Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Video Conference via Zoom
Meeting date: 24 February 2021
Meeting time: 09.00

For further information contact:
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In accordance with Standing Order 34.19, the Chair has determined that the public are excluded from the Committee's meeting in order to protect public health. This meeting will be broadcast live on senedd.tv

Informal pre-meeting (09.00-09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 COVID-19: Evidence session with local health boards

(09.30-10.30) (Pages 1 - 109)

Gill Harris, Deputy Chief Executive and Executive Director of Nursing and Midwifery – Betsi Cadwaladr University Health Board
Arpan Guha, Medical Director – Betsi Cadwaladr University Health Board
Steve Moore, Chief Executive – Hywel Dda University Health Board
Andrew Carruthers, Executive Director Of Operations – Hywel Dda University Health Board
Paul Mears, Chief Executive – Cwm Taf Morgannwg University Health Board
Professor Kelechi Nnoaham, Executive Director of Public Health – Cwm Taf Morgannwg University Health Board

Research brief
Paper 1 – Betsi Cawaladr University Health Board
Paper 2 – Hywel Dda University Health Board
Paper 3 – Cwm Taf Morgannwg University Health Board

Paper 4 – Aneurin Bevan University Health Board

Paper 5 – Cardiff and Vale University Health Board

Paper 6 – Powys Teaching Health Board

Paper 7 – Swansea Bay University Health Board

Break (10.30-10.45)

3 COVID-19: Evidence session with local health boards (continued)

(10.45-11.30)

Gill Harris, Deputy Chief Executive and Executive Director of Nursing and Midwifery – Betsi Cadwaladr University Health Board

Arpan Guha, Medical Director - Betsi Cadwaladr University Health Board

Steve Moore, Chief Executive - Hywel Dda University Health Board

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Paul Mears, Chief Executive – Cwm Taf Morgannwg University Health Board

Professor Kelechi Nnoaham, Executive Director of Public Health - Cwm Taf University Health Board

4 Paper(s) to note

(11.30)

4.1 Letter from the Chair of the Culture, Welsh Language and Communication Committee to the Deputy Minister for Culture, Sport and Tourism regarding follow-up work on the impact of COVID-19 on sport

(Pages 110 - 119)

4.2 Letter to the Chair from the Chair of the Petitions Committee regarding Petition P-05-812 Implement the NICE guidelines for Borderline Personality Disorder

(Pages 120 - 121)

4.3 Letter to the Chair of the Petitions Committee regarding Petition P-05-812 Implement the NICE guidelines for Borderline Personality Disorder

(Pages 122 - 123)

Agenda Item 2

Document is Restricted

v1.0 Approved

BCUHB Response to the Health, Social Care and Sport Committee Request for Information on the Impacts of the Pandemic on Waiting Times

Introduction

The Betsi Cadwaladr University Health Board (BCUHB) welcomes the opportunity to contribute to the Health, Social Care and Sport Committee's inquiry into the impact of Covid-19. In common with other Health Boards across Wales, BCUHB is experiencing a range of pressures as a result of the pandemic, not least on its waiting times. The key pressures are set out below, in response to the Committee's specific questions.

1. **What are the main areas of pressure, and what plans do you have in place to deal with these?**

Planned Care

All routine outpatient and inpatient activity related to patients who have been identified as being at P3/4 risk stratification has been paused. This means that a significant number of patients are now waiting over 36 weeks and over 52 weeks for their treatment. As of 7th February, 51,479 patients were waiting over 36 weeks and 36,000 of that number are waiting over 52 weeks. The main specialties for which patients are waiting for treatment are Orthopaedics, General Surgery, Urology and Ophthalmology.

As part of our requirement to increase the number of Intensive Care Unit (ICU) beds across the Acute sites in North Wales, a number of clinical staff who would have been providing clinical support to reduce waiting times have been redeployed thus reducing our capacity to provide routine surgeries.

During the pandemic, treatment of cancer and life threatening conditions has continued as part of what are categorised as 'essential services'. A 'once for north Wales' approach has been adopted, moving services across the region to ensure sustainability during Covid-19 surges.

An insourcing approach (sub-contracting services to an external provider) has been adopted at weekends in Ophthalmology on two of the main hospital sites in North Wales and it is planned to extend this model of care to the other specialties during February, subject to Covid-19 restrictions. It is believed that this approach, using a blended workforce model, will need to continue for the next 2-3 years to reduce the backlogs to pre-Covid-19 levels.

Medical Specialties

Long-standing medical workforce challenges exacerbate the service pressures being faced as a result of the Covid-19 pandemic in services such as Endocrinology,

Rheumatology and Dermatology. These challenges are being resolved by the appointment of locums, where clinically appropriate, converting staff grade posts into Physician Associates, and employing very senior nurses to undertake a higher level of clinical work in order to support the consultant team. These approaches have been successful and we are keen to take these new ways of working into the post Covid environment. The pandemic response has also meant that clinicians from the medical specialties have been required to give an increased commitment to the general medicine rota, to share the workload. This pressure will not reduce until there can be a return to the non-Covid-19 on call rota, for which there is no timescale confirmed currently.

Children and Young Peoples (CYP) Services

In order to address pressures on services to safeguard children and their emotional wellbeing, and to ensure that families can access support and health care in a timely way, there has been no redeployment of CYP staff during this second wave. This has allowed CYP to maintain community services and contact for children and their families.

In terms of Child and Adolescent Mental Health Services (CAMHS), challenges exist in terms of increasing referrals and a backlog of mental health assessments and interventions. This is compounded by a number of vacancies and staff absences. The plan to deal with this involves the commissioning of external providers and initiating recruitment processes.

In the field of Neurodevelopment (ND), face to face observational assessments of children awaiting a ND diagnosis had to pause earlier in the pandemic, however these have recently re-commenced for some children. The plan is to restart initial assessments for all children during the first quarter of 2021-22. Providing post diagnosis support for children with Autism Spectrum Disorder (ASD) remains a challenge. This is being addressed via workforce and service planning to better align the service to the needs of children and young people. Commissioning of external providers jointly with CAMHS to support children with neurodevelopment needs and anxiety will also improve waiting times.

Therapies

There has been a backlog of new routine Outpatient Department (OPD) activity across all therapy services, with particular pressures in Physiotherapy as a result of Covid pressures. Additional resource, including locums, has been brought in to deal with this backlog, although sourcing locums has been difficult and there are challenges regarding available physical clinic space due to social distancing requirements. A number of patients offered virtual appointments, are choosing to wait for face to face appointments, which increases waiting times for those individuals.

In addition, there are follow-up backlogs in services such as Podiatry and Speech and Language Therapy in particular, and longer waiting times in general for non-reportable services such as orthotics. Steps taken to deal with these pressures involve each service having a recovery plan in place, focusing on improving the

position to return to the 14 week waiting time. The timescale for achieving this will extend into 2021-22.

As with many services, physical capacity is a significant restriction. Clinical and rehabilitation space has been lost as part of surge plans or due to the needs of other users such as primary care, in addition to the impacts of implementing social distancing requirements. Office space to support clinical teams in a safe socially distanced way is also limited.

Increased pressures on non-OPD services, for example due to redeployment of staff to work in the temporary Enfys hospitals or on the vaccination programme, have had a knock-on effect in terms of pressure on OPD services.

Oncology and Haematology

Both areas are experiencing pressures due to issues relating to consultant recruitment and long term sickness. These pressures are being addressed via recruitment of a locum haematology middle grade, a consultant clinical oncologist, and plans to introduce consultant/ advance practice therapy radiographers who can work at an enhanced level to support the clinical oncology consultant team.

Physical capacity is a significant restriction for oncology and haematology services, with both clinical and office space impacted by social distancing constraints.

Endoscopy

The endoscopic waiting times have increased significantly since the start of the pandemic. Initially, services were paused during the first wave in accordance with national guidance. Since the service has recommenced, the downtime between cases due to enhanced infection control requirements, have halved productivity. Staff redeployment to support respiratory services, has also created challenges to maintaining capacity in terms of medical and nurse staffing. In order to maximize the available capacity, the service has implemented changes to its ways of working, including

- adopting a pan-BCU system of working, to mitigate differential waiting times resulting from the varying levels of pressure on different sites
- the introduction of insourcing that has enabled a 7 day working model.
- the introduction of faecal immunochemical testing (FIT) to enable more accurate patient risk stratification.

Radiology, Neurophysiology and Audiology

Diagnostic waiting times for radiology, neurophysiology and audiology are pressured. In order to deal with this, backlog clearance plans have been developed and additional capacity has been put in place for 2021-22.

2. **How will you prioritise the delivery of non-COVID services to target reductions in waiting times?**

Planned care

The prioritisation of non-Covid-19 activity is undertaken via the primary targeting list and identifies specialties with the longest waiting times (as listed in question 1 above). The availability of theatre and outpatient capacity is the limiting factor, and whether or not the activity required is day case or in-patient - the former being easier to find capacity for during the Covid-19 surges.

Medical Specialties

Cancer patients, and other patients deemed to be urgent, are currently being seen as per Welsh Government and BCU guidelines. However, some urgent waiting lists are increasing as a result of the reduction in clinic capacity due to Covid-19 social distancing restrictions and long term sickness of staff. Work is ongoing on follow-up waiting list validations, with a view to reducing the number of patients whose follow-up appointments are overdue.

Children and Young Peoples Services

Some increased waiting time exist in CAMHS, and in Neurodevelopment assessments (there has also been a slight increase in waiting times for acute paediatric care, but these remain well within the target time). Patients within services categorises as ‘essential services’ are being seen, with clinical prioritisation in place and use being made of innovative ways of delivering care, such as virtual clinics. These support the reduction in waiting times and have proven successful in acute and community paediatric clinics where patients do not need to be seen face to face. Validation of follow-up waiting lists is ongoing in all children’s services with a view to bringing about a reduction in those waiting 100% beyond their target date.

Therapies

Therapies patients are being seen in accordance with the essential services framework. Clinical prioritisation of cases in all services is ongoing and virtual clinics are being used where possible. There has been a steady reduction in waiting times for new patients in most therapy services during quarters 3 and 4, except where the second Covid-19 wave impacted negatively on progress. Such as in North East Wales. All waiting lists have been validated throughout quarter 3 when routine outpatient services restarted.

Oncology and Haematology

As essential services, both Haematology and Oncology have continued to treat patients in line with Royal College guidance and as per Welsh Government and BCU guidelines. Clinical prioritisation of cases is in place, as is the use of virtual clinics. It is likely that Oncology will begin to see an increase in demand due to the reduction in GP urgent suspected cancer referrals during the early months of the pandemic, coupled with the pausing of screening and some diagnostic services .Patients are

expected to present will more advanced disease and the services are devising plans to increase capacity if required.

Endoscopy

Urgent patients and suspected cancer patients are being prioritised as per Welsh Government and BCU guidelines, however waiting times are longer due to the reduction in capacity due to the infection control constraints and staffing shortages referred to earlier. All endoscopy referrals are triaged and validated to ensure that alternative pathways are explored, such as imaging or further diagnostics to ensure that only patients meeting national guidelines are listed for endoscopy. The FIT testing underway is helping to risk stratify the most urgent patients. The additional insourcing capacity aims to reduce waiting as quickly as possible.

Radiology, Neurophysiology and Audiology

The additional capacity put in place in excess of demand will support the prioritisation of non-Covid-19 services to target reductions in waiting times.

3. **How will you communicate with patients about what they can expect in terms of length of wait, prioritisation, and any management of their condition whilst waiting?**

Planned Care

A pilot is currently underway, whereby the Health Board will be contacting the longest waiting patients, to understand their status. If successful, the intention is to continue with this approach for the majority of patients waiting. Programmes such as “escape from pain” are used to help patients manage their condition, and group outpatient activity and digital applications are being developed to support those waiting for treatment. The Health Board’s web site has been further developed, and will provide information on expected waiting times at specialty level.

Medical Specialties

The Health Board’s website is updated with the relevant information in relation to those services currently being delivered and we encourage patients to keep up to date via this route and via social media. The Patient Advice and Liaison Support Service (PALS) is also used. As part of the referral triage process, patient self-management advice is issued via GPs, where a patient falls outside of the urgent and cancer categorisation.

Children and Young Peoples Services

In addition to Health Board website updates, signposting information for practitioners and families relating to CAMHS and Neurodevelopment services is communicated

via the single point of access system. Each service also writes to families to inform them of current service pressures, revisions to services provision and to offer advice on how to access care and support. Self-help tools are available.
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Therapies

Whilst the Therapies do not routinely communicate with patients about the above, patients are advised to contact the service should their situation change or if they wish to enquire about their waiting time.

Oncology and Haematology

Whilst it is essentially business as usual for these services, there is regular communication with the North Wales Cancer Patient Forum and provision of updated information for their website.

Endoscopy
Updates are provided on the Health Board's website in relation to that which the Endoscopy service is currently delivering to cancer patients and other urgent cases. Patients are advised to contact the hospital or their GP if their condition changes. Self-management advice is provided via GPs to patients triaged as non-urgent.

Radiology, Neurophysiology and Audiology

Length of wait and other related information is communicated to patients mainly by letter, or in response to individuals making contact via PALS, switchboard, or links with GPs.

4. **What estimates or projections have you made of the time needed to return to the pre-pandemic position?**

Planned Care

The Health Board is currently undertaking a projections exercise by specialty and it is anticipated that this work will be completed by the beginning of March. The current estimation is 2-3 years, with the longest recovery being orthopaedics.

Medical Specialties

Work is underway with Informatics colleagues on the capacity plan for 2021-22. These plans are based on current Covid-19 delivery for at least quarters 1 and 2. Monitoring is ongoing to assess the appropriate point at which to increase capacity for a return to pre-Covid-19 levels. The exact timescale for this is currently unknown.

Children and Young Peoples Services

Capacity planning is ongoing within all services in order to make projections. The Welsh Government's Delivery Unit is providing training to support capacity and demand modelling for neurodevelopment services across North Wales. Additional capacity will be required in neurodevelopment services in order to tackle the backlog and return to the pre-pandemic position. Current team capacity meets the monthly demand, but not the additional pressures from the backlog of 472 cases.

Acute paediatrics capacity planning is underway to reduce waiting times to the pre-pandemic position of 12 – 18 weeks. Some recent improvement has been seen in the numbers waiting over 26 weeks.

Therapies

A capacity and demand exercise will be undertaken to identify the additional capacity that will be required to support reduction to the pre-pandemic position and clear the backlog. This capacity exercise requires clarity on the plans of other services that impact on the demand on therapy services, such as orthopaedics. High level projections indicate that with some additional capacity, it will be possible to return to pre-pandemic levels before the end of 2021-22.

Endoscopy

A detailed modelling exercise has been undertaken, where the impact of insourcing has been estimated, assuming Covid-19 persists for some time. A business case is being prepared to support the recruitment of substantive staffing to support a more sustainable service, with capacity that is aligned to the demand.
Insourcing will need to continue to support the endoscopy service into 2021/22 whilst recruitment is undertaken. It is anticipated that providing the business case and the insourcing is agreed, the waiting time will adjust to meet national waiting times by October 2021.

Radiology, Neurophysiology and Audiology

Estimates suggest that it will take 1 year to return to normal waiting times across these services.

5. **Are you using or considering any new or different approaches to providing care in order to help reduce waiting times, including the use of new technologies, new care pathways, or of capacity elsewhere?**

Planned Care

Alternative non-surgical treatments are being developed within specific specialties, such as the previously mentioned Escape from Pain programme, with more involvement of therapy services. Digital applications are also being explored in Orthopaedics to support or offer an alternative treatment. For the longer term, a

strategic outline case is under development, for the introduction of a diagnostic and treatment centre (DTC) approach.

Medical Specialties

Work is underway on validation of the follow-up waiting list (with the exception of Endoscopy) with the aim of reducing the 100% overdue waits to the 35% target set by Welsh Government. This target has been achieved in Care of the Elderly and Rheumatology, with Dermatology reducing weekly. Endoscopy waits are currently increasing due to service pressures and consultant long term sickness absence.

Suspicion of sepsis (SOS) and patient initiated follow-up (PIFU) has been introduced across medical specialties to support the reduction of the follow-up waiting list.

The transfer of care of patients has taken place between acute sites and community hospitals in order to better utilise capacity across the system, such as the transfer of urgent Rheumatology patients from Wrexham Maelor Hospital to the Holywell Community Hospital clinic.

The use of Attend Anywhere video consultations has been trialled and the use of ‘P’ prioritisation codes has been employed for Dermatology minor outpatient procedures. Telephone clinics have been introduced across a range of specialities and are generally working well.

As referred to earlier, different approaches have been taken to tackling staff capacity issues, such as converting staff grade doctors into Physician Associates, and up-skilling very senior nurses to enable them to undertake a higher level of clinical work to support the consultant team. A Rheumatology Clinical Lead has been appointed, and this role will support a ‘once for BCU’ approach.

Children and Young Peoples Services

CYP services have implemented Attend Anywhere and telephone clinics. This has proven successful, particularly for follow-up patients. Initial feedback from families regarding this change to practice has been positive. The use of virtual platforms for consultations is becoming more acceptable and as well as supporting the control of waiting lists, is having some impact as regards reduced travel times and more efficient use of clinician time. Face to face interactions in person are still provided in a Covid-19 secure manner, where required.

In working through the follow up waiting list validations, particularly within community paediatrics and CAMHS, consideration is being given to alternative care pathways, involving the third sector as appropriate.

Therapies

New technologies have been embraced in therapy services. Digital technology has enabled Therapies to offer both telephone and video consultations between Allied Health Professionals and their service users.

New care pathways are being developed to ensure the best service provision, such as the dietetic pathways developed in association with nutrition and pharmacy teams to ensure patients who have been affected by Covid-19 receive the nutritional support they require.

Oncology and Haematology

Telephone clinics are being utilised and are working well.

Endoscopy

As previously mentioned, the introduction of FIT testing has enabled patients to be risk stratified and where appropriate, placed on different treatment pathways, other than endoscopy, reducing demand for endoscopy and improving patient experience.

Radiology, Neurophysiology and Audiology

Virtual telephone clinics are being employed and in Radiology, most consultants can now report from home with dedicated workstations.

6. **What factors may affect your plans for tackling waiting times (e.g. further spikes in COVID-19 rates, issues with the workforce or physical capacity), and what plans you have in place to manage these?**

Planned Care

There are many factors that will affect plans - predominantly escalation areas within theatres and recovery units. Staff redeployment and the ability to move colleagues back as soon as the pandemic will allow, will be important to enable a return to normal working. Also, staff fatigue following the pandemic, and the need to take annual leave will impact. The delivery of essential services and tackling backlogs will require further capacity in the short–term. The Health Board is exploring the procurement of three extra theatre and modular wards, staffed by a blended model using insourcing to provide the extra capacity. Capacity modelling is ongoing.

Medical Specialties

Capacity plans for 2021-22 are based on a number of assumptions that include the clinical and operational workforce, the OPD physical footprint and nursing support remaining the same, and the continuation of running clinics at current capacity. Any changes to these variables will impact on the capacity we can deliver. Any further spikes in Covid-19 may impact on the clinical workforce. Plans to appoint to permanent roles and locum vacancies will assist in managing waiting times.

Children and Young Peoples Services

A high vacancy factor in some elements of the service is impacting on waiting times, although the recruitment of staff to these existing vacancies is beginning to improve. Capacity plans for 2021-22 are based on a number of assumptions, therefore any changes to the variables will impact on the capacity to deliver. Any further spikes in Covid-19 may impact on the clinical workforce and the physical footprint of children's services. Surge planning is underway and discussions ongoing around relocation of existing services to ensure continuation of clinical capacity for essential services.

Therapies

Different demands will impact on different therapy services.

• All services will feel the impact of social distancing on their physical clinic capacity. Some services are more affected by the rates of Covid-19 in the community and in the acute hospitals, for example, there is more demand for physiotherapy input in the acute setting which has resulted in staff being moved from outpatient settings to cover this demand.

• Some staff are shielding; these staff are continuing to work from home and are key to the ongoing video and telephone consultations.

• Locum staff will continue to be sought where financial approval is in place.

• All service leads are proactively recruiting staff to any vacancies and are all engaged in the streamlining process which should ensure new graduate are available for posts later in the year.

• Physical capacity has been affected by social distancing and other constraints; there is no venue for outpatient physiotherapy services in Wrexham at present. A business case has been developed to identify an alternative solution.

• Rotas are being adapted as much as possible with some staff working longer days and weekends. Where social distancing is an issue, access to office areas is staggered to ensure compliance.

• All services are flexing to ensure that capacity is used to its optimum – where services can continue, they are doing so, where services have been reduced the service leads are monitoring the competing demands carefully and will redeploy staff as appropriate.

Oncology and Haematology

Capacity plans for 2021-22 are based on a number of assumptions remaining the same, although there are concerns that more patients will be presenting with later stage disease and this may require additional capacity within Oncology, as explained earlier. Changes to variables upon which planning assumptions are based will impact on the capacity to deliver. Any further Covid-19 spikes will inevitably have a negative impact.
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As with other services, Oncology and Haematology will feel the impact of social distancing on their physical clinic capacity. Some staff are shielding and continuing to work from home, and are key to the ongoing video and telephone consultations.

Active recruitment is underway where there are vacancies and there is engagement in the streamlining process which should ensure new graduates are available for posts later in the year. Rotas are being adapted as much as possible and all services are flexing

Endoscopy

The ongoing impact of the pandemic is resulting in capacity reductions due to redeployment of staff and reduced productivity. The insourcing companies alluded to earlier have experienced some issues with staffing their patient treatment lists due to workforce availability. Such issues inevitably impact on waiting times.

Radiology, Neurophysiology and Audiology

The lack of physical space due to Covid-19 restrictions is a significant issue in tackling waiting lists. A further wave in autumn/winter 2021 would prove challenging and would be likely to impact on plans to clear the backlog.

7. **What information have you received on your allocation from the £30m additional funding for waiting times, and how you intend to use the funding?**

The Health Board has received confirmation of its allocation for urgent and emergency care priorities of £4.9m, which has been provided for four specific areas:
- Enhancing delivery of Emergency Care, Same Day Emergency Care, Urgent Primary Care Pathfinder and Discharge to Recovery and Assess.

Conclusion

It is hoped that the responses provided are helpful to the Committee in ascertaining the current situation. The Health Board is fully committed to tackling its waiting times, for the benefit of the patients it serves. Optimum use will be made of new ways of working and the additional funding received, as part of concerted efforts to return to the pre-pandemic position.

HYWEL DDA UNIVERSITY HEALTH BOARD'S WRITTEN EVIDENCE to the HEALTH, SOCIAL CARE & SPORT COMMITTEE

Date of Submission: 16 February 2021

1. Hywel Dda University Health Board (the Health Board) welcomes the opportunity to contribute to the Health, Social Care and Sport Committee's inquiry into the impact of COVID-19 on services.

2. The Health Board is submitting this written evidence in advance of its attendance at the Committee meeting on 24 February 2021.

3. Steve Moore (Chief Executive) and Andrew Caruthers (Chief Operating Officer) will attend the meeting (virtually) to respond to the Committee's questions.

About the Organisation

4. The Health Board is responsible for the health and well-being of its resident population and plans, provides and oversees delivery of NHS healthcare services for people in Carmarthenshire, Ceredigion, Pembrokeshire and its bordering counties. Our 11,000 members of staff provide primary, community, in-hospital, mental health and learning disabilities services for around 384,000 people across a quarter of the landmass of Wales. We do this in partnership with our three local authorities and public, private and third sector colleagues, including our volunteers.

An overview on our response to the COVID-19 PANDEMIC

5. The Health Board provided the Committee with an overview of its response to the COVID-19 pandemic at a Committee meeting held on 10 July 2020; this evidence provides an update and addresses the questions raised by the Committee.

What are the main areas of pressure, and what plans do you have in place to deal with these?

6. As the COVID-19 pandemic has progressed from the first wave during the spring and early summer of 2020 through to the rise of the second wave during the later autumn and winter period of 2021, rising COVID-19 infections and seasonal emergency pressures have resulted in increasing pressure on our local health and social care capacity, characterised by:
   - Increasing volumes of emergency COVID and non-COVID patient demand, including increased winter demand; and critical care pressures
   - The significant impact and continuing legacy of COVID-19 nosocomial transmission rates on acute and community hospital capacity
   - Severe deficits in available nurse staffing resources due to the combined impact of vacancies and COVID related absence
   - Significant reduction in care home and other community based service capacity with a resultant adverse impact on discharge pathways

- The unavoidable impact of national guidance regarding safe discharge of patients to care homes during the pandemic period which, whilst helping to limit the spread of infection within care homes, has further limited discharge flow across the health and social care system
- Staff vacancies and COVID related absence (including shielding)
- Social distancing guidance (reduced physical capacity)

7. During periods of peak pressure, our acute hospital sites across Hywel Dda have consistently operated at the highest levels of emergency pressures escalation, with resultant lengthy delays in ambulance handover, emergency department waiting times and the volume of patients awaiting discharge. During December 2020 and early January 2021, our acute and community hospital sites treated the highest volume of inpatients with confirmed COVID-19 since the onset of the pandemic.

8. Continuing uncertainty regarding the impact of the new variant of concern (plus any other new variants that may emerge) and the anticipated easing of current restrictions through the remaining weeks of this year, poses significant challenges to accurate scenario planning, particularly beyond the summer. As the second wave of the pandemic has progressed, our modelling scenarios have deviated significantly from the original assumptions that underpinned our initial planning. Whilst community incidence and COVID related hospital admissions continue to show a downward trend since the introduction of the national lockdown measures, we also continue to experience a significant impact on extended length of stay (reflective of system-wide pressures across our community and care sector) and resultant bed occupancy levels, which are also impacted by periodic outbreaks across our hospital sites.

