Agenda - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:

Fideogynhadledd drwy Zoom

Dyddiad: Dydd Mercher, 24 Chwefror 2021

Amser: 09.00

I gael rhagor o wybodaeth cysylltwch a:

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Yn unol â Rheol Sefydlog 34.19, penderfynodd y Cadeirydd wahardd y cyhoedd o gyfarfod y Pwyllgor er mwyn diogelu iechyd y cyhoedd. Bydd y cyfarfod hwn yn cael ei ddarlledu'n fyw ar senedd.tv.

Rhag-gyfarfod anffurfiol (09.00-09.30)

1 Cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiannau

(09.30)

2 COVID-19: Sesiwn dystiolaeth gyda byrddau iechyd lleol

(09.30-10.30) (Tudalennau 1 - 109)

Gill Harris, Dirprwy Brif Weithredwr a Chyfarwyddwr Gweithredol Nyrsio a Bydwreigaeth - Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Arpan Guha, Cyfarwyddwr Meddygol - Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Steve Moore, Prif Weithredwr - Bwrdd Iechyd Prifysgol Hywel Dda

Andrew Carruthers, Cyfarwyddwr Gweithredol Gweithrediadau - Bwrdd Iechyd Prifysgol Hywel Dda

Paul Mears, Prif Weithredwr - Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Yr Athro Kelechi Nnoaham, Cyfarwyddwr Gweithredol Iechyd Cyhoeddus - Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Briff ymchwil

Papur 1 - Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Papur 2 - Bwrdd Iechyd Prifysgol Hywel Dda

Papur 3 – Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Papur 4 – Bwrdd Iechyd Prifysgol Aneurin Bevan

Papur 5 – Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Papur 6 – Bwrdd Iechyd Addygsu Powys

Papur 7 – Bwrdd Iechyd Prifysgol Bae Abertawe

Egwyl (10.30–10.45)

3 COVID-19: Sesiwn dystiolaeth gyda byrddau iechyd lleol (parhad)

(10.45–11.30)

Gill Harris, Dirprwy Brif Weithredwr a Chyfarwyddwr Gweithredol Nyrsio a Bydwreigaeth – Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Arpan Guha, Cyfarwyddwr Meddygol – Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Steve Moore, Prif Weithredwr – Bwrdd Iechyd Prifysgol Hywel Dda

Andrew Carruthers, Cyfarwyddwr Gweithredol Gweithrediadau – Bwrdd Iechyd Prifysgol Hywel Dda

Paul Mears, Prif Weithredwr – Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

Yr Athro Kelechi Nnoaham, Cyfarwyddwr Gweithredol Iechyd Cyhoeddus – Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg

4 Papurau i'w nodi

(11.30)

4.1 Llythyr gan Gadeirydd y Pwyllgor Diwylliant, y Gymraeg a Chyfathrebu at y Dirprwy Weinidog Diwylliant, Chwaraeon a Thwristiaeth ynghylch gwaith dilynol ar effaith COVID-19 ar chwaraeon

(Tudalennau 110 – 119)

4.2 Llythyr at y Cadeirydd gan Gadeirydd y Pwyllgor Deisebau ynghylch Deiseb P-05-812 Dylid gweithredu canllawiau NICE ar gyfer trin Anhwylder Personoliaeth Ffiniol

(Tudalennau 120 – 121)

4.3 Llythyr at Gadeirydd y Pwyllgor Deisebau ynghylch Deiseb P-05-812 Dylid gweithredu canllawiau NICE ar gyfer trin Anhwylder Personoliaeth Ffiniol

(Tudalennau 122 - 123)

4.4 Llythyr at y Gweinidog a'r Dirprwy Weinidog Iechyd a Gwasanaethau Cymdeithasol yn dilyn cyfarfod y Pwyllgor ar 27 Ionawr 2021

(Tudalennau 124 - 125)

4.5 Llythyr at y Cadeirydd gan y Gweinidog a'r Dirprwy Weinidog Iechyd a Gwasanaethau Cymdeithasol yn dilyn cyfarfod y Pwyllgor ar 27 Ionawr 2021

(Tudalennau 126 - 134)

5 Cynnig o dan Reol Sefydlog 17.42(ix) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod

(11.30)

6 COVID-19: Trafod y dystiolaeth

(11.30-11.40)

7 Ymchwiliad i effaith Covid-19, a'r modd y mae'n cael ei reoli, ar iechyd a gofal cymdeithasol yng Nghymru: Adroddiad 3 - Effaith ar y sector gofal cymdeithasol a gofalwyr di-dâl: Trafod yr adroddiad drafft

(11.40-12.10) (Tudalennau 135 - 192)

8 Ymchwiliad i effaith Covid-19, a'r modd y mae'n cael ei reoli, ar iechyd a gofal cymdeithasol yng Nghymru: Adroddiad 2 - Yr effaith ar iechyd meddwl a llesiant: Trafod ymateb Llywodraeth Cymru

(12.10-12.15) (Tudalennau 193 - 203)

Mae cyfyngiadau ar y ddogfen hon

Fersiwn 1.0 Cymeradwywyd

Ymateb BIPBC i Gais am Wybodaeth y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon ar Effeithiau'r Pandemig ar Amseroedd Aros

Cyflwyniad

Mae Bwrdd Iechyd Prifysgol Betsi Cadwaladr (BIPBC) yn croesawu'r cyfle i gyfrannu at ymchwiliad y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon i effaith Covid-19. Yn gyffredin â Byrddau Iechyd eraill ledled Cymru, mae BIPBC yn wynebu ystod o ffactorau sy'n achosi pwysau o ganlyniad i'r pandemig, yn cynnwys amseroedd aros. Mae'r prif ffactorau sy'n achosi pwysau wedi'u hamlinellu isod, mewn ymateb i gwestiynau penodol y Pwyllgor.

1. **Beth yw'r prif feysydd lle bo pwysau, a pha gynlluniau sydd gennych ar waith i fynd i'r afael â nhw?**

Gofal wedi'i Gynllunio

Mae'r holl weithgarwch rheolaidd i gleifion allanol a chleifion mewnol sydd wedi'u nodi fel rhai â haenau risg P3/4 wedi'i ohirio. Mae hyn yn golygu bod nifer sylweddol o gleifion bellach yn aros dros 36 wythnos a thros 52 wythnos am eu triniaeth. O 7 Chwefror, roedd 51,479 o gleifion yn aros dros 36 wythnos ac mae 36,000 o'r nifer hwnnw yn aros dros 52 wythnos. Y prif arbenigeddau lle mae cleifion yn aros am driniaeth yw Orthopaedeg, Llawfeddygaeth Gyffredinol, Wroleg ac Offthalmoleg.

Fel rhan o'n gofyniad i gynyddu nifer gwelyau'r Uned Gofal Dwys (ICU) ar draws y safleoedd Llym yng ngogledd Cymru, mae nifer o staff clinigol a fyddai wedi bod yn rhoi cymorth clinigol i leihau amseroedd aros wedi'u hadleoli gan felly leihau ein capasiti i ddarparu llawdriniaethau fel mater o drefn.

Yn ystod y pandemig, mae trin canser a chyflyrau sy'n bygwth bywyd wedi parhau fel rhan o'r hyn sy'n cael ei gategoreiddio fel 'gwasanaethau hanfodol'. Mae 'unwaith i Ogledd Cymru' wedi'i mabwysiadu, gan symud gwasanaethau ar draws y rhanbarth i sicrhau cynaliadwyedd pan fo ymchwydd mewn achosion Covid-19.

Mae ymagwedd ffynonellau mewnol (is-gontractio gwasanaethau i ddarparwr allanol) wedi'i mabwysiadu ar benwythnosau ym maes Offthalmoleg ar ddau o'r prif safleoedd ysbyty yng ngogledd Cymru a bwriedir ymestyn y model gofal hwn i'r arbenigeddau eraill yn ystod Chwefror, yn amodol ar gyfyngiadau Covid-19. Credir y bydd angen i'r ymagwedd hon, gan ddefnyddio model gweithlu cymysg, barhau am y 2-3 blynedd nesaf er mwyn lleihau ôl-groniadau i lefelau fel yr oeddent cyn Covid-19.

Arbenigeddau Meddygol

Mae heriau hirsefydledig yn y gweithlu meddygol yn gwaethygu pwysau ar y gwasanaeth yr ydym yn ei wynebu o ganlyniad i bandemig Covid-19 mewn gwasanaethau fel Endocrinoleg, Rhiwmatoleg a Dermatoleg. Mae'r heriau hyn yn

cael eu datrys trwy benodi staff locwm, lle bo'n glinigol briodol gwneud hynny, trosi swyddi gradd staff yn Gymdeithion Meddygol, a chyflogi nyrsys uchel iawn i ymgymryd â lefel uwch o waith clinigol er mwyn rhoi cymorth i'r tîm o feddygon ymgynghorol. Mae'r ymagweddau hyn wedi bod yn llwyddiannus ac rydym yn awyddus i fynd â'r ffyrdd newydd o weithio i'r amgylchedd ar ôl Covid. Mae ymateb y pandemig wedi golygu hefyd y bu angen i glinigwyr o'r arbenigeddau meddygol roi ymrwymiad mwy i rota meddygaeth gyffredinol, i rhannu’r llwyth gwaith. Ni fydd y pwysau hwn yn lleihau hyd nes bo modd dychwelyd at y rota ar alwad nad yw'n ymwneud â Covid-19, ac nid oes unrhyw derfyn amser wedi'i gadarnhau yn hyn o beth ar hyn o bryd.

Gwasanaethau Plant a Phobl Ifanc (CYP)

Er mwyn mynd i'r afael â phwysau ar wasanaethau i ddiogelu plant a'u lles emosiynol, ac i sicrhau bod modd i deuluoedd fanteisio ar gymorth a gofal iechyd yn brydlon, nid oes unrhyw staff CYP wedi'u hadleoli yn ystod yr ail don hon. Mae hyn wedi caniatáu i CYP gynnal gwasanaethau cymunedol a chyswllt i blant a'u teuluoedd.

