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_e

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.

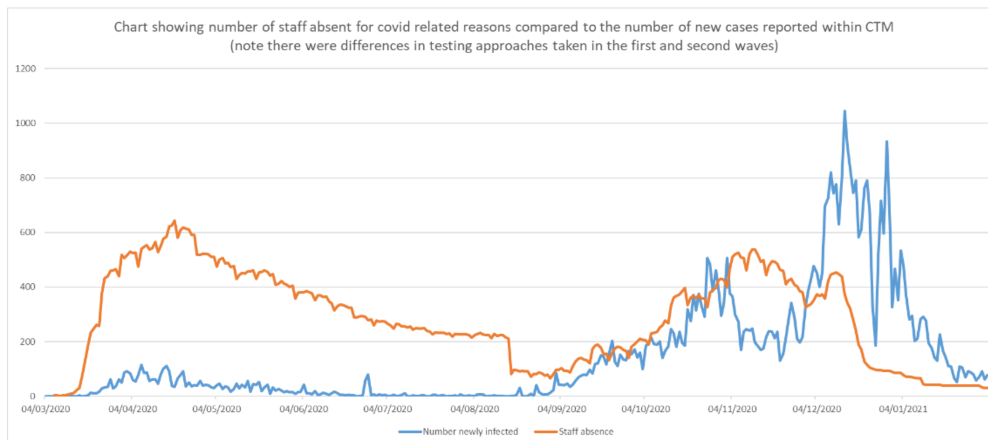
Staff group	Days absence for covid-19 related reasons
Nursing	79595

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.