

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [Effaith yr ôl-groniad o ran amseroedd aros ar bobl yng Nghymru sy'n aros am ddiagnosis neu driniaeth](#)

This response was submitted to the [Health and Social Care Committee](#) consultation on the [impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment](#)

WT 41

Ymateb gan: | Response from: Bwrdd Iechyd Prifysgol Hywel Dda | Hywel Dda University Health Board





HYWEL DDA UNIVERSITY HEALTH BOARD'S WRITTEN EVIDENCE to the HEALTH AND SOCIAL CARE COMMITTEE

Date of Submission: 20 January 2022

1. Hywel Dda University Health Board (the Health Board) welcomes the opportunity to contribute to the Health and Social Care Committee's inquiry into the impact of the waiting times backlog and the effectiveness of the Welsh Government's Health and Social Care Plan 2021-2022.

About the Organisation

2. 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.

Backlogs and waiting times

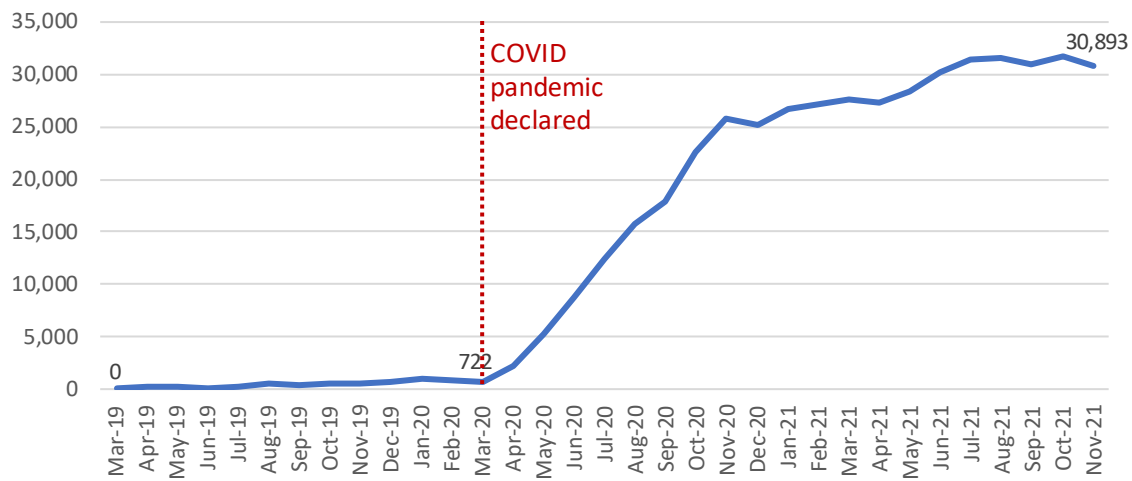
What is the current position on backlogs and waiting times within your health board? How were trends in waiting times changing before the emergence of COVID-19, and what effect has COVID-19 had on waiting times?

What is the anticipated size of the backlog and the pent-up demand from patients who require diagnostics or treatment? Are patients having to wait longer for some specialities than others, and if so, why?

3. To help ensure patients receive timely access to services, the following national pre-pandemic targets were set:
 - no patients to wait over 36 weeks from referral to treatment;
 - no patients to wait over 8 weeks for a diagnostic;
 - no patients to wait over 14 weeks for a specified therapy;
 - patients to wait less than 26 weeks for neurodevelopment assessments;
 - patients to wait less than 26 weeks for psychological therapies.

4. Referral to Treatment (RTT)

Number of patients waiting over 36 weeks from referral to treatment



5. In previous years, we have reduced the number of patients waiting over 36 weeks from RTT to 0 breaches by 31 March. In 2019/20 we were on track to achieve this until the pandemic was declared, and in March 2020, the Health Board suspended pathways in accordance with Welsh Government (WG) guidance. As a result, we ended 2019/20 with 722 breaches on 31 March 2020. As at 30 November 2021, there were 30,893 patients waiting over 36 weeks from RTT.

6. As a consequence of revised operational guidance applied during the course of the pandemic to strengthen Infection, Prevention and Control (IP&C) procedures, social distancing of patients and related Personal Protective Equipment (PPE) measures, planned care capacity level has reduced significantly compared to pre-pandemic levels. Key facilities have been re-prioritised to support emergency and unscheduled care pathways, and the requirement to ensure protected 'green' pathways for planned care patients has significantly limited the volume of activity we have been able to deliver.

