**Appendix 1: Recovery submission to Welsh Government 3rd February 2021**

Dear Andrew

Thank you for your letter dated 29th January 2021, setting out your expectations for the forthcoming plan submission. As requested, I have set out a position statement on the status of our recovery planning work.

**Overview**

Clearly, we are all aware of the full background and it is therefore unnecessary for us to set out the environment within which our operational and planning teams are operating within. It is worth underlining the importance of the start of the calendar year as a clear point of transition where the Health Board was able to further accelerate our recovery planning with a degree of confidence that the restart of services (elective and otherwise) could commence in relatively short timelines.

This transition was as a clear result of the factors affecting Covid prevalence – not least the impact of the national lockdown. Our modelling shows that the actual Covid prevalence in the community, admissions and critical care is closely tracking projections and we are now in a position to commence some elements of our elective activity in parallel with finalising the overall recovery plan.

**1. Status of recovery planning**

Recovery planning has been underway within CTM UHB from the moment we started to stand services down. We have evolved the previous Q3/4 plans and are updating them for the better understanding we now have of the impact of Covid on our services. This planning is due to complete within the Health Board by the end of February to allow modifications in advance of the final submission to you on the 31st March.

<u>Progress to date</u>

Our planning has two core aspects:

- The immediate approach to restarting elective services in a planned, risk assessed manner through to the end of 20/21. The reality is that this is an eight-week timeline that requires a responsiveness to the operational conditions on a daily and weekly basis. Plans for recommencing services developed by our Integrated Locality Groups (ILGs) are reviewed by our Silver and Gold command structure to gain the assurance that services proposed to restart can commence safely and in the context of prioritising valuable resource (predominantly staff)
- Full recovery planning for 2021/22 which is embedded within our IMTP process supported by a specific elective recovery planning cell and this overall paper describes

<u>Immediate Approach to restarting elective services during 20/21 (through Gold & Silver command)</u>

| | |
|---|---|
| **10th January 2021** | Gold requested a proposal from the ILGs for recommencing elective services within the capacity that would be available during 2020/21 as identified by |

| | |
|---|---|
| | the detailed modelling completed by the UHB. Tracking of the modelling provided confidence that we were moving to the recovery phase (although there remained questions around the potential and scale of a third wave). |
| **17th January 2021** | Gold command reviewed the proposal and agreed a set of principles under which detailing planning could progress. |
| **24th January 2021** | Gold command approved a decision to restart elective provision in a safe and controlled manner subject to and predicated on having a full and comprehensive understanding of the available capacity within Health Board. |

The key constraint to the immediate restarting of elective work has been access to critical care capacity (due to the Covid surge volumes) and the availability of theatre staff who have been redeployed to support the critical care surge plans. The shortage of theatre staff (where they have been deployed to critical care) has required us to focus on urgent and cancer cases with the remaining theatre capacity.

Operational plans have been developed to release critical care capacity and theatre staff to allow expansion of elective activity in a phased approach to the following timelines:

| ILG/ Hospital site | Restart date |
|---|---|
| Royal Glamorgan Hospital | 15th Feb 2021 |
| Prince Charles Hospital | 15th Feb 2021 |
| Prince of Wales Hospital | 15th Mar 2021 |

A CTM wide governance process is being established to ensure that the management of available capacity by specialty is reviewed at a HB level to ensure there is no postcode variation for access to services.

## 2. Early assessment of demand

Demand into secondary care across the UHB has dropped significantly since March 23rd 2020 when the first national lockdown was introduced. This recovered to an extent from around June 2020, where a relatively steady state has been maintained since that time. Referrals continue however to be well below pre-Covid levels, with little sign at the moment of any significant increase towards such levels.

Detailed demand and capacity modelling is well underway being led by the Planning & Performance Team and this will be included within our Annual Plan submission. Forward projections will need to be scenario based given the uncertainty in terms of future demand (e.g. will demand continue to be depressed as citizens are hesitant from accessing health care or will suppressed demand bounce back above previous levels).

