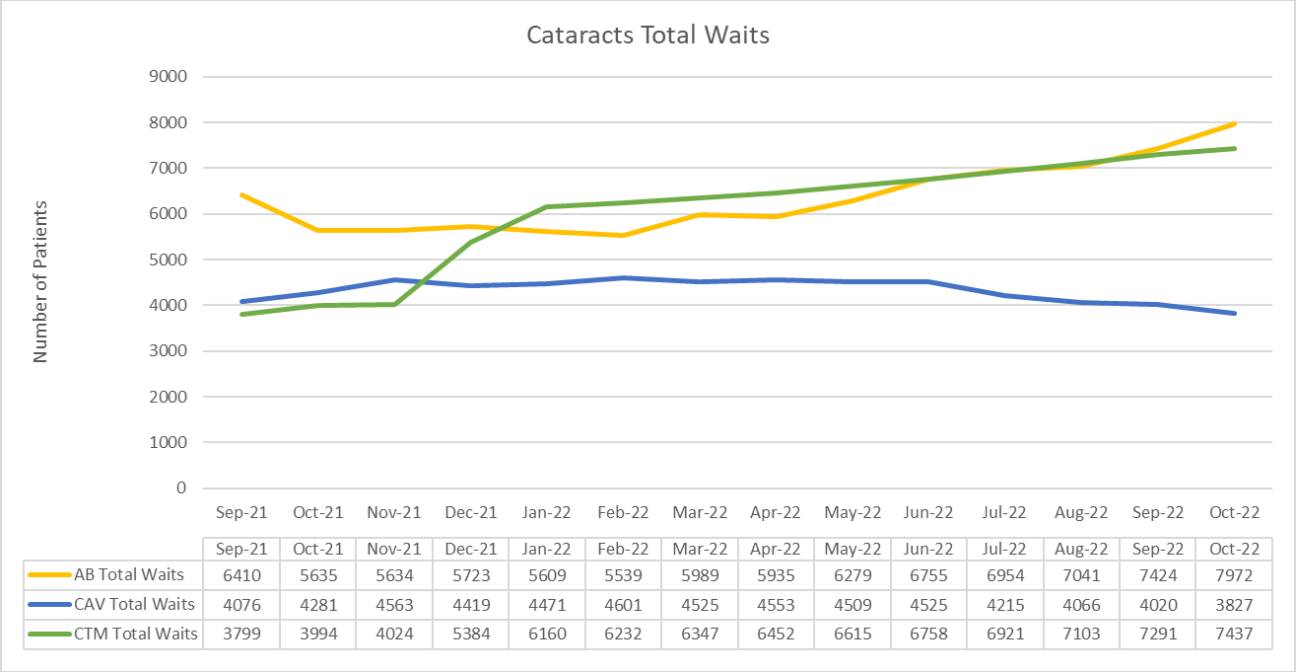
Current demand for cataract surgery is high. Across the region there are over 830 new cataract referrals every month and the current capacity across the region is struggling to cope with this level of demand. Across the region approximately 735 surgical procedures are undertaken per month. This will reduce to 495 per month From April 2023 if there is no further regional investment.

4.2 Current Waiting Lists

Waiting times are high for patients and are increasing across the region as capacity is consistently not able to meet the current demand. The total number of patients waiting across the region as at October 2022 is 19,236 and of these 6,163 (32%) have been waiting longer that 52 weeks



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Total Waits	14285	13910	14221	15526	16240	16372	16861	16940	17403	18038	18090	18210	18735	19236



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
AB Total Waits	6410	5635	5634	5723	5609	5539	5989	5935	6279	6755	6954	7041	7424	7972
CAV Total Waits	4076	4281	4563	4419	4471	4601	4525	4553	4509	4525	4215	4066	4020	3827
CTM Total Waits	3799	3994	4024	5384	6160	6232	6347	6452	6615	6758	6921	7103	7291	7437

4.3 Pre-pandemic Referral Levels and Demand

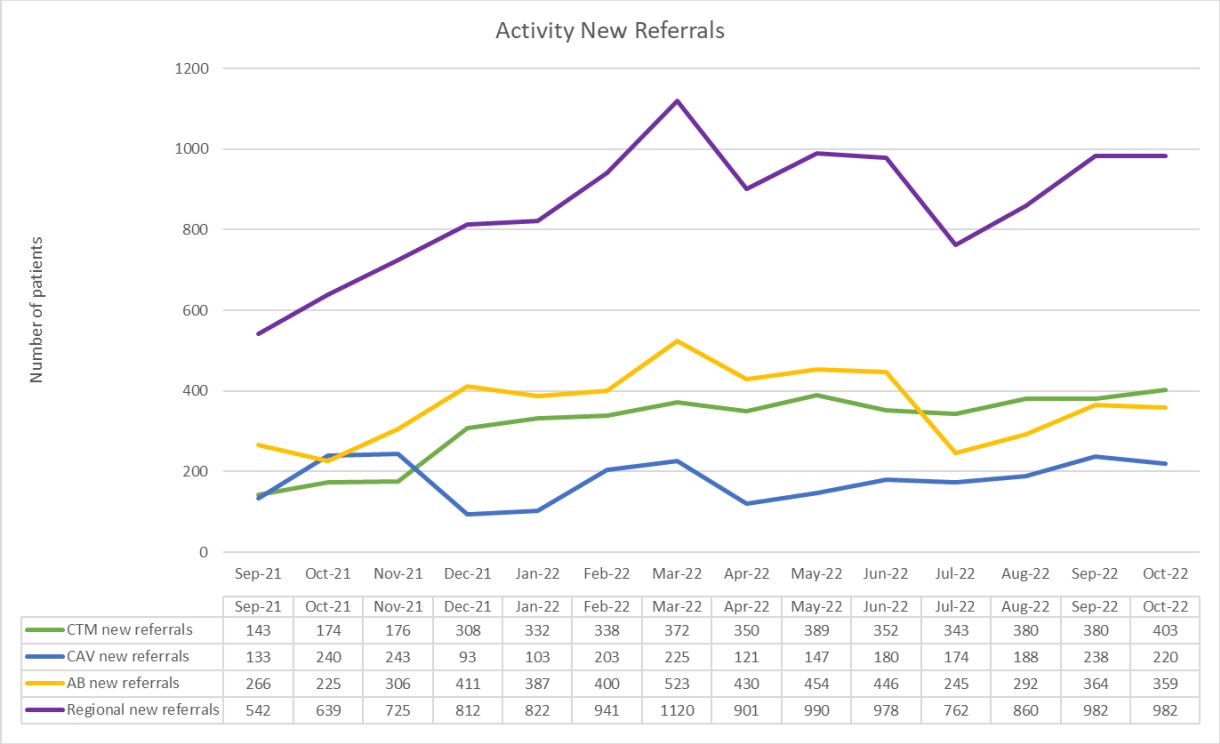
The referrals for cataracts are expected to return to pre pandemic levels once the referrals delayed through covid are received into the system. For planning purposes projections suggest that 830 referrals is the monthly level across the region. This results in approximately 10,000 referrals across the region per year.

Pre pandemic referral levels for cataracts are shown below:

Year	CTM	AB	CAV	Total	Average per Month
2018/19	3705	3571	2205	9481	790
2019/20	4438	3594	2094	10126	844

4.4 Current Referral Levels / Demand

The rate of new referrals in the region is further extending the waiting times for patients, as more patients are added to the list per month than are treated. New referrals have been steadily climbing since September 2021, reaching a peak of over 1,100 in March 2022. From arch 22 onwards referral levels stop climbing and provide a better basis for planning future demand. Between March 2022 and November 2022 inclusive, average demand across the region is Since For the last 5 months the referrals have been returning to pre covid levels or an average of 850 per month across the region.



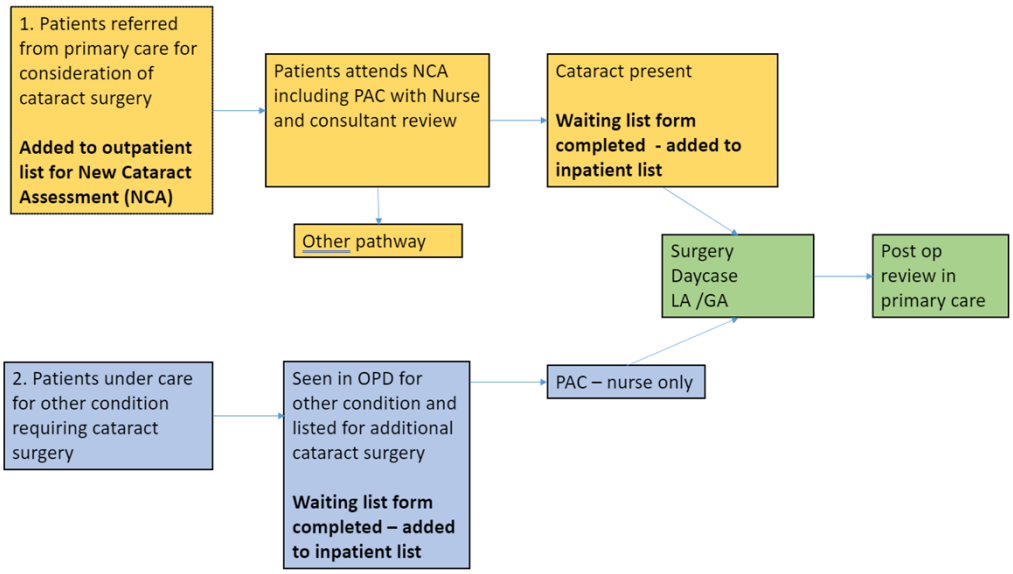
	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
CTM new referrals	143	174	176	308	332	338	372	350	389	352	343	380	380	403
CAV new referrals	133	240	243	93	103	203	225	121	147	180	174	188	238	220
AB new referrals	266	225	306	411	387	400	523	430	454	446	245	292	364	359
Regional new referrals	542	639	725	812	822	941	1120	901	990	978	762	860	982	982

For the purposes of this business case the demand is forecast for 2023/24 as shown below:

Health Board	Monthly	Annual
AB	340	4080
CAV	150	1800
CTM	340	4080
Regional Total	**830**	**9,960**

Current referral rates are now slightly higher than pre pandemic levels, indicating that there is still some latent demand coming through the system, however most of the demand that presented by mid-2022 is in line with pre pandemic referral levels for the service.

4.5 Patient Pathway and Case mix



The diagram above demonstrates the patient pathway and the outpatient and inpatient sections of the pathway. Many of the patients are waiting to start this pathway at the outpatient stage and 19% are waiting for the inpatient stage.

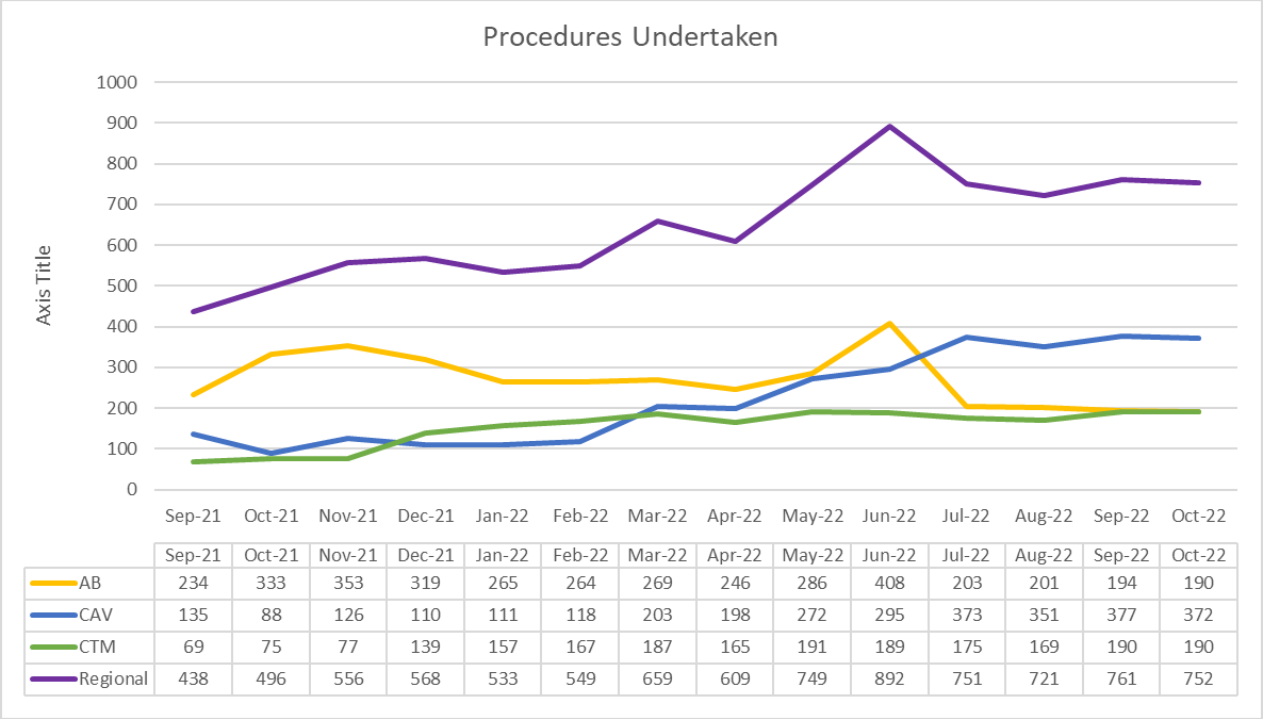
The case mix of the patients at the end of the waiting list has been clinically assessed as:

- 50% complex patients
- 30% non-complex (high flow)
- 20% no further action on cataracts pathway

It is anticipated that the increased capacity that this business case will provide will reduce the percentage of complex patients as backlogs are addressed. The case mix will then move towards a greater proportion of non-complex patients. This will in turn will release core capacity within Health Boards to provide optimal care for the remaining complex cases.

4.6 Current Activity Inpatient and Outpatient

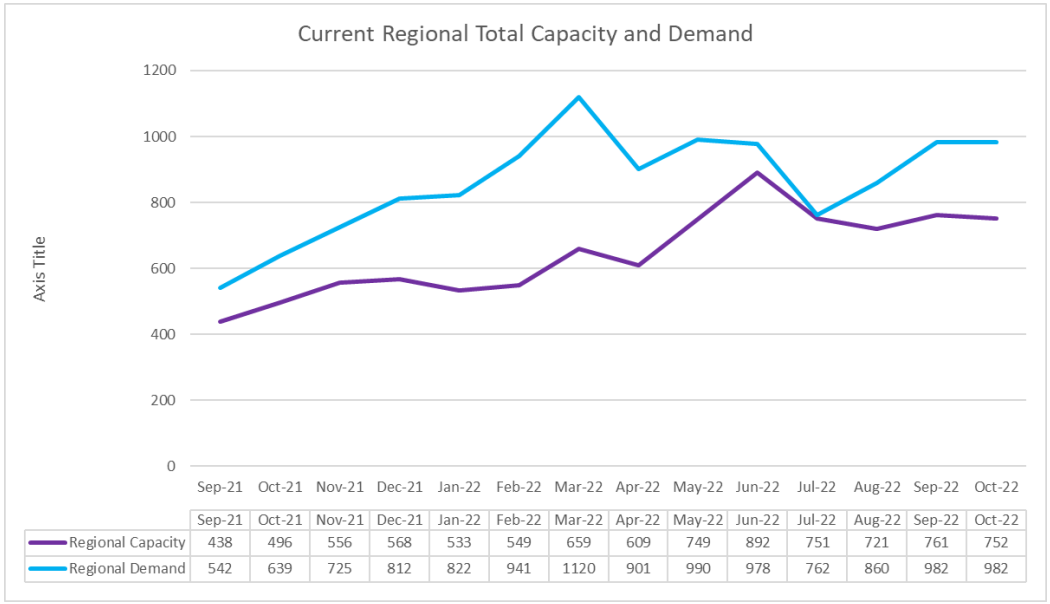
Activity across the region has been increasing, as operational teams and clinical staff work hard to restore sessions and undertake additional sessions to build back capacity post-COVID. The addition of the Vanguard mobile twin theatre theatre unit in Cardiff has also had a big impact towards increasing the activity the teams are able to provide. The Vanguard Unit opened in January 2022 and reached full capacity by March 2022. In September 2021 the regional inpatient activity including outsourcing was 438 procedures per month and in May 2022 including outsourcing, increasing capacity and opening the Vanguard theatres the activity was 749 procedures per month, an increase of 71% capacity in 8 months and demonstrating the work of the operational teams to increase capacity. Outpatient activity to prepare patients for surgery is also a critical step in the pathway. Outpatient activity was 1,038 in September, increasing to 1,564 in May 2022.



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
AB	234	333	353	319	265	264	269	246	286	408	203	201	194	190
CAV	135	88	126	110	111	118	203	198	272	295	373	351	377	372
CTM	69	75	77	139	157	167	187	165	191	189	175	169	190	190
Regional	438	496	556	568	533	549	659	609	749	892	751	721	761	752

Row Labels	Sum of Sep-21	Sum of Oct-21	Sum of Nov-21	Sum of Dec-21	Sum of Jan-22	Sum of Feb-22	Sum of Mar-22	Sum of Apr-22	Sum of May-22	Sum of Jun-22	Sum of Jul-22	Sum of Aug-22	Sum of Sep-22	Sum of Oct-22
AB	**234**	**333**	**353**	**319**	**265**	**264**	**269**	**246**	**286**	**408**	**203**	**201**	**194**	**190**
procedures outsourced	66	121	130	175	163	115	54	100	100	267	0	0	0	0
Procedures undertaken	168	212	223	144	102	149	215	146	186	141	203	201	194	190
CAV	**135**	**88**	**126**	**110**	**111**	**118**	**203**	**198**	**272**	**295**	**373**	**351**	**377**	**372**
procedures outsourced	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Procedures undertaken	135	88	126	110	111	118	203	198	272	295	373	351	377	372
CTM	**69**	**75**	**77**	**139**	**157**	**167**	**187**	**165**	**191**	**189**	**175**	**169**	**190**	**190**
procedures outsourced	12	18	20	20	15	20	20	20	15	15	15	15	15	15
Procedures undertaken	57	57	57	119	142	147	167	145	176	174	160	154	175	175
Regional	**438**	**496**	**556**	**568**	**533**	**549**	**659**	**609**	**749**	**892**	**751**	**721**	**761**	**752**
procedures outsourced	78	139	150	195	178	135	74	120	115	282	15	15	15	15
Procedures undertaken	360	357	406	373	355	414	585	489	634	610	736	706	746	737

The gap between demand and capacity is growing, as shown in the chart below.



4.7 Workforce

Workforce

The current session planning and job planning arrangements include some sessions that are assigned as cataract only lists and some theatres sessions that run mixed lists where cataracts procedures are on the same surgical list as other ophthalmic procedures. Running mixed lists does enable the service to use any available theatre time to undertake cataract surgery but makes identifying the exact workforce assigned to cataract surgery more difficult.

As an illustration, the workforce typically required to undertake cataract surgery, and the outpatient pre-operative assessment is shown below.

Outpatient Pre-Operative assessment

During 1 session the workforce can see approximately 7 patients on a list, however the numbers may reduce if the patients are more complex. Workforce for 1 session includes a Consultant, 2 pre-assessment Nurses, 2 Health Care Support Workers and a Receptionist. There is also workforce required for booking and for notes retrieval and typing after the session.

Theatre Session

During 1 theatre session there will be up to 6 patients booked on a theatre list, depending upon case complexity. Workforce for 1 session includes a Consultant, Anaesthetist, 2 Scrub Nurses, 1 ODP, 2 Health Care Support Workers and 2 Nurses for the recovery area and a Receptionist. There is also workforce required for booking and for notes retrieval and typing after the session.

Workforce Gaps

The vacancy levels across the region for Ophthalmology services have been identified as shown below. This information helps to demonstrate that in the short term the capacity can only be increased by an insourcing and outsourcing model.

CTMU

- 0.7 WTE Corneal consultant
- 1 WTE Specialty Doctor
- 1 WTE Band 6 nurse
- 1 WTE band 5 qualified nurse

ABUHB

- 1x Band 3 Scheduler & 1 x Band 3 Outpatient booking Clerk- Both Full time posts
- 5.8 WTE Band 5 Nurses

- 3.4 WTE Band 6 Nurse Practitioners,
- 4.7 WTE Band 2 HCSW
- 1 WTE Consultant

CVUHB

- 1 x trainee vacancy
- 2.5 x Band 3 admin vacancies
- 1 x Band 2 nursing vacancy
- 2 x Band 5 Directorate Support Managers

4.8 Service Improvements

All service provision is being reviewed on a continuous basis to identify where small changes can be made to improve the way the service is delivered. These changes will ensure optimal utilisation of existing core capacity in Health Boards, while this business case sets out the further additional capacity required to support cataracts recovery. Actions include:

CTMUHB

- All vacancies within theatres are in the process of being filled, which will ensure all available space can be adequately staffed.
- A Health Board theatre utilisation group has been formed to look at how we can maximise the theatre space we have in both areas, as well as looking at late starts and early finishes.
- IPC regulations are due to change, allowing the department to fill lists at short notice, which will help with utilisation when patients cancel at short notice.
- Eye bay nurse staffing is also being looked at with support from the main nursing hub being sought so that ophthalmic nurses can be utilised elsewhere, such as pre-assessment clinics.
- The concept of a 'golden list' has been developed, involving optimal circumstances of efficiency, flow and patient attendance. This will be rolled out to as many clinicians as possible

ABUHB

- Start and finish times of Theatre sessions are being monitored with reasons being audited for improvements to be identified.
- A patient "Stand by list" is being generated to utilise any very short notice cancellations.
- All patient biometry is being uploaded to Clinical Workstation for Consultants to review patients sooner to prevent delays to treatment and to reduce day of admission cancellations.

CVUHB

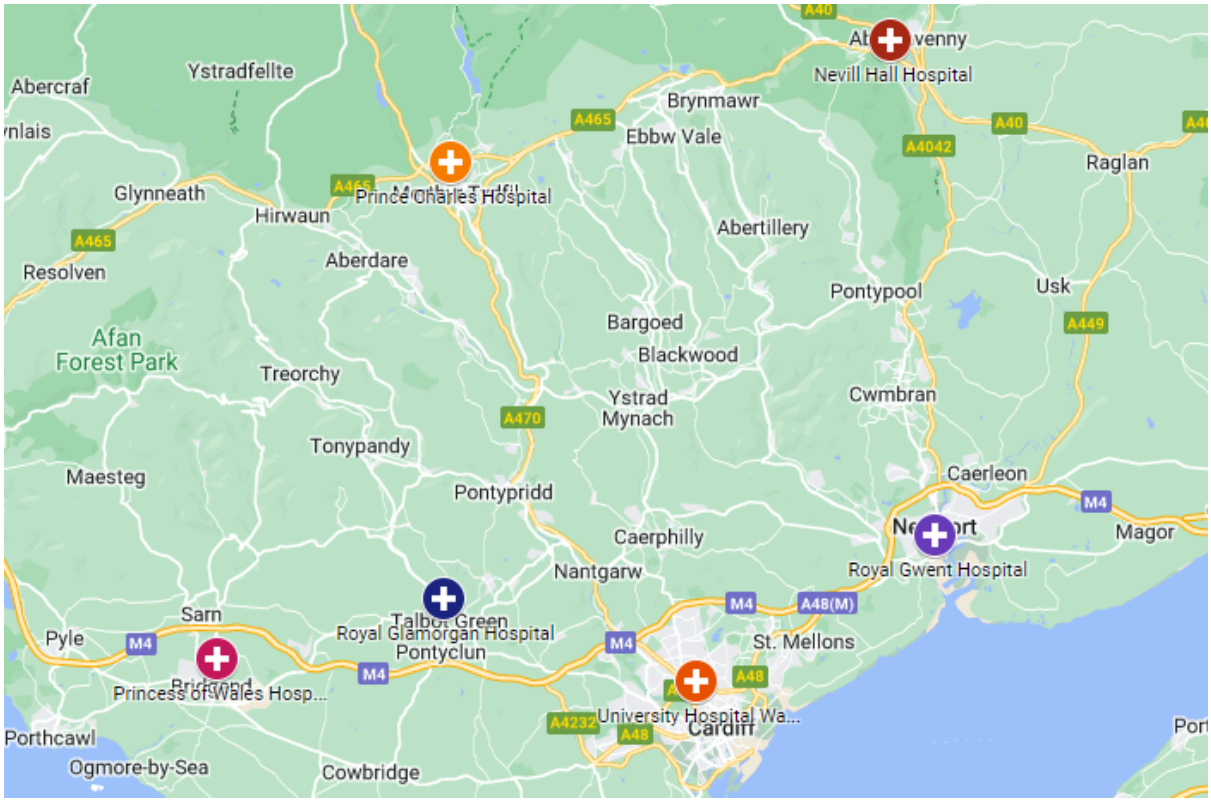
- Maximising utilisation by ensuring templates are booked to agreed capacity and backfilled as necessary when cancellations occur.
- Theatre utilisation – both booking and in-session – is monitored with the scheduling team on a weekly basis.

- HVLC lists are run where appropriate cases are identified, with performance and utilisation monitored with the scheduling team on a weekly basis

5. Cataracts and the opportunities for collaboration across the region

5.1 North and South Hubs and Patient Travel

The large geographical area of South East Wales, the road network and the position of the hospitals lends itself to a North / South split that can reduce patient travel across the region by providing hubs in the North and South of the region. These hub have the potential to provide additional capacity.



Geographical options for Cataracts in the North are Prince Charles Hospital (PCH) and Nevill Hall Hospital (NHH). There is no opportunity for expanding provision in PCH due to existing theatre usage and NHH is the remaining North option where 1 theatre is available. In Nevill Hall Hospital in Abergavenny as there is potential theatre space available to the region. The population in the North of the region is approximately 500,000 people and includes North Cwm Taf Morgannwg and North Aneurin Bevan.

In the South the Hub is proposed to be either University Hospital of Wales or Princess of Wales Hospital depending on the option taken forward both site use a twin theatre model. The population of the South of the region is approximately 1,000,000 people and includes South Cwm Taf Morgannwg, Cardiff and Vale and South Aneurin Bevan.

Travel Times By Car (From the centre of the town to the hospital site)

North Hub	South Hub	South Hub
To Abergavenny NHH	To Cardiff Vanguard	To Bridgend POWH
From Cwmbran = 30 minutes / 15 miles	From Newport = 30 minutes / 13 miles	From Pontypridd = 35 minutes / 25 miles
From Merthyr = 30 minutes / 18 miles	From Blackwood = 40 minutes / 23 miles	Treorchy = 35 minutes / 15 miles
From Blackwood = 35 minutes / 20 miles	From Bridgend = 45 minutes / 20 miles	From Newport = 40 minutes / 30 miles
From Aberdare = 45 minutes / 25 miles	From Aberdare = 50 minutes / 23 miles	From Cardiff = 40 minutes / 25 miles
From Newport = 40 minutes / 30 miles	From Treorchy = 55 minutes / 22 miles	From Aberdare = 55 minutes / 40 miles

Through the use of the North and south model no patient would travel further than 40 miles or for longer than 55 minutes by private car in normal traffic conditions.

The North and South hub model enables the additional regional capacity for cataract outpatient and inpatient stages to enact a collaborative regional approach to recovery and to maximise the use of our assets across the region.

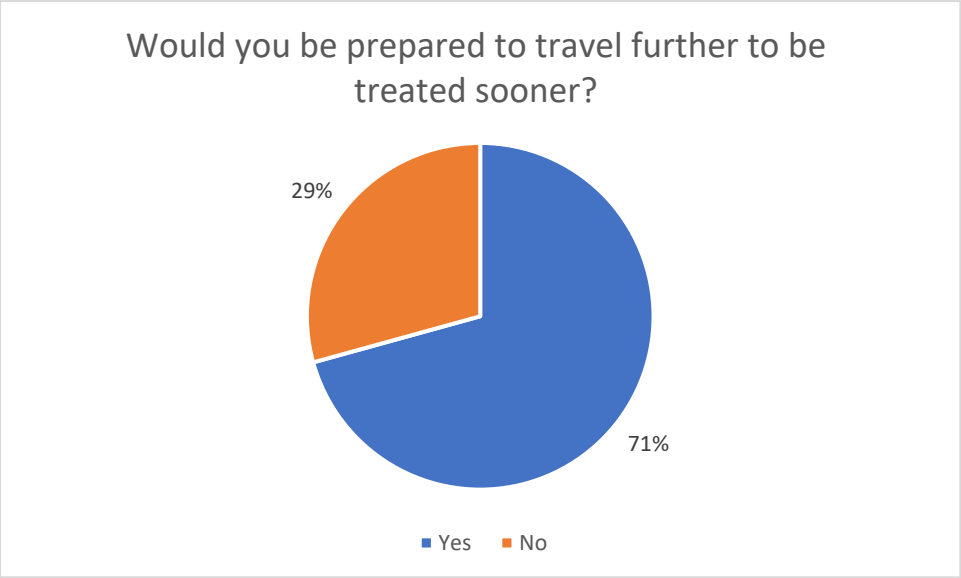
Patient Second Offer and Travel

Patients will be offered the opportunity to travel to receive their assessment and treatment as part of the additional capacity arrangements where thy may be able to be treated sooner. At a maximum travel would be 40 miles and 55 minutes by private car under normal traffic conditions and most of the patient travel will be shorter. Patients unable or unwilling to travel will keep their place on the waiting list and receive treatment from their home health board.

Patient travel Survey

A patients travel questionnaire was undertaken in Princess of Wales Hospital on 5th January, Royal Gwent Hospital on 11th January, and University of Wales Hospital on 12th January 2023. A total of 140 patients attending appointments on those day were asked questions about their travel to hospital and their willingness to travel to another hospital for treatment. All respondents were anonymous. An extract of the survey is shown below. Full results are in appendix ten

Would you be prepared to travel further if you could have been treated sooner?



Would you be prepared to travel further to the treated sooner?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
Yes	25 (71%)	27 (77%)	47 (67%)	99 (71%)
No	10 (29%)	8 (23%)	23 (33%)	41 (29%)
Grand Total	**35**	**35**	**70**	**140**

Where would you travel to?

- From Princess of Wales Hospital in Bridgend, of the 25 patients willing to travel 25 would go to Cardiff and 19 to Swansea
- From Royal Gwent Hospital in Newport, of the 27 patients willing to travel 19 would be willing to travel to Cardiff and 25 to Abergavenny
- From University Hospital of Wales in Cardiff, of the 47 patients willing to travel 38 would be willing to travel to Bridgend and 41 to Newport

Where would you travel to?	From Princess of Wales Hospital	From Royal Gwent Hospital	From University Hospital of Wales
Bridgend / POWH		7	38
Cardiff / UHW	25	19	
Newport / RGH	11		41
Abergavenny / NHH	5	25	30
Bristol	5	6	10
Swansea	19	3	10
Further in the UK	5	3	4
Grand Total	**70**	**63**	**133**

**patients could provide multiple answers to this question*

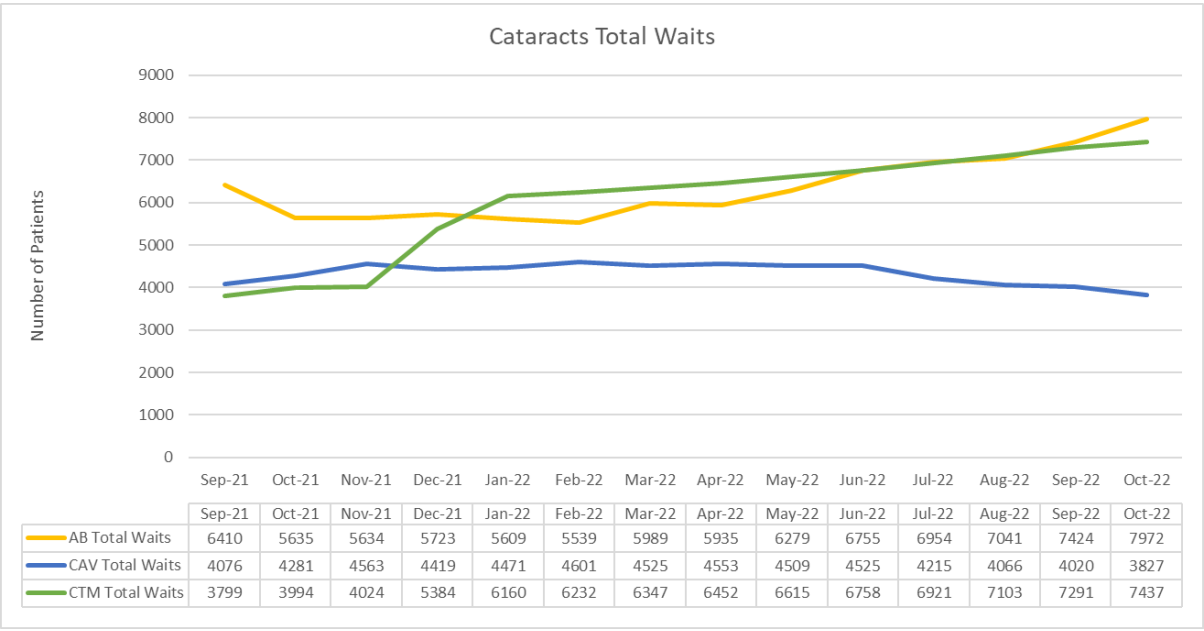
5.2 Regional Working Principles

The Regional Ophthalmology Programme Board have endorsed the following regional working principles

- Treating the longest waiters first, regardless of their 'home' health board
- Using the outsourcing, insourcing, evenings and weekends capacity for less complex patients
- Adopting best practice guidance in all centres
- Adopting shared waiting list management arrangements

The three Health Boards have committed to working as a region and understand that this does not necessarily mean sharing the provision requested in this business case equally, but equitably across the region and allocating this provision to the patients of greatest need regardless of their 'home' health board.

The chart below shows the waits for outpatient and inpatient appointments across the region and the variation across Health Boards. Both AB are approaching 8,000 total patients waiting and CTM 7,500. CAV have under 4,000 patients waiting with trajectories moving towards reducing this figure each month.



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5.3 Insourcing and Outsourcing

The capacity across the region can be rapidly increased by utilising the local opportunities for insourcing and outsourcing. These arrangements make the best use of our assets across the region for short-term flexible arrangements that protect our core capacity.

5.4 Shared Patient Treatment List (PTL)

As an agreed principle of this regional model, the three health boards have agreed to work together to share waiting list management (see section 5.4) and ensure that capacity is distributed across the region to the patients who have been waiting the longest and require this treatment.

The three health boards will share their patient treatment lists through a regional team and those patients at the end of the list that are suitable for this type of treatment will be assessed and treated as part of this regional capacity.

The table below shows the numbers of patients waiting and how this is split proportionally across the region. Data relates to August 2022 and includes the total number of patients waiting in each health board.

Patient Waits	Total			Over 52 weeks	
AB	7041	39%		2175	36%
CAV	4066	22%		891	15%
CTM	7103	39%		2939	49%
	18210			6005	

As a proportion of the patients waiting, 39% are from AB. 39% from CTM and 22% from CAV. When this is viewed as patients waiting at the end of the lists the proportions change and it is from this pool of patients that the additional capacity would be targeted.

Of this group of longer waiters 49% are from CTM, 36% from AB and 15% from CAV and this indicates how the additional capacity will be used.

5.5 Regional Waiting List Management

Also see section 5.3 (shared PTL)

5.5.1 Shared waiting list management arrangements

All health Boards have agreed to share waiting lists and treat the longest waiters from across the region first.

The waiting lists could be shared via a SharePoint which is supported from an information governance perspective as access is only via NADEX numbers so access can be limited and monitored. To ensure that longest waiters are treated first, the three spreadsheets could be merged.

In terms of how patients are removed from waiting lists once treated, this would be managed in the same way that patients are treated in Spire/Nuffield. The NHH/UHW centres would be added as options for removal on a drop down list a feature which is on the CTM and C&V waiting lists.

The regional team will hold the shared list and the patients waiting the longest will be treated first, any issues will be managed by the regional team and demonstrated with the data.

SLA type arrangements will be in place for sharing data and resolving issues

5.5.2 Regional Booking and Scheduling

There will be a joint Regional Booking and Scheduling Team across the region to book all the additional capacity patients into outpatient appointments and schedule them for surgery. This team will be hosted by a Health Board but work for the region to support this additional service for the patients. Bringing this team together offers resilience in the service and flexibility to book into the North and South hubs via access to all the systems operated by each of the Health Boards.

The manager of this team will also oversee the data integrity for the joint waiting list arrangements with the three regional Ophthalmology Directorate Managers.

5.6 IT and Data Systems

North Hub

Patients booked and scheduled for assessment and treatment in the North Hub will be assigned an AB patient number and recorded on the AB systems as AB patients. Records will be shared with other health boards via Welsh Clinical Portal (WCP). CTM and CAV patients treated in the North hub will be recorded as ‘outsourced’ on the CTM and CAV systems (see below)

South Hub

Patients booked for outpatient appointments in the South Hub will attend POWH for their appointment and, if required, UHW for surgery. Upon funding approval the specific details for sharing information across the two health boards for patients will be developed and delivered as part of the implementation plan

Outsourcing

There are established practices to follow for recording outsourced patients already as outsourcing is a continuing practice in health boards within the region. Patients are listed as outsourced on the home system and information is shared between the outsourcing provider and the home health board via Welsh Clinical Portal (WCP)

Uploading on to the Welsh Clinical Portal upload records between the Health Boards

IT and data systems will require more full scoping when funding is agreed.

5.7 Additionality

The service model represents additional capacity established in the region when compared to the core base capacity that was provided before the pandemic. In Cardiff and Vale, there were 7.5 cataract sessions per week and the Vanguard Unit has increased this to 20 sessions per week. Through this business case 62.5% (12.5 out of 20 sessions) of the Vanguard Unit would be available for regional use, returning the Cardiff and Vale capacity to pre pandemic levels.

In Aneurin Bevan the way services are delivered has been reconfigured but the total capacity for cataract surgery remains unchanged from pre pandemic levels, demonstrating that this business case represents additional capacity across the region.

6. Benefits, Risks and Governance

6.1 High Level Benefits

The high-level benefits associated with undertaking the additional capacity are demonstrated below. Through the do-nothing option, these benefits will be foregone.

Patient Benefits

- Reduced waiting times for patients
- Improved quality of life (measured through PROMS/PREMS)

Wider Regional and Health Board Benefits

- Increased Capacity across the region
- Reduced waiting list size
- Making the best use of regional resources

Health gain

- Reducing sight loss
- Reducing complications and other relating to sight loss e.g.falls
- Improving outcomes for patients
- Improving timely clinical care and patient experience

Equity

- Equity of service provision and access across the region
- Capacity for the longest waiters

6.2 High Level Risks

The high level risks associate with undertaking the additional capacity are demonstrated below.

High-level Risks to Delivery

Delivery of the business case is dependent on the following risks being managed and mitigated:

Risk	Assessment	Mitigation
Reliability of providers to deliver services: that the service provider cannot fulfil the staffing required to meet the sessions they are contracted for	Prob: 1 Impact: 3 Score: 3 (low)	Contract management and open communication with the provider to manage any changes in the volumes and arrange times to increase capacity in future weeks/months
Availability of additional support service and equipment, trays, HSDU: That the additional capacity on weekends compromises the core capacity and there	Prob: 2 Impact: 3 Score: 6 (Medium)	Early modelling of requirements and ordering of supplies with longer lead in times. Detailed planning of these

Risk	Assessment	Mitigation
is not enough equipment to service the whole capacity required		resources and close monitoring of all usage and risk areas
Booking and scheduling staff appointments: That there is not enough booking and scheduling time to manage the additional patients and that the additional capacity is not fully utilised	Prob: 1 Impact: 4 Score: 4 (Low)	Planning for resource required and bringing them together into a regional team to enable cross cover and resilience to the service.
Ensuring equity of provision across the region: That the regional provision does not go to the patients waiting longest and HB's benefit disproportionately	Prob: 1 Impact: 4 Score: 4 (Low)	Regular and robust waiting lists management processes and pooled lists that adjust and review on a monthly basis to manage the lists as a whole
Reduction in core capacity: That core capacity is reduced or compromised because the regional solution is in place	Prob: 3 Impact: 3 Score: 9 (Medium)	Regular monitoring and early corrective actions towards additional capacity and core capacity alongside waiting list reductions in size and waiting times
IT systems and record keeping: that IT systems can't share information across HB boundaries and that patient records get lost through manual processes	Prob: 3 Impact: 4 Score: 12 (High)	Bring additional IT support into the programme to provide expertise and enable accurate record keeping and sharing through system and maintenance of information governance
Contracting impacting on core capacity: That staff take on contracting shifts and are then not able to provide the core capacity required to maintain Health Board levels of activity	Prob: 3 Impact: 3 Score: 9 (Medium)	Working with the provider to limit impacts on HB staff and planning schedules in advance and communicating this widely. Monitoring sickness levels
Clinical Risk: That staff do not have the appropriate qualifications and experience	Prob: 2 Impact: 5 Score: 10 (Medium)	Clinical Governance processes and working with provider to ensure every member of staff is suitable qualified and experienced.
Clinical Risk: That unsuitable patients are referred for insourcing and outsourcing and are routed back into core capacity making the patient journey longer	Prob: 1 Impact: 4 Score: 4 (Low)	Clear and clinically agreed criteria for referring patients for insourcing and outsourcing treatment routes
Clinical Risk: That patient cancellation rates are high and the insourcing and outsourcing efficiency is compromised	Prob: 1 Impact: 3 Score: 3 (Low)	Communication with patients prior to referral and follow ups of cancelling patients for feedback/reasons

Low Risk 1-5, medium 6-10, High 12-20

6.3 Contracting arrangements

Local Health Boards will utilise the expertise of the All Wales Procurement team to undertake a tender process on behalf of all three Health Boards. Depending on their technical advice the intention would be to undertake one procurement exercise for both insourcing and outsourcing recognising that these will be awarded to separate providers. In

addition, given the scale of the volumes required, the awards may include a multitude of providers to enable flexibility of patients and to promote patient choice.

The procurement timetable will need to include a full 30 days tender advertisement given the volumes and financial value involved. The procurement process will be undertaken by the All Wales team, with the detailed specification around clinical requirements, patient pathways, governance and processes etc led by a small working group comprised of all three Health Boards and involving expertise from all relevant disciplines. This will confirm the contractual arrangements around the awarding and management of the contracts. Tenders will then be evaluated by a team drawn from all Health Boards and awarded to the successful providers.

Contracts are awarded on a cost per case basis with the expectation that the full number of procedures will be delivered by the Provider. The award of any new contracts would be underpinned by an activity plan, with clear timescales for delivery, and any appropriate scaling back of insourced activity in line with the implementation plan for the sustainable regional solution.

6.4 Clinical Governance

The Clinical Governance arrangements will be mainly managed through the contracting arrangements. The contracting will include all the clinical staffing required to undertake outpatient assessments and inpatient procedures.

Specific areas of attention for clinical governance are:

Surgeon Competence

Insourced and Outsourcing contracts need to ensure that surgeons are of an appropriate competence and quality and have comparable complication rates to consultant surgeons on the National Ophthalmic Database. Processes for checking and ageing the competence of surgeons will be in place as part of the contracting and implementation of the business case.

Follow Ups and Complications

As part of core Health Board delivery of this type of surgery, any complications are the responsibility of the operating surgeon and follow up arrangements of this nature will be included in the insourcing contracting details. If follow ups cannot be rectified by the operating surgeon (or insourcing company) then they will be invoiced for the follow up treatments required.

Clinical Processes

Insourcing staff will be expected to follow the clinical processes of the site on which they are working including incident reporting. There may be occasions where clinical policies vary

across sites and the implementation of the business case will aim to address areas of significant variation by aligning guidance across sites as far as practicable, although in the short term this will not be possible in every case.

6.5 Waiting List Modelling

The Regional Ophthalmology Programme have been working with the Delivery Unit to develop a mathematical model to inform the planning of the additional cataracts capacity. Data to feed into the model has been sourced from health boards and operational colleagues have been refining and testing the model with the Delivery unit and have finalised the model for this purpose. The model ensures that there is balance between the outpatient and inpatient capacity based on the following assumptions.

- There is a waiting list of 19,000 patients (forecast position end of March 2023)
- 80% of patients referred as suitable for surgery
- 18% of patients are not suitable for surgery
- 2% of patients DNA
- Patients are reviewed by primary care post-surgery within 3 weeks
- None of the outpatient appointments undertaken on patients expire
- 20% of patients require surgery on a second eye
- One outpatient appointment will cover both eyes
- Second eye surgery is undertaken at least 10 weeks after first eye surgery

In section 4.5 the case mix discusses that 20% of the patients who move through the outpatient stage will not require surgery. However, 20% of the patients who require surgery require it for both eyes and so the demand for surgery/inpatient stage is then in line with the demand for the outpatient stage.