9. We are working locally on what an increase to the Rt level following a release of restrictions through February and March 2021 looks like ahead of the summer, and expect a continuing level of COVID demand that is in excess of the levels we saw during the first wave in Hywel Dda. Non-COVID demand currently appears to have stabilised at a level lower than we saw prior to the pandemic. However, when COVID demand is added, our overall emergency demand looks much like it would do normally. Therefore, we are expecting our overall emergency demand to continue at similar levels to what we saw pre COVID, with the key difference being the proportion of COVID to non-COVID activity within it.

10. Coupled with an assumption that for the remainder of the year ahead, social distancing measures must remain in place with subsequent impacts on useable capacity, our planned care recovery capacity assumptions for Q1/2 of 2021/22 therefore broadly reflect those set out in our previous 2020/21 Q3/4 plan. These anticipate the continuing challenges we expect to face in managing COVID and non-COVID related demands on our system in the months ahead, whilst endeavouring to protect ‘Green’ planned care pathways on each site, all against the backdrop of a significant and sustained staffing challenge.

11. During the pandemic, our service planning and response has been guided by Welsh Government (WG) guidance for the prioritisation of essential services: https://gov.wales/nhs-wales-COVID-19-operating-framework-quarter-2-2020-2021). More latterly during the peak of the second wave, the NHS Wales Health and Social Care Department Local Options Framework provided organisations with the flexibility and support to respond to increasing service pressures, by maximising the use and deployment of our workforce resources to support COVID and other essential emergency pathways.

How will you prioritise the delivery of non-COVID services to target reductions in waiting times?

Risk Stratification

12. Clinical teams continue to assess and prioritise all existing and new patients, taking into account length of wait and clinical urgency, including suitability for virtual or F2F appointments.

13. Our teams follow a risk stratification model, supported by NHS Wales and the Royal College of Surgeons, which categorises patients according to five levels of urgency:
    - 1a – Emergency (< 24 hrs)
    - 1b – Urgent (< 72 hrs)
    - 2 - < 28 days / 4 weeks
    - 3 - < 92 days / 3 months
    - 4 - > 183 days / 4 months

14. As reflected above, our planned care recovery capacity assumptions for Q1/2 of 2021/22 broadly reflect those set out in our previous 2020/21 Q3/4 plan. These anticipate the continuing challenges we expect to face in managing COVID and non-COVID related demands on our system in the months ahead whilst endeavouring to protect 'Green' planned care pathways on each site, all against the backdrop of a significant and sustained staffing challenge.

Recovery Planning – Q1/2 2021/22

15. Work to re-start elective surgery has been in train since June 2020. During the summer/ autumn period, significant progress was achieved in recovering cancer pathway surgical backlogs, which had developed earlier in the pandemic, reflecting our commitment to ensure patients most in need of treatment were able to access care in a timely way.

16. With the rise of the second wave during the later autumn and winter period, along with amalgamation of seasonal pressures, rising COVID-19 infections and necessary adjustments to working practices, our planned care response for urgent and cancer pathway patients was significantly restricted over the Christmas/New Year period. The pressures we experienced necessitated us applying the Welsh Government Local Options Framework of actions to prioritise resources for COVID and other essential emergency pathways.

17. Throughout the pandemic, we have temporarily secured additional local independent sector capacity, although access to this supplementary capacity has reduced following the cessation of the All Wales approach to commissioning of independent sector providers. Through our local negotiations, we have managed to retain around 40% of the facilities capacity to support our planned care activity.

18. Physical capacity and staff availability are the key determinants of our ability to deliver safe, sustainable, accessible and kind elective care. In assessing our four acute sites, it is evident that it is not practical for the Health Board to provide a protected 'Green' Site in the short-medium term, as we face significant geographical challenges in rebalancing emergency flows, and limitations in our ability to provide supporting site-specific critical care capacity.

19. Limits to staffing resource both in theatre and post operatively, was a challenge before COVID. The additional factors of providing separate staffing teams for Red and Green areas is an added challenge and has shaped the model of provision suggested on each site. It is evident that our realisable capacity in the short term will not match that available prior to March 2020.

20. The plans we have outlined do however reflect the maximum capacity we can achieve within the footprint of our existing hospital sites, particularly during the first half of 2021.

Medium Term Recovery Plans

21. It is clear that in order to address the backlog on non-urgent cases that have developed through COVID, a different approach will be required. With this in mind, we are developing proposals for a modular solution at our Prince Phillip Hospital site, which is designed to further enhance our ability to provide protected 'Green' pathway capacity for planned care patients.

22. The proposed solution is for two Day Surgical Theatres (with Laminar Flow capability) and a Dual-Endoscopy Suite. The proposal, which is currently in draft stage and is unlikely to be operational before Q3 2021/22, would enable an approximate increase of up to 5,000 patients per annum beyond our current plans. The benefits are threefold:
    - All appropriate Orthopaedic day cases can be carried out in a dedicated DSU laminar flow theatre, ultimately freeing space in main theatres and Trauma and Orthopaedics ward to treat a greater number of inpatients. Demand in the facility can be utilised to create revenue for the Health Board and elevate the Orthopaedic department as a go to location in Wales.
    - Increased Endoscopy sessions will result in a higher number of patients treated within a facility fit for purpose.
    - The vacated departments within the main hospital site can be utilised for an array of opportunities; for example, a dedicated Urgent Suspected Cancer ward and/or a relocated Critical Care Unit.

23. The Business Case to implement these proposals is in development and will be discussed with Welsh Government in March 2021, as part of the Recovery Plan.

Regional solutions

24. As part of the Annual Plan for 2021/22, we are continuing to develop the key priority areas we will be looking to take forward with Swansea Bay University Health Board in particular. One priority area is our regional approach to cataract surgery.

25. Both Health Boards have historically had significant gaps between capacity and demand for cataract surgery, which was previously managed through high levels of outsourcing to private sector organisations using non-recurrent funding. The impact of severely reduced theatre activity during the COVID pandemic has worsened the position to the point where traditional solutions to lengthy and high volume waiting lists are insufficient and undesirable. Welsh Government has tasked all Health Boards to rapidly develop their recovery plans for cataracts.

26. The Ophthalmology departments of both organisations have over the past two or three years worked closely in several sub-specialty areas to develop a more regional approach, with a view to ensuring long-term sustainability for both populations. Key clinicians and management leads are committed to working collaboratively on solutions to resolving the cataract backlog and maximising the efficiency and productivity of the cataract services in both Health Boards.

27. We believe that the current circumstances lend themselves to the development of dedicated high-volume efficient cataract facilities serving both populations. The clinical and management teams intend to:
    - Undertake an assessment of current facilities and productivity and rapidly assess whether there is scope to significantly increase activity on each of these sites.

- Undertake an option appraisal of potential locations across both Health Boards for additional theatre(s) dedicated to the delivery of high-volume cataract lists.
- Develop a workforce plan to support the increased activity, which supports registered and non-registered staff working at the top of their license.
- Develop medium-term (recovery) and long-term (sustainability) capacity plans on a regional basis.

How will you communicate with patients about what they can expect in terms of length of wait, prioritisation, and any management of their condition whilst waiting?

Risk Stratification

28. Clinical teams continue to assess and prioritise all existing and new patients, taking into account length of wait and clinical urgency, including suitability for virtual or face-to-face appointments. Our teams follow a risk stratification model referred to in clause 13 above

Keeping in Touch with our Patients

29. During the pandemic and to date, we have adopted a number of approaches to achieve regular contact with our patients, these include:
    - Formal communication with long waiting orthopaedic, surgical and paediatric patients
    - Large scale validation of patients awaiting follow-up care
    - Digital updates via our intranet and social media
    - Ongoing roll-out of PROMS systems (patient-reported outcome measures) for orthopaedic patients
    - Four weekly review of patients on cancer pathways, by tumour site specific specialist nurses

Cancer Helpline

30. At the start of the pandemic, we established a telephone helpline for concerned cancer patients, staffed by the Oncology Clinical Nurse Specialist (CNS) Team to provide advice and support. A patient information leaflet for cancer patients, including helpline numbers, was developed and widely circulated. The helpline has been supplemented by a supporting communications strategy, including several social media video releases providing advice/information and any relevant links for patients. These included contributions from cancer patients currently undergoing treatment who shared their experiences during the pandemic. These activities have also been supported by our Macmillan GP Leads to encourage patients to attend their GP practice if they have any worrying symptoms.

Single Point of Contact (SPOC)

31. A Command Centre was set up as part of the COVID-19 response, to provide staff with a single point of contact, and has proven capable of receiving and responding to queries in a timely way through phone and email. Patients contacting the Health Board have multiple pathways to services, such as switch boards or direct service numbers with varying levels of call response due to the type of call handler. Switch boards are set up to transfer calls and not to provide information and advice.

32. Elective care waiting lists have been affected by COVID-19. There is currently no systematic process in place to contact, or receive calls from, patients who may be waiting and needing advice or assistance to prevent deterioration. However, the Planned Care Team has adopted a process for clinical risk assess of patients on waiting lists as guided by Welsh Government, using the recently developed risk stratification.

33. There are circa 30,000 patients on an elective waiting list. Those patients identified as high priority are clinically risk assessed with the expectation that those at high risk would be contacted directly by the responsible consultant team. Patients who have been booked and given a date for surgery whose treatment was then delayed due to the stepping down of elective pathways due to operational pressures from COVID, have been contacted directly by the responsible consultant team.

34. In order to effectively develop the personalised single point of contact strategy for the significant number of patients that have been identified as routine (Risk category 3 and 4 in current Welsh Government guidance), and who would not be covered under the direct contact described above, a system to develop a contact and response service that meets their individual needs is to be designed.

35. Orthopaedic Services have been identified as the initial pilot service for this work and will shape the initial development of the Single Point of Contact prior to other services being brought into the programme. The Planned Care Team has identified Otorhinolaryngology and Ophthalmology services to be the next services to be included in the programme. To date in line with the British Orthopaedic Association guidance, Orthopaedic Consultant teams have considered those who are on their waiting lists and have made contact with patients directly. By the end of January 2021, patients on an Orthopaedic waiting list within Hywel Dda will have received a letter, which will be followed up in February 2021 with a single point of contact offer to all patients waiting for hip or knee surgery. This will allow the Health Board to understand the demand and develop a robust response mechanism for all contacts by the end of March 2021.

36. This will be a pathfinder for roll out to other specialty routine waiting list cohorts during 2021/22, informing and shaping the development of the COVID Command Centre and its transition to the Hywel Dda Communication Hub.

37. A programme structure has been established to take this work forward. The oversight group meets bi-monthly, led by the Director of Nursing, Quality and Patient Experience and the Director of Operations. The Steering Group led by the Assistant Director of Quality Improvement, supported by Senior Transformation and Planning colleagues, meets monthly and has undertaken an initial baselining within the Orthopaedics service through working groups. The group is scoping potential digital platforms that can support the development of the Single Point of Contact. Work to scope the current call handling functions across the Health Board will be undertaken by the Command Centre Working Group, with an aim to provide a report to the Steering Group by the end of February 2021

What estimates or projections have you made of the time needed to return to the pre-pandemic position?

38. Based on our current plans for the remainder of Q4 this year, we anticipate our predicted end of year deficit against the 36-week referral to treatment target to be in excess of 26,000 patients. Unsurprisingly, the largest contributors to this position are Trauma and Orthopaedics, ENT and Ophthalmology.

39. The forecast end of year position for 2021/22 will be dependent on our finalised Annual Plan for next year, but also the impact/implications of any national strategies and workstreams that emerge over the period.

40. In parallel with all health boards, we are currently developing our planning scenarios of the timeframes required to restore planned care services to the levels achieved pre-pandemic. There are several variables that influence this work, including the future course of the pandemic, assumptions around length of stay, staff absence and an understanding of future non-COVID demand. Other factors that will influence these timelines will also include allowances for staff recovery post pandemic, supporting the wellbeing of frontline teams and the impact on our intensive care and respiratory services, which are likely to extend beyond other elements of the system.

41. Our modelling work will also take account of any long-term requirements for adaptations to our physical capacity undertaken during the pandemic, workforce challenges and alternative pathways for appropriate patients. We are equally working with neighbouring health boards to share our demand and capacity assumptions and gaps to support regional discussions.

42. A further key component of our planning for sustainability is recognising the potential for unknown demand in our communities, as well as restoration of preventative programmes for long-term conditions.

43. Whilst it is difficult to be definitive about the forecast timescales for recovery given the number of influencing variables, it is increasingly likely that full recovery for some specialties that are heavily dependent on surgical interventions will be measured in years, whilst other less complex pathways may be recoverable over a shorter timescale.

Are you using or considering any new or different approaches to providing care in order to help reduce waiting times, including the use of new technologies, new care pathways, or of capacity elsewhere?

Outpatient Transformation

44. In responding to challenges posed by the pandemic, the Health Board has adopted a range of new approaches to the delivery of outpatient care, as reflected in our Outpatient Transformation Plan published in April 2020. As we look forward to recovery of planned care pathways through 2021, the Health Board is mindful that future increases in the number of referrals received and increases in outpatient activity have the potential to create new demand for new and follow up care. We are working closely with our clinical teams to adopt new and innovative approaches to care delivery to mitigate the risk of further increases in the total number of patients awaiting care.

45. In March 2020, only 1% of outpatient activity was delivered via virtual methods. The pandemic created an environment where a change in practice was necessary. As of January 2021, 28% of outpatient activity was delivered via a virtual method; of those appointments delivered virtually, the median for new appointments was 27% and for follow up appointments this was 73%.

46. Activity to support the ongoing work to achieve the reduction in follow ups continues with a focus on working differently. The pandemic has presented an opportunity to rapidly deploy virtual consultation methods and encourage clinical teams to carefully consider options for reviewing patients virtually, than automatically booking patients into be seen face-to-face or cancelling appointments; encouraging a change in clinical behaviour.

47. Activity is monitored closely and all Out Patient Department activity is regularly challenged in order to ensure that there is a continued focus on promoting and encouraging the use of telephone and video consultations.

See On Symptom (SOS) and Patients Initiated Follow UP (PIFU)

48. The Health Board implemented the use of SOS in the autumn of 2019. In October 2020, an update was made to the Welsh Patient Administration System, which supported the ability to also manage patients using PIFU; providing a safe solution for managing and empowering those patients with a chronic/lifetime long condition.

49. All scheduled care services are encouraged to utilise SOS and PIFU. Targeted resources have been deployed to those specialities where it is anticipated this option could be more widely utilised. As of December 2020, 4,516 patients had been reviewed and placed on an SOS/PIFU pathway. This represented 6.65% of the total Follow-Up Waiting List, with plans in place to increase coverage towards 20% in the months ahead.

Stage 1 reviews: validation of the waiting lists

50. As indicated above, the number of referrals received during 2020 was affected by the pandemic. The need to support frontline activity and redirect staff across the organisation resulted in a reduction in the number of new patients being seen in the Out Patients Department, receiving treatment and being put onto a Follow-Up pathway. A snapshot review in January 2020, shows the number of patients waiting for a first Out Patient Department appointment before the onset of the pandemic was 37,516. By January 2021, this had grown to 46,005 as the pandemic impacted by the reduction in outpatient activity and need to focus services on those in need of urgent care/cancer pathways.

51. In January 2020, there were a total of **227** patients waiting over 36 weeks or a first appointment. By January 2021, this had increased to **15,329**. In January 2020, there was only one patient waiting over 52 weeks for a first appointment. By January 2021, this figure has sadly increased to 7,817**.**

52. Clinical teams continue to be encouraged and supported to utilise virtual consultations where possible. In some services, new referrals are being identified at triage as suitable for virtual or face-to-face, and ensures patients are booked into the correct clinic. This also identifies patients suitable for straight to test/one stop from point of referral; for example, Dermatology, Cardiology and Respiratory. Service teams continue to rag rate all stage 1 waits starting with longest waits and urgent cases, confirming clinical conditions and suitability for virtual or face-to-face appointment.

Video Group Clinics

53. A number of services and specialities are utilising video platforms to deliver various group activities to support and care for patients:
    - Therapies
    - Pain Management
    - Dementia care
    - Diabetes
    - Children's language & speech Therapy service
    - Heart failure care
    - Dietetics
    - Neonatal therapies
    - Various patient education programmes

54. Work to expand delivery continues and we are currently exploring if Consultant-led group consultations are possible.

Outpatient Strategy

55. Work will continue to our approach to deliver services differently and maximise the use of digital tools. The impact of the pandemic will be felt for some time to come and therefore our services and systems must adapt and change in order to find alternative ways of delivering care to patients what have been waiting.

56. Additional resources have been secured in order to support the transformation work at pace with the following workstreams:
    - Digital innovation has been a key part in the delivery of outpatient services during COVID. Working on the assumption clinicians are undertaking 'face to face' consultations for the most urgent cases only, and to endorse new ways of working as set out by WG, the health board continue to rollout digital services, including virtual clinics, SOS and clinical validation:
        - Consultant Connect - immediate phone advice to teams of NHS consultants. The service is accessible through an app and it will provide a single point of access to specialist advice
        - Attend Anywhere – video consultation process that will provide a virtual video consultation for patient and clinician
        - Microsoft Teams/Booking App – already established within the Health Board and being rolled out to support group consultations
        - Patient Knows Best - a patient portal to share and exchange health information, which empowers patients to manage their health.

57. These services are a key element within the Welsh Government's national Outpatients Strategy and have the potential to transform the way we manage outpatients in the future, as well as supporting patients during the current pandemic. The Health Board continues to roll out digital services to enable remote diagnosis, therefore reducing unnecessary hospital attendance, in particular for shielding and vulnerable individuals.

E-Referrals

58. Those services that are receiving electronic referrals have been configured to now enable the receiving clinician to indicate the preferred consultation method, enabling services to manage face-to-face and virtual booking processes more effectively, and only using face-to-face outpatients' slots where necessary. This also identifies patients suitable for straight to test/one stop from point of referral. There are four services that require this update to the system, which is in progress. Those services that are not yet receiving referrals will have this update added during configuration.

What factors may affect your plans for tackling waiting times (e.g. further spikes in COVID-19 rates, issues with the workforce or physical capacity), and what plans you have in place to manage these?

Our Planning Scenarios and Assumptions

59. We are working locally on what an increase to the Rt level following a release of restrictions through February and March 2021 looks like ahead of the summer, and expect a continuing level of COVID demand that is in excess of the levels we saw during the first wave. Non-COVID demand currently appears to have stabilised at a level lower than we saw prior to the pandemic. However, when COVID demand is added, our overall emergency demand looks much as it would do normally. Therefore, we are expecting our overall emergency demand to continue at similar levels to what we saw pre COVID, with the key difference being the proportion of COVID to non-COVID activity within it.

60. Coupled with an assumption that for the remainder of the year ahead that social distancing measures must remain in place with subsequent impacts on useable capacity, our planned care recovery capacity assumptions for Q1/2 of 2021/22 broadly reflect those set out in our previous 2020/21 Q3/4 plan. These anticipate the continuing challenges we expect to face in managing COVID and non-COVID related demands on our system in the months ahead, whilst endeavouring to protect 'Green' planned care pathways on each site, all against the backdrop of a significant and sustained staffing challenge.

Organisational Capacity Plans

61. Hywel Dda has continued to track COVID and Non-COVID demand as well as review its modelling scenarios to take into account new thinking at a national Wales and UK level. As the pandemic has developed, we progressed our local plan to establish additional field hospital capacity, to supplement the capacity we have available in our acute and community hospitals.

62. We are continuing to provide field hospital capacity through two sites across our three counties; Ysbyty Enfys Selwyn Samuel in Carmarthenshire, and Ysbyty Enfys Carreg Las (Bluestone) in Pembrokeshire.

Organisational Workforce Plans

63. Workforce remains central to our response as we move forward to enable recovery from the pandemic, reset of services and enable resilience within our current and future workforce. We continue to maintain scrutiny through the Workforce Bronze Command group linking directly to the Silver Command. Regular interface also continues with the other Bronze Command groups and also through the Bronze Chairs group, in order to ensure appropriate linkage and consistency of approach in relation to dialogue and communications.

64. The Staff Psychological Well-being service continues to deliver existing services addressing team well-being, supporting managers and staff and providing one to one psychological support. Investment has been made in our in-house counselling provision with an expansion of the team, as well as the continuation of our Employee Assistance Programme delivered through Care First. This is also now being extended to Primary Care. We are contributing to the evidence base for well-being at work through participation in appropriate research studies in collaboration with neighbouring universities.

65. Work has been done to progress a submission to access £242k funding from NHS Charities and it all focuses on initiatives and programmes to support staff well-being, both physical and psychological. For example, a development programme and network for health and well-being champions; a lifelong learning recovery and restoration educational fund; outdoor green gyms; bereavement counselling support; and arts and well-being activities for staff.

66. Due to the need to support those members of staff who are clinically extremely vulnerable to be at home, working whenever possible, we have put in place line managers briefings and peer support services to support their mental health and well-being, and to mitigate any potential feelings of isolation and disconnection from the workplace. Conversations at Board level are being held to enable our staff to build resilience as we move into year two of the pandemic; these include how we help our staff to rest and recover and recuperate, especially important as the organisation moves to reset its services moving forward.

67. Other significant activities are in progress to maintain and develop workforce supply internally and externally; managers have been encouraged to ensure vacancies in the budgeted establishment are stabilised by continuing with recruitment in the normal way via TRAC. We are recruiting up to establishment for Health Care Support Workers and Facilities posts, in order to provide stability in these areas. Managers are also leading on opportunities to increase the hours of part time staff and options for overtime hours when necessary.

68. A robust campaign was initiated for Registered Nurse recruitment, including extensive social media advertising, radio, newspaper and Nursing Times advert.

What information have you received on your allocation from the £30m additional funding for waiting times, and how you intend to use the funding?

69. The Health Board believes that the £30m referenced by the Committee related to unscheduled and emergency care funding, which was included in the Winter Protection Plan and formed part of the NHS stabilisation funding package announced in August last year. The Health Board received its share of this funding, as part of a wider package of support for this year in response to COVID-19 and winter; this was used to support services and provide resilience in emergency care services over the winter period.

Mass Vaccination Programme Delivery Plan

70. The Health Board recently approved its Mass Vaccination Programme Delivery Plan. The aim of the Mass Vaccination Programme is to protect those who are at most risk from serious illness or death from COVID-19, and to deliver the vaccine to those who are at risk of transmitting infection to multiple vulnerable persons or other staff in a healthcare environment. Based on the advice from the Joint Committee on Vaccination and Immunisation (JCVI), the Health Board aims to reach all its population in Priority Groups 1 to 9 by the spring (over 50s and those with a chronic condition), with a first dose, and completed a second dose vaccination where due.

71. The Health Board met the 15 February 2021 vaccination deadline to vaccinate Priority Groups 1 to 4 (over 70s, Older Adult Care Home residents and staff, health and Care frontline staff and those clinically extremely vulnerable (shielding)).

72. The Delivery Plan was received at Board and scrutinised at Committee recently. Our broad approach is to use a network of six Mass Vaccination Centres (MVCs) to deliver the Pfizer vaccine to discrete Priority Groups, and deploy the Oxford/AstraZeneca vaccine to all 48 local GP practices. This model balances the differing logistics of the two vaccines with our rurality and need to get to and reach our isolated communities. It also provides sufficient capacity to ensure we can vaccinate all Priority Groups 1 to 9 by the spring and give second doses as required, assuming sufficient supplies.

73. Delivery and oversight of the plan is embedded in the Health Board's Command structure, with Bronze Command focusing specifically on delivery.

Testing

74. The demand for testing remains manageable. Contact tracing continues to work effectively and the reduction in case numbers is supportive of this. Welfare checks are being undertaken with regard to travellers returning from the 13 countries currently on the Government list.

75. In additional to PCR testing capacity, routine asymptomatic testing of patient-facing staff using lateral flow devices is being implemented within the Chemotherapy Team and is also being offered to other sites when required.

Conclusion

76. Health Board executives are looking forward to the opportunity to discuss the above, and any other areas of interest to the Health, Social Care and Sport Committee, at the forthcoming scrutiny session.

Health, Social Care and Sport Committee
Cwm Taf Morgannwg UHB Written Evidence

Purpose

This written evidence provides feedback to the Health, Social Care and Sport Committee in relation to the ongoing inquiry into Covid-19.

1. **What are the main areas of pressure, and what plans do you have in place to deal with these?**

The prevalence of covid-19 in the community has widespread and inter-dependent consequences on the health and wellbeing of our population, on our staff and partners and on the quality and effectiveness of our services.

The key areas of challenge in responding to the Covid-19 pressures relate largely to our ability to deliver a response to the significant numbers of critically ill patients at times of high prevalence, whilst establishing and delivering multi-agency vaccination, surveillance and testing programmes and transforming an extensive range of health and care services across Cwm Taf Morgannwg (CTM) communities so as to provide the best service we can to the most people in the covid-19 operating environment.

Service capacity to manage the demands presented by Covid

Since the significant increase in Covid-19 cases across CTM in September 2020 and an increasing number of outbreaks across a range of premises, a Regional Incident Management Team has been operating as part of the Communicable Disease Outbreak Plan for Wales, July 2020. This meets weekly at present and through its work aims to protect public health by identifying sources of outbreaks and implementing necessary measures across CTM to prevent further spread of infection.