At this point, the known data shows a reduction in referrals ranging from 18% in Gynaecology to 62% for Chronic Pain. The headline levels are set out in Table 1 below:

| Outpatients (New) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Unit | Service | Demand Total | Capacity Recurrent | Backlog | | | Current Demand Reduction % |
| | | | | 52+ | 36-51 | 26-35 | |
| Surgery | Urology | 8625 | 6032 | 374 | 683 | 199 | 43.49% |
| | Orthopaedic | 36616 | 36243 | 701 | 1475 | 421 | 44.66% |
| | General Surgery | 14612 | 13929 | 683 | 1403 | 542 | 30.55% |
| | ENT | 14940 | 14072 | 1492 | 1429 | 379 | 48.11% |
| | Gynaecology | 11224 | 8428 | 457 | 1034 | 338 | 18.43% |
| | Ophthalmology | 10368 | 10042 | 1444 | 1814 | 139 | 41.62% |
| | Oral Surgery | 4570 | 2995 | 515 | 372 | 58 | 51.75% |
| | Pain | 879 | 478 | 408 | 268 | 90 | 61.54% |
| **Surgery Sub Total** | | **101834** | **92219** | **6074** | **8478** | **2166** | |
| Medicine | Medicine | 5628 | 5110 | 263 | 477 | 156 | 27.83% |
| | Rheumatology | 5428 | 6093 | 351 | 302 | 102 | 51.13% |
| | Cardiology | 7961 | 5778 | 763 | 983 | 379 | 38.00% |
| | Dermatology | 11053 | 7700 | 2712 | 1294 | 452 | 27.26% |
| | Endocrinology | 692 | 1138 | 0 | 0 | 9 | 27.26% |
| | Respiratory | 3583 | 3380 | 87 | 202 | 63 | 34.31% |
| | Gastroenterology | 3314 | 2539 | 539 | 595 | 217 | 30.16% |
| **Medicine Subtotal** | | **37659** | **31738** | **4715** | **3853** | **1378** | |
| **New Totals** | | **139493** | **123957** | **10789** | **12331** | **3544** | |

**Table 1: Initial Outpatient (New) demand modelling**

It is anticipated that this reduction in referral trend will continue into the early part of 2021/22 and potentially for longer, until people are confident that the vast majority of the population have been properly vaccinated. Our intention is to derive a number of potential scenarios as to what will happen with referrals as our demand and capacity work intensifies over the coming weeks.

In addition to the changes in patient behaviour we will factor in three additional components to our demand modelling:

- Administrative validation: i.e., where an administrative review of backlog waiting lists identifies demand that is no longer required. This may include the potential for patients opting out of planned treatments based on the changed context of Covid
- Clinical validation: i.e., where we deploy clinical reviews of patient cohorts to identify if the planned pathway remains the most appropriate or whether amended thresholds/ criteria should be introduced
- Pathway remodelling: i.e., the development of capacity in pathways that migrate patients away from traditional pathway routes

## 3. Assessment of capacity

As with demand, we are considering a range of potential scenarios as to enhance our available capacity in 2021/22. Elective capacity in our own hospitals has been severely limited during this year and whilst we have had some success in utilising independent hospital capacity, the total activity delivered is well below what we would have ordinarily expected to have delivered in pre-Covid times. Work is underway as part of our IMTP planning process to establish the actual capacity at specialty and point of delivery level to inform the 21/22 plan.

The analytical work is well underway and will include specific interventions (including but not restricted to):

- Increases in capacity driven by productivity as we learn to live with Covid measures
- Re-organisation of capacity (e.g. elective orthopaedic work) to improve pathway capacity and economies of scale/ aggregation
- The better use of existing physical capacity (due to increased appetite and availability of vacant lists, weekend working)
- The capture of transformational changes that have resulted from Covid pandemic responses (use of virtual outpatients, etc)
- The role of Ysbyty'r Seren in supporting overall capacity
- Outsourcing to independent sector capacity
- Insourcing for high priority areas such as Endoscopy

It is worth acknowledging that all measures to increase capacity, including new pathways, require additional staff. Attracting additional staff in the immediate post-Covid context where the availability of overtime and/ or recruitment will be a real constraint to new measures.

As a measure of capacity indicators, since June 2020 in overall terms we have seen the following scale of reduction in activity delivered within the UHB:

- New outpatient attendances reduced by 49%
- Follow up attendances reduced by 52%
- Treatments reduced by 62%

We anticipate the elective recovery programme will address some of this reduction in core capacity, and will be able to model the impact of these scenarios following the completion of the IMTP in March 2021.