O ran Gwasanaethau Iechyd Meddwl Plant a Phobl Ifanc (CAMHS), mae heriau'n bodoli o ran cyfeiriadau cynyddol ac ôl-groniad o asesiadau ac ymyriadau iechyd meddwl. Mae hyn wedi'i gymhlethu gan nifer y swyddi gwag ac absenoldeb staff. Mae'r cynllun i ddelio â hyn yn cynnwys comisiynu darparwyr allanol a rhoi prosesau recriwtio ar waith.

Ym maes Niwroddatblygiad (ND), bu'n rhaid i asesiadau arsylwadol wyneb yn wyneb yn cynnwys plant sy'n aros am ddiagnosis ND gael eu gohirio'n gynharach yn y pandemig, ond mae'r rhain wedi ailddechrau'n ddiweddar i rai plant. Y bwriad yw ailddechrau asesiadau cychwynnol ar gyfer yr holl blant yn ystod chwarter cyntaf 2021-22. Mae rhoi cymorth ar ôl diagnosis i blant ag Anhwylder ar y Sbectrwm Awtistiaeth (ASD) yn parhau i fod yn her. Mae prosesau gweithlu a chynllunio gwasanaethau'n mynd i'r afael â hyn er mwyn alinio'r gwasanaeth yn well i anghenion plant a phobl ifanc. Bydd comisiynu darparwyr allanol ar y cyd â CAMHS i roi cymorth i blant sydd ag anghenion niwroddatblygiadol a phryder hefyd yn gwella amseroedd aros.

Therapïau

Bu ôl-groniad o weithgarwch rheolaidd newydd mewn Adrannau Cleifion Allanol (OPD) ar draws yr holl wasanaethau therapi, gyda phwysau ar Ffisiotherapi, yn benodol o ganlyniad i Covid. Mae adnoddau ychwanegol, gan gynnwys staff locwm, wedi cael eu caffael i ddelio â'r ôl-groniad hwn, ond mae dod o hyd i staff locwm wedi bod yn anodd ac mae heriau o ran y mannau ffisegol ar gyfer clinigau sydd ar gael oherwydd gofynion ymbellhau cymdeithasol. Mae nifer o gleifion sy'n cael cynnig apwyntiadau rhithiol, yn dewis aros am apwyntiadau wyneb yn wyneb, sy'n cynyddu amseroedd aros i'r unigolion hynny.

Yn ogystal, mae ôl-groniadau o ran achosion dilynol mewn gwasanaethau fel Podiatreg a Therapi Iaith a Lleferydd yn benodol, ac amseroedd aros hwy ar y cyfan ar gyfer gwasanaethau nad oes rhaid adrodd arnynt fel orthotigau. Mae camau a

gymerwyd i fynd i'r afael â'r pwysau hwn yn cynnwys gofyniad i bob gwasanaeth fod â chynllun adfer ar waith, gan ganolbwyntio ar wella'r sefyllfa i ddychwelyd at yr amser aros o 14 wythnos. Bydd y terfyn amser i gyflawni hyn yn ymestyn at 2021-22.

Fel yn achos llawer o wasanaethau, mae capasiti ffisegol yn gyfyngiad sylweddol. Mae mannau clinigol ac adsefydlu wedi cael eu colli fel rhan o gynlluniau ymchwydd neu oherwydd anghenion defnyddwyr eraill fel gofal cychwynnol, yn ogystal ag effeithiau rhoi gofynion ymbellhau cymdeithasol ar waith. Mae mannau swyddfa i gynnal timau clinigol mewn ffordd lle bo pellter cymdeithasol diogel hefyd yn gyfyngedig.

Mae pwysau cynyddol ar wasanaethau nad ydynt yn rhai Adrannau Cleifion Allanol, er enghraifft, oherwydd adleoli staff i weithio mewn Ysbytai Enfys dros dro neu ar y rhaglen frechu, wedi cael sgil-effaith o ran pwysau ar wasanaethau Adrannau Cleifion Allanol.

Oncoleg a Haematoleg

Mae'r ddau faes yn wynebu pwysau oherwydd salwch yn ymwneud â recriwtio meddygon ymgynghorol a salwch hirdymor. Mae camau'n cael eu cymryd i fynd i'r afael â'r pwysau hwn trwy recriwtio meddyg locwm gradd ganol mewn haematoleg, oncolegydd clinigol ymgynghorol, a chynlluniau i gyflwyno radiograffwyr ymgynghorol/therapi arfer uwch sy'n gallu gweithio ar lefel uwch i roi cymorth i'r tîm o feddygon ymgynghorol mewn oncoleg glinigol.

Mae capasiti ffisegol yn gyfyngiad sylweddol i wasanaethau oncoleg a haematoleg, ac mae cyfyngiadau ymbellhau cymdeithasol yn effeithio ar fannau clinigol a swyddfeydd.

Endosgopi

Mae amseroedd aros endosgopi wedi cynyddu'n sylweddol ers dechrau'r pandemig. Yn y lle cyntaf, cafodd gwasanaethau eu gohirio yn ystod y don gyntaf yn unol ag arweiniad cenedlaethol. Ers i'r gwasanaeth ailddechrau, mae'r cyfnod segur rhwng achosion oherwydd gofynion rheoli heintiau ychwanegol wedi haneru cynhyrchiant. Mae adleoli staff i gynorthwyo gwasanaethau resbiradol, wedi creu heriau hefyd o ran cynnal capasiti yn nhermau staff meddygol a nyrsio. Er mwyn manteisio i'r eithaf ar y capasiti sydd ar gael, mae'r gwasanaeth wedi rhoi newidiadau i'w ffyrdd o weithio ar waith, gan gynnwys

- mabwysiadu system waith ar draws PBC cyfan, i leddfu amseroedd aros gwahaniaethol sy'n deillio o lefelau amrywiol o bwysau ar safleoedd gwahanol
- cyflwyno ffynonellau mewnol sydd wedi caniatáu model gwaith saith niwrnod.
- cyflwyno profion imiwnogemegol ymgarthol (FIT) i ganiatáu haenu risg cleifion yn fwy manwl-gywir.

Radioleg, Niwroffisioleg ac Awdioleg

Mae pwysau ar amseroedd aros diagnostig am radioleg, niwroffisioleg ac awdioleg. Er mwyn delio â hyn, mae cynlluniau clirio ôl-groniad wedi cael eu datblygu ac mae cynllun ychwanegol wedi'i roi ar waith ar gyfer 2021-22.

2. **Sut fyddwch yn blaenoriaethu cyflwyno gwasanaethau nad ydynt yn ymwneud â COVID er mwyn targedu lleihad mewn amseroedd aros?**

Gofal wedi'i gynllunio ymlaen llaw

Caiff blaenoriaethu o ran gweithgarwch nad yw'n ymwneud â Covid-19 ei gwblhau trwy'r rhestr targedu cychwynnol ac mae'n canfod arbenigeddau sydd â'r amseroedd aros hiraf (fel y'i rhestrir yng nghwestiwn 1 uchod). Argaeledd capasiti theatrau ac adrannau cleifion allanol yw'r ffactor cyfyngol, a pha un ai achosion dydd ynteu ofal cleifion mewnol yw'r gweithgarwch sydd ei angen - yn achos yr un cyntaf, mae'n haws dod o hyd i gapasiti pan fo ymchwydd mewn achosion Covid-19.

Arbenigeddau Meddygol

Caiff cleifion canser, a chleifion eraill y tybir eu bod yn rhai brys, eu gweld ar hyn o bryd yn unol â chanllawiau Llywodraeth Cymru a PBC. Fodd bynnag, mae rhai rhestrau aros brys yn cynyddu o ganlyniad i'r lleihad mewn capasiti clinigau oherwydd cyfyngiadau ymbellhau cymdeithasol ar gyfer Covid-19 a salwch hirdymor staff. Mae gwaith yn parhau i fynd ar drywydd dilysu rhestrau aros, gyda'r bwriad o leihau nifer y cleifion y mae eu hapwyntiadau dilynol yn hwyr.

Gwasanaethau Plant a Phobl Ifanc

Mae rhai amseroedd aros cynyddol yn bodoli yn CAMHS, ac mewn Asesiadau Niwroddatblygiadol (bu ychydig o gynnydd mewn amseroedd aros ar gyfer gofal paediatrig llym, ond mae'r rhain yn parhau i fod o fewn yr amser targed o gryn dipyn). Mae cleifion mewn gwasanaethau sydd wedi'u categoreiddio fel 'gwasanaethau hanfodol' yn cael eu gweld, gyda blaenoriaethu clinigol ar waith a defnyddio ffyrdd arloesol o gynnig gofal, fel clinigau rhithiol. Mae'r rhain yn cynorthwyo'r lleihad mewn amseroedd aros ac maent wedi bod yn llwyddiannus mewn clinigau paediatrig llym a chymunedol lle nad oes angen i gleifion gael eu gweld wyneb yn wyneb.
Mae dilysu rhestrau aros dilynol yn parhau yn yr holl wasanaethau i blant gyda'r bwriad o sicrhau lleihad o ran y rheiny sy'n aros 100% y tu hwnt i'w dyddiad targed.

Therapïau

Mae cleifion therapïau'n cael eu gweld yn unol â'r fframwaith gwasanaethau hanfodol. Mae blaenoriaethu clinigol o ran achosion yn yr holl wasanaethau'n parhau ac mae clinigau rhithiol yn cael eu defnyddio lle bo'n bosibl. Bu lleihad sefydlog mewn amseroedd aros i gleifion newydd yn y rhan fwyaf o wasanaethau therapi yn ystod chwarter 3 a 4, ac eithrio lle y gwnaeth ail don Covid-19 effeithio'n negyddol ar gynnydd. Fel yng ngogledd-ddwyrain Cymru. Mae'r holl restrau aros wedi cael eu

dilysu trwy gydol chwarter 3 pan ailddechreuodd wasanaethau rheolaidd i gleifion allanol.

