GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

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

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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