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.

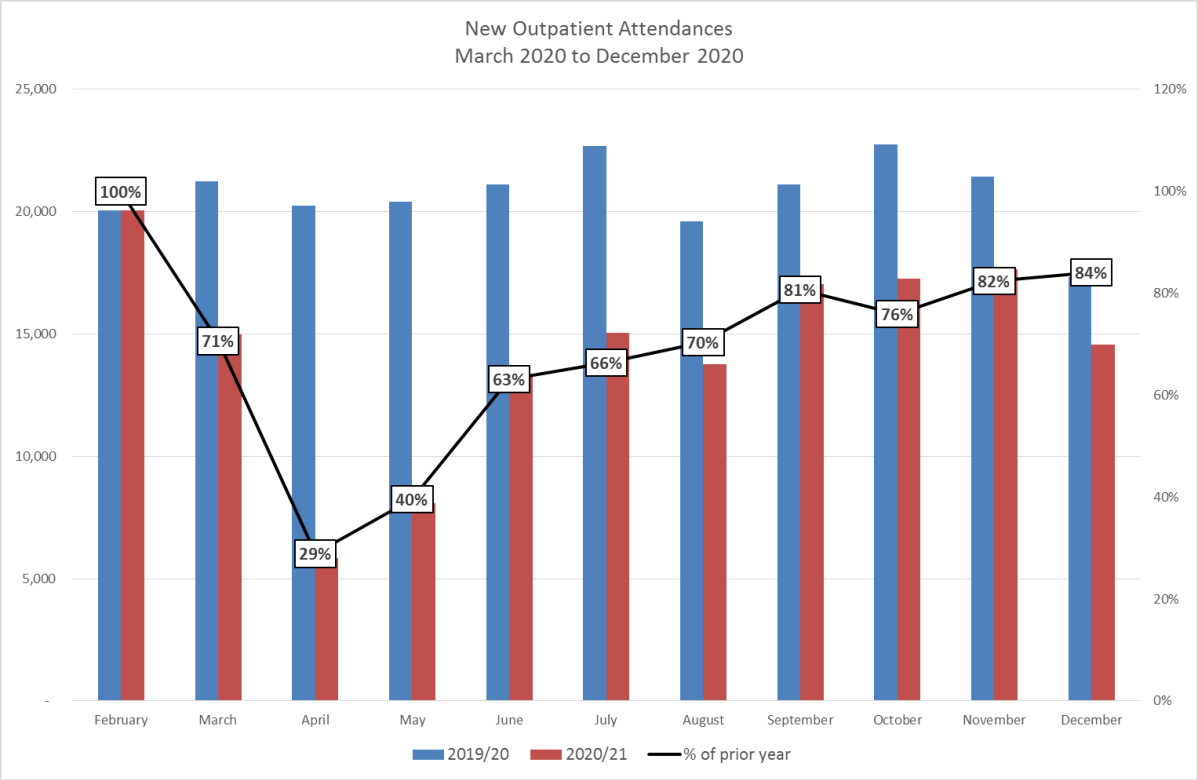
a) Services reduced due to Covid-19

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)