Cwm Taf Morgannwg University Health Board (CTMUHB) has a 3C structure, with the all three levels of Command and Co-ordination Strategic Tactical and Bronze levels in place, supported by a co-ordination hub across the structure.

An agile, multi-agency approach, using real time data and trajectories, has supported the effectiveness of the Test, Trace & Protect programme. The Lateral Flow Testing programmes have demonstrably resulted in many local increases being stemmed within 3-7 days of them having occurred.

Similarly, real time data and scenario planning has been used at the tactical and operational level to inform decisions ranging from the likely

demand for testing and personal, protective equipment (PPE) kit to the daily number of ward and critical care beds required in each of our localities and in our field hospital, Ysybyty'r Seren, in Bridgend. This data is shared widely with our partners. Embedded is the daily Health Board Covid-19 Hospital surveillance report as of 12th February 2021.

CTM_Covid_Hospital_
Surveillance_Report_ε

Whilst we were therefore prepared as a region for the levels of demand for critical care and ward beds that we experienced, the challenges in meeting the requirement to operate 40 additional critical care beds (c.133% of 'normal capacity') for covid-19 patients in addition to providing critical care services for non-covid-19 patients have been significant. It is testament to our many clinical, operational and support teams, and the wider clinical network, that we were able to meet the needs of our most sick patients effectively and prioritise those with urgent needs. However, the challenges in responding to covid-19 have demonstrated that some of our key services have significant sustainability challenges. As explored further in the workforce section, we need to take swift action to address these pressure points.

There are similar challenges and areas to address in Primary Care services. A large area of rapid adaption was in Out of Hours services that took on significant volumes of extra urgent care work to try and reduce pressures in other areas of primary and secondary care. This included rolling out Contact First. Palliative Care services also responded quickly to support the care home sector.

Partnership Working to Respond

Covid-19 prevalence in CTM communities and the Covid-19 operating environment has placed unprecedented pressure on all aspects of unscheduled care, elective care, critical care, cancer services, mental health services, primary care and our workforce in all areas.

Partnership working has been invaluable to supporting the wellbeing of our patients during the pandemic. In the first wave, the Health Board worked with all three Local Authorities and the third sector to create additional capacity in closed care homes. The units were live in a matter of weeks and the learning from this collaborative working has informed later developments such as the field hospital and will carry forward into the Regional Partnership Board Transformation and Integrated Care Fund work-streams including Discharge to Recover and Access (D2RA).

Described below are the implications for these areas, recognising the following questions focus primarily on the pressure within elective care.

Unscheduled care

The presence of covid-19 in our healthcare settings creates significant pressure within our inpatient areas. Five factors have had an impact on the available capacity within our health and social care system. These are:

- The risk of transmission which impacts on the number of beds we can provide in each room
- The closure of beds to support infection prevention & control standards
- The re-designation of beds to provide critical care and high care respiratory capacity
- The provision of spare covid-19 surge capacity to provide immediate capacity for patients that are admitted with a highly transmissible disease
- The closure of care homes to new admissions to protect care homes from further transmission

These pressures combine to reduce the number of patients we can safely care for within our settings at any one time.

Cancer care

Providing services to care for patients with cancer has been a particular challenge. Ongoing covid-19 pressures have meant compliance with the Single Cancer Pathway target has fallen since the start of the second surge. This has resulted from a combination of factors including the lack of availability of critical care capacity, which has been re-designated to support the covid-19 pandemic. The organisation has made huge efforts to ensure that as many cancer services as possible have been kept online since the beginning of the pandemic and as we look to the future, this will be an area of high priority for CTMUHB.

Workforce

CTMUHB has a workforce of approximately 14,300 equating to 11,450 Whole Time Equivalents (WTE). Since the 1st Feb 2020, we have lost 96,496 days due to covid-19. This works out at 2-3% of the workforce being off, with nursing and medical staff being most adversely affected.

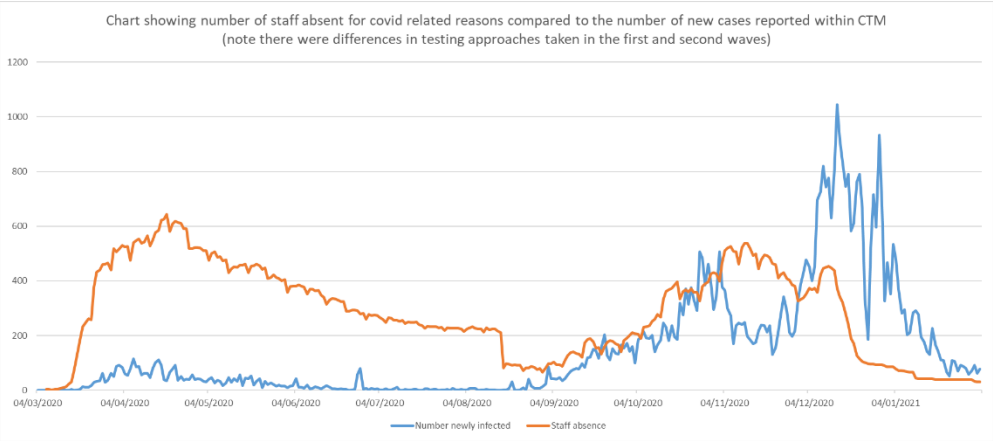
Staff group	Days absence for covid-19 related reasons
Nursing	79595

Medical and Dental	5496
Admin & Clerical	3742
Facilities	2260
Radiology	1774
Midwifery	1376
Operating Department Practitioners	648
Social Workers	639
AHPs	966
Total	**96496**

As at 9th February 2021.

The chart below shows that the absence very closely correlates with the number of new cases in the community. Whilst expected, at the very time that demand for services is at its highest, the availability of core workforce capacity is most adversely affected. The staffing response to this has challenge been excellent, with much goodwill and strong professionalism and leadership demonstrated to ensure that service requirements have been covered safely.

As can be seen from the chart the number of days lost for covid-19 reasons has declined as we have come down from the second wave peak and following some strong improvements to outbreak and infection control management following the outbreak in October.



As described in response to questions 4 and 6, future plans will very much be dependent on how health needs (both covid-19 and non-covid) present over the next six months.

Plans to Respond to the Pressures

There are a number of components to our response, including:

- We have clear plans for managing the available capacity to match demand wherever possible. Daily planning structures allow us to take

rapid operational decisions to manage which beds are available to which patient cohort to ensure we maximise all available capacity.
- We have robust control measures across the health system to provide assurance that the approach of all staff and facilities meets established infection prevention and control guidance best practice. This ensures bed closures are avoided or minimised wherever possible.
- We have paused non-urgent elective activity, in line with Welsh Government guidance to release vital estate and workforce resource to provide additional capacity into the covid-19 response.
- We have developed additional bed capacity at Ysbyty'r Seren, which is currently caring for 78 patients in their "covid recovering" phase.
- Each hospital site has a clear plan to de-escalate critical care capacity, which will release critical care beds and theatre staff to allow the re-commencement of cancer surgery across all specialties.
- In conjunction with all partners, we are developing an Elective Care Recovery Plan to set out the demand, required capacity, operational delivery plans and quality impact assessments needed to increase our capacity and prioritise how we tackle the backlog of elective care our patients will require.

Clearly, all of these interventions are supported by the national level vaccination programme, which will materially affect the number and acuity of patients being cared for within our valuable system capacity.

Vaccination

CTMUHB, with partners and volunteers, is successfully delivering a covid-19 vaccination programme for the population of CTM. Working closely with Welsh Government, we have been able to flex and adapt plans as vaccine supply has fluctuated. This was possible through innovate thinking – we were the first in Wales to safely use the Pfizer vaccine in are homes, the first to use the AstraZeneca vaccine in primary care and piloted GP delivery of Pfizer. Complying with the latest advice and guidance from the Joint Committee for Vaccination and Immunisation (JCVI), we vaccinated all those in Priority Groups 1-4 by mid-February.

The allocation of covid-1 vaccines to Health Boards has been on a population share, rather than a needs basis. This is in line with how the vaccines have been allocated across the four nations. However, for CTM where deaths from covid-19 have been amongst the highest in the UK, this has meant that access to vaccines has not reflected the disproportionate burden of impact from covid-19 that our communities have experienced relative to others across Wales.

Currently the programme is being delivered through CTMUHB Community Vaccination Centres, Mobile Teams and Primary Care. Staffing has been possible through a combination of recruitment, volunteers and prioritising

the work of health and local authority staff. As we move out of a period of lockdown, and as covid-19 prevalence reduces, existing Health Board and primary care teams will rightly be required to focus on the recovery of health and social care services. Our challenge, as we move into the next phase of the vaccination programme, is to ensure that the vaccination teams and sites selected are able to deliver not just in the coming months, but for at least the next year i.e. a number of our vaccination centres are based in leisure centres and if these were to re-open to the public for their primary use, the question of whether there is sufficient access to the building and car parking to allow vaccinations to be undertaken would need to be explored. A new 'vaccination department' is being established, at an unprecedented pace and scale.

2. **How will you prioritise the delivery of non-covid services to target reductions in waiting times?**

The resetting of elective services has brought a different focus on how treatments will be prioritised in the future and hence what performance reporting framework will be deployed. Referrals have been increasing since May and there has been a steady increase in the total number of open pathways. This total will continue to rise whilst the organisation is operating at between 30% and 35% of the activity levels being delivered at the same time last year.

The initial clinical prioritisation of open pathways to reflect a risk-based approach has been completed, though not all urgent pathways have been prioritised. Currently, a routine process for categorising new urgent patients added to the treatment list has not been implemented. Weekly scheduled care performance meetings have been set up in our three Integrated Locality Groups that cover the populations of Bridgend, Merthyr Cynon and Rhondda Taff Ely. The purpose of these meetings is to review all urgent patients waiting over 4 weeks since being listed for surgery and all patients waiting over 26 weeks since being listed for surgery.

Operational plans have been developed to release critical care capacity and theatre staff to allow for the expansion of elective activity in a phased approach. We have developed detailed operational plans to clear both the Unscheduled Care backlog and commence priority three (P3) activity. P3 activity is defined by the Royal College of Surgeons as where patients can wait up for up to three months for and priority four (P4) activity is defined as where patients can be delayed for more than three months.
We will continue to use Independent Hospital capacity in the Vale Nuffield and Cardiff Bay hospitals.

In terms of outpatients, the reduction of routine face-to-face appointments has given the UHB a rare opportunity to restart the outpatient service in a much more streamlined, digitally enabled way, providing the potential for increasing activity levels in a patient friendly

manner. We will continue to increase our use of virtual clinic appointments with the use of 'Attend Anywhere' and there is a Health Board 'Follow up not booked' working group to ensure a consistent approach is provided to patients at this stage of the pathway across all services and hospitals. The introduction of Patient Initiated Follow-Up (PIFU) and See on Symptom (SOS) will support the effort in reducing routine follow-up activity. These initiatives have been used in Ophthalmology for some time, but will now apply increasingly to all other elective services.

We are engaging with our colleagues in primary and community services to support them in managing their own backlog but also to look at the opportunities for making a switch from traditionally secondary care provision of services. We recognise that we will not reduce waiting times and clear the backlog that has built up without their support and by reverting to previous ways of working.

3. **How will you communicate with patients about what they can expect in terms of length of wait, prioritisation, and any management of their condition whilst waiting?**

Physical, video and telephone communication between patients and the clinical and administrative care team have remained the main channels for keeping patients informed about their individual care plans and to meet our population's demands for continuing care, management of chronic diseases and medication reviews. Regular briefings have been held with local elected representatives, who play a key role in supporting the dissemination of messages and information to our communities. We have also strengthened our relationships with local community groups, such as the RCT over 50s forum, and ensure that weekly briefings are sent to their representatives so they can disseminate information to their members.

Meetings with the CTMUHB Community Health Council and Stakeholder Reference Group have continued to communicate and share messages with messages relating to our waiting list position and recovery plans.

In the hospital setting, the process of prioritisation has been consistent with the guidance issued by the various Joint Royal Colleges. However the requirement to pause all but the most urgent elective operating over the Christmas and New Year as we faced the peak impact of the second wave on hospital workforce and bed capacity has resulted in some patient groups waiting in excess of these standards. The Health Board is committed to learning the lessons from the covid-19 pandemic and ensuring that this learning is reflected in our plans to transform services in the future.

4. **What estimates or projections have you made of the time needed to return to the pre-pandemic position?**

Covid-19 remains the key prior- determinant of our elective programme. From our conversations with the Welsh Government and our own modelling, we are working on having a three-month period where we can re-establish green islands that are safe environments within our District General Hospitals for those surgical cases that need to be provided on site. These will allow us to expand our elective programme and address the needs of our most vulnerable patients that are waiting.

The timing of when we hope to be able to return to pre-pandemic levels of productivity and activity are also dependent upon a number of factors, including the requirement for PPE and infection control procedures (such as testing, transport); whether we can expect any guidance on the management of unvaccinated patients; and workforce availability. We are mindful that we must continue to protect our communities and our staff & that whilst vaccination will certainly go some way to doing this; there is evidence to suggest that in 3 out of 10 cases, there is a possibility that the vaccine has not been fully effective in preventing infection and transmission.

From a service and accessibility perspective, primary care services remain at the core of our delivery to patients and General Practice, Dental and Optometry services have maintained the delivery of services throughout the pandemic. Similarly, our Mental Health provision has continued to function throughout and we have exceeded the targets for part one of the Mental Health Measure that relates to primary care assessment and treatment within 28 days. The organization has also exceeded the percentage of therapeutic interventions started within 28 days following an assessment by Local Primary Mental Health Support Services.

We are clear, working with our NHS and regional partners, that this is as much of a priority as hospital waiting times and we are seeking to ramp up our population health capacity to take the lessons from covid-19 in surveillance and protection along with Wales's strong position on health promotion too.

5. **Are you using or considering any new or different approaches to providing care in order to help reduce waiting times, including the use of new technologies, new care pathways, or of capacity elsewhere?**

Technology

The change in the operating environment and the rapid adoption of new working practices and technologies remains challenging but presents many new opportunities for pathway and service re-design in line with the prudent principles e.g. greater self-management of care and an emphasis on delivering seamless, integrated services.

We are co-developing numerous innovative and evidence-based pathways to ensure that we can improve the universality and access of our health and care services.

Underpinning these changes are transformational programmes around workforce skills, re-design and digital enablers.

The UHB, acting with our regional and NHS Wales partners have a large and ever-expanding Digital & Informatics programme. New technologies that will support elective services include:

a. Digital Referral triage/ referrer advice services {Consultant Connect} – enabling clinicians to receive immediate clinical advice, reducing the necessity to make a referral and requiring the patient to wait a period of time and attend another appointment
b. Electronic test requesting – reducing the effort and speeding up the time it takes for all clinicians to request a test
c. Electronic Results notifications and sign off – speeding up the time it takes for pathways of care to be delivered, in addition to reducing the number of times tests are not sent out or acted upon.
d. Virtual clinics {Attend Anywhere} – This technology was rolled out in April, providing a structured tool for patients and clinicians to communicate and agree their care.
e. Virtual MDTs/ clinical & team discussion areas (MS Teams)
f. Digital transcription and dictation – allowing clinicians to use voice to screen technologies that deliver improved productivity and enabling an element of the medical secretariats time to be directed to further enhancing communications with their patients and co-ordinating the wider care teams.
g. Digitising the paper medical records –reducing the reliance on the paper records and thus for care and advice to be provided through remote and mobile ways of working.
h. Digitally mobilising the workforce (Over 3,000 networked laptops have been provided to CTM UHB staff).
i. Clinical pathway support tools, such as in cancer, will provide the Multi-Disciplinary Team (MDT) with a complete and timely analytical understanding of all of the patients in their care, their progress to date and their presently agreed timed care plan.
j. Patient Portal – The provision of video libraries to support self-care and a platform for remote monitoring which is intended to result in patients receiving care when their need requires it rather than at pre-

established times/points has the potential to improve not just the quality of care, but also the care outcomes and make more effective use of clinical time.

k. E-whiteboard and bed management system –As an initiative to improve clinical communication and the quality of care provided to patients, we would anticipate fewer theatre and bed related cancellations and complications arising, thereby resulting in increased activity levels.

We are extremely cognisant that as we deploy these new technologies we must have in place the underpinning infrastructure that ensures they are reliable and of a high grade clinical quality, providing sufficient assurance to the users (e.g. the patient, their carer and their care team) that they are dependable and will not fail at critical points.

In this respect, new technologies that speed up the transfer of data over the network, reduce breakdowns in the network, or erase black spots in the Wi-Fi are being heavily invested in locally and nationally, with a continuing programme of improvement being overseen locally and by the All Wales NHS Wales Infrastructure Management Board. These technologies range from increasing the usable band-width of the Public Sector Broadband Aggregation (PSBA) & NHS: Cloud networks (from 1 to 10GB for PSBA and upto 20GB for Microsoft cloud) to upgrading firewalls to re-design data flow.

Only with these in place will we be able to maintain both the continuing use of existing digital technologies, and the pace of adoption of new digital technologies whilst also addressing the productivity loss incurred since the beginning of the covid-19 pandemic.

Alternative pathways

CTMUHB are currently working with clinical teams to consider alternative pathways that can be offered/provided. Assessed on a speciality basis, each assessment summarises the current waiting list position by waiting time and stage of pathway and looks at the guidance available from the Royal Colleges, professional bodies and third sector organisations to identify alternative pathways or treatments. Alternative pathways include the use of therapists to assess referrals to Orthopaedics; upskilling biomedical scientists to undertake increased sample-cutting work currently undertaken by Consultant Pathologists and using Community Wellbeing Co-ordinators to support individuals to access a range of local services relating to healthy lifestyle choices and emotional health and well-being.

6. **What factors may affect your plans for tackling waiting times (e.g. further spikes in Covid-19 rates, issues with the**

workforce or physical capacity), and what plans you have in place to manage these?

The extent to which covid-19 is present within our community and causing serious illness is a significant factor in our planning, and one of our priorities remains how we contribute to the global efforts to reduce its impact. There are three direct factors we consider important in this:

1. **Efficacy of the covid vaccine rates in regards to transmission, infection and ability to prevent serious disease and death**

Whilst there is little we can do in terms of the efficacy of the vaccine itself, the UHB is adhering to the advice of the JCVI in relation to whom it is administered to and when, whilst also endeavouring to maximise the number of people we have vaccinated from the supply available to us.

2. **Vaccine uptake amongst the community**

Alongside vaccine efficacy this is the critical determinant as to whether we will experience a 3rd wave of covid-19 and to the level of prevalence we will experience. It is also a key component in reducing inequalities in uptake - one of the three main aims of our vaccination programme.

We use the information we have through the Welsh immunisation System (WIS) on vaccination and population data to understand take up rates in local communities by age group to make strategic decisions. This enables us to make bespoke efforts where uptake of the vaccination is lower. We are also using the information on vaccination update at practice and primary care cluster level that is available on the NHS Wales Intranet.

We are using a blended model (outreach to care homes; using primary care; using community vaccination centres and staff programme) to maximise uptake.

We have ensured that the location of our community vaccination centres covers all three Local Authority areas within our Health Board and are due to increase the number of vaccination centres in March so that venues are more local for our population. Equalities Impact Assessments have been undertaken to help guide the planning in this.

In addition, we have a detailed communications plan to help improve understanding in the community and are working with a number of partners (third sector and statutory) to increase understanding of our programme and its delivery. Presentations, posters and leaflets have been made available to encourage uptake for those who are not online where the vaccination programme has been heavily promoted. New Black, Asian and Minority Ethnic (BAME) community workers are shortly to be in

place and they will be trained on how to answer questions on vaccination and deal with common myths and there have been targeted media campaigns to reach out to BAME communities.

3. Government policy decisions on social restrictions, the societal response, and their consequent impact on the general prevalence of covid-19 within the community

The UHB has numerous professionals who have been asked, and are actively contributing to, the UK and Welsh Government's understanding of covid-19 and how to respond to it. In addition we have worked with our partners regionally and nationally to ensure we have a strong, clear and consistent message and are able to debunk myths associated not just with the vaccine but with the nature of the disease more generally e.g. 'covid-19 is not much different to the flu'.

In addition, there are a number of factors that will determine how we respond and how quickly, to the presently unmet needs:

- The first is our uncertainty as to what has been the impact on our population's needs following 12 months of covid-19 and how these needs will manifest themselves as demand for health, care and wellbeing services increases. We are anticipating an increase in urgent (both emergency and urgent elective) presentations once our population sees that prevalence of covid-19 has been markedly reduced. Currently, emergency admissions are running at 2/3rds of 2020 levels. While we expect this to return, we are anticipating a greater need and demand for mental health, lifestyle and health promotion services in the short to medium term. Furthermore, we are anticipating that the complexity of the case mix may change as people present with more than one condition/co-morbidity. We are also aware of recent studies suggesting that 30% of people who suffered severe covid-19 are re-admitted to hospital within 6 months. With finite supply, how we prioritise and allocate our capacity to meet these demands in a fair and equitable way is something we are presently working through with the Welsh Government and regional partners.

- Our workforce capacity: The availability of our staff, many of whom have to balance work and private life requirements with the individual challenges that lockdown has brought to us all.

- The financial operating environment, both in respect to capital and revenue.

- Success of regional initiatives to create 'green' hospitals and islands – many of which may be dependent on the availability of workforce.

- Future infection control requirements post-vaccination. This will impacts on productivity in terms of PPE requirements and availability (self-isolation post-contact with a covid-19 positive individual).

- Attitudes and sensitivities within the hospital and wider Health Board. Staff groups have worked extremely hard during the pandemic. We are mindful of the professional and personal toll that this has taken on so many and the scale of the challenge that we have in terms of working through the backlog. We need to ensure that the workforce is not over-stretched. In addition, there will be sensitivities around the offering of additional enhanced rates of pay to staff groups with long waiting list backlogs, whilst minimal enhanced payments or rewards have been offered to the clinical groups managing covid-19.
- Our ability to recruit and retain staff in key areas. There is a risk that some senior, highly productive staff may resign or take career breaks once covid-19 is in a sustainably managed position.
- The UK & Welsh tax regimes may also affect the uptake of additional lists

7. What information have you received on your allocation from the £30m additional funding for waiting times, and how you intend to use the funding?

Our Health Board has not received any information on our allocation from the £30m additional funding for waiting times. Once received, we will be able to set out our intentions for its use as we are working up a number of schemes to enable and support the recovery of our waiting lists.

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Our Ref: RH/ses [redacted] [redacted] 12 February 2021

Dr Dai Lloyd, AM
Chair, Health, Social Care & Sport Committee
National Assembly for Wales
Cardiff Bay
CARDIFF
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Dear Dr Lloyd

Thank you for your letter dated 20th January 2021 regarding your inquiry into the impact of COVID-19 on health and social care in Wales. Please find the Health Board's responses to the questions raised.

1. ***What are the main areas of pressure, and what plans do you have in place to deal with these?***

The Health Board is proud of the way in which its staff, and partner organisations, have come together to collectively respond to the COVID-19 pandemic.

To provide some context regarding the pressures that have been faced, during the first peak (April / May 2020) the number of patients with COVID-19 in our hospitals totalled over 280, with the number of patients (COVID-19 and non-COVID-19) totalling less than 1,000. Patients being cared for in ICU totalled 49 at its peak, of which 37 were patients with COVID-19.

The demands on services during the winter have been even greater and more sustained. As part of its Q3/4 operational plan, the Health Board brought forward the opening of the Grange University Hospital (GUH), to November 2020, recognising the likely impact of COVID-19 and the anticipated seasonal demand on healthcare services.

Whilst the number of patients, with COVID-19, in local hospitals is currently falling, this is from a peak in early January 2021, of over 490, down to the

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current level which is still over 200 patients. Alongside caring for COVID-19 suspected, positive and recovering patients, the Health Board is caring for an increased number of non-COVID-19 patients, currently almost 1,000. In total, there are currently over 1,500 patients in hospitals across the Health Board.

During the winter period, the Health Board has also successfully implemented a mass COVID-19 vaccination programme for its population and worked with its partners to deliver an effective Test, Trace and Protect (TTP) service across Gwent.

Moving through the next phase, there are a number of factors that the Health Board is managing as part of recovery and implementing sustainable services going forward, which will feature in the Annual Plan for the 2021/22 financial year.

- ***Population health and addressing health inequalities***

The Health Board has always been aware of the challenge faced in improving the health of its population, prior to the COVID-19 pandemic, including addressing the health inequality that exists across its communities.

An analysis undertaken of deaths associated with COVID-19, by deprivation fifth across Wales, shows the most deprived fifth of the population had the highest mortality rate. It is reasonable to conclude, from what is known at this stage of the pandemic, that direct harm from COVID-19 is likely to widen health inequalities across local communities.

It is also expected that the broader health, economic and social impact of the pandemic will be profound in terms of scale and longevity. The consequences of additional demand on healthcare services is hard to quantify, but is likely to present at some stage.

Therefore, the Health Board's Annual Plan will have an increased focus on considering the health needs of its population, and addressing the health inequalities, across its communities.

- ***Workforce***

The response from staff during the pandemic has been tremendous. They have displayed dedication, professionalism and compassion throughout this period. The demand for staff – both registered and non-registered – has increased significantly as the Health Board has not only responded to the demands placed on existing healthcare services but implemented new and additional services in response to COVID-19 – such as COVID-19 surge capacity, Test, Trace and Protect and mass vaccination programmes. As services have been flexed to respond to those areas of greatest priority, many staff have worked additional hours and been redeployed to support those services.