7. Options

The business case considers six options to achieve the following key aims:-

- to enact a collaborative regional approach to recovery
- to provide additional regional capacity for cataract outpatient and inpatient stages
- to demonstrate optimal utilisation of our assets across the region
- to address current waiting list backlogs
- to reduce clinical risk on an equitable basis across the region

To achieve the stated aims of the business case, the options need to:

- Be mobilised quickly
- Be deliverable with the resources available
- Protect the viability of the core capacity
- Keep patient travel to a minimum
- Deliver value for money

The options are:

- **Option 1: Do nothing**
    - Core capacity 5,940 only

- **Option 2: Maximising the use of NHH and POWH**
    - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
    - North Hub: in NHH (1,500 Weekend Insourcing)
    - South Hub: in POWH (3,558, for 1 NHS session and Evenings and Weekend Insourcing)
    - Outsourcing (2,000)
    - Total additional 8,668 (plus 5,940 core is 14,608 total)
    - One theatre in NHH and twin theatres in POWH

- **Option 3a: Vanguard and NHH**
    - North Hub: in NHH (1,500 Weekend Insourcing)
    - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)
    - South Hub: in UHW (1,500 Weekend Insourcing)
    - Outsourcing (2,000)
    - Total additional 7700 (plus 6,120 core is 13,820 total)
    - One theatre in NHH and twin theatres in Vanguard

- **Option 3b: Vanguard and Maximising NHH**
    - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
    - North Hub: in NHH (1,500 Weekend Insourcing)
    - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)

  - South Hub: in UHW (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 9,310 (plus 7,140 core is 16,450 total)
  - One theatre in NHH and twin theatres in Vanguard

- **Option 4: Weekend Insourcing and Outsourcing only**
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: in POWH (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)
  - One theatre in NHH and twin theatres in POWH

- **Option 5: Outsourcing activity to external provider (s)**
  - Outsourcing (5,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)

Theatres Available

- University Hospital of Wales: The Vanguard Unit is a twin theatre set up based in the car park in UHW. This will be used for the weekday and the weekend sessions.
- Princess of Wales Hospital: In Bridgend Eye theatres there is a twin theatre set up. This would be used for the weekend and evening sessions. The 1 NHS session in POWH would be run as a single theatre set up.
- Nevill Hall Hospital: One theatre is available in the main theatres block in NHH. The weekday sessions and the weekend sessions will be run from this theatre.

Options Summary

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH **	Option 4 Weekends	Option 5 Outsourcing
North Hub: NHH Weekdays NHS Staff		1610		1610		
North Hub: NHH Weekends Insourcing		1500	1500	1500	1500	
South Hub: Vanguard Weekdays NHS Staff			2700	2700		
South Hub: Vanguard Weekends Insourcing			1500	1500		
South Hub: POWH Evenings insourcing (+1 NHS session)		2058				
South Hub: POWH Weekends Insourcing		1500			1500	
Outsourcing		2000	2000	2000	2000	5000
Total Additional	0	8668	7700	9310	5000	5000
Plus Core	5940	5940	6120	7140	5940	5940
Total	**5940**	**14608**	**13,820**	**16450**	**10940**	**10940**

*Yellow – Provision on AB site, Blue – provision on CAV site, Green – provision on CTM site

**Option 3b is for 14 months

High level Financials

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Core Capacity	5,940	5,940	6,120	7,140*	5,940	5,940
Additional Regional Capacity	0	8668	7,700	9,310	5,000	5,000
Total Capacity	5,940	14,608	13,820	16,450	10,940	10,940
Total Revenue Costs	£0	£12.4m	£10.5m	£12.9m**	£7.5m	£7m
Total Capital Costs	£0	£0	£2.4m	£2.4m	£0	£0
Total Costs (Capital + Revenue)	£0	£12.4m	£12.9m	£15.3m	£7.5m	£7m

Cost per patient	n/a	£1,436	£1,672	£1,640	£1,504	£1,410

**Option 3b is for 14 months*
***Costing for this option include 5% increase on all pay costs*

Waiting List Changes
The table below shows the impact of each of the options on the total size of the waiting list. The start position for each option is 19,000 patients waiting.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Waiting list project end	23,046	14,352	15,186	14,168	18,483	18,483
Waiting list change from 19,000 baseline	+4,046	-4,648	-3,814	-4,832	-517	-517

Options Appraisal
The six options have been through an options appraisal process. An exercise was undertaken with each health board individually to score and assess each option against the business case aims and the principles of regional working in section 2.1 below and appendix two.
Weighting for the scoring was allocated as follows:

- Quality and Safety: 35%
- Effective use of resources: 10%
- Strategic Fit: 10%
- Sustainability: 15%
- Access: 10%
- Deliverability: 20%

Results of the appraisal process are shown below. All three health boards have selected the same option as the highest scoring option against the criteria. Results are shown below. Scores are out of 5, with the regional total out of 15.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH	Option 4 Weekends	Option 5 Outsourcing

Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Regional Total	5.05	10.75	11.00	12.15	6.30	5.80

Preferred Option

The preferred option in this business case is Option 3b Vanguard and Max NHH

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

8. Option 1 - Do Nothing

This option involves providing no further funding and resources to cataract surgery across the region at this stage. Each health board will continue with only their planned core capacity and there will be no sharing of patient treatment lists (PTL's). The Vanguard rental will end on 30th June 2023 following the short term regional extension arrangement.

8.1.1 Core capacity

The annual core capacity of each Health Board is shown below

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	**Regional Total Core**	Regional Demand	Difference
Annual capacity	2400	1920	180	1440	5940	9,960	-4,020

8.1.2 Option Assumptions

This option is based on the following assumptions

- Use of Vanguard ends by 30th June 2023
- Capacity in CTM and AB for 23/24 remains at 2022 activity levels
- CAV have 7.5 sessions in main theatres to undertake core cataracts activity, reverting to pre-Vanguard capacity.

8.2 Option 1 – Option Appraisal

8.2.1 Option 1 Benefits

The high level benefits identified above (section 6.1) are foregone in this option. The benefits identified for this option are listed below

- No changes to the way that services are currently run
- No management capacity required to organise additional services
- No direct costs

8.2.2 Option 1 Risks

The specific risks associated with option 1 are:

- Demand continues to outstrip supply (high risk as business case is mitigation action)
- Backlogs will continue to grow (high risk as business case is mitigation action)
- Planned Care target will be missed (high risk as business case is mitigation action)
- Increased proportions of higher complexity patients as waiting times are increased (medium risk as business case is mitigation action)
- Loss of experienced and well trained staff at the Vanguard Unit (medium risk as business case is mitigation action)

- Reduction in training capacity across the region (medium risk as business case is mitigation action)
- Increases the backlog by 4,046 patients (high risk as business case is mitigation action)

8.2.3 Option 1 Patient Considerations

Through this option all patients will continue to be treated by their home health board. They will be treated within their own health board boundary but are likely to have to wait more than 1 year for assessment and treatment. As patient waits lengthen, the risk increases of patients coming to harm while waiting.

8.2.4 Option 1 costs

There are no direct costs associated with this option

Indirect costs include:

- Increased reliance on WLI's / agency staff
- Increased patient complaints
- Multiple patient referrals as primary care escalate patients due to deterioration
- Additional waiting list validation required
- Increased costs of complications as patient complexity increases

8.2.5 Option 1 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 5,940 cataracts procedures per year (114 per week, 495 per month)
- 5,940 outpatients per year (114 per week, 495 per month)
- 9,960 referrals per year (192 per week, 830 per month)

After 52 weeks of the total capacity of 5,940 per year the waiting list is increased from 19,000 across the region to 23,046

9. Option 2 – Maximising the use of NHH and POWH

Option 2 is an NHS recruitment, insourcing and outsourcing option involving a two-hub model of NHH in the North and POWH in the South. At both sites the weekday and weekend capacity is utilised, along with outsourcing in the following volumes over a 12 month period:

- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- South Hub: 3,558 (2,058 weekdays plus 1,500 weekends) outpatient assessment and inpatient procedures carried out by an insourcing company in POWH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 8,668 additional**
- **Total capacity 14,608 per year**
- Waiting list reduction 3,814 (from 19,000 to 15,186)
- Total costs: £12.4m
- Cost per patient: £1,436

9.1. Option 2 - Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

9.1.1 Clinical Service Model North Hub (NHH)

The North hub would primarily provide outpatient and inpatient provision to patients primarily in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits. There is 1 theatre available in NHH that will be used for 7 sessions in the week by NHS staff and both days on the weekend by an insourcing team.

Delivery Plan for NHH Sessions

Delivery Plan Outpatients

	Month 1	Month 2	Month 3	Month 4	Months 5-11	Month 12		Total

Patients per list	6	7	8	8	8	8		
Sessions per week	5	5	5	5	5	5		
weeks	4	4	4	4	25	1		42
total patients	120	140	160	160	1000	40		1620

Delivery Plan Inpatients

	Month 1	Month 2	Month 3	Month 4	Months 5-11	Month 12		Total
Patients per list	4	5	6	6	6	6		
Sessions per week	4	5	5	7	7	5		
weeks	1	4	4	4	28	1		42
total patients	16	100	120	168	1176	30		1610

Delivery Plan for Insourcing Sessions in NHH

	Outpatients	Inpatients
Patients per list	8	7.5
Sessions per week	4	4
Patients per week	32	30
weeks per year	47	50
total patients	1504	1500

9.1.2 Clinical Service Model South Hub (POWH)

Through Option 2 the South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from Princess of Wales Hospital site on weekdays and weekends via an insourcing company with one weekday session per week provided by NHS staff.

Delivery Plan

weekdays

Outpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
1 day session	Insourcing	8	1	8	38	304
Evenings	Insourcing	8	6	48	38	1824
Total				**56**		**2128**

Inpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
1 day session	NHS Staff	7	1	7	42	294

Evenings	Insourcing	7	6	42	42	1764
Total				**49**		**2058**

weekends

Outpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
Saturday	Insourcing	8	4	32	32	1024
Sunday	Insourcing	8	2	16	31	496
Total				**48**		**1520**

Inpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
Saturday	Insourcing	7	4	28	36	1008
Sunday	Insourcing	7	2	14	36	504
Total				**42**		**1512**

9.1.3 Outsourcing Arrangements

Option 2 Outsourcing @ 2,000 cases per year

9.1.4 Booking and scheduling For Option 2 (Maximising the use of NHH and POWH):

In one year the team will need to book 6,700 outpatient appointments across both the North and South Hubs and schedule 6,700 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 15,400 patient bookings per year. A Regional booking and scheduling team are required for these patient volumes, along with a POWH Eye Unit Manager and NHH Eye Unit Manager to ensure capacity levels are maximised.

9.1.5 Option 2 Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed

- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

9.2 Option 2 – Option Appraisal

9.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Regional	**Total**	Average Demand	Difference
AB	2400	36%	3121	**5521**	4080	1441
CAV	1440	15%	1300	**2740**	1800	940
CTM	2100	49%	4247	**6347**	4080	2267
Regional Total	5940		8668	**14608**	9960	4648

9.2.2 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
Capacity	2400	3121	5521

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
Capacity	1920	180	4247	6347

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
Capacity	1440	1300	2740

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
Capacity	5521	2740	6347	14608

9.2.3 Option 2 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Recruiting additional NHS workforce for NHH
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the POWH Eye Unit 7 days per week
- Enables a greater reduction in the backlog
- No additional capital required
- Reduces the backlog by 4,648 patients waiting

9.2.4 Option 2 Risks

The specific risks associated with option 2 are:

- High volumes of surgery through POWH Eye Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

9.2.5 Option 2 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

9.2.6 Option 2 costs

Option 2: POWH and NHH

Revenue Costs **2023/24**

Provider Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
Aneurin Bevan	Weekday Capacity	1,610	£184,342	1,610	£1,659,078	£1,843,420
Cwm Taf	Insource Weekend	1,500		1,500	£2,200,500	£2,200,500
Cwm Taf	Insource Weekday	2,058		2,058	£2,671,284	£2,671,284
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£934,145
TOTAL		**8,668**	**£758,374**	**8,668**	**£10,754,006**	**£12,446,525**

Indicative Cost per Patient £1,436

9.2.7 Option 2 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 14,608 cataracts procedures per year (281 per week, 1217 per month)
- 14,608 outpatients per year (282 per week, 1224 per month)

After 52 weeks of the total capacity of 14,608 per year the waiting list is reduced from 19,000 across the region to 14,352

Further details on Option 2 can be found in Appendix Four

10. Option 3a –Vanguard and NHH

Option 3a is an insourcing and outsourcing option involving a two-hub model of NHH in the North and the Vanguard Unit in the South with the following volumes over a 12 month period:

- South Hub: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 6,120
- **Plus 7,700 additional**
- **Total capacity 13,820 per year**
- Waiting list reduction 3,814 (from 19,000 to 15,186)
- Total costs 23/24: £12.9m
- Cost per patient: £1,672

10.1 Option 3a - Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

10.1.1 Maximising the Use of the Vanguard Unit in UHW

The Vanguard Unit in UHW is a mobile twin theatre alongside modular units for consulting, patient waiting and recovery. It is currently contracted for use for cataract surgery by CAV on a 5 day per week basis Monday to Friday with this arrangement running until 8th January 2023. As a short-term solution and to maximise the options available for this business case, the unit will be extended until 31st March 2023 and the capacity during this extension period will be divided between the three health boards in the region.

If extended, then the new contract for the Vanguard Unit will be for 7 days per week to maximise the use of the unit for the regional extension of the cataracts service. The Vanguard Unit requires capital funding.

The benefits of retaining the Vanguard Unit include the stability of staff and retaining this well trained and experienced staffing group, the ability to treat more complex patients than the insourcing and outsourcing will enable, increasing the training opportunities available across the region and providing a solid foundation for the second sustainable phase of the cataracts expansion to be based.

10.1.2 Clinical Service Model North Hub

The North hub would primarily provide outpatient and inpatient provision to patients in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits. There is 1 theatre available in NHH that will be used on both days on the weekend by an insourcing team.

Delivery Plan for Insourcing Sessions in NHH

	Outpatients	Inpatients
Patients per list	8	7.5
Sessions per week	4	4
Patients per week	32	30
weeks per year	47	50
total patients	1504	1500

10.1.3 Clinical Service Model South Hub

Through this option The South Hub would provide outpatient and inpatient provision for patients in the south of the region. The Vanguard Unit would be used 7 days per week.

On weekdays the twin theatre unit will be staff by NHS staff in a continuation of current practice. These 20 sessions will be split, 7.5 for CAV and 12.5 for regional patients. On the weekends the provision in the vanguard unit will be staffed via an insourcing company.

Weekdays

Outpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekdays	NHS Staff	8	7.5	60	46	2760

Inpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients (less CNA's)
Weekdays	NHS Staff	5	12.5	62.5	48	2700

Weekends

Outpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekends	Insourcing	8	6	48	32	1536

Inpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekends	Insourcing	7	6	42	36	1500

10.1.4 Outsourcing Arrangements

Outsourcing @ 2,000 cases per year

10.1.5 Booking and scheduling For Option 3a (Vanguard Capacity and North Hub NHH Weekends):

In one year the team will need to book 5,900 outpatient appointments across both the North and South Hubs and schedule 5,900 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 13,800 patient bookings per year. A Regional booking and scheduling tam are required for these patient volumes, along with a Vanguard Unit Manager and NHH Eye Unit Manager to ensure capacity levels are maximised.

10.1.6 Option 3a Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- Vanguard workforce can continue into 23/24
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

10.2 Option 3a – Option Appraisal

10.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity	**Total**	Average Demand	Difference
AB	2400	36%	2772	**5172**	4080	1092
CAV	1620	15%	1155	**2775**	1800	975
CTM	2100	49%	3773	**5873**	4080	1793
Regional Total	6120		7700	13820	9960	3860

10.2.2 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
Capacity	2400	2772	5172

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
Capacity	1920	180	3773	5873

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
Capacity	1620	1155	2775

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
Capacity	5172	2775	5873	13820

10.2.3 Option 3a Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Retaining a well trained and experienced staff within the Vanguard unit
- Ability to treat more complex patients are part of the regional capacity[5]
- Continuity and stability of employment for Vanguard staff
- Increased opportunities for staff training learning and development[6]
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the Vanguard unit 7 days per week
- Enables a greater reduction in the backlog
- Stabilises the short term regional arrangement (Jan-March 2023)
- Reduces the backlog by 3,814 patients waiting

10.2.4 Option 3a Risks

The specific risks associated with option 3a are:

- High volumes of surgery through Vanguard Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

10.2.5 Option 3a Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

[5] Insourcing and Outsourcing will take the less complex patients

[6] Vanguard offers the opportunity for more training lists that are shorter in size

10.2.6 Option 3a Costs

Option 3a: Use of NHH weekends and Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Cardiff and Vale	Insource Weekend	1,500		1,500	£2,831,000	£2,831,000
Cardiff and Vale	NHS Weekday	2,700		2,700	£1,944,000	£1,944,000
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£899,438
TOTAL		**7,700**	**£574,032**	**7,700**	**£8,998,144**	**£10,471,614**

Revenue: Indicative Cost per Patient £1,360

Capital Costs

Temporary Theatre @UHW	**£2,400,000**
Indicative Cost per Patient	£1,672

10.2.7 Option 3a Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 13,820 cataracts procedures per year (266 per week, 1152 per month)
- 13,820 outpatients per year (266 per week, 1152 per month)

After 52 weeks of the total capacity of 13,820 per year the waiting list is reduced from 19,000 across the region to 15,186

Further details on Option 3a can be found in Appendix Five

11. Option 3b –Vanguard and maximising NHH

This is the preferred option

As the preferred option this option has been developed in more detail than the other options.

Realistic assumptions have been made about the feasibility of delivery and the model has been designed to be distributed over 14 months split across 23/24 and 24/25.

Option 3b

As option 3a but with the addition of 7 weekday NHS sessions in NHH

Option 3b is an insourcing and outsourcing option involving a two-hub model of NHH in the North and the Vanguard Unit in the South with the following volumes over a 14 month period:

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

11.1 Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

11.1.1 Maximising the Use of the Vanguard Unit in UHW

The Vanguard Unit in UHW is a mobile twin theatre alongside modular units for consulting, patient waiting and recovery. It is currently contracted for use for cataract surgery by CAV on a 5 day per week basis Monday to Friday with this arrangement running until 8th January 2023. As a short-term solution and to maximise the options available for this business case, the unit will be extended until 30th June 2023 and the capacity during this extension period will be divided between the three health boards in the region.

If extended, then the new contract for the Vanguard Unit will be for 7 days per week to maximise the use of the unit for the regional extension of the cataracts service. The Vanguard Unit requires capital funding.

The benefits of retaining the Vanguard Unit include the stability of staff and retaining this well trained and experienced staffing group, the ability to treat more complex patients than the insourcing and outsourcing will enable, increasing the training opportunities available across the region and providing a solid foundation for the second sustainable phase of the cataracts expansion to be based.

11.1.2 Clinical Service Model North Hub

The North hub would primarily provide outpatient and inpatient provision to patients primarily in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits using an additional theatre in NHH on weekdays, staffed by NHS staff and on both days on the weekend by an insourcing team

Delivery Plan for NHH Sessions Weekdays NHS Staff

Delivery Plan Outpatients

Delivery from months 3-14 of the plan

	Month 3	Month 4	Month 5	Month 6	Months 7-13	Month 14		Total
Patients per list	6	7	8	8	8	8		
Sessions per week	5	5	5	5	5	5		
weeks	4	4	4	4	25	1		42
total patients	120	140	160	160	1000	40		1620

Delivery Plan Inpatients

Delivery from months 3-14 of the plan

	Month 3	Month 4	Month 5	Month 6	Months 7-13	Month 14		Total
Patients per list	4	5	6	6	6	6		
Sessions per week	4	5	5	7	7	5		
weeks	1	4	4	4	28	1		42
total patients	16	100	120	168	1176	30		1610

Delivery Plan for Insourcing Sessions in NHH Weekends

	Outpatients	Inpatients
Patients per list	8	7.5
Sessions per week	4	4
Patients per week	32	30
weeks per year	47	50
total patients	1504	1500

11.1.3 Clinical Service Model South Hub

Through this option The South Hub would provide outpatient and inpatient provision for patients in the south of the region. The Vanguard Unit would be used 7 days per week.

On weekdays the twin theatre unit will be staff by NHS staff in a continuation of current practice. These 20 sessions will be split, 7.5 for CAV and 12.5 for regional patients. On the weekends the provision in the vanguard unit will be staffed via an insourcing company.

Weekdays

Outpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekdays	NHS Staff	8	7.5	60	46	2760

Inpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients (less CNA's)
Weekdays	NHS Staff	5	12.5	62.5	48	2700

Weekends

Outpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients

Weekends	Insourcing	8	6	48	32	1536

Inpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekends	Insourcing	7	6	42	36	1500

11.1.4 Outsourcing Arrangements

Outsourcing @ 2,000 cases per year

11.1.5 Booking and scheduling For Option 3a (Vanguard Capacity and North Hub NHH Weekends):

In one year the team will need to book 7,310 outpatient appointments across both the North and South Hubs and schedule 7,310 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 16,620 patient bookings per year. A Regional booking and scheduling team are required for these patient volumes, along with a Vanguard Unit Manager and NHH Eye Unit Manager to ensure capacity levels are maximised.

11.1.6 Delivery Plan

The delivery will run for 14 months and individual streams of activity will start and finish as follows:

- Month 1 to month 12
    - Vanguard Weekdays
- Month 2 to month 12
    - Vanguard Insourcing
- Month 2 to month 13
    - NHH Insourcing
    - Outsourcing
- Month 3 to month 14
    - NHH Weekdays

11.1.7 Option 3b Assumptions

- NHH Workforce can be fully recruited
- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement

- Effective clinical governance arrangements
- Vanguard workforce can continue into 23/24
- CTM continue with their current levels of outsourcing (15 per month)
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

11.2 Option 3b – Option Appraisal

11.2.1 Additional Regional Capacity

Capacity	Core 14 months	Additional Capacity %	Additional Regional	**Total**	14 months demand	Difference
AB	2800	36%	3352	**6152**	4760	1392
CAV	1890	15%	1397	**3287**	2100	1187
CTM	2440	49%	4562	**7002**	4760	2242
Regional Total	7140		9310	**16450**	11620	4830

11.2.2 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages.

Delivery is split over 2 financial years as follows:

- 9 months of 23/24 from 1st July 2023 to 31st March 2024
- 5 months of 24/25 from 1st April 2024 to 31st August 2024

AB Patients

	Core: AB In House	AB 39%	AB Total from this business case
1st July 2023 to 31st March 2024	1800	2313	4113
1st April 2024 to 31st August 2024	1000	1039	2039
Total Allocation	2800	3352	6152

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
1st July 2023 to 31st March 2024	1215	964	2179

1st April 2024 to 31st August 2024	675	433	1108
Total Allocation	1890	1397	3287

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
1st July 2023 to 31st March 2024	1440	135	3148	4723
1st April 2024 to 31st August 2024	800	75	1414	2289
Total Allocation	2240	210	4562	7012

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
1st July 2023 to 31st March 2024	4113	2179	4723	11014
1st April 2024 to 31st August 2024	2039	1108	2289	5436
Total Allocation	6152	3287	7012	**16450**

11.2.3 Option 3b Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Retaining a well trained and experienced staff within the Vanguard unit
- Ability to treat more complex patients are part of the regional capacity[7]
- Continuity and stability of employment for Vanguard staff
- Increased opportunities for staff training learning and development[8]
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the Vanguard unit 7 days per week
- Greater proportion of cataracts surgery undertaken by NHS staff
- Enables a greater reduction in the backlog
- Stabilises the short term regional arrangement (Jan-March 2023)
- Reduces the backlog by 4,832 patients waiting

11.2.4 Option 3b Risks

The specific risks associated with this option are:

- High volumes of surgery through Vanguard Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing

[7] Insourcing and Outsourcing will take the less complex patients

[8] Vanguard offers the opportunity for more training lists that are shorter in size

capacity (low risk following mitigation actions)

11.2.5 Option 3b Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

11.2.6 Option 3b Costs

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs

			2023/24				2024/25			TOTAL ACTIVITY	TOTAL COST
Host Health Board	Delivery	Pre Go Live costs	Patients	Patients	Total Estimated Costs	Cost per Patient	Host Health Board	Delivery	Patients	Patients	Patients	Patients
Provider			Activity	Cost		Cost per case excl capital and pre go live			Activity	Cost	Activity	Cost
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589	Cardiff and Vale	Insource Weekend	410	£651,344	1,500	£2,382,967
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812	Cardiff and Vale	Weekday	675	£547,907	2,700	£2,191,628
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328	Aneurin Bevan	Insource Weekend	500	£664,206	1,500	£2,118,401
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151	Aneurin Bevan	Weekday Capacity	670	£771,366	1,610	£2,017,103
External	Outsource		1,334	1,861,757	£1,861,757	£1,396	External	Outsource	666	£929,483	2,000	£2,791,240
Regional Operational Team		£50,642		£871,566	£922,208		Regional Operational Team			£443,449		£1,365,656
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**		**TOTAL**		**2,921**	**£4,007,754**	**9,310**	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW		**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS		**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the 'long waiters' commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as 'pre go live'. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The 'regional operational team' meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

11.2.7 Option 3b Activity Modelling

This scenario is based on the following assumptions:

- 9,960 referrals per year (192 per week, 830 per month)
- 15,430 cataracts procedures per year (297 per week, 1286 per month)
- 15,430 outpatients per year (297 per week, 1286 per month)

Over 14 months this would be:

- 11,620 referrals per year
- 16,450 cataracts procedures per year
- 16,450 outpatients per year

After 14 months the total capacity of 16,450 per year the waiting list is reduced from 19,000 across the region to 14,168

Further details on Option 3b can be found in Appendix Six

12. Option 4 – Weekend Insourcing and Outsourcing Only

The Insourcing and outsourcing option involves a two hub model of NHH in the North and the use of POWH in the south for outpatients and Inpatients, along with outsourcing in the following volumes over a 12 month period:

- North Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- South Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in POWH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 5,000 additional**
- **Total capacity 10,940 per year**
- Waiting list reduction 517 (from 19,000 to 18,483)
- Total costs 23/24: £7.5m
- Cost per patient: £1,504

12.1 Option 4 – Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

12.1.1 Clinical Service Model North Hub

The North hub would primarily provide outpatient and inpatient provision to patients in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits. There is 1 theatre available in NHH that will be used on both days on the weekend by an insourcing team.

Delivery Plan for Insourcing Sessions in NHH

	Outpatients	Inpatients
Patients per list	8	7.5
Sessions per week	4	4
Patients per week	32	30
weeks per year	47	50

total patients	1504	1500

12.1.2 South Hub

Through this Option the South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from Princess of Wales Hospital in Bridgend on weekends via an insourcing company

weekends

Outpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
Saturday	Insourcing	8	4	32	32	1024
Sunday	Insourcing	8	2	16	31	496
Total				**48**		**1520**

Inpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
Saturday	Insourcing	7	4	28	36	1000
Sunday	Insourcing	7	2	14	36	500
Total				**42**		**1500**

12.1.3 Outsourcing Arrangements

This Option will deliver an additional 2,000 cases per year. Outsourcing arrangements and costs include patient travel.

12.1.4 Booking and scheduling for Option 4 (Weekend Insourcing and Outsourcing)

In one year the team will need to book 3,000 outpatient appointments across both the North and South Hubs and schedule 3,000 inpatient procedures in addition to facilitating 2,000 outsourced patients totalling 8,000 patient contacts per year. A Regional booking and scheduling tam are required for these patient volumes.

12.1.5 Option 4 Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements

- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

12.2 Option 4 – Option Appraisal

12.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity	**Total**	Average Demand	Difference
AB	2400	36%	1800	**4200**	4080	120
CAV	1440	15%	750	**2190**	1800	390
CTM	2100	49%	2450	**4550**	4080	470
Regional Total	5940		5000	**10940**	9960	980

12.2.2 Regional Capacity by expected patients treated

Reviewing the end of the list, 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total
Capacity	2400	1800	4200

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total
Capacity	1920	180	2450	4550

CAV Patients

	Core: CAV In House	CAV 15%	CAV Total
Capacity	1440	750	2190

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
Capacity	4200	2190	4550	10940

12.2.4 Option 4 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Outpatient assessments and inpatients treatments are performed on the same site
- Reduces the backlog by 517 patients waiting

12.2.5 Option 4 Risks

The specific risks associated with this option are:

- Loss of experienced and well trained staff at the Vanguard Unit (low risk following mitigation actions)
- Reduction in training capacity across the region (medium risk following mitigation actions)
- Reduced capacity to treat more complex patients (medium risk following mitigation actions)

12.2.6 Option 4 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will remain at current levels. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

12.2.7 Option 4 Costs

Option 4 costs are shown here

Option 4: POW and NHH weekends without Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
Cwm Taf	Insource Weekend	1,500		1,500	£2,200,500	£2,200,500
External	Outsource	2,000	316,000	2,000	2,379,333	2,695,333
Regional Operational Team						£524,453
TOTAL		**5,000**	**£574,032**	**5,000**	**£6,423,644**	**£7,522,129**

Indicative Cost per Patient £1,504

Costing assumptions-

- Cost assumptions are based on locally provided figures
- Insource cost estimates are based on Framework expectation of PbR plus 10% but will depend on casemix and provider
- Outsourcing estimates are based on PbR with an element for transport but dependent on casemix and provider

12.2.8 Option 4 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 10,940 cataracts procedures per year (202 per week, 874 per month)
- 10,940 outpatients per year (202 per week, 874 per month)

After 52 weeks of the total capacity of 10,940 per year the waiting list is reduced from 19,000 across the region to 18,483

Further details on Option 4 can be found in Appendix Seven

13. Option 5 – Outsourcing

The option involves outsourcing the whole additional capacity. By using outsourcing only, the demands on the regional booking and scheduling team also reduce. It is unlikely that one supplier would be able to fulfil the whole 5,000 procedures per year and so it would be split across different providers with the following volumes over a 12 month period:

- An additional 5,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 5,000 additional**
- **Total capacity 10,940 per year**
- Waiting list reduction 517 (from 19,000 to 18,483)
- Total costs 23/24: £7m
- Cost per patient: £1,410

13.1 Option 5 – Clinical and Service Model

13.1.1 Outsourcing Arrangements

Outsourcing can relieve some of the management and back office administrative time associated with working through the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Through this option 5,000 cases are outsourced. Outsourcing arrangements and costs include patient travel.

Patients are reviewed by a non-clinical administrator for their suitability for outsourcing and then referred on to the outsourcing company for assessment and treatment. Communication with the patient about booking and scheduling and locations are conducted by the outsourcing company. Follow ups post-surgery are conducted in primary care. Hospital patient records are updated.

13.1.2 Booking and scheduling For Option 5 (Outsourcing)

In one year the team would need to facilitate 5,000 outsourced patients and ensure records are kept up to date and that these patients are suitable for the outsourcing route.

13.1.3 Option 5 Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Outsourcing contracting will be done at a National level
- Outsourcing may be through a number of providers

- That outsourcing capacity will be available in the market through contracting arrangements
- Outsourcing company(ies) to carry out enough outpatient assessments to treat 5,000 patients
- Effective clinical governance arrangements

13.2 Option 5 – Option Appraisal

13.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity (outsourced)	**Total**	Average Demand	Difference
AB	2400	36%	1800	**4200**	4080	120
CAV	1440	15%	750	**2190**	1800	390
CTM	2100	49%	2450	**4550**	4080	470
Regional Total	5940		5000	**10940**	9960	980

13.2.3 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total
Capacity	2400	1800	4200

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total
Capacity	1920	180	2450	4550

CAV Patients

	Core: CAV In House	CAV 15%	CAV Total
Capacity	1440	750	2190

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
Capacity	4200	2190	4550	10940

13.2.4 Option 5 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Outpatient assessments and inpatients treatments are performed on the same site
- Additional capacity delivered at reduced costs from insourcing
- Reduces the backlog by 517 patients waiting

13.2.5 Option 5 Risks

The specific risks associated with option 2 are:

- Loss of experienced and well trained staff at the Vanguard Unit (medium risk following mitigation actions)
- Reduction in training capacity across the region (medium risk following mitigation actions)
- Reduced capacity to treat more complex patients (medium risk following mitigation actions)
- Increased number of patients required to travel further for treatment

13.2.6 Option 4 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will remain at current levels.

This option is for outsourcing activity where patients who meet the criteria for this additional capacity would be directed to outsourcing for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and outsourcing capacity provision. This option also includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity does not include patient travel contributions.

13.2.7 Option 5 Costs

Option 5: Outsourcing Only

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
External	Outsource	5,000	£790,000	5,000	£5,948,333	£6,738,333
Regional Operational Team						£312,427
TOTAL		**5,000**	**£790,000**	**5,000**	**£5,948,333**	**£7,050,760**

Indicative Cost per Patient £1,410

13.2.8 Option 5 Activity Modelling

The assumptions used in this option are the same as in option 4, as the capacity stays the same but the mode of delivery changes.

After 52 weeks of the total capacity of 10,940 per year the waiting list is reduced from 19,000 across the region to 18,483

Further details on Option 5 can be found in Appendix Eight

14.Preferred Option

14.1 Preferred Option

The preferred option in this business case is Option 3b Vanguard and Max NHH

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

14.2 Options Appraisal

The six options have been through an options appraisal process. An exercise was undertaken with each health board individually to score and assess each option against the business case aims and the principles of regional working in section 2.1 below and appendix two.

Weighting for the scoring was allocated as follows:

- Quality and Safety: 35%
- Effective use of resources: 10%
- Strategic Fit: 10%
- Sustainability: 15%
- Access: 10%
- Deliverability: 20%

Results of the appraisal process are shown below. All three health boards have selected the same option as the highest scoring option against the criteria. Results are shown below. Scores are out of 5, with the regional total out of 15.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard	Option 4 Weekends	Option 5 Outsourcing

				and Max NHH		
Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Regional Total	5.05	10.75	11.00	12.15	6.30	5.80

14.3 Option Costs

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs

			2023/24					2024/25			TOTAL ACTIVITY	TOTAL COST
Host Health Board	Delivery	Pre Go Live costs	Patients	Patients	Total Estimated Costs	Cost per Patient	Host Health Board	Delivery	Patients	Patients	Patients	Patients
Provider			Activity	Cost		Cost per case excl capital and pre go live			Activity	Cost	Activity	Cost
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589	Cardiff and Vale	Insource Weekend	410	£651,344	1,500	£2,382,967
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812	Cardiff and Vale	Weekday	675	£547,907	2,700	£2,191,628
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328	Aneurin Bevan	Insource Weekend	500	£664,206	1,500	£2,118,401
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151	Aneurin Bevan	Weekday Capacity	670	£771,366	1,610	£2,017,103
External	Outsource		1,334	1,861,757	£1,861,757	£1,396	External	Outsource	666	£929,483	2,000	£2,791,240
Regional Operational Team		£50,642		£871,566	£922,208		Regional Operational Team			£443,449		£1,365,656
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**		**TOTAL**		**2,921**	**£4,007,754**	**9,310**	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW		**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS		**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the ‘long waiters’ commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as ‘pre go live’. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The ‘regional operational team’ meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

15.Summary

The business case demonstrates a clear need for additional capacity for cataracts assessment and surgery in the South East Wales Region. By working together the three health boards can provide this capacity for patients and deliver the benefits described in the case.

This business case has strong strategic links with the National Planned Care goals, the Ophthalmology GIRFT Programme report and the Royal College of Ophthalmologists External Review of Eye Care Services in Wales and contributes towards the delivery of reducing waiting times for patients.

The additional capacity addresses the significant backlog in this area and provides the headroom necessary to plan and implement longer term sustainable solution and to demonstrate the successes of regional working. This business case enables the region to maximise the existing capacity available on our hospital sites and more provide timely care to patients regardless of where they live within the region.

The table below summarises the options

High level Financials

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Core Capacity	5,940	5,940	6,120	7,140*	5,940	5,940
Additional Regional Capacity	0	8668	7,700	9,310	5,000	5,000
Total Capacity	5,940	14,608	13,820	16,450	10,940	10,940
Total Revenue Costs	£0	£12.4m	£10.5m	£12.9m**	£7.5m	£7m
Total Capital Costs	£0	£0	£2.4m	£2.4m	£0	£0
Total Costs (Capital + Revenue)	£0	£12.4m	£12.9m	£15.3m	£7.5m	£7m
Cost per patient	n/a	£1,436	£1,672	£1,640	£1,504	£1,410

**Option 3b is for 14 months*

***Costing for this option include 5% increase on all pay costs*

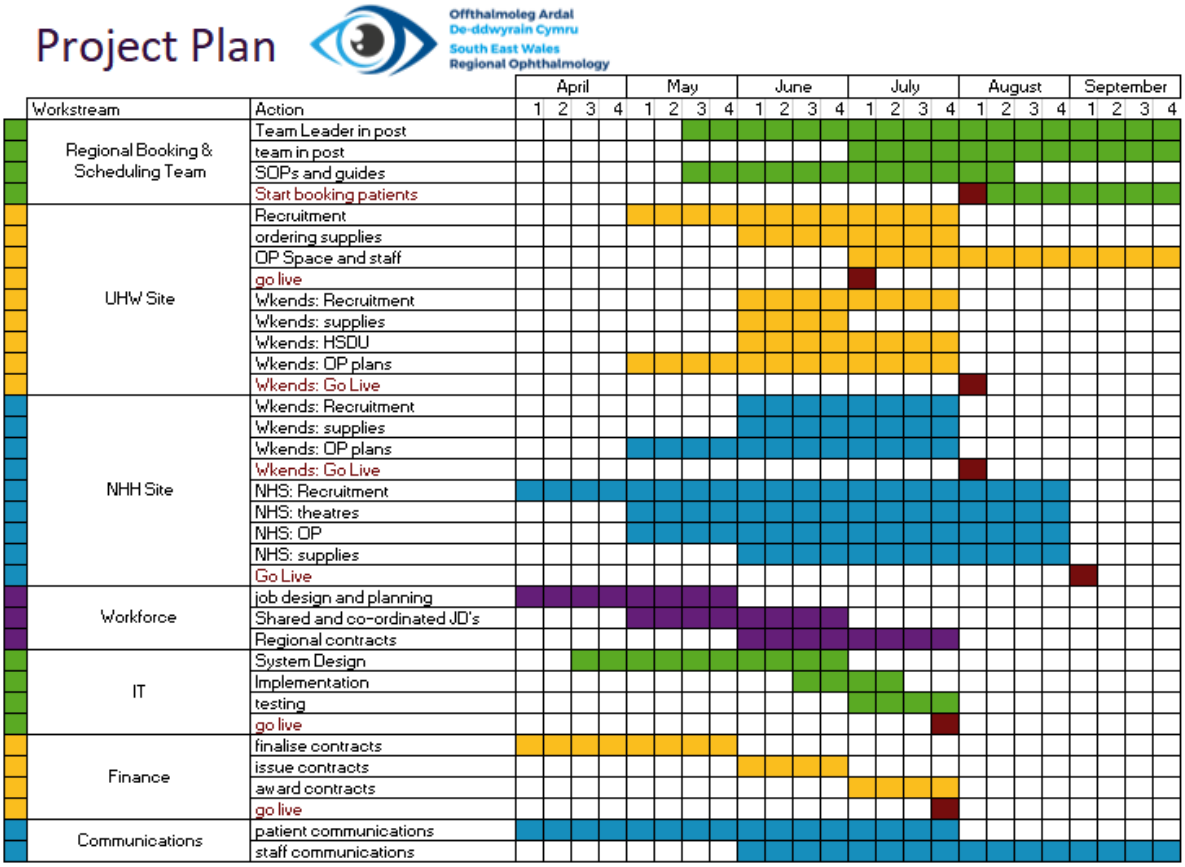
16.Interdependencies

The interdependencies identified through this work are:

- Stabilising and protecting core capacity in CAV
- Stabilising and protecting core capacity in CTM
- Stabilising and protecting core capacity in AB
- Commissioners –appropriate commissioning frameworks to be developed
- Capital funding required for Vanguard.

17.Implementation Plans

The implementation plan for the business case is shown below.



Implementation

The Implementation of this business case is a priority across Health Boards and the outline plan above is for the implementation phase. This will be an intensive phase of activity across the health boards and will require an additional project manager to work full time on this work as part of the programme. There will likely be a soft launch of the additional capacity and time will be required to embed the new models and make improvements to processes. As part of the wider Regional Programme proposals for a regional Vitreo-Retinal hub service need to be planned and implemented early in the calendar year to support the complications arising from the cataract service and so additional project support and a dedicated clinical lead is required for the programme.

18.Approvals

Milestone	Date	Decision
Completion by the working group	Wednesday 16th November	Agreement to go forward to Ophthalmology Programme Board
Ophthalmology Programme Board	12th December	Approved to go forward to next stage
Regional Portfolio Delivery Board	6th April 2023	Approved to go forward to next stage
Regional Portfolio Oversight Board	13th April 2023	Approved to go forward to next stage
Management Execs AB	13th April 2023	Approved to go forward to next stage
Investment Group CAV	18th April 2023	Approved to go forward to next stage
Management Execs (SLB) CAV	4th May 2023	Approved to go forward to next stage
Management Execs CTM	9th May 2023	Approved to go forward to next stage
Welsh Gov Submission	12th May	
Board Meeting AB	24th May 2023	
Board Meeting CAV	25th May 2023	
Board Meeting CTM	25th May 2023	

Appendix One: Financials

Option 3b - Preferred Option

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs

			2023/24				2024/25		TOTAL ACTIVITY	TOTAL COST
Host Health Board	Delivery	Pre Go Live costs	Patients	Patients	Total Estimated Costs	Cost per Patient	Host Health Board	Delivery	Patients	Patients	Patients	Patients
Provider			Activity	Cost		Cost per case excl capital and pre go live			Activity	Cost	Activity	Cost
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589	Cardiff and Vale	Insource Weekend	410	£651,344	1,500	£2,382,967
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812	Cardiff and Vale	Weekday	675	£547,907	2,700	£2,191,628
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328	Aneurin Bevan	Insource Weekend	500	£664,206	1,500	£2,118,401
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151	Aneurin Bevan	Weekday Capacity	670	£771,366	1,610	£2,017,103
External	Outsource		1,334	1,861,757	£1,861,757	£1,396	External	Outsource	666	£929,483	2,000	£2,791,240
Regional Operational Team		£50,642		£871,566	£922,208		Regional Operational Team			£443,449		£1,365,656
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**		**TOTAL**		**2,921**	**£4,007,754**	**9,310**	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW	**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS	**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the ‘long waiters’ commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as ‘pre go live’. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The ‘regional operational team’ meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

Option 1 – Do nothing

Do nothing – no additional costs

Option 2 – Maximising NHH and POWH

Option 2: POWH and NHH

Revenue Costs **2023/24**

Provider Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
Aneurin Bevan	Weekday Capacity	1,610	£184,342	1,610	£1,659,078	£1,843,420
Cwm Taf	Insource Weekend	1,500		1,500	£2,200,500	£2,200,500
Cwm Taf	Insource Weekday	2,058		2,058	£2,671,284	£2,671,284
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£934,145
TOTAL		**8,668**	**£758,374**	**8,668**	**£10,754,006**	**£12,446,525**

Indicative Cost per Patient £1,436

Option 3a Costs vanguard and NHH Weekends

Option 3a: Use of NHH weekends and Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Cardiff and Vale	Insource Weekend	1,500		1,500	£2,831,000	£2,831,000
Cardiff and Vale	NHS Weekday	2,700		2,700	£1,944,000	£1,944,000
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£899,438
TOTAL		**7,700**	**£574,032**	**7,700**	**£8,998,144**	**£10,471,614**

Revenue: Indicative Cost per Patient £1,360

Capital Costs

Temporary Theatre @UHW	**£2,400,000**

Indicative Cost per Patient £1,672

Option 4 - Weekend Insourcing and Outsourcing Only

Option 4: POW and NHH weekends without Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
Cwm Taf	Insource Weekend	1,500		1,500	£2,200,500	£2,200,500
External	Outsource	2,000	316,000	2,000	2,379,333	2,695,333
Regional Operational Team						£524,453
TOTAL		**5,000**	**£574,032**	**5,000**	**£6,423,644**	**£7,522,129**

Indicative Cost per Patient £1,504

Option 5 - Outsourcing

Option 5: Outsourcing Only

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
External	Outsource	5,000	£790,000	5,000	£5,948,333	£6,738,333
Regional Operational Team						£312,427
TOTAL		**5,000**	**£790,000**	**5,000**	**£5,948,333**	**£7,050,760**

Indicative Cost per Patient £1,410

Appendix Two: Options Appraisal details

The following six options were considered as part of the options appraisal.

Business Case
Options Appraisal Criteria

Offthalmoleg Ardal
De-ddwyrain Cymru
South East Wales
Regional Ophthalmology

The options developed in the business case will be assessed through separate financial and non-financial appraisals. The proposed criteria for assessing non-financial options in the business case is set out below

Domain	Weight	Principles	Business Case Aims
Quality & safety	35%	Evidences a reduction in unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level. Evidences patient safety, quality and/or compliance issues Evidences any poor benchmarking indicators across the region are being addressed.	to address current waiting list backlogs to reduce clinical risk on an equitable basis across the region
Effective use of resources	10%	Makes effective use of capacity and capability across the region Evidences a direct link to one or more operational 'targets' for HBs and/or region	to provide additional regional capacity for cataract outpatient and inpatient stages to demonstrate optimal utilisation of our assets across the region Deliver value for money
Strategic Fit	10%	Evidence of fit with national clinical strategies and professional reviews Evidences a direct link to improving population health Evidences a direct link to key national policy / frameworks / legislation	to enact a collaborative regional approach to recovery
Sustainability	15%	Evidences improved sustainable service resilience. Evidences a link to the NHS Wales decarbonization agenda	Protect the viability of the core capacity
Access	10%	To agree approaches to engagement and communications together.	Keep patient travel to a minimum
Deliverability	20%	Evidence that benefits, measures and a critical path for delivery is understood and achievable.	Be mobilised quickly Be deliverable with the resources available

Method: There are six options in the business case, each Health board will assess each option against each domain and award a score between 1-5 (5 fully meets, 1 does not meet). The scores will be combined to determine the preferred option.

Results of the Options appraisal are shown below

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH	Option 4 Weekends	Option 5 Outsourcing
Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Total	5.05	10.75	11.00	12.15	6.30	5.80

Appendix Three: Option 1 Details

This option involves providing no further funding and resources to cataract surgery across the region at this stage. Each health board will continue with only their planned core capacity and there will be no sharing of patient treatment lists (PTL's). The Vanguard rental will end on 31st March 2023 following the two month short term regional arrangement.

8.1.1 Core capacity

The annual core capacity of each Health Board is shown below

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	**Regional Total Core**	Regional Demand	Difference
2023/24	2400	1920	180	1440	5940	9,960	-4,020

8.1.2 Option Assumptions

This option is based on the following assumptions

- Use of Vanguard ends by March 31st 2023
- Capacity in CTM and AB for 23/24 remains at 2022 activity levels
- CAV have 7.5 sessions in main theatres to undertake core cataracts activity, reverting to pre-Vanguard capacity.