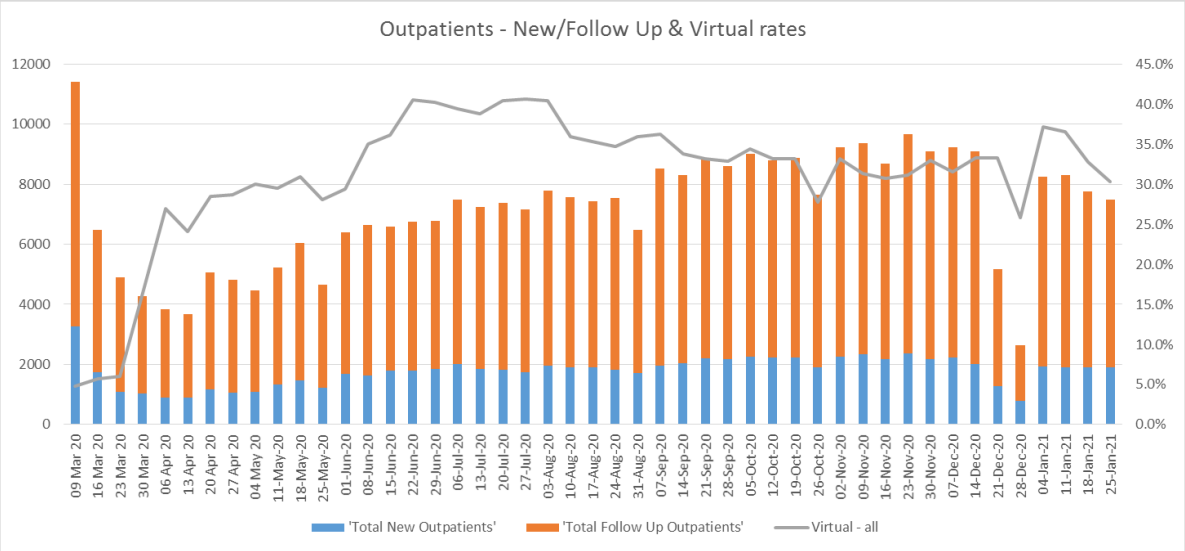


New or 1st Outpatient activity started to decline in March and reached its lowest point (29%) in April 2020. Activity recovered to 84% by the end of December 2020.

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

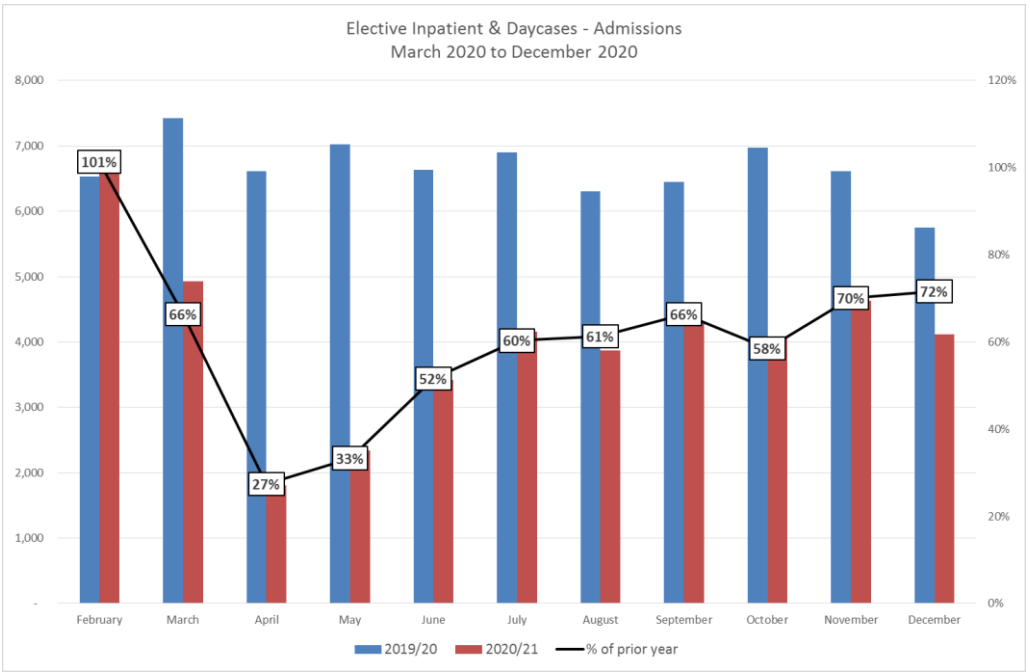
30% of Outpatient Consultations continue to be delivered in a virtual setting. Figure 2 illustrates the impact of Covid-19 on Outpatient attendances and the adoption of Virtual Consulting, which rose from 2.4% to over 40% at the peak and remains around a third of our overall Outpatient activity.