7. These factors, and the associated impact on reduced staffing levels, have affected capacity levels to varying degrees, with surgical pathways particularly affected. A full breakdown by specialty is included in **Appendix A**. The specialties with the highest number of patients waiting over 36 weeks as at 30 November 2021 were:

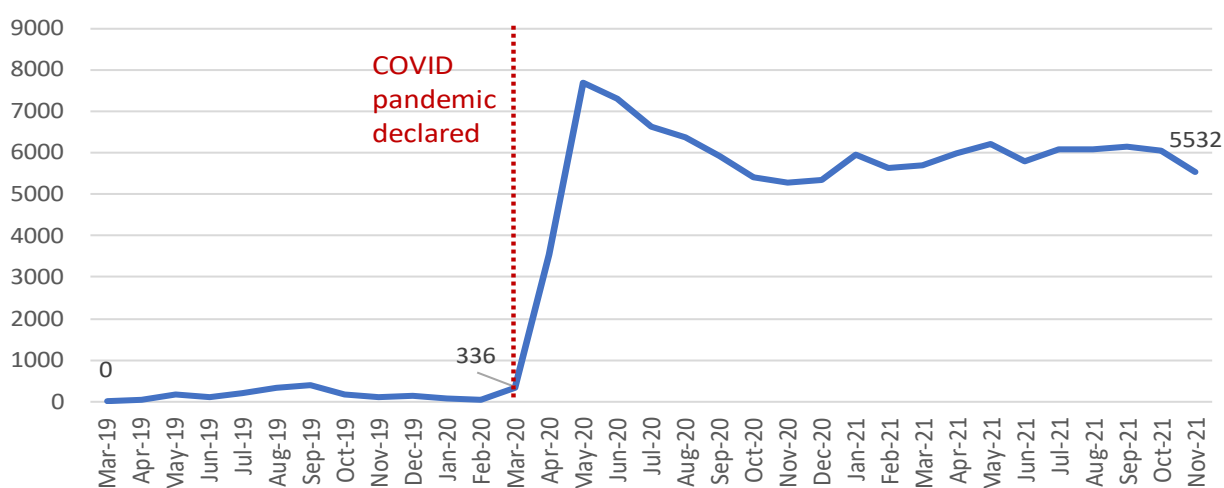
- Ophthalmology 4,630
- Orthopaedics 4,446
- ENT 3,955
- Urology 3,382
- General Surgery 3,247

8. We are working to risk assess all patients waiting for treatment to ensure those patients at highest risk of harm are prioritised. As at 8 December 2021, there were 4,081 patients awaiting treatment that needed to be risk assessed. The table below provides a summary for those patients awaiting treatment who have been risk assessed in accordance with the Royal College of Surgeons Federation of Surgical Speciality Associations' (FSSA) *Clinical Guide to Surgical Prioritisation during the Coronavirus Pandemic* that is updated monthly.

	Risk category 2 (P2) Procedure to be performed within 1 month	Risk category 3 (P3) Procedure to be performed within 3 months	Risk category 4 (P4) Procedure to be performed in more than 3 months
Total numbers of pathways in category	855	3,758	9,047
Total numbers of pathways exceeding target	609	2,238	6,372

9. Diagnostics

Number of patients waiting over 8 weeks for diagnostic



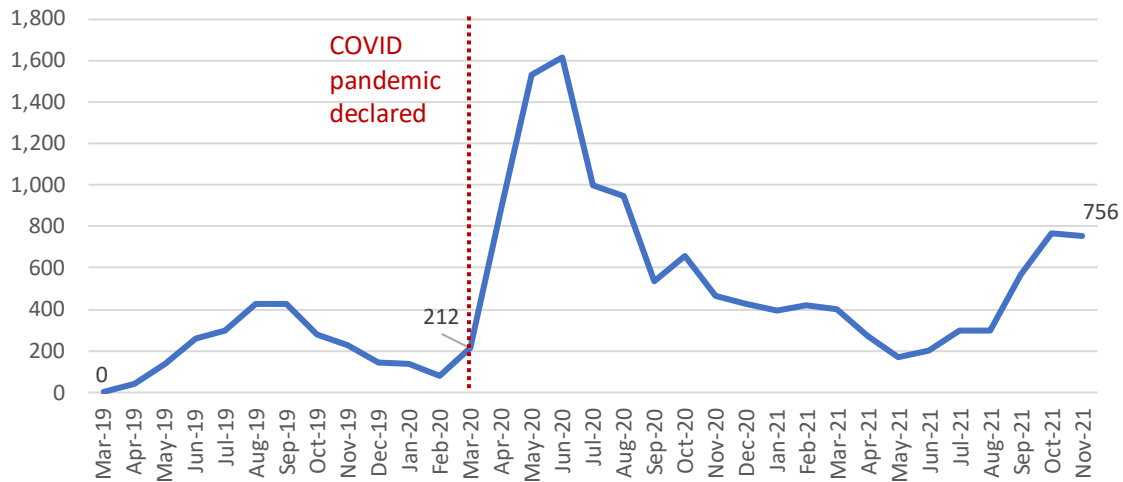
10. In previous years, we had reduced the number of patients waiting over 8 weeks for a diagnostic to 0 breaches by 31 March. As with RTT pathways, we were on track to achieve this in 2019/20 until the application of the WG guidance to suspend services in March 2020. As a result, we ended the year with 336 breaches on 31 March 2020. As at 30 November 2021, there were 5,532 patients waiting over 8 weeks for a diagnostic.