Oncoleg a Haematoleg

Fel gwasanaethau hanfodol, mae Haematoleg ac Oncoleg wedi parhau i drin cleifion yn unol ag arweiniad y Coleg Brenhinol ac yn unol â chanllawiau Llywodraeth Cymru a PBC. Mae blaenoriaethu clinigol o ran achosion ar waith, fel y mae'r defnydd o glinigau rhithiol. Mae'n debygol y bydd Oncoleg yn dechrau gweld cynnydd yn y galw oherwydd lleihad o ran cyfeiriadau brys gan feddygon teulu am ganser tybiedig yn ystod misoedd cyntaf y pandemig, ynghyd â gohirio sgrinio a rhai gwasanaethau diagnostig. Disgwylir i gleifion ddod atom gydag afiechyd mwy datblygedig ac mae'r gwasanaethau'n dyfeisio cynlluniau i wella capasiti os bydd angen.

Endosgopi

Mae cleifion brys a chleifion canser tybiedig yn cael eu blaenoriaethu yn unol â chanllawiau Llywodraeth Cymru a PBC, ond mae amseroedd aros yn hwy oherwydd lleihad mewn capasiti oherwydd y cyfyngiadau rheoli heintiau a phrinder staff y cyfeiriwyd ato’n gynharach. Caiff yr holl gyfeiriadau endosgopi eu brysbennu a'u dilysu er mwyn sicrhau bod llwybrau amgen yn cael eu hystyried, fel delweddu neu ddiagnosteg bellach er mwyn sicrhau mai dim ond cleifion sy'n bodloni canllawiau cenedlaethol sy'n cael eu rhestru ar gyfer endosgopi. Mae llwybr profi FIT sydd ar y gweill i helpu i ganfod haenau risg o ran y cleifion mwyaf brys. Nod y capasiti ffynonellau mewnol ychwanegol hwn yw lleihau arosiadau cyn gynted â phosibl.

Radioleg, Niwroffisioleg ac Awdioleg

Bydd y capasiti ychwanegol a roddwyd ar waith i ddelio â'r galw uwch yn cynorthwyo blaenoriaethu gwasanaethau nad ydynt yn ymwneud â Covid-19 er mwyn targedu lleihad mewn amseroedd aros.

3. **Sut fyddwch yn cyfathrebu â chleifion ynghylch yr hyn y gallant ei ddisgwyl o ran hyd arhosiad, blaenoriaethu, ac unrhyw ddulliau i reoli eu cyflwr tra byddant yn aros?**

Gofal wedi'i Gynllunio

Mae cynllun peilot ar y gweill ar hyn o bryd, lle bydd y Bwrdd Iechyd yn cysylltu â'r cleifion sydd â'r arhosiad hiraf, er mwyn deall eu statws. Os bydd yn llwyddiannus, y bwriad yw parhau â'r ymagwedd hon ar gyfer y rhan fwyaf o'r cleifion sy'n aros. Caiff rhaglenni fel "dianc rhag poen" eu defnyddio i helpu cleifion i reoli eu cyflwr, ac mae gweithgarwch grwpiau cleifion allanol a chymwysiadau digidol yn cael eu datblygu i gynorthwyo'r rheiny sy'n aros am driniaeth. Mae gwefan y Bwrdd Iechyd wedi'i datblygu ymhellach, a bydd yn darparu gwybodaeth am amseroedd aros disgwyliedig ar lefel arbenigedd.

Arbenigeddau Meddygol

Mae gwefan y Bwrdd Iechyd yn cael ei diweddaru gyda'r wybodaeth berthnasol mewn perthynas â'r gwasanaethau hynny a ddarperir ar hyn o bryd ac rydym yn annog cleifion i aros yn ymwybodol o'r wybodaeth ddiweddaraf trwy'r llwybr hwn a thrwy'r cyfryngau cymdeithasol. Mae'r Gwasanaeth Cyngor a Chyswllt Cleifion (PALS) hefyd yn cael ei ddefnyddio. Fel rhan o broses brysbennu cyfeiriadau, caiff cyngor ar ddulliau hunanreoli i gleifion ei roi trwy feddygon teulu, lle bo claf y tu allan i gategori brys a chanser.

Gwasanaethau Plant a Phobl Ifanc

Yn ogystal â diweddariadau i wefan y Bwrdd Iechyd, caiff gwybodaeth am gyfeirio i ymarferwyr a theuluoedd yn ymwneud â gwasanaethau CAMHS a Niwroddatblygiad ei chyfleu trwy system un pwynt mynediad. Mae pob gwasanaeth hefyd yn ysgrifennu at deuluoedd er mwyn rhoi gwybod iddynt am y pwysau presennol ar wasanaethau, diwygio darpariaeth gwasanaethau a hefyd i gynnig cyngor ar sut i fanteisio ar ofal a chymorth. Mae offer hunangymorth ar gael.
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Therapïau

Er nad yw Therapïau fel mater o drefn yn cyfathrebu â chleifion ynghylch yr uchod, cynghorir cleifion i gysylltu â'r gwasanaeth os bydd eu sefyllfa'n newid neu os byddant am holi ynghylch eu hamser aros.

Oncoleg a Haematoleg

Er bod y drefn arferol yn parhau i bob pwrpas ar gyfer y gwasanaethau hyn, mae cyfathrebu rheolaidd â Fforwm Cleifion Canser Gogledd Cymru a darperir y wybodaeth ddiweddaraf ar gyfer eu gwefan.

Endosgopi

Caiff diweddariadau eu rhoi ar wefan y Bwrdd Iechyd mewn perthynas â'r hyn y mae'r Gwasanaeth Endosgopi yn ei gynnig ar hyn o bryd i gleifion canser ac achosion brys eraill. Cynghorir cleifion i gysylltu â'r ysbyty neu eu meddyg teulu os bydd eu cyflwr yn newid. Rhoddir cyngor hunanreoli trwy feddygon teulu i gleifion sy'n cael eu brysbennu fel rhai nad ydynt yn frys.

Radioleg, Niwroffisioleg ac Awdioleg

Caiff gwybodaeth am hyd arhosiad a gwybodaeth gysylltiedig arall ei chyfleu i gleifion trwy lythyr yn bennaf, neu mewn ymateb i unigolion sy'n cysylltu trwy PALS, switsfwrdd neu gysylltiadau gyda meddygon teulu.

4. **Pa amcangyfrifon neu ragamcaniadau a ydych wedi'u gwneud o ran yr amser sydd ei angen i ddychwelyd at y sefyllfa fel yr oedd cyn y pandemig?**

Gofal wedi'i Gynllunio

Mae'r Bwrdd Iechyd yn cynnal ymarfer rhagamcaniadau fesul arbenigedd ar hyn o bryd a disgwylir i'r gwaith hwn gael ei gwblhau erbyn dechrau mis Mawrth. Yr amcangyfrif presennol yw 2-3 blynedd, ac ym maes orthopaedig y mae'r adferiad hiraf.

Arbenigeddau Meddygol

Mae gwaith ar y gweill gyda chydweithwyr Gwybodeg ar y cynllun capasiti ar gyfer 2021-22. Mae'r cynlluniau hyn wedi'u seilio ar y ddarpariaeth bresennol ar gyfer Covid-19 ar gyfer chwarter 1 a chwarter 2, o leiaf. Mae monitro'n parhau i asesu'r adeg briodol i wella capasiti er mwyn dychwelyd at lefelau cyn Covid-19. Mae'r union derfyn amser yn hyn o beth yn anhysbys ar hyn o bryd.

Gwasanaethau Plant a Phobl Ifanc

Mae cynllunio capasiti'n parhau yn yr holl wasanaethau er mwyn gwneud rhagamcaniadau. Mae Uned Gyflenwi Llywodraeth Cymru yn darparu hyfforddiant i ategu modelau capasiti a galw ar gyfer gwasanaethau niwroddatblygiad ar draws Gogledd Cymru. Bydd angen capasiti ychwanegol mewn gwasanaethau niwroddatblygiad er mwyn mynd i'r afael â'r ôl-groniad ac i ddychwelyd at y sefyllfa cyn y pandemig. Mae capasiti presennol y tîm yn ateb y galw presennol, ond nid y pwysau ychwanegol sy'n deillio o'r ôl-groniad o 472 o achosion.

Mae cynllunio capasiti paediatreg lem ar y gweill er mwyn lleihau amseroedd aros i'r sefyllfa fel yr oedd cyn y pandemig o 12 - 18 wythnos. Mae rhywfaint o wella wedi'i weld yn ddiweddar o ran y niferoedd sy'n aros dros 26 wythnos.

Therapïau

Caiff ymarfer capasiti a galw ei gynnal er mwyn canfod y capasiti ychwanegol y bydd ei angen i ategu lleihad fel bo modd dychwelyd at y sefyllfa fel yr oedd cyn y pandemig ac i glirio'r ôl-groniad. Mae'r ymarfer capasiti hwn yn gofyn am eglurder ar gynlluniau gwasanaethau eraill sy'n effeithio ar y galw am wasanaethau therapi, fel orthopaedeg. Mae rhagamcaniadau lefel uchel yn dangos gyda rhywfaint o gapasiti ychwanegol, y bydd yn bosibl dychwelyd i lefelau fel yr oeddent cyn y pandemig cyn diwedd 2021-22.

Endosgopi

Mae ymarfer modelu manwl wedi'i gynnal, lle mae effaith defnyddio ffynonellau mewnol wedi'i hamcangyfrif, o gymryd y bydd Covid-19 yn parhau am gryn amser. Mae achos busnes yn cael ei baratoi i ategu recriwtio staff parhaol i gynnal gwasanaeth mwy cynaliadwy, gyda chapasiti sydd wedi'i alinio â'r galw.

Bydd angen i ffynonellau mewnol barhau i gynnal y gwasanaeth endosgopi hyd at 2021/22 tra bydd recriwtio ar y gweill. Rhagwelir, ar yr amod bod modd cytuno ar achos busnes a'r ffynonellau mewnol a ddefnyddir, y bydd yr amser aros yn addasu i fodloni amseroedd aros cenedlaethol erbyn Hydref 2021.

Radioleg, Niwroffisioleg ac Awdioleg

Mae amcangyfrifon yn awgrymu y bydd yn cymryd blwyddyn i ddychwelyd at amseroedd aros arferol ar draws y gwasanaethau hyn.