The impact of COVID-19 has resulted in higher than normal staff absence. Across the Health Board, absence levels are currently at 9.58%, which equates to 1,181 WTE. This includes high levels of absence for Registered Nurses (10.35%), Health Care Support Workers – HCSW (14.72%) and Facilities staff (16.14%).

Whilst absence related to COVID-19 infections is currently reducing and non-related COVID-19 absence is lower, compared to January 2020, the impact of staff shielding or self-isolating is contributing to an additional 300 WTE staff absent from the workplace.

In terms of workforce plans, these have included an overseas nursing recruitment campaign, which was restarted as travel restrictions were lifted in September 2020. The Health Board has recruited 160 WTE, of which 106 WTE have already joined and the remaining nurses are expected to join by the end of March 2021. In addition, the Health Board has recruited 145 WTE HCSWs, of which 103 WTE have commenced in role.

A significant feature of the plans included staff engagement and consultation, particularly ahead of the early opening of the GUH in November 2020.
The Health Board is very much aware that staff are physically and mentally tired and will need to take annual leave which they may not have had the opportunity to take for rest and recuperation. Likewise, many staff will need well-being support to recover. The Health Board has increased its resources to support the well-being of its staff. This includes a peer support phone line and additional psychological support. Occupational Health services continue to offer advice and support to managers and all staff, with a particular focus on those with underlying health conditions.

- ***COVID-19 services***

Whilst COVID-19 infection rates and related hospital admissions are falling, the Health Board will still need to plan for a level of COVID-19 demand and provision of services during the next financial year, including the consequences of safely maintaining COVID-19 and non-COVID-19 care pathways.

The Health Board continues to review and update its plans to deliver a mass vaccination programme and is working collaboratively, with its partners, to provide an ongoing TTP service.

- ***Non-COVID-19 services***

The Health Board resumed some services following the first peak and throughout the summer. This included some routine services where these could be re-started safely. In addition, endoscopy services have increased to levels prior to the pandemic with a focus on timely access for suspected cancer and urgent patients. The Health Board also has recovery plans in place with regard to other diagnostic services such as CT, MR and non-MSK ultrasound. The impact of these plans can be evidenced by the improving position against the 8 week diagnostic target, from a high point in August 2020 and with a month on month reduction up to end December 2020.

Embedding services effectively across the GUH and the Health Board's enhanced local general hospitals (e-LGHs) will be a critical part of resuming some routine services and implementing alternative pathways.

2. How will you prioritise the delivery of non-COVID-19 services to target reductions in waiting times?

The Health Board has developed and implemented its operational plans, throughout the pandemic, applying the guidance provided by Welsh Government on Maintaining Essential Services. It has followed guidance on risk stratifying patients within each stage of their pathway and prioritised patients with suspected cancers or waiting urgent review. This has involved reorganising capacity to comply with COVID-19 safe socially distanced environments and has resulted in some services operating at lower levels than normal.

As the number of COVID-19 patients in hospital reduces, the Health Board is reviewing the opportunities to safely resume routine elective care, taking advice from its Nosocomial Transmission Group in implementing safe, elective care pathways. Making facilities available to deliver more outpatient, diagnostic and treatment capacity remains a priority in the organisation.

Work has already been in place to implement the single cancer pathway and there has been a regular focus on improving timely access to diagnosis and treatments available.

An important part of the Health Board's operational plans have included using the independent hospital sector for a range of outpatient, diagnostic, therapy and treatment facilities.

3. How will you communicate with patients about what they can expect in terms of length of wait, prioritisation, and any management of their condition whilst waiting?

The Health Board regularly updates its local communities on the effects of the COVID-19 pandemic on services, including the restarting of our services. This is provided through a variety of methods and channels, including web pages and articles, social media updates and engagement with patients, answering email enquiries, weekly and monthly stakeholder newsletters, through the local media, updates at partnership meetings, and through the popular live Q&A sessions.

Discussions with patients are taking place using video and telephone consultations ("Attend Anywhere") about their condition and the Health Board has used mass text conversations to inform patients and to undertake two way conversations about their individual care.

The Health Board has launched a dedicated webpage, entitled 'Restarting our Services during the COVID-19 Pandemic', to offer updates and information on how services are impacted by COVID-19. Each service within the Health Board will continue to provide weekly updates for patients through this webpage. Patients will proactively and reactively be encouraged to refer to the webpage for updates on the particular service(s) in which they have a particular interest.

4. What estimates or projections have you made of the time needed to return to the pre-pandemic position?

There are a number of factors involved in estimating, with some certainty, the timescales for returning to the pre-pandemic position. Some of these have been identified in responding to Question 1. As a result, this makes implementing these plans extremely complex.

Nevertheless, the Health Board has developed three planning scenarios which consider the course of the pandemic. These are broadly based on R values of 1.5, 1 and 0.8, as well as factoring in assumptions around hospital lengths of stay, staff absence and availability and an understanding of potential non-COVID-19 demand.

Workforce availability will be critical. The Health Board has redeployed a significant number of staff to support existing COVID-19 services in hospital as well as prioritising the vaccination programme. The impact of the pandemic on staff well-being and availability is hard to quantify but cannot be underestimated when it comes to implementing plans.

In addition, the level of latent demand in communities is unknown, when looking at the existing backlog of patients currently on waiting lists. When and to what extent unmet demand may surface is a significant variable in being able to provide reliable estimates. In practice, the Health Board believes a graduated approach to implementing plans, to address waiting times for elective care, is a realistic one.

5. Are you using or considering any new or different approaches to providing care in order to help reduce waiting times, including the use of new technologies, new care pathways, or of capacity elsewhere?

During the first peak of the pandemic, the Health Board implemented some alternative ways of providing care. Significant use has been made of virtual consultations with patients and between April and September 2020, the Health Board undertook over 19,000 consultations across its range of services. Where appropriate and safe to do so, clinicians are discharging patients onto "see on symptoms" or patient initiated follow up pathways. This allows patients to take greater ownership of their care, whilst allowing outpatient consultations to be re-prioritised.

The Health Board has been applying value based healthcare principles to the delivery of care for its patients understanding what matters most to patients - and re-designing services to achieve this. Whilst the changes have been incremental, they have been important in re-prioritising the way care is delivered.

Given the scale of backlog that exists for some routine elective care and the availability of appropriate elective capacity, applying these principles at scale will be critical in providing patients with appropriate alternative pathways, addressing timely access to care and improving health outcomes.

6. What factors may affect your plans for tackling waiting times (e.g. further spikes in COVID-19-19 rates, issues with the workforce or physical capacity), and what plans you have in place to manage these?

It will be important that COVID-19 infection rates, and the impact on admissions to hospital, continue to fall. Any further rises may impact on the ability to implement plans to resume greater levels of non-COVID-19 services, particularly routine services. A number of the factors will affect plans to tackle waiting times and many of these have been identified in response to some of the previous questions.

It should be emphasised that the Health Board is acutely aware of the importance of having available a healthy and appropriately skilled workforce, as it faces the various challenges involved in successfully coming out of the pandemic, maintaining new and additional services – such as TTP and mass vaccination programme – resuming routine services. The welfare of staff, which has been outlined previously, will be key to achieving this.

In the short-term, some staff have been redeployed or are working additional hours, to work in mass vaccination centres or care for COVID-19 patients in hospital. These include medical staff, registered nurses, therapists and pharmacists as well as health care support workers and administrative staff. Many of these staff will be important in resuming some routine services. Therefore, the Health Board is developing plans which consider a phased return to some services and alternative models of care, which take account of the workforce required to achieve this.

The use of the independent hospital sector has been key during the pandemic. Going forward it is likely to be an important element of delivering additional healthcare capacity.

7. What information have you received on your allocation from the £30m additional funding for waiting times, and how you intend to use the funding?

The Health Board received funding from £30m funding allocated non-recurrently as part of delivering the Winter Protection Plan during 2020/21. This has enabled the Health Board, in collaboration with the partners, to implement the following services:

- Accelerate and further enhance the use of 111 and Contact First services – to provide medical advice remotely and refer people to appropriate services including GP, pharmacies and other community services.
- Increased ambulatory and same day emergency care provision,
- Urgent Primary Care Centre Pathfinder programme, to enhance the existing Urgent Primary Care Out of Hours and provide an Urgent Primary Care Centre on a 24/7 basis - providing care for patients in the right place first time, and
- Four discharge to recover then assess pathways.

Evaluation has been built into some of the work described and will be key to determining the appropriate service models moving forward.

Thank you for the opportunity to respond to your questions in support of your inquiry into the impact of COVID-19-19 on health and social care in Wales.

I hope these responses fully answer your questions, but if you require any further information please let me know.

Yours sincerely

Judith Paget

Judith Paget
Prif Weithredwr/ Chief Executive

Health, Social Care and Sport Committee - inquiry into the impact of Covid-19 on health and social care in Wales.

Evidence response document from Cardiff & Vale University Health Board

Introduction

Thank you for the invitation to respond to the inquiry into the impact of Covid-19 on health and social care in Wales. Cardiff & Vale University Health Board welcomes the opportunity to engage with the Senedd Health, Social Care and Sport Committee on the challenges arising from the Covid-19 pandemic on Health care provision and delivery for our patients both in the current period and looking forward over the medium and longer term.

We appreciate your understanding regarding the current challenges and therefore as you requested, we have provided a brief response to each of the areas you have raised. Where possible, we have sought to provide data which illustrates each of the areas, showing the impact of Covid-19 and our operational responses. There are inevitably some areas where we are still assessing, with colleagues across the NHS in Wales, the impact of Covid -19 and the likely impact into the future.

In this document, we will seek to draw out some emerging lessons learnt regarding the response to the first wave and the second wave of Covid-19, and some of the underlying pressures this has raised, particularly in respect of workforce, in addition to the immediate impact on the delivery of front line services to patients.

The Health Board was able to maintain all "essential services" throughput the pandemic and continues to do so. This does not overlook the fact that frontline clinical services were interrupted and there have been and will continue to be delays in the treatment of patients as a result of the exceptional demands placed on the Health Board, and its partners in other sectors, by Covid-19.

1. What are the main areas of pressure, and what plans do you have in place to deal with these?

There are three broad categories where the Health Board has pressures arising from the Covid-19 pandemic:

a) Services where the Health Board has had to reduce its levels of activity in order to reprioritise resources for Covid -19 response. The main areas include elective care and treatment, outpatients diagnostics and surgery.
b) Services which are receiving exceptional demand as a result of Covid-19. The main areas include Critical Care, Unscheduled care, Acute Medical inpatients, Primary Care and Mental Health
c) Services where demand was suppressed and where there may be unmet demand which will likely emerge as the pandemic subsides.

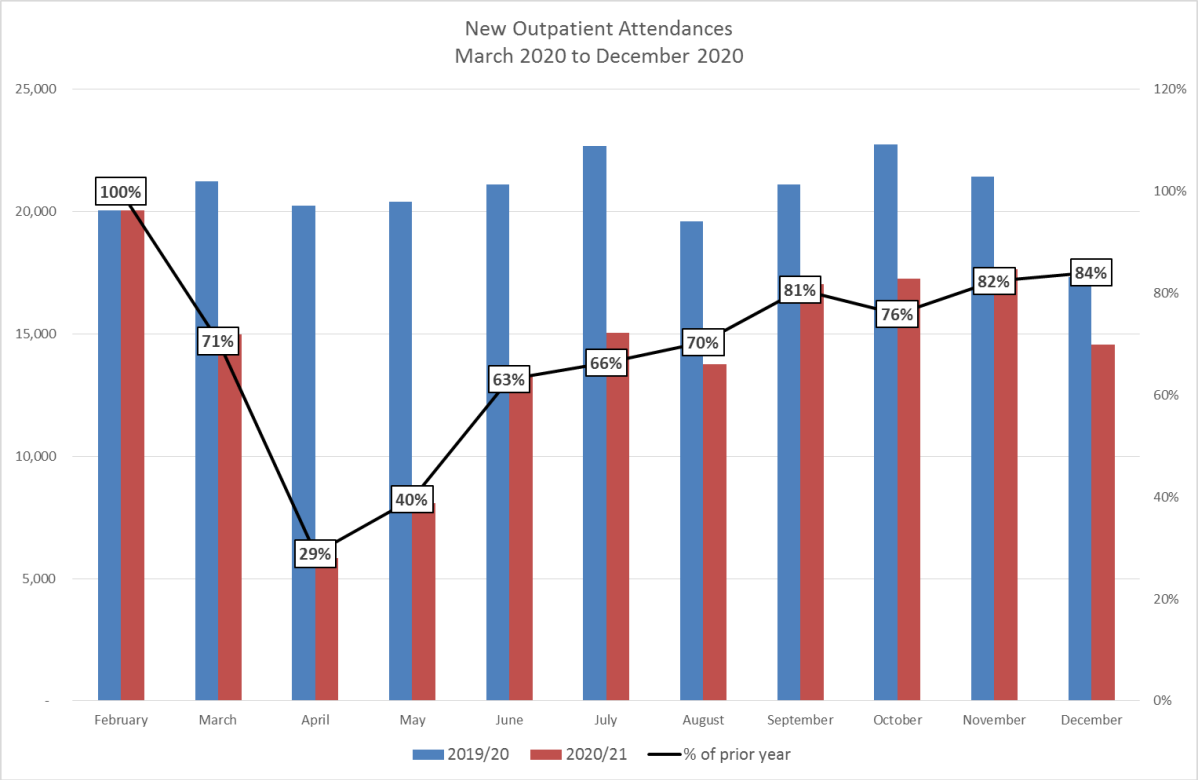
a) Services reduced due to Covid-19

From mid-March and into April, there was a rapid reduction, in particular in elective services. This arose due to the following factors:

- The need to transfer staff from elective services to support Covid-19 response in escalating and expansion of e.g. Critical Care capacity and Medicine.
- Reduction in referrals
- Reduction in the willingness of patients to come into hospital for fear of infection
- Reluctance in some cases for Clinical Teams to continue to deliver specified services where the perceived risk of Covid-19 infection may outweigh the benefits of treatment.

Figure 1 illustrates the impact of Covid-19 on New or 1st Outpatient attendances for Elective services.

Figure 1: Elective New Outpatient Attendances (Impact of Covid-19 & Recovery)

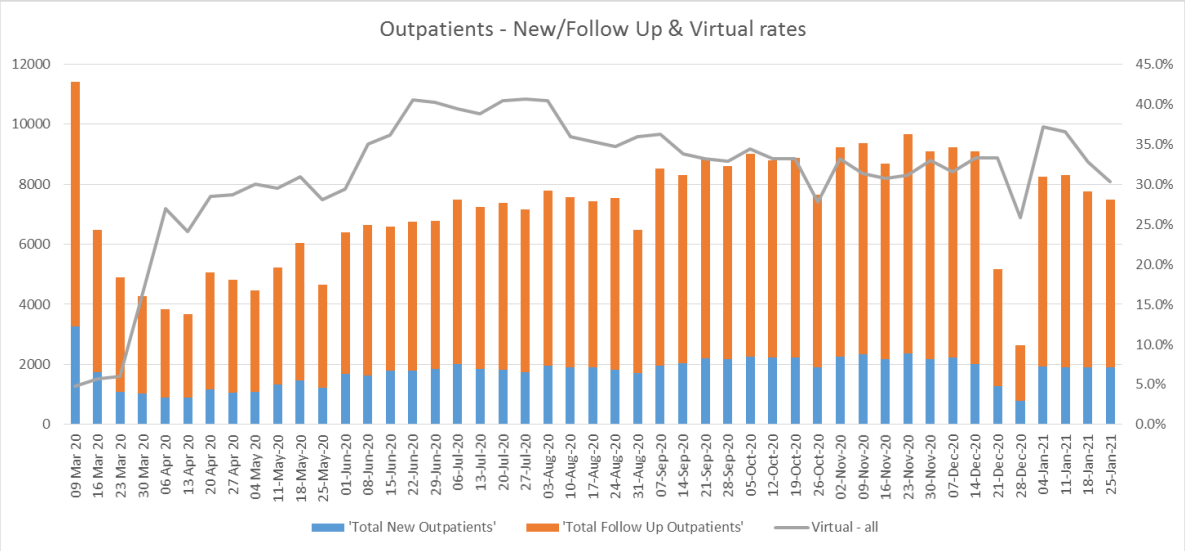


New or 1st Outpatient activity started to decline in March and reached its lowest point (29%) in April 2020. Activity recovered to 84% by the end of December 2020.

In Outpatients services, the Health Board rapidly adopted virtual consultations and reviews as a major element of its Covid-19 response. Over 40% of our Outpatient consultations were conducted via Virtual means in the first wave of Covid-19, thereby reducing the risk to patients and ensuring more patients could be assessed. As Outpatient services returned to higher levels, the necessity to see some patients in a face to face setting has reduced the percentage of virtual consultations but volumes have remained high and consistently over

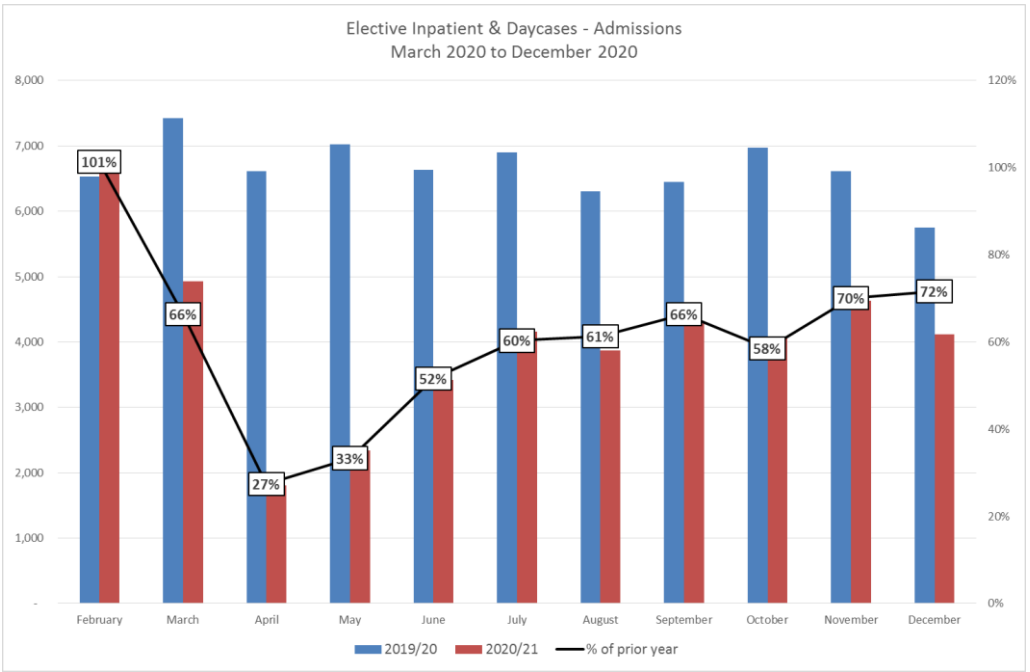
30% of Outpatient Consultations continue to be delivered in a virtual setting. Figure 2 illustrates the impact of Covid-19 on Outpatient attendances and the adoption of Virtual Consulting, which rose from 2.4% to over 40% at the peak and remains around a third of our overall Outpatient activity.

Figure 2: Outpatients Activity & Virtual Rates (Impact of Covid-19 & Recovery)



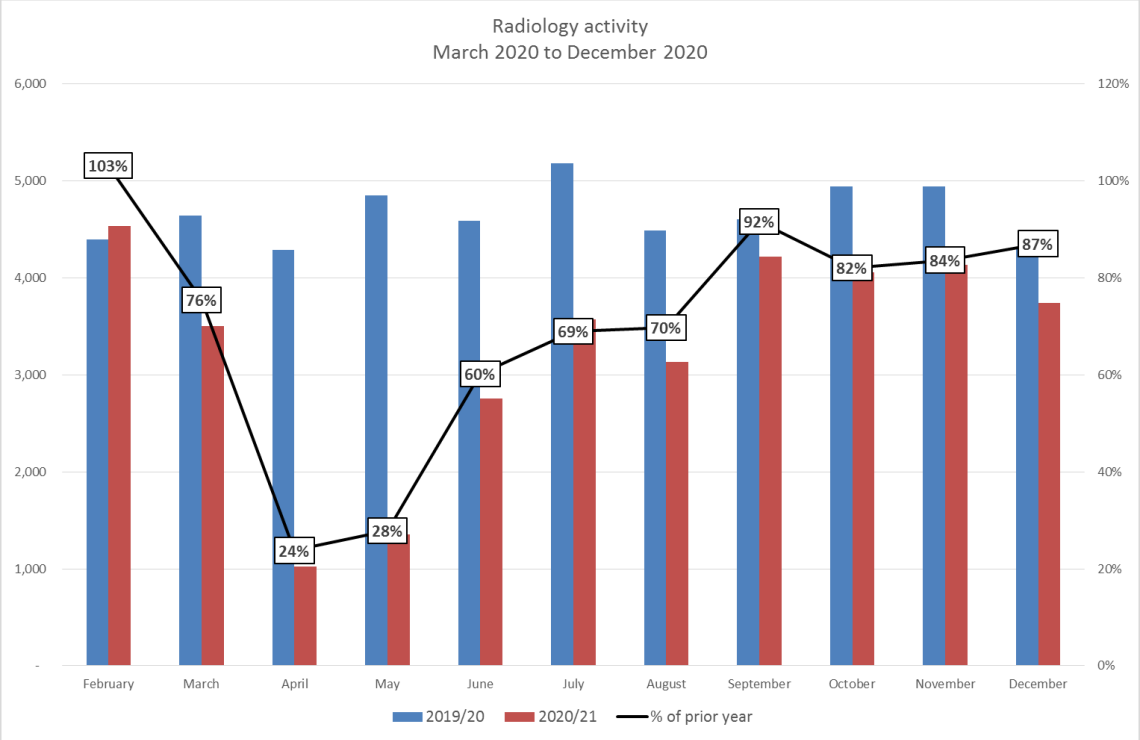
Elective or planned treatments requiring inpatient or daycase admission to Hospital started to decline in March and reached its lowest point (27%) in April 2020. Activity recovered to 72% by the end of December 2020. Figure 3 illustrates the impact of Covid-19 on Elective Hospital admissions for treatment.

Figure 3: Elective Inpatient & Daycase Admissions (Impact of Covid-19 & Recovery)



Radiology activity across all modalities (CT, MRI, Ultrasound and General, including Plain Film X-Ray) started to decline in March and reached its lowest point (24%) in April 2020. Activity recovered to 92% by the end of September 2020 and has remained consistently above 80% in successive months. Figure 4 illustrates the impact of Covid-19 on Radiology activity.

Figure 4: Radiology Activity (Impact of Covid-19 & Recovery)



Additional learning from first wave of Covid-19

A central element of our response to the first wave of Covid-19 was the creation of designated Green and Amber Zones at both University Hospital of Wales and University Hospital Llandough. This has contributed towards our capacity to continue to deliver significantly higher levels of elective care through the second wave in comparison with the first wave.

Continuing Infection Prevention and Control (IPC) constraints remain in place to protect patients and staff from unnecessary exposure to Covid-19. This includes wearing of Personal Protective Equipment (PPE), social distancing in patient areas, cleaning of equipment, facilities and physical areas between procedures and use by different patients. These IPC procedures enable the Health Board to continue to deliver safe elective care but also reduce our capability to recover to 100% of pre-Covid levels in the current position.

b) Services experiencing exceptional demand due to Covid-19

Certain services have received additional and exceptional pressures as a direct consequence of Covid-19. These additional pressures are both in terms of additional workload (volume) and in terms of additional complexity. An additional complicating factor has been the necessary relocation and reconfiguration of some services which has been necessary in order to maintain safe environments for patients and staff during this period.

We highlight here the following specific areas:

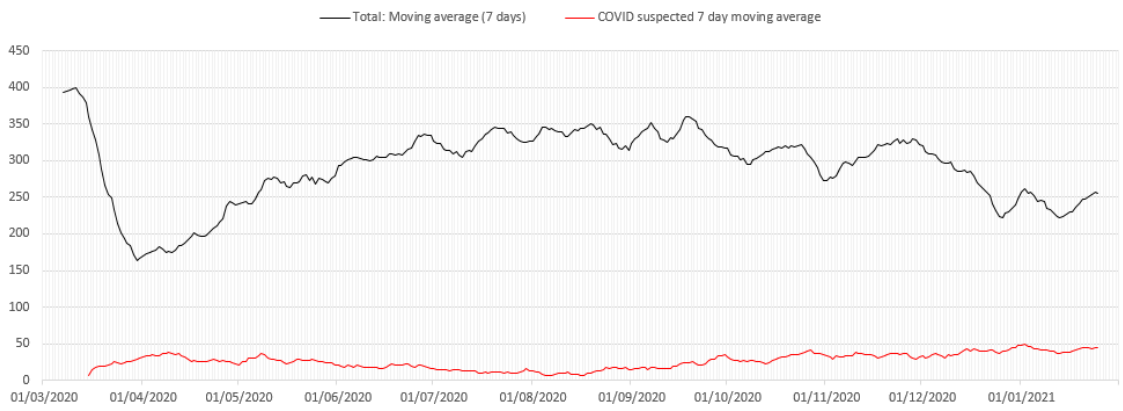
- Unscheduled care
- Acute Medical Beds
- Critical care
- Primary Care
- Mortuary services
- Mental Health

However, there are few if any areas of the Health Boards services where the impact of Covid-19 has not been felt, whether directly or indirectly.