8.2 Option 1 – Option Appraisal

8.2.1 Option 1 Benefits

The high level benefits identified above (section 6.1) are foregone in this option. The benefits identified for this option are listed below

- No changes to the way that services are currently run
- No management capacity required to organise additional services
- No direct costs

8.2.2 Option 1 Risks

The specific risks associated with option 1 are:

- Demand continues to outstrip supply (high risk as business case is mitigation action)
- Backlogs will continue to grow (high risk as business case is mitigation action)
- Planned Care target will be missed (high risk as business case is mitigation action)
- Increased proportions of higher complexity patients as waiting times are increased (medium risk as business case is mitigation action)

- Loss of experienced and well trained staff at the Vanguard Unit (medium risk as business case is mitigation action)
- Reduction in training capacity across the region (medium risk as business case is mitigation action)
- Increases the backlog by 4,046 patients (high risk as business case is mitigation action)

8.2.3 Option 1 Patient Considerations

Through this option all patients will continue to be treated by their home health board. They will be treated within their own health board boundary but are likely to have to wait more than 1 year for assessment and treatment. As patient waits lengthen, the risk increases of patients coming to harm while waiting.

8.2.4 Option 1 costs

There are no direct costs associated with this option

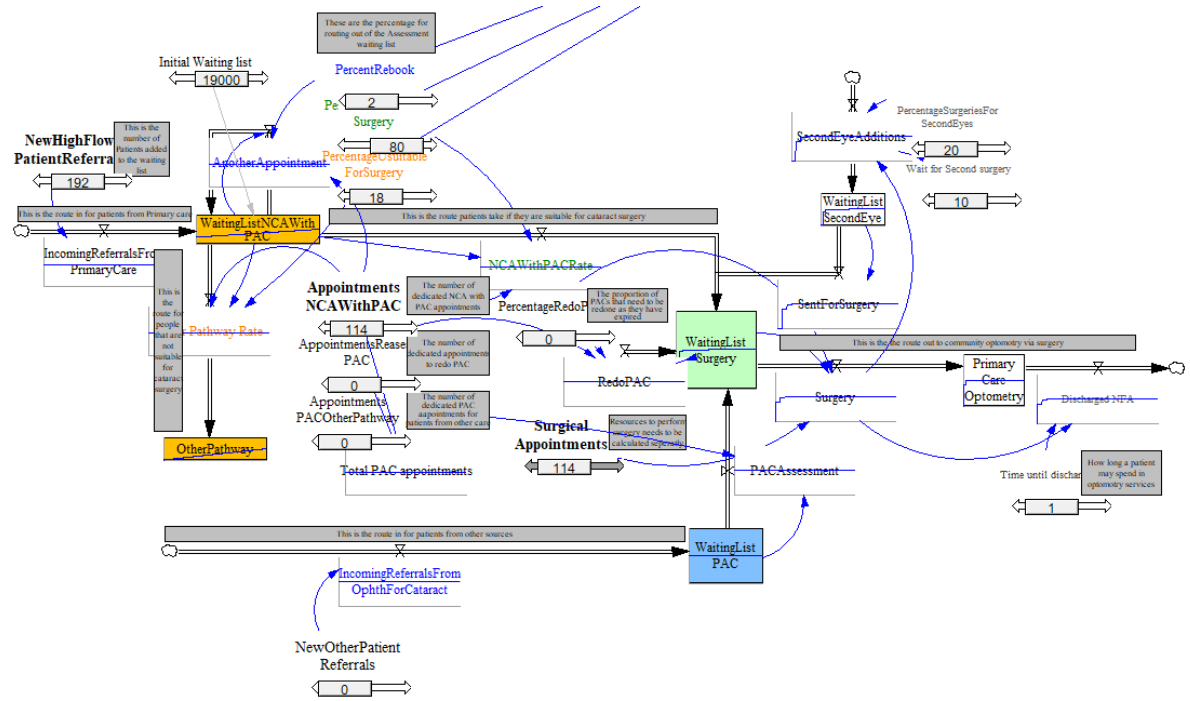
Indirect costs include:

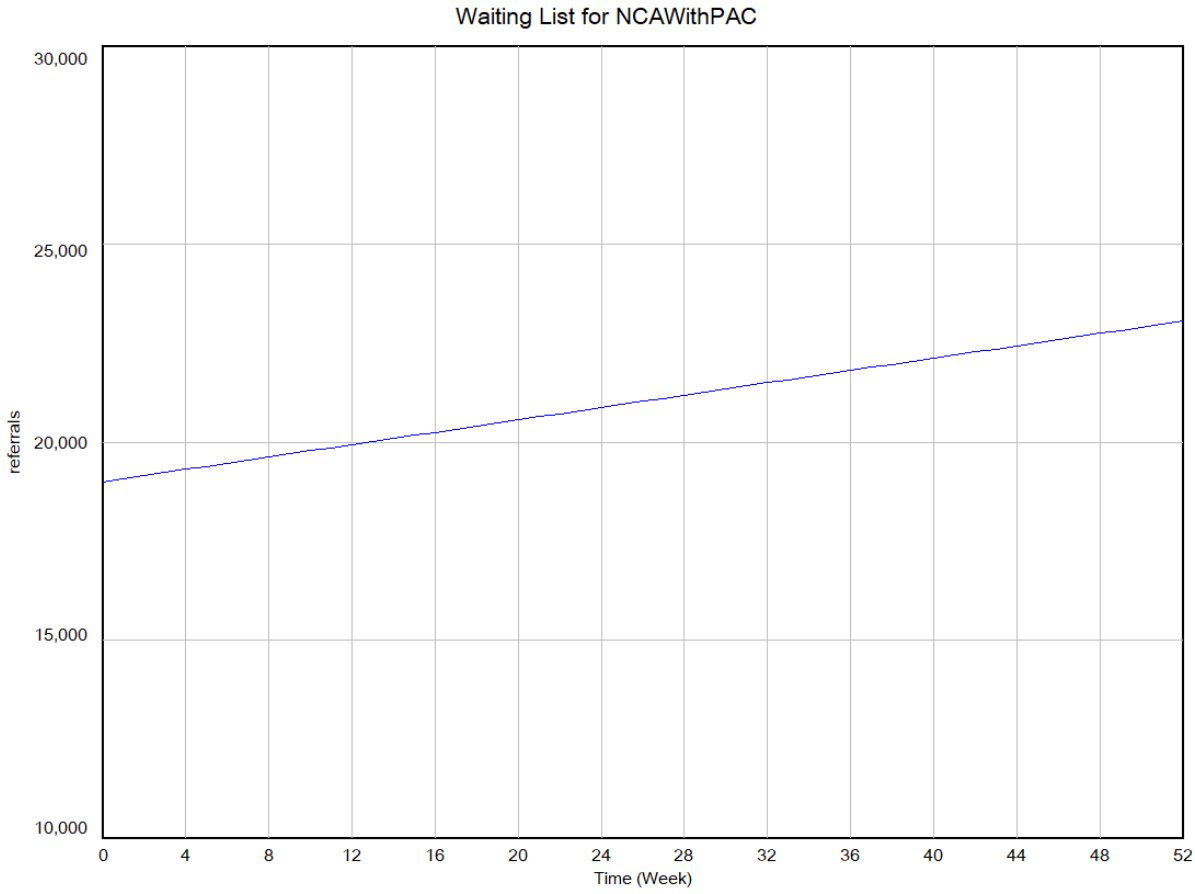
- Increased reliance on WLI's / agency staff
- Increased patient complaints
- Multiple patient referrals as primary care escalate patients due to deterioration
- Additional waiting list validation required
- Increased costs of complications as patient complexity increases

8.2.5 Option 1 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 5,940 cataracts procedures per year (114 per week, 495 per month)
- 5,940 outpatients per year (114 per week, 495 per month)
- 9,960 referrals per year (192 per week, 830 per month)





After 52 weeks of the total capacity of 5,940 per year the waiting list is increased from 19,000 across the region to 23,046

Appendix Four: Option 2 Details

Option 2 is an NHS recruitment, insourcing and outsourcing option involving a two-hub model of NHH in the North and POWH in the South. At both sites the weekday and weekend capacity is utilised, along with outsourcing in the following volumes over a 12 month period:

- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- South Hub: 3,558 (2,058 weekdays plus 1,500 weekends) outpatient assessment and inpatient procedures carried out by an insourcing company in POWH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 8,668 additional**
- **Total capacity 14,608 per year**
- Waiting list reduction 3,814 (from 19,000 to 15,186)
- Total costs 23/24: £12.4m
- Cost per patient: £1,436

9.1. Option 2 - Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

9.1.1 Clinical Service Model North Hub (NHH)

The North hub would primarily provide outpatient and inpatient provision to patients primarily in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits.

Weekdays: Outpatients Stage (NHS Staff)

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 135 outpatient appointments per month (38 per week, 1,620 per year) the sessions will be a ‘one stop shop’ model, held on weekdays in the OP dept in NHH.

4 consulting rooms will be required plus a waiting area. This weekday activity will be staffed through recruitment of NHS staff for all of the clinical and not clinical staff required.

Weekends: Outpatient Stage (Insourcing Staff)

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 125 outpatient appointments per month (30 per week, 1,500 per year) the sessions will be a 'one stop shop' model, held on a Saturday in the OP dept in NHH. 4 consulting rooms will be required plus a waiting area. This will be staffed thought an insourcing company

Assuming that the required clinical staff including Consultants, PAC nurse and biometry staff will be provided by the Insourcing provider, the following additional staff will also be required to run weekly Saturday OP clinics for 1 year:

- 0.5 WTE Receptionist Band 2 £15,780
- 0.5 WTE Health Records Clinical Notes Band 2 £15,780
- 0.5 WTE Governance Nurse band 6 £29,372

Other non staff requirements for the OP sessions are

- Cleaning (Saturday) £7500

Lenses will be also ordered at this point if the patient is suitable for surgery. Costs of lenses will be included in the Inpatient section.

Outpatients Clinical Model

These patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Weekdays; Inpatient Stage (NHS Staff)

Patients attending the weekday regional capacity for cataract surgery in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub weekday arrangements in NHH with NHS staff.

In order to undertake 38 procedures per week (135 per month, 1,610 per year) the procedures will be undertaken in Main Theatres at NHH on weekdays, Mondays and Wednesday to Friday.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity.

Weekends: Inpatient Stage (Insourcing Staff)

Patients attending the weekend regional capacity for cataract surgery in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub weekend arrangements in NHH with insourcing staff.

In order to undertake 30 procedures per week (125 per month, 1,500 per year) the procedures will be undertaken in Main Theatres at NHH on Saturdays and Sundays.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity.

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.6 WTE Receptionist Band 2 £18,936
- 0.6 WTE Health Records Clinical Notes Band 2 £18,936
- 0.6 WTE Governance Nurse band 6 £35,246

Non-Staff Requirements

Other non-staff requirements for the Inpatient sessions are:

Weekends
Cleaning / Waste / Facilities - £47,883

HSDU costs (Including transport) - £30,000 Purchase of additional surgical trays and equipment - £38,284 Stellaris Handpieces- £87,500 Pharmacy costs, Lens and consumables - £224,310 Additional lens costs £7,716

9.1.2 Clinical Service Model South Hub (POWH)

Through Option 2 the South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from Princess of Wales Hospital site on weekdays and weekends via an insourcing company with one weekday session per week provided by NHS staff.

Weekdays: Outpatient Stage

During Weekdays the outpatient stage will be undertaken through insourcing with all clinical staff provided by the insourcing company. Outpatient assessments will be carried out during evenings on the POWH site. Two pre assessment rooms are available.

Weekends: Outpatient Stage

The POWH site has two pre-assessment rooms which can be used concurrently during weekends during 2023/24. Each room would house one pre-assessment nurse each, and both could be serviced with one doctor in clinic. All the clinical staff would be provided through the insourcing company. In one session using two PAC nurses concurrently, 10 patients could be assessed.

Staff Recruitment

In addition the staffing costs for running outpatient clinics evenings and weekends would be:

Weekends
• 0.5 WTE B2 Receptionist • 0.5 WTE B3 Booking • 0.5 WTE B6 Governance Nurse

Non- staffing costs

- Cleaning for evenings and weekends

Outpatient Clinical Model

Patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Weekdays: Inpatient Stage (Insourcing, plus 1 NHS staffed session)

Patients accessing the additional capacity for weekday insourcing in the South Hub will be booked through the regional booking team (see section 5.4). They will also have had their OP assessment through the South hub weekday arrangements in POWH.

POWH has a twin theatre set up and the flow enables a maximum of 7 patients on a list for high flow low complexity patients. Running the twin theatres enables 14 patients to be seen in a morning. Weekday capacity in POWH will be achieved through 1 weekday 'in hours' session to be staffed by NHS staff and 3 evenings per week to be staffing through insourcing.

By running the two theatres on three evenings per week on weekdays, 42 patients can be seen in the evenings (total 6 sessions) plus the additional day session with 7 patients on a list totalling 49 patients per week on evenings and the 1 day session.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Weekends: Inpatient Stage (Insourcing)

Patients accessing the additional capacity for weekend insourcing in the South Hub will be booked through the regional booking team (see section 5.4). They will also have had their OP assessment through the South hub weekend arrangements in POWH.

POWH has a twin theatre set up and the flow enables a maximum of 7 patients on a list for high flow low complexity patients. Running the twin theatres enables 14 patients to be seen

in a morning. By running the two theatres on Saturdays all day and Sunday mornings, 42 patients can be seen in a weekend (total 6 sessions). This model can run for 36 weeks to treat the 1,500 patients through the insourcing.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Staff Recruitment

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

Weekends
• 0.6 WTE Receptionist Band 2 £18,936 • 0.6 WTE Health Records Clinical Notes Band 2 £18,936 • 0.6WTE Governance Nurse band 6 £35,246

Non Staff Requirements

Other non-staff requirements for the Inpatient sessions are:

Weekends
• Cleaning / Waste / Facilities - £47,883 • HSDU costs (Including transport) - £30,000 • Purchase of 45 additional surgical trays and handpieces - £239,682 • Pharmacy costs, Lens and consumables - £225,000 - This is based on a consumable pack costing £150 per patient (1500 patients)Alcon managed contract

9.1.3 Outsourcing Arrangements

In addition to the insourcing arrangements the capacity across the region can be further increased by utilising the local opportunities for outsourcing. Outsourcing can relieve some of the management and back office administrative time associated with working through

the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Outsourcing arrangements and costs include patient travel.

- Option 2 Outsourcing @ 2,000 cases per year

9.1.4 Booking and scheduling For Option 2 (Maximising the use of NHH and POWH):
In one year the team will need to book 6,700 outpatient appointments across both the North and South Hubs and schedule 6,700 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 15,400 patient bookings per year

A team of 16 booking and scheduling staff on Band 3 are required to support the regional arrangements along with a band 7 team leader and 3 waiting list managers band 5. A POWH Eye Unit Manager and NHH Eye Unit Manager is also required to manage the unit on evenings and weekends as much of the activity is happening outside of usually office hours and to ensure capacity levels are maximised.

Staff Required:

- 8 WTE Patient Schedulers Band 3
- 8 WTE Booking Clerks Band 3
- 3 WTE Waiting list managers Band 5
- 1 WTE Team Leader Band 7
- 1 WTE POWH Eye Unit Manager Band 7
- 1 WTE NHH Unit Manager Band 7

Non Staff Costs

- Facilities costs for 22 members of staff, IT costs and office space have been estimated at £90,000

9.1.5 Option 2 Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through

- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

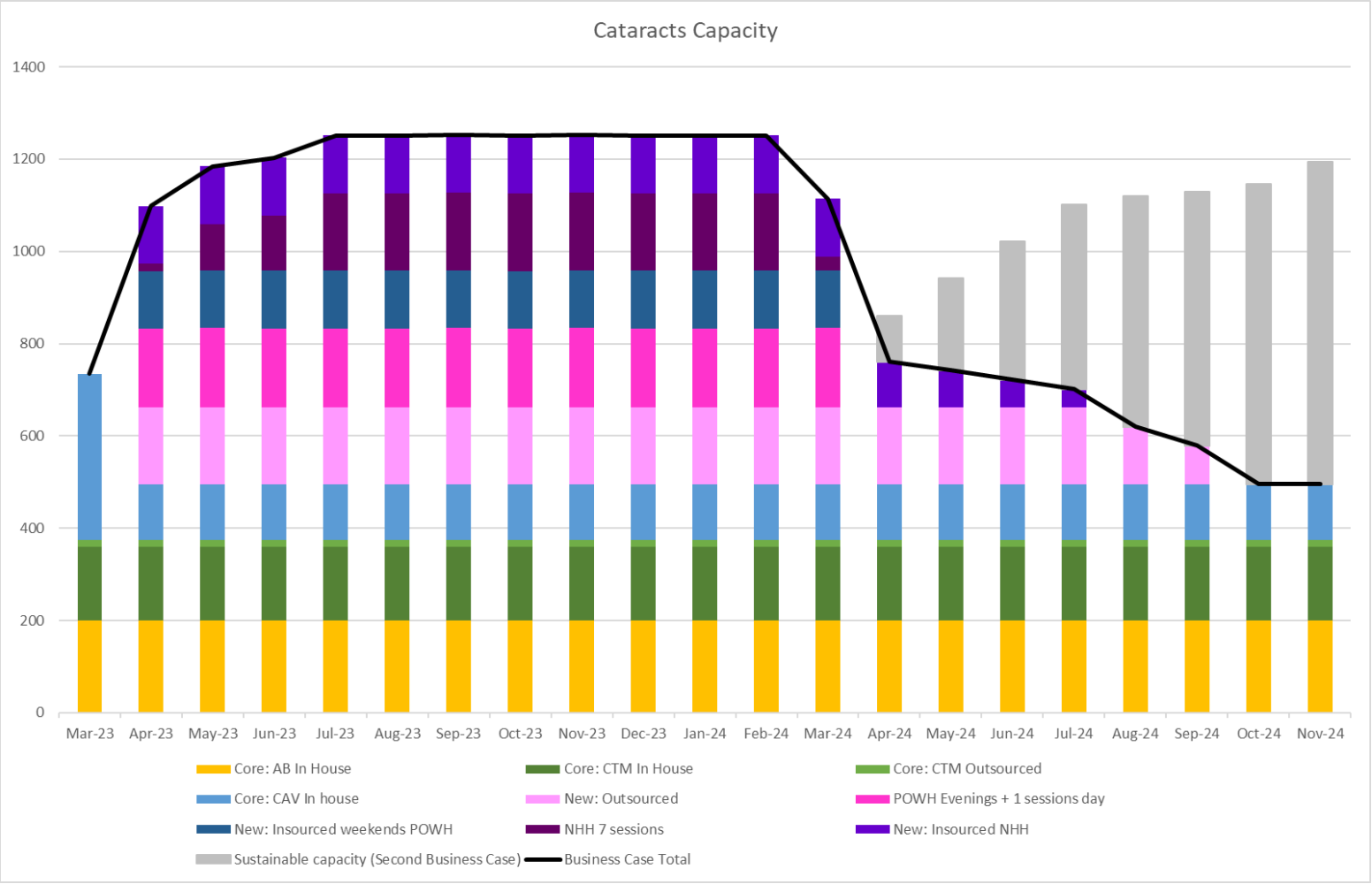
9.2 Option 2 – Option Appraisal

9.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Regional	**Total**	Average Demand	Difference
AB	2400	36%	3121	**5521**	4080	1441
CAV	1440	15%	1300	**2740**	1800	940
CTM	2100	49%	4247	**6347**	4080	2267
Regional Total	5940		8668	**14608**	9960	4648

9.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.



	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: POWH	New: NHH	**Business Case Total**
2023/24	2400	1920	180	1440	2000	3558	3110	**14608**
2024/25	1200	960	90	720	875	0	280	**4125**

9.2.3 Regional Delivery by Site

This chart indicates the volumes that will be delivered on each site, for outpatients and for day case/inpatients

For Outpatients

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: POWH	New: NHH	Business Case Total
23/24	2400	1920	180	1440	2000	3628	3120	14688
24/25	1200	960	90	720	875	0	280	4125

For Inpatients

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: POWH	New: NHH	Business Case Total
23/24	2400	1920	180	1440	2000	3558	3110	14608
24/25	1200	960	90	720	875	0	280	4125

9.2.4 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
2023/24	2400	3121	5521
2024/25	1200	416	1616

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
2023/24	1920	180	4247	6347
2024/25	960	90	566	1616

CAV Patients (estimated)

	Core: CAV In house	CAV 15%	CAV Total from this business case
2023/24	1440	1300	2740
2024/25	720	173	893

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
2023/24	5521	2740	6347	14608
2024/25	1616	893	1616	4125

9.2.5 Option 2 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Recruiting additional NHS workforce for NHH
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the POWH Eye Unit 7 days per week
- Enables a greater reduction in the backlog
- No additional capital required
- Reduces the backlog by 4,648 patients waiting

9.2.6 Option 2 Risks

The specific risks associated with option 2 are:

- High volumes of surgery through POWH Eye Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

9.2.7 Option 2 Patient Considerations

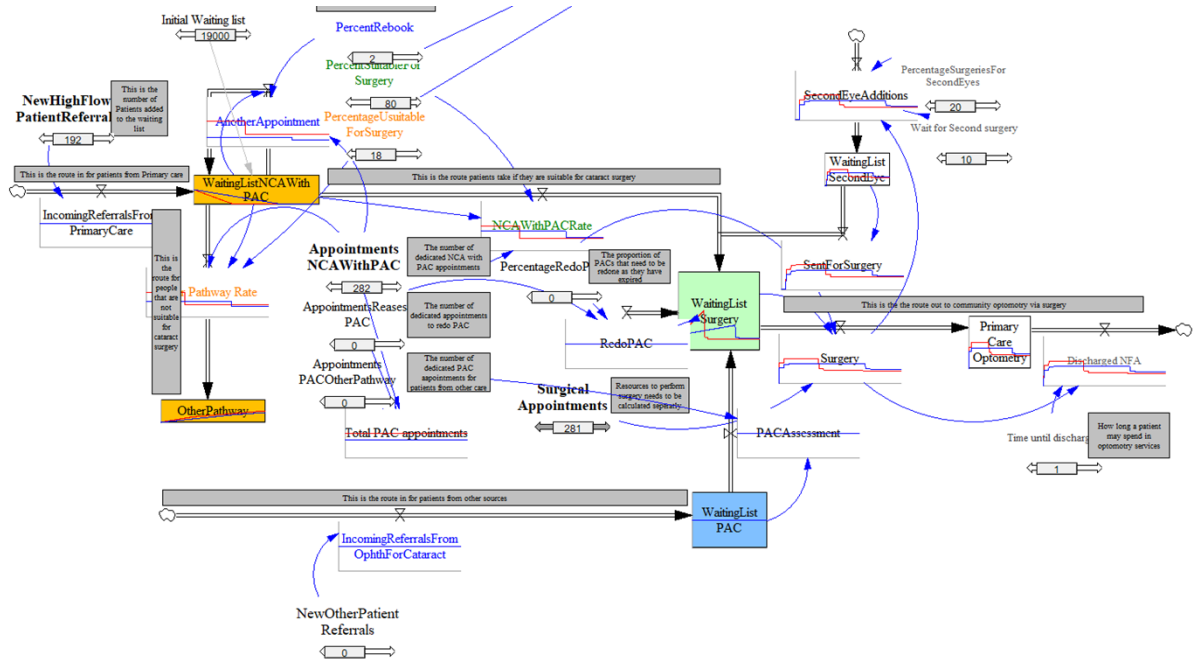
Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

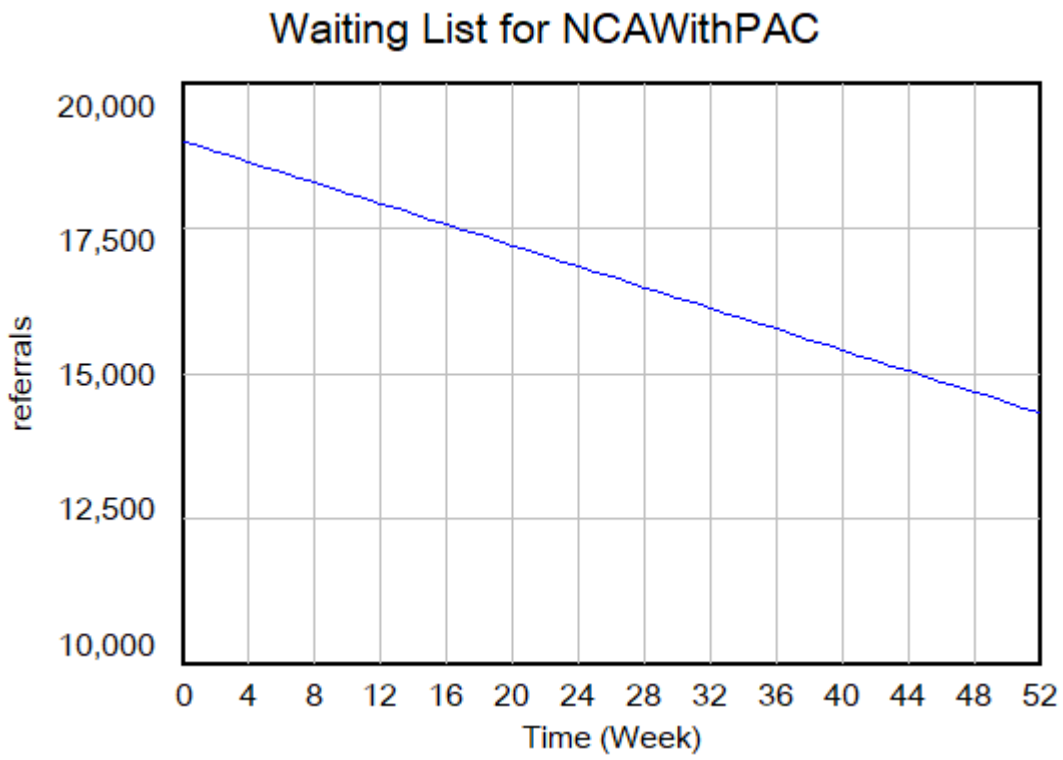
This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

9.2.9 Option 2 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 14,608 cataracts procedures per year (281 per week, 1217 per month)
- 14,608 outpatients per year (282 per week, 1224 per month)





After 52 weeks of the total capacity of 14,608 per year the waiting list is reduced from 19,000 across the region to 14,352

Appendix Five: Option 3a Details

Option 3a –Vanguard and NHH

Option 3a is an insourcing and outsourcing option involving a two-hub model of NHH in the North and a combination of POWH for outpatients and Vanguard for Inpatients in the South, along with outsourcing in the following volumes over a 12 month period:

- South Hub: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 6,120
- **Plus 7,700 additional**
- **Total capacity 13,820 per year**
- Waiting list reduction 3,814 (from 19,000 to 15,186)
- Total costs 23/24:
- Cost per patient:

10.1 Option 3a - Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

10.1.1 Maximising the Use of the Vanguard Unit in UHW

The Vanguard Unit in UHW is a mobile twin theatre alongside modular units for consulting, patient waiting and recovery. It is currently contracted for use for cataract surgery by CAV on a 5 day per week basis Monday to Friday with this arrangement running until 8th January 2023. As a short-term solution and to maximise the options available for this business case, the unit will be extended until 31st March 2023 and the capacity during this extension period will be divided between the three health boards in the region.

If extended, then the new contract for the Vanguard Unit will be for 7 days per week to maximise the use of the unit for the regional extension of the cataracts service. The Vanguard Unit requires capital funding.

The benefits of retaining the Vanguard Unit include the stability of staff and retaining this well trained and experienced staffing group, the ability to treat more complex patients than the insourcing and outsourcing will enable, increasing the training opportunities available across the region and providing a solid foundation for the second sustainable phase of the cataracts expansion to be based.

10.1.2 Clinical Service Model North Hub

The North hub would primarily provide outpatient and inpatient provision to patients in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny.

Outpatient Stage

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 125 outpatient appointments per month (30 per week, 1,500 per year) the sessions will be a 'one stop shop' model, held on a Saturday in the OP dept in NHH. 4 consulting rooms will be required plus a waiting area.

Assuming that the required clinical staff including Consultants, PAC nurse and biometry staff will be provided by the Insourcing provider, the following additional staff will also be required to run weekly Saturday OP clinics for 1 year:

- 0.5 WTE Receptionist Band 2 £15,780
- 0.5 WTE Health Records Clinical Notes Band 2 £15,780
- 0.5 WTE Governance Nurse band 6 £29,372

Other non staff requirements for the OP sessions are

- Cleaning (Saturday) £7500

Lenses will be also ordered at this point if the patient is suitable for surgery. Costs of lenses will be included in the Inpatient section.

Clinical Model

These patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies

- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Inpatient Stage

Patients accessing the additional capacity for insourcing in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub arrangements in NHH.

In order to undertake 30 procedures per week (125 per month, 1,500 per year) the procedures will be undertaken in Main Theatres at NHH every Saturday and Sunday.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.6 WTE Receptionist Band 2 £18,936
- 0.6 WTE Health Records Clinical Notes Band 2 £18,936
- 0.6 WTE Governance Nurse band 6 £35,246

Other non-staff requirements for the Inpatient sessions are:

- Cleaning / Waste / Facilities - £47,883
- HSDU costs (Including transport) - £30,000
- Purchase of additional surgical trays and equipment - £38,284
- Stellaris Handpieces- £87,500
- Pharmacy costs, Lens and consumables - £224,310
- Additional lens costs £7,716.

10.1.3 Clinical Service Model South Hub Weekends (Option 1 UHW)

Through Option 1 The South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from University Hospital of Wales on weekends via an insourcing company

Outpatients Stage (Weekend Insourcing in UHW)

The UHW site has two pre-assessment rooms which can be used concurrently during weekends during 2023/24. Each room would house one pre-assessment nurse each, and both could be serviced with one doctor in clinic. All the clinical staff would be provided through the insourcing company. In one session using two PAC nurses concurrently, 10 patients could be assessed.

In addition the staffing costs for running outpatient clinics evenings and weekends would be:

- 0.5 WTE B2 Receptionist
- 0.5 WTE B3 Booking
- 0.5 WTE B6 Governance Nurse

Non- staffing costs are

- Cleaning

Clinical Model

These patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Inpatient Stage (Weekend Insourcing in Vanguard Unit UHW)

Patients accessing the additional capacity for insourcing in the South Hub will be booked through the regional booking team (see section 5.4). They will also have had their Outpatient assessment through the South hub insourcing arrangements in UHW.

In the Vanguard theatres the flow enables a maximum of 7 patients on a list for high flow low complexity patients. Running the twin theatres enables 14 patients to be seen in a

morning. By running the two theatres for AM and PM on Saturdays and AM on Sundays 42 patients can be seen in a weekend (total 6 sessions). This model can run for 36 weeks to treat the 1,500 patients through the insourcing.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.33WTE Receptionist Band 2 £TBC
- 0.33WTE Health Records Clinical Notes Band 2 £TBC
- 0.33WTE Governance Nurse band 6 £TBC
- 1 wte Manager 8b (included in section 8.1.5)

Other non-staff requirements for the Inpatient sessions are:

- Cleaning / Waste / Facilities
- HSDU costs - £TBC
- Purchase of 45 additional surgical trays and handpieces - £239,682
- Pharmacy costs, Lens and consumables - £225,000 - This is based on a consumable pack costing £150 per patient (1500 patients)Alcon managed contract

10.1.4 Additional Vanguard Capacity for the Region

This option includes the additional Vanguard capacity for the region. The Vanguard Unit surgical capacity and the associated outpatient capacity required to run the service would continue to operate as it has since January 2022, retaining the same staff, maintaining the same list size, training opportunities and job plans as are currently in place and operational Monday to Friday for 20 sessions per week across the twin theatre arrangement. Through this option this existing service model would be retained until March 2024.

7.5 sessions out of 20 per week (37.5%) of the capacity would be for Cardiff and Vale core capacity funded by Cardiff and Vale and the other 12.5 sesions ourt of 20 (62.5%) would be available to the regional patients and funded by this regional business case.

As it is currently set up, the Vanguard Unit treats more complex patients that the outsourcing and insourcing capacity can. The unit will continue to treat the same complexity

of patient and clinical criteria will need to be developed to determine the referral criteria for the regional proportion of the Unit.

Under this model, patients treated in the Vanguard unit will have their outpatient assessment on the UHW site on a weekday and this will continue to run as it currently is with the Cardiff and Vale staff and estates.

10.1.5 Outsourcing Arrangements

In addition to the insourcing arrangements the capacity across the region can be further increased by utilising the local opportunities for outsourcing. Outsourcing can relieve some of the management and back office administrative time associated with working through the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Outsourcing arrangements and costs include patient travel.

- Outsourcing @ 2,000 cases per year

10.1.6 Booking and scheduling For Option 3a (Vanguard Capacity and North Hub NHH Weekends):

In one year the team will need to book 5,900 outpatient appointments across both the North and South Hubs and schedule 5,900 inpatient procedures and facilitate 2,000 outsourced patients.

A team of 14 booking and scheduling staff on Band 3 are required to support the regional arrangements along with a band 7 team leader and 3 waiting list managers band 5. A Vanguard Unit Manager and NHH Eye Unit Manager are also required to manage the unit and to ensure capacity levels are maximised.

Staff Required:

- 7 WTE Patient Schedulers Band 3
- 7 WTE Booking Clerks Band 3
- 3 WTE Waiting list managers Band 5
- 1 WTE Team Leader Band 7
- 1 WTE Vanguard Unit Manager Band 8b
- 1 WTE NHH Eye Unit Manager Band 7

Non Staff Costs

- Facilities costs for 20 members of staff, IT costs and office space have been estimated at £90,000

10.1.7 Option 3a Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- Vanguard workforce can continue into 23/24
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

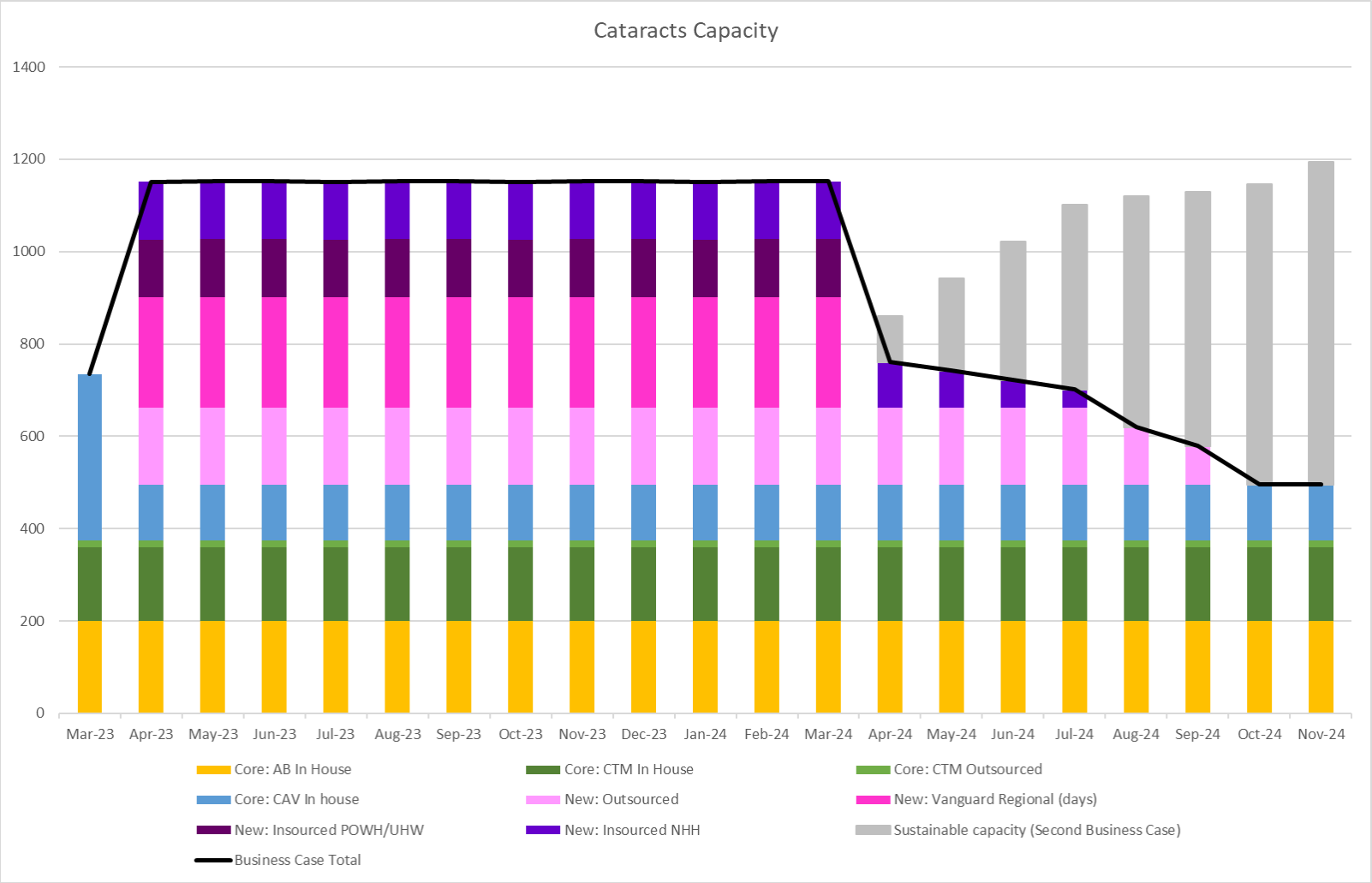
10.2 Option 3a – Option Appraisal

10.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Vanguard	Additional Capacity	**Total**	Average Demand	Difference
AB	2400	36%	1037	1800	**5237**	4080	1157
CAV	1440	15%	432	750	**2622**	1800	822
CTM	2100	49%	1411	2450	**5961**	4080	1881
Regional Total	5940		2880	5000	**13820**	9960	3860

10.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.



	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Vanguard Regional (days)	New: Insourced POWH/UHW	New: Insourced NHH	**Business Case Total**
2023/24	2400	1920	180	1440	2000	2880	1500	1500	**13820**
2024/25	1200	960	90	720	875	0	0	280	**4125**

10.2.3 Regional Delivery by Site

This chart indicates the volumes that will be delivered on each site, for outpatients and for day case/inpatients

For Outpatients

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Vanguard Regional (days)	New: Insourced POWH	New: Insourced NHH	Business Case Total
23/24	2400	1920	180	1440	2000	2880	1500	1500	13820
24/25	1200	960	90	720	875	0	0	280	4125

For Inpatients

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Vanguard Regional (days)CAV Surgery	New: Insourced UHW	New: Insourced NHH	Business Case Total
23/24	2400	1920	180	1440	2000	2880	1500	1500	13820
24/25	1200	960	90	720	875	0	0	280	4125

10.2.4 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
2023/24	2400	2837	5237
2024/25	1200	416	1616

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
2023/24	1920	180	3861	5961
2024/25	960	90	566	1616

CAV Patients (estimated)

	Core: CAV In house	CAV 15%	CAV Total from this business case
2023/24	1440	1182	2622
2024/25	720	173	893

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
2023/24	5237	2622	5961	13820
2024/25	1616	893	1616	4125

10.2.5 Option 3a Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Retaining a well trained and experienced staff within the Vanguard unit
- Ability to treat more complex patients are part of the regional capacity[9]
- Continuity and stability of employment for Vanguard staff
- Increased opportunities for staff training learning and development[10]
- Provides a solid base to develop the sustainable regional solution

[9] Insourcing and Outsourcing will take the less complex patients

[10] Vanguard offers the opportunity for more training lists that are shorter in size

- Fully utilised the Vanguard unit 7 days per week
- Enables a greater reduction in the backlog
- Stabilises the short term regional arrangement (Jan-March 2023)
- Reduces the backlog by 3,814 patients waiting

10.2.6 Option 3a Risks

The specific risks associated with option 1 are:

- High volumes of surgery through Vanguard Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

10.2.7 Option 3a Patient Considerations

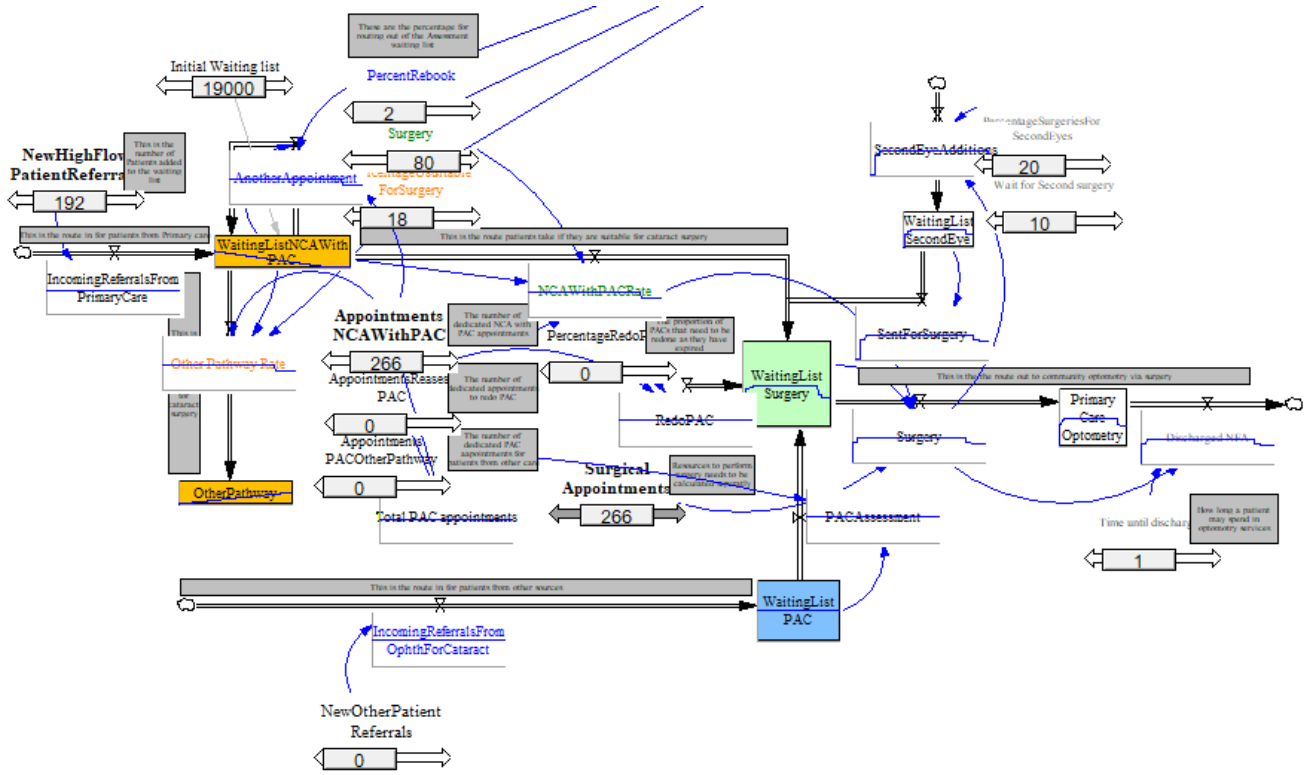
Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

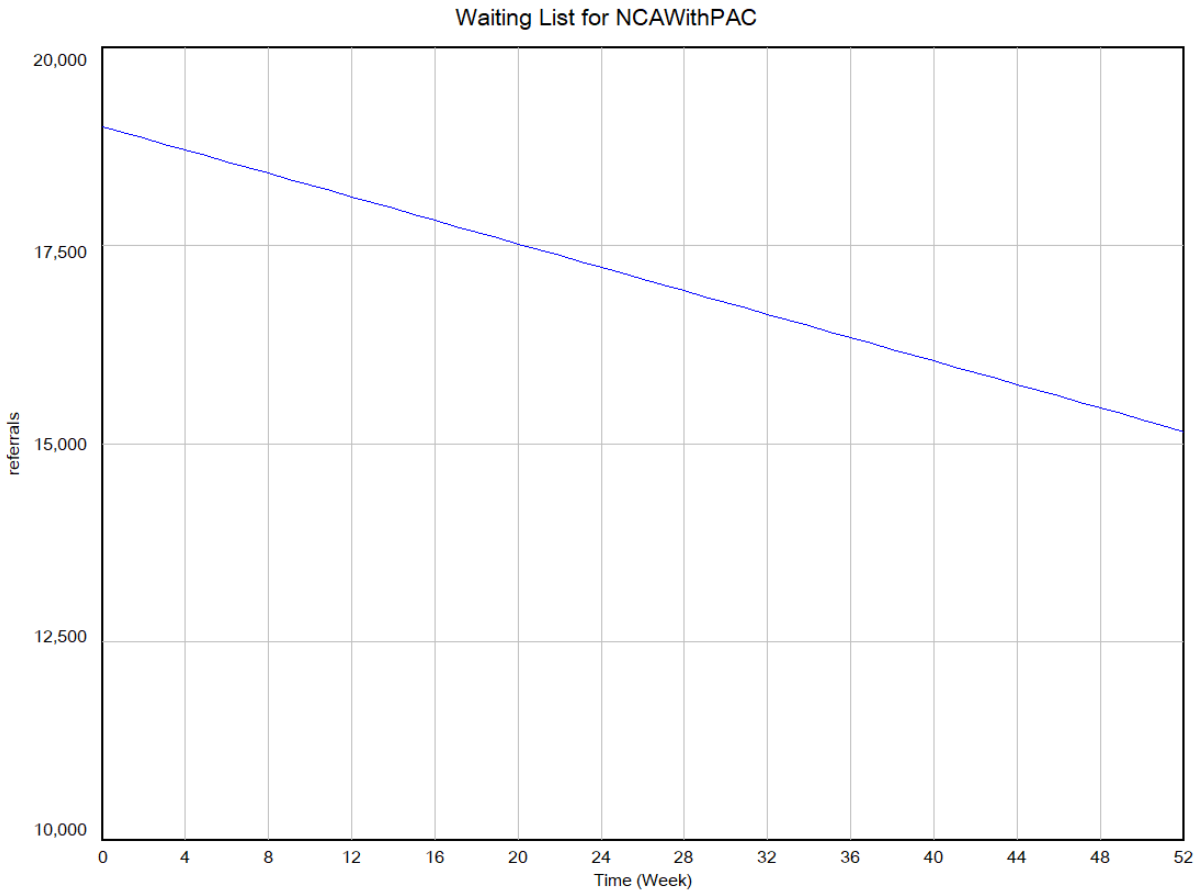
This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

10.2.9 Option 3a Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 13,820 cataracts procedures per year (266 per week, 1152 per month)
- 13,820 outpatients per year (266 per week, 1152 per month)


Initial Waiting list
19000
PercentRebook
2
Surgery
80
AnotherAppointment
ForSurgery
18
NewHighFlow PatientReferra
192
WaitingListNCAWith PAC
IncomingReferralsFrom PrimaryCare
NCAWithPACRate
Appointments NCAWithPAC
266
AppointmentsReased PAC
0
PercentageRedoP
RedoPAC
WaitingList Surgery
SentForSurgery
Surgery
Primary Care Optometry
Discharged NCA
Time until discha
1
SecondEyeAdditions
20
Wait for Second surgery
WaitingLis SecondEye
10
Appointments PACOtherPathway
0
Total PAC appointments
Surgical Appointments
266
PACAssessment
OtherPathway
Other Pathway Rate
WaitingList PAC
IncomingReferralsFrom OphthForCataract
NewOtherPatient Referrals
0


Waiting List for NCAWithPAC
20,000
17,500
15,000
12,500
10,000
referrals
0
4
8
12
16
20
24
28
32
36
40
44
48
52
Time (Week)

After 52 weeks of the total capacity of 13,820 per year the waiting list is reduced from 19,000 across the region to 15,186

Appendix Six: Option 3b Details

Option 3b –Vanguard and maximising NHH

This is the preferred option

As the preferred option this option has been developed in more detail than the other options.