5. **A ydych yn defnyddio unrhyw ymagweddau newydd neu wahanol tuag at roi gofal neu'n ystyried eu defnyddio er mwyn helpu i leihau amseroedd aros, gan gynnwys defnyddio technolegau newydd, llwybrau gofal newydd, neu gapasiti mewn meysydd eraill?**

Gofal wedi'i Gynllunio

Mae triniaethau amgen nad ydynt yn rhai llawfeddygol yn cael eu datblygu mewn arbenigeddau penodol, fel rhaglen Dianc rhag Poen y cyfeiriwyd ati gynt, trwy gynnwys gwasanaethau therapi fwyfwy. Mae cymwysiadau digidol hefyd yn cael eu hystyried ym maes Orthopaedeg er mwyn ategu triniaeth amgen neu i'w chynnig. Yn y tymor hwy, mae achos amlinellol strategol yn cael ei ddatblygu ar hyn o bryd, i gyflwyno ymagwedd canolfan diagnostig a thriniaeth (DTC).

Arbenigeddau Meddygol

Mae gwaith ar y gweill i ddilysu'r rhestr aros ddilynol (ac eithrio Endosgopi) gyda'r nod o leihau 100% o arosiadau sy'n hwyr i'r targed o 35% a bennwyd gan Lywodraeth Cymru. Mae'r targed hwn wedi'i gyflawni ym maes Gofal yr Henoed a Rhiwmatoleg, ac mae Dermatoleg yn lleihau bob wythnos. Mae arosiadau endosgopi'n cynyddu ar hyn o bryd oherwydd pwysau gwasanaeth ac absenoldeb salwch hirdymor ymhlith meddygon ymgynghorol.

Mae amheuaeth o sepsis (SOS) a gofal dilynol wedi'i gymell gan gleifion (PIFU) wedi'u cyflwyno ar draws arbenigeddau meddygol i gynnal lleihad yn y rhestr aros dilynol.

Mae trosglwyddo gofal cleifion wedi'i gwblhau rhwng safleoedd llym ac ysbytai cymunedol er mwyn defnyddio capasiti'n well ar draws y system, fel trosglwyddo cleifion Rhiwmatoleg brys o Ysbyty Maelor Wrecsam i glinig Ysbyty Cymuned Treffynnon.

Mae defnyddio ymgynghoriadau fideo 'Attend Anywhere' wedi'i dreialu ac mae defnyddio codau blaenoriaethu 'P' wedi'u rhoi ar waith ar gyfer mân weithredoedd Dermatoleg i gleifion allanol. Mae clinigau dros y ffôn wedi'u cyflwyno ar draws ystod o arbenigeddau ac maent yn gweithio'n dda, ar y cyfan.

Fel y soniwyd yn gynharach, mae ymagweddau gwahanol wedi'u rhoi ar waith i fynd i'r afael â materion capasiti, fel trosi meddygon gradd staff i Gymdeithion Meddygol, ac uwchraddio sgiliau nyrsys lefel uchel iawn er mwyn eu galluogi i ymgymryd â lefel uwch o waith clinigol i gefnogi'r tîm o feddygon ymgynghorol. Mae Arweinydd Clinigol Rhiwmatoleg wedi'i benodi, a bydd y rôl hon yn ategu ymagwedd 'unwaith i PBC'.

Gwasanaethau Plant a Phobl Ifanc

Mae Gwasanaethau CYP wedi rhoi 'Attend Anywhere' a chlinigau dros y ffôn ar waith. Mae wedi bod yn llwyddiannus, yn enwedig o ran cleifion dilynol. Mae'r adborth cychwynnol gan deuluoedd ar y newid hwn i ymarfer wedi bod yn bositif. Mae defnyddio llwyfannau rhithiol ar gyfer ymgynghoriadau'n fwyfwy derbyniol ac yn ogystal ag ategu rheoli rhestrau aros, mae'n cael rhywfaint o effaith o ran lleihau amseroedd teithio a gwneud defnydd mwy effeithlon o amser clinigwyr. Mae rhyngweithiadau wyneb yn wyneb yn dal i gael eu darparu mewn ffordd sy'n ddiogel rhag Covid-19, lle bo angen.

Wrth fynd ar drywydd dilysu rhestrau aros, yn enwedig ym maes paediatreg gymunedol a CAMHS, mae llwybrau gofal amgen yn cael eu hystyried, gan gynnwys y trydydd sector fel bo'n briodol.

Therapïau

Mae technolegau newydd wedi'u rhoi ar waith mewn gwasanaethau therapi. Mae Technoleg Ddigidol wedi caniatáu i Therapïau gynnig ymgynghoriadau dros y ffôn a fideo rhwng Gweithwyr Proffesiynol Perthynol i Iechyd a'u defnyddwyr gwasanaeth.

Mae llwybrau gofal newydd yn cael eu datblygu i sicrhau'r ddarpariaeth gwasanaeth gorau, fel datblygu llwybrau deietegol ar y cyd â thimau maeth a fferylliaeth er mwyn sicrhau bod cleifion yr effeithir arnynt gan Covid-19 yn derbyn y cymorth maethol sydd ei angen arnynt.

Oncoleg a Haematoleg

Mae clinigau dros y ffôn yn cael eu defnyddio ac maent yn gweithio'n dda.

Endosgopi

Fel y soniwyd yn flaenorol, mae cyflwyno profion FIT wedi caniatáu pennu haenau risg o ran cleifion a lle bo'n briodol, eu gosod ar lwybrau triniaeth gwahanol, ar wahân i endosgopi, gan leihau'r galw am endosgopi a gwella profiad cleifion.

Radioleg, Niwroffisioleg ac Awdioleg

Mae clinigau rhithiol dros y ffôn yn cael eu defnyddio ac ym maes Radioleg, mae'r rhan fwyaf o feddygon ymgynghorol bellach yn gallu gweithio o'r cartref gyda gweithfannau pwrpasol.

6. **Pa ffactorau a allai effeithio ar eich cynlluniau i fynd i'r afael ag amseroedd aros (e.e ymchwydd pellach mewn cyfraddau COVID-19, problemau gyda'r gweithlu neu gapasiti ffisegol), a pha gynlluniau sydd gennych ar waith i'w rheoli?**

Gofal wedi'i Gynllunio

Mae llawer o ffactorau a fydd yn effeithio ar gynlluniau - yn bennaf mannau dwysáu mewn theatrau ac unedau adfer. Bydd adleoli staff a'r gallu i symud cydweithwyr yn ôl cyn gynted ag y bydd y pandemig yn caniatáu hynny, yn bwysig er mwyn dychwelyd at ffyrdd arferol o weithio. Hefyd, bydd syrffed staff yn dilyn y pandemig, a'r angen i gymryd gwyliau blynyddol yn cael effaith. Bydd darparu gwasanaethau hanfodol a mynd i'r afael ag ôl-groniadau yn gofyn am gapasiti pellach yn y tymor byr. Mae'r Bwrdd Iechyd yn ystyried caffael tair ward theatr a modiwlaidd arall, wedi'u staffio gan fodel cymysg gan ddefnyddio ffynonellau mewnol i ddarparu'r capasiti ychwanegol. Mae modelu capasiti'n parhau.

Arbenigeddau Meddygol

Mae cynlluniau capasiti ar gyfer 2021-22 yn seiliedig ar nifer o ragdybiaethau sy'n cynnwys y tebygolrwydd y bydd y gweithlu clinigol a gweithredol yn parhau i fod yr un fath, y bydd ôl-troed ffisegol Adrannau Cleifion Allanol a chymorth i nyrsys yn aros fel y mae ac y bydd y clinigau sy'n cael eu cynnal yn parhau gyda'u capasiti presennol. Bydd unrhyw newidiadau i'r newidynnau hyn yn effeithio ar y capasiti y gallwn ei gynnig. Gallai unrhyw ymchwydd pellach mewn achosion Covid-19 effeithio ar y gweithlu clinigol. Bydd cynlluniau i benodi i rolau penodol a swyddi gwag meddygon locwm yn helpu i reoli amseroedd aros.

Gwasanaethau Plant a Phobl Ifanc

Mae nifer fawr o swyddi gwag o ran rhai elfennau o'r gwasanaeth yn effeithio ar amseroedd aros, ond mae recriwtio staff i'r swyddi gwag presennol hyn yn dechrau gwella. Mae cynlluniau capasiti ar gyfer 2021-22 yn seiliedig ar nifer o ragdybiaethau, felly bydd unrhyw newidiadau i'r newidynnau'n effeithio ar y gallu i ddarparu. Gallai unrhyw ymchwydd pellach mewn achosion Covid-19 effeithio ar y gweithlu clinigol ac ôl-troed ffisegol gwasanaethau plant. Mae cynllunio ar gyfer ymchwydd ar y gweill ac mae trafodaethau'n parhau am adleoli'r gwasanaethau presennol er mwyn sicrhau bod modd parhau â chapasiti clinigol ar gyfer gwasanaethau hanfodol.

Therapïau

Bydd gofynion gwahanol yn effeithio ar wasanaethau therapi gwahanol.

• Bydd yr holl wasanaethau'n teimlo effaith ymbellhau cymdeithasol ar eu capasiti am glinigau ffisegol. Mae rhai gwasanaethau wedi'u heffeithio i raddau mwy gan gyfraddau Covid-19 yn y gymuned ac yn yr ysbytai llym, er enghraifft, mae mwy o alw am gymorth ffisiotherapi yn y lleoliad llym sydd wedi arwain at symud staff o leoliadau cleifion allanol i ateb y galw hwn.

• Mae rhai staff yn cysgodi; mae'r aelodau hyn o staff yn parhau i weithio o'r cartref ac maent yn allweddol i barhau i gynnig ymgynghoriadau fideo a thros y ffôn.

• Byddwn yn parhau i geisio cyflogi staff locwm lle bo cymeradwyaeth ariannol ar waith.

• Mae'r holl arweinwyr gwasanaeth yn mynd ati'n rhagweithiol i recriwtio staff i unrhyw swyddi gwag ac mae pob un ynghlwm wrth y broses symleiddio a ddylai sicrhau bod graddedigion newydd ar gael ar gyfer swyddi'n ddiweddarach yn y flwyddyn.

• Mae ymbellhau cymdeithasol a chyfyngiadau wedi effeithio ar gapasiti ffisegol; nid oes unrhyw leoliad ar gyfer gwasanaethau ffisiotherapi i gleifion allanol yn Wrecsam ar hyn o bryd. Mae achos busnes wedi'i ddatblygu i ddod o hyd i ddatrysiad amgen.