11. Some subcategories have been significantly impacted more than others, reflecting the nature of these clinical interventions and the appropriate measures required, which have limited throughput and productivity levels during the period. A full breakdown by subcategories is included in **Appendix A**. The subcategories with the highest number of patients waiting over 8 weeks as at 30 November 2021 are:

- Radiology - GP referral 1,819
- Radiology - Consultant referral 1,350
- Diagnostic Endoscopy 1,225
- Neurophysiology 706

12. Therapies

Number of patients waiting over 14 weeks for a specific therapy



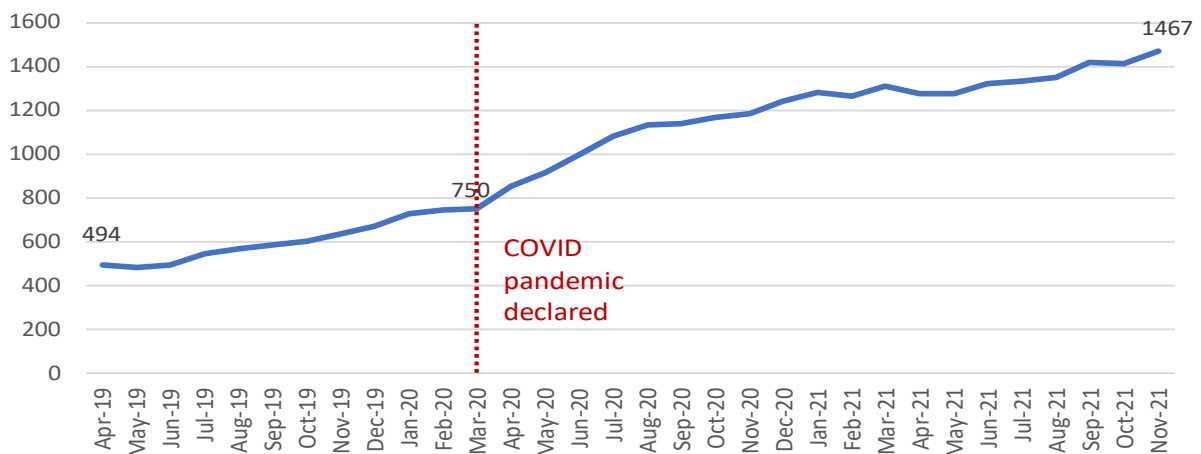
13. In keeping with the impact on RTT and diagnostic pathways, we were on course to achieve a zero breach performance position by the end of the 2019/20 year until the application of the WG guidance to suspend services in March 2020. As a result, we reported 212 breaches on 31 March 2020. During the pandemic and through the respective waves, waiting times have fluctuated, influenced by the necessity to prioritise therapy staff to support emergency and discharge pathways at various points. At 30 November 2021, there were 756 patients waiting 14 weeks and over for a specified therapy.

14. A full breakdown by specialty is included in **Appendix A**. The specialties with the highest number of patients waiting over 14 weeks as at 30 November 2021 were:

- Occupational Therapy 283
- Physiotherapy 185
- Dietetics 180
- Podiatry 103

15. Mental Health

Number of patients waiting over 26 weeks for Neurodevelopment Assessments



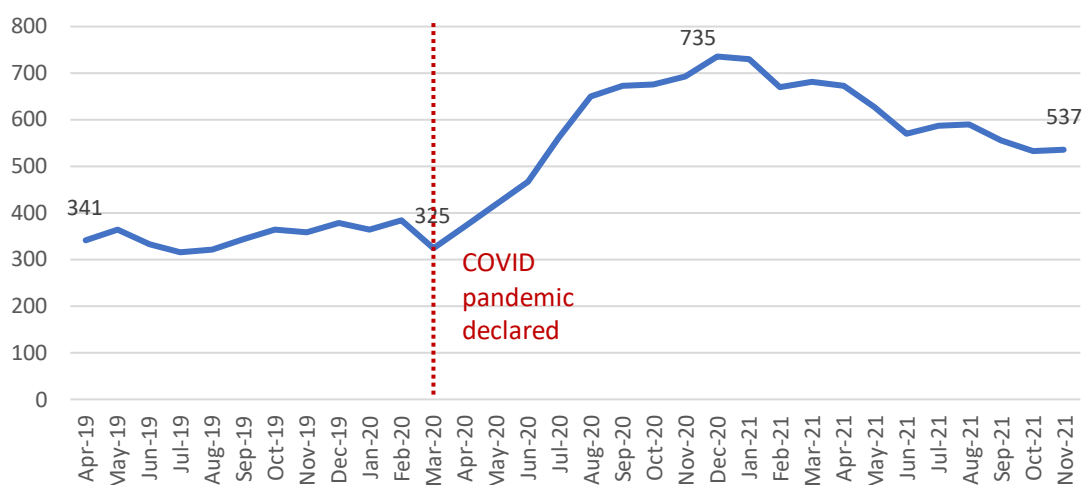
16. Prior to the pandemic, neurodevelopmental service capacity had been compromised by historical recruitment challenges. Whilst we had not achieved the 26-week target for several years, the impact of the pandemic and suspension of key pathways in March 2020 further contributed to a year end breach position of 750 patients waiting more than 26 weeks for a neurodevelopmental assessment.