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



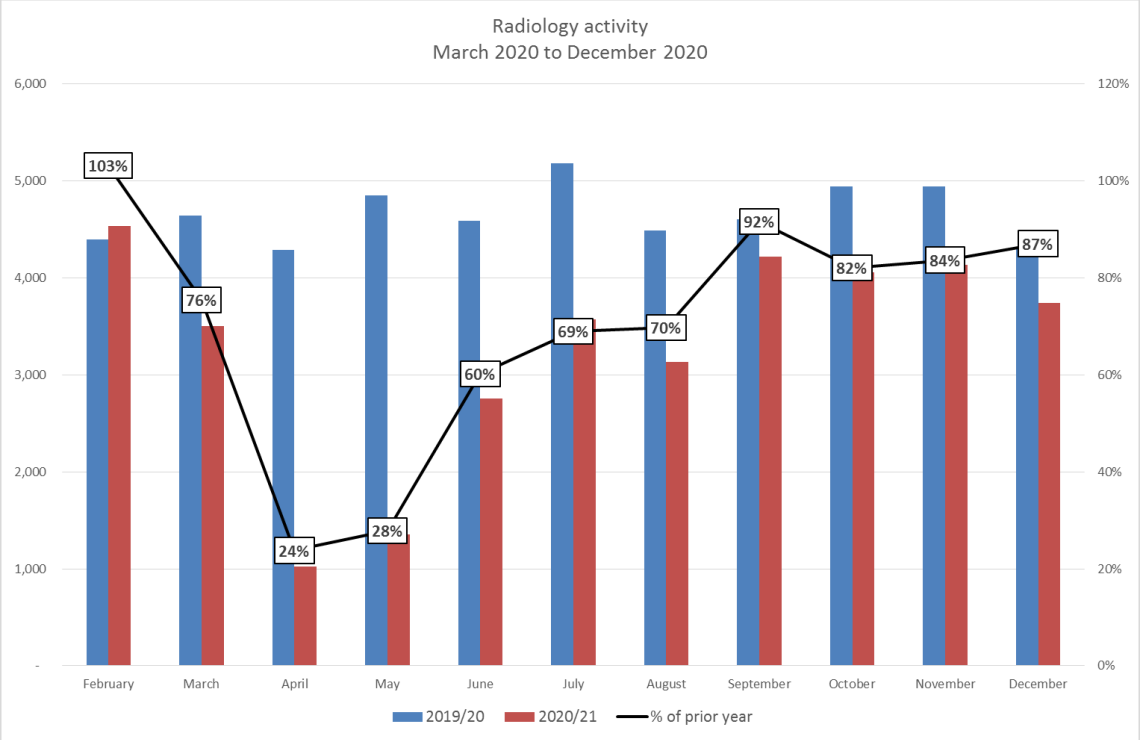
Elective or planned treatments requiring inpatient or daycase admission to Hospital started to decline in March and reached its lowest point (27%) in April 2020. Activity recovered to 72% by the end of December 2020. Figure 3 illustrates the impact of Covid-19 on Elective Hospital admissions for treatment.

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)



<u>Additional learning from first wave of Covid-19</u>

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:

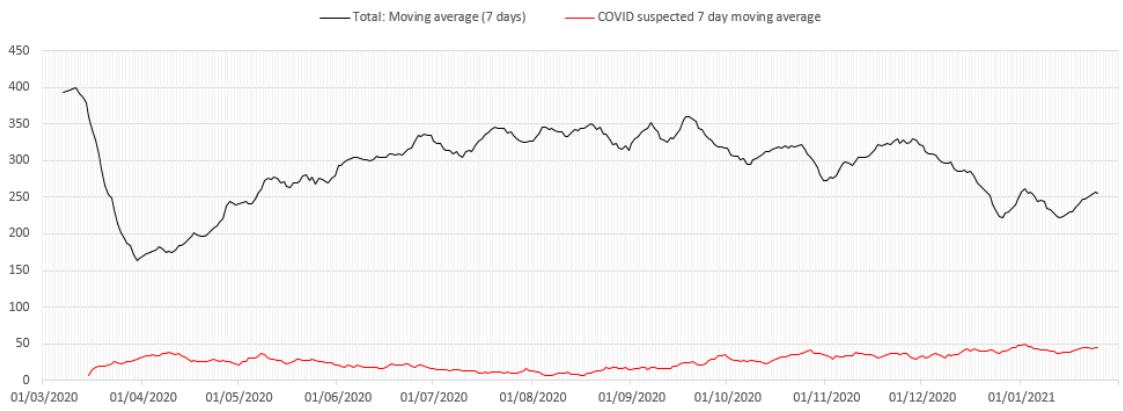
- Unscheduled care
- Acute Medical Beds
- Critical care
- Primary Care
- Mortuary services
- Mental Health

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

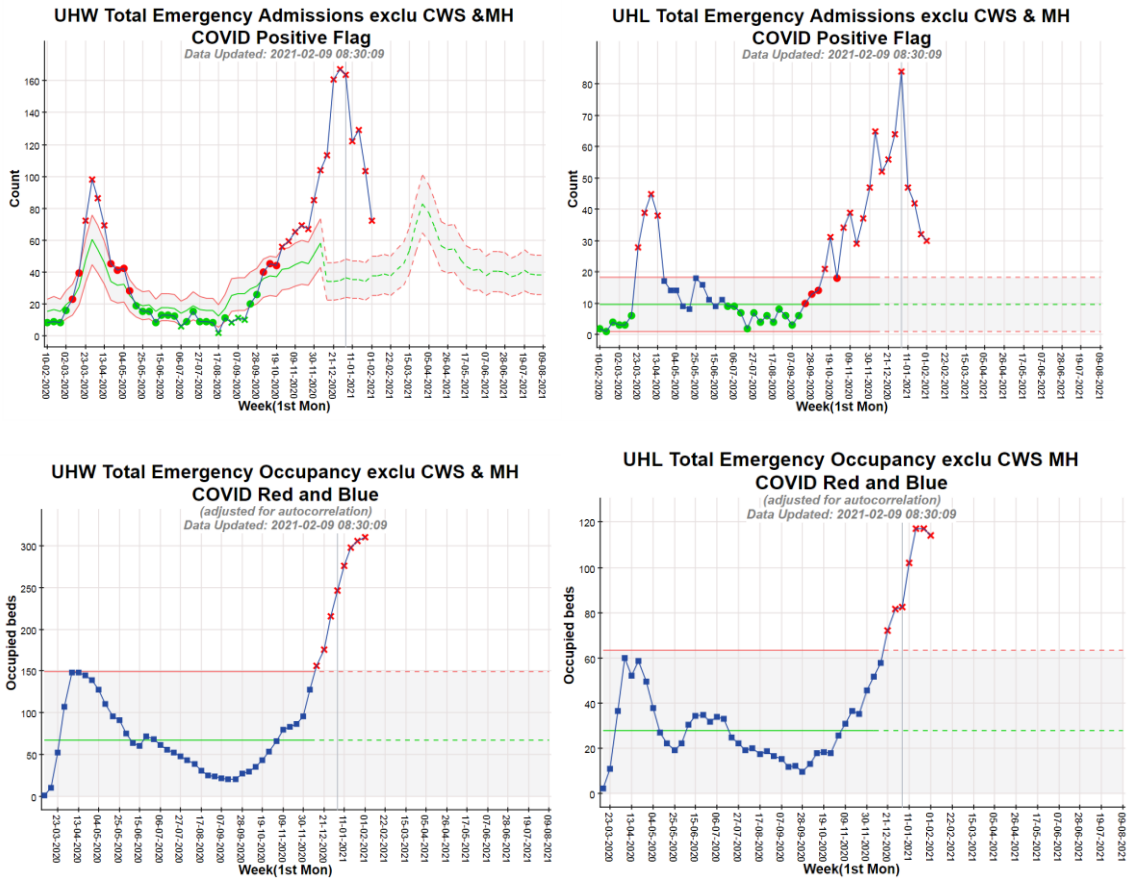


Acute Medical Beds (Covid-19 inpatients)

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.