Realistic assumptions have been made about the feasibility of delivery and the model has been designed to be distributed over 14 months split across 23/24 and 24/25.

Option 3b

As option 3a but with the addition of 7 weekday NHS sessions in NHH

Option 3b is an insourcing and outsourcing option involving a two-hub model of NHH in the North and the Vanguard Unit in the South with the following volumes over a 14 month period:

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

11.1 Clinical and Service Model

11.1.1 Clinical Service Model North Hub (NHH) Additional for Option 3b

The North hub would primarily provide outpatient and inpatient provision to patients primarily in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits.

Weekdays: Outpatients Stage (NHS Staff)

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 135 outpatient appointments per month (38 per week, 1,620 per year) the sessions will be a 'one stop shop' model, held on weekdays in the OP dept in NHH. 4 consulting rooms will be required plus a waiting area. This weekday activity will be staffed through recruitment of NHS staff for all of the clinical and not clinical staff required.

Outpatients Clinical Model

These patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Weekdays; Inpatient Stage (NHS Staff)

Patients attending the weekday regional capacity for cataract surgery in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub weekday arrangements in NHH with NHS staff.

In order to undertake 38 procedures per week (135 per month, 1,610 per year) the procedures will be undertaken in Main Theatres at NHH on weekdays, Mondays and Wednesday to Friday.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional

Non-Staff Requirements

Other non-staff requirements for the Inpatient sessions are:

Weekends
Cleaning / Waste / Facilities - £47,883 HSDU costs (Including transport) - £30,000 Purchase of additional surgical trays and equipment - £38,284 Stellaris Handpieces- £87,500 Pharmacy costs, Lens and consumables - £224,310 Additional lens costs £7,716

11.1.2 Booking and scheduling For Option 3b (Vanguard and Maximising NHH):
In one year the team will need to book 7,500 outpatient appointments across both the North and South Hubs and schedule 7,500 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 17,000 patient bookings per year

A team of 18 booking and scheduling staff on Band 3 are required to support the regional arrangements along with a band 7 team leader and 3 waiting list managers band 5. A Vanguard Unit Manager and NHH Eye Unit Manager are also required to manage the unit and to ensure capacity levels are maximised.

Staff Required:

- 9 WTE Patient Schedulers Band 3
- 9 WTE Booking Clerks Band 3
- 3 WTE Waiting list managers Band 5
- 1 WTE Team Leader Band 7
- 1 WTE Vanguard Unit Manager Band 8b
- 1 WTE Eye Unit Manager NHH band 7

Non Staff Costs

- Facilities costs for 24 members of staff, IT costs and office space have been estimated at £100,000

11.1.3 Option 3b Assumptions

- NHH Workforce can be fully recruited
- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters

- 52 weeks waiters numbers under monthly review
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- Vanguard workforce can continue into 23/24
- CTM continue with their current levels of outsourcing (15 per month)
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes
- NHH Workforce can be fully recruited

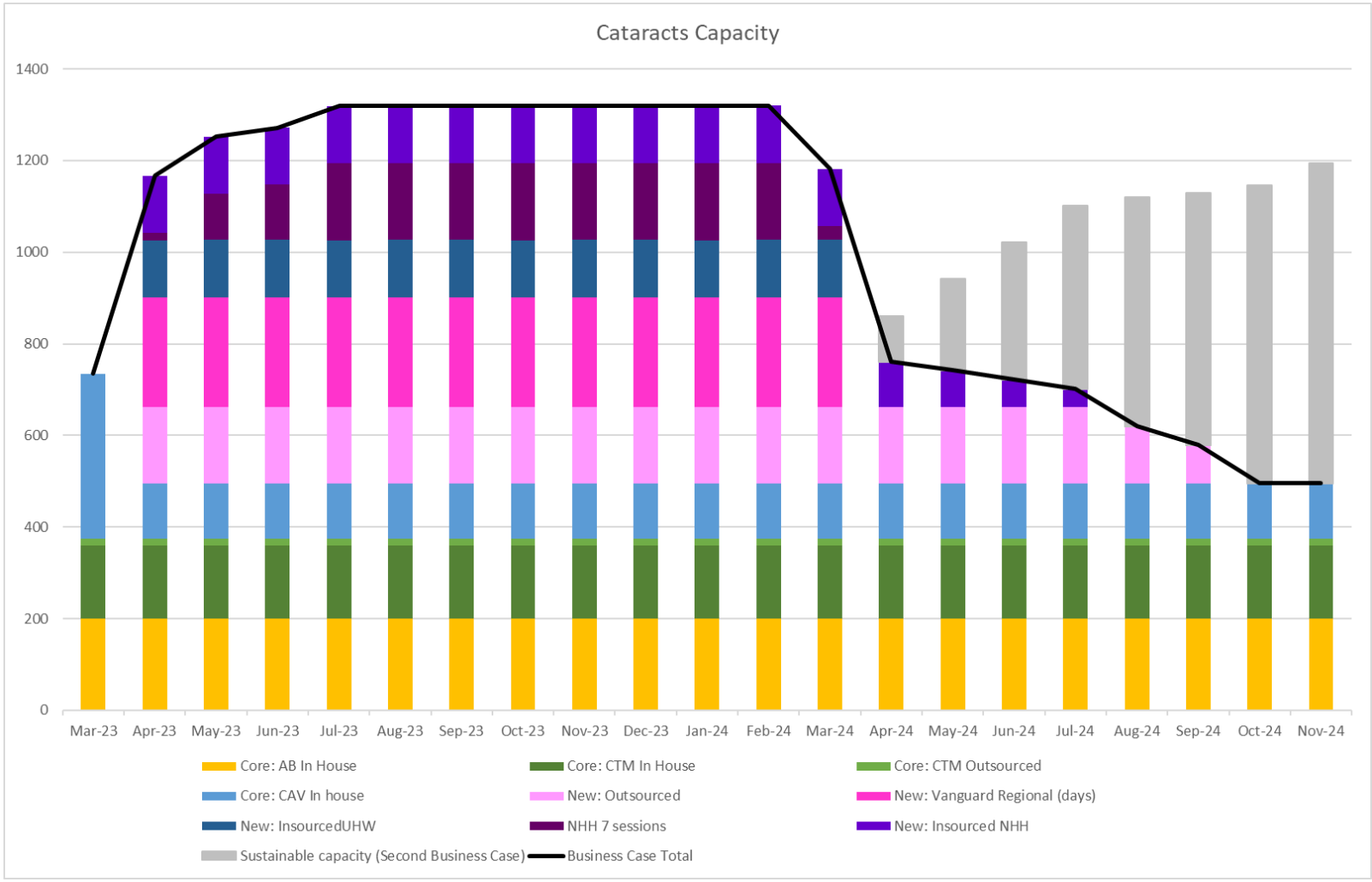
11.2 Option 3b – Option Appraisal

11.2.1 Additional Regional Capacity

Capacity	Core 14 months	Additional Capacity %	Additional Regional	**Total**	14 months demand	Difference
AB	2800	36%	3352	**6152**	4760	1392
CAV	1890	15%	1397	**3287**	2100	1187
CTM	2440	49%	4562	**7002**	4760	2242
Regional Total	7140		9310	**16450**	11620	4830

11.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a ‘tail’ of 6 months to enable the sustainable capacity (second business case) to build up.


Cataracts Capacity
1400
1200
1000
800
600
400
200
0
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Core: AB In House
Core: CTM In House
Core: CTM Outsourced
Core: CAV In house
New: Outsourced
New: Vanguard Regional (days)
New: InsourcedUHW
NHH 7 sessions
New: Insourced NHH
Sustainable capacity (Second Business Case)
Business Case Total

11.2.3 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages.

Delivery is split over 2 financial years as follows:

- 9 months of 23/24 from 1st July 2023 to 31st March 2024
- 5 months of 24/25 from 1st April 2024 to 31st August 2024

AB Patients

	Core: AB In House	AB 39%	AB Total from this business case
1st July 2023 to 31st March 2024	1800	2313	4113
1st April 2024 to 31st August 2024	1000	1039	2039
Total Allocation	2800	3352	6152

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
1st July 2023 to 31st March 2024	1215	964	2179
1st April 2024 to 31st August 2024	675	433	1108
Total Allocation	1890	1397	3287

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
1st July 2023 to 31st March 2024	1440	135	3148	4723
1st April 2024 to 31st August 2024	800	75	1414	2289
Total Allocation	2240	210	4562	7012

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
1st July 2023 to 31st March 2024	4113	2179	4723	11014
1st April 2024 to 31st August 2024	2039	1108	2289	5436
Total Allocation	6152	3287	7012	**16450**

11.2.4 Option 3b Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Retaining a well trained and experienced staff within the Vanguard unit
- Ability to treat more complex patients are part of the regional capacity[11]
- Continuity and stability of employment for Vanguard staff
- Increased opportunities for staff training learning and development[12]
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the Vanguard unit 7 days per week
- Greater proportion of cataracts surgery undertaken by NHS staff
- Enables a greater reduction in the backlog
- Stabilises the short term regional arrangement (Jan-March 2023)
- Reduces the backlog by 4,832 patients waiting

11.2.5 Option 3b Risks

The specific risks associated with this option are:

- High volumes of surgery through Vanguard Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

11.2.6 Option 3b Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

[11] Insourcing and Outsourcing will take the less complex patients

[12] Vanguard offers the opportunity for more training lists that are shorter in size

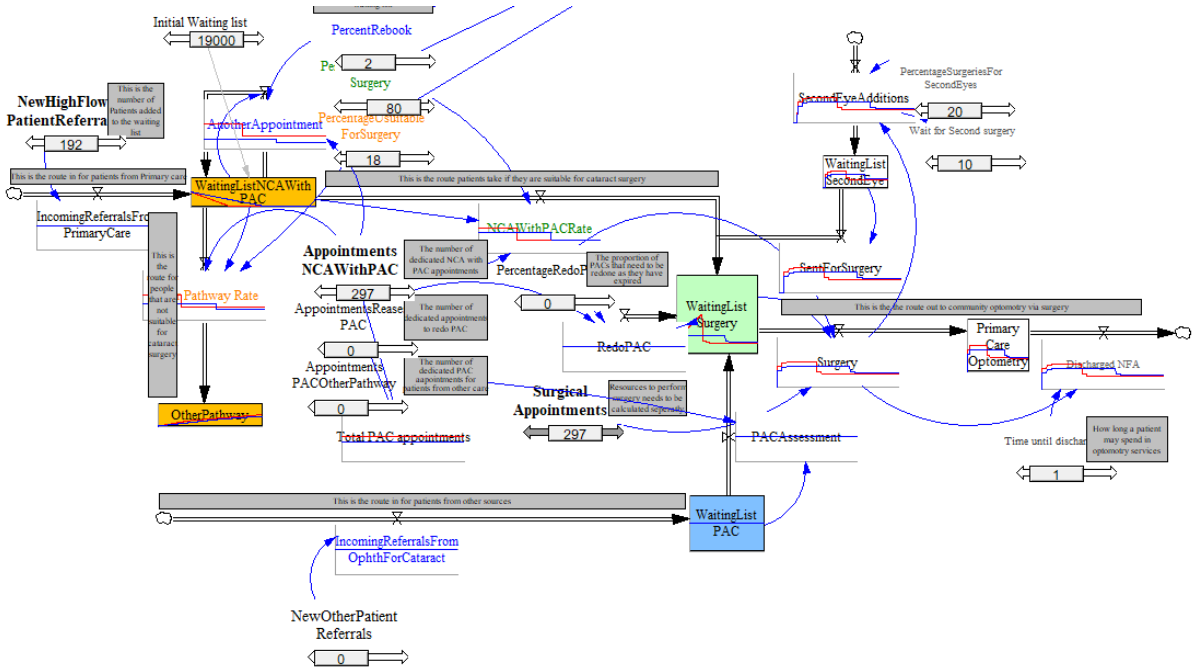
11.2.8 Option 3b Activity Modelling

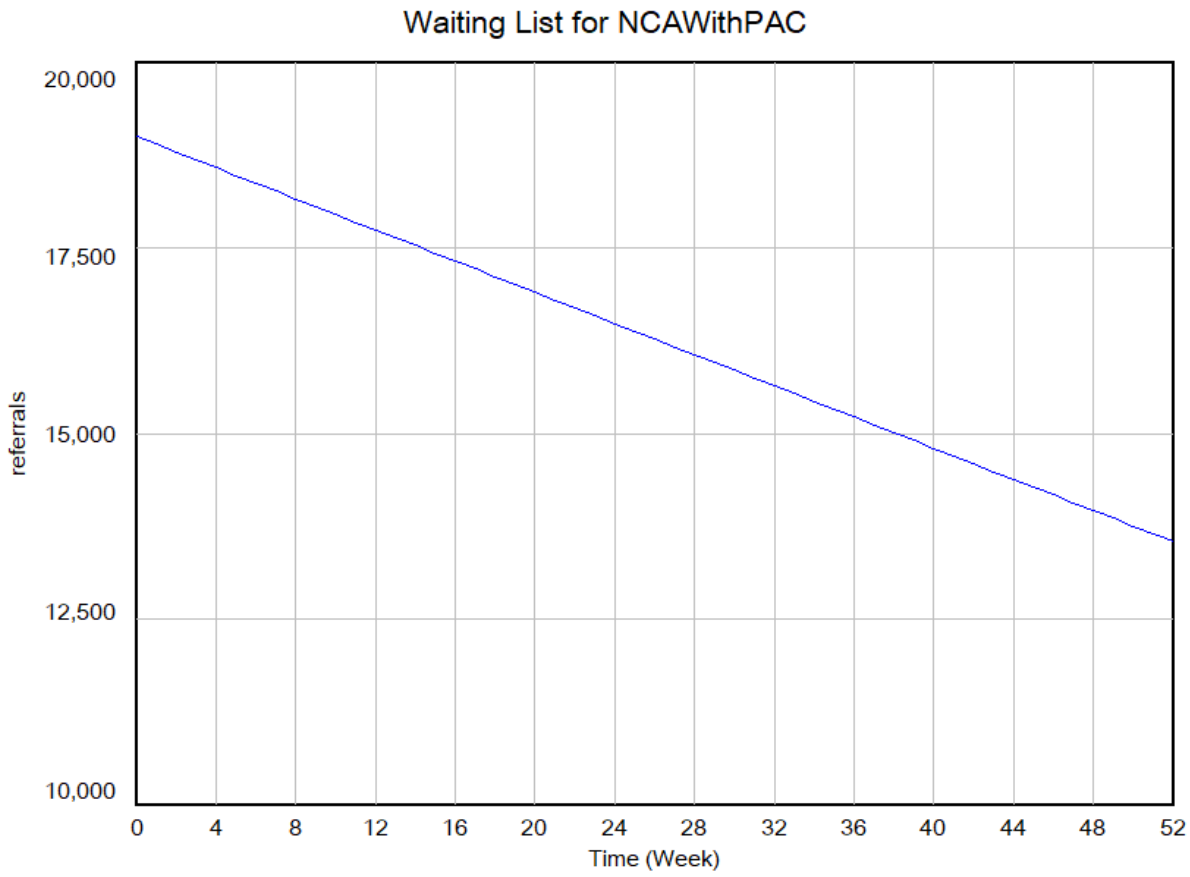
This scenario is based on the following assumptions:

- 9,960 referrals per year (192 per week, 830 per month)
- 15,430 cataracts procedures per year (297 per week, 1286 per month)
- 15,430 outpatients per year (297 per week, 1286 per month)

Over 14 months this would be:

- 11,620 referrals per year
- 16,450 cataracts procedures per year
- 16,450 outpatients per year





This scenario is based on the following assumptions:

- 9,960 referrals per year (192 per week, 830 per month)
- 15,430 cataracts procedures per year (297 per week, 1286 per month)
- 15,430 outpatients per year (297 per week, 1286 per month)

Over 14 months this would be:

- 11,620 referrals per year
- 16,450 cataracts procedures per year
- 16,450 outpatients per year

After 14 months the total capacity of 16,450 per year the waiting list is reduced from 19,000 across the region to 14,168

Appendix Seven: Option 4 Details

Option 4 – Weekend Insourcing and Outsourcing Only

The Insourcing and outsourcing option involves a two hub model of NHH in the North and the use of POWH in the south for outpatients and Inpatients, along with outsourcing in the following volumes over a 12 month period:

- North Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- South Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in POWH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 5,000 additional**
- **Total capacity 10,940 per year**
- Waiting list reduction 517 (from 19,000 to 18,483)
- Total costs 23/24: £7,193,028
- Cost per patient: £1,439

12.1 Option 4 – Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

12.1.1 North Hub

The North hub would primarily provide outpatient and inpatient provision to patients in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny.

Outpatient Stage

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 125 outpatient appointments per month (30 per week, 1,500 per year) the sessions will be a ‘one stop shop’ model, held on a Saturday in the OP dept in NHH. 4 consulting rooms will be required plus a waiting area.

Assuming that the required clinical staff including Consultants, PAC nurse and biometry staff will be provided by the Insourcing provider, the following additional staff will also be required to run weekly Saturday OP clinics for 1 year:

- 0.5 WTE Receptionist Band 2 £15,780
- 0.5 WTE Health Records Clinical Notes Band 2 £15,780
- 0.5 WTE Governance Nurse band 6 £29,372

Other non staff requirements for the OP sessions are

- Cleaning (Saturday) £7500

Lenses will be also ordered at this point if the patient is suitable for surgery. Costs of lenses will be included in the Inpatient section.

Patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Inpatient Stage

Patients accessing the additional capacity for insourcing in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub arrangements in NHH.

In order to undertake 30 procedures per week (125 per month, 1,500 per year) the procedures will be undertaken in Main Theatres at NHH every Saturday and Sunday.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.6 WTE Receptionist Band 2 £18,936
- 0.6 WTE Health Records Clinical Notes Band 2 £18,936
- 0.6 WTE Governance Nurse band 6 £35,246

Other non-staff requirements for the Inpatient sessions are:

- Cleaning / Waste / Facilities - £47,883
- HSDU costs (Including transport) - £30,000
- Purchase of additional surgical trays and equipment - £38,284
- Stellaris Handpieces- £87,500
- Pharmacy costs, Lens and consumables - £224,310
- Additional lens costs £7,716.

12.1.2 South Hub

Through Option 2 The South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from Princess of Wales Hospital in Bridgend on weekends via an insourcing company

Outpatients Stage (Weekend Insourcing in POWH)

The POWH site has two pre-assessment rooms which can be used concurrently during weekends during 2023/24. Each room would house one pre-assessment nurse each, and both could be serviced with one doctor in clinic. All the clinical staff would be provided through the insourcing company. In one session using two PAC nurses concurrently, 10 patients could be assessed.

In addition the staffing costs for running outpatient clinics evenings and weekends would be:

- 0.5 WTE B2 Receptionist
- 0.5 WTE B3 Booking
- 0.5 WTE B6 Governance Nurse

Non- staffing costs are

- Cleaning

Patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Inpatient Stage *(Weekend insourcing at POWH)*

Patients accessing the additional capacity for insourcing in the South Hub will be booked through the regional booking team (see section 5.4). They will also have had their OP assessment through the South hub arrangements in POWH.

POWH has a twin theatre set up and the flow enables a maximum of 7 patients on a list for high flow low complexity patients. Running the twin theatres enables 14 patients to be seen in a morning. By running the two theatres on Saturdays all day and Sunday mornings, 42 patients can be seen in a weekend (total 6 sessions). This model can run for 36 weeks to treat the 1,500 patients through the insourcing.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.6 WTE Receptionist Band 2 £18,936
- 0.6 WTE Health Records Clinical Notes Band 2 £18,936
- 0.6WTE Governance Nurse band 6 £35,246

Other non-staff requirements for the Inpatient sessions are:

- Cleaning / Waste / Facilities - £47,883
- HSDU costs (Including transport) - £30,000
- Purchase of 45 additional surgical trays and handpieces - £239,682
- Pharmacy costs, Lens and consumables - £225,000 - This is based on a consumable pack costing £150 per patient (1500 patients)Alcon managed contract

12.1.3 Outsourcing Arrangements

In addition to the insourcing arrangements the capacity across the region can be further increased by utilising the local opportunities for outsourcing. Outsourcing can relieve some of the management and back office administrative time associated with working through the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Option 4 will deliver an additional 2,000 cases per year. Outsourcing arrangements and costs include patient travel.

12.1.4 Booking and scheduling for Option 4 (Weekend Insourcing and Outsourcing)

In one year the team will need to book 3,000 outpatient appointments across both the North and South Hubs and schedule 3,000 inpatient procedures in addition to facilitating 2,000 outsourced patients. There is also a requirement to confirm which patients are suitable for the additional capacity and which need to be treated as part of core capacity as they are more complex cases.

A team of 8 booking and scheduling staff on Band 3 are required to support the regional arrangements along with a band 7 team leader and 3 waiting list managers band 5.

Staff Required:

- 4 WTE Patient Schedulers Band 3
- 4 WTE Booking Clerks Band 3
- 3 WTE Waiting list managers Band 5
- 1 WTE Team Leader Band 7

Non Staff Costs

- Facilities costs for 14 members of staff, IT costs and office space have been estimated at £30,000

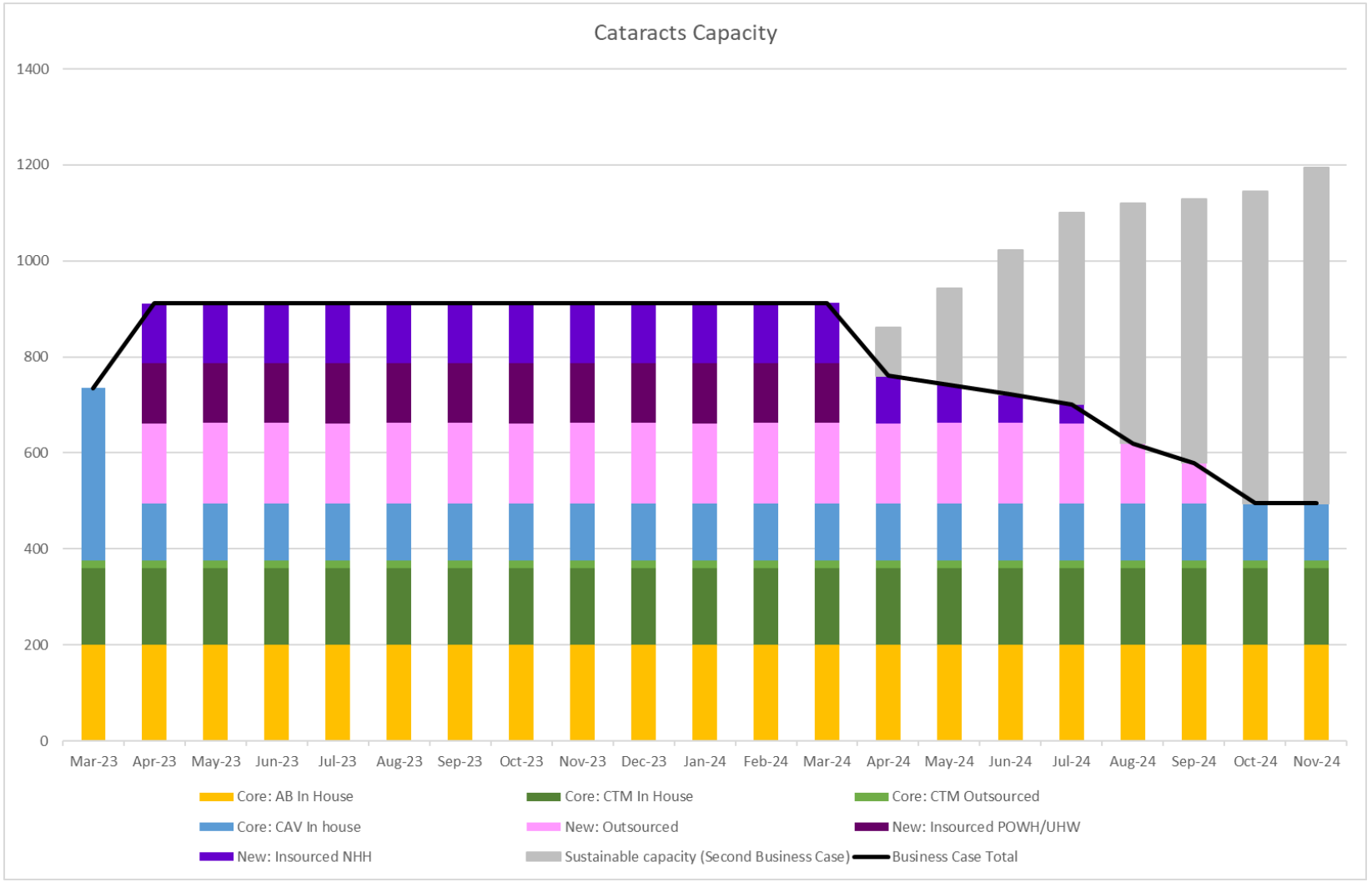
12.2 Option 4 – Option Appraisal

12.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity	**Total**	Average Demand	Difference
AB	2400	36%	1800	**4200**	4080	120
CAV	1440	15%	750	**2190**	1800	390
CTM	2100	49%	2450	**4550**	4080	470
Regional Total	5940		5000	**10940**	9960	980

12.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.



	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Insourced POWH	New: Insourced NHH	**Business Case Total**
2023/24	2400	1920	180	1440	2000	1500	1500	**10940**
2024/25	1200	960	90	720	875	0	280	**4125**

12.2.3 Regional Capacity by expected patients treated

Reviewing the end of the list, 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total
2023/24	2400	1800	4200
2024/25	1200	416	1616

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total
2023/24	1920	180	2450	4550
2024/25	960	90	566	1616

CAV Patients

	Core: CAV In House	CAV 15%	CAV Total
2023/24	1440	750	2190
2024/25	720	173	893

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
2023/24	4200	2190	4550	10940

2024/25	1616	893	1616	4125

12.2.4 Option 4 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Outpatient assessments and inpatients treatments are performed on the same site
- Reduces the backlog by 517 patients waiting

If the Vanguard theatres are not taken forward after March 2023 there will be additional staff from UHW that could be utilised at one of the other hub areas.

12.2.5 Option 4 Risks

The specific risks associated with this option are:

- Loss of experienced and well trained staff at the Vanguard Unit (low risk following mitigation actions)
- Reduction in training capacity across the region (medium risk following mitigation actions)
- Reduced capacity to treat more complex patients (medium risk following mitigation actions)

12.2.6 Option 4 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will remain at current levels. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

12.2.7 Option 4 Costs

Option 4 costs are shown here

Option 2: Use of NHH and POWH and not retaining Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Cardiff and Vale						
Aneurin Bevan	Insource	1,500	£246,182	1,500	£1,711,811	£1,957,993
Cwm Taf	Insource	1,500	£246,182	1,500	£1,711,811	£1,957,993
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£581,709
TOTAL		**5,000**	**£808,364**	**5,000**	**£5,802,955**	**£7,193,028**

Indicative Cost per Patient £1,439

2024/25

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Cardiff and Vale	Insource					
Aneurin Bevan	Insource	280	£45,954	280	£319,538	£365,492
Cwm Taf	Insource	280	£45,954	280	£319,538	£365,492
External	Outsource	875	£138,250	875	£1,040,958	£1,179,208
Regional Operational Team						£229,441
TOTAL		**1,435**	**£230,158**	**1,435**	**£1,680,034**	**£2,139,633**

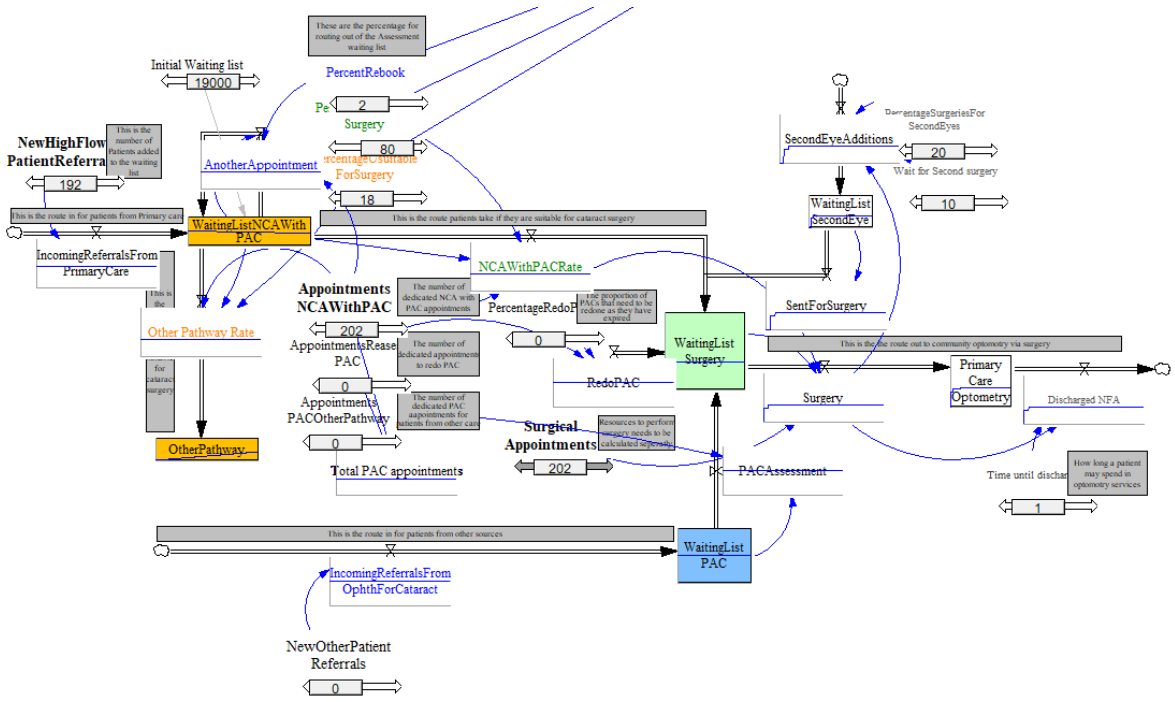
Assumptions-

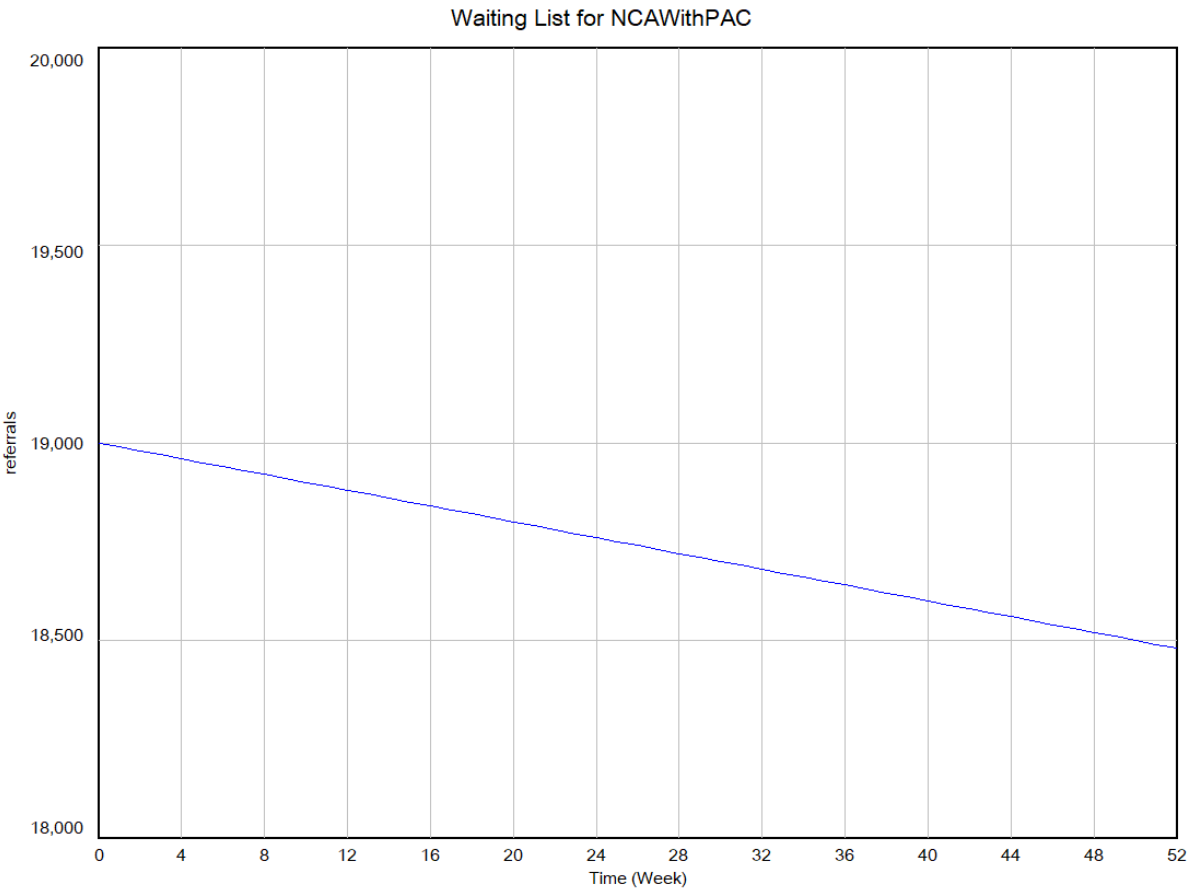
- Cost assumptions are based on locally provided figures
- Insource cost estimates are based on Framework expectation of PbR plus 10% but will depend on casemix and provider
- Outsourcing estimates are based on PbR with an element for transport but dependent on casemix and provider

12.2.8 Option 4 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 10,940 cataracts procedures per year (202 per week, 874 per month)
- 10,940 outpatients per year (202 per week, 874 per month)





After 52 weeks of the total capacity of 10,940 per year the waiting list is reduced from 19,000 across the region to 18,483

Appendix Eight: Option 5 Details

Option 5 – Outsourcing

The option involves outsourcing the whole additional capacity and not insourcing or using the Vanguard Unit for capacity. By using outsourcing only, the demands on the regional booking and scheduling team also reduce. It is likely that one supplier would not be able to fulfil the whole 5,000 procedures per year and so it would be split across different providers with the following volumes over a 12 month period:

- An additional 5,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 5,000 additional**

- **Total capacity 10,940 per year**
- Waiting list reduction 517 (from 19,000 to 18,483)
- Total costs 23/24: £6,978,436
- Cost per patient: £1,396

13.1 Option 5 – Clinical and Service Model

13.1.1 Outsourcing Arrangements

Outsourcing can relieve some of the management and back office administrative time associated with working through the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Through this option 5,000 cases are outsourced. Outsourcing arrangements and costs include patient travel.

Patients are reviewed by a non-clinical administrator for their suitability for outsourcing and then referred on to the outsourcing company for assessment and treatment. Communication with the patient about booking and scheduling and locations are conducted by the outsourcing company. Follow ups post-surgery are conducted in primary care. Hospital patient records are updated.

13.1.2 Booking and scheduling For Option 5 (Outsourcing)

In one year the team would need to facilitate 5,000 outsourced patients and ensure records are kept up to date and that these patients are suitable for the outsourcing route.

A team of 4 patient liaison, 1 waiting list manager and a team leader are required to support the outsourcing

Staff Required:

- 4 WTE Patient Liaison Band 3
- 1 WTE Waiting List Manager Band 5
- 1 WTE Team Leader Band 7

Non Staff Costs

- Facilities costs for 6 members of staff, IT costs and office space have been estimated at £15,000

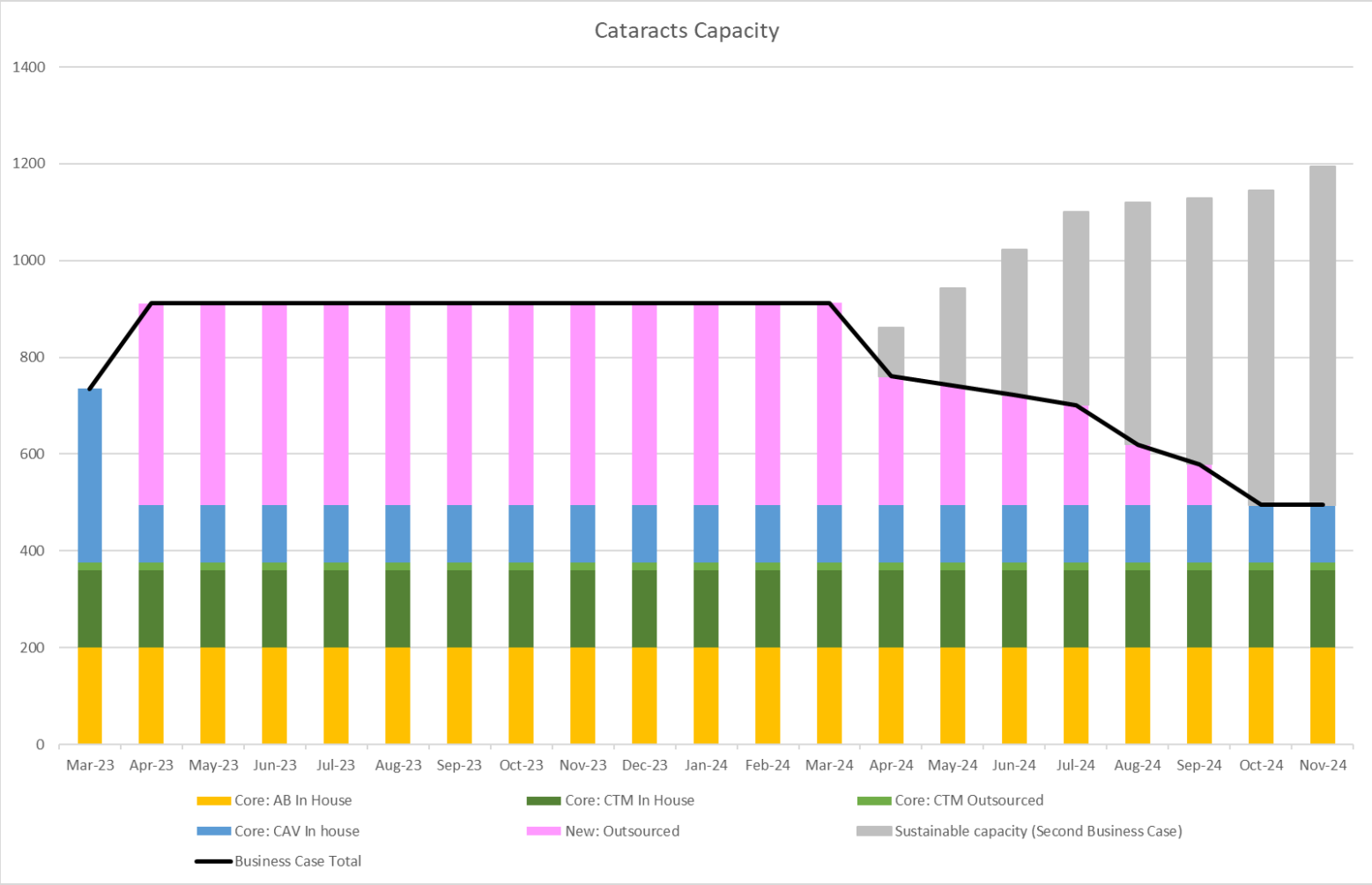
13.2 Option 5 – Option Appraisal

13.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity (outsourced)	**Total**	Average Demand	Difference
AB	2400	36%	1800	**4200**	4080	120
CAV	1440	15%	750	**2190**	1800	390
CTM	2100	49%	2450	**4550**	4080	470
Regional Total	5940		5000	**10940**	9960	980

13.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.



	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Insourced POWH	New: Insourced NHH	**Business Case Total**
2023/24	2400	1920	180	1440	5000	0	0	**10940**
2024/25	1200	960	90	720	1155	0	0	**4125**

13.2.3 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total
2023/24	2400	1800	4200
2024/25	1200	416	1616

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total
2023/24	1920	180	2450	4550
2024/25	960	90	566	1616

CAV Patients

	Core: CAV In House	CAV 15%	CAV Total
2023/24	1440	750	2190
2024/25	720	173	893

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
2023/24	4200	2190	4550	10940

2024/25	1616	893	1616	4125

13.2.4 Option 5 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Outpatient assessments and inpatients treatments are performed on the same site
- Additional capacity delivered at reduced costs from insourcing
- Reduces the backlog by 517 patients waiting

13.2.5 Option 5 Risks

The specific risks associated with option 2 are:

- Loss of experienced and well trained staff at the Vanguard Unit (medium risk following mitigation actions)
- Reduction in training capacity across the region (medium risk following mitigation actions)
- Reduced capacity to treat more complex patients (medium risk following mitigation actions)
- Increased number of patients required to travel further for treatment

13.2.6 Option 4 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will remain at current levels.

This option is for outsourcing activity where patients who meet the criteria for this additional capacity would be directed to outsourcing for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and outsourcing capacity provision. This option also includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity does not include patient travel contributions.

13.2.7 Option 5 Costs

Option 3: Outsourcing

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
External	Outsource	5,000	£790,000	5,000	£5,948,333	£6,738,333
Regional Operational Team						£240,103
TOTAL		**5,000**	**£790,000**	**5,000**	**£5,948,333**	**£6,978,436**

Indicative Cost per Patient £1,396

2024/25

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
External	Outsource	875	£138,250	875	£1,040,958	£1,179,208
Regional Operational Team						£120,052
TOTAL		**875**	**£138,250**	**875**	**£1,040,958**	**£1,299,260**

13.2.8 Option 5 Activity Modelling

The assumptions used in this option are the same as in option 4, as the capacity stays the same but the mode of delivery changes.

After 52 weeks of the total capacity of 10,940 per year the waiting list is reduced from 19,000 across the region to 18,483

Appendix Nine: Split of Preferred Option By Health Board

Delivery is split over 2 financial years as follows:

- 9 months of 23/24 from 1st July 2023 to 31st March 2024
- 5 months of 24/25 from 1st April 2024 to 31st August 2024

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
1st July 2023 to 31st March 2024	1800	2313	4113
1st April 2024 to 31st August 2024	1000	1039	2039
Total Allocation	2800	3352	6152

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
1st July 2023 to 31st March 2024	1215	964	2179
1st April 2024 to 31st August 2024	675	433	1108
Total Allocation	1890	1397	3287

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
1st July 2023 to 31st March 2024	1440	135	3148	4723
1st April 2024 to 31st August 2024	800	75	1414	2289
Total Allocation	2240	210	4562	7012

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
1st July 2023 to 31st March 2024	4113	2179	4723	11014
1st April 2024 to 31st August 2024	2039	1108	2289	5436
Total Allocation	6152	3287	7012	**16450**

Appendix Ten: Full Patient Travel Survey

Patient Travel Survey

January 2023

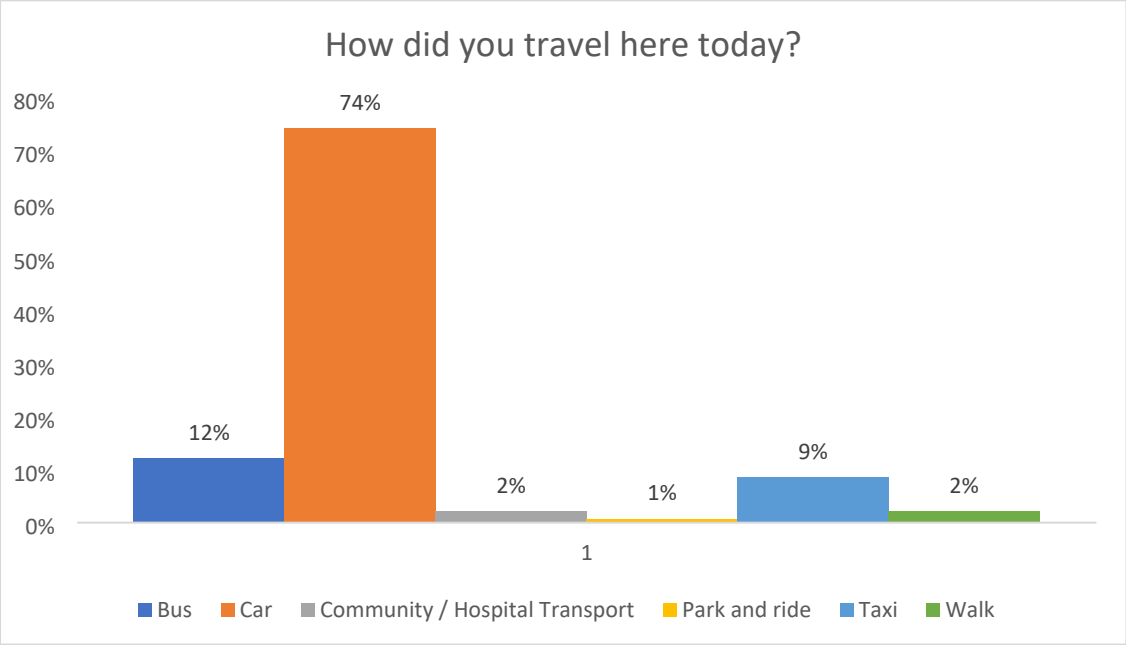
Offthalmoleg Ardal De-ddwyrain Cymru
South East Wales Regional Ophthalmology

A patients travel questionnaire was undertaken in Princess of Wales Hospital on 5th January, Royal Gwent Hospital on 11th January, and University of Wales Hospital on 12th January. 140 patients attending appointments on those day were asked questions about their travel to hospital and their willingness to travel to another hospital for treatment. All respondents were anonymous. This report show the total responses from each location and will form part of the supporting information for the Regional Cataracts business case.