17. Despite the re-establishment of these pathways as part of our portfolio of essential services early in the pandemic, waiting times have continued to be compromised due to reduced availability of staffing and a significant re-emergence of demand after the initial first wave of the pandemic. Our local experience suggests the application of virtual and other innovative approaches to delivery of clinically based services has limited effectiveness for patients awaiting neurodevelopmental assessments, and by the end of November 2021, the number of patients waiting more than 26 weeks had increased to 1,467 patients.

18. Waiting times over 26 weeks can be broken down to sub-specialty:

Specialty	Apr-19	Apr-20	Apr-21	Nov-21
Autism Spectrum Disorder (ASD)	298	576	940	1,168
Attention Deficit Hyperactivity Disorder (ADHD)	196	276	336	299

Number of patients waiting over 26 weeks for Psychological Therapies



19. The number of patients waiting more than 26 weeks for Psychological Therapies began to grow following the onset of the COVID pandemic in March 2020, where 325 patients were waiting over 26 weeks. This growth peaked at 735 patients in December 2020. The number waiting has steadily been reducing following this peak, and by the end of November 2021, there were 537 waiting. Some of this improvement can be attributed to a waiting list validation exercise that was undertaken in Q1 2021/22, although the numbers waiting over 26 weeks has steadied in recent months.

Support Services

What services (for example, mental health and wellbeing support, pain management support, social prescribing etc) are in place to support people who are waiting for diagnostics and treatment? Given the scale of the current backlogs, how accessible are such support services?

20. Across the Health Board's seven Primary Care Clusters, a range of services are commissioned to meet the needs of the local population that include social prescribing and mental health services for both younger people and adults. These services are available to all patients who are registered with a GP within a Cluster and therefore it is not possible to determine specifically how many patients waiting for support services, such as diagnostics, will have accessed these services.
21. During 2020/21, the Health Board's Education Programme for Patients (EPP) continued to offer limited courses to support patients and carers virtually (through Microsoft Teams), including Pain Management courses. This programme delivers self-management and health and well-being programmes working with a number of volunteer lay tutors. In 2021/22, and in response to the increased waiting lists, this programme has been extended and plans to develop courses for Long COVID, Supporting the Orthopaedic Pathway and Healthy Ageing. The team is planning on introducing more specific condition specific courses in Mental Health, Prevention in young people (12-18 years), Healthy Hearts, and Working Links (people who are unable to work due to their health condition).
22. All Primary Care contractors have continued to deliver services in line with national guidelines during the pandemic. At some points, this has meant restrictions to services that patients would normally expect to see; however, essential services continued to be delivered along with any urgent care required:
- General Medical Services: all essential services continued to be provided; patients may have been asked to have had remote (video or telephone) consultations where appropriate rather than attending the practice;
 - General Dental Services: the service remains in amber, which priorities urgent care for patients. During the first wave of the pandemic Urgent Dental Centres were established through the Community Dental Service. We brought outreach specialist minor oral surgery services into the model;
 - Community Pharmacy: whilst there has been the flexibility for pharmacies to have some time to work behind closed doors to manage the raised demand, they have remained open with some limited service provision where the service could be considered to constitute an Aerosol Generating Procedure, such as sore throat test and treat; and
 - Optometry: a number of new services were developed and implemented during the first wave of the pandemic in line with national guidance, which included Independent Prescribing Optometric Services (IPOS) and Domiciliary Emergency Eye Care Service (DEECS), which have continued to run.
23. A range of reset and recovery schemes across all contractor professions have been established to support contractors in being able to clear the backlog of work, as well as providing some enhanced pathways for patients.

How are you working with care services and/or the third sector to support patients, and their carers and families?

24. The Health Board delivers a broad range of actions to support unpaid Carers of all ages, working through the Regional Partnership Board (RPB) Carers Group. The Health Board has a specific core budget to commission support services for unpaid Carers. Over 95% of this budget is used to commission services delivered through third-sector partners, and the Health Board acknowledges the additional social value that working collaboratively with the charitable organisations can bring.

25. Early identification and self-identification of unpaid Carers is a key priority. Our Investors in Carers (IiC) scheme provides the foundation for work with health professionals in primary (GP practices and pharmacies), community and acute hospital teams, as well as a wide range of settings extending beyond health, including: schools, libraries, local authority teams, Job Centre Plus and third sector organisations. In total, 113 settings are participating in this scheme and are “Carer aware” and able to signpost Carers to specific support services to support them with their caring needs.
26. The Health Board and its local authority partners have taken a whole system approach to support and engage Carers in the discharge planning of patients. Carer Officers (who are third sector employees) have a specific role in supporting Health Board staff in the early identification of Carers, enabling improved involvement in the discharge planning process and active provision of information and support.