Unscheduled care

Demand for unscheduled care has risen following a sharp reduction during the first national lockdown. The introduction of CAV 24/7 has help to mitigate this but January 2021 saw an average of 243 attendances per day at the Emergency Department (ED) with an average of 40 suspected Covid-19 attendances. There was an urgent need to redesign the operational management and flow of patients through the ED. This entailed an immediate change in the footprint, with the department expanding to encompass the Trauma Clinic space, which was temporarily available due to the transfer of Trauma surgery to Llandough. This also required a complete reorganisation of the department workflows to manage suspected and confirmed Covid-19 patients safely and reduce risks to both staff and patients. Figure 5 illustrates the impact of Covid-19 on attendances at ED.

Figure 5: Attendances at ED

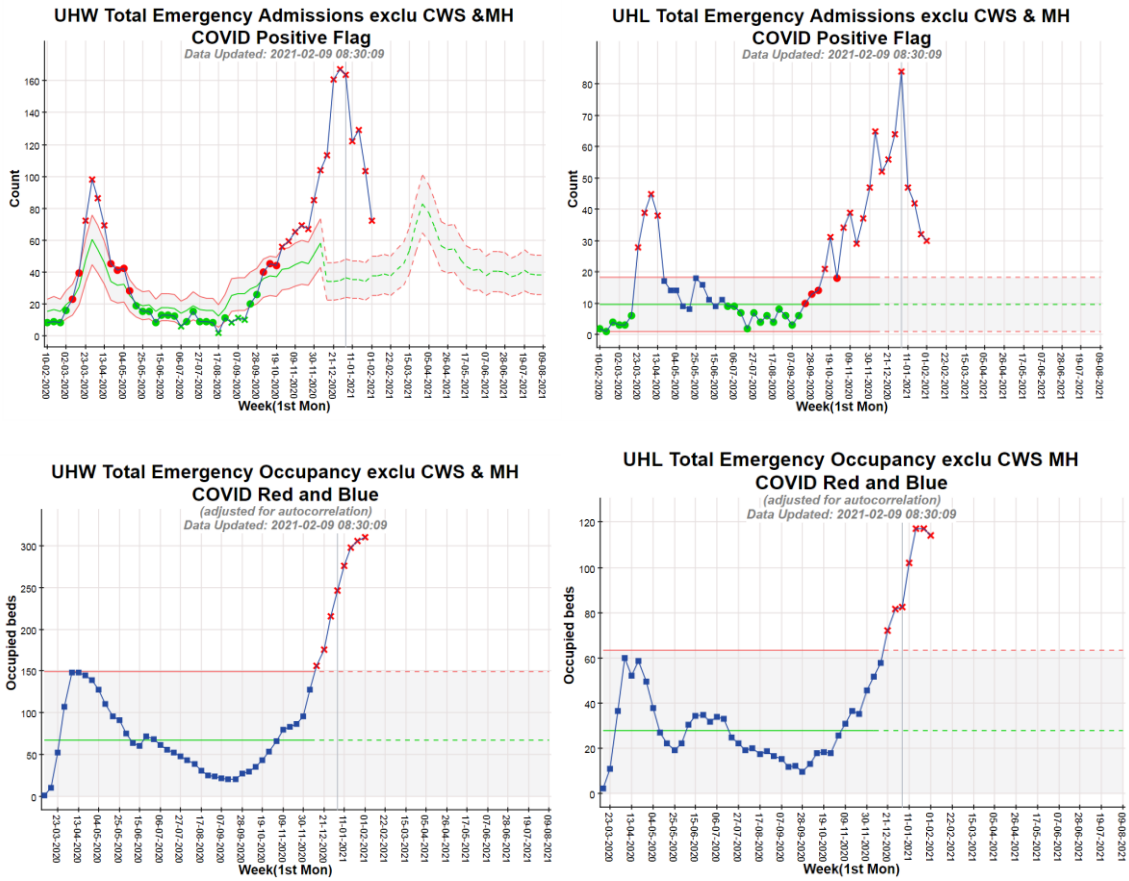


Acute Medical Beds (Covid-19 inpatients)

The second Covid-19 wave has seen an increase in Covid admissions with both acute hospital sites seeing Covid-19 admission and occupancy numbers in excess of those experienced in the first wave. The complexities, discussed previously, around patient flow, capacity and staffing have contributed to the challenges of managing medical inpatients. Since December, the UHB has seen an increase in patients with a >21 day length of stay with a fluctuating picture since mid-January. By contrast the number of Covid-19 patients with a >21 day length of stay has continued to increase.

Figure 6 illustrates the impact of Covid -19 on emergency admissions and bed occupancy to our main hospital inpatient sites.

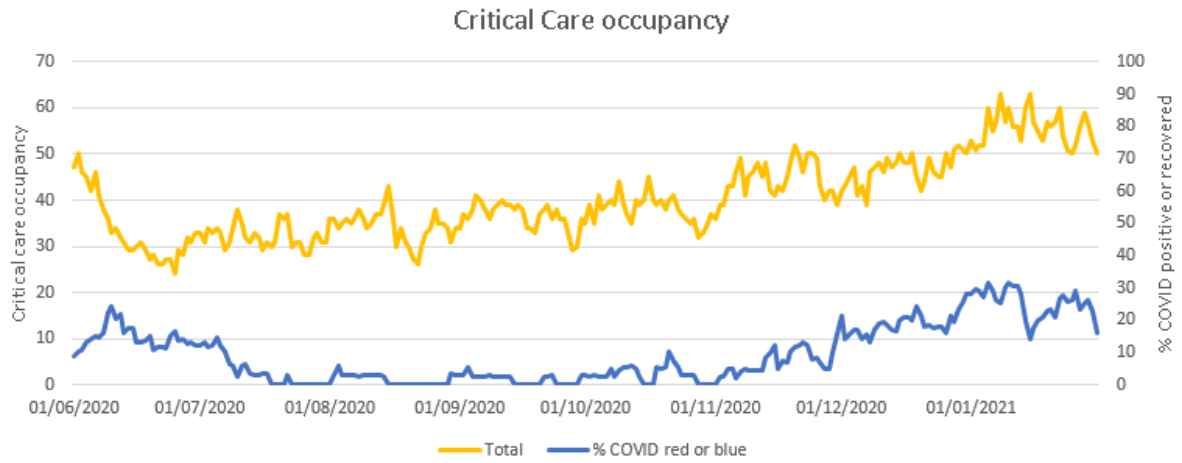
Figure 6: Acute Medical Beds (Impact of Covid & Recovery)



Critical Care

During the first wave of the pandemic the Critical Care footprint was expanded. Critical Care continues to operate above its pre-pandemic capacity. After the initial peak occupancy in April 2020, occupancy fell to lower levels during the summer months before further increases through the winter period. The average daily occupancy for January 2021 was 55.6 occupied beds with Covid-19 patients (positive and recovered) accounting for between 20-32% of occupied beds. Figure 7 illustrates the impact of Covid-19 on Critical Care occupancy.

Figure 7: Critical Care Occupancy (Impact of Covid-19 & Recovery)



Mortuary

Mortuary services have been operating at 90% capacity for more than 12 months, this is above the usual 70% average. We have seen a 10% increase in admissions on the previous highest year.

During two peaks in deaths we operated at over 150% capacity for many weeks. We designed and facilitated the procurement of a temporary body store at the Dragon's Heart Hospital and worked with Local Resilience Forum partners to facilitate and staff a regional excess deaths body store, which at the peak in January held nearly 300 deceased patients from this Health Board and Cwm Taff UHB. We worked with partners to ensure everybody was competent and capable of managing the deceased with dignity and respect.

While spreading our trained mortuary staff thinly we have supported service delivery by re-skilling laboratory support staff during the first wave downturn in elective surgical activity, this has not been possible during the current wave of deaths, where elective activity has remained at 80% of the comparable period pre-Covid. Cancer diagnostic turnaround times have remained within expectation to maximise clinical benefit during this period of sustained pressure.

We have seen an increased length of stay of patients in our care as funeral directors have reached capacity, and as families struggle with the emotional loss and limited funeral attendance exacerbated by the financial burden of funerals, there has been a significant increase in local authority supported funerals during the pandemic.

The pandemic has prevented us supporting the bereaved by curtailing visits to the deceased, we have developed a memorial wall with DOB's and initials of the deceased to convey to the bereaved that while they couldn't be with their loved one, we did provided care and respect to them, while maintaining our very high levels of dignity.

Primary Care

The immediate impact on Primary care in the Health Board was variable, in that some services such as General Dental Care and Optometry services were subject to emergency service levels only and the bulk of services were temporarily stopped. General Practitioners continued to deliver the majority of GMS services, albeit with a radical and immediate change in the mode of operation adopting virtual means of contact with the majority of patients.

General Medical Services (GMS) have faced these pressures in conjunction with an extended flu program, the delivery of a new Covid-19 vaccination program, the impact of pressures within secondary care and complexities associated with Covid-19 regulations to ensure safe premises and manage the effect on teams as a result of positive diagnosis and self-isolations guidelines.

Many of the initiatives enacted during the first Covid-19 wave are now common-place in practices to minimise unnecessary risk associated with attending the practice, and provide patients with virtual ways of contacting the practice and accessing services. This has been facilitated by the use of UHB procured e-Consult software, SMS/Video software, Microsoft Office 365/Teams and Consultant Connect.

In addition, significant work has been undertaken by the CAVUHB Primary Care Team to support clusters to strengthen business continuity plans leading into the winter period. The team has developed a local escalation process with clear direction given to describe the expected intervention by the practice, the cluster, and CAVUHB if a practice reports that its level of escalation is rising. The tool is reviewed daily by the Primary Care Team and those practices reporting level 3 or above (out of 5 levels) are followed up to understand the circumstances and identify any support that may be required.

Currently, the picture across Cardiff and Vale shows mainly low levels of escalation. However, we have seen recently that this situation can change quickly when a local practice had to close for a period due to a Covid-19 outbreak amongst staff. As a result, significant lessons have been learned and shared with all practices, and work is being concluded with CAV24/7 colleagues to set up contingency arrangements to ensure continuation of urgent services when a practice has to close (once all practice and cluster business continuity plans have failed) or are instructed to close by Public Health Wales.

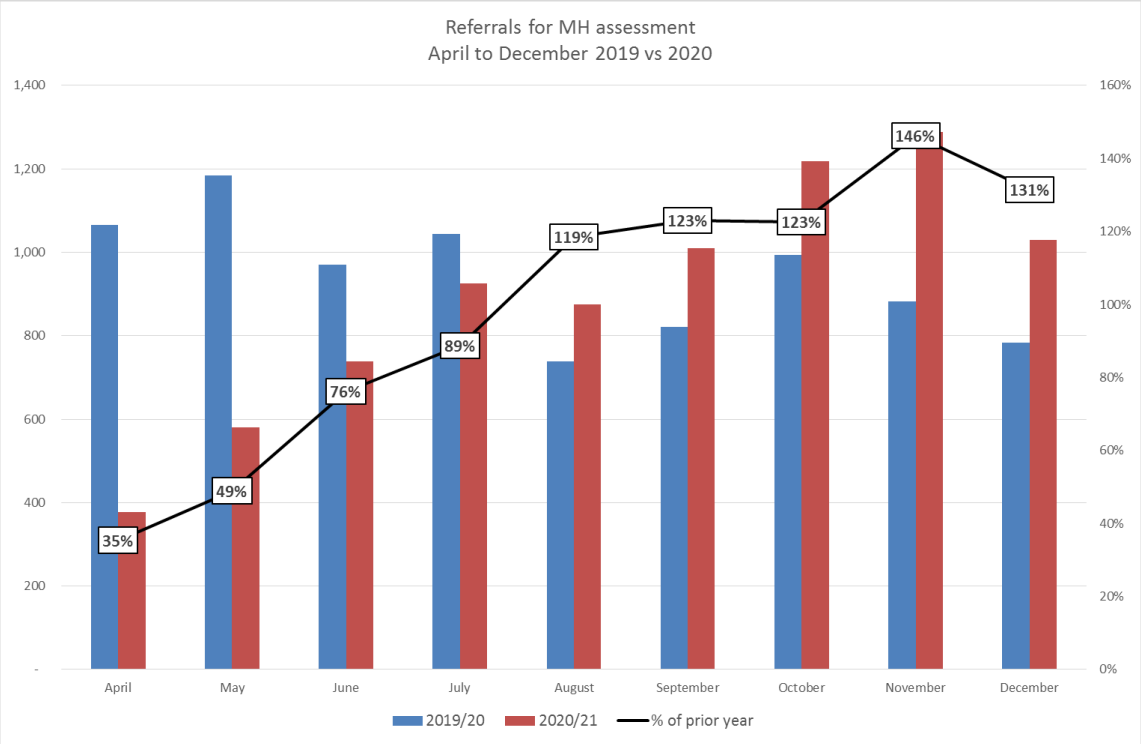
Sustainability and Recovery plans are in place for Optometry and Dental services, who are facing similar challenges related to contract obligations and IP&C considerations. A small number of Optometry practices have not seen a return to normal/average activity following the routine recall of patients attending practices and the return of routine domiciliary services.

Welsh Government wrote to all Health Boards in December 2020 advising of the Covid-19 vaccination roll-out, a review and update of the SOP, 2020/2021 quarter four arrangements and support. The communication outlined measures in 2020/2021 quarter four and detailed planning and requirements to join contract reform in 2021/2022.

Mental Health

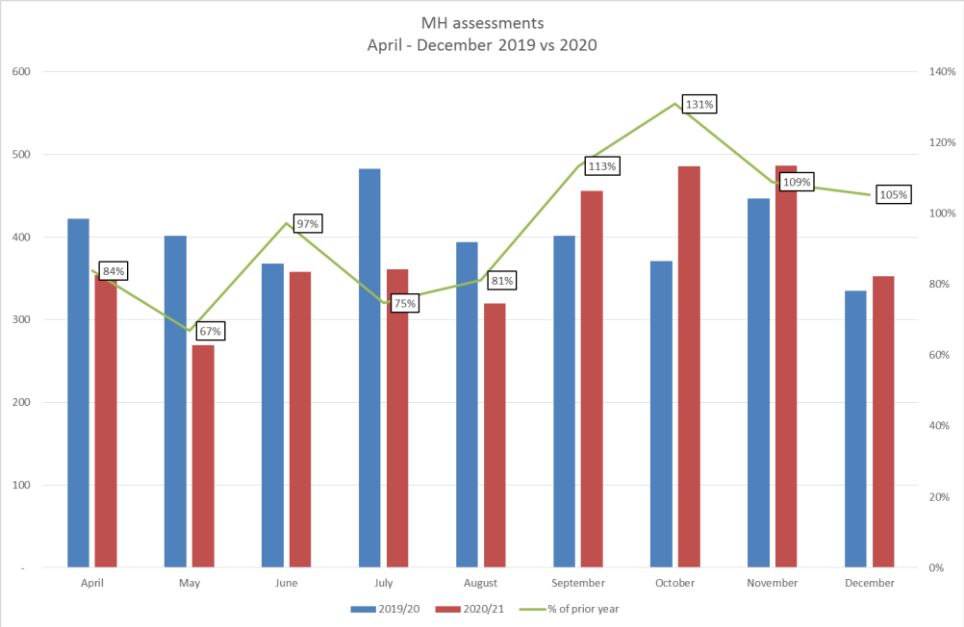
Mental Health also experienced an initial decline in referral volumes. However the planning assumption was that we anticipated a lag between the onset of Covid-19 and an increase in demand for Mental Health services. From May onwards, the service started to see an immediate recovery of referral demand and from August 2020 onward this has been at unprecedented levels, remaining at extremely high levels. Figure 8 illustrates the impact of Covid-19 on referrals for Mental Health Assessments.

Figure 8: Referrals for Mental Health Assessments (Impact of Covid-19 & Recovery)



The response of the Mental Health Services has been to increase the volume of Mental Health Assessments and since September 2020, the Health Board Mental Health service has been operating in excess of pre-Covid levels consistently. Figure 9 illustrates the response to Covid-19 by the Mental Health Assessment teams.

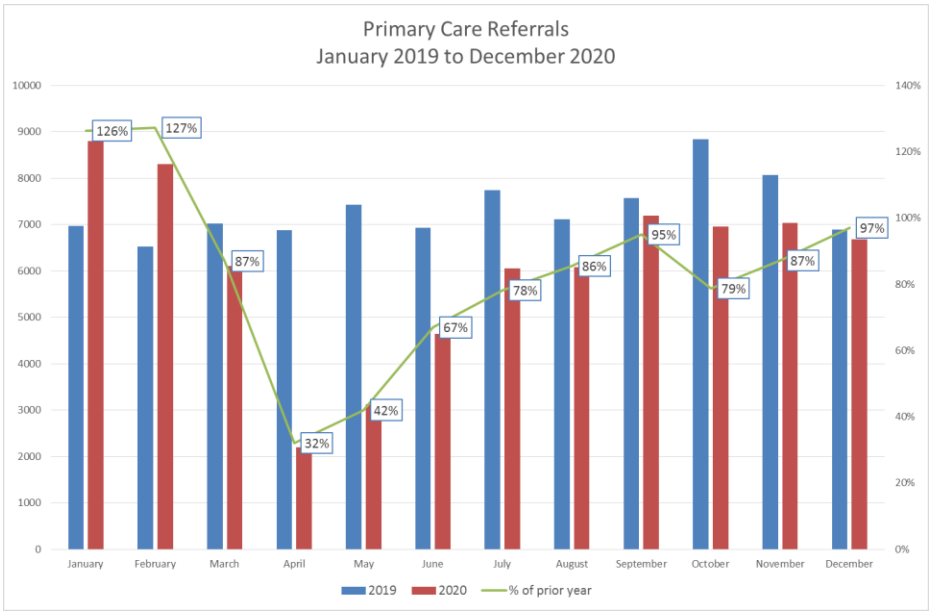
Figure 9: Mental Health Assessments (Impact of Covid-19 & Recovery)



c) Services where they may be suppressed demand due to Covid-19

The decline in referrals for services was severe and whilst recovery has been steep, referrals remain below pre-Covid levels. The assessment of what level of this demand will recover and what level of demand has been "suppressed" but will return continues to be monitored on a weekly basis. Figure 10 illustrates the impact of Covid-19 on referrals from primary care to secondary care.

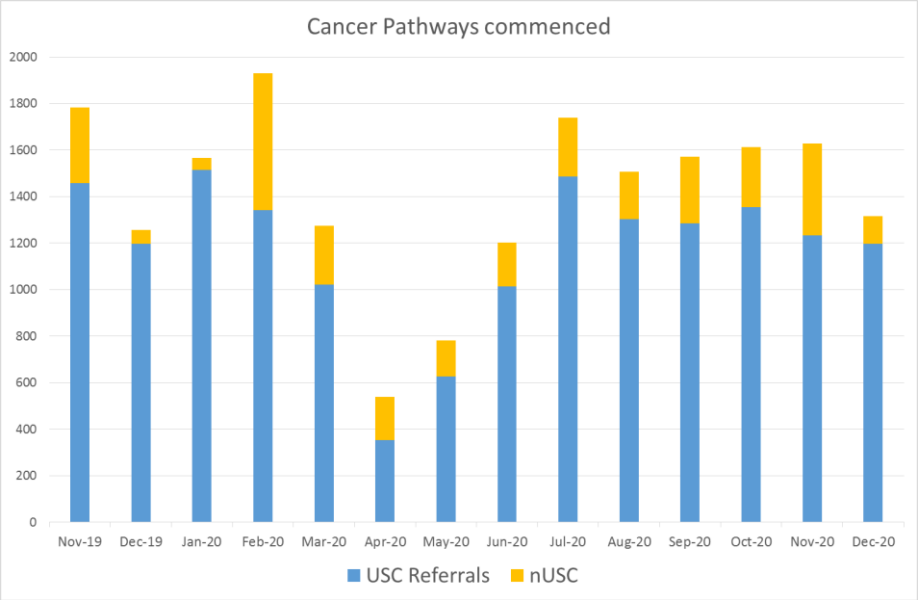
Figure 10: Referrals from Primary Care to Secondary Care (Impact of Covid-19 & Recovery)



Referrals into Hospitals from Primary Care were significantly reduced as a result of Covid-19. Volumes started to decline in March and reached its lowest point (32%) in April 2020. Activity recovered to 95% by the end of September 2020.

Figure 11 illustrates the impact of Covid-19 on the volumes of Cancer Pathways commenced in response to referrals received.

Figure 11: Cancer Pathways (Impact of Covid-19 & Recovery)



Cancer services were maintained throughout Covid-19 with the Health Board continuing to maintain essential services including diagnostics and treatments for urgent including cancer patients. There was a decline in referrals during this period, but the recovery of cancer referrals to “normal” levels was evident by July 2020. However, it is not possible to assess with any degree of accuracy the impact of the months of March to June when referrals for cancer were noticeably reduced.

2. How will you prioritise the delivery of non-Covid services to target reductions in waiting times?

Risk Prioritisation

For new referrals, there are established Clinical Risk measures in Ophthalmology which are monitored by the Health Board and reported to Welsh Government on a monthly basis. In addition, each clinical department and specialty reviews its referrals and uses clinical judgement to determine the relative priority (Urgent/Routine) and identifies the most suitable option in terms of face to face appointments or virtual outpatients.

The Health Board is taking part in national working groups under the National Planned Care Programme Board, coordinated by Welsh Government, which is proposing a national standardised and evidence based approach to risk prioritisation.

As part of our Covid-19 response, the Health Board adopted the Royal College of Surgeons criteria for prioritising surgical treatments. The Health Board undertook an exercise in Quarter three of 2020/21 to classify all of the patients on existing Inpatient & Daycase waiting lists using the Royal College of Surgeons urgency criteria.

Additional Capacity

<u>Internal capacity</u>

Whilst the creation of designated amber and green zone elective surgical capacity has not created additional capacity, it has enabled continuation of elective work at higher levels than in the first wave. The creation of a Protected Elective Surgical Unit (PESU) at University Hospital of Wales has enabled higher volumes of surgical treatments to be delivered throughout the second wave in comparison with the first wave.

<u>Independent Sector (Outsourcing)</u>

Due to the Covid-19 pandemic, the Health Board has an ongoing requirement for additional capacity to ensure the continuing delivery of essential services and the recovery of planned care in particular. The use of independent sector capacity is a core part of the Health Board's plan for both stability and recovery within and following the pandemic period and will support the reduction in backlog of patients waiting for treatment.

Cardiff and Vale Health Board was the highest user of the Independent Sector National Contract, which was funded by Welsh Government and coordinated by the Welsh Health Specialised Services Committee (WHSSC) from April 2020 onwards.

10,074 patients (of the 20,872 treated in the Independent Sector across Wales from April to December 2020) were seen and treated in Spire Cardiff by Health Board staff during this period. 43% of surgical cases were Cancer cases with the remaining 57% urgent surgery. Over 90% of Outpatients were for urgent Ophthalmology treatments, Clinical Haematology and Breast Cancer patients.

Using NHS facilities (Insourcing)

Insourcing is a tried and tested approach to maximise the use of NHS premises and equipment to deliver extra clinical capacity, outside of when they are normally in use. The Health Board has traditionally used such approaches during periods of high demand and from January 2021, a contract has been in place to support additional capacity in Endoscopy, a fundamentally important area of diagnostics supporting urgent care and particularly Cancer services. This is currently delivering between 200-300 cases per month for the Health Board.

3. How will you communicate with patients about what they can expect in terms of length of wait, prioritisation, and any management of their condition whilst waiting?

Cardiff and Vale Health Board has continued to communicate with patients and patient groups through the usual channels including through Primary Care, Community Health Councils and the Medical Advisory Group. Long waiting patients have been contacted by letter to validate waiting lists, however, there has been no explicit communication regarding predicted waiting times or delays to procedures or treatments due the uncertainty created by the continuing effects of the pandemic.

The Health Board recently undertook a significant communications exercise as part of the introduction of the CAV24/7 model for urgent care to ensure people we able to access urgent care in the most appropriate fashion. The evaluation of this identified that 91% of the population of Cardiff and Vale were reached, with useful learning regarding the most effective advertising mediums and use of the CAV website. This will be used to inform future communications exercises.

The Keeping Me Well Covid-19 Rehabilitation Model was launched in May 2020. The remit includes;
Cohort 1: People recovering from Covid-19
Cohort 2: People with Paused Planned Care
Cohort 3: People who have avoided accessing health services
Cohort 4: People who are socially isolated or part of a shielding group
The resources associated with this model include the 'Keeping Me Well' website and app – www.keepingmewell.com. The website includes information and links to support regarding, Covid-19, preparing for treatment and recovery, rehab support, children's services and resources related to self-care and caring for others. The app compliments the website and has been developed to support patients with a range of rehabilitation needs, including as a result of the Covid-19 pandemic.

4. What estimates or projections have you made of the time needed to return to the pre-pandemic position?

It would not be prudent at this stage to be specific about the length of time it will take to return to pre-pandemic waiting times.

Our key dependencies in respect of planned care include the following:

- Progression of the Covid-19 pandemic
- Time to recover to 100% levels of activity
- Backlog capacity plans
- Issue of forecasting deferred / suppressed demand

Elective Demand, Activity & Waiting Lists

The indirect impact of the pandemic on health services has been profound. Elective activity reduced to 25% at the peak of the first wave and despite some recovery, elective capacity remains at around 70% of pre-Covid levels. This has led to an unprecedented increase in the number of long-waiting patients, rising from 1,747 to 37,434. This has occurred despite the UHB protecting 'Essential' services throughout the pandemic, the extensive use of the independent sector (more than the rest of Wales combined), and the establishment of 'green zones' which allowed the Health Board to continue to deliver higher levels of elective operating than in the first wave and maintain safe operating despite the higher levels of Covid-19 in the second wave.