**4. Anticipated Capacity Gaps**

At this point, given the work that is underway within the IMTP process, any assessment of the size of the capacity shortfall will give an incomplete picture. **Appendix 1** sets out the demand and capacity assessment at a macro level for outpatient and treatment, but is yet to develop to include the impact of proposed demand and capacity interventions as set out in sections 2 and 3. Once this planning (specifically to quantify the impact of the proposed interventions), the capacity deficit position for CTM will be finalised.

Whilst the detail provided is at a specialty level, work is also underway for diagnostic and therapy services. For Endoscopy in particular, we are understandably committed to the demand and capacity work within the national programme and we have particular challenges in that area. We also continue to engage with Welsh Government around measures we can put in place to help address this capacity shortfall (e.g. the use of mobile units).

Whilst some specialties such as Orthopaedics appear to be in recurrent balance for new outpatients for example, this may not always be the case at a sub-specialty level and we will be pursuing this further with our operational colleagues.

For surgical specialties, the conversion rate from both new and follow-up outpatients is calculated at a sub-specialty level wherever possible, resulting in the ranges detailed in **Appendix 1.**

As described, we are yet to finalise the likely percentage reduction in available capacity and we will also need to establish the year-end target for 2021/22 prior to finalising the demand and capacity gaps. The approach we are undertaking however should be clear from the results of our work to date and provides a measure of assurance regarding our ability to finalise the work in time for IMTP submission. The issuing of the MDS later this month will further support our cause.

**5. Local and regional options/ schemes**

Each ILG is working towards the consistent planning framework set out by the Health Board. Within that framework, Appendix 2 sets out the headline options that each ILG is developing

**6. Size of backlog**

We will establish a year-end target backlog for March 2021. Nevertheless, the detail provided in Appendix 1 outlines the scale of backlog at both outpatient and treatment level. Whilst we anticipate that these numbers will increase by the end of March 2021, we have not made this assessment as yet, but will be doing so in the more detailed work underway.

As well as the March 2021 position, the backlog at March 2022 will obviously be affected by both our assumptions on the pace/ extent of demand and capacity returning to pre-Covid levels, our measures to influence demand from a value perspective, and our plans for increased capacity including new pathways.

**7. Timeframes**

The initial combined IMTP and elective recovery planning work is due to complete internally by the end of February 2021. This will allow further iterations to be worked through prior to submission as part of the Annual Planning process by 31st March 2021.

**8. Costs**

We are developing our financial plan on the basis that:

- The gradual return to delivering pre-Covid core capacity will be within the current budget (with non-pay underspends for the period are delivering lower activity)
- Measures to expend capacity (either extended hours or extended physical capacity), and measures to implement new pathways/ interventions will generally have an increased cost over the current budget
- The existing use of Nuffield facilities/ insourcing/ mobile capacity will continue until such time as we have completed the overall plan

**9. Conclusion**

As you will see from the above position statement, our recovery planning work and capacity and demand modelling is well underway. The transition into the phase of reducing Covid prevalence since the Christmas period has provided the opportunity for Operational Teams to engage heavily in the detailed planning and drive forward the excellent work that our Planning and Performance teams are leading on.

Given the increased confidence we now also have on releasing capacity back into elective care work, we have developed detailed operational plans to clear USC backlog and commence P3 and P4 activity in a considered fashion under the assurance mechanism of our Gold and Silver Command.

Thank you for your ongoing support and I look forward to the opportunity to talk these plans through in detail over the coming weeks ahead of our final submission prior to 31st March.

**Appendix 1: Top down modelling of recurrent outpatient and surgical capacity**

## Outpatients (New)

| Unit | Service | Demand Total | Capacity Recurrent | Backlog | | | Current Demand Reduction % |
|---|---|---|---|---|---|---|---|
| | | | | 52+ | 36-51 | 26-35 | |
| Surgery | Urology | 8625 | 6032 | 374 | 683 | 199 | 43.49% |
| | Orthopaedic | 36616 | 36243 | 701 | 1475 | 421 | 44.66% |
| | General Surgery | 14612 | 13929 | 683 | 1403 | 542 | 30.55% |
| | ENT | 14940 | 14072 | 1492 | 1429 | 379 | 48.11% |
| | Gynaecology | 11224 | 8428 | 457 | 1034 | 338 | 18.43% |
| | Ophthalmology | 10368 | 10042 | 1444 | 1814 | 139 | 41.62% |
| | Oral Surgery | 4570 | 2995 | 515 | 372 | 58 | 51.75% |
| | Pain | 879 | 478 | 408 | 268 | 90 | 61.54% |
| **Surgery Sub Total** | | **101834** | **92219** | **6074** | **8478** | **2166** | |
| Medicine | Medicine | 5628 | 5110 | 263 | 477 | 156 | 27.83% |
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| | Dermatology | 11053 | 7700 | 2712 | 1294 | 452 | 27.26% |
| | Endocrinology | 692 | 1138 | 0 | 0 | 9 | 27.26% |
| | Respiratory | 3583 | 3380 | 87 | 202 | 63 | 34.31% |
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| **Medicine Subtotal** | | **37659** | **31738** | **4715** | **3853** | **1378** | |
| **New Totals** | | **139493** | **123957** | **10789** | **12331** | **3544** | |