• Mae rotas yn cael eu haddasu gymaint â phosibl ac mae rhai staff yn gweithio diwrnodau a phenwythnosau hirach. Lle bo ymbellhau cymdeithasol yn broblem, mae mynediad i fannau swyddfa wedi'i arwahanu er mwyn sicrhau cydymffurfiaeth.

• Mae'r holl wasanaethau'n hyblyg er mwyn sicrhau bod capasiti yn cael ei ddefnyddio yn y ffordd orau bosibl - lle bo modd i wasanaethau barhau, maent yn gwneud hynny, lle bo gwasanaethau wedi lleihau, mae'r arweinwyr gwasanaeth yn monitro'r gofynion sy'n gwrthdaro'n ofalus a byddant yn adleoli staff fel bo'n briodol.

Oncoleg a Haematoleg

Mae cynlluniau capasiti ar gyfer 2021-22 yn cymryd y bydd nifer o ragdybiaethau'n parhau i fod yr un fath, ond mae pryderon y bydd mwy o gleifion yn dod atom gydag afiechyd mwy datblygedig ac y gallai hyn olygu bod angen capasiti ychwanegol ym maes Oncoleg, fel yr esboniwyd yn gynharach. Bydd newidiadau i newidynnau y mae rhagdybiaethau cynllunio wedi'u seilio arnynt yn effeithio ar y gallu i ddarparu. Bydd unrhyw ymchwydd pellach mewn achosion Covid-19 yn cael effaith negyddol, yn anochel.

Yn yr un modd â gwasanaethau eraill, bydd Oncoleg a Haematoleg yn teimlo effaith ymbellhau cymdeithasol ar eu capasiti ffisegol am glinigau. Mae rhai staff yn cysgodi ac yn parhau i weithio o'r cartref, ac maent yn allweddol i barhau i gynnig ymgynghoriadau fideo a thros y ffôn.

Mae recriwtio rhagweithiol ar y gweill lle bo swyddi gwag ac mae ymgysylltu â'r broses symleiddio a ddylai sicrhau bod graddedigion newydd ar gael ar gyfer swyddi yn ddiweddarach yn y flwyddyn. Mae rotas yn cael eu haddasu gymaint â phosibl ac mae'r holl wasanaethau'n hyblyg

Endosgopi

Mae effaith barhaus y pandemig yn arwain at leihad mewn capasiti gan fod staff wedi cael eu hadleoli a chan fod llai o gynhyrchiant. Mae'r cwmnïau ffynonellau mewnol y cyfeiriwyd atynt gynt wedi wynebu rhai problemau o ran staffio eu rhestrau

triniaeth i gleifion oherwydd argaeledd y gweithlu. Mae problemau o'r fath yn effeithio'n anochel ar amseroedd aros.

Radioleg, Niwroffisioleg ac Awdioleg

Mae diffyg mannau ffisegol oherwydd cyfyngiadau Covid-19 yn broblem sylweddol o ran mynd i'r afael â rhestrau aros. Byddai ymchwydd pellach yn hydref/gaeaf 2021 yn heriol a byddai'n debygol o effeithio ar gynlluniau i glirio'r ôl-groniad.

7. **Pa wybodaeth a ydych wedi'i derbyn am eich dyraniad o'r £30m o gyllid ychwanegol ar gyfer amseroedd aros, a sut ydych yn bwriadu defnyddio'r cyllid?**

Mae'r Bwrdd Iechyd wedi derbyn cadarnhad o'i ddyraniad £4.9m ar gyfer blaenoriaethau gofal brys ac argyfwng, sydd wedi creu darpariaeth ar gyfer pedwar maes penodol: - Gwella darpariaeth Gofal Brys, Gofal Brys ar yr un Diwrnod, Braenaru Gofal Cychwynnol Brys a Rhyddhau at Adferiad ac Asesu.

Casgliad

Y gobaith yw bod yr ymatebion a roddwyd o gymorth i'r Pwyllgor o ran amgyffred y sefyllfa bresennol. Mae'r Bwrdd Iechyd yn gwbl ymrwymedig i fynd i'r afael â'i amseroedd aros, er budd y cleifion y mae'n eu gwasanaethu. Gwneir defnydd helaeth o ffyrdd newydd o weithio a'r cyllid ychwanegol a dderbynnir, fel rhan o ymdrechion ar y cyd i ddychwelyd at y sefyllfa fel yr oedd cyn y pandemig.

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.

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.

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.

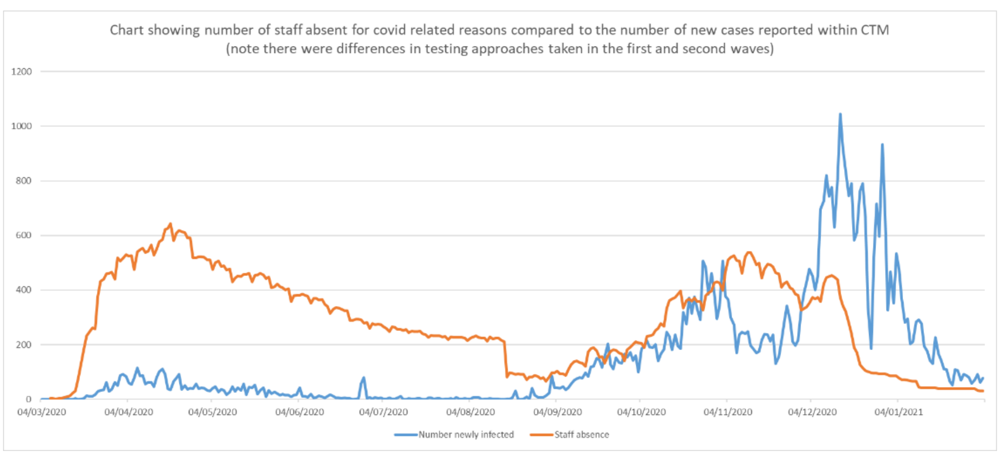
Staff group	Days absence for covid-19 related reasons
Nursing	79595

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.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Our Ref: RH/ses [redacted] 12 February 2021

Dr Dai Lloyd, AM
Chair, Health, Social Care & Sport Committee
National Assembly for Wales
Cardiff Bay
CARDIFF
CF99 1NA

Dear Dr Lloyd

Thank you for your letter dated 20th January 2021 regarding your inquiry into the impact of COVID-19 on health and social care in Wales. Please find the Health Board's responses to the questions raised.

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

The Health Board is proud of the way in which its staff, and partner organisations, have come together to collectively respond to the COVID-19 pandemic.

To provide some context regarding the pressures that have been faced, during the first peak (April / May 2020) the number of patients with COVID-19 in our hospitals totalled over 280, with the number of patients (COVID-19 and non-COVID-19) totalling less than 1,000. Patients being cared for in ICU totalled 49 at its peak, of which 37 were patients with COVID-19.

The demands on services during the winter have been even greater and more sustained. As part of its Q3/4 operational plan, the Health Board brought forward the opening of the Grange University Hospital (GUH), to November 2020, recognising the likely impact of COVID-19 and the anticipated seasonal demand on healthcare services.

Whilst the number of patients, with COVID-19, in local hospitals is currently falling, this is from a peak in early January 2021, of over 490, down to the

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Aneurin Bevan University Health Board is the operational name of Aneurin Bevan University Local Health Board

current level which is still over 200 patients. Alongside caring for COVID-19 suspected, positive and recovering patients, the Health Board is caring for an increased number of non-COVID-19 patients, currently almost 1,000. In total, there are currently over 1,500 patients in hospitals across the Health Board.

During the winter period, the Health Board has also successfully implemented a mass COVID-19 vaccination programme for its population and worked with its partners to deliver an effective Test, Trace and Protect (TTP) service across Gwent.

Moving through the next phase, there are a number of factors that the Health Board is managing as part of recovery and implementing sustainable services going forward, which will feature in the Annual Plan for the 2021/22 financial year.

- ***Population health and addressing health inequalities***

The Health Board has always been aware of the challenge faced in improving the health of its population, prior to the COVID-19 pandemic, including addressing the health inequality that exists across its communities.

An analysis undertaken of deaths associated with COVID-19, by deprivation fifth across Wales, shows the most deprived fifth of the population had the highest mortality rate. It is reasonable to conclude, from what is known at this stage of the pandemic, that direct harm from COVID-19 is likely to widen health inequalities across local communities.

It is also expected that the broader health, economic and social impact of the pandemic will be profound in terms of scale and longevity. The consequences of additional demand on healthcare services is hard to quantify, but is likely to present at some stage.

Therefore, the Health Board's Annual Plan will have an increased focus on considering the health needs of its population, and addressing the health inequalities, across its communities.

- ***Workforce***

The response from staff during the pandemic has been tremendous. They have displayed dedication, professionalism and compassion throughout this period. The demand for staff – both registered and non-registered – has increased significantly as the Health Board has not only responded to the demands placed on existing healthcare services but implemented new and additional services in response to COVID-19 – such as COVID-19 surge capacity, Test, Trace and Protect and mass vaccination programmes. As services have been flexed to respond to those areas of greatest priority, many staff have worked additional hours and been redeployed to support those services.

The impact of COVID-19 has resulted in higher than normal staff absence. Across the Health Board, absence levels are currently at 9.58%, which equates to 1,181 WTE. This includes high levels of absence for Registered Nurses (10.35%), Health Care Support Workers – HCSW (14.72%) and Facilities staff (16.14%).

Whilst absence related to COVID-19 infections is currently reducing and non-related COVID-19 absence is lower, compared to January 2020, the impact of staff shielding or self-isolating is contributing to an additional 300 WTE staff absent from the workplace.

In terms of workforce plans, these have included an overseas nursing recruitment campaign, which was restarted as travel restrictions were lifted in September 2020. The Health Board has recruited 160 WTE, of which 106 WTE have already joined and the remaining nurses are expected to join by the end of March 2021. In addition, the Health Board has recruited 145 WTE HCSWs, of which 103 WTE have commenced in role.

