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

Date of Submission: 16 February 2021

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

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

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

About the Organisation

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

An overview on our response to the COVID-19 PANDEMIC

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

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

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

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

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

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

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

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

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

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

Risk Stratification

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

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

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

Recovery Planning – Q1/2 2021/22

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

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

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

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

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

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

Medium Term Recovery Plans

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

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

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

Regional solutions

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

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

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

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

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

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

Risk Stratification

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

Keeping in Touch with our Patients

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

Cancer Helpline

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

Single Point of Contact (SPOC)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Outpatient Transformation

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

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

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

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

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

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

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

Stage 1 reviews: validation of the waiting lists

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

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

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

Video Group Clinics

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

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

Outpatient Strategy

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

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

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

E-Referrals

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

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

Our Planning Scenarios and Assumptions

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

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

Organisational Capacity Plans

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

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

Organisational Workforce Plans

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

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

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

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

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

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

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

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

Mass Vaccination Programme Delivery Plan

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

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

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

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

Testing

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

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

Conclusion

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