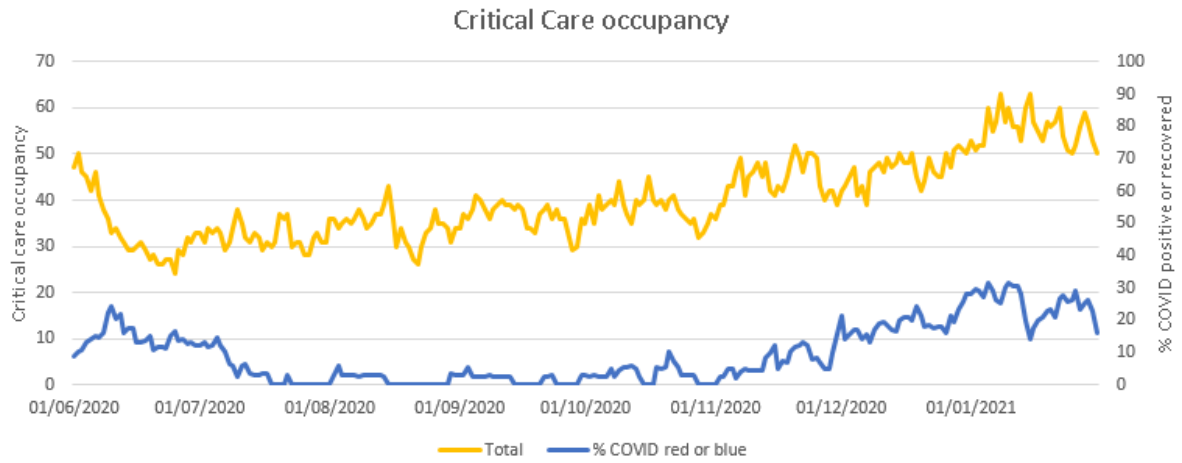
Figure 6: Acute Medical Beds (Impact of Covid & Recovery)



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.