Capacity and resources

What are your views on whether the health board has the capacity and resources required to deal with the current backlog, including the right number of staff with the right skills mix?

27. Aligned to the changing national demographic over the last 5-10 years we have seen an aging workforce profile that mirrors our population, which has seen a greater incidence of retirement and a reduction in hours within the older workforce.
28. Therefore, with the additional backlog that has prevailed from the pandemic, poses significant questions on how we might ensure the future capacity and capability of the workforce. That said, a robust workforce planning exercise is progressing across the Health Board as part of the IMTP and wider AHMWW Strategy as we move to a social model of health. The first iteration of this will be published as part of our workforce plan for 2022-2025.

Prioritisation

Which services have you prioritised in terms of tackling the backlog?

How are you prioritising people on waiting lists, for example in respect of clinical need and time waiting? Has any consideration been given to taking other factors into account, for example population group or deprivation? Given your local population, what implications might such an approach have?

29. Recovery priorities for 2021/22 are reflected in the Health Board’s Annual Recovery Plan for 2021/22. This anticipates continuing challenges in managing COVID and non-COVID related emergency demands for the year ahead whilst endeavouring to provide ‘green’ planned care pathways on each site, all against the backdrop of a significant and sustained staffing challenge. This denotes actions to reduce the backlog internally.
30. Planned care recovery during 2021/22 has focused on the following priority areas:
- Outpatient transformation and improvement;
 - Maximising theatre capacity;
 - Utilisation of the independent sector through non-recurrent resource support provided by WG;
 - Progress towards sustainable medium term expansion of day surgical capacity via a demountable facility solution;

- Phased progress towards a sustainable, regional recovery plan for cataract surgery, in partnership with Swansea Bay University Health Board;
 - Maximising Endoscopy Capacity;
 - Maximising Therapy Capacity; and
 - Maintenance and further improvement of essential cancer pathways.
31. These processes are underpinned by risk stratification of the Waiting lists, which is the methodology of how lists are currently managed as part of the response to the pressures put on the NHS following the COVID-19 pandemic.
32. As mentioned in Point 8 above, in response to the pandemic, The Royal College of Surgeons has created a reprioritisation code list. The onset of the pandemic meant that many elective surgeries were cancelled for a period. Following recommencement of elective surgery, a large proportion of these patients waiting are now either approaching or have exceeded their 26-week target. When used together, the code list and associated documentation creates a new way of working that can be used to help reprioritise patients already on an elective waiting list, in order to make sure that those with the highest clinical need are seen at the earliest opportunity, irrespective of their original position on a waiting list. It is important to note that this new reprioritisation method does not replace the current three priority stages of Urgent Suspected Cancer (USC), Urgent and Routine and is to be used in collaboration with these prioritisation methods.
33. In May 2021, WG approved the Health Board's activity recovery proposals in respect of the Phase 1 Recovery funding allocation made available to NHS Wales. These proposals reflected an initial scoping of potential outsource capacity available through the independent sector, in addition to separate plans to progress a medium term demountable solution for the Prince Philip Hospital site in Llanelli to enable the provision of two additional day case theatres.
34. In addition to the above, the Phase 1 allocation also supported modest investments in additional internal activity across cardiology diagnostic, Bowel Screening Wales and pathology activity.
35. Due to the timelines associated with the NHS Wales Shared Service Partnership (NWSSP) tender and commissioning framework, and operational challenges faced by providers in scaling up capacity to meet the needs of commissioning Health Boards, the majority of commissioned activity is scheduled to be delivered during Q3 and Q4 of 2021/22. Planning and delivery of outsourced activity via the independent sector is being tracked and monitored on a weekly basis.
36. In September 2021, WG approved the Health Board's further recovery proposals in respect of the Phase 2 Recovery funding allocation made available to NHS Wales. These proposals reflected an initial scoping of potential additional outsource capacity available through the independent sector, in addition to plans to increase internally delivered activity across diagnostic and outpatient pathways. The planned additional activity to be delivered through a combination of the independent sector and additional internal capacity is profiled below. Planned outsource activity is currently being tendered and delivered in accordance with the All Wales Framework.