## Outpatients (FuP)

| Unit | Service | Demand Total | Capacity Recurrent | Backlog waiting 100% Over Target |
|---|---|---|---|---|
| Surgery | Urology | 14367 | 13504 | 470 |
| | Orthopaedic | 44641 | 36900 | 1698 |
| | General Surgery | 16767 | 18665 | 782 |
| | ENT | 23752 | 19840 | 790 |
| | Gynaecology | 10930 | 9516 | 674 |
| | Ophthalmology | 41866 | 39267 | 3421 |
| | Oral Surgery | 6511 | 5322 | 316 |
| | Pain | 2318 | 948 | 127 |
| **Surgery Sub Total** | | **161152** | **143962** | **8278** |
| Medicine | Medicine | 19251 | 17173 | 1642 |
| | Rheumatology | 14241 | 16236 | 596 |
| | Cardiology | 10113 | 10433 | 423 |
| | Dermatology | 22803 | 15235 | 678 |
| | Endocrinology | 3213 | 4668 | 0 |
| | Respiratory | 6905 | 3732 | 588 |
| | Gastroenterology | 6586 | 4774 | 197 |
| **Medicine Subtotal** | | **83112** | **72251** | **4124** |
| **FuP Totals** | | **244264** | **216213** | **12402** |

## New + FuP

| Unit | Service | Demand Total | Capacity Recurrent |
|---|---|---|---|
| Surgery | Urology | 22992 | 19536 |
| | Orthopaedic | 81257 | 73143 |
| | General Surgery | 31379 | 32594 |
| | ENT | 38692 | 33912 |
| | Gynaecology | 22154 | 17944 |
| | Ophthalmology | 52234 | 49309 |
| | Oral Surgery | 11081 | 8317 |
| | Pain | 3197 | 1426 |
| **Surgery Sub Total** | | **262986** | **236181** |
| Medicine | Medicine | 24879 | 22283 |
| | Rheumatology | 19669 | 22329 |
| | Cardiology | 18074 | 16211 |
| | Dermatology | 33856 | 22935 |
| | Endocrinology | 3905 | 5806 |
| | Respiratory | 10488 | 7112 |
| | Gastroenterology | 9900 | 7313 |
| **Medicine Subtotal** | | **120771** | **103989** |
| **Total Totals** | | **383757** | **340170** |

## THR

| Unit | Service | Demand Total | Capacity Recurrent | Backlog | | | nversion Range (Subspecialty Variar | |
|---|---|---|---|---|---|---|---|---|
| | | | | 52+ | 36-51 | 26-35 | From NOP | From FOP |
| Surgery | Urology | 1814 | 1708 | 477 | 358 | 162 | 5-10% | 5-17% |
| | Orthopaedic | 3986 | 2849 | 3447 | 1234 | 125 | 5-41% | 4-24% |
| | General Surgery | 4336 | 4005 | 1593 | 834 | 246 | 4-30% | 9-24% |
| | ENT | 2658 | 1679 | 707 | 346 | 34 | 7-12% | 5-7% |
| | Gynaecology | 3103 | 3001 | 781 | 413 | 104 | 10-16% | 5-16% |
| | Ophthalmology | 6107 | 4092 | 503 | 348 | 29 | 1-28% | 1-12% |
| | Oral Surgery | 761 | 794 | 376 | 171 | 27 | 6-53% | 13-17% |
| | Pain | 401 | 289 | 260 | 205 | 30 | 3-23% | 4-17% |
| **Surgery Sub Total** | | **23166** | **18417** | **8144** | **3909** | **757** | | |

**Appendix 2: High Level Plans for each ILG**

This appendix sets out the key operational changes that are being developed by each local ILG. These are being fully developed as part of the capacity and demand modelling within the IMTP

A full line by line assessment of the recovery plan needs has been completed for Mental Health and Primary Care services. This has been reviewed by Gold and is available to be shared if required in advance of the full Annual Plan submission

**RTE ILG/ ROYAL GLAMORGAN HOSPITAL**

**Phase 1:**

- An accelerated uplift in activity to return to the activity levels prior to the Dec Covid 19 Surge
- Continued use of the Vale (Nuffield) with available capacity following a review of the case mix to determine the most productive way to utilise the combined capacity of the RGH and the Vale.