Question 1. Which Hospital are you attending today?

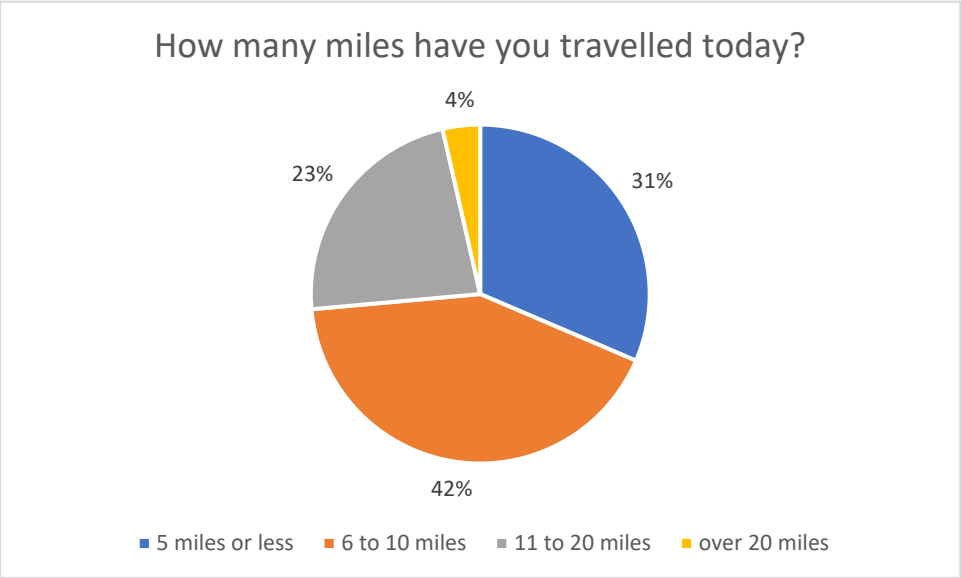
Princess of Wales	35 patients	25%
Royal Gwent	35 patients	25%
University Hospital of Wales	70 patients	50%
Total	140 patients	100%

Question 2. How did you travel here today?



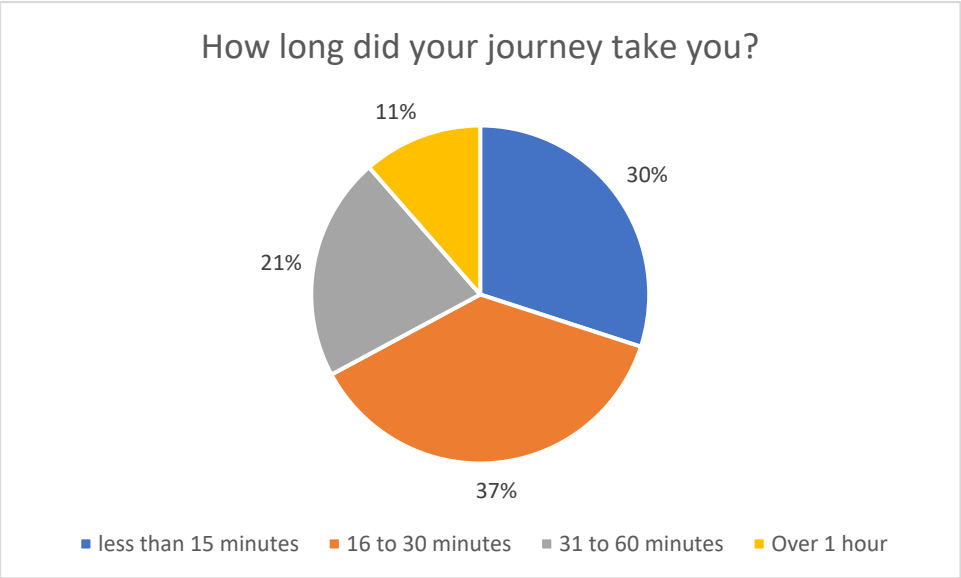
How did you travel here today?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
Bus	6	1	10	17
Car	28	29	47	104
Community / Hospital Transport			3	3
Park and ride			1	1
Taxi		4	8	12
Walk	1	1	1	3
Grand Total	**35**	**35**	**70**	**140**

Question 3. How many miles Have you travelled today?



How many miles have you travelled today?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
5 miles or less	17	7	20	44
6 to 10 miles	16	15	28	59
11 to 20 miles	2	13	17	32
over 20 miles			5	5
Grand Total	**35**	**35**	**70**	**140**

Question 4. How long did your journey take you?

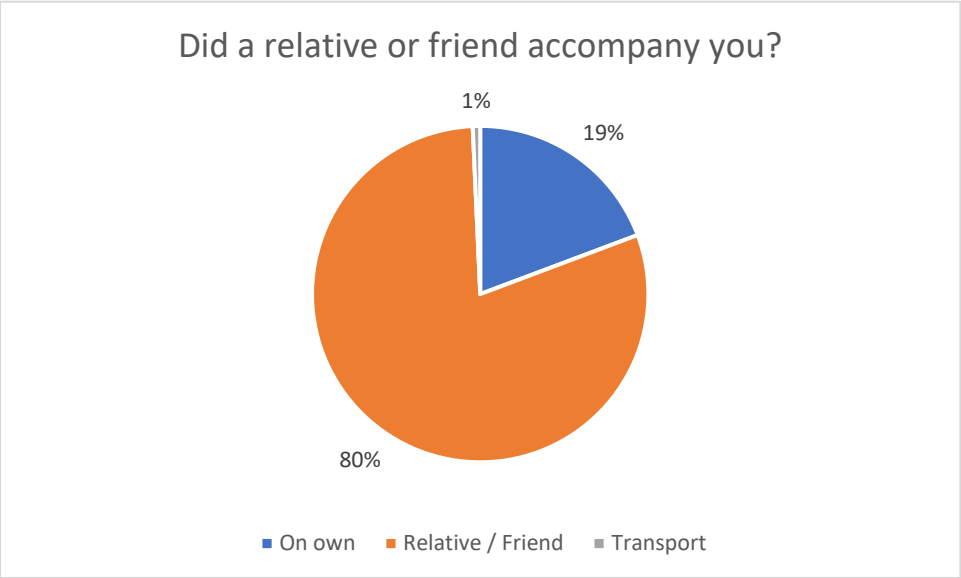


How long did your journey take you?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
less than 15 minutes	16	6	20	42
16 to 30 minutes	16	18	18	52
31 to 60 minutes	3	10	17	30
Over 1 hour		1	15	16
Grand Total	**35**	**35**	**70**	**140**

*on the day of the survey in UHW there was sever weather, flooding and an accident on the A470 resulting in journeys that were longer than the patients were expecting.

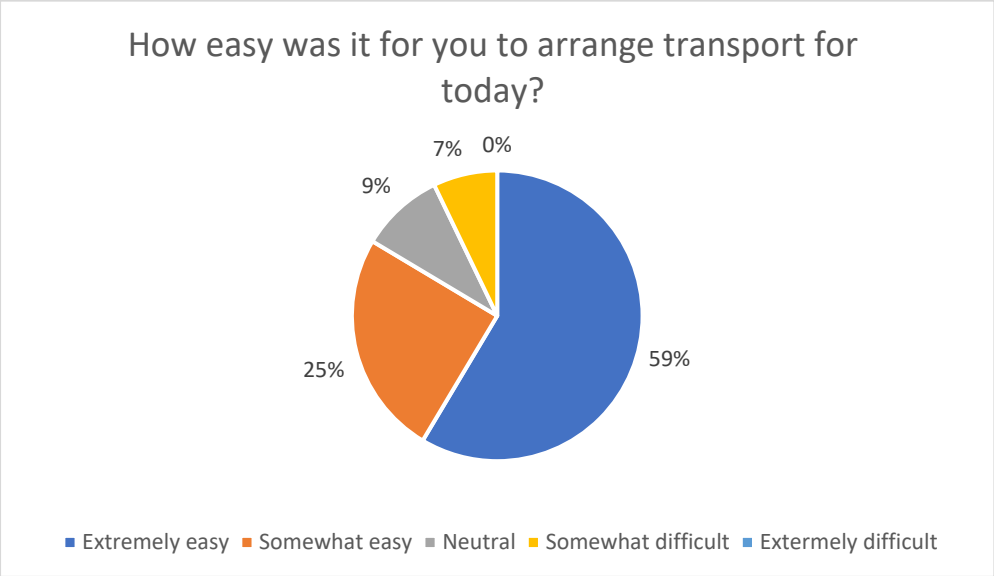
Question 5 asked patients where they travelled from

Question 6. Did a Relative or friend accompany you?



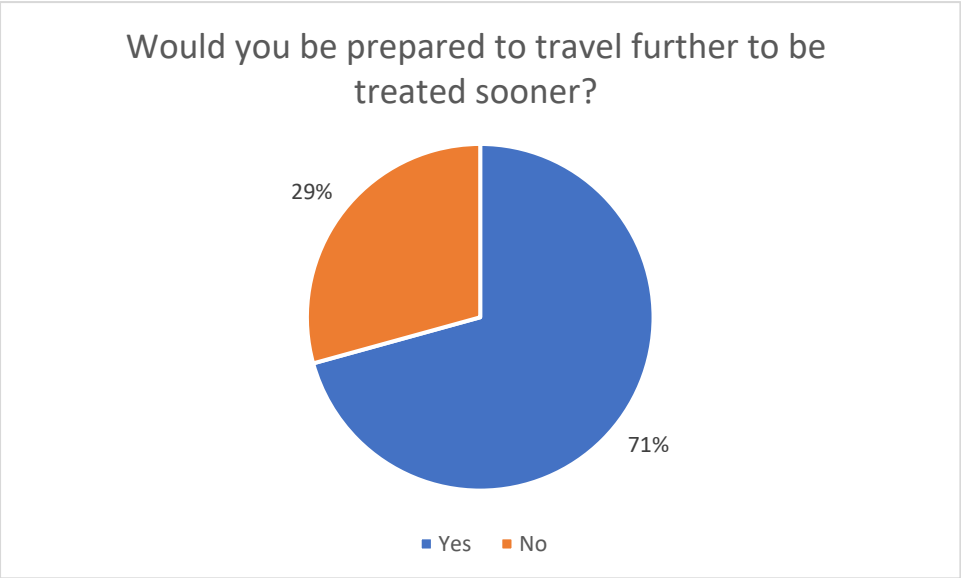
Did a relative or friend accompany you?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
On own	5	3	19	27
Relative / Friend	30	32	50	112
Transport			1	1
Grand Total	**35**	**35**	**70**	**140**

Question 7. How easy has it been for you to arrange transport today?



How easy was it for you to arrange transport for today?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
Extremely easy	24	23	35	82
Somewhat easy	6	9	20	35
Neutral	4	1	8	13
Somewhat difficult	1	2	7	10
Extremely difficult				0
Grand Total	**35**	**35**	**70**	**140**

Question 8. Would you be prepared to travel further if you could have been treated sooner?



Would you be prepared to travel further to the treated sooner?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
Yes	25 (71%)	27 (77%)	47 (67%)	99 (71%)
No	10 (29%)	8 (23%)	23 (33%)	41 (29%)
Grand Total	**35**	**35**	**70**	**140**

Question 9. Where would you travel to?

- From Princess of Wales Hospital in Bridgend, of the 25 patients willing to travel 25 would go to Cardiff and 19 to Swansea
- From Royal Gwent Hospital in Newport, of the 27 patients willing to travel 19 would be willing to travel to Cardiff and 25 to Abergavenny
- From University Hospital of Wales in Cardiff, of the 47 patients willing to travel 38 would be willing to travel to Bridgend and 41 to Newport

Where would you travel to?	From Princess of Wales Hospital	From Royal Gwent Hospital	From University Hospital of Wales
Bridgend / POWH		7	38
Cardiff / UHW	25	19	
Newport / RGH	11		41
Abergavenny / NHH	5	25	30
Bristol	5	6	10
Swansea	19	3	10
Further in the UK	5	3	4
Grand Total	**70**	**63**	**133**

**patients could provide multiple answers to this question*

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

nVCC FULL BUSINESS CASE (FBC) APPROVAL

DATE OF MEETING	24/05/2023

PUBLIC OR PRIVATE REPORT	Private

IF PRIVATE PLEASE INDICATE REASON	Commercially Confidential Content

PREPARED BY	Gavin Bryce, Associate Director of Programmes
PRESENTED BY	
EXECUTIVE SPONSOR APPROVED	Steve Ham, Chief Executive Officer, Velindre University NHS Trust

REPORT PURPOSE	Approve

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
N/A	N/A	N/A

INITIALISMS	
ABUHB	Aneurin Bevan University Health Board
ASP	Annual Service Payment
DoP's	Directors of Planning
DoF's	Directors of Finance
CAVUHB	Cardiff and Vale University Health Board
FBC	Full Business Case
FC	Financial Close
HBN's	Health Building Notes
IRS	Integrated Radiotherapy Solution
LHB	Local Health Board
MiM	Mutual Investment Model

INITIALISMS	
nVCC	new Velindre Cancer Centre
OBC	Outline Business Case
PA	Project Agreement
RSC	Radiotherapy Satellite Centre
SACT	Systemic Anti-Cancer Treatment
SP	Successful Participant
VCC	Velindre Cancer Centre (Existing)
WG	Welsh Government

1. INTRODUCTION

1.1 On the 29/03/2023 the Aneurin Bevan University Health Board (ABUHB) received a Full Business Case (FBC) relating to the proposed new Velindre Cancer Centre (nVCC). The business case received by ABUHB consisted of four cases, these were the Strategic, Economic, Financial and Management cases. The Commercial Case, more relevant to Welsh Government (WG), was not presented as the project is still concluding final commercial discussions ahead of Financial Close (FC).

1.2 The four cases were accompanied by a cover report which set out details of the required revenue support requested from ABUHB and followed a period of engagement between Velindre University NHS Trust (VUNHST), ABUHB, Directors of Planning (DoP) and Directors of Finance (DoF) Groups and the Cancer Commissioning Group (CCG).

1.3 The financial support requested fell into two main categories:

(i) Costs associated with the transition between the VCC and nVCC including dual site running costs

(ii) Ongoing revenue support for nVCC

***NB**: all costs associated with the construction of the nVCC referred to as the Annual Service Payment (ASP) will be met by WG as set out in the WG Mutual Investment Model Policy.*

1.4 ABUHB duly considered the business case and provided the following feedback, which has been summarised:

"The ABUHB Board agreed that it supported the case for change in principle, as it is evident that the current environment at Velindre NHST is no longer sustainable, and there is a need to improve the environment by building a new setting which would provide better surroundings for our patients. However, given the current operating environment and financial situation, the Health Board agreed it could not commit to paying an additional £1.9 million at this time for running costs of a building (which could be £2.4m if WG assumed funding

isn't secured), and the Board asked that VNHT reconsiders the associated finance and economic cases.

Please accept my assurance that we remain fully committed to working with VNHST as one of our key partners and are happy to engage in further discussions in respect of the FBC as required".

2. PURPOSE

2.1 Following the ABUHB decision in March 2023 further discussions have been held between the Executive Officers of both organisations with a view to addressing the outstanding matters with the ABVUHB Board reconsidering the FBC (4 cases at the May 2023 Board meeting). It is intended that this cover report addresses the points raised in the Board decision of March 2023.

2.1 The main issue feedback to VUNHST relates to ABUHB's ability to commit to the revenue investment in the context of the challenging financial environment for NHS Wales over the coming years.

2.2 In response this report is set out as follows:

- Context and previous approvals
- Key issues raised for additional work including:-
  - Investment Context and Programme Benefits
  - Demonstrating the nVCC is appropriately sized
  - Strengthening the clinical model for cancer services in ABUHB
  - Affordability

3. Context and previous approvals

3.1 Following a period of extensive engagement in 2017/18 ABUHB approved its revenue support to the nVCC Outline Business Case (OBC) at its Board meeting on the 24/10/2018. Details of this approval are set out in Appendix A.

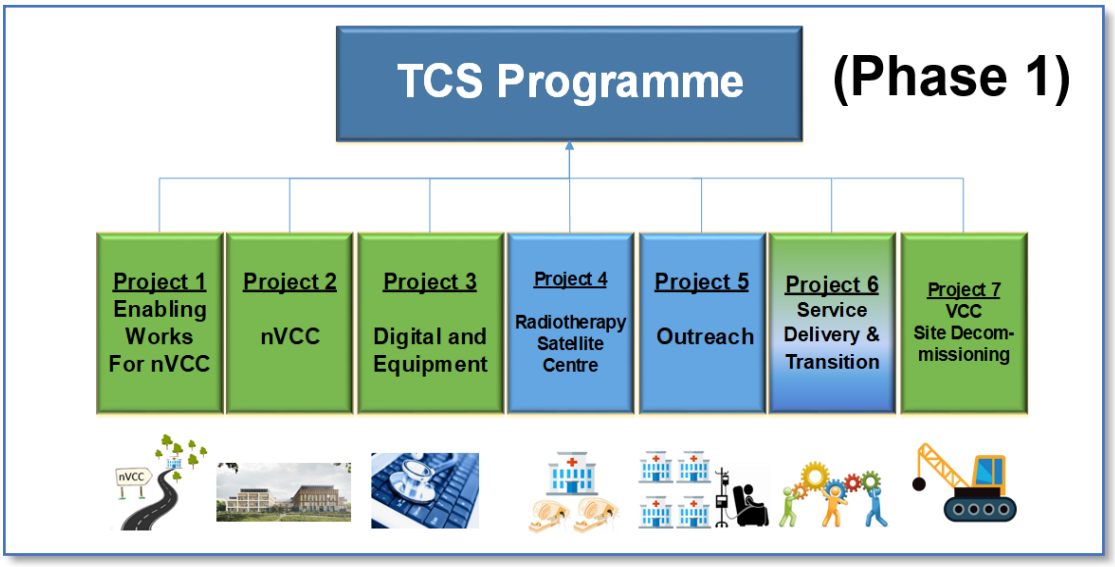
3.2 This approval, and that of other VUNHST commissioners and Welsh Government (WG), allowed for the nVCC project to proceed from planning into procurement. As such, the competitive dialogue process commenced on the 01/09/2021 and concluded on the 17/03/2022. The Acorn Consortium was confirmed as the Successful Participant (SP) following the evaluation of final tender submissions in July 2022. Work has continued from the SP stage of the procurement to achieve Financial Close (FC), which is imminent; and the subsequent finalisation of the FBC (most notably the Commercial Case) will follow.

4. Investment Context and Programme Benefits

4.1 One of the areas which required additional information was the range of benefits that the nVCC project and FBC would provide to the health economy. The nVCC project FBC was presented as a standalone case to the ABUHB Board in March 2023 and this did not fully assist in demonstrating the overall benefit of the investment as a result of the approach that Velindre University NHS Trust have had to follow as a result of its overall strategic requirements and the use of the Mutual Investment Model (MiM) to procure and construct the nVCC. These are described below:

4.2 The Transforming Cancer Services Programme (TCS) consists of 7 separately defined yet co-dependent projects which each deliver a set of defined benefits which combine to deliver the TCS Programme spending objectives (see Fig.1).

Fig 1. TCS Programme's scope.



4.3 The TCS programme is vital in supporting the region to develop sustainable tertiary non-surgical cancer services in the medium/long-term and also in delivering operational services today. This need resulted in Velindre University NHS Trust having to advance a number of the projects at the earliest opportunity i.e., decoupling Project 3 (the procurement of the Integrated Radiotherapy solution (10 linacs)) from the nVCC project to allow it to replace its ageing Linac fleet (some Linacs where 16 years old) and provide operational capacity at the earliest opportunity i.e. in 2023 to ensure operational service capacity across South East Wales.

4.4 The use of the MIM policy to procure the nVCC project also required the enabling works to be taken forward as a separate project (Project 1) as the various consortiums in the Public Private Partnership sector who registered an interest in the project all indicated that the provision of an 'over ready' site i.e., with access to the site and utilities for construction provided by VUNHST in advance of signing contracts was likely to be more attractive. The Trust and

the Welsh Government also viewed this approach as offering best value for money in the longer-term. Therefore, the Enabling Works for nVCC project was decoupled from the Project 2 (nVCC Project) and is due to complete in August 2023.

4.5 This approach is different to a traditional design and build approach where a new hospital scheme would include the access to the site; all of the equipment; and the facility as part of one single business case. Consequently, the business case would also set out the consolidated range of benefits in a single case. This is not the case for the nVCC Project for the strategic and operational reasons set out above. It is therefore useful to consider the wider set of benefits in Project 1 (enabling works), Project 3 (Integrated Radiotherapy Solution) and Project 2 (nVCC Project) together for a more accurate comparison with other new hospital schemes.

4.6 It is important to note that Velindre University NHS Trust has also been clear in not double counting the various benefits contained within each of the projects within the TCS Programme. The important point to note is that the approach VUNHST has needed to take has the potential effect of under-playing the overall benefits that the nVCC will generate (i.e., Projects 1, 2 and 3 should be seen as collection of benefits directly relating to the nVCC project) when compared to the approach a traditional capital funded case would adopt.

4.7 It should also be noted that VUNHST has been clear that the nVCC project, like all other buildings, will support the overall improvement in system benefits (i.e., improved quality of care; survival rates etc..) but would not singularly result in a step change given it's a tertiary service facility. The radical transformation of services will require continued change and investment across the whole pathway (public health; primary care; diagnostics; surgery; prehab/rehabilitation; living beyond cancer) over many years.

4.8 With regard to the benefits for Project 2 (nVCC) and all other projects, the Trust has worked closely with its commissioners and WG colleagues in Health and Treasury, and followed Treasury Green Book and Better Business Case Project specific guidance.

4.9 The FBC benefits have been thoroughly tested by WG economists and this has led to only those monetised benefits that have a strong economic basis have been included in the nVCC FBC. These are set out at Appendix B and include compliance with WG guidance on air quality and environmental benefits.

4.10 In addition to the work carried out on the monetised benefits VUNHST has also developed a comprehensive nVCC project benefits register that includes a wider range of benefits including non-monetised and qualitative benefits, some of these are partially, or wholly attributable to the nVCC (a comprehensive list is included at Appendix C).

Demonstrating the nVCC is appropriately sized and the design is appropriate

4.11 The business need for the nVCC is set out in the strategic case which reflects the acknowledged inadequacies of the current Velindre Centre built in 1956. The patient environment is not fit for purpose with 35% of in-patient accommodation below the required standard and 75% of the estate does not comply with current space standards (HBN's). The building presents problems with poor adjacencies, multiple cross-overs and restricted patient privacy leading to inefficiency, sub-optimal infection prevention and control (IPC) practices and poor patient experience.

4.12 The OBC set out four options for the nVCC (do nothing; do minimum; do minimum plus; and do maximum). The OBC appraisal identified the do minimum plus option as the best option which was approved by Velindre University NHS Trust and all partners in October 2018.

4.13 Today, Velindre Cancer Centre is 17,500 square metres and to simply rebuild the existing facility to current HBN and HTM standards would require a facility of 28,500sqm. The nVCC design is 30,200 square metres and the additional 1,700sqm is based upon the forecast demand; the requirements for fit-for-purpose education/learning facilities; a regional research bunker. All of these facilities and equipment will be accessible to regional partners.

4.13 The planned nVCC is driven by:

- The forecast demand for services (2% annual increases in the incidences of cancer).
- The clinical model (delivering more services at home; in LHB / outreach settings; radiotherapy satellite centre in Nevill Hall; specialist services at nVCC)
- Services that can only be delivered in nVCC (i.e., radiotherapy; brachytherapy; specialist SACT etc.)

4.14 The nVCC design has been optimised and is designed with flexibility as a key principle and as such the nVCC contains within its design an imaging/radiotherapy treatment 'area' which can respond to changing technology and a clinical area (inpatient; assessment/ambulatory care; SACT etc.) which can adapt to changes in clinical practice.

4.15 The design of the nVCC has followed all WG policy guidance at a macro level i.e. Well Being of Future Generations Act; Decarbonisation requirements and also at a health level i.e. Health Building Notes; Health Technical Memorandum. The NHS Wales Shared Services Partnership – Estates have been involved during the design process to ensure that the nVCC facility is approrpitaely designed to achieve the maximum value at the best cost. This robust external review process also provides assurance to the Trust Board and its partners that the design is not over-engineered and/or seeking to achieve objectives which sit outside of Welsh Government policy i.e. ensuring it addresses needs and not wants.

Strengthening the clinical model for cancer services in Aneurin Bevan and South East Wales

4.16 Independent advice on the TCS Clinical Operating Model for non-surgical tertiary oncology service in Southeast Wales was commissioned from the Nuffield Trust by VUNHST in September 2020. The commissions terms of reference was agreed with by the Trusts commissioners

4.17 This advice was received by the Trust on 1st December 2020 and publicly published on the Nuffield Trust website the same day, with supporting communications to staff and other key stakeholders announcing its publication. The report was welcomed by the Trust and was formally received by the Trust Board on 10th December 2020.

4.18 The Nuffield Trust advice was also considered by the Southeast Wales Collaborative Cancer Leadership Group (CCLG) on 21st January 2021 where it accepted all recommendations and responsibility for supporting the delivery of regional recommendations. The Group agreed to provide the oversight and leadership required at a regional level, working together to deliver on the recommendations in order to improve the cancer system and related outcomes.

4.19 A joint statement was issued on 6th January 2021 by Velindre University NHS Trust and its four main commissioners confirmed the following:

"We are committed to working together to deliver the best care and outcomes for patients with cancer within the population we serve. Both Organisations welcome the recent Nuffield Trust Report regarding the delivery of non-surgical cancer services in Southeast Wales and the development of the new Velindre Cancer Centre. The recommendations have been formally accepted by the VUNHST Trust Board."

4.12 The report set out 11 recommendations for Velindre University NHS Trust and Health Board partners to consider in securing planned and sustained improvements in cancer services in the immediate, medium and longer term.

4.21 A high-level action plan was developed by VUNHST, Cwm Taf Morgannwg ULHB, Cardiff and Vale ULHB, Aneurin Bevan ULHB to deliver the recommendations. This has been overseen by the Southeast Wales Collaborative Cancer Leadership Group (CCLG).

4.22 There are a number of recommendations specific to ABUHB and VUNHST which have progressed, including:

Recommendation 3/4: unwell patient: unscheduled care pathways have been revised and admission criteria's reviewed to ensure safe and effective management of patients. This is supported by the provision of an Acute Oncology Services which is currently being implemented across the region following business case approval.

Recommendation 6 of the Nuffield Trust advice also referred to 'bringing the models for haemato-oncology and solid tumour work' together. Recent work between ABUHB and VUNHST have continued and focused on a new initiative relating to the delivery of a shared Haemato-oncology, SACT and Outpatient

development at the Nevill Hall site sitting alongside the Radiotherapy Satellite Centre (RSC) which VUNHST can confirm its continued commitment to.

5. Affordability

5.1 The costs and affordability of the nVCC project have been subject to a significant amount of engagement with Local Health Boards over the last five years of the nVCC project. The costs and funding requirements contained within the FBC considered by Boards in March 2023 had been subject to significant scrutiny by LHB partners prior to inclusion in the Finance Case with the Directors of Finance of ABUHB; C&VUHB; CTMUHB and PTHB and the Velindre Collective Commissioning Group (CCG) having concluded that the revenue costs, from a professional perspective, were considered to be 'fair and reasonable'.

5.2 However, given the challenging financial environment within which VUNHST is seeking the investment, ABUHB considered them to be unaffordable.

5.3 VUNHST have subsequently worked with a range of stakeholders to review the costs and funding requirement with a view to reducing the levels of investment required and the risk sharing of partners. VUNHST have been engaging with WG officers to seek agreement to certain costs being funded by WG and not by the Trusts commissioners. This has led to VUNHST reducing the commissioner funding requirement based on the following positions in respect of the key areas for further work raised by the ABUHB Board following consideration of the FBC in March 2023:

Position 1: Welsh Government agreement to funding insurance as it's directly related to the MIM procurement approach

Position 2: Welsh Government agreement to VUNHST retaining underspend of the Annual Service Payment (ASP) in the event there is relief due to non-availability or other performance issues to fund the cost of contract management.

Position 3: VUNHST continue to accept the financial risk on contract management, energy (if there is any future premium) and any digital requirements that are not core to the nVCC project. This was the position in the FBC presented in March 2023 and has been re-affirmed by the VUNHST Board.

5.4 VUNHST are finalising arrangements with WG to seek Ministerial approval for positions 1 and 2 and are aware that the Finance Case of the FBC now reflects this position.

5.5 Commissioners are therefore being asked to approve funding at OBC levels plus inflation i.e. support the funding that was agreed in October 2018. The LHB total requirements is £4.08million compared to the FBC additional funding requirement of £5.155 million; a reduction of £1.075 million

5.6 The recurring revenue investment sought from ABUHB is £1.490m recurrent revenue; a reduction of £0.393 million from the FBC considered by the ABUHB Board in March 2023.This is set out in Table 1.

Table 1 Recurring Revenue

	October 2018 As Approved by ABUHB	Inflated to November 2022	Additional Funding	Original FBC Request	Revised Funding Ask post Funding Assumptions change
Recurring Revenue	£1.281m	£1.490m	£0.209m	£1.883m	£1.490m

5.7 The non-recurrent investment revenue sought from ABUHB is £0.745million, as set out in Table 2.

Table 2 Non-recurrent revenue

	October 2018 As Approved by ABUHB	Inflated to November 2022	Additional Funding	Original FBC Request	Funding Ask
Non - Recurring Revenue	£0.690m	£0.881m	£0.191m	£0.881m	£0.881m

6. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The Clinical Service Model has been approved by commissioners and assured by Nuffield Trust.
RELATED HEALTHCARE STANDARD	Safe Care
	As Above
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes

	Completed at TCS Programme Level
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The nVCC Project is part of the WG Mutual Investment Model (MIM).
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Funding is required from WG and commissioners.

7. RECOMMENDATION

7.1 The Aneurin Bevan University Health Board is requested to:

- consider approval of the FBC (4 cases) with a reduction in revenue funding of £0.393 million from the case it considered in March 2023.
- note that the reduction in recurrent revenue funding at a system level (i.e. £1.075 million) will be applied proportionately to other commissioners of VUNHST.

Appendix A – Prior OBC Approval

Aneurin Bevan University Health Board (received 24/10/18) Extract from Trust Board Minutes. Letter of support to follow.	**ABUHBIC 2303/07** **Velindre Cancer Centre Outline Business Case** Nicola Prygodzicz presented the Executive Summary of the Outline Business Case for the new Velindre Cancer Centre, highlighting that the full Business Case had been considered by the Planning and Strategic Change Committee. It was noted that this was the new Cancer Centre element of the Transforming Cancer Services Strategy. All Health Boards were required to approve the OBC prior to submission to Welsh Government. It was noted that a unique funding model would be used – a Mutual Investment Model. ABUHB patients accounted for 40% of patients at Velindre. The costs were outlined, highlighting that the total recurrent costs for the Health Board would be £1,281k. It was agreed that the Health Board would include a condition on approving the OBC, that the percentage contribution would be flexible to reflect patient flows. The OBC for the Satellite Radiotherapy Unit at NHH was being prepared. The Board approved the OBC, with the following caveats to be included in the response: • The Velindre Cancer Centre is one part of the overarching Strategy which the Health Board are committed to, including better screening services and single cancer pathway; 3 Board In Committee-23/05/18 nmittee Meeting - 21st March 2018 Aneurin Bevan University Health Board Wednesday 23 May 2018 Agenda Item: IC2 2 • The percentage financial contribution would be flexible to reflect patient flows.

Appendix B – Monetised Benefits

Benefits Summary

Organsation Name:	Velindre
Project Title:	nVCC FBC

ID	Benefit Name	Benefit Description	Beneficiary	Benefit Type	Metric	Baseline	Target Improvement	Monetary Value 60 years	Calculation assu
Cash releasing benefits (CRB)									
CRB1	Improved recruitment and retention	Improved staff recruitment and retention resulting in reduced reliance on overtime, bank and agency	Velindre NHS Trust	Cash Releasing	'25% reduction applied to current bank, overtime and agency	0%	25%	21,562	Percentage of a 25% re current staffing costs
CRB2	Additional income from Centre for Learning and Innovation	Additional income from Centre for Learning and Innovation	Velindre NHS Trust	Cash Releasing	Additional income generated less cost to deliver	0%	£170k p.a.	9,690	Percentage of estimate from CfL activities (£9,5
Non-cash releasing benefits (NCRB)									
NCRB1	Improved adjacencies	Improved adjacencies contributing to more efficient ways of working	Velindre NHS Trust	Non-Cash Releasing	0.5% productivity improvement applied to current cost of Soft FM and Clinical workforce	0%	100%	8,480	Percentage of the prod improvement
NCRB2	Greater flexibility	More flexible facilities contributing to more efficient ways of working	Velindre NHS Trust	Non-Cash Releasing	0.5% productivity improvement applied to current cost of Soft FM and Clinical workforce	0%	100%	8,075	Percentage of the prod improvement
NCRB3	Greater compliance	Greater ability to comply with standards contributing to more efficient ways of working	Velindre NHS Trust	Non-Cash Releasing	0.5% productivity improvement applied to current cost of Soft FM and Clinical workforce	0%	100%	8,075	Percentage of the prod improvement
NCRB4	Innovation opportunities	Increased innovation opportunities that maximise delivery of wider programme benefits	Various	Non-Cash Releasing	5.0% - 7.5% of wider programme benefits (clinical service model, improved survival rates, increased employment)	0%	8%	68,555	Percentage of the wide benefits
Societal benefits (SB)									
SB01a	More energy efficient building - Greenhouse gases	Improved energy efficiency resulting in changes in carbon emissions and air quality	Societal	Societal	Change in energy usage - Impact on carbon emissions			30,792	
SB01b	More energy efficient building - Air quality	Improved energy efficiency resulting in changes in air quality	Societal	Societal	Change in energy usage - Impact on air quality			- 3,592	
SB2	Wider social benefit from ongoing presence of the cancer centre	Un-measurable benefits on the wider community of access to the cancer centre	Societal	Societal	N/A	-	-	-	

Appendix C – Non-Monetised Benefits Register

Unique Benefit ID	Outcome Category	Apportionment	Benefit for Patient Carers or Family	Benefit to VCC	Benefit to LHB and Partners	WG and Wider Society	Benefit Type 1	Benefit Type 2	Baseline	Owner
BR92	**Patient receive right care in the right place in the heath care system**	**Programme Level Benefit Partially attributable to nVCC**	Increased patient choice				**Non-Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	**Medical Director**
BR93			More patients choose to receive appropriate treatment				**Non-Quantifiable**	**Non - Cash Releasing**	**Current Access Rates**	
BR95			Improved patient experience				**Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	
BR96			Reduced anxiety				**Non-Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	
BR97				Higher take up of treatments			**Non-Quantifiable**	**Non - Cash Releasing**	**Current Access Rates**	
BR98				More efficient use of resources			**Non-Quantifiable**	**Non - Cash Releasing**	**No Measure**	
BR99				Improved utilisation of workforce			**Quantifiable**	**Non - Cash Releasing**	**No Measure**	

BR100				Supports delivery of Velindre Trust strategy			**Non-Quantifiable**	**Non - Cash Releasing**	**IMTP Delivery**	
BR101					Better utilisation of third sector		**Non-Quantifiable**	**Non - Cash Releasing**	**No Measure**	
BR102						Higher take up of treatments	**Non-Quantifiable**	**Non - Cash Releasing**	**Current Access Rates**	
BR103						Increased spend in local community	**Non-Quantifiable**	**Non - Cash Releasing**	**No Measure**	
BR104						Supports delivery of WG strategy	**Non-Quantifiable**	**Non - Cash Releasing**	**N / A**	

Unique Benefit ID	Outcome Category	Apportionment	Benefit for Patient Carers or Family	Benefit to VCC	Benefit to LHB and Partners	WG and Wider Society	Benefit Type 1	Benefit Type 2	Baseline	Owner
BR105	**Extended Clinical opening hours**	**Benefit Solely Attributed to the nVCC**	More patients are seen				**Quantifiable**	**Non - Cash Releasing**	**Current Access Rates**	**Medical Director**
BR106			More patients are treated				**Quantifiable**	**Non - Cash Releasing**	**Current Access Rates**	
BR107			Increased patient choice				**Non-Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	
BR108			Care is delivered around the patients day to day life				**Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	
BR109			Less disruption to normal routine				**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR110			More people receive appropriate treatment				**Quantifiable**	**Non - Cash Releasing**	**Current Access Rates**	
BR111			Improved patient experience				**Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	
BR112				More patients are seen			**Quantifiable**	**Non - Cash Releasing**	**Current Access Rates**	

BR113				More patients are treated			**Quantifiable**	**Non - Cash Releasing**	**Current Access Rates**		
BR114				Higher take up of treatments			**Quantifiable**	**Non - Cash Releasing**	**Current Access Rates**		
BR115				Higher utilisation of capital assets			**Quantifiable**	**Non - Cash Releasing**	**Current Access Rates**		
BR116				More flexible working for staff			**Quantifiable**	**Non - Cash Releasing**	**Staff Survey Results**		
BR117				Better work life balance			**Quantifiable**	**Non - Cash Releasing**	**Staff Survey Results**		
BR118				Supports delivery of Velindre Trust strategy			**Quantifiable**	**Non - Cash Releasing**	**IMTP Delivery**		
BR119					Better utilisation of third sector		**Quantifiable**	**Non - Cash Releasing**	**No Baseline**		
BR120						Higher take up of treatments	**Quantifiable**	**Non - Cash Releasing**	**Current Access Rates**		
BR121						Supports delivery of WG strategy	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**		

Unique Benefit ID	Outcome Category	Apportionment	Benefit for Patient Carers or Family	Benefit to VCC	Benefit to LHB and Partners	WG and Wider Society	Benefit Type 1	Benefit Type 2	Baseline	Owner
BR191	**Improved take up of treatment and services**	**Programme Level Macro Benefit partially attributable to nVCC**	More patients receive appropriate treatment				**Quantifiable**	**Non - Cash Releasing**	**Current Activity**	**Medical Director**
BR192			Improved patient experience				**Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	
BR193			Reduced patient and family anxiety				**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR194			Better symptom control and pain management				**Non-Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	
BR195				Supports compliance with national clinical guidance / advice			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR196				Clinicians treat more patients			**Quantifiable**	**Non - Cash Releasing**	**Current Activity and Performance Measures**	
BR197				Improves clinical job satisfaction			**Quantifiable**	**Non - Cash Releasing**	**Staff Survey Results**	

BR198				More efficient use of resources			**Quantifiable**	**Non - Cash Releasing**	**Current Activity**	
BR199				Improved reputation			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR200				Supports delivery of Velindre Trust strategy			**Quantifiable**	**Non - Cash Releasing**	**IMTP Delivery**	
BR201					Improved reputation		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR202					Better utilisation of third sector		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR203						Enhances WG reputation	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR204						Supports delivery of WG strategy	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	

Unique Benefit ID	Outcome Category	Apportionment	Benefit for Patient Carers or Family	Benefit to VCC	Benefit to LHB and Partners	WG and Wider Society	Benefit Type 1	Benefit Type 2	Baseline	Owner
BR205	Construction of Hospital	**Benefit Solely Attributed to the nVCC**		Enhanced reputation			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	**Infra Structure Programme Director**
BR206				Improved recruitment / retention			**Non-Quantifiable**	**Non - Cash Releasing**	**Current Workforce information**	
BR207				Improved brand awareness nationally / internationally			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR208				Increased strategic / commercial partnership opportunities			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR209					Enhanced reputation		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR210					Improved recruitment / retention		**Non-Quantifiable**	**Non - Cash Releasing**	**Current Workforce information**	
BR211					Increased strategic / commercial partnership opportunities		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR212					Positive media stories		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	

BR213				Supports delivery of Velindre Trust strategy		**Non-Quantifiable**	**Non - Cash Releasing**	**IMTP Delivery**
BR214					Supporting delivery of the WG Innovative Finance PPP pipeline	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**
BR215					Enhanced reputation	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**
BR216					Improved recruitment / retention in SE Wales	**Non-Quantifiable**	**Non - Cash Releasing**	**Current Workforce information**
BR217					Employment opportunities for local people / business (direct / indirect)	**Quantifiable**	**Non - Cash Releasing**	**No Baseline**
BR218					Boost to local economy	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**
BR219					Increased Training / Apprenticeship opportunities	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**
BR220					Investment in local community	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**
BR221					Inward investment into Wales	**Non Quantifiable**	**Non - Cash Releasing**	**No Baseline**

BR222				Educational visits to schools to talk about career opportunities	**Non Quantifiable**	**Non - Cash Releasing**	**No Baseline**
BR223				Supports delivery of WG strategy	**Non Quantifiable**	**Non - Cash Releasing**	**No Baseline**

Unique Benefit ID	Outcome Category	Apportionment	Benefit for Patient Carers or Family	Benefit to VCC	Benefit to LHB and Partners	WG and Wider Society	Benefit Type 1	Benefit Type 2	Baseline	Owner
BR224	Compliance with standards	**Benefit Solely Attributed to the nVCC**	Better patient experience				**Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	**Director of VCC**
BR225			Improved patient dignity				**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR226			Reduced patient anxiety				**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR227			Less patient harm through safer environment				**Quantifiable**	**Non - Cash Releasing**	**Reduced Datix, AI, SAI**	
BR228			Reduced slips, trips and falls				**Quantifiable**	**Non - Cash Releasing**	**Reduced Datix, AI, SAI**	
BR229			Better patient / family facilities / amenities				**Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	
BR230				Compliance with BREEAM			**Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR231				Reduced unit energy costs			**Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR232				Reduced backlog maintenance			**Quantifiable**	**Non - Cash Releasing**	**From Current Baseline**	

BR233				Less workplace incidents / accidents			**Quantifiable**	**Non - Cash Releasing**	**Reduced Datix, AI, SAI**
BR234				Reduced financial liabilities			**Quantifiable**	**Non - Cash Releasing**	**From Current Baseline**
BR235				Reduced HAIs			**Quantifiable**	**Non - Cash Releasing**	**Reduced Datix, AI, SAI**
BR236				Reduced risk of regulatory enforcement			**Quantifiable**	**Non - Cash Releasing**	**Reduced Datix, AI, SAI**
BR237				Enhanced reputation			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**
BR238				Enhanced working environment			**Quantifiable**	**Non - Cash Releasing**	**Staff Survey Results**
BR239				Supports delivery of Velindre Trust strategy			**Quantifiable**	**Non - Cash Releasing**	**IMTP Delivery**
BR240					Assurance for commissioners that services are delivered from facilities that are compliant with standards		**Quantifiable**	**Non - Cash Releasing**	**N / A**
BR241					Reduced risk / premium to Welsh Risk Pool		**Quantifiable**	**Non - Cash Releasing**	**Reduced level of litigation costs**

BR242						More capital available to spend on other schemes / requirements due to use of Innovative finance	**Quantifiable**	**Non - Cash Releasing**	**N / A**	
BR243						Improved reputation	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR244						Reduced CO2 emissions	**Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR245						Supports delivery of WG strategy	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	

Unique Benefit ID	Outcome Category	Apportionment	Benefit for Patient Carers or Family	Benefit to VCC	Benefit to LHB and Partners	WG and Wider Society	Benefit Type 1	Benefit Type 2	Baseline	Owner
BR246	**PPP Allows flexible design to meet future challenges**	**Benefit Solely Attributed to the nVCC**	Ability to adapt to meet changing patient needs and expectations				**Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	**Infra Structure Programme Director**
BR247			Ability to adapt to meet changing family / carer needs and expectation				**Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	
BR248			Ability to adapt to meet clinical / technological advances in treatment and practice to ensure patient needs are met				**Quantifiable**	**Non - Cash Releasing**	**Patient Satisfaction Survey**	
BR249				Improved ability to meet changes in service requirements e.g. future growth +/- forecast			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	

BR250				Provide a level of future proofing which will minimise costs / future investment in building re-configuration			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**
BR251				Supports delivery of Velindre Trust strategy			**Quantifiable**	**Non - Cash Releasing**	**IMTP Delivery**
BR252					Commissioners have assurance that future population requirements will be met		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**
BR253						Welsh Government have assurance that future population requirements will be met	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**
BR254						Provide a level of future proofing which will minimise costs / future investment in building re-configuration from the All Wales	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**

						Capital Programme					
BR255						Supports delivery of WG strategy	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**		