Recovery Planning 2022/23 Onwards

37. To support recovery planning for 2022/23 onwards, a proposed Reset and Recovery Programme is currently being considered by the Health Board's Operational Planning and Delivery Programme (Tactical) Group. This is centred on the National Planned Care Strategy's 5 Planned Care Goals, which provide a roadmap for NHS organisations to follow when rebuilding and transforming services, building on the learning from the pandemic and evidence based models:
1. Effective referral: Ensure that referral guidance and thresholds are in place to ensure that those most in clinical need are referred to the appropriate setting.
 2. Advice and guidance: Develop access to high quality advice and guidance to enable informed decision making for individuals as well as primary and secondary care clinicians.
 3. Treat accordingly: Access to appropriate care at the right time at the right place.
 4. Follow up prudently: Giving individuals more choice and control over their care.
 5. Measure what's important: Transforming care to better meet the clinical need of the patient.
38. This process is currently in semi paralysis due to the Omicron crisis; however, the organisation is planning for reset and recovery as soon a practicably possible.

Information and Communication

How are you communicating with people who are waiting for care or treatment, and what steps are you taking to ensure that people who are waiting do not feel forgotten? For example, how are you responding to the findings of the Board of Community Health Councils in its report 'Feeling forgotten? Hearing from people waiting for NHS care and treatment during the coronavirus pandemic'?

39. The Health Board identified the impact of its response to the Coronavirus Pandemic on people waiting for care, and as part of its response set a clear objective in 2021 to establish a process to maintain personalised contact with patients waiting for elective care. An initial letter of contact has been issued to patients as part of the Health Board's waiting list validation process. The style and content of the letter was developed collaboratively with colleagues from the Community Health Council and the service.
40. A Waiting List Support Service (WLSS) has been established and a process to offer a single point of contact was piloted in 2021; the findings of the Board of Community Health Council's Report informed the development of the pilot. Now that proof of concept has been provided, this process is being rolled out across all elective specialties. A phased approach has been adopted to ensure that the offer made is kind, compassionate and meaningful.
41. Patients are initially contacted by letter containing a link to specific clinically identified, or developed, self-management online resources, a single point of telephone number and email address to contact the dedicated WLSS team. This single point of contact is managed through the Health Board's Covid Command Centre, and the WLSS Team is led by professional nurses. In cohorts where there are lower patient numbers, or during periods of high demand in the Command Centre, patients will be contacted directly by telephone by a member of the WLSS Team.
42. When in contact with patients, the WLSS team give further advice and support, which can include connecting patients to other specific support services, or escalating to the responsible clinical team as appropriate.

43. The corporate Communications Team has supported both our scheduled care teams and the WLSS Team in the areas of communication and support for people waiting care or treatment. This has included development, publication and updating of a base line of supportive materials on our website, which are referenced on appropriate letters to patients, in promotional materials, and to answer people's enquiries into the Health Board.

44. Key resources include:

- Restarting services webpages: where you can choose the service you are awaiting and see a high level update as to whether these services are running and to what extent. Signposting for anyone who needs to discuss further is offered through the contact telephone numbers on appointment letters or a link to our patient support team and there is also a Frequently Asked Questions section.
- Preparing for treatment lifestyle advice: to compliment the general lifestyle advice our health care professionals provide people when face-to-face, we have created a web resource for people to be able to access this information in their own time from home. This link is also provided in appropriate patient letters. General advice is available for all patients in areas, such as eating well, being active, drinking alcohol and smoking. There are also links to support for mental health and coping with anxiety, which we promote in campaign work and with media. In addition, we have worked with professionals to provide targeted advice for cancer patients and orthopaedic patients.

Do you have any plans to publish and share information about indicative waiting times for your local population? What challenges or benefits would be associated with this? Welsh Government support

45. The Health Board provide local GP services with a weekly output of waiting times, which is in the public domain; this has also been supported by national declarations of waiting times in the media

46. The Health Board publishes information on performance regularly through Board meetings, which are now virtual to assist the public in attending and scrutinising. Reference to the impacts of the pandemic on waiting times has been referenced in national media and more locally, but this has been limited as we try and assess what the full impact is and how we can best support people. For example, we have made reference to long waiting times in media releases and interviews, internal staff communication, and in regular briefings to key stakeholders and influencers in our communities, such as with the Community Health Council and elected public representatives.

47. Challenges arise as there are so many situations/pathways for patients and this can be difficult to communicate at scale; it is probably better to have direct communication with patients. In addition, the need to communicate with all the public, including those who do not have access to digital technology.

What could the Welsh Government do to support health boards to tackle the backlog, and ensure that people who are waiting for diagnostics and treatment get the care and support they need so that their physical and mental health does not deteriorate while they are waiting?

48. The WG is already promoting the importance of promote behavioural change towards healthy lifestyles, and is also communicating that the impact on planned care is likely to take a longer period to reach pre-pandemic levels.

49. The Health Board would benefit from advice on working with non-digital communities, and considers that this might be role for the third sector nationally.
50. The extent of the backlogs that have developed during the course of the pandemic will, in some cases, take several years to resolve, and will necessitate changes to established pathways and the development of more regional approaches to care delivery as health boards work together to maximise capacity. Inevitably, some patients will need to travel further distances to access care than may have been the case prior to the pandemic, and health boards and WG will need to work together to appropriately resource effective transport solutions and manage public expectations about the locations where some pathways can be delivered in the next few years.