**Phase II**

- As Covid activity reduces in line with the model an additional template will be converted delivering 2 wards (this may vary depending on ward area but minimum 15 beds per ward for surgical activity)
- HDU discussions for 'green' are underway and ongoing with a view to replace bed capacity with ITU patients
- Deep cleaning schedule developed for wards and other clinical areas being converted from Red to Amber/Green

Aim to achieve 60% of activity (approximately 5000 procedures per quarter), as a minimum, based on a non Covid impacted year i.e. 2019/20. Focus will be on the following specialties initially:

- Urology
- General Surgery
- ENT
- Colorectal
- Breast
- Gynae
- Ophthalmology – This will be part of a wider CTM plan in collaboration with POW

**Endoscopy**. CTM UHB is part of the development team for the National Endoscopy programme. However, given the size of the challenge around our waiting lists we are putting in place a number of local initiatives to start reducing the long waits. These local initiatives include the use of In-reach providers and Outsourcing. We are also exploring the use of externally staffed unit provision.

**T&O**. Demand is very challenging and the Health Board are in negotiation with the Independent Sector around outsourcing as part of a wider review of Orthopaedic provision which also includes discussions with neighbouring Health Boards about shared use of Theatres.

**MERTHYR CYNON ILG/ PRINCE CHARLES HOSPITAL**

As described for the Royal Glamorgan the objective is to increase activity levels back to the levels being delivered prior to the December Covid Surge

Advanced plans are in place based on new developments within the Hospital which will facilitate the elective restart programme as follows:

- A new Protected Elective Surgical Unit (PESU) 8 beds by the end of February with SEAL/MDU changes and if/when green ITU moves back to ward 4 this facilitates the reopening of SSSU which provides a further 9 beds.
- Covid Lite 6 beds mostly MaxFacs & Gynae
- PESU – Elective Orthopaedic Ward 8 beds*
- SSSU – Colorectal & General Surgical Ward 9 beds

Analysis is underway to determine how best to use this capacity to ensure there is equity across the health board for patients based on clinical priority.

**BRIDGEND ILG/ PRINCE OF WALES HOSPITAL**

The main theatre complex at POW is currently carrying a fire enforcement notice and therefore represents an additional challenge that needs an urgent decision on procure and deploy modular Theatres to the site this will allow for the creation of a green end on the hospital and maximise activity.

The configuration will be as follows:

- **Emergency Surgery** - Two theatres 24/7 for emergency – circa 35 cases per week
- **Obstetrics** - One theatre – emergency and planned c-section - circa 9.5 cases per week increasing to 12 cases per week over the next three months
- **Ophthalmology** - One theatre for emergency - circa 8 cases per week, From 8th February this will increase by 1 theatre to 9 sessions per week emergency and urgent – adding 30 additional cases 30 per week . From 1st April 2021 (depending on return of shielding staff) – Two theatres will be brought on stream – delivering an additional 40 cases per week
- **Planned Surgery** – Currently two theatres for cancer and urgent life an limb– circa 15 cases per week. From 1st March – there will be three theatres on stream – delivering an additional 10 cases per week
- **Minor Surgery** ( Dermatology Suite) - Minor Surgery Suite – circa 30 – 40 cases per week
- **Endoscopy** - 2 suites 51 procedures – uppers 16, lowers 35 plus bronchoscopy and ERCP – this specialty is being looked at pan Health Board to ensure that we maximise all available internal and external capacity
- **Neath Port Talbot** – Initially 6 sessions – 4 breast and 2 gynae day cases only). From 22nd February 16 sessions Orthopaedics 10 sessions, Breast 4 sessions Gynae 2 sessions.
- **The Vale** – Pan Health Board maximisation of allocated capacity and early notification of ad-hoc capacity as it becomes available.