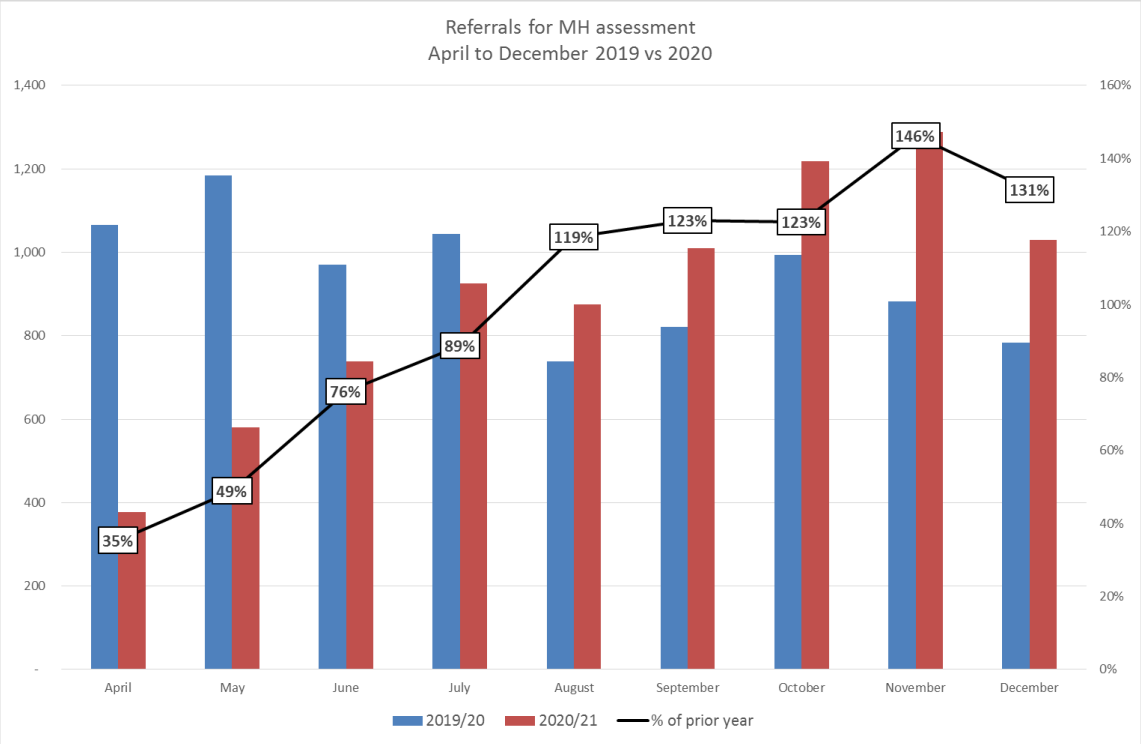
Sustainability and Recovery plans are in place for Optometry and Dental services, who are facing similar challenges related to contract obligations and IP&C considerations. A small number of Optometry practices have not seen a return to normal/average activity following the routine recall of patients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

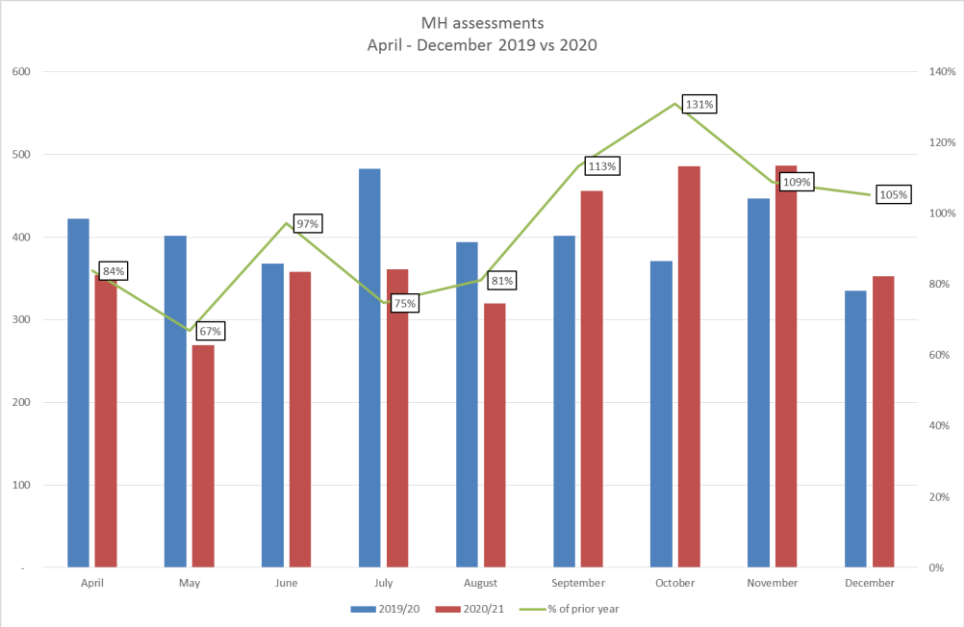
Mental Health also experienced an initial decline in referral volumes. However the planning assumption was that we anticipated a lag between the onset of Covid-19 and an increase in demand for Mental Health services. From May onwards, the service started to see an immediate recovery of referral demand 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.