Unique Benefit ID	Outcome Category	Apportionment	Benefit for Patient Carers or Family	Benefit to VCC	Benefit to LHB and Partners	WG and Wider Society	Benefit Type 1	Benefit Type 2	Baseline	Owner
BR256	Improved car parking facilities	Benefit Solely Attributed to the nVCC	Easier to park				Quantifiable	Non - Cash Releasing	Patient Satisfaction Survey	Infra Structure Programme Director
BR257			Less time spent looking for car parking space				Non-Quantifiable	Non - Cash Releasing	No Baseline	
BR258			Reduced frequency of being late for appointments				Quantifiable	Non - Cash Releasing	Current time in attendance and clinic throughput data	
BR259			Reduced anxiety for patients, carers and families				Quantifiable	Non - Cash Releasing	Patient Satisfaction Survey	
BR260			Improved patient experience for patients, carers and families				Quantifiable	Non - Cash Releasing	Patient Satisfaction Survey	
BR261			Less accidents				Quantifiable	Non - Cash Releasing	Reduced Datix, AI, SAI	
BR262				Easier to park for staff			Quantifiable	Non - Cash Releasing	Current Timeliness Data	

BR263				Fewer patients delayed allowing clinics to run on-time			**Quantifiable**	**Non - Cash Releasing**	**Current time in attendance and clinic throughput data**	
BR264				Easier to park for staff			**Quantifiable**	**Non - Cash Releasing**	**Staff Survey Results**	
BR265				Less time spent looking for car parking space			**Quantifiable**	**Non - Cash Releasing**	**Current time in attendance and clinic throughput data**	
BR266				Reduced frequency of being late for appointments			**Quantifiable**	**Non - Cash Releasing**	**Current time in attendance and clinic throughput data**	
BR267				Reduced anxiety for staff			**Quantifiable**	**Non - Cash Releasing**	**Staff Survey Results**	
BR268				Fewer appointment delays			**Non-Quantifiable**	**Non - Cash Releasing**	**Current time in attendance and clinic throughput data**	
BR269				Improved staff morale			**Non-Quantifiable**	**Non - Cash Releasing**	**Staff Survey Results**	
BR270				Less accidents			**Quantifiable**	**Non - Cash Releasing**	**Reduced Datix, AI, SAI**	

BR271				Supports delivery of Velindre Trust Strategy			**Quantifiable**	**Non - Cash Releasing**	**IMTP Delivery**	
BR272					Easier for partner clinicians to park when visiting MDTs / appointments		**Non-Quantifiable**	**Non - Cash Releasing**	**Duplicate**	
BR273					Less accidents		**Quantifiable**	**Non - Cash Releasing**	**Reduced Datix, AI, SAI**	
BR274						Less congestion on roads	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR275						Fewer people parking in local area	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR276						Residents able to park outside their own homes	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR277						Supports delivery of WG strategy	**Non-Quantifiable**	**Non - Cash Releasing**	**N / A**	

Unique Benefit ID	Outcome Category	Apportionment	Benefit for Patient Carers or Family	Benefit to VCC	Benefit to LHB and Partners	WG and Wider Society	Benefit Type 1	Benefit Type 2	Baseline	Owner
BR278	Improved access to public transport	Benefit Solely Attributed to the nVCC	Easier for patients to travel to appointments				Quantifiable	Non - Cash Releasing	Patient Satisfaction Survey	Infra Structure Programme Director
BR279			Reduced dependence upon family and friends				Non-Quantifiable	Non - Cash Releasing	N / A	
BR280			Improved availability of car parking				Non-Quantifiable	Non - Cash Releasing	No Baseline	
BR281				Easier for staff to travel to work			Quantifiable	Non - Cash Releasing	Travel Survey	
BR282				Improved availability of car parking			Quantifiable	Non - Cash Releasing	Staff Survey Results	
BR283				Reduced DNAs			Quantifiable	Non - Cash Releasing	Current DNA Rate	
BR284				Reduced spend on patient transport			Quantifiable	Non - Cash Releasing	Cannot be modelled as all locations not known	
BR285				Supports delivery of Velindre Trust strategy			Quantifiable	Non - Cash Releasing	IMTP Delivery	

BR286					Increased number of people using public transport		**Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR287					Reduced use of Non-Emergency Patient Transport		**Quantifiable**	**Non - Cash Releasing**	**Cannot be modelled as all locations not known**	
BR288						Increased number of people using public transport	**Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR289						Reduced CO2 emissions	**Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR290						Reduced congestion	**Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR291						Support delivery of WG strategy	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	

Unique Benefit ID	Outcome Category	Apportionment	Benefit for Patient Carers or Family	Benefit to VCC	Benefit to LHB and Partners	WG and Wider Society	Benefit Type 1	Benefit Type 2	Baseline	Owner
BR292	Improved clinical and departmental adjacencies	Benefit Solely Attributed to the nVCC	Improved patient dignity				Quantifiable	Non - Cash Releasing	Patient Satisfaction Survey	Infra Structure Programme Director
BR293			Easier to navigate the hospital for patient, family and carers				Non-Quantifiable	Non - Cash Releasing	No Baseline	
BR294			Reduced patient movement between departments / services				Quantifiable	Non - Cash Releasing	No Baseline	
BR295			Reduced anxiety for patients, families and carers				Quantifiable	Non - Cash Releasing	Patient Satisfaction Survey	
BR296				Reduced staff movement between departments / services			Quantifiable	Non - Cash Releasing	No Baseline	
BR297				Increased patient facing time for clinicians and healthcare professionals			Quantifiable	Non - Cash Releasing	No Baseline	
BR298				Improved productivity			Quantifiable	Non - Cash Releasing	No Baseline	

BR299				Supports delivery of Velindre Trust strategy			**Quantifiable**	**Non - Cash Releasing**	**IMTP Delivery**	
BR300					Improved integration and effectiveness of services in Outreach settings		**Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR301						Supports delivery of WG strategy	**Quantifiable**	**Non - Cash Releasing**	**No Baseline**	

Unique Benefit ID	Outcome Category	Apportionment	Benefit for Patient Carers or Family	Benefit to VCC	Benefit to LHB and Partners	WG and Wider Society	Benefit Type 1	Benefit Type 2	Baseline	Owner
BR321	Access to Centre for Learning and Innovation	Benefit Solely Attributed to the nVCC	Better educated / more informed patient, family and carers				Non-Quantifiable	Non - Cash Releasing	No Baseline	Medical Director
BR322			Patients, family and carers make better, more informed decisions about care				Non-Quantifiable	Non - Cash Releasing	No Baseline	
BR323			Better self-management				Non-Quantifiable	Non - Cash Releasing	No Baseline	
BR324			Improved range of treatments / techniques / information available to the patient				Non-Quantifiable	Non - Cash Releasing	No Baseline	
BR325			Patient, family and carers able to drive clinical practice and learning (co-production)				Non-Quantifiable	Non - Cash Releasing	No Baseline	
BR326			Improved patient experience				Non-Quantifiable	Non - Cash Releasing	No Baseline	
BR327				Ability to deliver / comply with statutory and			Non-Quantifiable	Non - Cash Releasing	No Baseline	

				mandatory training						
BR328				Staff are able to enhance continuing professional development			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR329				Increased capacity to undertake research development and innovation			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR330				Better understanding of patient, family and care needs and values.			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR331				Better knowledge sharing and collaboration with Health Boards / Partners and HEIs			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR332				Enhanced commercial opportunities			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR333				Income generation			**Quantifiable**	**Cash Releasing**	**No Baseline**	

BR334				Improved reputation			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR335				Supports delivery of Velindre Trust strategy			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR336					Staff are able to enhance continuing professional development		**Quantifiable**	**Non - Cash Releasing**	**Training Statistics and Staff Survey**	
BR337					Increased capacity to undertake research development and innovation		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR338					Better understanding of patient, family and care needs and values.		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR339					Better knowledge sharing and collaboration with Health Boards / Partners and HEIs		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR340					Enhanced commercial opportunities		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR341					Income generation		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	

BR342					Improved reputation		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR343						Enhanced job creation in research / knowledge economy	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR344						Increased employment opportunities	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR345						Increased training and education opportunities	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR346						Opportunities to attract inward investment	**Quantifiable**	**Cash Releasing**	**No Baseline**	
BR347						Supports delivery of WG strategy	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	

Unique Benefit ID	Outcome Category	Apportionment	Benefit for Patient Carers or Family	Benefit to VCC	Benefit to LHB and Partners	WG and Wider Society	Benefit Type 1	Benefit Type 2	Baseline	Owner
BR348	Increased access for patients to clinical trials	Programme Level Benefit partially attributable to nVCC	All patients able to access patient clinical trials				Quantifiable	Non - Cash Releasing	Current Baseline Activity	Medical Director
BR349			Improves patient confidence and outlook on life				Non-Quantifiable	Non - Cash Releasing	No Baseline	
BR350			Improves family and carer confidence and outlook on life				Non-Quantifiable	Non - Cash Releasing	No Baseline	
BR351			Increased treatment choices				Quantifiable	Non - Cash Releasing	No Baseline	
BR352			Improved clinical outcomes				Quantifiable	Non - Cash Releasing	Covered Under Outcomes	
BR353			Improved quality of life				Quantifiable	Non - Cash Releasing	Covered under Quality	
BR354			Improved patient experience				Quantifiable	Non - Cash Releasing	Patient Satisfaction Survey	

BR355				Improved reputation as leader in R&D			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR356				Increased income generation opportunities			**Non-Quantifiable**	**Non - Cash Releasing**	**Current Baseline Income**	
BR357				Reduced drugs costs			**Non-Quantifiable**	**Non - Cash Releasing**	**Current Baseline Income**	
BR358				Improved clinical practice			**Quantifiable**	**Non - Cash Releasing**	**Linked to Outcome and Quality**	
BR359				Better knowledge sharing			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR360				Improved staff morale			**Quantifiable**	**Non - Cash Releasing**	**Staff Survey Results**	
BR361				Improved ability to attract and retain highly skilled staff			**Non-Quantifiable**	**Non - Cash Releasing**	**Current Recruitment and Retention**	
BR362				Increased opportunities with strategic			**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	

				/ commercial partners						
BR363				Supports delivery of Velindre Trust strategy			**Quantifiable**	**Non - Cash Releasing**	**IMTP Delivery**	
BR364					Improved reputation as leader in R&D		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR365					Improved clinical practice		**Quantifiable**	**Non - Cash Releasing**	**Linked to Outcome and Quality**	
BR366					Better knowledge sharing		**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR367					Improved clinical decision making		**Non-Quantifiable**	**Non - Cash Releasing**	**Linked to Outcome and Quality**	
BR368					Improved staff morale		**Quantifiable**	**Non - Cash Releasing**	**Staff Survey Results**	
BR369					Improved ability to attract and retain highly skilled staff		**Quantifiable**	**Non - Cash Releasing**	**Current Recruitment and Retention**	
BR370					Increased opportunities with strategic / commercial partners		**Non Quantifiable**	**Non - Cash Releasing**	**No Baseline**	

BR371						Improved reputation as a leader in research	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR372						Inward investment into Wales	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR373						Better knowledge	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	
BR374						Supports delivery of WG strategy	**Non-Quantifiable**	**Non - Cash Releasing**	**No Baseline**	

Schedule 4.1

STANDING ORDERS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

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

Foreword

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

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

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

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

Contents

Section: A – Introduction

Statutory framework

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

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

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

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

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

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

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

3 c.42
4 c.41

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

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

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

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

NHS framework

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

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

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

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

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

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

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

Joint Committee Framework

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

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

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

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

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

Applying WHSSC Standing Orders

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

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

Variation and amendment of WHSSC Standing Orders

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

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

Interpretation

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

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

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

Relationship with LHB Standing Orders

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

The role of the Committee Secretary

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

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

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

Section: B – WHSSC Standing Orders

1. THE JOINT COMMITTEE

1.1 Purpose and Delegated functions[7]

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

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

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

1.1.4 The Joint Committee's role is to:

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

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

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

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

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

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

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

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

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

1.2 Membership of the Joint Committee[8]

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

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

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

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

Chief Executives

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

Officer Members [known as WHSST Directors]

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

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

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

Associate Members

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

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

In attendance

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

Use of the term 'Independent Members'

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

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

- Chair
- Vice-Chair
- Non-Officer Members

unless otherwise stated.

1.3 Member Responsibilities and Accountability

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

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

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

The Chair

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

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

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

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

The Vice-Chair

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

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

Non-Officer Members

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

WHSST Director of Specialised and Tertiary Services

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

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

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

1.4 Appointment and tenure of Joint Committee members

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. RESERVATION AND DELEGATION OF JOINT COMMITTEE FUNCTIONS

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

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

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

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

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

3.1 Chair's action on urgent matters

3.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Joint Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Joint Committee. In these circumstances, the Joint Committee Chair and the Lead Director, supported by the Committee Secretary, may deal with the matter on behalf of the Joint Committee - after first consulting with at least one other Independent Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Joint Committee for consideration and ratification.

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

3.2 Delegation to joint sub-Committees and others

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

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

3.3 Delegation to Officers

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

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

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

and agreed by the Joint Committee.

4. JOINT SUB-COMMITTEES

4.0.1 In accordance with WHSSC Standing Order 4.0.3, the Joint Committee may and, where directed by the LHBs jointly or the Welsh Ministers must, appoint joint sub-Committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

4.0.2 These may consist wholly or partly of Joint Committee members or LHB Board members or of persons who are not LHB Board members or Board members of other health service bodies.

4.0.3 The Joint Committee shall establish a joint sub-Committee structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs. As a minimum, it shall establish joint sub-Committees which cover the following aspects of Joint Committee business:

- Quality and Safety
- Audit

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

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

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

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

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

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

4.0.8 The membership of any such joint sub-Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements, regulations or directions agreed by the LHBs or the Welsh Ministers. Depending on the joint sub-Committee's defined role and remit; membership may be drawn from the Joint Committee, LHB Board or committee members, staff (subject to the conditions set in WHSSC Standing Order 4.0.9) or others.

4.0.9 WHSST Directors or officers should not normally be appointed as joint sub-Committee Chairs, nor should they be appointed to serve as members on any committee set up to review the exercise of functions delegated to officers. Designated WHSST Directors or officers shall, however, be in attendance at such joint sub-Committees, as appropriate.

4.1 Other Groups

4.1.1 The Joint Committee may also establish other groups to help it in the conduct of its business.

4.2 Reporting activity to the Joint Committee

4.2.1 The Joint Committee must ensure that the Chairs of all joint sub-Committees and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the Joint Committee on their activities. Joint sub-Committee Chairs' shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4.2.2 Each joint sub-Committee shall also submit an annual report to the Joint Committee through the Chair within 10 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

5. EXPERT PANEL AND OTHER ADVISORY GROUPS

5.0.1 The Joint Committee may, and where directed by the LHBs jointly or the Welsh Ministers must appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the Joint Committee, including detailed terms of reference are set out in Annex 4 of the WHSSC SOs.

5.0.2 Any Expert Panel or Advisory Group established by the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.0.3 In doing so, the Joint Committee shall specify which aspects of the WHSSC SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

5.0.4 The membership of any Expert Panel or Advisory Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements or directions agreed by the LHBs or the Welsh Ministers.

5.1 Reporting activity

5.1.1 The Joint Committee shall ensure that the Chairs of any Expert Panel or Advisory Group reports formally, regularly and on a timely basis to the Joint Committee on their activities. Expert Panel or Advisory Group Chairs shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.1.2 Any Expert Panel or Advisory Group shall also submit an annual report to the Joint Committee through the Chair within 10 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has

established.

6. MEETINGS

6.1 Putting Citizens first

6.1.1 The Joint Committee's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The Joint Committee, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read, where requested or required, and in electronic formats;
- Requesting that attendees notify the Committee Secretary of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g. Disability Discrimination Act, as well as its Communication Strategy and the provisions made by the host body in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

6.1.2 The Joint Committee Chair will ensure that, in determining the matters to be considered by the Joint Committee, full account is taken of the views and interests of all citizens served by the Joint Committee on behalf of each LHB, including any views expressed formally.

6.2 Working with Community Health Councils

6.2.1 The Joint Committee shall make arrangements to ensure arrangements are in place to liaise with CHC members as appropriate.

6.3 Annual Plan of Committee Business

6.3.1 The Committee Secretary, on behalf of the Joint Committee Chair, shall produce an Annual Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Plan shall also set out any standing items that shall appear on every Joint Committee agenda.

6.3.2 The plan shall set out the arrangements in place to enable the Joint Committee to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Joint Committee members to contribute in either English or Welsh languages, where appropriate.

6.3.3 The plan shall also incorporate formal Joint Committee meetings, regular Committee Development sessions and, where appropriate, the planned activities of joint sub-Committees, Expert Panel and Advisory Groups.

6.3.4 The Joint Committee shall agree the plan for the forthcoming year by the end of March, and this plan shall be published on the organisation's website.

6.4 Calling Meetings

6.4.1 In addition to the planned meetings agreed by the Joint Committee, the Joint Committee Chair may call a meeting of the Joint Committee at any time. Any LHB may request that the Chair call a meeting, or an individual committee member may also request that the Joint Committee Chair call a meeting provided that in either case at least one third of the whole number of Committee members supports such a request.

6.4.2 If the Chair does not call a meeting within seven days after receiving such a request from Joint Committee members, then those Joint Committee members may themselves call a meeting.

6.5 Preparing for Meetings

Setting the agenda

6.5.1 The Joint Committee Chair, in consultation with the Committee Secretary and the Lead Director, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Joint Committee business; any standing items agreed by the Joint Committee; any applicable items received from joint sub-Committees and other groups as well as the priorities facing the Joint Committee. The Joint Committee Chair must ensure that all relevant matters are brought before the Joint Committee on a timely basis.

6.5.2 Any Joint Committee member may request that a matter is placed on the Agenda by writing to the Joint Committee Chair, copied to the Committee Secretary, at least 12 calendar days before the meeting. The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of Joint Committee business.

Notifying and equipping Joint Committee members

6.5.3 Joint Committee members should be sent an Agenda and a complete set of supporting papers at least 10[18] calendar days before a formal Joint Committee meeting. This information may be provided to Joint Committee members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Joint Committee Chair is satisfied that the Joint Committee's ability to consider the issues contained within the paper would not be impaired.

6.5.4 No papers should be included for decision by the Joint Committee unless the Joint Committee Chair is satisfied (subject to advice from the Committee Secretary, as appropriate) that the information contained within it is sufficient to enable the Joint Committee to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Joint Committee, and the outcome of that assessment shall accompany the report to the Joint Committee to enable the Joint Committee to make an informed decision.

6.5.5 In the event that at least half of the Joint Committee members do not receive the Agenda and papers for the meeting as set out above, the Joint Committee Chair must consider whether or not the Joint Committee would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Joint Committee Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.5.6 In the case of a meeting called by Joint Committee members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.5.7 Except for meetings called in accordance with WHSSC Standing Order 6.4, at least 10 calendar days before each meeting of the Joint Committee a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On each LHB's website, together with the papers supporting the public part of the Agenda; as well as

18 See Schedule 3, 2(3) of the LHB (Constitution, Membership and Procedures) Regulations 2009

- Through other methods of communication as set out in the Joint Committee's communication strategy.

6.5.8 When providing notification of the forthcoming meeting, each LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

6.6 Conducting Joint Committee Meetings

Admission of the public, the press and other observers

6.6.1 The Joint Committee shall encourage attendance at its formal Joint Committee meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the Joint Committee. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility.

6.6.2 The Joint Committee shall conduct as much of its formal business in public as possible[19]. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter affecting a WHSST officer or a patient. In such cases the Chair (advised by the Committee Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Joint Committee shall resolve:

> *That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].*

6.6.3 In these circumstances, when the Joint Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Joint Committee in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Joint Committee meeting held in public session.

6.6.4 The Committee Secretary, on behalf of the Joint Committee Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.6.5 In encouraging entry to formal Joint Committee Meetings from members of

19 Schedule 3, 8 of the LHB(Constitution, Membership and Procedures) Regulations 2009

the public and others, the Joint Committee shall make clear that attendees are welcomed as observers. The Joint Committee Chair shall take all necessary steps to ensure that the Joint Committee's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

6.6.6 Unless the Joint Committee has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Joint Committee, its joint sub-Committees, Expert Panel or Advisory Groups

6.6.7 The Joint Committee shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the Joint Committee, its joint sub-Committees, Expert Panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Joint Committee will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Joint Committee (whether directly or through the activities of bodies such as Community Health Councils) and to demonstrate openness and transparency in the conduct of business.

Chairing Joint Committee Meetings

6.6.8 The Chair of the Joint Committee will preside at any meeting of the Joint Committee unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice-Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

6.6.9 The Chair must ensure that the meeting is handled in a manner that enables the Joint Committee to reach effective decisions on the matters before it. This includes ensuring that Joint Committee members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Joint Committee must have access to appropriate advice on the conduct of the meeting through the attendance of the Committee Secretary. The Chair has the final say on any matter relating to the conduct of Joint Committee business.

Quorum

6.6.10 At least 8 voting members, at least 4 of whom are LHB Chief Executives and 2 are Independent Members, must be present to allow any formal business to take place at a Joint Committee meeting.

6.6.11 If a LHB Chief Executive is unable to attend a Joint Committee meeting they may nominate a deputy to attend on their behalf. The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have delegated voting rights.

6.6.12 If the Lead Director or another WHSST Director is unable to attend a Joint Committee meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, their voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Joint Committee member in their own right, e.g., a person deputising for the Lead Director will usually be another WHSST Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

6.6.13 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Joint Committee member or their deputy disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.6.14 In the normal course of Joint Committee business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Joint Committee member may put forward a motion proposing that a formal review of that service area is undertaken. The Committee Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Joint Committee unless moved by a Joint Committee member and seconded by another Joint Committee member (including the Joint Committee Chair).

6.6.15 **Proposing a formal notice of Motion –** Any Joint Committee member wishing to propose a motion must notify the Joint Committee Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and

the Joint Committee Chair has determined that the proposed motion is relevant to the Joint Committee's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the Joint Committee Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.6.16 The Joint Committee Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Joint Committee business.

6.6.17 **Amendments –** Any Joint Committee member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Joint Committee alongside the motion.

6.6.18 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

6.6.19 **Motions under discussion –** When a motion is under discussion, any Joint Committee member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Joint Committee member may not be heard further;
- The Joint Committee decides upon the motion before them;
- An ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.6.20 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.6.21 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Joint Committee Chair.

6.6.22 **Motion to rescind a resolution –** The Joint Committee may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Joint Committee members.

6.6.23 A Motion that has been decided upon by the Joint Committee cannot be proposed again within six months except by the Joint Committee Chair, unless the motion relates to the receipt of a report or the recommendations of a joint sub-Committee/WHSSC Director to which a matter has been referred.

Voting

6.6.24 The Joint Committee Chair will determine whether Joint Committee members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Joint Committee Chair must require a secret ballot or recorded vote if the majority of voting Joint Committee members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Joint Committee.

6.6.25 In determining every question at a meeting the Joint Committee members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of citizens in Wales. Such views may be presented to the Joint Committee through the Chairs of the LHB's Advisory Groups.

6.6.26 The Joint Committee will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

6.6.27 A nominated deputy of a LHB Chief Executive may vote. In no circumstances may a nominated deputy of a WHSST member vote. Absent Joint Committee members may not vote by proxy. Absence is defined as being absent at the time of the vote.

6.7 Record of Proceedings

6.7.1 A record of the proceedings of formal Joint Committee meetings (and any other meetings of the Joint Committee where the Joint Committee members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Joint Committee member attendance (including the Joint Committee Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Joint Committee, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.7.2 Agreed minutes shall be circulated in accordance with Joint Committee

members' wishes, and, where providing a record of a formal Joint Committee meeting shall be made available to the public on each LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act, the Joint Committee's Communication Strategy and the host LHB's Welsh language requirements.

6.8 Confidentiality

6.8.1 All Joint Committee members (including Associate Members), together with members of any joint sub-Committee, Expert Panel or Advisory Group established by or on behalf of the Joint Committee and Joint Committee and/or LHB officials must respect the confidentiality of all matters considered by the Joint Committee in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Joint Committee Chair or relevant joint sub-Committee or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the WHSSC Values and Standards of Behaviour (including Gifts and Hospitality) Policy or legislation such as the Freedom of Information Act 2000, etc.

7. VALUES AND STANDARDS OF BEHAVIOUR

7.0.1 The Joint Committee must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, WHSST officers and others, as appropriate. The framework adopted by the Joint Committee will form part of the WHSSC SOs.

7.1 Declaring and recording Joint Committee members' interests

7.1.1 **Declaration of interests –** It is a requirement that all Joint Committee members should declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Joint Committee member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Joint Committee's business. Joint Committee members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations. Joint Committee members must notify the Joint Committee of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Joint Committee members.

7.1.2 Joint Committee members must also declare any interests held by family members or persons or bodies with which they are connected. The Committee Secretary will provide advice to the Joint Committee Chair and the Joint Committee on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Joint Committee members are in any doubt about what may be considered as an interest, they should seek advice from the Committee Secretary. However, the onus regarding declaration will reside with the individual Joint Committee member.

7.1.3 **Register of interests –** The Lead Director, through the Committee Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Joint Committee members. The register will include details of all Directorships and other relevant and material interests which have been declared by Joint Committee members.

7.1.4 The register will be held by the Committee Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Joint Committee members. The Committee Secretary will also arrange an annual review of the register, through which Joint Committee members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the Joint Committee's commitment to openness and transparency, the Committee Secretary must take reasonable steps to ensure that citizens served by the Joint Committee are made aware of, and have access to view the Joint Committee's Register of Interests. This may include publication on the Joint Committee's website.

7.1.6 **Publication of declared interests in Annual Report –** Joint Committee members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in each LHB Board's Annual Report.

7.2 Dealing with Members' interests during Joint Committee meetings

7.2.1 The Joint Committee Chair, advised by the Committee Secretary, must ensure that the Joint Committee's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Joint Committee members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the Joint Committee and as a member of the Board of an LHB that provides

specialised and tertiary services.

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

7.2.3 It is the responsibility of the Joint Committee Chair, on behalf of the Joint Committee, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may include determination that:

i. The declaration is formally noted and recorded, but that the Joint Committee member should participate fully in the Joint Committee's discussion and decision, including voting.

ii. The declaration is formally noted and recorded, and the Joint Committee member participates fully in the Joint Committee's discussion, but takes no part in the Joint Committee's decision;

iii. The declaration is formally noted and recorded, and the Joint Committee member takes no part in the Joint Committee discussion or decision;

iv. The declaration is formally noted and recorded, and the Joint Committee member is excluded for that part of the meeting when the matter is being discussed. A Joint Committee member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Joint Committee.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Joint Committee member is compatible with an identified conflict of interest.

7.2.5 Where the Joint Committee Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice-Chair, on behalf of the Joint Committee.

7.2.6 In all cases the decision of the Joint Committee Chair (or the Vice-Chair in the case of an interest declared by the Joint Committee Chair) is binding on all Joint Committee members. The Joint Committee Chair should take

advice from the Committee Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 **Members with pecuniary (financial) interests –** Where a Joint Committee member, or any person they are connected with[20] has any direct or indirect pecuniary interest in any matter being considered by the Joint Committee including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Joint Committee may determine that the Joint Committee member concerned shall be excluded from that part of the meeting.

7.2.8 **The Local Health Boards (Constitution, Membership and Procedures) Wales Regulations 2009** define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. The WHSSC SOs must be interpreted in accordance with these definitions.

7.2.9 **Members with Professional Interests –** During the conduct of a Joint Committee meeting, an individual Joint Committee member may establish a clear conflict of interest between their role as a Joint Committee member and that of their professional role outside of the Joint Committee. In any such circumstance, the Joint Committee shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Committee Secretary.

7.3 Dealing with officers' interests

7.3.1 The Joint Committee must ensure that the Committee Secretary, on behalf of the Lead Director, establishes and maintains a system for the declaration, recording and handling of WHSST officers' interests in accordance with the Values and Standards of Behaviour Framework.

7.4 Reviewing how Interests are handled

7.4.1 The Joint Committee's Audit Committee will review and report to the LHBs upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

7.5 Dealing with offers of gifts,[21] hospitality and sponsorship

7.5.1 The Standards of Behaviour (including Gifts and Hospitality) Policy adopted by the Joint Committee prohibits Joint Committee members and WHSST

[20] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

[21] The term gift refers also to any reward or benefit.

officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any Joint Committee member or WHSST officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Joint Committee member or WHSST officer. Failure to observe this requirement may result in disciplinary and/or legal action.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Committee Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Joint Committee;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Joint Committee; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it must always be declined.

7.5.4 A distinction shall be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

7.6 Sponsorship

7.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

7.6.2 All sponsorship must be approved prior to acceptance in accordance with the WHSSC Values and Standards of Behaviour (including Gifts and Hospitality) Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

7.7 Register of Gifts, Hospitality and Sponsorship

7.7.1 The Committee Secretary, on behalf of the Joint Committee Chair, will maintain a Register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Joint Committee members. WHSST Directors will adopt a similar mechanism in relation to WHSST officers working within their areas.

7.7.2 Every Joint Committee member and WHSST officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship made in their capacity as Joint Committee members, including those offers that have been refused. The Committee Secretary, on behalf of the Joint Committee Chair and Lead Director, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship is kept under active review, taking appropriate action where necessary.

7.7.3 When determining what should be included in the register with regard to gifts and hospitality, individuals must apply the following principles, subject to the considerations in WHSSC Standing Order 7.5:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value would not usually need to be recorded, e.g., seasonal items such as diaries/calendars with normally fall within this category.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[22]' hospitality need not be included in the Register.

7.7.4 Joint Committee members and WHSST Officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the Joint Committee;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.7.5 The Committee Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Joint Committee to be submitted to the designated Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the LHBs jointly upon the adequacy of the Joint Committees arrangements for dealing with offers of gifts, hospitality and sponsorship.

8. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

8.0.1 The Joint Committee shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

8.0.2 The Joint Committee shall ensure that its assurance arrangements are operating effectively, advised by the Joint Committee's Audit Committee.

8.1 The role of Internal Audit in providing independent internal assurance

8.1.1 The Joint Committee shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Ministers.

[22] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

8.2 Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups

8.2.1 The Joint Committee shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its joint sub-Committees, Expert Panel and any other Advisory Groups. Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated.

8.2.2 Each joint sub-Committee and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the Joint Committee through the Chair within 10 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

8.2.3 The Joint Committee, and in turn the LHBs jointly shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Committee Development Programme, as part of an overall Organisation Development framework; and
- Inform each LHBs report of its alignment with the Welsh Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

8.3 External Assurance

8.3.1 The Joint Committee shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

8.3.2 The Joint Committee may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Joint Committee itself may commission specifically for that purpose.

8.3.3 The Joint Committee shall keep under review and ensure that, where appropriate, the Joint Committee implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the National Assembly for Wales's Public Accounts Committee and other appropriate bodies.

8.3.4 The Joint Committee shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

9. DEMONSTRATING ACCOUNTABILITY

9.0.1 Taking account of the arrangements set out within these WHSSC SOs, the Joint Committee shall demonstrate to the LHBs jointly, citizens and other stakeholders and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the citizens it serves, its officers and healthcare professionals.

9.0.2 The Joint Committee shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

9.0.3 The Joint Committee shall ensure that within the WHSST, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

9.1 Support to the Joint Committee

9.1.1 The Committee Secretary, on behalf of the Joint Committee Chair, will ensure that the Joint Committee is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the Joint Committee;
- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Joint Committee Chair on the conduct of its business and its relationship with LHBs, the host LHB and others;
- Ensuring the provision of secretariat support for Joint Committee meetings;
- Ensuring that the Joint Committee receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups;
- Ensuring an effective relationship between the Joint Committee and its host LHB; and

- Facilitating effective reporting to each LHB

enabling each LHB Board to gain assurance on the conduct of business carried out by Joint Committee on its behalf.

10. REVIEW OF STANDING ORDERS

10.0.1 The WHSSC SOs shall be reviewed annually by the Joint Committee, which shall report any proposed amendments to the LHBs jointly for consideration and approval. The requirement for review extends to all documents having the effect as if incorporated in WHSSC SOs, including the appropriate impact assessment.

Annex 1

SCHEME OF RESERVATION AND DELEGATION OF POWERS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

Introduction

As set out in WHSSC Standing Order 3, the Welsh Health Specialised Services Committee (the Joint Committee) - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively, and in a manner that secures the achievement of the Joint Committee's aims and objectives. The Joint Committee may delegate functions to:

i. A sub-Committee of the Joint Committee, e.g., Audit Committee;

ii. A Group, Expert Panel or Advisory Group , e.g., with other LHBs established to take forward certain matters relating to specialist services; and

iii. Officers of the Joint Committee (who may, subject to the Joint Committee's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Joint Committee is notified of any matters that may affect the operation and/or reputation of the Joint Committee.

The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Joint Committee;
- Scheme of delegation to sub-Committees or sub-Groups and others; and
- Scheme of delegation to officers.

all of which form part of the WHSSC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Joint Committee will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- *Everything is retained by the Joint Committee unless it is specifically delegated in accordance with the requirements set out in WHSSC SOs or WHSSC SFIs*

- *The Joint Committee must retain that which it is required to retain (whether by statute or as determined by the Welsh Government) as well as that which it considers is essential to enable it to fulfil its role in setting the Joint Committee's direction, equipping the Joint Committee to deliver and ensuring achievement of its aims and objectives through effective performance management*

- *Any decision made by the Joint Committee to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility*

- *The Joint Committee must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development*

- *The Joint Committee must take appropriate action to assure itself that all matters delegated are effectively carried out*

- *The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes*

- *The Joint Committee may delegate authority to act, but retains overall responsibility and accountability*

- *When delegating powers, the Joint Committee will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.*

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Joint Committee

The Joint Committee will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Lead Director

The Lead Director will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Joint Committee must formally agree this scheme.

In preparing the scheme of delegation to officers, the Lead Director will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in WHSSC SFIs);
- The Memorandum of Agreement agreed with the seven LHBs and approved by the Joint Committee; and
- The Hosting Agreement agreed with the host LHB and approved by the Joint Committee.

The Lead Director may re-assume any of the powers they have delegated to others at any time.

The Committee Secretary

The Committee Secretary will support the Joint Committee in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Joint Committee is presented to the Joint Committee for its formal agreement;
- Effective arrangements are in place for the delegation of Joint Committee functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Joint Committee for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Joint Committee of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Lead Director of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the Joint Committee has set out alternative arrangements.

If the Lead Director is absent their nominated Deputy may exercise those powers delegated to the Lead Director on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Lead Director or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Joint Committee. The Scheme is to be used in conjunction with the system of control and other established procedures within the Joint Committee.

SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE[23]

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
1	FULL	GENERAL	The Joint Committee may determine any matter for which it has statutory or delegated authority, in accordance with WHSSC SOs
2	FULL	GENERAL	The Joint Committee must determine any matter that will be reserved to the whole Joint Committee. These are detailed below:
3	FULL	GENERAL	Approve the Joint Committee's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Vary, amend and recommend for approval to the Boards of the Local Health Boards: ▪ WHSSC SOs ; ▪ WHSSC SFIs; ▪ Schedule of matters reserved to the Joint Committee; ▪ Scheme of delegation to sub-Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING	Ratify any urgent decisions taken by the Chair and the Lead Director in accordance

[23] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

		ARRANGEMENTS	with WHSSC Standing Order requirements
6	NO – Nominated Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Committee Secretary on any non-compliance with WHSSC Standing Orders, making proposals to the Joint Committee on any action to be taken.
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with WHSSC Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's Values and Standards of Behaviour framework
9	NO - Chair on behalf of Joint Committee, Vice-chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Joint Committee members' interests, in accordance with advice received, e.g. From Audit Committee or Committee Secretary.
10	FULL	STRATEGY & PLANNING	Determine the long term strategic plan for the development of specialised services and tertiary services in Wales, in conjunction with Welsh Ministers.
11	FULL	STRATEGY & PLANNING	Approve the Joint Committee's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan

			▪ The development and delivery of patient and population centred specialised and tertiary services for the population of Wales ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
12	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
13	FULL	STRATEGY & PLANNING	Approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
14	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's framework and strategy for performance management.
15	FULL	STRATEGY AND PLANNING	Approve the LHBs framework and strategy for risk and assurance
16	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with Putting Things Right and health and safety requirements.
17	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Joint Committee, including standards/requirements determined by Welsh Government, regulators, professional bodies/others, e.g., National Institute of Health and Care Excellence (NICE)
18	FULL	STRATEGY & PLANNING	Approve the Joint Committee's patient, public, staff, partnership and stakeholder engagement and co-production.
19	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Joint Committee determines

			it so based upon its contribution/impact on the achievement of the Joint Committee's aims, objectives and priorities
20	FULL	ORGANISATION STRUCTURE & STAFFING	Appointment, appraisal, discipline and dismissal of the officer members of the Joint Committee (Directors) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions.
21	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Joint Committee level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Committee Secretary.
22	FULL	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
23	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the Joint Committee's top level organisation structure and Joint Committee policies
24	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Joint Committee sub-Committees, including any joint sub-Committees directly accountable to the Joint Committee
25	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any sub-Committee, joint sub-Committee or Group set up by the Joint Committee
26	FULL	ORGANISATION STRUCTURE &	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Joint Committee on outside bodies and groups

		STAFFING	
27	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all sub-Committees, joint sub-Committees and groups established by the Joint Committee
28	FULL – except where Chapter 6 specifies appropriate to delegate to Officers.	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
29	FULL – except where Chapter 6 specifies appropriate to delegate to Officers.	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Lead Director and officers
30	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Joint Committee
31	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Lead Director set out in the WHSSC SFIs
32	FULL	PERFORMANCE & ASSURANCE	Approve the Joint Committee's audit and assurance arrangements

33	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Joint Committee's WHSST Directors on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
34	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the Joint Committee's sub-Committees, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans
35	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Joint Committee's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-Committees (as appropriate)
36	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Joint Committee's Chief Internal Auditor and approve action required, including improvement plans
37	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Joint Committee's external auditor and approve action required, including improvement plans
38	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the Joint Committee's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
39	FULL	REPORTING	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required.
40	FULL	REPORTING	Receive, approve and ensure the publication of Joint Committee reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE-CHAIR AND INDEPENDENT MEMBERS			
	Chair		Chair of the Integrated Governance Committee
	Independent Member or Vice-Chair		Audit Lead
	Independent Member or Vice-Chair		Chair of the Quality and Patient Safety Committee

DELEGATION OF POWERS TO SUB-COMMITTEES AND OTHERS[24]

WHSSC Standing Order 3 provides that the Joint Committee may delegate powers to sub-Committees and others. In doing so, the Joint Committee has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such sub-Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others.

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Joint Committee has delegated a range of its powers to the following sub-Committees and others:

- Audit & Risk Committee (of the host organisation)
- Quality and Patient Safety Committee
- Individual Patient Funding Request (IPFR) Panel (WHSSC)
- Integrated Governance Committee
- Welsh ~~Renal Clinical~~Kidney Network (WKN)
- Management Group

The scope of the powers delegated, together with the requirements set by the Joint Committee in relation to the exercise of those powers are as set out in i) sub-Committee terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the Joint Committee's Scheme of Delegation to sub-Committees.

[24] As defined in Standing Orders.

SCHEME OF DELEGATION TO WHSST DIRECTORS AND OFFICERS

The WHSSC SOs and WHSSC SFIs specify certain key responsibilities of the Lead Director, the Director of Finance and other officers. The Lead Director's Job Description sets out their specific responsibilities, and the individual job descriptions determined for other WHSST Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the WHSSC SFIs form the basis of the Joint Committee's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
Agreeing and signing Health Care Agreements and Contracts with service providers for health care services	Lead Director Director of Finance (Deputy)
Approval to commission Specialist healthcare services	Lead Director
Information Governance arrangements	Committee Secretary (in conjunction with the host LHB)
Management of Concerns	Director of Nursing & Quality Assurance
Health and Safety arrangements	Lead Director/ Committee Secretary (in conjunction with the host LHB)
Investigate any suspected cases of irregularity not related to fraud and corruption in accordance with government directions.	Chair/ Lead Director Director of Finance (Deputy)
Issuing tenders and post tender negotiations.	Lead Director Director of Finance (Deputy)
Legal advice	Committee Secretary

Action on litigation	Lead Director/ Committee Secretary
Operation of detailed financial matters, including bank accounts and banking procedures	Director of Finance (in conjunction with the host LHB Director of Finance)
Workforce	Committee Secretary
Public consultation	Lead Director
Manage central reserves and contingencies	Director of Finance
Management and control of stocks other than pharmacy stocks	Lead Director
Management and control of computer systems and facilities	Committee Secretary
Monitor and achievement of management cost targets	Lead Director
Recording of payments under the losses and compensation regulations	Director of Finance
Individual Patient Funding Requests	Director of Nursing & Quality Assurance
Approve and ensure the publication of non-statutory Annual Report	Lead Director
Welsh Kidney Network (WKN)	Programme Director

This scheme only relates to matters delegated by the Joint Committee to the Lead Director and other WHSST Directors, together with certain other specific matters referred to in WHSSC SFIs.

Each WHSST Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Annex 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

Joint Committee framework

The Joint Committee's governance and accountability framework comprises these WHSSC SOs, incorporating schedules of Powers reserved for the Joint Committee and Delegation to others, together with the following documents:

- ***WHSSC SFIs***
- ***Values and Standards of Behaviour Framework (link to document)***
- ***Risk Management Strategy (link to document)***
- ***Key policy documents***

agreed by the Joint Committee. These documents must be read in conjunction with the WHSSC SOs and will have the same effect as if the details within them were incorporated within the WHSSC SOs themselves.

These documents may be accessed from the Committee Secretary by written request.

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.Directions or guidance on specific aspects of Joint Committee business are also issued electronically, usually under cover of a Welsh Health Circular.

Annex 3

JOINT COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

Management Group

Quality & Patient Safety Committee

Integrated Governance Committee

Welsh ~~Renal Clinical Netwtork~~ Kidney Network (WKN)

Annex 4

ADVISORY GROUPS AND EXPERT PANELS TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the Welsh Health Specialised Services Committee Standing Orders

MEMORANDUM OF AGREEMENT

RELATING TO

WELSH HEALTH SPECIALISED SERVICES COMMITTEE

(WALES) DIRECTIONS 2009

MEMORANDUM OF AGREEMENT

THIS MEMORANDUM OF AGREEMENT is made the ***13 July 2021***
BETWEEN

(1) ANEURIN BEVAN UNIVERSITY LOCAL HEALTH BOARD, having headquarters at St Cadoc's Hospital, Lodge Road, Caerleon, Newport, NP18 3XQ

(2) BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW

(3) CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD, having headquarters at 2nd Floor, Woodland House, Maes-y-coed Road, Cardiff CF14 4HH,

(4) CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ynysmeurig House, Navigation Park, Abercynon, Rhondda Cynon Taff, CF45 4SN.

(5) HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ystwyth Building, St David's Park Carmarthen, SA31 3BB.

(6) POWYS TEACHING LOCAL HEALTH BOARD, having headquarters at Mansion House, Bronllys, Brecon, Powys, LD3 0LS

(7) SWANSEA BAY UNIVERSITY LOCAL HEALTH BOARD, having headquarters at 1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot, SA12 7BR

WHEREAS:

A. In accordance with the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009 No.35), the LHBs are required to establish a Joint Committee for the purpose of jointly exercising its Delegated Functions and providing the Relevant Services from 1 April 2010.

B. The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (SI 2009 No 3097) make provision for the constitution of the Joint Committee including its procedures and administrative arrangements.

C. Cwm Taf Morgannwg University Local Health Board (CTMUHB) has been identified as Host LHB to provide administrative support for the running of the Joint Committee and to establish the Welsh Health Specialised Services Team as per Direction 3(4) and Regulation 3(1)(d) and the interpretation

sections of both the Directions and the Regulations and the Joint Committee Standing Orders: Statutory Framework and Joint Committee Framework.

D. The Joint Committee has been established in accordance with the Directions and Regulations to enable the seven LHBs in NHS Wales to make collective decisions on the review, planning, procurement and performance monitoring of agreed specialised and tertiary services (Relevant Services) and in accordance with their defined Delegated Functions. The Joint Committee therefore comprises, and is established by, all the LHBs.

E. The LHBs have been given the financial responsibility for all of the specialised and tertiary health needs for their respective populations. Refer to Standing Order 1.1.

F. The Directions and Regulations require that the Chief Executives of each of the 7 LHBs listed as Parties to this Agreement be members of the Joint Committee. This Agreement defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executives of the constituent LHBs as individual members of the Joint Committee. This is in accordance with their objective to make collective decisions as to the provision of national services as described above and in the interests of NHS Wales and the health needs of their individual populations. Refer to Standing Orders: Statutory Framework, NHS Framework and Joint Committee Framework (for governance arrangements); and to Standing Orders 1.2 and 1.3 (for membership, responsibilities and accountability).