Effectiveness of the Welsh Government's Health and Social Care Winter Plan 2021 to 2022

How well are health and care services coping, including any particular pressure points and areas of concern as we move further into winter?

51. A key challenge in planning for 2021/22 and the winter period has been the significant uncertainty about how the COVID pandemic would unfold through the year. The operational outlook for health and care services in the Hywel Dda area has changed significantly during this period. The emergence of the Omicron variant in early December 2021 has led to unprecedented levels of community transmission and has prompted a rapid acceleration in the roll out of the vaccine booster programme across the UK.
52. The risks associated with the increase in pressures across primary, community and social care services are being managed by working in partnership across the urgent and emergency care system. The risks and associated actions are centred on key themes of conveyance, capacity and workforce.
53. Whilst hospitalisations of COVID-19 positive patients are currently below previous peaks, they are rising steadily. More positively, admissions to ICU/Critical Care have continued to fall, which reflect both the protective effect of the vaccines and new treatment options. Every stage of this pandemic has presented a different set of challenges and in this current wave, there is considerable concern, locally and nationally, about staffing availability. With such high levels of community transmission, we have been actively planning for abnormally high levels of staff absence.
54. As part of our plan for the year (including the winter period), we set out a number of priorities to mitigate the level of pressures anticipated. These centred on an integrated 24/7 single point of contact model for urgent clinical assessment and 'streaming', so that patients access the right service at the right time in the right place. These include:
- A 'Contact First'/Urgent Primary Care model in order to co-ordinate our urgent care response to the exacerbating health and care needs of our population and maintain people in their own homes and communities. Our vision is to create an integrated 24/7 single point of contact for urgent clinical assessment and 'streaming' - Conveyance and Self-Presentation to Emergency Departments (ED);
 - Clinical Streaming Hub, including Physician Streaming, Assessment & Triage (PTAS) of potential ambulance demand; Urgent Primary Care 'eyes on' assessment of patients;
 - Same Day Emergency Care (SDEC) models in acute and community settings, including comprehensive frailty assessment; and
 - Management of the frail elderly, including comprehensive geriatric assessment.

55. However, as the winter has progressed, infection rates have increased to levels not seen since the start of this pandemic in early 2020. This is driven by the emergence in late 2021 of the Omicron variant of concern, now the dominant strain across the UK; a variant that is significantly more transmissible than the variant it displaced (Delta) and has had the ability to infect previously vaccinated or infected individuals. These characteristics, coupled with less stringent restrictions on individual freedoms than were in place last winter, have driven the very large wave of infections.
56. As infections have risen, the risk of outbreaks in hospitals and closure of care homes to admission has also increased with several outbreaks across our ward areas. Whilst these are actively managed by our Outbreak Control Teams and in accordance with our policies and procedures, they have significantly impacted upon overall bed capacity and the flexibility with which we have been able to utilise these beds in response to rising demand.
57. Following the extensions to the Vaccine Programme agreed by the Joint Committee on Vaccinations and Immunisations (JCVI), our vaccination team has delivered a rapid acceleration in our local vaccination programme. We are pleased to report that, as a result, we were able to meet the revised milestones announced by WG in December 2021 to ensure all eligible people in our local population were offered a booster jab by 31 December 2021.
58. Our operational position remains extremely challenged, with increasing pressures right across our integrated health and social care system, affecting discharge pathways and the timely progression of patients beyond the hospital phase of their care. This inevitably impacts upon capacity at our hospital 'front doors' with resultant challenges in achieving the timely receipt of patients arriving via ambulance.
59. An equally significant concern during the winter period has been the availability of staffing. Currently, sickness absence rates remain at approximately 8% overall – high by historical standards but similar to those we have experienced in Q.3. The concern is that with such high levels of community transmission, there is a strong possibility that this position will deteriorate quickly.
60. We have therefore, focused our attention on planning for a total absence rate of up to 30% during January 2022 and have deployed the following actions:
- The Workforce team has been deployed into local sites to collect real-time sickness absence data at regular points throughout the day, to allow for real-time decision making by site teams;
 - All escalation plans have been reviewed;
 - A decision to stand down all remaining routine planned work (with some exceptions) from 10 January 2022 has been made, consistent with the NHS Wales Choices Framework to manage peaks in COVID and other unscheduled care demand.
 - All urgent cancer services (with some limited exceptions) have been centralised onto the Prince Philip Hospital (PPH) site to protect, as far as possible, this potentially life-saving intervention from disruption;
 - Rapid dissemination of an Internal and External Communications Plan, including local political representatives and the Community Health Council (CHC).

61. At the time of submission of this report, the number of COVID-19 patients in our beds continues to rise and is adding to the complexity of operational delivery. At time of writing, there were 101 COVID patients (including 15 suspected) in our beds, 6 of which are in Critical Care. These numbers continue to be far lower than would be expected given the infection rates in our communities but are likely to continue their upward trajectory.