A significant feature of the plans included staff engagement and consultation, particularly ahead of the early opening of the GUH in November 2020.
The Health Board is very much aware that staff are physically and mentally tired and will need to take annual leave which they may not have had the opportunity to take for rest and recuperation. Likewise, many staff will need well-being support to recover. The Health Board has increased its resources to support the well-being of its staff. This includes a peer support phone line and additional psychological support. Occupational Health services continue to offer advice and support to managers and all staff, with a particular focus on those with underlying health conditions.

- ***COVID-19 services***

Whilst COVID-19 infection rates and related hospital admissions are falling, the Health Board will still need to plan for a level of COVID-19 demand and provision of services during the next financial year, including the consequences of safely maintaining COVID-19 and non-COVID-19 care pathways.

The Health Board continues to review and update its plans to deliver a mass vaccination programme and is working collaboratively, with its partners, to provide an ongoing TTP service.

- ***Non-COVID-19 services***

The Health Board resumed some services following the first peak and throughout the summer. This included some routine services where these could be re-started safely. In addition, endoscopy services have increased to levels prior to the pandemic with a focus on timely access for suspected cancer and urgent patients. The Health Board also has recovery plans in place with regard to other diagnostic services such as CT, MR and non-MSK ultrasound. The impact of these plans can be evidenced by the improving position against the 8 week diagnostic target, from a high point in August 2020 and with a month on month reduction up to end December 2020.

Embedding services effectively across the GUH and the Health Board's enhanced local general hospitals (e-LGHs) will be a critical part of resuming some routine services and implementing alternative pathways.

2. *How will you prioritise the delivery of non-COVID-19 services to target reductions in waiting times?*

The Health Board has developed and implemented its operational plans, throughout the pandemic, applying the guidance provided by Welsh Government on Maintaining Essential Services. It has followed guidance on risk stratifying patients within each stage of their pathway and prioritised patients with suspected cancers or waiting urgent review. This has involved reorganising capacity to comply with COVID-19 safe socially distanced environments and has resulted in some services operating at lower levels than normal.

As the number of COVID-19 patients in hospital reduces, the Health Board is reviewing the opportunities to safely resume routine elective care, taking advice from its Nosocomial Transmission Group in implementing safe, elective care pathways. Making facilities available to deliver more outpatient, diagnostic and treatment capacity remains a priority in the organisation.

Work has already been in place to implement the single cancer pathway and there has been a regular focus on improving timely access to diagnosis and treatments available.

An important part of the Health Board's operational plans have included using the independent hospital sector for a range of outpatient, diagnostic, therapy and treatment facilities.

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?*

The Health Board regularly updates its local communities on the effects of the COVID-19 pandemic on services, including the restarting of our services. This is provided through a variety of methods and channels, including web pages and articles, social media updates and engagement with patients, answering email enquiries, weekly and monthly stakeholder newsletters, through the local media, updates at partnership meetings, and through the popular live Q&A sessions.

Discussions with patients are taking place using video and telephone consultations ("Attend Anywhere") about their condition and the Health Board has used mass text conversations to inform patients and to undertake two way conversations about their individual care.

The Health Board has launched a dedicated webpage, entitled 'Restarting our Services during the COVID-19 Pandemic', to offer updates and information on how services are impacted by COVID-19. Each service within the Health Board will continue to provide weekly updates for patients through this webpage. Patients will proactively and reactively be encouraged to refer to the webpage for updates on the particular service(s) in which they have a particular interest.

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

There are a number of factors involved in estimating, with some certainty, the timescales for returning to the pre-pandemic position. Some of these have been identified in responding to Question 1. As a result, this makes implementing these plans extremely complex.

Nevertheless, the Health Board has developed three planning scenarios which consider the course of the pandemic. These are broadly based on R values of 1.5, 1 and 0.8, as well as factoring in assumptions around hospital lengths of stay, staff absence and availability and an understanding of potential non-COVID-19 demand.

Workforce availability will be critical. The Health Board has redeployed a significant number of staff to support existing COVID-19 services in hospital as well as prioritising the vaccination programme. The impact of the pandemic on staff well-being and availability is hard to quantify but cannot be underestimated when it comes to implementing plans.

In addition, the level of latent demand in communities is unknown, when looking at the existing backlog of patients currently on waiting lists. When and to what extent unmet demand may surface is a significant variable in being able to provide reliable estimates. In practice, the Health Board believes a graduated approach to implementing plans, to address waiting times for elective care, is a realistic one.

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?

During the first peak of the pandemic, the Health Board implemented some alternative ways of providing care. Significant use has been made of virtual consultations with patients and between April and September 2020, the Health Board undertook over 19,000 consultations across its range of services. Where appropriate and safe to do so, clinicians are discharging patients onto "see on symptoms" or patient initiated follow up pathways. This allows patients to take greater ownership of their care, whilst allowing outpatient consultations to be re-prioritised.

The Health Board has been applying value based healthcare principles to the delivery of care for its patients   understanding what matters most to patients - and re-designing services to achieve this. Whilst the changes have been incremental, they have been important in re-prioritising the way care is delivered.

Given the scale of backlog that exists for some routine elective care and the availability of appropriate elective capacity, applying these principles at scale will be critical in providing patients with appropriate alternative pathways, addressing timely access to care and improving health outcomes.

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

It will be important that COVID-19 infection rates, and the impact on admissions to hospital, continue to fall. Any further rises may impact on the ability to implement plans to resume greater levels of non-COVID-19 services, particularly routine services. A number of the factors will affect plans to tackle waiting times and many of these have been identified in response to some of the previous questions.

It should be emphasised that the Health Board is acutely aware of the importance of having available a healthy and appropriately skilled workforce, as it faces the various challenges involved in successfully coming out of the pandemic, maintaining new and additional services – such as TTP and mass vaccination programme – resuming routine services. The welfare of staff, which has been outlined previously, will be key to achieving this.

In the short-term, some staff have been redeployed or are working additional hours, to work in mass vaccination centres or care for COVID-19 patients in hospital. These include medical staff, registered nurses, therapists and pharmacists as well as health care support workers and administrative staff. Many of these staff will be important in resuming some routine services. Therefore, the Health Board is developing plans which consider a phased return to some services and alternative models of care, which take account of the workforce required to achieve this.

The use of the independent hospital sector has been key during the pandemic. Going forward it is likely to be an important element of delivering additional healthcare capacity.

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?***

The Health Board received funding from £30m funding allocated non-recurrently as part of delivering the Winter Protection Plan during 2020/21. This has enabled the Health Board, in collaboration with the partners, to implement the following services:

- Accelerate and further enhance the use of 111 and Contact First services – to provide medical advice remotely and refer people to appropriate services including GP, pharmacies and other community services.
- Increased ambulatory and same day emergency care provision,
- Urgent Primary Care Centre Pathfinder programme, to enhance the existing Urgent Primary Care Out of Hours and provide an Urgent Primary Care Centre on a 24/7 basis - providing care for patients in the right place first time, and
- Four discharge to recover then assess pathways.

Evaluation has been built into some of the work described and will be key to determining the appropriate service models moving forward.

Thank you for the opportunity to respond to your questions in support of your inquiry into the impact of COVID-19-19 on health and social care in Wales.

I hope these responses fully answer your questions, but if you require any further information please let me know.

Yours sincerely

Judith Paget

Judith Paget
Prif Weithredwr/ Chief Executive

Health, Social Care and Sport Committee - inquiry into the impact of Covid-19 on health and social care in Wales.

Evidence response document from Cardiff & Vale University Health Board

Introduction

Thank you for the invitation to respond to the inquiry into the impact of Covid-19 on health and social care in Wales. Cardiff & Vale University Health Board welcomes the opportunity to engage with the Senedd Health, Social Care and Sport Committee on the challenges arising from the Covid-19 pandemic on Health care provision and delivery for our patients both in the current period and looking forward over the medium and longer term.

We appreciate your understanding regarding the current challenges and therefore as you requested, we have provided a brief response to each of the areas you have raised. Where possible, we have sought to provide data which illustrates each of the areas, showing the impact of Covid-19 and our operational responses. There are inevitably some areas where we are still assessing, with colleagues across the NHS in Wales, the impact of Covid -19 and the likely impact into the future.

In this document, we will seek to draw out some emerging lessons learnt regarding the response to the first wave and the second wave of Covid-19, and some of the underlying pressures this has raised, particularly in respect of workforce, in addition to the immediate impact on the delivery of front line services to patients.

The Health Board was able to maintain all "essential services" throughput the pandemic and continues to do so. This does not overlook the fact that frontline clinical services were interrupted and there have been and will continue to be delays in the treatment of patients as a result of the exceptional demands placed on the Health Board, and its partners in other sectors, by Covid-19.

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

There are three broad categories where the Health Board has pressures arising from the Covid-19 pandemic:

a) Services where the Health Board has had to reduce its levels of activity in order to reprioritise resources for Covid -19 response. The main areas include elective care and treatment, outpatients diagnostics and surgery.
b) Services which are receiving exceptional demand as a result of Covid-19. The main areas include Critical Care, Unscheduled care, Acute Medical inpatients, Primary Care and Mental Health
c) Services where demand was suppressed and where there may be unmet demand which will likely emerge as the pandemic subsides.