However, despite the reduction in activity, the longer-term impact on waiting times is less clear-cut. The fall in activity has been broadly matched by a reduction in referrals, consequently the total number of patients waiting has increased by 5%.

However the latent demand in the population is probably significant. For most services the lack of referrals is unlikely to reflect a change in the true health needs of the population - more likely the demand has simply been supressed by the pandemic. As the pandemic recedes it is reasonable to assume this demand will resurface and therefore, added to normal demand, the total referred demand may significantly exceed pre-Covid levels for many months.

A key question therefore, in planning the recovery, is how much latent demand exists in the population, in which services, and over what timescale will this present. There is no data or precedent to inform the answer to this question and as a result the Health Board has to consider a range of scenarios. Nonetheless, few (if any) services in the NHS had surplus capacity prior to the pandemic and therefore once demand in a service consistently exceeds 100% it will require sustained action to avoid waiting lists growing. It can therefore be anticipated that additional capacity will be required for most services on a 'semi-recurrent' basis.

5. Are you using or considering any new or different approaches to providing care in order to help reduce waiting times, including the use of new technologies, new care pathways, or of capacity elsewhere?

Improvement initiatives

- CAV convention approach, using our shared learning from Canterbury Health (New Zealand) and adapted for Cardiff and Vale, is our proposed model for review of all of our services. This is based on integrated working across Primary and Secondary care, clinically led and delivered via the development, agreement and compliance with evidence based Clinical Pathways.
- Supporting this approach is the continued investment and development of Data Driven Demand Modelling and analytics across all of our Health Board Operational planning and management.
- See on Symptoms and Patient Initiated Follow Up pathways are being rolled out at greater pace to reduce unnecessary 'follow up' outpatient appointments, ensure timely follow-ups for those meeting the criteria for an appointment and create capacity to see more 'new' outpatients more quickly
- Virtual tools and techniques are being adopted across more areas to increase the capacity of our clinical workforce to see more patients more quickly and safely. This includes Virtual outpatient clinics using video technology, telephone consultations and virtual reviews by Consultants of patient referrals, notes and diagnostics which can support quicker decision making and more joint management between primary and secondary care. The creation of a "Virtual Village" for expansion of Virtual Consulting at University Hospital Llandough forms part of our plans.
- Advice & Guidance tools and technologies are being used to expand options for primary care referrers to seek advice and guidance and both improve the quality of referrals to secondary care but also to where possible reduce the volumes of referrals and support management of more care and treatment in primary care, including the promotion of self-care and management by patients.
- Additional capacity via both Insourcing and Outsourcing to the Independent Sector will be an important continuing element of the Health Board response to clearing the backlog of planned care treatments. The Health Board has already included within its 2020/21.
- CAV24/7. Introduction of a 'phone first' triage system for people requiring urgent care. Operates 24 hours a day 7 days a week to signpost people to the most appropriate medical help (not necessarily EU). Calls are taken by a call handler who will escalate in the case of a life threatening emergency. Non- life/limb emergencies are logged for a clinician call back within 20 mins (urgent) or 60 mins (less urgent). A referral is then made to the most appropriate service; people requiring attendance at EU or MIU are given a timeslot for attendance.

6. What factors may affect your plans for tackling waiting times (e.g. further spikes in COVID-19 rates, issues with the workforce or physical capacity), and what plans you have in place to manage these?

Our response to question 4 sets out some elements and uncertainties which will affect the rate at which waiting times can reduce. The following are all factors when considering this:

- *Workforce* – Our staff remain our most important asset, and as a Health Board we are very aware of the exceptional pressures and demands which Covid-19 has placed on our people, in addition to the challenges the NHS faces and has faced throughout the past year and current Winter period. It is a point worth noting that there are now around 550 more people working for the UHB in medical, nursing and general areas compared to last year. In addition, the Board has invested in specific targeted initiatives focussed on retaining people to the UHB which is starting to deliver tangible improvements. Operational challenges remain around meeting winter and Covid-19 pressures, and a weekly taskforce is in place to discuss issues.

  Our immediate workforce priorities include a specific focus on expansion of our Theatre staffing groups. The Board has recently approved a major recruitment plan for our Peri Operative Directorate to recruit both experienced and newly qualified Nurses /Operating Department Practitioners to support our Operating Theatres. This includes a UK wide and internal recruitment process.

- *Essential services* – we have continued to maintain all essential services throughout the pandemic and we anticipate this will remain the case throughout 2021/22.

- *Green zones and resuming non-Covid activity* - we have done a great deal of work to develop *protected elective surgical units* at both UHW and UHL and this has enabled us to safely increase the volume of surgical activity undertaken, even during the deteriorating Covid-19 position over the past few months. There has been some reduction during January, in order to re-direct nursing staff to open additional Covid-19 treatment areas, but elective admissions remain at around 70% of pre-Covid levels. In addition our outpatient activity is currently running at 80% of pre-Covid levels (including virtual activity) and endoscopy at 85%. Our planning assumption therefore is that we will be able to maintain elective activity at above 70% of pre-Covid levels at all pathway stages, even in the event of a large third wave. As set out in our Q3/Q4 plan when Covid recedes to low levels we expect to be in a position to increase surgical activity to at least 80% of pre-Covid activity and clearly as the requirement for additional IP&C measures diminish we anticipate we will return to pre-Covid levels and beyond.

- *Independent sector* – A key contributor to us maintaining essential services and resuming elective activity, as described above, has been our extensive use of the independent sector. It is clear that continuing this into 2021/22 will be critical to ourselves and NHS Wales securing sufficient staffed capacity to begin the long post-Covid recovery.

- *Backlog* – The number of patients waiting over 36 weeks peaked at the end of November at nearly 40,000 breaches (an 18-fold increase) but has in fact begun to reduce over December and January. 60% of this increase is at stage one, new outpatients. In contrast the total RTT waiting list has grown by only 4.5%, reflecting the sharp reduction in referrals. For this reason we anticipate the backlog is only part of the story and our recovery planning will also need to consider the latent demand across our population, see below.

- *Mass Vaccination programme* – We have an existing mass vaccination plan in place, aligned to the national strategy, and in the past two weeks we have completed a 14-day 'sprint' to identify and review options for a much more rapid deployment of the vaccine should sufficient supplies become available. Vaccination is of course the route out of the pandemic and the rate at which we are able to vaccinate our population is informing our scenario planning for Covid, and in turn our post-Covid recovery.

- *Covid scenario planning* – the profile of Covid prevalence will, at least initially, be the primary determinant of the level of elective activity we are able to undertake. As part of our planning for 2021/22 we are continuing our approach from Q3/Q4 and developing three broad scenarios: Covid best-case, Covid worst-case and Covid central scenario. These will be used to ensure we can continue to respond to all eventualities and inform our understanding of the implications of these scenarios on finance, workforce and delivery of services (including recovery).

- *Latent demand* – The critical element in understanding the scale, and therefore the timescales, for post-Covid recovery is the extent to which there is unmet demand across our population that will resurface as health care demand at a later date. We know, for example, that we have undertaken 16,000 fewer surgical procedures over the past 12 months compared to the previous year. Some of this demand will have been addressed in other ways or naturally resolved, but it is likely a significant proportion will require some form of health care support over the coming years. We have the ability to analyse this by specialty and procedure and will over the coming months be taking a service-by-service approach to understand the implications of, and potential options for, this latent demand.

- *Increased Population Need* – In addition to the existing backlogs, plus latent demand, there is an expectation that the broader health, economic and social effects of the pandemic may be profound and long-lasting. We are therefore expecting the consequences of this may present as additional demand for health care services at some stage - it is likely for example that we will see an increase in demand for mental health services and there are some indications this has already begun.

Given the range of possible trajectories for Covid-19 and the uncertainty with latent demand, our planning work is predominantly taking the form of scenarios and understanding the implications of these on the recovery profile.

7. What information have you received on your allocation from the £30m additional funding for waiting times, and how you intend to use the funding?

The UHB is in dialogue with Welsh Government regarding the strategic direction of the recovery programme. To date there is no detail yet confirmed on the overall resource envelope or the share of that allocated to Cardiff and Vale. We have emerging plans on our intended approach and some specific proposals to increase capacity in some key areas, including endoscopy, radiology and ophthalmology; all of which aligns to the UHB's strategic direction and developing clinical strategy.

We have already reintroduced endoscopy in-sourcing and approved, at risk, the commission of a MRI scanner into the first six months of next year. In addition we are proceeding to 'over-recruit' theatre staffing in recognition that this is typically the rate-limiter to increasing surgical activity and in the anticipation that central funding will be available for this purpose. Over the medium-term we have a number of capital-dependent schemes in progress to increase physical capacity in key areas, aligned to our strategy, in particular endoscopy expansion at UHL and increased theatre provision.

We continue to work with our neighbouring Health Boards to align our planning and identify opportunities for regional working. This is being led through our South East Regional Planning forum that is constituted of Directors and Assistant Directors of Planning, Medical Directors and appropriate operational leadership.

Vivienne Harpwood, Cadeirydd / Chair
[redacted]

Carol Shillabeer, Y Prif Weithredwr / Chief Executive
[redacted]

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

16th February 2021

HT/SP/CS

Dr Dai Lloyd MS
Chair, Health, Social Care and Sport Committee
Welsh Parliament
Cardiff Bay
Cardiff
CF99 1SN

Sent via Email to: SeneddHealth@senedd.wales

Dear Dr Lloyd,

Evidence Submission from Powys Teaching Health Board to the Health, Social Care and Sport Committee Inquiry into the impact of COVID-19 on health and social care in Wales

1. I am pleased to provide this written evidence to contribute to the Committee's inquiry in response to the letter received on 20th January 2021 which sought responses on the matter of the impact of the pandemic on waiting times.

Context

2. Powys Teaching Health Board (PTHB) serves a population of approximately 133,000 people, in an entirely rural County with no major conurbations and no District General Hospitals (DGH) in its own borders.

3. The provision of healthcare for the residents of Powys is therefore complex, with significant cross border interdependencies. The health board is both a commissioner and a direct provider of healthcare. The issue of waiting times for the Powys population is set in this context of multiple providers across England and Wales.

Further detail is provided below on the specific Committee Lines of Enquiry.

What are the main areas of pressure, and what plans do you have in place to deal with these?

4. As noted in the context above, Powys has a complex network of provision and the areas of pressure are not solely in one provider but across providers in England and Wales.

5. The majority of Powys patients waiting times are dependent on the delivery of neighbouring providers all of whom are continuing to manage the ongoing response to the pandemic and make difficult decisions in relation to the subsequent impact on service capacity.

6. In addition, whilst the pandemic itself has not impacted as strongly in Powys as other areas, the wider socio-economic impact is significant in this rural area. Residents are experiencing the same set of restrictions on their social and economic lives with greater isolation, and a lower income and employment base. Initial analysis points to effects on the population of Powys over a very long period ahead and this has a consequential impact on health and well-being pressures.

7. The health board has a unique role as a commissioner as well as a provider of healthcare. It has a strong community based model which has played a crucial role in supporting flow across the DGH systems in both England and Wales during the pandemic.

8. The health board also has a shared long term Health and Care Strategy, 'A Healthy, Caring Powys', which is building and strengthening this community model of care. This work is even more important in the context of the pandemic, as a cornerstone for longer term renewal and recovery.

9. Our approach to addressing the challenge of waiting times is therefore in development as a holistic, strategic and operational programme of work which will be set out in more detail in our Annual Plan 2021/22.

How will you prioritise the delivery of non-COVID services to target reductions in waiting times?

10. All new referrals and existing referrals continue to be risk manage; this provides the most rapid and equitable care possible during the current period.

11. The health board has a clear 6 step approach to developing the organisation's priorities for 2021/22 and the formulation of the Annual Plan that underpins delivery.

12. A programme of renewal will be core to the Annual Plan. This is work that requires a depth of time, resource and consideration to fully explore the problem and target solutions. This will include value based approaches and careful assessment of relative risks, priorities and system impacts of any choices that are made.

13. It is already known that the impact of the pandemic is being experienced differentially by some groups in our communities, in Powys, and in Wales, as it is globally. It is this differential that will help form underlying principles for renewal and recovery.

14. The health board will be taking an approach, with partners locally, regionally and nationally, to ensure the challenges of equity and access for vulnerable groups are thought through and written into the design of the next year and beyond.

15. A focus on renewal and recovery is the key feature of partnership working, in particular the Regional Partnership Board. A draft plan has been developed and approved by the RPB which cover a range of schemes with particular expansion and emphasis on children, given the disproportionate impact on children and young people. The work of other partnerships is also key: Public Services Board, Mid Wales Joint Committee for Health and Care and other regional, cross border and national collaborations are key to our future strategy.

16. The key elements of the system working between primary and secondary care will be the wider impact of the unprecedented level of waiting times in terms of quality and safety, including:

    - shared decision making and to keep patients informed
    - risk stratification
    - investigation and response to a much higher volume of concerns
    - review of harm

17. 'A Healthy, Caring Powys' has an emphasis on collaboration not only between statutory partners for health and care but with an aim of connecting communities to improve resilience and well-being. This includes a recognition of the importance of the third sector as a first line of support for many communities. This whole system approach is critical to fully understand the roots as well as the more prominent branches of the problem now faced by our populations

18. The health board will develop its approach in line with national policies and positions to uphold equity and the principles of the NHS and to communicate and engage with communities to understand the situation, the options and the way forward.

How will you communicate with patients about what they can expect in terms of length of wait, prioritisation, and any management of their condition whilst waiting?

19. As noted above, the health board has a strong community based model which has been further strengthened during the pandemic. All health board essential services have continued to be delivered throughout the pandemic, albeit at reduced levels of capacity in the service, due to the requirements of infection prevention and control measures. Primary and Community teams involve health, social care and third sector professionals in case reviews and management.

20. Individual conversations with those most at risk or with the most complex needs are held on a daily basis through the Primary and Community teams including specialist nurses and therapists, to discuss their conditions and options. This may include well-being support, pain management or alternative local services for those people waiting for care.

21. For the wider population, a Communications Plan has been implemented focused on the promotion of access to healthcare, particularly in response to the significant change in the behaviour of the population in the first wave of the pandemic, which saw a reduction in people presenting in primary care and other access points.

22. The health board website has also been used as a portal for information on access routes to specific services and to explain any changes in the ways in which people are able to contact teams or the ways in which services may be delivered.

23. As noted above, for the majority of care pathways these will be dependent on the arrangements in neighbouring DGH providers, who are also providing tailored communications to their patients depending on the speciality and the current status of that service provision.

24. The health board established a 'DGH Log' in the early stage of the pandemic to ensure service status was tracked and communicated to stakeholders including the Community Health Council and key stakeholders.

25. The health board participates in the system arrangements and resilience forums in the main provider geographies for the Powys population to ensure the needs of Powys residents are built into their planning and communications. The main provider systems by scale of use are Shropshire, Telford and Wrekin, Herefordshire and Worcestershire and Dyfed Powys / wider NHS Wales.

What estimates or projections have you made of the time needed to return to the pre-pandemic position?

26. The time needed is determined both by external factors in relation to the pandemic but also to structural considerations across health and care. If the system operates in the same way as it did prior to the pandemic that is likely to be a slower route to recovery. The route to renewal can be quickened by innovations, collaboration and technologies already being forged during the pandemic.

27. As a provider the service capacity has held up well, and essential services have been maintained, albeit a 30% capacity reduction in some areas. More broadly, Health Boards and Trusts (England and Wales) have reduced elective activity to prioritise urgent and emergency care. The impact and timeframes across systems are not fully clear at this stage.

28. The health board has carried out initial analysis of demand and capacity and the associated trajectories over time and is conducting further work to ensure this is fully understood. The assessment is by necessity whole system and population focused, informed by an understanding of the latest evidence regarding impact on health and wellbeing. PTHB has commissioned specific pieces of work to provide this intelligence.

    - Population Healthcare Demand Trends: A desktop review of evidence is being finalised on the impacts of the pandemic on population healthcare demand in Powys including new forms and patterns of demand and inequalities.

    - Strategic Demand and Capacity analysis: this is being commissioned in partnership between health and care to provide a detailed analysis of impacts and opportunities.

    - Commissioned Services: Systematic tracking and analysis of commissioner demand and capacity including neighbouring health boards in Wales and English systems.

    - PTHB Provider Demand and Capacity Planning: local operational tracking and planning including acute flows across the system.

29. This analysis work has demonstrated that significant changes in demand were seen in 2020, in Powys as they were nationally across Wales and the rest of the UK.

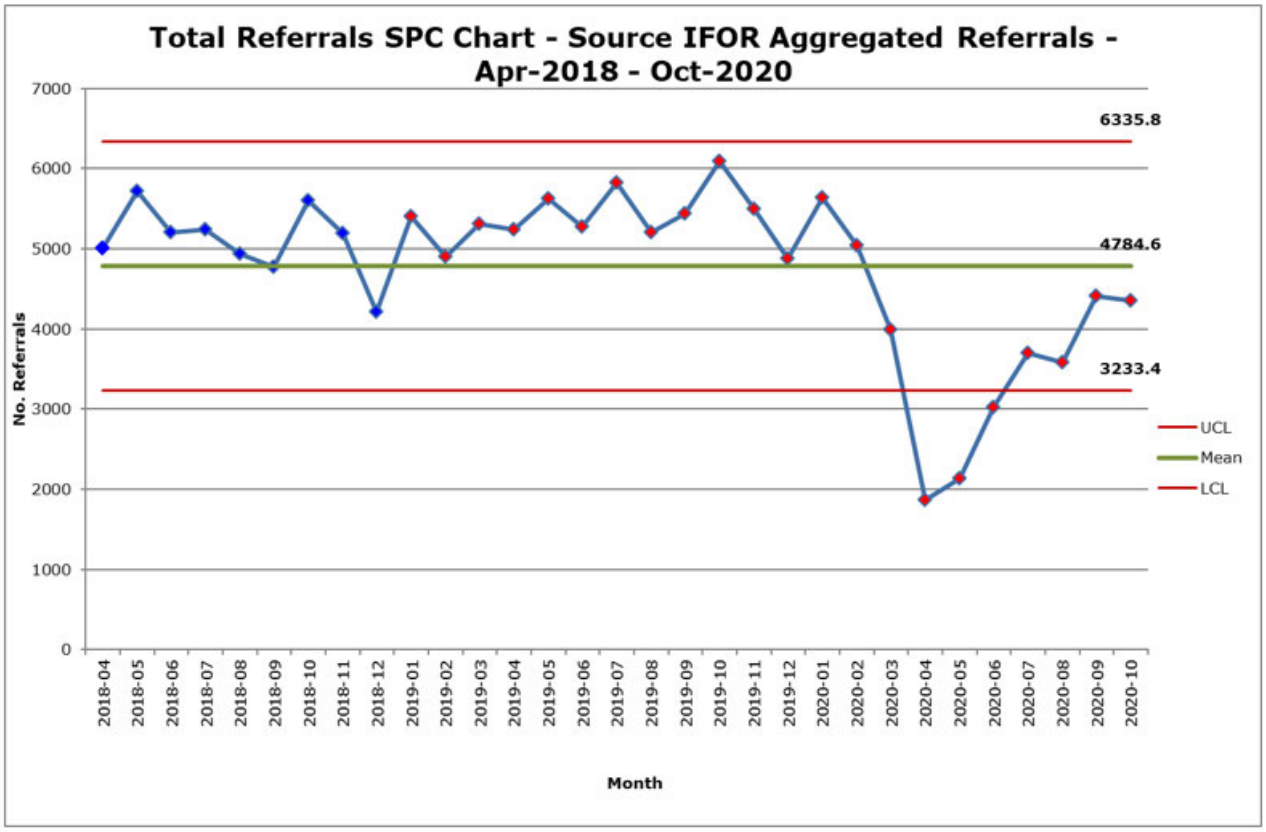
30. In the health board, as a direct provider, the use of primary and community care including community hospitals was significantly reduced as demand behaviour changed in the first wave of the pandemic Spring / Summer 2020.

31. A comprehensive communications and engagement programme was implemented to mitigate these reductions in demand and to ensure that residents understood that services were open and accessible.

32. Demand had gradually been increasing in the Autumn 2020 and Table 1 below (management information) demonstrates the pattern to the beginning of November 2020 which is the latest available data. Referral counts had returned to 92% of the mean.

33. Preliminary data for November and December 2020 is showing another wave of reduction in line with the timing of the second wave of the pandemic and the decisions being made by both providers and in terms of population behaviours at this time.

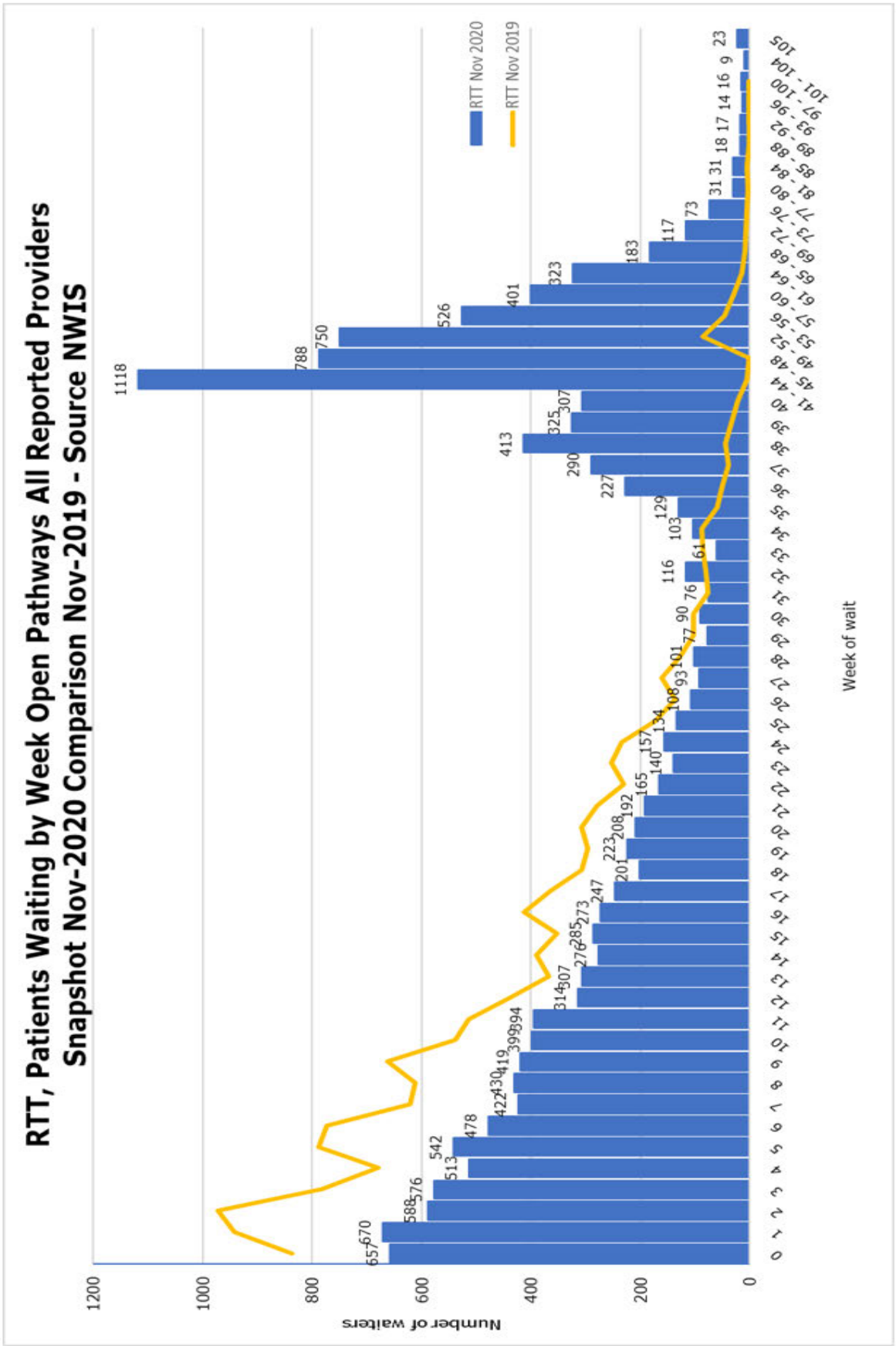
Table 1: Total Referrals (Apr 2018 – Oct 2020)



34. Table 2 below (management information) outlines the pattern of waiting times for all reported providers (PTHB provider, English and Welsh HB/Trust providers) at the November 2020 snapshot.

35. This shows the impact of national service suspensions during the first wave of the pandemic. Second wave/winter impacts are expected with a similar but potentially not as pronounced second cohort of impact resulting from service contraction/suspension.

36. Table 2: Referral to Treatment across all reported providers, Snapshot November 2020



Are you using or considering any new or different approaches to providing care in order to help reduce waiting times, including the use of new technologies, new care pathways, or of capacity elsewhere?

37. There have been significant innovations to date and these are being appraised and evaluated constantly as part of the response to the pandemic and the requirements for infection prevention and control, mitigation of nosocomial spread, physical space restrictions and social distancing. This will be a core part of the health boards Annual Plan 2021/22 and longer term renewal as part of 'A Healthy Caring Powys'.

38. For example, the digital rollout in Powys has seen significant acceleration of new ways of working and alternative service delivery, enabling healthcare to continue to be delivered across all essential services throughout the pandemic.