What are your views on the effectiveness of this year's approach to winter planning, including the timing of the Welsh Government's winter plan and associated planning at regional/local level? Are these sufficiently joined up?

62. We welcome the approach adopted to integrate health and social care planning for winter pressures through a co-ordinated approach. Across West Wales, we have a strong track record of joint planning between agencies and the approach set out by WG this year builds upon the foundations already in place.

63. Regionally, we have been working collectively throughout the year and hence our transformation plan negated the need for a winter plan. Any funding that became available was targeted at our improvement planning. The WG Urgent and Emergency Care Funding and the Regional Transformation Scaling Fund were all utilised to invest in our Regional Plan.

64. The Health Board supports co-ordination of winter planning through the Regional Partnership Board (RPB); the West Wales Care Partnership. The eight priority areas for preventative activities to enhance patient safety and wellbeing and manage the demand for urgent and emergency care complement the NHS Wales planning guidance already in place for urgent and emergency care (the 6 Goals). The additional funding allocated by the RPB is supplementary to the targeted allocations provided to health boards to address wider Urgent and Emergency Care pressures.

65. This approach allowed partners to be able to appreciate the challenges across all organisations and understand what the third sector could provide to help support these challenges. The approach also acknowledges that service improvement within the NHS is wholly dependent on integrated working with other sectors and adopting a population and preventative focus.

66. Inevitably, the effectiveness of any supporting investment will be limited by its non-recurrent nature, particularly where plans are heavily reliant on recruitment of additional staffing resources. In the current operating climate as a consequence of the continuing pandemic, the specific nature of 'winter' related pressures are increasingly difficult to distinguish from year round overall emergency and unscheduled care pressures, and the ability of both health boards and local authorities to respond to such pressures would be enhanced by greater certainty over funding streams for the longer term.

What lessons can be learned from this year's approach?

67. Each year, we undertake a review of our winter planning approach, jointly with our local authority partners, and we will undertake a similar process in the Spring through the RPB. Whilst we are not in a position to anticipate the outcome of this review at this stage, we are nonetheless very aware that the impact of the pandemic on both staffing recruitment, retention and sickness/absence levels, across the health and social care sectors has compromised the effectiveness of plans currently in place. All organisations will need to further consider this aspect in the development of future plans.

Appendix A

Patients waiting over 36 weeks from referral to treatment by specialty

Specialty	Mar-19	Mar-20	Mar-21	Nov-21
130 - Ophthalmology	0	124	3,733	4,630
110 - Orthopaedics	0	254	4,711	4,446
120 - ENT	0	82	3,763	3,955
101 - Urology	0	51	2,211	3,382
100 - General Surgery	0	61	2,101	3,247
502 - Gynaecology	0	35	2,006	2,818
104 - Colorectal	0	8	880	1,831
330 - Dermatology	0	8	1,281	962
191 - Pain Management	0	10	879	888
301 - Gastroenterology	0	0	476	883
410 - Rheumatology	0	0	485	812
430 - Geriatric Medicine	0	20	609	720
107 - Vascular	0	0	379	585
300 - General Medicine	0	0	133	274
103 - Breast	0	0	224	267
400 - Neurology	0	43	0	249
320 - Cardiology	0	18	819	241
340 - Respiratory Medicine	0	5	391	199
998 - Other Specialties	0	0	1,897	117
401 - Clinical Neurophysiology	0	0	189	117
420 - Paediatrics	0	3	197	114
303 - Clinical Haematology	0	0	42	71
314 - Rehabilitation	0	0	1	21
822 - Chemical Pathology	0	0	2	13
328 - Stroke Medicine	0	0	2	12
324 - Anticoagulation Service	0	0	1	8
361 - Nephrology	0	0	24	6
302 - Endocrinology	0	0	13	1
329 - Transient Ischaemic Attack	0	0	3	1
999 - Other Specialties	0	0	132	0
311 - Clinical Genetics	0	0	1	0
All specialties	0	722	27,585	30,893

Patients waiting over 8 weeks for a diagnostic

Diagnostic	Mar-19	Mar-20	Mar-21	Nov-21
Radiology - GP referral	0	7	2,045	1,819
Radiology - Consultant referral	0	6	1,447	1,350
Diagnostic Endoscopy	0	54	1,067	1,225
Neurophysiology	0	9	874	706
Cardiology	0	256	235	412
Imaging	0	1	26	14
Physiological Measurement	0	3	8	6
All sub categories	0	336	5,702	5,532

Patients waiting 14 weeks and over for a specific therapy

Therapy	Mar-19	Mar-20	Mar-21	Nov-21
Occupational Therapy	0	23	112	283
Physiotherapy	0	62	2	185
Dietetics	0	0	0	180
Podiatry	0	127	127	103
Audiology (Adult hearing aids)	0	0	155	4
Speech Language	0	0	5	1
Art	0	0	0	0
All sub-categories	0	212	401	756