1. INTERPRETATIONS

'the Act'	the National Health Service (Wales) Act 2006 (C.42)
'Associate Members'	the Chief Executives of Public Health Wales NHS Trust, Velindre University NHS Trust, Welsh Ambulance Services NHS Trust. Refer to Regulation 3(3) and Standing Order 1.2.6
'the Directions'	the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)
'Chair'	the person appointed by the Minister to lead the Welsh Health Specialised Services Committee and to ensure it successfully discharges its overall responsibility on behalf of the LHBs. Refer to Regulation 4(1) and Standing Orders 1.3.4 to 1.3.6.
'Chief Executives'	the Chief Executives of the constituent LHBs
'Committee Secretary'	the person appointed by the Welsh Health Specialised Services Committee as its principal advisor on all aspects of governance. Refer to Standing Orders: The Role of the Committee Secretary.
'Role of the Joint Committee	the role ascribed to the Joint Committee ascribed to the Joint Committee in section 4 of this Agreement. Refer to Standing Order 1.1.
'Dispute Process'	the arbitration process agreed with WG.
'WHSST Directors'	the Officer Members of the Joint Committee as defined in Regulation 3(2) of the Regulations.
'Host LHB'	Cwm Taf Morgannwg University Local Health Board
'Joint Committee'	the Welsh Health Specialised Services Committee established in accordance with the Directions and Regulations
'LHB'	Local Health Board established in accordance with s 11(2) of the Act
'Management Group'	the purpose of the Management Group is to be the Specialised Services Commissioning operational body

	responsible for the implementation of the Specialised Services Strategy. It will underpin the commissioning of Specialised Services to ensure equitable access to safe, effective, sustainable and acceptable services for the people of Wales. The Membership of the Group is determined locally but as a minimum consists of LHB planning/commissioning representation and/or Finance representation.
'Management Team'	the team appointed in accordance with paragraph 10.2 of the Agreement, comprising of the Lead Director, Medical Director, Finance Director and Nurse Director of Specialised and Tertiary Services. Refer to Regulations 3(2) and Standing Order 1.2.4.
'NHS Wales'	the comprehensive health service for Wales established by the NHS (Wales) Act 2006 (C.42)
'Provider LHB'	a LHB which provides specialised and tertiary services to the Joint Committee
'the Regulations'	the Welsh Health Specialised Services Committee (Wales) Regulations 2009 (2009/3097 (W.270))
'Relevant Services'	the planning and securing of specialised and tertiary services consisting of those functions and services listed in Annex (i) of the Welsh Health Specialised Services Committee (Wales) Directors 2009, and incorporated as Annex (i) in this this Agreement, subject to any variations to those functions agreed from time to time by the Joint Committee.
'WG'	Welsh Government as announced by the First Minister of Wales on 12 May 2011
'WHSST'	the Welsh Health Specialised Services Team consisting of staff employed by the Host LB to provide the Relevant Services, including WHSST Directors.

2. CORPORATE IDENTITY

2.1 The corporate identity for the Joint Committee will be in accordance with the Corporate Identity Guidelines issued by Welsh Government to LHBs. The Joint Committee will be referred to as the 'Welsh Health Specialised Services Committee' on stationery and signage.

3. PRINCIPLES

3.1 The Joint Committee is a statutory committee established under sections 12 (1)(b) and (3), 13(2)(c), (3)(c) and (4)(c) and 203(9) and (10) of the Act. The LHBs are required to jointly exercise the Relevant Services. Refer to Standing Orders: Statutory Framework

3.2 The principle of subsidiarity will apply so that the Joint Committee will agree annually a List of Specialist Services which has approved by the Joint Committee as part of the Annual Planning process. The Joint Committee will be only responsible for the provision of those services which are identified in the List of Specialist Services. Any other service not identified in the List of Specialist Services will be the responsibility of each LHB to provide locally. Nothing in this paragraph shall prevent any LHB from exercising its discretion as to how to provide these services, either individually, or in conjunction with other LHBs or other bodies. Refer to Standing Order 1.1.2

3.3 Each LHB is accountable, through its statutory responsibilities, to use its resources to plan, fund, design, develop and secure the delivery of primary, community, in-hospital care services and specialised services for their population. For a number of national services, this can only be achieved by working collaboratively with all LHBs. The Joint Committee is established on this basis of a shared, national approach to the joint planning of specialised and tertiary services on behalf of each LHB, ultimately accountability to citizens and other stakeholders for the provision of specialised and tertiary services for residents within their area remains with individual LHBs. Refer to Standing Order 1.1.2.

3.4 In performing its role, the Joint Committee and each individual Chief Executive shall work in the wider interest of NHS Wales. In so doing, they shall work with all of the Joint Committee's appropriate partners and stakeholders in the best interests of NHS Wales. In so doing, the Joint Committee will take account of the following key principles:

3.4.1 Collaboration should be designed to deliver changes in services and demonstrable population benefit;

3.4.2 Collaboration should ensure a more extensive and consistent use of evidence supported by a robust analysis of need;

3.4.3 Collaboration must not diminish clinical engagement;

3.4.4 Collaboration should support LHBs in working together more effectively, in an open and transparent way, for the benefit of the local population;

3.4.5 Collaboration must enhance resource utilisation in the planning process to reduce duplication and overlap;

3.4.6 Collaboration should focus upon articulating need, reviewing evidence of good practice, designing models of care and producing clear service specification;

3.4.7 Collaboration should promote equity in service delivery.

Refer to Standing Orders 1.1 and 1.4

3.5 Each LHB acknowledges the following principles:

3.5.1 the Management Team will be held to account by the Joint Committee for the delivery of a strategy for the provision of specialised and tertiary services for Wales as well as providing assurance that the systems of control in place are robust and reliable.

3.5.2 that any decision taken and approved by the Joint Committee in respect of the provision of the Relevant Services is binding on the constituent LHBs and may not be undermined by any subsequent decision or action taken by a constituent LHB. Refer to Standing Order 1.1.5

3.5.3 that each individual LHB is responsible for the people who are resident in their area. This means that the Joint Committee of which each Chief Executive is a member is acting on behalf of the 7 LHBs in undertaking its role. Refer to Standing Order 1.1.2.

3.5.4 that their respective Chief Executives have an individual responsibility to contribute to the performance of the role of the Joint Committee and to share in the decision making in the interests of the wider population of NHS Wales. At the same time, they acknowledge their own Chief Executive's individual accountability to their constituent LHB and their obligation to

act transparently in the performance of their functions. Refer to Standing Orders 1.1.2 and 1.1.4.

3.5.5 that each Chief Executive as a member of the Joint Committee will require the Management Team of the Joint Committee to ensure that, in the timetabling of the annual work programme, sufficient time will normally be allowed to enable each Chief Executive to consult with their own LHB and appropriate local partners and stakeholders.

3.5.6 that when an individual Chief Executive is unable to attend a meeting of the Joint Committee, he/she will appoint in advance and identify to the Committee Secretary a deputy to attend on their behalf. The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have delegated voting rights. Refer to Standing Order 6.6.10 and 6.6.11

3.6 Each Chief Executive will agree to advise the Chair of any circumstances where it is considered that there may be a conflict of interest between the performance of the national planning functions of the Joint Committee and the effect of any such decision on the scope of the services which the constituent LHB provides. Refer to Standing Order 7: Values and Standards of Behaviour

3.6.1 where the Chair considers that the conflict is not clear he will consult with the remainder of the Committee and reach a collective view.

3.6.2 where the Chair decides that there is a clear conflict of interest the Chief Executive will be required to abstain from the discussion.

3.7 The Joint Committee will strive to make decisions by consensus, failing which it will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no two thirds majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

4. ROLE OF THE JOINT COMMITTEE

4.1 The role of the Joint Committee as determined by the Welsh Ministers are (refer to Standing Order 1.1.4):

- Determine a long-term strategic plan for the development of specialised and tertiary services in Wales, in conjunction with the

Welsh Ministers;

- Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services;

- Develop national policies for the equitable access to safe and sustainable, high quality specialised and tertiary healthcare services across Wales, whether planned, funded and secured at national, regional or local level;

- Agree annually those services that should be planned on a national basis and those that should be planned locally;

- Produce an Integrated Commissioning Plan, for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans;

- Agree the appropriate level of funding for the provision of specialised and tertiary services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the WHSST) in accordance with any specific directions set by the Welsh Ministers;

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

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

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

5. ANNUAL WORK PROGRAMME AND PLANNING

5.1 The Joint Committee and its Management Team will adhere to the standards of good governance set for the NHS in Wales and which are based on Welsh Government's Citizen Centred Governance Principles. Refer to Standing Order: NHS Framework.

5.2 The Joint Committee will:

5.2.1 report to the individual LHBs on its activities. It is formally accountable to the individual LHBs in respect of its role carried

out on their behalf. Refer to Standing Order 9: Demonstrating Accountability.

5.2.2 lead and scrutinise the operations, functions and decision making of the Management Team. It will require the Management Team to report to it on its activities and it will hold the Management Team to account on behalf of the seven LHBs. Refer to Standing Order 1.1.6.

5.3 The Joint Committee will therefore require:

5.3.1 the Management Team to co-operate with them as members of the Joint Committee in securing agreed processes so that patients in Wales may have the equal opportunity to access new advances in treatment but in a way which ensures that services which no longer require collaborative planning are stepped down at the appropriate time to the individual LHBs as local providers.

5.3.2 the Management Team to prepare for their approval a Plan of Business for the year. They will also require the Management Team to agree with the Joint Committee an appropriate way of working. This will include submitting to the Joint Committee for discussion and agreement (following an appropriate internal and external consultation process) a Priorities Programme, an annual List of Specialised Services to be planned nationally and identifying the services to be stepped down for local provision, national Planning Policies and a Schedule of other appropriate policies for development and review on an annual basis.

5.3.3 in developing any new or amended policy the Management Team will prepare a suggested process which will be subject to an approved corporate standard for agreement by the Joint Committee.

5.3.4 the Management Team will undertake on an annual basis a mapping exercise of the Healthcare Standards which apply to the Joint Committee. An annual return will be submitted to the LHBs for inclusion in their annual return to Welsh Government.

5.3.5 a Quality and Patient Safety Sub Committee will be established to provide evidence based and timely advice to the Joint Committee to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare. The Quality and Patient Safety Sub Committee will also provide assurance to the Joint Committee in relation to the

arrangements for safeguarding and improving the quality and safety of specialised healthcare services within the remit of the Joint Committee. The Quality and Patient Safety Sub-Committee will operate in accordance with the Terms of Reference annexed to the Standing Orders. Refer to Standing Order 4.0.3

5.3.6 the production of an Annual Report (to be prepared by the Committee Secretary) each year. Refer to Standing Order 9.0.2.

5.3.8 the Director of Finance for the Joint Committee to agree with the relevant Provider LHBs information requirements and reporting timescales to enable the Joint Committee to discharge its duties on behalf of each LHBs

5.3.9 the Management Team to act in accordance with the Welsh Language Scheme of the Host LHB in preparing papers on behalf of the Joint Committee. Refer to Standing Order 6.1.1.

5.3.10 the Lead Director to lead the consultation process on behalf of each LHB where the Joint Committee supports proposals which result in a major change in service provision.

6. ROLE OF CHAIR

6.1 The LHBs acknowledge that the Regulations require that the Chair be appointed by the Minister for Health and Social Services as an independent appointment and in accordance with the Nolan Principles. It is further acknowledged that the Chair is accountable to the Minister for Health and Social Services and is required by the Minister to act in accordance with the terms of his/her Accountability Agreement. Refer to Standing Orders 1.2.1 and 1.3.6.

6.2 The Chair will:

6.2.1 be accountable to the individual LHBs in relation to the delivery of the role of the Joint Committee exercised by the Committee on their behalf.

6.2.2 be required to secure consensus where possible in the making of collective decisions in the wider interests of NHS Wales and in accordance with the individual obligations of the Chief Executives and the non-officer members.

6.2.3 the Chair will work in close collaboration with the Chairs of LHBs to ensure that the strategic development of Specialised and Tertiary Services meets the needs of NHS Wales.

6.2.4 the Chair will attend the All Wales Chairs Meeting at least twice a year.

7. APPOINTMENT AND ROLE OF NON-OFFICER MEMBERS

7.1 Each non-officer member (including the Vice-Chair) appointed to the Committee in accordance with the Regulations is individually accountable to the Chair. Refer to Standing Orders 1.3.8 and 1.3.9.

7.2 The Chair will seek nominations from the Chair of each individual LHB for the appointment of a non-officer member. The Chair will determine and agree with the Chairs of the LHBs the appropriate process for the selection of the non-officer member but in so doing must take account of the following requirements: Refer to Standing Orders 1.4. 2 and 1.4.3

7.2.1 A balanced knowledge and understanding amongst the membership of the needs of all geographical areas served which will include consideration as to whether the constituent LHB is regarded as a major provider of services to the Joint Committee;

7.2.2 wherever possible, the overall membership of the Joint Committee reflects the diversity of the population.

7.3 The audit lead non-officer member role will be recruited through a fair and open recruitment process. To enable the WHSSC Independent Member Remuneration appointment arrangements to be consistent with the other two HB IM roles, with an emphasis on the skills required to participate in the Audit 7 Risk Committee (ARC). The audit lead IM will be required to attend the CTMUHB part 2 ARC meetings which WHSSC attends to discharge its audit and accountability requirements"

Each non-officer member will be required to acknowledge their individual responsibility to contribute to the performance of the Delegated Functions of the Joint Committee and to share in the decision making in the interests of the wider NHS Wales.

~~7.3~~7.4 The Chair and non-officer members will participate fully in the Performance Review Process as set down by the Welsh Government. Refer to the appropriate Accountability Agreements.

8. STATUS AND ROLE OF ASSOCIATE MEMBERS

8.1 The LHBs acknowledge that the Associate Members will attend the Joint Committee meetings on an ex-officio basis but in accordance with the directions will not have the right to vote in any meetings or proceedings of the Joint Committee. Refer to Standing Order 1.2.6.

8.2 Associate Members will be entitled to engage and participate in the discussions. It will be the responsibility of the Chair to secure that they may seek to influence and/or challenge the decision making by their participation during the course of the debate.

9. ROLE OF MANAGING DIRECTOR OF SPECIALISED AND TERTIARY SERVICES COMMISSIONING (LEAD DIRECTOR)

9.1 The Lead Director will:

9.1.1 be the head of the Management Team and will report to the Chair. In so doing the Director will be accountable to the Joint Committee in relation to its role delegated to the Management Team by the Joint Committee. Refer to Standing Order 1.3.10

9.1.2 be accountable to the Chief Executive of the Host LHB in respect of the administrative arrangements supporting the operation of the team. Refer to Standing Order 1.3.10

9.2 The Lead Director is responsible for ensuring that the Joint Committee enters into suitable Health Care Agreements and Contracts with service providers for health care services. The Lead Director will need to ensure that regular reports are provided to the Joint Committee detailing performance and associated financial implications of all health care agreements. Refer to Standing Order 3: Reservations and Delegations of Joint Committee Delegated Functions.

10. MANAGEMENT ARRANGEMENTS

10.1 In accordance with the Standing Orders, the Joint Committee may delegate certain functions to the WHSST Directors. Refer to Standing Order 3: Reservations and Delegations of Joint Committee Delegated Functions.

10.2 The Joint Committee will determine the nature and extent of any functions which it is appropriate to delegate to a Sub Committee and to the WHSST Directors.

10.3 The Joint Committee's approach to delegation will be set out in the Standing Orders, Standing Financial Instructions and Scheme of Reservations and Delegation.

10.4 The delegation of any function will be subject to regular review by the Joint Committee to ensure that the distribution of functions is accurately and appropriately described and continues to remain appropriate to respond to the requirements of the Joint Committee.

10.5 The LHBs acknowledge that the WHSST Directors will constitute the Management Team.

10.6 Any Chief Executive or other member of the Joint Committee who wishes to attend a Management Team meeting will agree their attendance with the Lead Director in advance.

10.7 The individual WHSST Directors are employed by the Host LHB but in exercising the performance of their functions they are individually accountable to the Joint Committee. Refer to Standing Orders 1.3.10 and 1.3.11.

10.8 The Management Group reports directly to the Joint Committee and membership includes the WHSST Directors and representation from the LHBs. The Membership of the Group is determined locally but as a minimum consists of LHB planning/commissioning representation and/or Finance representation. The purpose of the Management Group is to be the Specialised Services Commissioning operational body responsible for the implementation of the Specialised Services Strategy. It will underpin the commissioning of Specialised Services to ensure equitable access to safe, effective, sustainable and acceptable services for the people of Wales.

11. ROLE OF COMMITTEE SECRETARY

11.1 The LHBs acknowledge that the role of the Committee Secretary is crucial to the ongoing development and maintenance of a strong governance framework within the Joint Committee, and is a key source of advice and support to the Chair and Joint Committee members. Independent of the Joint Committee, the Committee Secretary will be required to act as the guardian of good governance within the Joint Committee by: Refer to Standing Orders: The role of the Committee Secretary

11.1.1 providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance;

11.1.2 facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, its sub-committees and Advisory Groups and producing an Annual Plan of Committee Business;

11.1.3 ensuring that Joint Committee members have the right

information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these Standing Orders;

11.1.4 ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination;

11.1.5 contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and

11.1.6 monitoring the Joint Committee's compliance with the law, Joint Committee Standing Orders and the framework set by the LHB and Welsh Government.

11.2 It is agreed that the Committee Secretary is directly accountable for the conduct of his/her role to the Chair of the Joint Committee. The Committee Secretary will also be accountable to the Board Secretaries of the LHBs to ensure that robust governance arrangements are in place for the Joint Committee.

12. RELATIONSHIP WITH HOST

12.1 The responsibilities of the Host LHB are:

12.1.1 to appoint and employ such officers as may be required to support the commissioning of the Relevant Services and provide all necessary corporate services and management support, to include human resources, estates, procurement, banking and accountancy services, as may be required, including the making of payments to providers of the Relevant Services;

12.1.2 to provide advice to the Joint Committee on compliance with CTMUHB's policies, Standing Financial Instructions, Procurement Rules, Human Resource policies and other procedures;

12.1.3 to be the legal entity which enters into agreed tenders, procurement contracts, service level agreements and terms of engagement commissioned by the Joint Committee, and to ensure that the individuals appointed and employed to support the functions of the Joint Committee carry out those tasks which are stated in this Agreement to be the role of the Joint Committee;

12.1.4 to hold the management budget for the Joint Committee/Relevant Services and make payments and receive income as necessary;

12.1.5 to be authorised to appoint lawyers and other professional advisors (in consultation with the Host LHB's Procurement Services team), and to agree the terms and conditions of their engagement and give them instructions from time to time on behalf of the Joint Committee.

12.1.6 All banking arrangements are the responsibility of the host LHB.

12.2 The Host LHB will not be responsible or accountable for the planning, funding and securing of the Relevant Services save in respect of the residents within the area of the Host LHB. Refer to Standing Order 2.0.2

12.3 The Joint Committee will require the Host LHB to enter into a separate Hosting Agreement, annexed to this Agreement as Annex (ii) to record the agreed accounting arrangements and resulting responsibilities. Refer to Standing Orders: Joint Committee Framework.

13. ACCOUNTABILITY AND AUDIT & RISK COMMITTEE

13.1 Audit & Risk Committee arrangements will be the responsibility of the Host LHB.

13.2 The WHSSC Director of Finance and the WHSSC Committee Secretary will attend all Audit & Risk Committee meetings held by the Host LHB.

13.3 The Audit Lead will provide reports to the Joint Committee following the Host LHB Audit & Risk Committee meetings.

14. PROCUREMENT

14.1 Each LHB will ensure that appropriate internal arrangements are made to delegate their respective functions to the Joint Committee for the procurement of the Relevant Services. The Joint Committee (acting through the Host LHB) will establish collaborative commissioning and managerial arrangements to negotiate, agree and manage all aspects of service level agreements/contracts for the Relevant Services on such terms and for such purposes as may be agreed by the Joint Committee.

14.2 Agreed tenders, procurement contracts, service level agreements and terms of engagement will be entered into and signed by the Host LHB on behalf of the Joint Committee in accordance with the Host LHB's procurement policy and Standing Financial Instructions.

15. FINANCIAL PRINCIPLES

15.1 The following represent the key financial principles to be adhered to by the LHBs:

15.1.1 to achieve financial neutrality and stability, where possible, for LHBs;

15.1.2 to adopt a fair and practical approach to the challenges of establishing the Joint Committee and to the functioning of the Joint Committee;

15.1.3 to ensure that funds are to be blocked back to the Joint Committee;

15.1.4 to ensure that the status quo with England is maintained until further review;

15.1.6 to ensure that a risk sharing methodology will be reviewed and agreed annually.

16. BUDGET AND FUNDING

16.1 In accordance with the Joint Committee's Standing Orders, the Joint Committee must agree the total budget to plan and secure the Relevant Services delegated to it. The Joint Committee must also agree the appropriate contribution of funding required from each LHB. Refer to Standing Order 1.1.4

16.2 Each year the Joint Committee will prepare an annual plan which shall outline the funding requirements in relation to the Relevant Services and be analysed by each constituent LHB as providers and purchasers. Refer to Standing Order 1.1.4

16.3 Each LHB will be required to make available to the Joint Committee the level of funds outlined in the annual plan and calculated in accordance with paragraph 16.1. The funds shall be drawn down in cash on a monthly basis from each of the LHB's as proposed by the Director of Finance for the Joint Committee.

16.4 On a monthly basis, the Director of Finance for the Joint Committee shall prepare a report to the Joint Committee which outlines the performance of the Joint Committee, highlighting any variances from the original annual plan, in total, and also broken down to each LHB commissioner level.

16.4.1 in cases where the performance report highlights an adverse variance to the annual plan or where the report anticipates future unfunded cost pressures, the Joint Committee will be required to put in place contingency measures to ensure that a break-even position is maintained.

16.4.2 in cases where the performance report highlights a favourable variance to the annual plan, the Joint Committee shall be required to return the funding to each LHB in accordance with the risk sharing agreement.

16.5 The Joint Committee will comply with all Welsh Government financial monitoring arrangements. The Director of Finance of the Joint Committee is responsible for ensuring that a financial monitoring return is submitted to WG in the prescribed format and to the required deadlines.

16.6 Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its delegated functions. Any disputes over the level of funding proposed by Joint Committee shall be referred to the Welsh Government for resolution by the Welsh Minsters.

17. GIFTS AND HOSPITALITY

17.1 Each member of the Joint Committee is required to declare any gifts and hospitality in accordance with the Joint Committee Standing Orders to the Committee Secretary in relationship to their membership of the Joint Committee. The Committee Secretary will maintain a register of such declarations. Refer to Standing Orders: Values and Standards of Behaviour.

18. DISPUTES AND ARBITRATION

18.1 In accordance with the principles set out at paragraph 3 of this Agreement, the LHBs will seek to work cooperatively with each other as constituent members of the Joint Committee, with the Joint Committee as a whole, and with the Management Team. Where there is an impasse which cannot be resolved by means of conciliation between appropriate individuals, then as a last resort the Chair will be requested to invoke the Dispute Process which is set out in the Business Framework (Annex (iii)).

19. CONCERNS

19.1 **Concerns about treatment funded through the Joint Committee arrangements**

Concerns notified about care and treatment will be dealt with by the organisation providing the treatment. Concerns will be considered under The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Provider organisations must, as part of the contractual agreement, advise the LHB in which the patient lives that a complaint has been made and the LHB will ensure that this is reviewed in conjunction with the Quality and Patient Safety Sub Committee.

19.2 **About individual patient funding decisions**

These concerns will be handled by the LHB in which the patient lives, in accordance with the All Wales Individual Patient Funding Request Policy agreed by the Welsh Government.

19.3 **About any function of the Joint Committee, its staff or its performance**

Concerns notified about the function of the WHSS Team (for these purposes including Joint Committee members and WHSS staff), if not resolved internally, will be dealt with by the Host LHB on behalf of all LHBs in Wales.

19.4 An Operational Agreement will be developed between the LHBs which sets out clearly operationally how concerns will be dealt with.

19.5 **Financial or other Redress**

When qualifying liability in tort has been determined, following an investigation of a concern, each constituent LHB is responsible for managing and funding the redress payment arising from their resident populations.

20. INDEPENDENT PATIENT REVIEWS

20.1 Where a matter is considered to be a review of funding decisions it will be dealt with in accordance with the Review Process set out in All Wales Policy for Making Decisions on Individual Patient Funding Requests (IPFR).

21. COMMUNICATION

21.1 The Committee Secretary and the Board Secretaries of the respective LHBs will develop a Communication Strategy to ensure robust communication methods are in place to support the operation of the Joint Committee.

21.2 Each LHB will ensure that they utilise appropriate mechanisms to facilitate active debate amongst stakeholders, professionals and communities served to ensure appropriate independent representation and participation on the planning of the Relevant Services.

21.3 Each LHB is responsible for responding to individual enquires concerning their individual geographical population. Where it is an issue relating to a decision made by the Joint Committee, for example, as to the planning of a service, then the Committee Secretary will be responsible for co-ordinating the response in consultation with the Board Secretaries for the respective LHBs.

21.4 Each Member of the Management Team is required to work in collaboration with their colleagues in the LHBs to ensure the planning of the Relevant Services.

21.5 Where a request under the Freedom of Information Act is received by the Joint Committee, the request will be dealt with in accordance with the Host LHB's Freedom of Information Act procedure. Where the request is considered to be an issue relating to a specific LHB and it relates to recorded information which is held by that LHB, then the request will be forwarded to the respective LHB to respond in accordance with the Freedom of Information Act Code of Practice.

22. INTERFACE WITH CLINICAL NETWORKS

22.1 The arrangements with the Clinical Networks are set out at Annex (iv).

23. MENTAL HEALTH RESPONSIBILITIES

23.1 It will be the responsibility of the Lead Director to prepare a report for each meeting of the Joint Committee (where appropriate) on the conduct by the Management Team of the Committee's responsibilities to mental health patients who are detained under the Mental Health Legislation including any requirement by the Crown Court or the Mental Health Tribunal to give evidence as to appropriate placement of a patient detained under the Mental Health Legislation.

24. CROSS BORDER SLA ARRANGEMENTS

24.1 The Director of Finance of the Joint Committee will agree appropriate contracts with a defined list of English NHS Trusts and Foundation Trusts for the purposes of delivering specialised services for the Welsh population.

24.2 The Director of Finance for the Joint Committee will be responsible for securing that the contracts are cost effective and achieve the delivery of services of appropriate quality.

24.3 In the interests of simplified patient care pathways and reducing administrative complexity these contracts may include non-specialised activity.

24.4 The Director of Finance of the Joint Committee will prepare performance reports on these contracts for each Joint Committee meeting.

24.5 The Lead Director will ensure that NHS Wales continues to maintain and develop appropriate relationships with the counterpart specialised planning arrangements in England and Scotland. The Lead Director will represent the LHBs in this regard and will be given the appropriate delegated authority to do so. These arrangements currently include English Specialist Commissioning Groups, the Scottish National Services Division of Scotland, the National Specialist Commissioning Groups and the National Commissioning Advisory Group or National Commissioning Group for highly specialised services.

25. ROLE OF PUBLIC HEALTH

25.1 A Service Level Agreement will be entered into between the Host LHB and Public Health Wales describing the services which Public Health Wales will provide to the Joint Committee and the process of engagement which will take place.

26. EQUALITY AND DISCRIMINATION

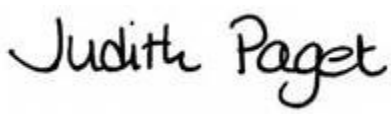
26.1 The LHBs undertake, in relation to the provision of the Relevant Services by the Joint Committee to the public or any member of the public, to exercise the role of the Joint Committee so as to have regard to the need to eliminate discrimination, and other prohibited conduct, in accordance with human rights and equality legislation.

27. REVIEW

27.1 This Agreement will be reviewed on a bi-annual basis.

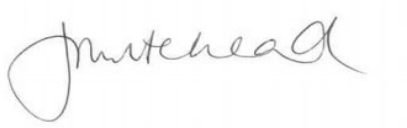
SIGNED under hand and delivered the day and year first above written

SIGNED and DELIVERED
by **Aneurin Bevan University Local Health Board**
acting by



~~Judith Paget~~ Nicola Prygodzicz
Chief Executive

SIGNED and DELIVERED
by **Betsi Cadwaladr University Local Health Board**
acting by



~~Jo Whitehead~~ Gill Harris
Chief Executive

SIGNED and DELIVERED
by **Cardiff and Vale University Local Health Board**
acting by

~~Len Richards~~
Suzanne Rankin
~~-~~Chief Executive

SIGNED and DELIVERED
by **Cwm Taf Morgannwg University Local Health Board**
acting by

Paul Mears
Chief Executive

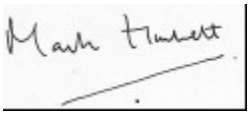
SIGNED and DELIVERED
by **Hywel Dda University Local Health Board**
acting by

Steve Moore
Chief Executive

SIGNED and DELIVERED
by **Powys Teaching Local Health Board**
acting by

Carol Shillabeer
Chief Executive

SIGNED and DELIVERED
by **Swansea Bay University Local Health Board**
acting by



Mark Hackett
Chief Executive

Annex (i) to Memorandum of Agreement

Services delegated from LHBs to WHSSC for planning and funding in ~~2020-21~~2023-2024

Range of Services Commissioned by WHSSC

Assistant Director of Planning Lead
Intestinal Failure
Home Parental Nutrition
Hyperbaric Oxygen Therapy

Mental Health & Vulnerable Groups
High Secure Psychiatric Services
Medium Secure Psychiatric Services
All Wales Traumatic Stress Quality Improvement Initiative (Traumatic Stress Wales)
Gender Identity Services for Adults
Gender Identity Development Service for Children and Young People
Specialised Eating Disorder Services (Tier 4)
Mental Health Services for Deaf People (Tier 4)
Specialised Perinatal Services
CAMHS (Child and Adolescent Mental Health Services) Tier 4
Forensic Adolescent Consultation and Treatment Service (FACTS)
Neuropsychiatry

Cancer & Blood
PET scanning
All Wales Lymphoma Panel
Specialist services for Sarcoma
Haematopoietic Stem Cell Transplantation (BMT)
Extra corporeal photopheresis for graft versus host disease
CAR-T therapy for lymphoma and acute lymphoblastic leukaemia
Thoracic surgery
Hepatobiliary cancer surgery
Microwave ablation for liver cancer
Brachytherapy (prostate and gynaecological cancers)
Proton Beam Therapy
Radiofrequency Ablation for Barrett's Oesophagus
Stereotactic Ablative Body Radiotherapy
Specialist service for Neuroendocrine Tumours
Peptide Receptor Radionuclide Therapy (PRRT) for Neuroendocrine Tumours
Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for Pseudomyxoma Peritonei

All Wales Medical Genomics Service

Burns and Plastics
Specialist service for Paroxysmal Nocturnal Haemoglobinuria
Inherited Bleeding Disorders
Welsh Blood Service
Hereditary Anaemias specialist service
ECMO
Long Term Ventilation
Immunology
Hepatobiliary Surgery Cardiff
Pancreatic Surgery Morriston
Hepato Celluar Carcinoma (HCC) MDT
Syndrome Without a Name (SWAN) Clinic
Molecular Radio Therapy

Cardiac Services
Cardiac Surgery
Heart Transplantation including VAD's
Electrophysiology, ablation and complex ablation
Complex Cardiac devices
Interventional Cardiology, (PPCI, PCI, PFO closures, TAVI, PMVLR)
Inherited Cardiac Conditions
Adult Congenital Heart Disease
Pulmonary Hypertension
Cystic Fibrosis
Cardiac Networks (SWSWCHD Network, NWNWCHD Network, All Wales Cardiac Network)
Bariatric Surgery

Neurosciences & Long Term Conditions
Neurosurgery Emergency and elective neurosurgery (including stereotactic radiosurgery and Deep Brain Stimulation)
Neuroradiology (diagnostic and interventional undertaken by neuroradiologists)
Neurorehabilitation
Spinal rehabilitation
Artificial Limbs and Appliances Service including: ○ Wheelchair and special seating ○ Prosthetics ○ Orbital prosthetics
Electronic assistive technology
Alternative Augmentative Communication (AAC)
Immunology for Primary Immuno Deficiency
Cochlear and BAHA
Rare Diseases – RDIG

Spinal
Inherited White Matter Disorders

Women and Children
Fetal Cardiology
Fetal Medicine
Neonatal
Neonatal Transport
Paediatric Cardiology

Paediatric Cystic Fibrosis
Paediatric Endocrinology
Paediatric ENT
Paediatric Gastroenterology
Paediatric Intensive Care
Paediatric Immunology
Paediatric Inherited Metabolic Disease
Paediatric Nephrology
Paediatric Neurology
Paediatric Neuro-rehab
Paediatric Oncology
Paediatric Radiology
Paediatric Radiotherapy
Paediatric Rheumatology
Paediatric Surgery
Paediatric Orthopaedic Surgery
Paediatric Infectious Diseases

North Wales
IVF

Annex (ii) to Memorandum of Agreement

HOSTING AGREEMENT

THIS HOSTING AGREEMENT is made the ~~13 July 2021~~14 March 2023

BETWEEN

(1) CWM TAF MORGANNW~~Y~~G UNIVERSITY LOCAL HEALTH BOARD ("Cwm Taf Morgannwg UHB")

and

(2) ANEURIN BEVAN UNIVERSITY LOCAL HEALTH BOARD, having headquarters at St Cadoc's Hospital, Lodge Road, Caerleon, Newport NP18 3XQ,

BETSI CADWALADR UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW,

CARDIFF AND VALE UNIVERSITY LOCAL HEALTH BOARD, having headquarters at 2nd Floor, Woodland House, Maes-y-coed Road, Cardiff CF14 4HH,

CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ynysmeurig House, Navigation Park, Abercynon, Rhondda Cynon Taff, CF45 4SN,

HYWEL DDA UNIVERSITY LOCAL HEALTH BOARD, having headquarters at Ystwyth Building, St David's Park, Carmarthen, Sa31 3BB.

POWYS TEACHING LOCAL HEALTH BOARD, having headquarters at Mansion House, Bronllys, Brecon, Powys, LD3 0LS,

SWANSEA BAY UNIVERSITY LOCAL HEALTH BOARD, having headquarters at 1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot, SA12 7BR,

Collectively established as the Joint Committee of WELSH HEALTH SPECIALISED SERVICES COMMITTEE ("Joint Committee").

WHEREAS:

(1) In accordance with the Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009 No.35), the seven Local Health Boards are required to establish the WHSSC for the purpose of jointly exercising its Delegated Functions and providing the services from 1 April 2010.

(2) The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (SI 2009 No 3097) makes provision for the constitution of the Joint Committee including its procedures and administrative arrangements.

(3) Cwm Taf Morgannwg University Local Health Board has been identified as the Host LHB to provide administrative and management support as further described in section 2 for the running of the WHSSC and to establish the Welsh Health Specialised Services Team (WHSST).

(4) This Agreement should be read in conjunction with the Memorandum of Agreement made between the 7 Local Health Board themselves which defines the governance arrangements for the Joint Committee and the agreed roles and responsibilities of the Chief Executives of the constituent LHBs as individual members of the Joint Committee.

(5) The purpose of this Agreement is to outline what the accountability arrangements and resulting responsibilities will mean, both for Cwm Taf Morgannwg UHB and for the Joint Committee.

AGREEMENT

Index **Page No.**

1. INTERPRETATION

'the Act'	the National Health Service (Wales) Act 2006
'Delegated Functions'	those functions ascribed to the Joint Committee in section 4 of the Memorandum of Agreement and reproduced at Annex (i) 1.
'the Directions'	the Welsh Health Specialised Services Committee (Wales) Directions 2009
'Director'	the Director of Specialised and Tertiary Services appointed in accordance with regulation 3 (2) of the Regulations
'Joint Committee'	the Welsh Health Specialised Services Committee established in accordance with the Directions and Regulations
'LHB'	Local Health Board established in accordance with s 11(2) of the Act
'Management Team'	the team appointed in accordance with paragraph 10.2 of the Memorandum of Agreement. Refer to Standing Order 1.2.4.
'Memorandum of Agreement'	the agreement dated 1 April 2010 between the 7 LHBs and described at paragraph (4) of the recital
'NHS Wales'	the comprehensive health service for Wales established by the NHS (Wales) Act 2006
'the Regulations'	the Welsh Health Specialised Services Committee (Wales) Regulations 2009
'Relevant Services'	the planning and securing of specialised and tertiary services consisting of those functions and services listed in Annex (i) of the Memorandum of Agreement, subject to any variations to those functions and services agreed from time to time by the Joint Committee.

'.

'WG' Welsh Government as announced by the First Minister of Wales on 12th May 2011.

'WHSST' the Welsh Health Specialised Services Team consisting of staff employed by the Host Board to provide the Relevant Services

2. ROLE OF CWM TAF MORGANNWG UNIVERSITY LOCAL HEALTH BOARD

The responsibilities of Cwm Taf Morgannwg UHB are:

2.1 To appoint and employ such officers as may be required to support the commissioning of the Relevant Services and provide all necessary corporate services and management support, to include human resources, estates, procurement, banking and accountancy services, as may be required, including the processing of orders and the making of payments to providers of the Relevant Services, with such officers being members of the WHSST;

2.2 To provide advice to the Joint Committee on compliance with Cwm Taf Morgannwg UHB's policies, Standing Financial Instructions, Procurement Rules, Human Resource policies and other procedures;

2.3 To be the legal entity which enters into agreed procurement arrangements to include, but not restricted to, quotations, tenders, procurement contracts, service level agreements and terms of engagement commissioned by the Joint Committee and to ensure that the individuals appointed and employed to support the functions of the Joint Committee carry out those tasks which are stated in Annex (i) to be the role of the Joint Committee;

2.4 To have in place such appropriate governance arrangements and Schemes of Delegation as may be necessary and required on the part of Cwm Taf Morgannwg UHB to enable the Joint Committee's role to be carried out;

2.5 To hold the management budget for the Joint Committee / Relevant Services and make payments and receive income as necessary;

2.6 To be authorised to appoint lawyers and other professional advisors (in consultation with Cwm Taf Morgannwg UHB's Procurement Services team), and to agree the terms and conditions of their engagement and give them instructions from time to time on behalf of the Joint Committee.

2.7 Cwm Taf Morgannwg UHB will not be responsible or accountable for the planning, funding and securing of the Relevant Services save in respect of the residents within the geographical area of responsibility of Cwm Taf Morganng UHB. Refer to Standing Order 2.0.2

2.8 In fulfilling its obligations and responsibilities under this Agreement, Cwm Taf Morgannwg UHB shall not be required to do or not do and shall not do or omit to do anything which does not comply with Cwm Taf Morgannwg UHB's statutory powers and duties, Standing Orders and Standing Financial Instructions, corporate governance requirements generally, procurement requirements or any legal obligations not covered by the foregoing.

3. EMPLOYMENT OF STAFF

3.1 New Officers who are appointed to work with the Joint Committee from the 1 April 2010 will be employed by Cwm Taf Morgannwg UHB.

3.2 The Officers working with the Joint Committee, and comprising the Management Team and WHSST, will therefore be employees of Cwm Taf Morgannwg. They will be required to abide by Cwm Taf Morgannwg UHB's Policies, Procedures and Guidance and will be entitled to be treated as any other employee of Cwm Taf Morgannwg UHB and have the benefit of all applicable policies and procedures.

3.3 The Officers will also be accountable for their performance to the Joint Committee.

3.4 The human resource services which will be provided are identified at **Appendix B**.

4. PROCEDURES FOR TENDERS & PROCUREMENT

4.1 Cwm Taf Morgannwg UHB will provide all the support services to the Joint Committee as described at **Appendix C**.

4.2 Agreed procurement arrangements via quotations, tenders, procurement contracts, service level agreements and terms of engagement will be entered into and signed by Cwm Taf Morgannwg on behalf of the Joint Committee in accordance with Cwm Taf Morgannwg UHB's procurement policy and Standing Financial Instructions.

4.3 Cwm Taf Morgannwg UHB shall not execute or, through performance create, any third party contract in respect of the Joint Committee unless authorised to do so by the Director.

4.4 The Joint Committee will provide sufficient funds and other relevant resources to meet the requirements of all third party contracts entered into by Cwm Taf Morgannwg UHB in pursuance of paragraph 4.3.

4.5 Cwm Taf Morgannwg UHB shall provide the Lead Director with drafts of all third party contracts and the Lead Director and/or the Joint Committee shall be entitled to require Cwm Taf Morgannwg UHB to use its reasonable endeavours to negotiate such amendments to the terms of such contract as the Lead Director and/or the Joint Committee reasonably see fit.

5. GOVERNANCE ARRANGEMENTS

5.1 The Joint Committee will utilise Cwm Taf Morgannwg UHB's Committee arrangements to assist it in discharging its governance responsibilities.

5.2 Where the Joint Committee utilises Cwm Taf Morgannwg UHB's sub-committee arrangements such as the Quality, Safety and Risk Committee, Cwm Taf Morgannwg UHB will ensure that the appropriate responsibilities are afforded to the Joint Committee and the agenda is constructed to ensure relevant issues are to be properly managed to allow the Joint Committee to satisfy itself from a risk management and controls assurance perspective.

5.3 The Joint Committee will adopt the risk assessing mechanisms of the host subject to appropriate adaptation to take into account the specific functions WHSSC.

5.5 The Lead Director will provide reports from the Joint Committee to Cwm Taf Morgannwg UHB's Board in line with Cwm Taf Morgannwg UHB's scheme of delegation to enable Cwm Taf

Morgannwg UHB to assure itself that appropriate control measures are in place in accordance with the requirements of the Statement of Internal Control.

6. BUDGET AND FUNDING

6.1 The Joint Committee will transfer funds to Cwm Taf Morgannwg UHB on a quarterly basis in advance to allow Cwm Taf Morgannwg UHB to perform its functions on behalf of the Joint Committee, provided that the Joint Committee may attach conditions to the expenditure of such funds.

6.2 The Joint Committee will meet Cwm Taf Morgannwg UHB's overhead costs reasonably incurred in the support of the Joint Committee as may be agreed by the Joint Committee acting reasonably at all times.

6.3 The Director of Finance for the Joint Committee will authorise the transfer of funds to Cwm Taf Morgannwg UHB in line with agreed funding levels, which funds shall be accounted for by Cwm Taf Morgannwg UHB as income to the Joint Committee.

6.4 Cwm Taf Morgannwg UHB will set up and manage an Income and Expenditure Account for the Joint Committee, namely a Joint Committee Account. This includes all the income for the Joint Committee received from the LHBs and all other Joint Committee expenditure. This account shall be separate from all other Cwm Taf Morgannwg UHB funds. The Director of Finance for the Joint Committee shall make decisions relating to expenditure from this account provided that Cwm Taf Morgannwg UHB shall not at any time be obligated to operate the Joint Committee Account in deficit.

6.5 The Director of Finance for the Joint Committee is responsible for ensuring that all relevant reports, financial information and commentary are provided to the Host LHB so that the appropriate monitoring return can be prepared.

7. OWNERSHIP OF ASSETS

7.1 All assets (including intellectual property rights) acquired by Cwm Taf Morgannwg UHB in connection with the Joint Committee shall belong to Cwm Taf Morgannwg UHB but be held upon trust for the Joint Committee.

7.2 Cwm Taf Morgannwg UHB shall, to the extent it is legally entitled to do so, transfer ownership and any other rights in such assets to such party or body as the Joint Committee shall require and within such timescales as are reasonably required.

7.3 In the event that any income is derived from such assets or from their disposal, such revenues shall be regarded as part of the Joint Committee income and accounted for accordingly.

8. ACCOUNTABILITY ARRANGEMENTS

8.1 The accountability arrangements of the Management Team and their relationship with Cwm Taf Morgannwg UHB are set out in Appendix D

8.2 The constituent LHBs will delegate to the Chief Executive of Cwm Taf Morgannwg UHB and the Chair of the Joint Committee their responsibility for performance appraisal and all employment related issues of the Lead Director In exercising those responsibilities, the Chief Executive of Cwm Taf Morgannwg UHB is required to liaise with the Chief Executives of the constituent LHBs as members the Joint Committee and the Chair of the Joint Committee.

8.3 The constituent LHBs will delegate to the Lead Director the performance appraisal of the individual members of the Management Team. In exercising those responsibilities, the Director is required to liaise with the Chief Executives of the constituent LHBs as members of the Joint Committee and the Chair of the Joint Committee.

9. DUTY OF CARE

9.1 Cwm Taf Morgannwg UHB shall be responsible for ensuring that all reasonable skill, care and diligence are exercised in carrying out those services which it is required to perform under this Agreement properly and efficiently in accordance with this Agreement and the Memorandum of Agreement and its overall responsibilities under the Act and all other appropriate legislation. Cwm Taf Morgannwg UHBshall keep the Joint Committee informed of any foreseeable or actual changes in circumstances which are likely to affect its ability to comply with the terms of this Agreement as the Host LHB.

10. CWM TAF MORGANNWG UHB ORGANISATION

10.1 Cwm Taf Morgannwg UHB shall provide and maintain an organisation having the necessary facilities, equipment and employees of appropriate experience, to undertake the specific functions and provide all the services identified in this Agreement

10.2 All personnel deployed on work relating to the Agreement must have appropriate skills and competence.

11. LEGISLATION

11.1 Cwm Taf Morgannwg UHB shall ensure that it, and its employees and agents, shall in the course of this agreement comply with all relevant legislation, Welsh Government Directions and Guidance and procedures.

12. AUDIT

12.1 Cwm Taf Morgannwg UHB, through the Shared Services arrangements, will provide an effective independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Government. Refer to Standing Order 8.1.1

12.2 Cwm Taf Morgannwg UHB will ensure that relevant external audit arrangements are in place which give due regard to the functions of the Joint Committee. Refer to Standing Order 8.3. External Assurance

13. MANAGEMENT OF CONCERNS (INCLUDING INCIDENTS, COMPLAINTS & CLAIMS)

13.1 Paragraph 19 of the Memorandum of Agreement sets out the procedures to be followed for the management of concerns relating to the Joint Committee.

13.2 Where a matter is regarded as an individual concern, Cwm Taf Morgannwg UHB will only be responsible for the management of those concerns where qualifying liability in Tort is established, which relate to its geographical area of responsibility. In such circumstances, the Chief Executive of

Cwm Taf Morgannwg UHB will be responsible for investigating and responding to the concern in accordance with The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

13.3 Individual concerns relating to patients resident outside Cwm Taf Morgannwg UHB's geographical area of responsibility will be referred to the Chief Executive of the LHB in the appropriate geographical area.

13.4 Where a matter is regarded as a concerns and where qualifying liability in Tort has been established, Cwm Taf Morgannwg will only be responsible for managing the arrangements for redress arising from its own resident population.

13.5 Where a matter is considered to be a review of funding decisions it will be dealt with in accordance with the Review Process set out in All Wales Policy for Making Decisions on Individual Patient Funding Requests (IPFR).

14. MANAGEMENT OF FOIA / DPA REQUESTS

14.1 Where a request under the Freedom of Information Act or Data Protection Act is received by the Joint Committee, the request will be dealt with in accordance with Cwm Taf Morgannwg UHB's procedures. Where the request is considered to be an issue relating to a specific LHB, other than Cwm Taf Morgannwg UHB, and it relates to recorded information which is held by that other LHB, then the request will be forwarded to the Board Secretary of the respective LHB to respond in accordance with the Freedom of Information Act Code of Practice.