39. Virtual appointments have been embedded into practice where appropriate, including the roll-out of "Attend Anywhere" across our services. In many cases, the use of virtual methods of delivery facilitated even greater numbers of users supported and across a greater geography, with none of the usual travel and transport difficulties that can be experienced in a very rural County. In some cases where group work was delivered, this exceeded the contracted levels of activity across providers, at no extra cost, providing greater value and leverage of public monies.

40. Virtual delivery does not fully meet the needs of all clients such as those providing support for mental health or advocacy. In these cases the organisations have reinstated face to face support where it is safe and appropriate to do so, with some new measures and changes in the use and flow of physical spaces.

41. The third sector has also played a significant role, with an increase in activity, groups and volunteers as well as an increase in clients. The Community Connectors model was expanded to support multi-disciplinary case reviews and case management.

42. A pathway for 'Long COVID-19' has also been developed in line with NICE Guidance. This will provide access for any individual with on-going signs and symptoms or with Post-COVID-19 Syndrome.

43. Further areas are being assessed as part of the analysis of demand and capacity noted earlier. This is highlighting not only particular specialities as areas of both challenge and opportunity but also the importance of diagnostics as a critical enabler.

44. Similarly, the approach to outpatients and follow up appointments are key points in the several patient journeys across pathways which present opportunities for modernisation nationally and locally. This is

part of the health boards approach and will be given specific and detailed consideration.

What factors may affect your plans for tackling waiting times (e.g. further spikes in COVID-19 rates, issues with the workforce or physical capacity), and what plans you have in place to manage these?

45. The ongoing challenge and uncertainty of the pandemic is the primary factor.

46. Significant capacity and resource is currently being directed to the Covid-19 Vaccination programme which is a significant priority for NHS Wales, and the Covid Prevention and Response Programme, which has a number of components including Test, Trace and Protect.

47. The balance of delivery between covid and non covid healthcare, the risk of an overwhelmed system, a fatigued workforce and the wider societal impacts of the pandemic represent a significant and ongoing challenge. Addressing these 'Four Harms' will require a continual appraisal and rebalancing of priorities through the year.

48. There remain significant unknowns in relation to the course of the pandemic, and a need for a 'fluid' approach as recommended by Welsh Government in the Planning Framework for 2021/22. This will be reflected in the health boards Annual Plan.

49. Key transformation programmes will continue to be taken forward, in line with the balance of delivery noted above, reshaping and refocusing against the emerging learning and intelligence. This includes flagship partnership programmes such as the North Powys Well-being Programme, Powys Workforce Futures and the Powys Well-being Plan within which we are setting the Innovative Environments framework.

50. The key partnerships in Powys including the Regional Partnership Board and Public Services Board have begun to re-establish and reframe these key programmes and areas of work in line with our shared ambition for 'A Healthy Caring Powys' and are providing crucial spaces for wider reflection and learning across the region.

51. The response to the pandemic still requires the greatest amount of effort across all sectors, communities and individuals. It is also forging innovations that will be part of the solutions within longer term strategy, as the whole system learns and evolves.

What information have you received on your allocation from the £30m additional funding for waiting times, and how you intend to use the funding?

52. The health board is awaiting confirmation of the allocation to support recovery activity in 2021/22 having been informed that it will be subject to a separate funding allocation.

53. As a provider and commissioner, the health board will utilise the funding in line with our Annual Plan priorities and the agreed approach to 'Planning Ahead' (the Boards strategic priority for renewal and recovery). This will include further assessment of demand and capacity across provider plans internally and externally to understand the position and identify and cost robust activity and capacity plans.

54. In previous years funding has been allocated on a provider basis in Wales and we would seek to ensure that the appropriate commissioning allocation for the Powys population is fully included in any provider plans, given the unique arrangements for this part of the Welsh population. This will ensure that health board can agree appropriate levels of activity and funding for the Powys resident population share of that funding.

55. The health board is taking a whole system and value based approach to Planning Ahead, as noted above, building on the innovations and collaboration forged during the pandemic to accelerate capacity and speed of delivery and maximise the use of funding provided.

I hope this provides a useful overview of our approach. Please do let me know if the Committee requires any further information.

Yours sincerely

Carol Shillabeer
Chief Executive

COVID 19 : EVIDENCE TO THE HEALTH, SOCIAL CARE & SPORTS COMMITTEE

INTRODUCTION

The Health, Social Care and Sports Committee, in a letter dated 20th January 2021, sought Health Board perspectives on the impact of COVID-19 on health and social care, with a particular focus on waiting times. Provided below is Swansea Bay University Health Board's perspective to each of the questions asked:

1. What are the main areas of pressure, and what plans do you have in place to deal with these?

Whilst the overall number on the waiting list has grown significantly through the period of the pandemic, the largest increase in Swansea Bay University Health Board is at the first outpatient stage. The reason for this has been the cessation of appointments during the first lockdown and the limited re-introduction since. The Health Board is currently providing approximately 70% of the outpatient capacity it had pre-Covid and 40% of all appointments (new and follow up appointments) are being provided virtually. We continue to promote the use of virtual appointments, particularly for follow up appointments.

Demand from Primary Care has reduced during the pandemic and the Health Board is promoting virtual platforms that will provide advice, guidance and triage to GPs to prevent unnecessary referrals into secondary care and to advise on treatment options. This will form a key part of the Health Board's strategy for managing demand and we are targeting the top 10 referring specialties in the first instance with a view to ensuring that all specialties are able to provide this service to GPs by the end of September 2021. The evidence base is that this reduces considerably referral demand but will require change and investment within the HB.

We are working with GP clusters to maximise the management of patients within primary care, in particular those with chronic conditions and where minor surgical procedures can be undertaken at practice or cluster level. The modelling against international best practice would suggest considerable opportunities to develop these based on local alternatives through joint Primary and Secondary care clinician working linked to agreed pathways of care, digitally enabled change and a change in working practices.

Whist the demand for diagnostic investigations has not increased significantly during the pandemic this is in part because of the reduced level of outpatient activity. When this activity begins to increase there will be latent demand that will need to be addressed. Currently the Health Board's greatest pressure is in relation to non-obstetric ultrasound and this will be the area of focus as services return to normal activity levels. There are also backlogs in other modalities such as MRI and CT scanning. We will seek to commission additional capacity through both insourcing and outsourcing in both these areas on top of the internal solutions, such as extending the hours that such diagnostics are made available. This will be needed in the medium term for a sustainable reduction in the HB and will require revenue and capital investment.

It is important to highlight that improved access to diagnostic investigation in general practice will be a key component in managing demand at the outpatient

stage, which the Health Board will facilitate. This will include improved access to endoscopic investigations, some of which may be provided on a regional basis given the need to increase cancer capacity and maintain waiting times at an acceptable level.

The number of patients requiring either in-patient or day case treatment at the end of January had grown to 17,172. In terms of volume the greatest numbers are in orthopaedics, ophthalmology (in particular cataracts) and general surgery. However, there will be other regional services (plastics, cardiac, vascular, hepto-biliary, spinal) provided at Morriston Hospital will equally need to be addressed because of the clinical urgency.

It is anticipated that the levels of theatre capacity will be at 60-65% of pre-Covid activity level during the first quarter of 2021/22 with further improvements into the 2nd quarter. Therefore, the current backlog will increase until such time that theatre capacity returns to pre-Covid level. Addressing the backlog will then require additional activity above pre-Covid levels to be undertaken. There will be a number of components to this including additional internal capacity, regional solutions to address capacity, and in-sourcing and outsourcing support. The Health Board will need to consider how it can use increasing elective centres in its bed base to maximise efficiency and operate these more than 5 days a week. Finally, we have to acknowledge the uncertainties around Covid incidents in 2021/22 and its impact on capacity and our workforce. The current impacts of Covid are considerable and have resulted in service levels being unchanged, higher staff sickness and reduced productivity in elective cases, as a result of infection practices for example.

2. How will you prioritise the delivery of non-COVID services to target reductions in waiting times?

The Health Board has followed the Royal College of Surgeons (RCS) advice on recommencing surgery and we have established a system where patients are prioritised based on risk. This will continue to be the case.

For surgical activity, patients are prioritised both within the surgical specialities as well as across the specialty areas ensuring that there is senior clinical oversight into the prioritisation and case selection process to ensure that the available surgical capacity is targeted at the most clinically urgent cases. For example, for paediatric cases we have established a surgical clinical reference group which reviews the surgical waiting list to determine the priority order of patients.

In terms of outpatient and diagnostic activity the Health Board established a Quality Impact Assessment (QIA) process to reactivate services and it is our intention that we would continue to utilise this process as we gradually restore service levels to ensure that those at greatest risk of harm are prioritised. We are refocusing our Reset and Recovery work cells into our Planned Care Recovery Board which will ensure we adopt a whole system approach to planning and delivering on our recovery actions. This will include the actions we will take at a local, regional and national level.

We are aware of work being undertaken through the auspices of Welsh Government to develop a risk stratification approach to addressing the current backlog and this would be extremely beneficial in ensure that a consistent approach is taken across Wales, especially as a provider of regional services.

3. **How will you communicate with patients about what they can expect in terms of length of wait, prioritisation, and any management of their condition whilst waiting?**

We have developed a specific section of our website which summarises the service provision for essential and routine services

We have utilised technological solutions to improve access for patients virtually to consultants and to their GPs via *Attend Anywhere* and *Consultant Connect* respectively. Speeding up advice and opinion for patients on waiting lists who are concerned about their condition and allowing us to prioritise face to face appointments if necessary and if relevant reprioritise patients for treatment using the RCS criteria. There is a need to embed these consistently for use across the health board to maximise their effectiveness.

All services are connecting with their patients differently depending on the needs of the service. For example in spinal surgery, surgeons are working with MCAS (Musculoskeletal Clinical Assessment Service) in clinic settings to increase the number of patients seen in outpatient services and have significantly reduced the number waiting in Stage 1 during the pandemic. They are able to offer scans, alternatives to surgical treatment options when suitable and follow-up access to virtual advice

We have regular discussions with the Community Health Council in order to keep them appraised of the position across our services. In January 2021 we have worked with the CHC to distribute a patient experience questionnaire to a sample of 2000 patients waiting on the orthopaedic waiting list. The response will go to the CHC anonymised for analysis and will provide a significant insight into patient experiences whilst on a waiting list and offer opportunity for use to consider how we improve experience and access further for patients.

4. **What estimates or projections have you made of the time needed to return to the pre-pandemic position?**

The Health Board is in the process of undertaking a detailed demand and capacity analysis to inform the timescale for recovery plan for planned care. Initial projections suggest that it could take approximately 5 years to return to pre-pandemic waiting list numbers and considerable additional investment to meet the service sustainability challenge which would be outside the resources the Health Board can reasonably expect or generate to support investment. However, the impact of demand management initiatives and a more risk based approach to the delivery of planned care have not yet been modelled; these may result in these timescales being decreased.

5. **Are you using or considering any new or different approaches to providing care in order to help reduce waiting times, including the use of new technologies, new care pathways, or of capacity elsewhere?**

   As referred to above the Health Board is actively promoting the utilisation of virtual platforms to deliver services. There has been very good take up in Primary Care of *Ask MyGP*, a practice management system and digital platform that has increased access to primary care (use of the system is our Cwm Tawe cluster, for instance, led to a tripling of patient contacts). The system allows for virtual consultations in line with patient preferences. By the end of December 2020, we had over 130,000 registered users of the system in Swansea Bay. We are also championing the use of Consultant Connect to enable improved interaction between primary and secondary care. This is supporting the appropriate management of demand. This is in additional to telephone consultations and clinical note reviews which have been part of normal practice for some time.

   The Health Board is also participating in some pilot work in the area of Virtual Group Consultations (VGC), initially in Rheumatology and Dermatology, where patients with the same clinical conditions are seen collectively. This enables advice to be shared with a number of patients at the same time and also provides peer support for the patients, who are able to share experiencing. Face-to-face group consultations has been part of the Health Board delivery plan in Mental Health (including CMMHS) to date but VGC has the potential to support a wider range of condition specific group consultations.

   We are focused on standardising initiatives and pilot activity to ensure it becomes standard practice where they have proven to improve patient experience and outcomes or efficiencies.

   We are working on a regional footprint in a number of high volume or clinically urgent areas on joint solutions to joint challenges, for example working with Hywel Dda UHB on Ophthalmology and Cardiff and Vale UHB on cleft lip and palate. There is an advanced business case and the use of NPTH as an elective orthopaedic centre development and interim capacity until this is developed. We would strongly suggest this should be supported and rapidly implemented. There are a myriad of further changes we will be making.

6. **What factors may affect your plans for tackling waiting times (e.g. further spikes in COVID-19 rates, issues with the workforce or physical capacity), and what plans you have in place to manage these?**

   Any plans that the Health Board develop is obviously contingent on there being no further spikes in Covid rates. Should it be the case that there is a further spike in the Summer months then clearly the current plans to increase activity at all stages of elective care will be delayed. Similarly, a judgment has to be made in formulating demand and capacity plans whether periods of “lockdown” will become more common place as the Covid virus will mutate and current vaccines’ effectiveness may necessitate it.

There were workforce challenges in a number of specialities in Swansea Bay prior to Covid and the ability to increase capacity will exacerbate these. Therefore as well as enhancing current staffing levels, the ability to ensure that all staff work at the top of the professional licence will be key to delivery of the recovery plans. There will be a need to develop working across the whole week including weekends to address the scale of change and increases in the workforce in key specialties to secure this. The role of GPs, optometrists and dentists in supporting the delivery of elective care must also be enhanced to provide additional capacity with the necessary access to diagnostic investigation to facilitate this.

The scale of the recovery plans is such that there will be a requirement to provide additional physical capacity to ensure that clean “green” streams are maintained for surgery. This will necessitate additional theatre and ward capacity on some sites together with potential opportunities for regional collaboration e.g. orthopaedics, endoscopy, imaging and ophthalmology. There is also a key role for the independent sector in Wales in providing “green streams” for some specialties and long term commitments (3-5years) will need to be established to secure regular capacity to support recovery.

Finally, there will be a need for capital and revenue investment linked to robust plans for recovery to enable the changes required to occur.

7. **What information have you received on your allocation from the £30m additional funding for waiting times, and how you intend to use the funding?**

Through our annual planning process, we are prioritising the allocation of resource in line with priorities. The Health Board has welcomed previous performance funds to meet access needs. It is likely that that significant funds will be needed over a number of years to address the access issues exacerbated to the pandemic and to provide sustainable clinical service models. These need to be based on certainty of recurrent funding and not “one-off” non-recurrent finance and service solutions. This is because we need to deliver in the medium term a re-balance of system demand, invest in digitally enhanced change, focus our hospitals on care functions and expand our primary/community service offers and invest capital in out-of-hospital and specific developments such as orthopaedic centres for the regional partners. Our focus will always be to drive internal efficiencies and exhaust opportunities to maximise internal capacity prior to looking at other solutions.

Lord Dafydd Elis-Thomas

Deputy Minister for Culture, Sport and Tourism

Dyddiad | Date: 9 February 2021

Pwnc | Subject: Follow-up work on the impact of COVID-19 on sport

Annwyl Dafydd,

Since the beginning of the COVID-19 pandemic, the Culture, Welsh Language and Communications Committee has examined many of the implications of COVID-19 for areas within your ministerial portfolio. This has included our initial **report on the impact on sport in Wales** published in June 2020. In January 2021 we agreed to revisit this area of work and took evidence from the following individuals and organisations:

- Brian Davies, Sport Wales;
- Victoria Ward, Welsh Sport Association (WSA);
- Jonathan Ford,Football Association of Wales (FAW);
- Marcus Kingwell, EMD UK; and
- Steve Phillips, Welsh Rugby Union (WRU).

We are very grateful to all those who assisted the Committee in its work. It is important to stress from the beginning that, due to the limited amount of time currently available to the Committee, we were unable to take a broader look at other sports that undoubtedly play an important role in local communities and our national life. Instead we hope to raise some of the issues which are common to the whole sector.

A **transcript of the session** is available on our website. Following the session the Committee agreed to write to you with a number of questions, findings and recommendations which are set out in the annex below.

I am also copying this letter to Dai Lloyd MS, Chair of the Health, Social Care and Sport Committee.

Yours sincerely,

Bethan Sayed MS

Chair of the Culture, Welsh Language and Communications Committee

Annex

Impact of the pandemic on participation and physical activity

The impact of the pandemic and lockdown measures were variously described as "catastrophic" and "devastating" for sport in Wales.[1] Brian Davies of Sport Wales described the impact of the current lockdown measures as "paralysing" particularly at a grassroots level.[2] Under current level four restrictions, all but a very small number of elite sporting activities are prohibited. Outside the professional sports (such as rugby, football and netball) Mr Davies estimated that only around 200 athletes in Wales have a dispensation from the lockdown regulations.[3]

In terms of physical activity, **research by Sport Wales** suggests that the pandemic has, to an extent, reinforced and exacerbated existing trends. The Sport Wales survey found that overall participation in sport and physical activity in Wales kept to roughly the same levels during lockdown, despite no structured sport taking place. However, children, older adults (55+) and those from lower socioeconomic backgrounds tended to take part in less sport and physical activity during lockdown than they had done previously.

Victoria Ward from WSA and Brian Davies from Sport Wales agreed that the pandemic has exacerbated the existing "inequalities gap" in terms of physical activity.[4] Similarly, Marcus Kingwell of EMD UK stated that the impact of pandemic had been, in particular, "very detrimental to women." Mr Kingwell said:

> "[…] within group exercise, which is pretty much the most popular physical activity that women take part in, 80 per cent of the participants are female. So, with restrictions on that—and I fully accept them in level 4, by the way—it disproportionately impacts women. And if we look back through the history of sport and physical activity in an organised manner, there's been significantly more barriers to female participation across the board, and those are starting to return."[5]

When our evidence session took place, the level four restrictions in Wales limited individuals to outdoor exercise, once a day and alone, with members of their household or support bubble. Victoria Ward of the WSA stated that they would welcome an adjustment to these regulations allowing for more than one household to join together for the outdoor exercise, which would "bring us into line with other home countries". [6] At the most recent three-week review of the coronavirus regulations on 29 January, the First Minister announced that the regulations would be amended to allow a maximum of two people from two different households to exercise together.[7]

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[1] Welsh Parliament, Record of Proceedings, paragraphs 91, 92, 98
[2] Paragraph 8
[3] Paragraph 10
[4] Paragraphs 28 + 31
[5] Paragraph 147
[6] Paragraph 73
[7] Written Statement, **Written Statement: Review of the Health Protection (Coronavirus Restriction) (No.5) (Wales) Regulations 2020** – 29 January 2021

The consequences of the pandemic continue to be felt keenly across the sector and at all levels. There are continuing signs that the impact of the pandemic on participation and levels of physical activity are being felt unevenly across different socio-economic and demographic backgrounds. We have also heard concerns through our day-to-day work about the impact that a lack of physical and sporting activities is having on children and young people and the toll that this is having on their physical and mental health and well-being.

Recommendation 1) The Welsh Government should work with Sport Wales and others to conduct further research on the impact of the pandemic on levels of participation in physical activity on groups with protected characteristics in order to inform post-pandemic planning and policy. This research must include an assessment of the impact on participation for women, the BAME community, and on children and young people.

As noted in evidence – different level/tier four restrictions apply in Wales, Scotland, and England as regards outdoor exercise and the Committee heard calls for these to be looked at again.

We welcome the decision by the First Minister to allow two people from two different households to exercise together (provided every effort is made to maintain social distancing) along with an exemption for accompanying children under the age of 11. In our view this exemption should also be retained in any future level four lockdown.

While tackling the pandemic must take precedence – there are clear public health benefits (both physical and mental) to physical activity and exercise. Currently all but a very small and limited set of activities are prohibited and (in addition to the concerns relating to specific groups noted above) this is having a significant negative impact on individuals and the sector as a whole.

Recommendation 2) When conditions (in terms of controlling the virus) allow, the Welsh Government must ensure that gyms, sport venues, and other exercise settings (including group exercise classes that meet outdoors) are among the priorities when coming out of lockdown.

Guidance and the coronavirus control plan

Stakeholders were supportive of the new **coronavirus control plan** published in December 2020 which outlines the different activities that are permissible across the four alert levels in Wales.

Sport Wales, EMD UK, the WRU and the FAW all agreed that the level of engagement with the Welsh Government had been good.[8] Moreover Jonathan Ford of the FAW and Marcus Kingwell of EMD UK both wanted to be more heavily involved in the detailed aspects of future guidance. In particular Mr Ford stated that there was sometimes "a disconnect" between discussions and the eventual policy as it is written and communicated more broadly. Mr Ford cited the example of the 30 person limit on outdoor activities (previously in place during the summer of 2020) stating that it

[8] Paragraphs 17, 111, 112, 113

seemed "an arbitrary figure that was used across society" and was not "generated with any consultation."[9]

The Committee welcomes the good levels of engagement between the sector, the Welsh Government and officials at senior levels and expects this to continue in the coming months. We have subsequently received information which suggests, however, that information is not always cascading from senior levels to the grassroots in an effective and timely manner. We therefore expect every effort to be made to ensure that guidance and information is disseminated effectively by the Welsh Government and relevant bodies to the grassroots level when future changes take place.

In terms of future guidance, we note that the rule regarding a maximum of 30 participants for outdoor exercise remains in place in the new coronavirus control plan across alert levels two and three. This rises to 100 participants at alert level one.

Recommendation 3) We would welcome more detail on how the maximum number of 30 was decided on. To enable us to do this, the Welsh Government should publish the scientific evidence upon which this rule is based. Furthermore, the Welsh Government should outline what assessment it has made of the impact that a 30 person limit will have on the resumption of sport activities particularly at grassroots level.

Spectators and spectator sports

COVID-19 restrictions since the beginning of the pandemic in Wales have prohibited all spectators from physically attending sporting events. The detrimental economic impact on sport of prohibiting spectators - and the revenue they bring - has undoubtedly been profound.[10]

Jonathan Ford, from the FAW and Steve Phillips, from WRU, stressed the importance of establishing a clear road map for the safe return of spectators to sporting events (across all levels of the game). Mr Ford explained:

> "It's having a little bit more clarity so that people can see that there's light at the end of the tunnel. At the moment, there's no light at the end of the spectator tunnel, and we would just like to have some assurances that there is a plan going to be put in place, and if things go according to plan, which we appreciate that everything changes, but if they go according to plan and the vaccination roll-out works and the numbers come down and we go down the scales, it will be increased. If people can understand that, they can start putting their business models back in place. At this moment in time, the business model is broken without match-day attendances and without the additional spend, and we just need to try and find that solution, otherwise people are looking back at me and I cannot be the bank, unfortunately; we only have so much money and we are looking at survival ourselves."

[9] Paragraph 112
[10] Paragraphs 66, 102, 158

Jonathan Ford from the FAW, explained that the mixture of professional and semi-professional teams playing in the Welsh premiership means that the Welsh premier league cannot currently operate. The WRU added that this is also the case for the Welsh rugby premiership.[11]

In terms of the 2021 Six Nations Tournament, Steve Phillips of the WRU explained that normally the three tournaments (senior women; senior men; and the under 20s tournaments) are run concurrently but that with the coronavirus protocols around facilities, testing etc. this would not be possible. Mr Phillips explained that it was now their intention to run each tournament separately and in turn.[12]

The sector as a whole is to be commended for the way in which it has worked to ensure that some sporting activities have been able to take place, sometimes involving personal sacrifices by the sportspeople themselves. Notable examples of sporting activity have included the safe resumption of the professional football league and the recent Autumn Nations Cup.

We note that the mixture of professional and semi-professional clubs playing in important sporting leagues such as the Welsh rugby and football premierships means that those leagues are currently at a stop. This is in contrast to the small number of professional football clubs playing in the English football league.

When the Committee set out to revisit the issue of COVID-19 and sport, one of the key areas of interest to us was the safe resumption of spectator sports. During the autumn, Wales was the only UK nation to prohibit spectators attending sporting events in a limited way. The fact that the public health situation across the UK deteriorated so significantly in the interim, is proof of the difficult job the Welsh Government and the sector, has had in terms of responding to an unpredictable and fast-moving pandemic.

Recommendation 4) The Welsh Government should outline its view on:

- ***the conditions that would enable piloting of safe spectator sporting events;***
- ***the relationship between the vaccination programme and the return of spectators to sporting events;***
- ***details of any engagement it is having with Welsh clubs playing in the English football league to ensure joined-up thinking; and***
- ***an update on the current timescales that it is working towards in that regard.***

The Committee notes the decision to postpone the 2021 Six Nations Women's tournament and expects every effort to be made to ensure that the tournament can take place later this year.

[11] Paragraphs 95 + 96

[12] Paragraph 143

Funding

Financial support for the sector has been critical to weathering the storm of the pandemic. Sport Wales outlined how a total of £22.7 million in funding had been allocated so far in response to the COVID-19 pandemic.[13] Mr Davies said:

> "the Be Active Wales fund has been the primary source for community clubs et cetera to apply, but we've also supported governing bodies, and some governing bodies have also allocated some of that resource down to that level of their membership. We've allocated around about £2.2 million of the Be Active Wales fund, and that has all gone to community grass-roots organisations. I'd have to dig out the exact stats, but it's something like around about 900 supported applicants, who would all be different entities. Football has been a big beneficiary of that, but that's what you'd expect; there are far more football clubs than any other type of clubs at grass-roots level. So, around about £2.2 million has gone, through the Be Active Wales fund, and we've supported governing bodies, not only with protected funding they would have had annually, but also £2.5 million worth of additional funding for, primarily, grass-roots activity that they're responsible for."[14]

At the same time, Victoria Ward of the WSA cautioned that while Sport Wales had "done a great job in terms of getting money out into communities," the funding to date was small in relative terms and would not offset the loss of income faced by the sector.[15]

Similarly the FAW described the funding through the Be Active and Sport Resilience Fund as "a lifeline" but cautioned that more funding would be needed to ensure that the nearly 1,000 football clubs can survive. Mr Ford also highlighted other sources of funding that his sport had benefitted from including FIFA and the National Lottery.[16]

In terms of the impact on individual practitioners within the sector, Marcus Kingwell from EMDUK, highlighted the **gaps in support,** particularly for those who are self-employed.