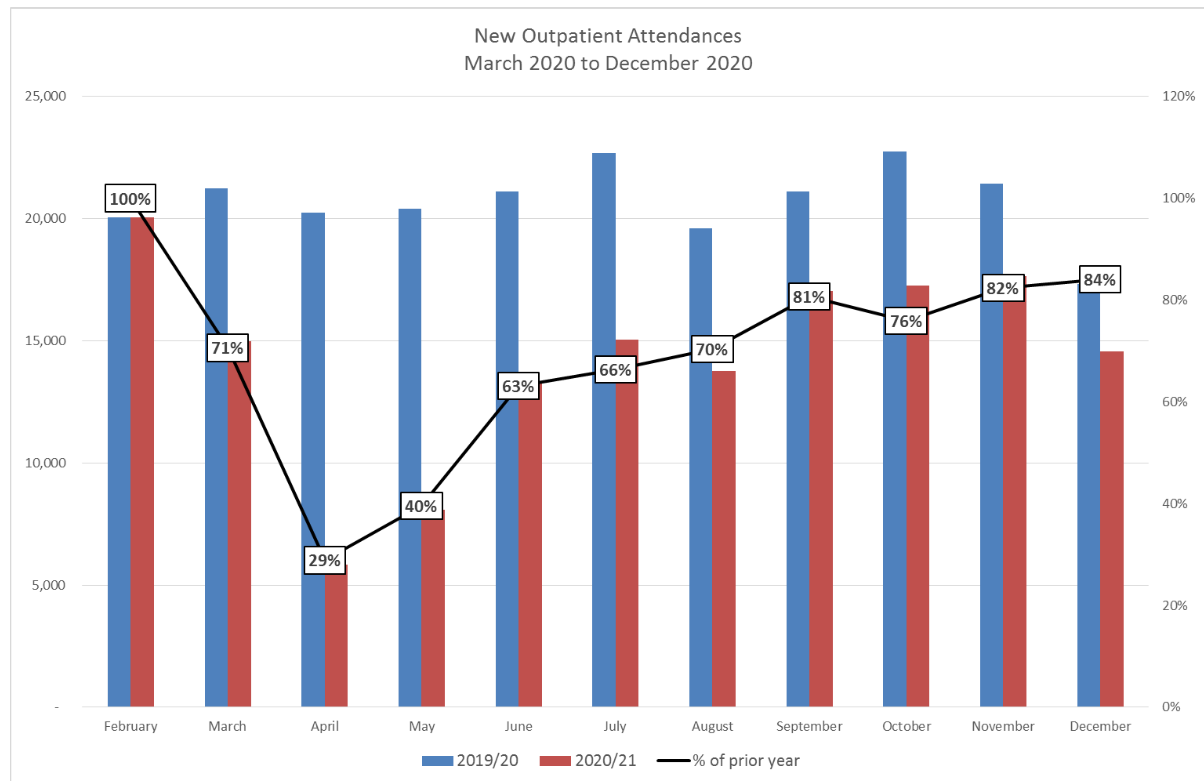
a) Services reduced due to Covid-19

From mid-March and into April, there was a rapid reduction, in particular in elective services. This arose due to the following factors:

- The need to transfer staff from elective services to support Covid-19 response in escalating and expansion of e.g. Critical Care capacity and Medicine.
- Reduction in referrals
- Reduction in the willingness of patients to come into hospital for fear of infection
- Reluctance in some cases for Clinical Teams to continue to deliver specified services where the perceived risk of Covid-19 infection may outweigh the benefits of treatment.

Figure 1 illustrates the impact of Covid-19 on New or 1st Outpatient attendances for Elective services.

Figure 1: Elective New Outpatient Attendances (Impact of Covid-19 & Recovery)

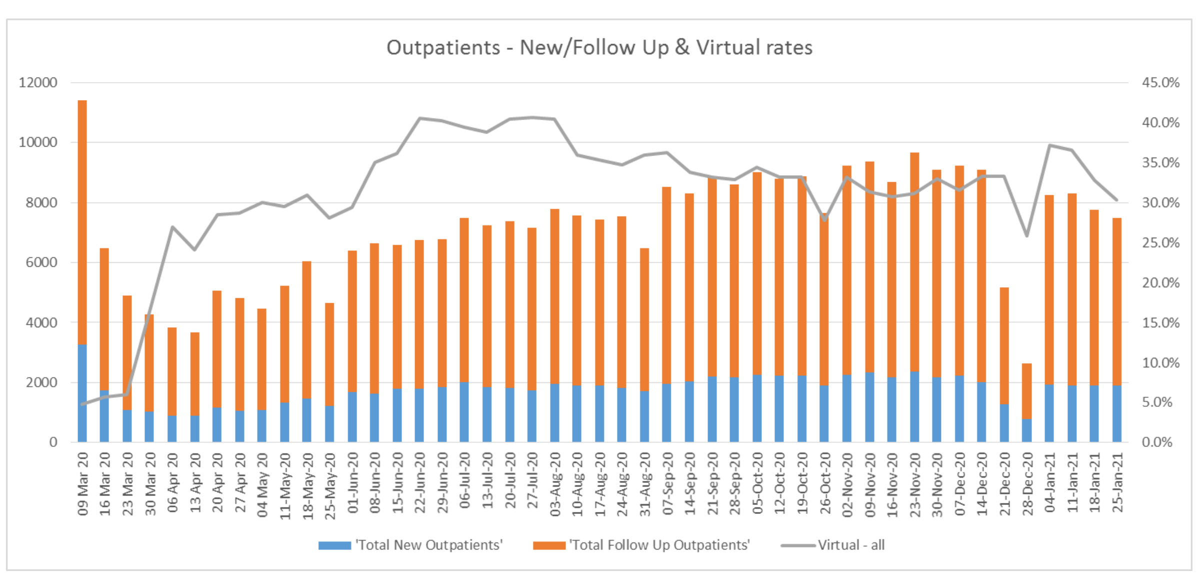


New or 1st Outpatient activity started to decline in March and reached its lowest point (29%) in April 2020. Activity recovered to 84% by the end of December 2020.

In Outpatients services, the Health Board rapidly adopted virtual consultations and reviews as a major element of its Covid-19 response. Over 40% of our Outpatient consultations were conducted via Virtual means in the first wave of Covid-19, thereby reducing the risk to patients and ensuring more patients could be assessed. As Outpatient services returned to higher levels, the necessity to see some patients in a face to face setting has reduced the percentage of virtual consultations but volumes have remained high and consistently over

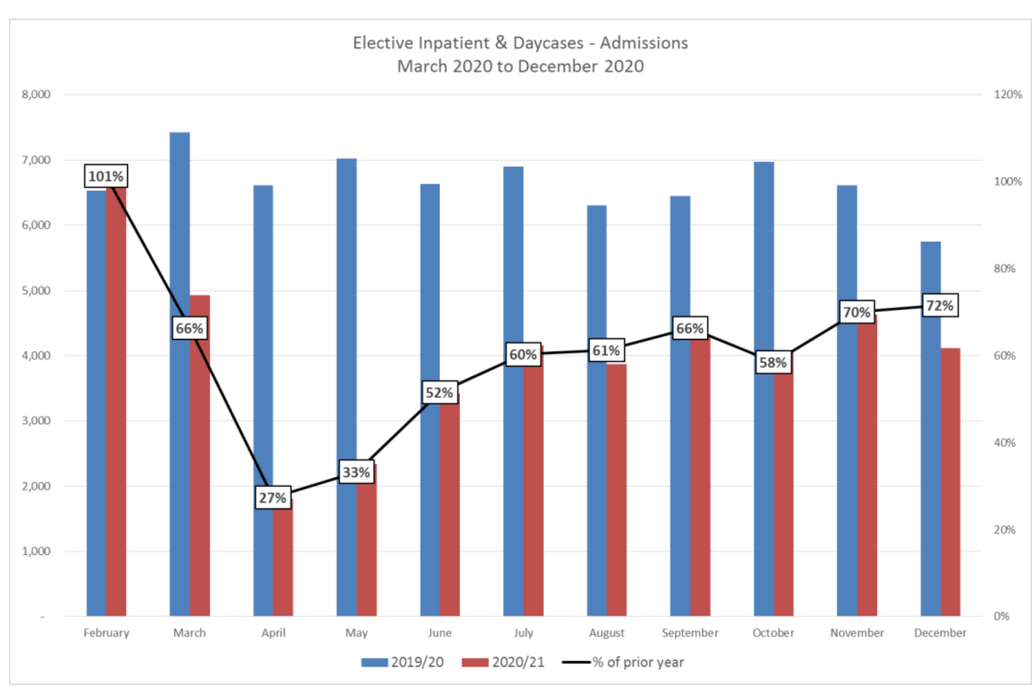
30% of Outpatient Consultations continue to be delivered in a virtual setting. Figure 2 illustrates the impact of Covid-19 on Outpatient attendances and the adoption of Virtual Consulting, which rose from 2.4% to over 40% at the peak and remains around a third of our overall Outpatient activity.

Figure 2: Outpatients Activity & Virtual Rates (Impact of Covid-19 & Recovery)



Elective or planned treatments requiring inpatient or daycase admission to Hospital started to decline in March and reached its lowest point (27%) in April 2020. Activity recovered to 72% by the end of December 2020. Figure 3 illustrates the impact of Covid-19 on Elective Hospital admissions for treatment.

Figure 3: Elective Inpatient & Daycase Admissions (Impact of Covid-19 & Recovery)



Radiology activity across all modalities (CT, MRI, Ultrasound and General, including Plain Film X-Ray) started to decline in March and reached its lowest point (24%) in April 2020. Activity recovered to 92% by the end of September 2020 and has remained consistently above 80% in successive months. Figure 4 illustrates the impact of Covid-19 on Radiology activity.

Figure 4: Radiology Activity (Impact of Covid-19 & Recovery)

Additional learning from first wave of Covid-19

A central element of our response to the first wave of Covid-19 was the creation of designated Green and Amber Zones at both University Hospital of Wales and University Hospital Llandough. This has contributed towards our capacity to continue to deliver significantly higher levels of elective care through the second wave in comparison with the first wave.

Continuing Infection Prevention and Control (IPC) constraints remain in place to protect patients and staff from unnecessary exposure to Covid-19. This includes wearing of Personal Protective Equipment (PPE), social distancing in patient areas, cleaning of equipment, facilities and physical areas between procedures and use by different patients. These IPC procedures enable the Health Board to continue to deliver safe elective care but also reduce our capability to recover to 100% of pre-Covid levels in the current position.

b) Services experiencing exceptional demand due to Covid-19

Certain services have received additional and exceptional pressures as a direct consequence of Covid-19. These additional pressures are both in terms of additional workload (volume) and in terms of additional complexity. An additional complicating factor has been the necessary relocation and reconfiguration of some services which has been necessary in order to maintain safe environments for patients and staff during this period.