15. NOTICES

15.1 Any notices served in respect of matters covered by this Agreement shall be sent to the Chief Executive of Cwm Taf Morgannwg on behalf of Cwm Taf Morgannwg UHB and the Lead Director on behalf of the Joint Committee.

16. DISPUTE

16.1 In the event of any dispute between Cwm Taf Morgannwg UHB and those involved in the Joint Committee, such dispute shall be escalated in line the Business Framework.

16.2 If such dispute cannot be resolved in accordance with the provisions of paragraph 16.1 it shall be referred to the Joint Committee and the Chief Executive of Cwm Taf Morgannwg UHB.

16.3 If such a dispute cannot be resolved in accordance with the provisions of paragraph 16.2, it shall be referred to Welsh Government's Minister for Health and Social Services for resolution.

17. GENERAL

17.1 This agreement shall be capable of being varied only by a written instrument signed by a duly authorised officer or other representative of each of the parties.

17.2 No third party shall have any right under the Contracts (Rights of Third Parties) Act 1999 in connection with this Agreement.

17.3 This Agreement shall be governed and construed in accordance with the laws of England and Wales. Subject to paragraph 16, the parties hereby irrevocably submit to the exclusive jurisdiction of the Courts of England and Wales.

17.4 In the event of Cwm Taf Morgannwg UHB's Board determining (acting reasonably) that the performance by Cwm Taf Morgannwg UHB of its obligations under this Agreement is having a detrimental or prejudicial effect on the Cwm Taf Morgannwg UHB's ability to fulfil its core functions, Cwm Taf Morgannwg UHB's Board may instruct the Lead Director and Cwm Taf Morgannwg UHB's Chief Executive to review the operation of this Agreement further to clause 16.

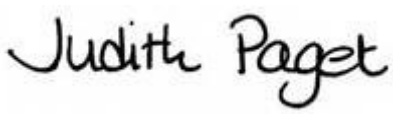
17.5 In carrying out a review of this Agreement further to clause 17.4, the Lead Director and Cwm Taf Morgannwg UHB's Chief Executive shall consider the source and manner of any detriment identified by Cwm Taf Morgannwg UHB's Board further to clause 17.4 and shall put forward such amendments and variations to this Agreement and the associated governance arrangements between the Joint Committee and Cwm Taf Morgannwg as they may consider appropriate.

17.6 Cwm Taf Morgannwg's UHB Board shall consider the recommendations made further to clause 16.5 and may recommend to the Joint Committee and the Chief Executive of Cwm Taf Morgannwg UHB that this Agreement and the

associated governance arrangements are amended accordingly.

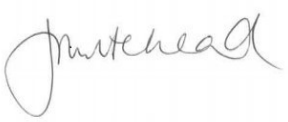
SIGNED under hand and delivered the day and year first above written

SIGNED and DELIVERED
by Aneurin Bevan University Local Health Board acting
by



~~Judith Paget~~Nicola Prygodzicz
-Chief Executive

SIGNED and DELIVERED
by Betsi Cadwaladr University Local Health Board acting
by



~~Jo Whitehead~~ Gill Harris
Chief Executive

SIGNED and DELIVERED
by Cardiff and Vale University Local Health Board acting
by

~~Len Richards~~

Suzanne Rankin

-Chief Executive

SIGNED and DELIVERED
by Cwm Taf Morgannwg University Local Health Board
acting by

Paul Mears
Chief Executive

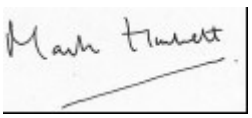
SIGNED and DELIVERED
by Hywel Dda University Local Health Board
acting by

Steve Moore
Chief Executive

SIGNED and DELIVERED
by Powys Teaching Local Health Board
acting by

Carol Shillabeer
Chief Executive

SIGNED and DELIVERED
by Swansea Bay University Local Health Board
acting by



Mark Hackett
Chief Executive

APPENDIX A

Role of the Joint Committee
The Joint Committees role is: (refer to Standing Order 1.1.):

- Determine a long-term strategic plan for the development of specialised and tertiary services in Wales, in conjunction with the Welsh Ministers;

- Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services;

- Develop national policies for the equitable access to safe and sustainable, high quality specialised and tertiary healthcare services across Wales, whether planned, funded and secured at national, regional or local level;

- Agree annually those services that should be planned on a national basis and those that should be planned locally;

- Produce an Integrated Commissioning Plan, for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans;

- Agree the appropriate level of funding for the provision of specialised and tertiary services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the WHSST) in accordance with any specific directions set by the Welsh Ministers;

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

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

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

APPENDIX B

EMPLOYMENT OF STAFF
Identified human resources services

Service	Description
Recruitment and Selection	• To provide a comprehensive recruitment and selection service which complies with employment legislation and standards of good practice as directed by the Welsh Government.
Employee Relations	• To provide support to the Welsh Health Specialised Services Team in the management of sensitive issues relating to all employment policies including discipline, grievance, collective disputes, performance and capability, allegations of bullying and harassment whistle blowing and sickness absence etc.
Policy Development	• To develop, implement and advise on employment policies and procedures which comply with employment legislation and NHS guidance; and • To provide training to WHSST Managers in the interpretation and use of policies and procedures.
Remuneration and Payroll	• To provide advice on pay (including assimilation to new A4C bands) and associated terms and conditions of employment; • To provide a comprehensive payroll service; and • To undertake the matching and evaluation of all new and revised roles.
Training and Development	• To provide appropriate training and development to WHSST.
HR administration	• To maintain securely employment records for WHSST and provide accurate workforce data and information as required.
Occupational health	• To provide a comprehensive Occupational health service to employees of WHSSC

APPENDIX C

3.1 Procedures for Tenders & Procurement

Service	Description
Procurement (Tendering and ordering goods and services)	• Tendering for goods & services in accordance with SOs and SFIs • Entering into procurement contracts and agreements • Raise orders for properly approved requisitions
Creditor Payments (Payment of suppliers, contractors and service providers)	• Pay all duly authorised invoices • Deal with supplier queries etc • Provide management information on payment performance in accordance with WAG requirements
Systems maintenance and administration (ORACLE)	• Process feeders into WHSSC ledger and maintain financial management system • Maintain passwords and hierarchies (cost centre and approval) • Oracle training as and when required including external training if required • Access to help desk facility • Undertake testing of upgrades • Liaise with Oracle Central Team and All Wales groups
Accounting Services (bank accounts, annual accounts consolidation, VAT)	• Provision of bank accounts and petty cash facilities • Consolidation of Annual Accounts and other returns as required by WG • Provide VAT advice and consolidate VAT returns, including access to contracted out VAT advisory services • Payment of Tax, National Insurance and Superannuation to appropriate authorities

Financial Governance (internal and external audit, counter fraud, audit committee)	• Responsible for the securing of internal audit service via external contract • Access to Local Counter Fraud Specialist • Advice on financial procedures and other issues of governance • Ensure appropriate external audit provision in place

3.2 **Estates, Facilities and IT Support**

Service	**Description**
Estates Maintenance	• To provide an efficient service in response to all aspects of estates maintenance in the running of the WHSSC offices.
Fire Safety	• To provide professional advice and support in relation to all aspects of Fire Safety ensuring compliance with legislation and guidance issued by the Welsh Government; and • To provide appropriate training to WHSST.
Health and Safety	• To provide a Health and Safety Policy statement as and when required. The Policy must comply with the requirements of the Health and Safety at Work Act. All other relevant rules and regulations must be observed at all times; • To be responsible for the testing, where appropriate, labelling and recording of all portable appliances in their ownership under the Electricity at Work Act 1989; • To provide advice and support on the operational delivery of health and safety arrangements in WHSST in accordance with Cwm Taf Morgannwg UHB policies and procedures; and • To provide appropriate training to WHSST.

IT Support	• To provide a comprehensive IT support service including :
	  ○ User registration;
	  ○ Resolution of faults reporting via the Helpdesk;
	  ○ Purchase and set up new IT equipment;
	  ○ Supply of printing consumables
	• To provide support in relation to the management of files and databases;
	• To ensure the secure storage of data, back up, restore and recovery

3.3 **Others**

Service	**Description**
Corporate Support	• To provide access to the Board Secretary for advice and support on Corporate Governance matters as required.
Welsh Language	• Offer advice and information about the Welsh Language • Promote and encourage the use of Welsh within the workplace • Encourage the use of bilingual aids within the workplace such as signage, stationery etc • Provide Welsh Language taster lessons for staff • Give bilingual front-line telephone training • Translate small in-house, day-to-day, translations • Help co-ordinate the translation of larger documents • Attend public meetings to provide a Welsh Language service for Welsh speakers.

Equality and Diversity	• To provide advice and information to the Welsh Health Specialised Services Committee; • To ensure the business of WHSSC is included within plans and policies of the Host LHB; • To develop a work plan and meet quarterly to review progress against the plan; • To ensure that relevant training is provided to the WHSST in relation to awareness raising and impact assessment; • To provide an assurance mechanism on behalf of the LHBs that robust processes are in place to meet the Equality and Diversity agenda
Risk Management	• To provide advice and information on all areas of Risk Management to the Welsh Health Specialised Services Committee; • To support the development of a Risk Assurance Framework for WHSSC • To provide support (structure and advice) for the use of DATIX to facilitate the management of risk within WHSSC • To develop a work plan and meet quarterly to review progress against the plan
Concerns	• To provide training and awareness for all staff in relation to the management of concerns; • To provide advice and support in relation to the concerns process; • To provide support (structure and advice) for the use of DATIX to facilitate the management of concerns within WHSSC To be responsible for all claims relating to staff and services commissioned which relate to Cwm Taf Morgannwg UHB Residents
Information Governance	• To provide timely advice to all information governance related enquires; • To support the WHSSC Information Governance Group providing relevant advice as required; • To provide training and awareness for all staff in all areas of Information Governance

APPENDIX D

Accountability Arrangements

1. The Directions state that the LHBs will jointly exercise the Delegated Functions from 1 April 2010.

2. This means that the Delegated Functions are those of the individual constituent LHBs and not Cwm Taf Morgannwg UHB.

3. The Directions state that Cwm Taf Morgannwg UHB will exercise its functions so as to provide administrative support for the running of the Joint Committee and establish the WHSST.

4. The membership of the Joint Committee consists of the Chief Executives and the Chair, who is appointed by the Minister.

5. The Chair is directly accountable to the Minister.

6. The Director of Specialised and Tertiary Services is appointed as an Officer member of the Joint Committee to have such responsibilities as may be prescribed by the Joint Committee.

7. For the performance of the Delegated Functions on behalf of the Joint Committee and each constituent LHB, the Director can only be accountable to the Chief Executives of the constituent LHBs.

8. The Chief Executives of the Constituent LHBs are individually accountable to the Director General and Chief Executive of the NHS in Wales.

9. The Chief Executive of Cwm Taf Morgannwg UHB is only accountable to the Director General and Chief Executive of the NHS in Wales insofar as his/her functions relate to administrative support.

10. The Director of Specialised and Tertiary Services is jointly accountable to the Joint Committee and Chief Executive of Cwm Taf Morgannwg UHB.

11. The Finance Director of Cwm Taf Morgannwg UHB is only accountable to the Director of Finance for the NHS in Wales insofar as his functions relate to administrative support.

12. The Finance Director of the Joint Committee has a dual responsibility to the Joint Committee and to the Finance Director of Cwm Taf Morgannwg UHB.

13. The Audit Committee of the host LHB is the central means by which the Joint Committee ensures effective internal control arrangements are in place.

Annex (iii) to Memorandum of Agreement

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

JOINT COMMITTEE BUSINESS FRAMEWORK

~~July~~ March 2023~~1~~

1. INTRODUCTION

1.1 WHSSC in the exercise of its statutory duties is expected to maintain public confidence in a process which is free of actual conflict.

1.2 LHBs, who are constituent members of WHSSC, have differing or conflicting local priorities and objectives which may impede collaboration. Different priorities may arise from the immediate need to support local health services. Yet WHSSC is required to commission specialist services to the benefit of NHS Wales as a whole and acting in accordance with its statutory obligations.

1.3 WHSSC through each constituent member remains accountable for the commissioning decisions it makes and for ensuring that conflicts between the exercise of the commissioning and provider functions are managed appropriately.

1.4 The Chief Executive of each constituent LHB is personally accountable to NHS Wales for the good governance and accountability of WHSSC. This includes ensuring that WHSSC manages transparently any potential conflict of interest.

1.5 The purpose of this document is to set out a framework so that Members of the Joint Committee and sub-committees/sub groups have a clear understanding of the decision making processes.

2. KEY PRINCIPLES

The Joint Committee will:

2.1 Support Members in striving to reduce the inequalities in access to and delivery of services for the populations the Members serve;

2.2 Support the cost effective utilisation of the funds made available by Members to commission specialised services;

2.3 In commissioning and procuring services, comply with all applicable statutory duties;

2.4 Establish Management Group which will ensure provider issues are dealt with at a local level.

2.5 At all times demonstrate value for money and an effective and efficient commissioning programme;

2.6 Ensure that the financial risks to individual Members of unforeseen/unplanned activity are minimised, and that inequalities in access to and delivery of services are reduced;

2.7 Review, plan, develop and monitor the Services in partnership with clinicians, providers and service users; and

2.8 Use, where practically possible, other mechanisms to keep Members updated in terms of progress rather than the formal Joint Committee meetings.

The following additional key principles will also apply:

2.9 Commitments made by the Joint Committee in accordance with the delegated powers will be binding on all Members until the Joint Committee agrees otherwise;

2.10 Whilst agreement on the proposed way forward can be discussed and agreed at other forums (e.g. CEO Peer Group) all decisions will be taken at Joint Committee meetings unless otherwise delegated; and

2.11 A standard facilitation/arbitration procedure will apply.

3. BUSINESS PROCESSES

3.1. The Joint Committee's key business processes and products will be delivered through a clear and consistent annual business cycle. Each product that will be developed and implemented through appropriate structures that already exist and include:

3.1.1 Chief Executive Peer Group

3.1.2 Executive Directors Peer Groups

3.1.3 Programme Teams

3.1.4 Existing Governance structures

4. MEETINGS OF THE JOINT COMMITTEE

4.1 General Principles

4.1.1 The dates of Joint Committee meetings will be agreed in advance with the membership for a rolling period of one year.

4.1.2 It is expected that the Joint Committee will meet up to five times each year.

4.1.3 All reports will be concise and clear. The body (introduction to conclusion) of the report will be a maximum of six A4 pages in length, where reasonably practical.

4.1.4 The Annual Plan for Specialised Services will be agreed annually. Any requests for additional funding outside of the agreed annual planning business cycle will need to demonstrate exceptionality. *(Refer to the All Wales Policy on Dealing with Individual Funding Requests for guidance).*

4.1.5 All reports prepared for meetings of the Joint Committee will include a summary which will be no longer than one A4 page in length. This summary should include the title of the report, its purpose and the name of the responsible Executive Director. It should also clearly state what is required from the Joint Committee and outline the potential and/or likely implications of the decision.

4.1.6 All reports will be agreed by the Management Group before consideration by the Joint Committee.

4.1.7 The Joint Committee will not normally consider reports for information during the meetings. These will be circulated outside of the meetings. This will ensure that time is maximised during Joint Committee Meetings. Where further discussion and agreement is required on specific items this will be undertaken through the Management Group and the decision will be taken at the Joint Committee in accordance with the Governance and Accountability Framework.

4.1.8 All papers will be sent electronically to Joint Committee Members, Directors of Finance and

Directors of Planning (see *WHSSC Standing Orders* reference 6.5.3). Copies of the agenda and papers will also be available on the WHSSC website http://www.whssc.wales.nhs.uk/

4.1.9 On the occasions when the Chief Executive of the LHB is unable to attend the meeting, an Executive Director must be nominated to attend the Joint Committee meetings. The nomination must be approved by the Chair of the Joint Committee before the meeting (please refer to *WHSSC Standing Orders* reference 6.6.11). The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have delegated voting rights.

4.1.10 On the occasions where the Joint Committee meeting is not quorate (please refer to *WHSSC Standing Orders* reference 6.6.10), the Chair may seek the views of those Members present and request that the Committee Secretary writes to each Member of the Joint Committee to support the decisions.

4.1.11 In dealing with such issues requiring an urgent decision, and if timescales allow, the Chair may call a meeting of the Joint Committee using video or telephone conferencing facilities. Emails may also be used to gather views and/or reach a consensus. All such decisions will be ratified by the Joint Committee at its next formal meeting.

4.2 Confidential Agenda

The Joint Committee will discuss items in confidence that would be exempt under the Freedom of Information Act 2000. Such items would generally be considered to be personal and confidential in nature or their disclosure would be otherwise prejudicial to the public interest.

4.3 Declaration of Interests

Please refer to *WHSSC Standing Orders* reference 7.1.

4.4 Managing Conflict

4.4.1 The Joint Committee must exercise its functions in a way which ensures that any conflicts of interest and local and prejudicial interests are dealt with as a preliminary to the decision making.

4.4.2 At each meeting any specific conflicts pertinent to an issue on the agenda must be declared at the start and then recorded in the Minutes. In each meeting the Chair will ask Members to agree as preliminary whether the conflicted LHB should remain in the meeting and/or be able to participate in the discussion and to what degree.

4.5 Decision Making

4.5.1 The Joint Committee will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no two thirds majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

4.5.2 On reaching a Joint Committee decision, all members will support that decision and its consequences in every respect.

4.6 Additional Items of Business

The Chair will be notified in advance of any items of other business to be raised for discussion at a meeting of the Joint Committee (see *WHSSC Standing Orders* reference 6.5.2). Where this is not possible or in exceptional circumstances, items of other business may be raised by a member at the appropriate point on the agenda. Acceptance of items of other business is at the discretion of the Chair.

4.7 Chair's Ruling

The decision of the Chair of the Joint Committee on questions of order, relevancy and regularity and the Chair's interpretation of the Business Framework and the Governance and Accountability Framework shall be final. In this interpretation the Chair shall be advised by the Director of Specialised and Tertiary Services and the Committee Secretary.

5. MINUTES AND ACTIONS

5.1 Minutes

5.1.1 The proceedings of each meeting of the Joint Committee will be formally recorded. The Committee Secretary will be responsible for the production of these minutes.

5.1.2 The Chair will be responsible for summarising action points and decisions after each item of business during the meeting.

5.1.3 The Director of Specialised and Tertiary Services will write out to all Joint Committee Members with a summary of the discussions and actions following the meetings.

5.1.4 Following a meeting of the Joint Committee, the Director of Specialised and Tertiary Services will review the accuracy of the unconfirmed minutes with the Committee Secretary, prior to submission to the Chair for approval.

5.1.5 Once reviewed and approved by the Chair, the unconfirmed minutes will be circulated to Joint Committee Members and the Board Secretary of each LHB.

5.1.6 At the next meeting of the Joint Committee, all members will review the minutes and confirm that they are an accurate record. If any changes are required, the amendments will be discussed and agreed at the meeting.

5.1.7 The Chair will sign a copy of the minutes when agreed as an accurate record. This creates an official record of the meeting.

5.2 Actions

5.2.1 Actions resulting from the Joint Committee meetings will be summarised in tabular form which clearly indicates who is responsible and the agreed timescales.

5.2.2 The summary of actions should be circulated with the papers of the next Joint Committee meeting.

5.3. Briefing

5.3.1 A Joint Committee Briefing summarising the key discussion and decisions at Joint Committee meetings will be distributed within 7 days of each Joint Committee meeting.

6. DISPUTE RESOLUTION

6.1 In accordance with the Governance and Accountability Framework the Health Boards will seek to work cooperatively with each other as constituent Members of the Joint Committee. Where there is an impasse which cannot be reached by means of conciliation between appropriate individuals, then the dispute process set out in Annex (iii) of the Governance and Accountability Framework will be followed.

6.2 Disputes relating to the Hosting Agreement between Cwm Taf Health Board and the Health Boards will be dealt with in accordance with Section 16 of the Hosting Agreement.

6.3 Most disputes arising between the Commissioners and Providers should be managed and resolved locally. Where there is need for escalation, the objectives of the Welsh Health Specialised Services Committee (WHSSC) ("Joint Committee") Dispute Resolution Process are:

6.3.1 To resolve disputes promptly, transparently, fairly and consistently;

6.3.2 To provide confidence to parties that the process is fair and transparent;

6.3.3 To mitigate risks and protect the reputation of the NHS in Wales;

6.3.4 To prevent where possible legal challenge or other external referral processes.

6.4 Facilitation and/or arbitration (Stage 1 and Stage 2) of disputes may be required in the following circumstances:

6.4.1 The Chair or any Member of the Joint Committee requests facilitation because an impasse has been reached between Members of the Committee.

6.5 Formal dispute resolution may be required in the following circumstances but shall not be limited to:

6.5.1 Any Provider dispute concerning the contractual agreement between WHSSC and the Provider which has not been able to be resolved with Officers of WHSSC;

6.5.2 Any dispute concerning the contractual agreement between the Provider and WHSSC which has not

been able to be resolved with Officers of the Provider organisation;

6.6 This document should be read in conjunction with the Governance and Accountability Framework *Disputed Debts within the NHS in Wales Arbitration Process* (see Appendix A).

6.6.1 There is no formal arbitration process between England and Wales, however in the past disputes have been resolved through intervention by Welsh Government and DoH representatives.

6.6.2 The final decision made by the route followed is final and on completion the dispute cannot be taken through the alternative route.

6.7 Definitions

6.7.1 *Locally*, within this section, means amongst the individuals raising the dispute.

6.7.2 *NHS Wales* refers to all Local Health Boards and NHS Trusts

6.7.3 *Member*, within this section, refers to both Voting Members, Officer Members and Associate Members of the Joint Committee.

6.8. Raising a Dispute

6.8.1 In the case of any dispute arising out of or in connection with the Commissioning of Specialised Services for NHS Wales, the parties involved will make every reasonable effort to communicate and co-operate with each other with a view to resolving the dispute, before formally referring the dispute for local resolution.

6.8.2 In the event of a dispute arising between two or more parties which cannot be resolved between "WHSSC" the Commissioner and the Provider, the parties should refer to section 6.6.6.

6.8.3 Disputes may arise over any aspect of a Heads of Agreement, or Service Level Agreement including that is deemed to be fair and reasonable, the management of performance variations and the imposition of penalties.

6.8.4 Where any conflicts are identified between the requirements of the Heads of Agreement and any national directives and circulars, the requirements of the latter shall take precedence.

6.8.5 All parties recognise that it is in the best interests of patients, the organisations themselves, and the services they provider, for any disputes to be resolved locally.

Local Dispute Resolution

6.8.6 The first level of resolution should be:

For WHSSC: Mr. Stuart Davies, Director of Finance or nominated Officer.

For Provider: Director of Finance or nominated Officer.

6.8.7 The second resolution shall be:

For WHSSC: The Director of Specialised & Tertiary Services

For the Provider: The Chief Executive

Formal Dispute Resolution

6.8.8 In the event that the dispute is not resolved at the local resolution stage one or more parties may submit a formal request for dispute resolution.

The request for formal dispute should be addressed to:

Committee Secretary
Welsh Health Specialised Services Committee
Unit G1
The Willowford
Treforest Industrial Estate
Pontypridd
CF37 5YL

6.8.8.1 The names of the parties to the dispute;

6.8.8.2 A brief statement describing the nature of the circumstances of the dispute and

outlining the reasons why the commissioner/providers are in disagreement; and

6.8.8.3 What has been done to try and resolve matters.

6.8.9 On receipt of formal referral for review of case, the request will be acknowledged within five working days.

6.8.10 The decision shall be so referred immediately upon receipt of such notice and the effect of that decision shall be suspended until the conclusion of dispute resolution.

6.8.11 A decision not required to be referred to dispute resolution within the time specified shall be binding on all Members.

6.8.12 A record of all disputes (formal and informal) will be maintained and will be made available to Members and the Chief Executive of NHS Wales (and their Executive team) on request.

6.9 Process for Dispute Resolution

6.9.1 Stage 1 – Facilitation

6.9.1.1 All parties involved in the dispute must try to reach an agreement. This will involve meeting to discuss and try to resolve the issues. All reasonable efforts must have been made (local resolution level 1 and 2).

6.9.1.2 A meeting is held which includes the following:

- a representative of the Chief Executive Officer for the LHB area of the Member(s) in dispute;
- an appropriate Director from the NHS organisation(s) in dispute; and
- a representative of WHSSC

6.9.1.3 The meeting will be chaired by the Chair of WHSSC or Vice-Chair and involve expert advice (clinical/commissioning/financial) where appropriate.

6.9.1.4 If resolution is reached, the process will conclude at this stage.

6.9.2 Stage 2 – Arbitration

6.9.2.1 Both the party raising the dispute and the Director of Specialised and Tertiary Services or deputy (acting on behalf of the Joint Committee) will produce a joint statement of facts as well as a separate report setting out their positions and submit them to the Chair of the Dispute Resolution Panel.

6.9.2.2 The Chair of the Dispute Resolution Panel may invite the Director of Specialised and Tertiary Services or deputy (acting on behalf of the Joint Committee) and the Member bringing their dispute to present their positions or they may choose to decide on the basis of the information submitted.

6.9.2.3 Each Member of the Panel hereby recognises and agrees the role and responsibility of the Dispute Resolution Panel in relation to dispute resolution both as part of any initial Facilitation process and, further, as part of any Arbitration process. In resolving any such dispute the Panel shall have regard to ensuring each Member is fulfilling its statutory responsibilities and ensuring the highest clinical standards and patient safety issues are upheld.

6.9.2.4 The decision of the arbitration process will be binding.

6.10 Dispute Resolution Panel

6.10.1 Each formal dispute will be conducted by a panel appointed by the Chair of the Joint Committee. The panel will have a minimum of three members, including one member with commissioner and one member with provider experience. The panel may call on expert advice at its discretion. None of the

panel will have strong prior relationships with the key staff involved in the adjudication.

6.10.2 The exact make up of the panel and advice to be taken by it will be decided by the Chair and one Independent Member once Stage 1 (level 1 and 2) of the process has been completed and there has not been any resolution.

6.10.3 Disputes will be heard by the panel (where possible given the criteria outlined in 6.9) within 8 weeks of the dispute being raised formally.

6.10.4 The panel will make decisions based on a simple majority vote.

6.11 Dispute Resolution Panel Acceptance Criteria

The panel will only accept disputes that meet the following criteria:

6.11.1 Stage 1 of the process has been completed but there is no resolution;

6.11.2 There must have been a full and frank disclosure of all relevant and applicable information. (This does not preclude the panel from asking for further information as it requires);

6.11.3 Individuals connected to the dispute should be able to make themselves available to provide further evidence as required;

6.11.4 There must be evidence that the party bringing the dispute has made reasonable effort to have this resolved at NHS Wales level, or can demonstrate that this was inappropriate, and that all other attempts at resolution have been completed;

6.11.5 All disputes must be formally lodged with the Dispute Resolution Panel within 3 weeks of the date the issue arose, otherwise the dispute will be invalid;

6.11.6 The dispute must not be not trivial, vexatious or an abuse of the Joint Committee Governance and Accountability Framework;

6.11.7 There must be adequate time to hear the dispute.

6.12 Timescales for Dispute Resolution

The maximum timescales for action in relation to resolution of disputes is outlined below:

Age of Dispute (weeks)	Action
0 – 3	Referral of a dispute to resolution Local agreement sought
3 - 5	Escalation of dispute to formal stage of dispute resolution
5	Preparation for Panel (Stage 2)
6	Case Submission
7	Final Submission Deadline
8	Panel held and decision made

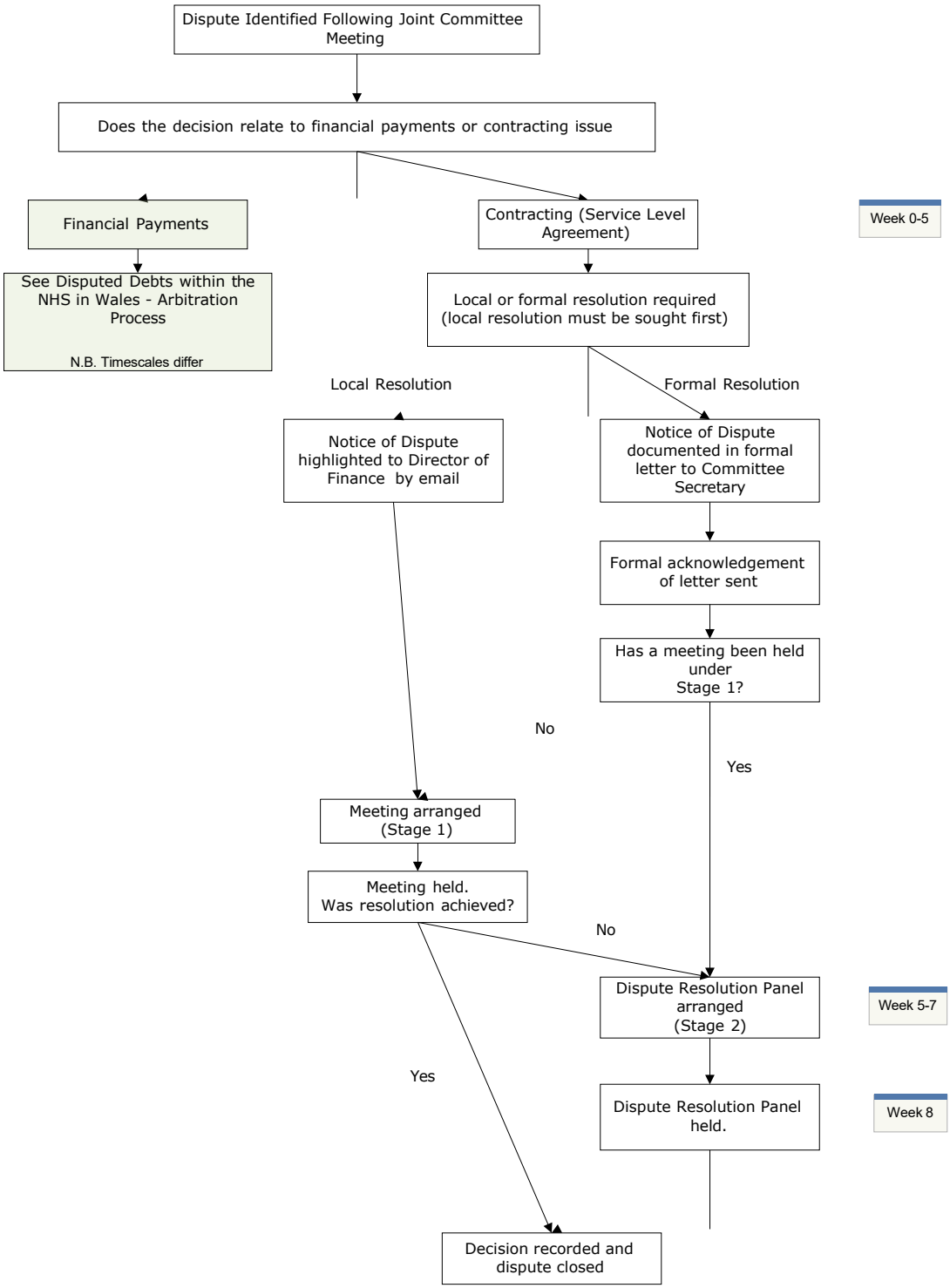
Appendix A

Disputed Debts within the NHS in Wales - Arbitration Process

Disputed debts between Welsh NHS organisations will be dealt with in accordance with the 'Disputed Debts within the NHS in Wales - Arbitration Process 2010/11' or such subsequent relevant arbitration process as is issued by or on behalf of Welsh Government from time to time.

Appendix B

Flow Chart for Dispute Resolution



Annex (iv) to Memorandum of Agreement

CLINICAL NETWORKS

Welsh ~~Clinical Renal Network~~ Kidney Network (WKN)

The Welsh ~~Clinical Renal~~ Kidney Network (WKN) is established as a Sub-Committee of the Welsh Health Specialised Services Committee. This arrangement will be reviewed on a regular basis as part of the Governance and Accountability Framework for the Joint Committee.

The Chair of the Welsh ~~Clinical Renal~~Kidney Network will be accountable to the Chair and will be an Associate Member of the Joint Committee.

The Welsh ~~Clinical Renal~~Kidney Network will provide a national focus for planning and performance management of all renal services, work closely with each LHB to support service improvement, local planning, and resource management. It will be the focal point to inform the LHBs and WG on the effectiveness and efficiency of adult renal services in Wales as well as the strategic implementation of the Renal National Service Framework and performance against the Annual Operating Framework and the associated Local Delivery Plans.

The Welsh ~~Clinical Renal~~ Kidney Network Chair / Lead Clinical Advisor will be directly accountable to the Chair of the Joint Committee but will also provide advice to WG through the Director of Strategy and Planning and the NHS Medical Director and Chief Medical Officer on an agreed sessional basis.

The Renal Network Manager will be managerially responsible to the Director of Finance and accountable to the Network Chair / Lead Clinical Advisor for the development and delivery of the Network objectives and work plan as appropriate to this role.

Welsh Health Specialised Services - Additional Delegations Linked to the SFI's

Contents

Welsh Health Specialised Services - Additional Delegations Linked to the SFI's

1. Budget delegation and virements

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Delegation of the management of a budget to permit the performance of a defined range of activities	6.2.1	Lead Director	Director of Finance
B	All budget holders are required to sign up to their allocated budgets at the start of the financial year.	6.1.4	Budget holders	All budget holders
C	Delegation to include the authority to exercise virement and budget transfers	6.2.1	Lead Director	See C1below

		Delegated to:	Signed off by:
A1	Delegation of the management of defined Revenue budgets to budget holders: i. Direct Running Costs WHSSC ii. Direct Running Costs WKN iii. Direct Running Costs TSW	i. Committee Secretary ii. WKN Manager iii. TSW Manager	i. Committee Secretary to £20,000 ii. WKN Manager to £10,000 iii. TSW Manager to £10,000 Thereafter Director of Finance to £50,000

C1-Approval of variation of budgets, including authority to vire

Delegated Authority	Between budget lines	Capital to revenue & *vice versa*
Between directorates	Director of Finance	Not allowed
Budget transfers between Reserves and Delegated budgets	Director of Finance	

Welsh Health Specialised Services - Additional Delegations Linked to the SFI's

2. Banking arrangements

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	The Director of Finance of the Host LHB will prepare detailed instructions on the operation of bank accounts which must include: i. The conditions under which bank accounts is to be operated ii. Those authorised to sign cheques or other orders drawn on the LHB accounts	9.1.1	Director of Finance of the Host LHB	As per Host LHB SFI's

3. Income, fees and charges.

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority Delegated to
A	**Fees and Charges**- The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges , other than those determined by the Welsh ministers or by statute	10.1.2	Director of Finance	Financial Accountant
B	**Debt recovery-** The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.	10.1.4	Director of Finance	Financial Accountant

	Fees and Charges:	**Authority Delegated to**
A1	**Risk Sharing Funding** i. Approval and Signing of the Risk Sharing Agreements and Annual Financial Plan	i. Joint Committee ii. WHSSC Management Group

Welsh Health Specialised Services - Additional Delegations Linked to the SFI's

4. Procurement and contracts for good and services

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	Maintaining detailed policies and procedures for procurement, tendering and contracting	11.1.4	Host LHB	As per Host LHB SFI's

5. Contracts for Health Care Services

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority Delegated to
A	The Lead Director is responsible for ensuring the LHB enters into suitable Health Care Agreements or individual patient commissioning agreements where appropriate.	12.1.1	Lead Director on behalf of the Joint Committee	Director of Finance
B	The Lead Director will need to ensure that regular reports are provided to the Joint Committee detailing performance and associated financial implications of all health care agreements	12.3.1	Lead Director	Director of Finance

	Agreements for the purchase of services	Authority delegated to
A1	**Long Term Agreements with other NHS bodies** i. Approval and Signing of the Long Term Agreement ii. Variations to the Agreement	Level 1 – Lead Director – In accordance with delegated authority within the Standing Financial Instructions Level 2 – Director of Finance – In accordance with delegated authority within the Standing Financial Instructions

Welsh Health Specialised Services - Additional Delegations Linked to the SFI's

A4	**Individual NHS patient treatment charges outside of LTAs and SLAs** Agreement to fund treatment: i. Individual Patient Packages ii. Lifetime Costs	>£1,000,000 – Included in ARC & JC assurance report >£1,000,000 Level 1 – Lead Director <£1,000,000 Level 2 – Director of Finance <£500,000 Level 3 Directors >£1,000,000 – Included in ARC & JC assurance report >£1,000,000 Level 1 – Lead Director <£1,000,000 Level 2 – Director of Finance <£500,000 Level 3 Directors Below these limits individual directors can delegate their authority to officers as detailed in the Standing Financial Instructions

6. Pay expenditure

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	All appointments or recruitments	13.1.2	Host LHB	Committee Secretary

7. Non Pay expenditure

Ref	SFI requirement	SFI Ref.	SFI responsibility	Authority Delegated to
A	The Lead Director will approve the level of non pay expenditure and operational scheme of delegation and authorisation to budget holders the scheme of delegation	SFI 14.1.0	Lead Director	Director of Finance

B	The Director of Finance will advise the board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders should be sought.	14.3.1	Director of Finance	Financial Accountant

8. Losses and special payments

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
B	**Losses and Special payments** • Ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses and special payments cases are properly managed in accordance with the guidance set out in the Assembly Government's Manual for Accounts. • Ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write off' action is recorded on the system. • The Audit Committee shall approve the writing off of losses or the making of special payments within delegated limits determined by Welsh Ministers and as set out in Schedule 3 of the SOs. • Ensure that all losses and special payments are reported to the Audit Committee at every meeting	**16.1.2** **16.1.6** **16.1.7** **16.1.11**	Director of Finance Director of Finance Audit committee Director of Finance	Financial Accountant Financial Accountant See Below Financial Accountant

Welsh Health Specialised Services - Additional Delegations Linked to the SFI's

B1	**Approve losses, write-offs and compensation payments due to:** i. losses of cash (theft, fraud, etc) ii. damage to buildings, fittings, furniture and equipment and property in stores and in use due to culpable cause (theft, fraud, arson) iii. extra contractual payments to contractors; iv. ex-gratia payments to patients and staff for loss of personal effects v. fruitless payments including abandoned capital schemes vi. ex-gratia payments - voluntary release payments to staff vii. bad debts and claims abandoned - <£10,000 - £10,000 to £50,000 - No delegated approval over £50,000 – WG approval required	i to iv Lead Director (within delegated limits issued by Welsh Government - £50,000) v. Lead Director (delegated limits - £250,000) vi. Remuneration Committee (within delegated limits issued by Welsh Government - £50,000) vii. Director of Finance (to £10,000) and Lead Director (£10,000 to £50,000).
B2	**Approve compensation payments made under legal obligation:** • Personal injury claims i. up to £20,000 ii. £20,000 to £50,000 iii. Over £50,000 • Employment matters	• Personal injury- On receipt of legal advice to pay i. Committee Secretary ii. Director of Finance iii. Lead Director (within delegated limits issued by Welsh Government - £1million • Employment matters Lead Director (with advice from Committee Secretary)

B3	**Approve compensation payments made without legal obligation**	• Lead Director (within delegated limits issued by Welsh Government - £50,000)

9. IM&T

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	The Director of IM&T has specific responsibilities within this Section which need to be reviewed to determine if any formal delegation is required.	17.1.1	Host LHB	As per Host LHB SFI

10. Retention of Records

Ref	SFI requirement	SFI Ref	SFI responsibility	Authority delegated to
A	The Lead Director shall be responsible for maintaining archives for all records required to be retained in accordance with Welsh Ministers guidance.	18.1.1	Lead Director	• Committee Secretary

WHSSC Delegated Authorisation Matrix

17 May 2023

Corporate Directors Direct Authority Through Financial Limits Policy									Delegated Authority																												Delegated Functions	
		Tier 1 Director	Tier 1 Director	Tier 2 Director	Tier 3 Director				Assistant Directors			Commissioning					Corporate			Finance Delegations				Clinical		EASC / NCCU										
Post	**Cost Centre**	**Director of EASC**	**Director of Specialised Services**	**Director of Finance & Information**	**Director of Planning & Performance**	**Committee Secretary**	**Nurse Director**	**Medical Director**	**Assistant Director of Finance**	**Assistant Director of Planning**	**Assistant Medical Director**	**MH & CAMHS Commissioner**	**CAMHS Case Manager**	**Gender Services Manager**	**Traumatic Stress Wales**	**Renal Network Manager**	**Corporate Governance Manager**	**Corporate Governance Officer**	**Office Manager**	**Financial Accountant**	**Head of Contracting**	**Head of Financial Planninng**	**Assistant Financial Accountant**	**Head of Quality & Patient Care**	**IPFR Manager**	**Commissioning**	**Corporate**	**NEPTS**	**Clinical**	**Quality**	**Delegated to NWSSP**	**Delegated to Cwm Taf**
Current Post Holder		**Stephen Harrhy**	**Sian Lewis**	**Stuart Davies**	**Nicola Johnson**	**Jacqueline Evans**	**Carole Bell**	**Iolo Doull**	**James Leaves**	**Claire Harding**	**Various**	**Emma King**	**VACANCY**	**Krysta Hallewell**	**Emma Smith**	**Susan Spence**	**Helen Tyler**	**VACANCY**	**Laura Holburn**	**Helen Harris**	**VACANCY**	**Kendal Smith**	**Nicola Skinner**	**Adele Roberts**	**Catherine Dew**	**VACANCY**	**Gwenan Roberts**	**Nicola Bowen**	**Jo Mower**	**Shane Mills**		
Corporate Responsibility as per the Standing Financial Instructions																																					
Sign off of Annual Financial Plan for JC		√ *Cost Centres H700-H799*	√ *Cost Centre H100*	√ *Cost Centre H100*																																	
Service Level Agreements in line with Standing Financial Instructions																																					
SLA Contract Agreements		√	√	√	√				√	√																											
SLA Contract Payments in Line With Contract Agreements - Wales	*Cost Centres Wales H200-H290*	√ >£2m	√ >£2m	√ <£2m	√ <£1m				√ <£750k	√ <£750k																											
SLA Contract Payments in Line With Contract Agreements - England	*Cost Centres England H300-H399, H400*	√ >£2m	√ >£2m	√ <£2m	√ <£1m				√ <£750k	√ <£750k																											
IPFR Requests and Other Non Contract Payments																																					
All Patient Funding Requests	*Cost Centres H400-H411*		√* >£1m	√* <£1m	√* <£500k	√* <£500k	√* <£500k	√* <£500k	√**	√**	√**									√ <£50k	√ <£50k	√ <£50k		√ <£50k	√ < £10k ***											
Non Contract and Emergency Activity	*Cost Centre H412*	√ >£100k	√* >£1m	√* <£1m	√* <£500k		√ <£250k		√ <£250k	√ <£250k						√ <£50k								√ <£50k	√ < £10k ***											
Payments Supporting Approved Funding Releases and Developmetns	*Cost Centre H900 - H998*	√ >£100k	√* >£1m	√* <£1m	√* <£500k		√ <£250k		√ <£250k	√ <£250k						√ <£50k																					
																Cost Centre H600 / H601																					
Mental Health																																					
Mental Health CAMHS Contracts	*Cost Centre H550*		√* <£1m	√* <£1m	√* <£500k	√* <£500k	√* <£500k	√* <£500k	√**	√**	√**	√ <£50k	√ <£30k	√ <£30k						√ <£50k	√ <£50k	√ <£50k		√ <£50k	√ < £10k ***											
Other Mental Health Contracts	*Cost Centres H510-H530*		√* <£1m	√* <£1m	√* <£500k	√* <£500k	√* <£500k	√* <£500k	√**	√**	√**	√ <£50k								√ <£50k	√ <£50k	√ <£50k		√ <£50k	√ < £10k ***											
Mental Health Secure Services Contracts	*Cost Centres H500 / H505*	√	√	√	√							√ <£50k																									
Networks Running Costs																																					
Networks According to Oracle Authorisation Limits			√ <£100k	√ <£50k											√ <£10k	√ <£10k																				
															Cost Centre H040	*Cost Centre H050*																					
Committee Running Costs																																					
DRC Requisitions and Orders According to Oracle Authorisation Limits		√ <£100k	√ <£100k	√ <£50k		√ <£20k											√ <£10k	√ <£3k	√ <£0.5k						√ <£20,000	√ <£20,000	√ <£20,000	√ <£20,000	√ <£20,000							
		Cost Centre H090	*Cost Centre H090*	*Cost Centre H090*		*Cost Centre H090*											*Cost Centre H090*	*Cost Centre H090*	*Cost Centre H090*																		
Payroll	*Cost Centres H001-H089*		*Cost Centre H001*	*Cost Centre H004*	*Cost Centre H002*	*Cost Centre H005*	*Cost Centre H003*	*Cost Centre H006*							*Cost Centre H040*	*Cost Centre H050*																					
Payroll New Starters		√	√	√	√	√	√	√							√	√									√	√	√	√	√							
Payroll Leavers		√	√	√	√	√	√	√							√	√									√	√	√	√	√							
Establishment Vacancy Authorisation		√	√																																	
Payroll Changes Financial		√	√	√	√	√	√	√							√	√	√			√	√					√	√	√	√	√							
Payroll Changes Non Financial (eg Financial Coding)		√	√	√	√	√	√	√							√	√	√			√	√					√	√	√	√	√							
Payroll Travel Expenses		√	√	√	√	√	√	√							√	√	√			√	√					√	√	√	√	√							
Payoll Study Leave						√											√																				
Operational Finance Teams Only																																					
Ledger Journals - Reversing				√					√											√	√																
Ledger Journals - Standard				√					√											√	√																
Ledger Journals - Final Accounts				√					√											√																	
Delegated to External Bodies																																					
Bank Account Management																																				√	
Ledger Integrity																				√																√	
Payroll Calculations																																				√	
PANISU																																				√	