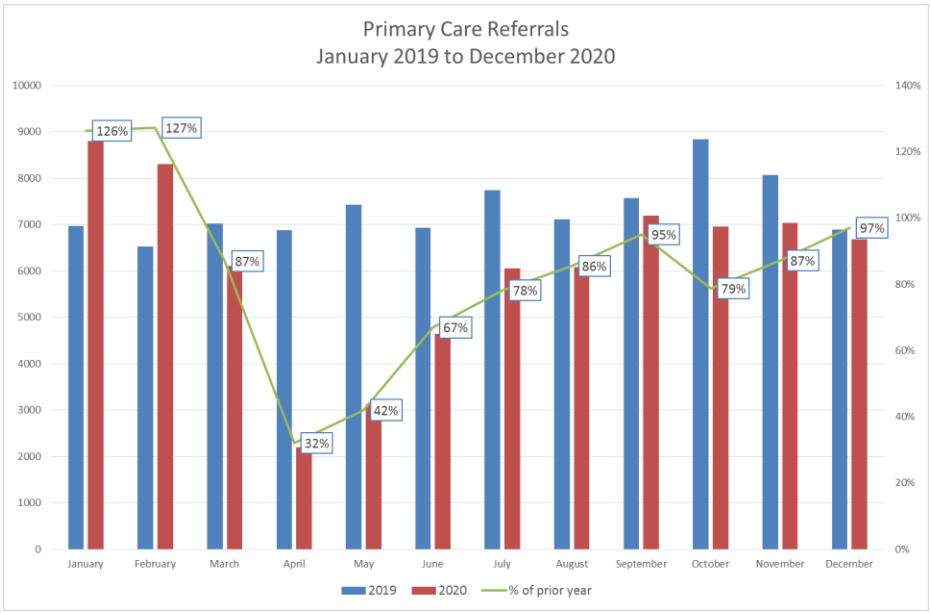
Figure 9: Mental Health Assessments (Impact of Covid-19 & Recovery)



c) <u>Services where they may be suppressed demand due to Covid-19</u>

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.

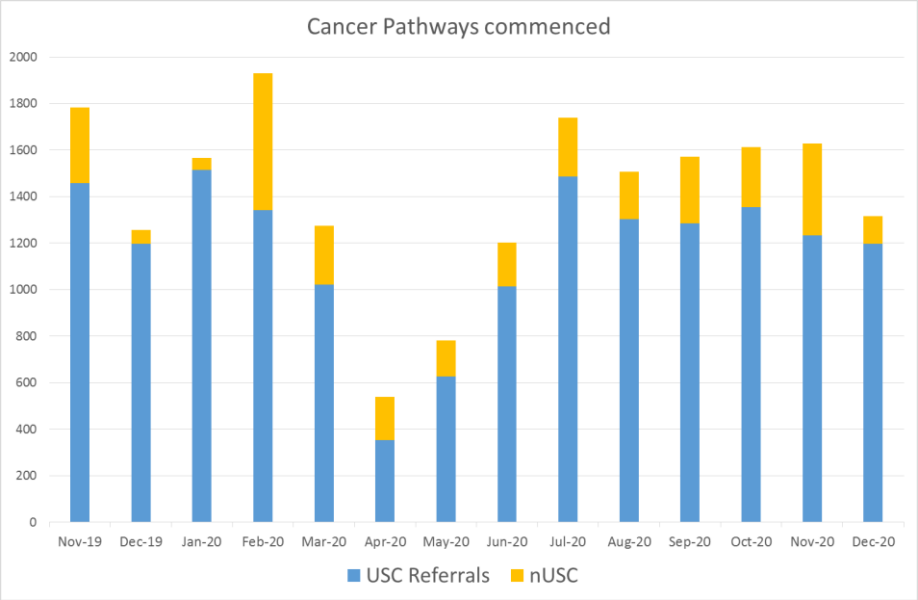
Figure 10: Referrals from Primary Care to Secondary Care (Impact of Covid-19 & Recovery)



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.