On 25 January the Welsh Government announced a £17.7 million **Spectator Sports Survival Fund**. The vast majority of this Fund (£13.5 million) has been allocated to the Welsh Rugby Union with the next three main recipients – football, cricket, and horseracing – receiving between £1 and £1.5 million each. The Welsh Government said that this funding was "based on an assumption that spectators are unlikely to return in any significant numbers before the summer".[17]

In response to this pandemic, the Welsh Government has allocated an unprecedented package of funding support for the sector and the Committee commends the way in which the sector has worked together to distribute this funding.

In terms of support for the self-employed we heard of gaps in the support provided, and despite one-off payments of £1,500 – which are very welcomed - from the Sport Freelancers

[13] Paragraph 51
[14] Paragraph 55
[15] Paragraph 59
[16] Paragraphs 157 - 158
[17] Welsh Government written statement, 29 January 2021

Fund, it is clear that the self-employed face another prolonged period without access to income. Furthermore, we understand that different criteria applied to Phase 2 may make it more difficult for some self-employed people to claim (see additional information from EMD UK).

Recommendation 5) The Welsh Government should respond to the concerns of EMDUK regarding Phase 2 of the Sport Freelancers Fund. In particular, the effectiveness of arrangements to support self-employed people within the sector.

We welcome the funding to support spectator sports in Wales and agree that while spectators are prohibited from attending events the Welsh Government should continue to support them. We note that the vast proportion of this funding has been allocated to the Welsh Rugby Union and would welcome more detail on the rationale for this.

Recommendation 6) In terms of the Spectator Sports Survival Fund, the Welsh Government should:

- ***provide more detail on the rationale behind allocating the vast proportion of the Fund to Rugby Union;***
- ***confirm whether this funding has been re-allocated from spending elsewhere or is it new money;***
- ***confirm the timescales for reaching a decision in relation to any additional funding mentioned in the written statement from 29 January 2021; and***
- ***confirm whether there are any conditions attached to the funding provided to governing bodies, if so, how will the Welsh Government ensure that funding is fairly distributed among different tiers and levels of activity – particularly the grassroots level.***

We also previously heard concerns regarding the financial sustainability of leisure trusts, given the extended reduction in incomes they have faced. What assessment has the Welsh Government made of the financial sustainability of leisure trusts, and what financial support is available to help those trusts that need it to survive the pandemic?"

Post-pandemic recovery for the sector

Looking ahead to post-pandemic recovery, stakeholders agreed that more could be done to align sport and physical activity policy with public health in future.[18]

Brian Davies explained that Sport Wales has been involved in discussions on COVID recovery at a high level, but that he and the sector would like to play a more "fundamental role".[19] In particular Mr Davies cautioned that the future resilience of the sector is "interlinked" and that "what we don't

[18] Paragraphs 182, 183, 184

[19] Paragraph 36

want to do is focus on one thing more than another, and certainly not an elite at the expense of community sport."[20]

This was also a key theme in **our previous report** where we called for greater cooperation between the health and sports sectors in planning for post-pandemic recovery.

The second wave of the pandemic has meant that planning for post-pandemic recovery has been put on hold for the time being. However, there are encouraging developments on the horizon including the roll-out of mass vaccination.

The Welsh Government should ensure that post-pandemic recovery has a strong emphasis on the benefits of sport and physical activity.

Recommendation 7) We would welcome an update on the Welsh Government's post-pandemic recovery planning to include:

- ***detail on how it is engaging with the sport and health sectors to ensure a joined-up approach to policy-making;***
- ***the implications of the rollout of mass vaccination for the COVID-19 recovery timetable; and***
- ***what lessons it has learnt from the pandemic about the preventative health benefits of physical activity. Will this experience lead to a step-change in this area, and if so, how will this be achieved?***

[20] Paragraph 44

Senedd Cymru
Welsh Parliament
Petitions Committee

Dai Lloyd MS
Chair, Health, Social Care and Sport Committee
Welsh Parliament
Ty Hywel
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10 February 2021

Dear Dai

Petition P-05-812 Implement the NICE guidelines for Borderline Personality Disorder

The Petitions Committee has been considering the above petition, which we discussed most recently at our meeting on 26 January.

We considered correspondence in which the Minister for Health and Social Services stated that, whilst clinical guidelines produced by the National Institute for Health and Care Excellence (NICE) are not mandatory for NHS organisations to follow, the Welsh Government would expect all organisations to take relevant NICE guidelines into account. The Minister also noted that NICE and Healthcare Inspectorate Wales (HIW) have recently signed a Memorandum of Understanding and are exploring options to consider the implementation of NICE guidelines more systematically as part of the inspection process.

In light of this, we agreed to write to you to ask whether the Health, Social Care and Sport Committee has undertaken any scrutiny of the implementation of NICE guidelines in Wales, or whether this would be an area that you would consider recommending that your successor committee may wish to look into further in the Sixth Senedd?

In writing to you, the Committee also agreed to close the petition at this point.

Further information about the petition, including related correspondence, is available on our website at: https://business.senedd.wales/ieIssueDetails.aspx?IId=21491&Opt=3.

If you have any queries, please contact the Committee clerking team at the e-mail address above, or on 0300 200 6454.

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Yours sincerely

Janet Finch-Saunders MS
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Welsh Parliament
Health, Social Care and Sport Committee

Janet Finch-Saunders MS
Chair
Petitions Committee

12 February 2021

Dear Janet

Petition P-05-812 Implement the NICE guidelines for Borderline Personality Disorder

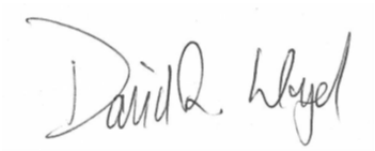
Thank you for your letter dated 10 February regarding the above petition, and seeking information about whether the Health, Social Care and Sport Committee has undertaken any scrutiny of the implementation of NICE guidelines in Wales.

In response to the question in your letter, the HSCS Committee takes account of NICE guidelines where relevant during our scrutiny work, for example in respect of the Committee's work on **endoscopy services** in 2019, or the **Welsh Government's draft national dementia strategy** in 2017.

We anticipate including in our legacy report an indication of issues our successor committee in the Sixth Senedd may wish to consider. We will include a reference to the Petition Committee's suggestion in respect of the implementation of NICE guidelines in Wales.

Thank you for your continued engagement with the Health, Social Care and Sport Committee on these cross-cutting matters.

Yours sincerely



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—
Welsh Parliament
Health, Social Care and Sport Committee

Vaughan Gething MS
Minister for Health and Social Services

Julie Morgan MS
Deputy Minister for Health and Social Services

29 January 2021

Dear Ministers

Thank you for attending Wednesday's meeting of the Committee to discuss the impact of COVID-19 on the social care sector and unpaid carers.

Unfortunately, there were a number of issues we were unable to cover fully in the time available, so Members have asked that I follow these up with you in writing. Can you please provide us with the following:

1. Details of any further longer term financial commitments that the Welsh Government is planning to make to support the sector, in particular to ensure that care homes remain viable;

2. Details of how the Welsh Government intends to improve access to respite care for unpaid carers during the pandemic;

3. Your views on the evidence the Committee has heard from stakeholders about concerns that service users and unpaid carers having 'managed' with fewer formal care and support services during the pandemic could be interpreted as demonstrating that they need less intervention from social services in future;

4. Details of any further measures you are considering to facilitate care home visits and how you will assess the impact of measures such as the leasing of pods in facilitating safe visits;

5. The Committee notes the addition of £250k to the £1million carers support fund. However, as this only runs until March 2021, could you provide clarification on what help will be available beyond March for carers who are struggling financially;

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6. The Committee notes that some support services for young carers have been able to move online during the pandemic and that the launch of the young carers' card is in progress. Is the Welsh Government taking any further steps to support young carers or provide them with respite, particularly those who are currently unable to attend school;
7. Details of how the Welsh Government's COVID-19 recovery planning is taking account of the implications for social care of:
    - Delays in dementia assessment and reviews during the pandemic; and
    - Needs that may arise as a result of long COVID.
8. An update on PPE supplies for the social care sector. In particular, any steps that the Welsh Government is taking to ensure that there is an appropriate and sustainable supply of PPE to effectively meet needs in social care for the foreseeable future.

It would be helpful if you could let us have your response by **15 February 2021** to help inform the Committee's report on this issue.

Yours sincerely

Dr Dai Lloyd MS
Chair, Health, Social Care and Sport Committee

Vaughan Gething AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Julie Morgan AS/MS
Y Dirprwy Weinidog Iechyd a Gwasanaethau Cymdeithasol
Deputy Minister for Health and Social Services

Llywodraeth Cymru
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15 February 2021

Dear Dai,

Thank you for your letter of the 29th January. As requested we have set out below our response to those issues that were not covered fully in the recent Committee meeting.

Details of any further longer term financial commitments that the Welsh Government is planning to make to support the sector, in particular to ensure that care homes remain viable.

Social care is a priority for the Welsh Government. The Welsh Government has continued to place health and social care at the top of priorities for the 2021-22 budget. The statutory responsibility for delivery of social services rests with local authorities. Welsh Government provides these bodies with funding through the Revenue Support Grant; overall an additional £176m has been allocated to the local government settlement in the Draft Budget for 2021-22.

Beyond this core investment, the Welsh Government has central budgets to support the social care sector and related areas. The majority of these budgets are within the Health and Social Services MEG. The Welsh Government is investing an additional £431 million revenue in health and social care in 2021-22

We will continue our investment in the Integrated Care Fund (ICF) for a further year with a revenue budget of £89m in 2021-22. The Fund is managed through Regional Partnership Boards, bringing health and social services together to deliver services around the needs of citizens.

Given the significant pressures facing the sector as a consequence of the pandemic the Social Care Workforce Sustainability grant has been increased from £40m to £50m in the draft budget for 2021-22. Officials are currently reviewing the criteria attached to this funding to ensure that it continues to support our strategic objectives relating to workforce sustainability.

We acted quickly to provide Local Authorities with the financial support necessary to enable them meet the additional costs of care provision during the pandemic through the Hardship Fund, and using this mechanism we have provided more than £88m to the sector to date. In addition to supporting the costs of additional staff and general provision through a flat rate uplift, this also included an element to support Local Authorities in responding to market stability pressures for

providers within their areas to ensure continuity of provision during the pandemic. We also provided £22.4 million to support Local Health Boards with health care and support for continuing health care through to the end of September 2020. We have since extended this provision with a further £22.4m available to the end of the financial year. Currently the Hardship Fund, and the additional support to Local Health Boards, ends at the end of March but we recognise the concerns raised about this by partners in the context of an ongoing pandemic.

The Finance Minister said in the draft budget that we will build on the small number of allocations for Covid response over the coming weeks and in the final Budget, once we can better assess how funding can best be targeted into 2021-22. In particular considering what additional funding is needed to support the NHS and local government as they stand at the forefront of our response to the pandemic.

The need for continued support for adult social care will be considered alongside other local government pressures within that context.

Details of how the Welsh Government intends to improve access to respite care for unpaid carers during the pandemic.

Local authorities continue to provide a range of support to unpaid carers (carers) as per their statutory duties under the Social Services and Well-being (Wales Act) 2014, including ensuring carers can access a carers' needs assessment. We expect local authorities to continue to meet people's care and support needs and those of carers. Respite for a carer can be identified as an eligible need, however we recognise the impact the pandemic has had on the delivery of face to face local support services.

We expect community based and other forms of provision to be reopened, as soon as it is safe to do so. Local authorities and the third sector have been nimble in developing other ways of maintaining contact and providing forms of respite, such as keep in touch phone calls and on-line activities. We gave an additional £50k to Carers Wales to operate their online MeTime psychological support sessions which have been popular. Local health boards and communities have also been creative and developed alternative approaches; for example in Rhondda Cynon Taf they have used funding from our £1m LHB Carers Fund allocation to Cwm Taf Morgannwg LHB to deliver the Carers Support Project. It has been providing a range of activities, workshops and social events to support a life alongside caring, using social media to give advice; delivering "boredom buster" packs; online-led activities like exercise classes; workshops on topics such as managing your child's anxiety; food and mood with a nutritionist; and fun things such as virtual takeaway nights.

Our Integrated Care Funding (ICF) also provides direct support for projects enabling carers to access opportunities for respite and help improve carers' own well-being. In 2020-21 RPB direct spend on carers was £8.9m. Our expectation is that this will increase in 2021-22 with carers, including young carers, continuing to be a priority group within the funding programme. The ICF is therefore helping to deliver the three National Priorities for Carers, including "Supporting life alongside caring".

Looking ahead at the wider picture of how carers want to access appropriate and timely respite support, officials are currently analysing more than 80 responses to our public consultation to develop a new national plan for carers. Specific questions about respite and short breaks were included in the consultation document and we are considering these views and examples of good practice. Our Carers Ministerial Advisory Group has been also been discussing respite as a key issue for carers, and will be working with us to see how best public, private and third sector organisations can provide respite and / or short breaks, for carers of all ages.

Your views on the evidence the Committee has heard from stakeholders about concerns that service users and unpaid carers having 'managed' with fewer formal care and support services during the pandemic could be interpreted as demonstrating that they need less intervention from social services in future.

Regarding social care packages available, thus far, the information we are receiving is that local authorities and providers are not systematically reducing packages. However, the wider protections that have been necessary to limit the transmission of the virus have had an impact on how people access their care and support. We know that some people are choosing to make changes themselves, due to anxiety over allowing care workers into their home and the risk of infection this may bring. Others have chosen to draw on the ability of furloughed family or relatives, who are able to provide the care needed from within the family.

Despite these challenges we know that individuals, care providers and local authorities have worked together to explore and identify alternative solutions to maintaining care and support. If anyone who has a care and support plan believes their physical or emotional wellbeing has been adversely impacted by a reduction or change in the services provided, they should contact their local authority social services department to discuss this and, if necessary, request a review of their care and support plan.

From the outset our expectations have been clear. Local authorities must comply with requirements of their statutory duties for as long and as far as possible. Any changes should only be implemented where this is essential in order to maintain the highest possible level of services, and any changes must only be temporary, justifiable due to unavoidable local circumstances, and removed at the first available opportunity. Our statutory guidance states: individuals' care and / or support must return to their agreed arrangements at the earliest opportunity; the onus should not be on individuals or their families/carers to ensure that their care and support is restored; and local authorities need to establish arrangements and communicate to those impacted how this will be achieved.

Details of any further measures you are considering to facilitate care home visits and how you will assess the impact of measures such as the leasing of pods in facilitating safe visits.

Restrictions around care home visits have been one of the most difficult consequences of this pandemic. The need to balance people's rights and support their well-being with the desire to protect people living in care homes from the risk of infection remains very challenging. The new variant of the virus adds to that challenge and we are still trying to understand its impact. Our position is that collectively we must do all we can to support people to see their loved ones as safely as possible. We will continue to keep the situation under review and will amend our advice and guidance should it be necessary.

The Welsh Government's Coronavirus Control Plan provides guidance on what each alert level means for care home visits. We have updated our detailed national visiting guidance for care home providers (published on 1 February), to make it consistent with the alert levels and to give additional detail around the safe use of visitor pods. We hope that this will provide greater clarity for everyone – individuals and their families, providers and local authorities - both now and as restrictions ease.

In developing our visitor guidance we have worked very closely with our stakeholder visitor group which includes representation from the offices of the Older People's Commissioner and the Children's Commissioner as well as other representatives from the sector, including Public Health Wales.

We will be evaluating the impact of our £3 million pilot programme and are pleased by the level of interest and engagement in this scheme so far. We have now sourced a total of 101 visitor pods through the programme and 93 pods are in situ at care homes cross Wales. The pilot programme includes up to £1 million funding available through the hardship fund to support providers who choose to hire their own visitor pods. Claims for funding are being considered as they are received.

The Committee notes the addition of £250k to the £1million carers support fund. However, as this only runs until March 2021, could you provide clarification on what help will be available beyond March for carers who are struggling financially.

One aspect of support for unpaid carers is welfare benefits, where they are entitled to these. When we established our Single Advice Fund we required providers to offer welfare benefit entitlement checks to all those who accessed their service, regardless of their presenting problem. In the first year of operations, the benefit advice services delivered through the Single Advice Fund have helped people in Wales to claim over £34 million of additional welfare benefit income. This extra income is helping to lift people out poverty, easing their financial pressures and, importantly, boosting spending within local economies across Wales.

However, we know that more needs to be done to reach those groups who consistently fail to claim their entitlement to welfare benefits, including carers. Therefore, Single Advice Fund (SAF) Advice and Access partners are running 'Test and Learn' pilots in the six SAF regions, delivering tailored messages and support to encourage take-up amongst groups least likely to be claiming all the financial support they are entitled to. The pilots started in October 2020 and will end March 2021 and the learning will be shared. During the first 3 months the pilots reached 601 people advising them on over 1,600 issues relating to their welfare benefit entitlements and helping them to gain additional income of around £1m per annum. The learning from the pilots will be widely shared in early May, helping people from key groups, such as carers, to continue to claim all the financial support they are entitled to.

The financial pressures on carers have increased during the pandemic and whilst small grants for individual carers and families can provide some immediate relief to those eligible, as through the Carers Fund, or local authority assistance grants, our funding to support systems and delivery of services is the primary means to support carers now and in the future. We continue to provide significant resources to local authorities to enable them to deliver the services and support that their communities rely on. In addition to the Settlement, the Local Government Hardship Fund continues to be available to support local authorities with the additional costs of responding to the pandemic.

Discrete Welsh Government funding for carers concentrates on providing additionality to statutory services and we are providing £2.6 million over three years (2020-23) to Carers Wales, All Wales Forum of Parents and Carers, Carers Trust Wales and Age Cymru, via our Third Sector Sustainable Social Services Grant Scheme. The four projects aim to provide a range of support for carers of all ages as well as working with health and social care staff to improve awareness of the issues affecting carers, and how to better support carers. Additionally, our £1m annual carers funding to local health boards has been used in 2020-21 to support carers struggling with the increased pressures of the pandemic, and we are currently considering this funding for 2021-22. Finally, as noted above, carers continue to benefit from projects under the Integrated Care Fund (ICF) and in 2020-21 we invested £89m revenue and £35m capital in that Fund. Building on success to date we are investing in the ICF for a further year, with a revenue budget of £89m in 2021-22.

The Committee notes that some support services for young carers have been able to move online during the pandemic and that the launch of the young carers' card is in progress. Is the Welsh Government taking any further steps to support young carers or provide them with respite, particularly those who are currently unable to attend school.

The needs and issues affecting young carers were identified and several questions asked about how to improve help and support for young carers and young adult carers, as part of our recently closed public consultation to develop a new national plan for carers. This included a proposal for a new fourth national carers' priority which would focus on carers in education and employed carers. Officials are currently analysing the responses.

Since the beginning of the pandemic however, we have worked with national carers' organisations, including Carers Trust Wales, to understand how young carers are being affected. We were pleased to work with Carers Trust Wales, Community Pharmacy Wales and others to develop a guide and resources to help all carers access medication for those they care for. Also, as vulnerable learners, young carers remain eligible to access learning settings alongside the children of key workers. Even before the pandemic we knew that school provides a form of respite from the caring role, for many young carers. We continue to encourage them to contact their local authority to discuss their needs as vulnerable learners, and it remains the case that under the Social Services and Well-being (Wales) Act, young carers have the right to a carers' needs assessment. Whilst they are at home, activities have been provided by a wide range of organisations, to help them take a form of break. Our £1m Local health board and carers partnership funding has been used in a range of ways by these partnerships to support young carers projects. Examples include online cooking classes and delivery of "wellbeing packs".

However, we know there is a need for a wide range of support mechanisms to help all young people, including young carers, particularly with emotional and mental health needs. In 2020 we produced the Young Person's Mental Health Toolkit and they can access help via the CALL helpline service, and MEIC helpline and website. On 1 February, the Minister for Mental Health, Wellbeing and Welsh Language announced an extra £9.4 million will be available specifically to support children and young people in Wales, with the additional funding recognising the effect being away from school and their regular support networks has had on young people during the pandemic. https://gov.wales/pledge-support-youth-extra-ps94m-investment-children-and-young-people-mental-health-services

Details of how the Welsh Government's COVID-19 recovery planning is taking account of the implications for social care of:

- ***Delays in dementia assessment and reviews during the pandemic; and***
- ***Needs that may arise as a result of long COVID.***

In relation to Dementia Assessments, the Welsh Government will continue to invest £10m to support the implementation of the Dementia Action Plan 2018-22 next year, with the majority of this funding (over £9m) allocated to Regional Partnership Boards. We recognise that the pandemic will have impacted on services and so, in conjunction with the Dementia Oversight of Impact and Implementation Group, we are reviewing our current action plan to consider what further action is needed.

Additionally, in the draft budget for 2021/22 we propose that up to £3m of service improvement money be made available to support memory assessment services and the required wrap-around support to ensure people are supported whilst they go through this assessment and diagnosis process.

More broadly, we are continuing to learn more about long COVID from research and people's experiences. We know people are experiencing a range of longer-term difficulties and while every person is different, these include fatigue, breathlessness, pain and cardiac, respiratory, cognitive

and neurological issues. We are taking a personalised approach in Wales to meet the specific needs of the individual because long COVID has such a wide range of impacts.

The National Institute for Health and Care Excellence (NICE) has developed a clinical guideline, published on 18 December 2020: https://www.nice.org.uk/guidance/NG188.

The guideline covers identifying, assessing and managing the long-term effects of COVID-19 and uses the following clinical definitions:

- **Acute COVID-19**: signs and symptoms of COVID-19 for up to four weeks.
- **Ongoing symptomatic COVID-19**: signs and symptoms of COVID-19 from four to 12 weeks.
- **Post-COVID-19 syndrome**: signs and symptoms that develop during or after an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis.

In addition to the clinical case definitions, NICE acknowledges *'long COVID'* is commonly used to describe signs and symptoms that continue or develop after acute COVID-19 i.e. it includes both ongoing symptomatic COVID-19 and post-COVID-19 syndrome.

A Written Statement was issued on 20 January providing an update on action in Wales to support people experiencing longer term effects of COVID 19: https://gov.wales/written-statement-longer-term-effects-covid-19. .

In addition, the Technical Advisory Group (TAG) has published a paper on 3 February entitled '*Long Covid - what do we know and what do we need to know*?' which pulls together latest UK and international evidence and research to support policy and local action: https://gov.wales/technical-advisory-group-long-covid. The paper identifies further important research questions to understand and monitor the impact of long COVID on individuals and services in Wales, and develop effective care pathways. These will require continual review as evidence needs are fulfilled through ongoing and future research studies, and as new areas of need emerge.

The impact of these longer term impacts affects all patients and services and is a consideration of recovery plans. We want people with post-Covid syndrome to be able to access the majority of the services they need – be that assessment, diagnosis, treatment and rehabilitation support – as close to home as possible or via remote services, only having to travel for more specialised services, which have to be provided in an acute hospital setting.

Rehabilitation is a critical component of care for people recovering from COVID-19. It is also critical for groups of people indirectly affected by the pandemic, including those with dementia. This includes people whose planned care was paused, those who may have delayed seeking advice on a health problem, and those people affected by the lockdown measures, such as those who have been isolated or were shielding.

Allied health professionals (AHPs) and colleagues have worked creatively and consistently to maintain routine service delivery where possible by remaining in contact with their known patients without urgent needs, to provide advice to help them self manage. AHPs have implemented many innovations, such as running rehabilitation groups or sessions online, using Attend Anywhere for consultations, and providing psychological support via video consultation in order to provide the advice and care safely where they are not able to see people face to face.

An update on PPE supplies for the social care sector. In particular, any steps that the Welsh Government is taking to ensure that there is an appropriate and sustainable supply of PPE to effectively meet needs in social care for the foreseeable future.

We have worked in partnership with NHS Wales Shared Services Partnership (NWSSP) and have developed a strategic plan for PPE procurement. As a result of this partnership working, I'm pleased to confirm that our PPE position continues to be stable. The majority of recommended items are held in stocks sufficient for a 24 week period and that will be the case for all item types by the end of this month.

We have also helped to facilitate a service level agreement for the provision of PPE between NWSSP and the Welsh Local Government Association. This agreement provides for the continued supply of 100% of the recommended PPE for social care, which will continue to be fully funded by the Welsh Government. The service level agreement is in place until the end of August 2021.

We continue to follow the Infection Prevention and Control (IPC) guidance on use of PPE in health and social care settings – this guidance is UK-wide and based on the latest evidence and data. The IPC guidance was recently considered in light of the new variant and our PPE position is unchanged by the newly published guidance. The guidance, and consequently our PPE position, will be kept under review as more evidence and data becomes available.

We trust that you find the above information of assistance in preparing the Committee's report.

Yours sincerely

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Agenda Item 7

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Agenda Item 8

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