We highlight here the following specific areas:

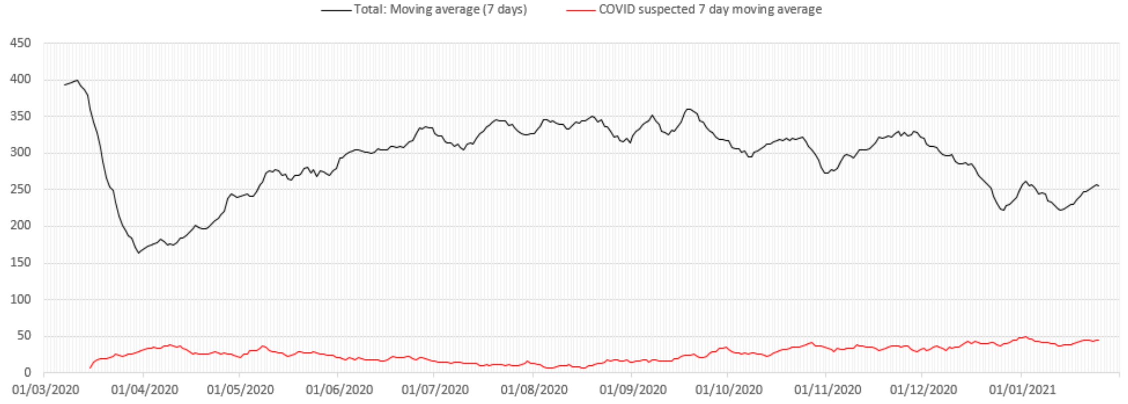
- Unscheduled care
- Acute Medical Beds
- Critical care
- Primary Care
- Mortuary services
- Mental Health

However, there are few if any areas of the Health Boards services where the impact of Covid-19 has not been felt, whether directly or indirectly.

Unscheduled care

Demand for unscheduled care has risen following a sharp reduction during the first national lockdown. The introduction of CAV 24/7 has help to mitigate this but January 2021 saw an average of 243 attendances per day at the Emergency Department (ED) with an average of 40 suspected Covid-19 attendances. There was an urgent need to redesign the operational management and flow of patients through the ED. This entailed an immediate change in the footprint, with the department expanding to encompass the Trauma Clinic space, which was temporarily available due to the transfer of Trauma surgery to Llandough. This also required a complete reorganisation of the department workflows to manage suspected and confirmed Covid-19 patients safely and reduce risks to both staff and patients. Figure 5 illustrates the impact of Covid-19 on attendances at ED.

Figure 5: Attendances at ED

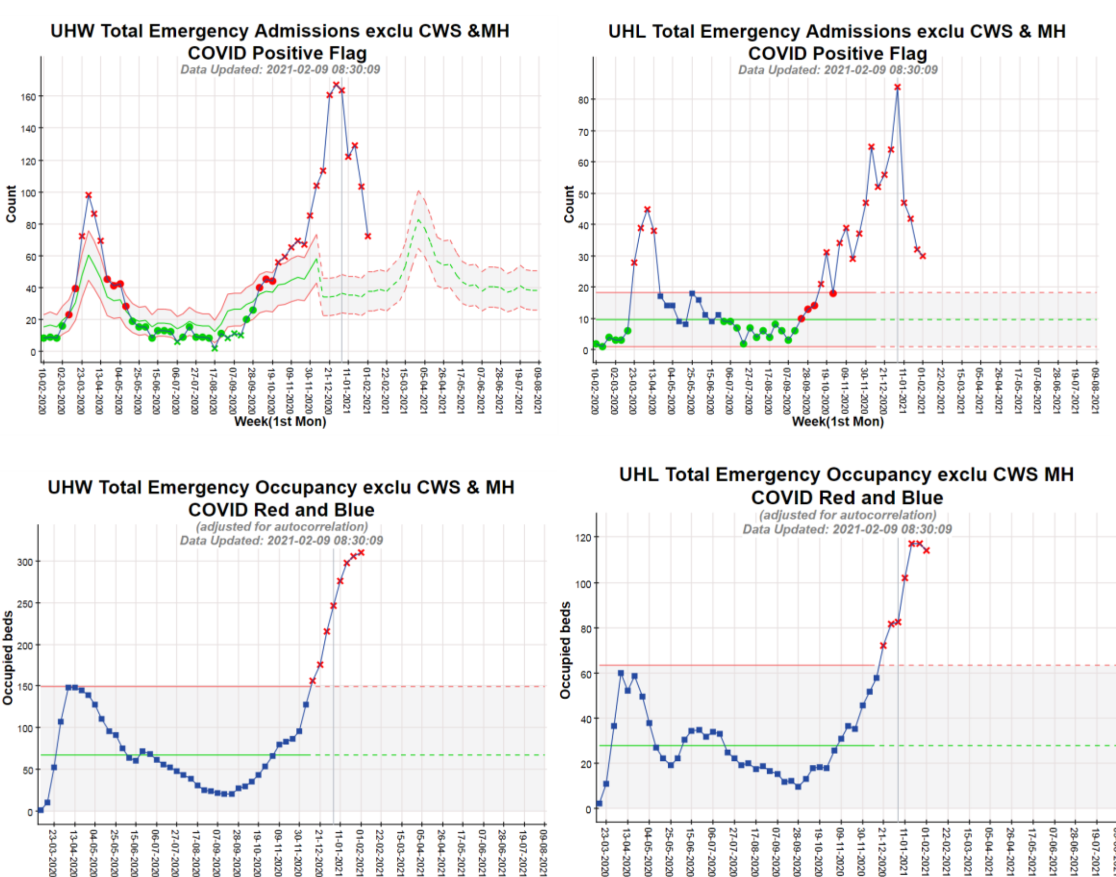


Acute Medical Beds (Covid-19 inpatients)

The second Covid-19 wave has seen an increase in Covid admissions with both acute hospital sites seeing Covid-19 admission and occupancy numbers in excess of those experienced in the first wave. The complexities, discussed previously, around patient flow, capacity and staffing have contributed to the challenges of managing medical inpatients. Since December, the UHB has seen an increase in patients with a >21 day length of stay with a fluctuating picture since mid-January. By contrast the number of Covid-19 patients with a >21 day length of stay has continued to increase.

Figure 6 illustrates the impact of Covid -19 on emergency admissions and bed occupancy to our main hospital inpatient sites.

Figure 6: Acute Medical Beds (Impact of Covid & Recovery)



Critical Care

During the first wave of the pandemic the Critical Care footprint was expanded. Critical Care continues to operate above its pre-pandemic capacity. After the initial peak occupancy in April 2020, occupancy fell to lower levels during the summer months before further increases through the winter period. The average daily occupancy for January 2021 was 55.6 occupied beds with Covid-19 patients (positive and recovered) accounting for between 20-32% of occupied beds. Figure 7 illustrates the impact of Covid-19 on Critical Care occupancy.

Figure 7: Critical Care Occupancy (Impact of Covid-19 & Recovery)

Critical Care occupancy

Critical care occupancy: 0, 10, 20, 30, 40, 50, 60, 70
% COVID positive or recovered: 0, 10, 20, 30, 40, 50, 60, 70, 80, 90, 100
01/06/2020, 01/07/2020, 01/08/2020, 01/09/2020, 01/10/2020, 01/11/2020, 01/12/2020, 01/01/2021
Total
% COVID red or blue

Mortuary

Mortuary services have been operating at 90% capacity for more than 12 months, this is above the usual 70% average. We have seen a 10% increase in admissions on the previous highest year.

During two peaks in deaths we operated at over 150% capacity for many weeks. We designed and facilitated the procurement of a temporary body store at the Dragon's Heart Hospital and worked with Local Resilience Forum partners to facilitate and staff a regional excess deaths body store, which at the peak in January held nearly 300 deceased patients from this Health Board and Cwm Taff UHB. We worked with partners to ensure everybody was competent and capable of managing the deceased with dignity and respect.

While spreading our trained mortuary staff thinly we have supported service delivery by re-skilling laboratory support staff during the first wave downturn in elective surgical activity, this has not been possible during the current wave of deaths, where elective activity has remained at 80% of the comparable period pre-Covid. Cancer diagnostic turnaround times have remained within expectation to maximise clinical benefit during this period of sustained pressure.

We have seen an increased length of stay of patients in our care as funeral directors have reached capacity, and as families struggle with the emotional loss and limited funeral attendance exacerbated by the financial burden of funerals, there has been a significant increase in local authority supported funerals during the pandemic.

The pandemic has prevented us supporting the bereaved by curtailing visits to the deceased, we have developed a memorial wall with DOB's and initials of the deceased to convey to the bereaved that while they couldn't be with their loved one, we did provided care and respect to them, while maintaining our very high levels of dignity.

Primary Care

The immediate impact on Primary care in the Health Board was variable, in that some services such as General Dental Care and Optometry services were subject to emergency service levels only and the bulk of services were temporarily stopped. General Practitioners continued to deliver the majority of GMS services, albeit with a radical and immediate change in the mode of operation adopting virtual means of contact with the majority of patients.

General Medical Services (GMS) have faced these pressures in conjunction with an extended flu program, the delivery of a new Covid-19 vaccination program, the impact of pressures within secondary care and complexities associated with Covid-19 regulations to ensure safe premises and manage the effect on teams as a result of positive diagnosis and self-isolations guidelines.

Many of the initiatives enacted during the first Covid-19 wave are now common-place in practices to minimise unnecessary risk associated with attending the practice, and provide patients with virtual ways of contacting the practice and accessing services. This has been facilitated by the use of UHB procured e-Consult software, SMS/Video software, Microsoft Office 365/Teams and Consultant Connect.

In addition, significant work has been undertaken by the CAVUHB Primary Care Team to support clusters to strengthen business continuity plans leading into the winter period. The team has developed a local escalation process with clear direction given to describe the expected intervention by the practice, the cluster, and CAVUHB if a practice reports that its level of escalation is rising. The tool is reviewed daily by the Primary Care Team and those practices reporting level 3 or above (out of 5 levels) are followed up to understand the circumstances and identify any support that may be required.

Currently, the picture across Cardiff and Vale shows mainly low levels of escalation. However, we have seen recently that this situation can change quickly when a local practice had to close for a period due to a Covid-19 outbreak amongst staff. As a result, significant lessons have been learned and shared with all practices, and work is being concluded with CAV24/7 colleagues to set up contingency arrangements to ensure continuation of urgent services when a practice has to close (once all practice and cluster business continuity plans have failed) or are instructed to close by Public Health Wales.

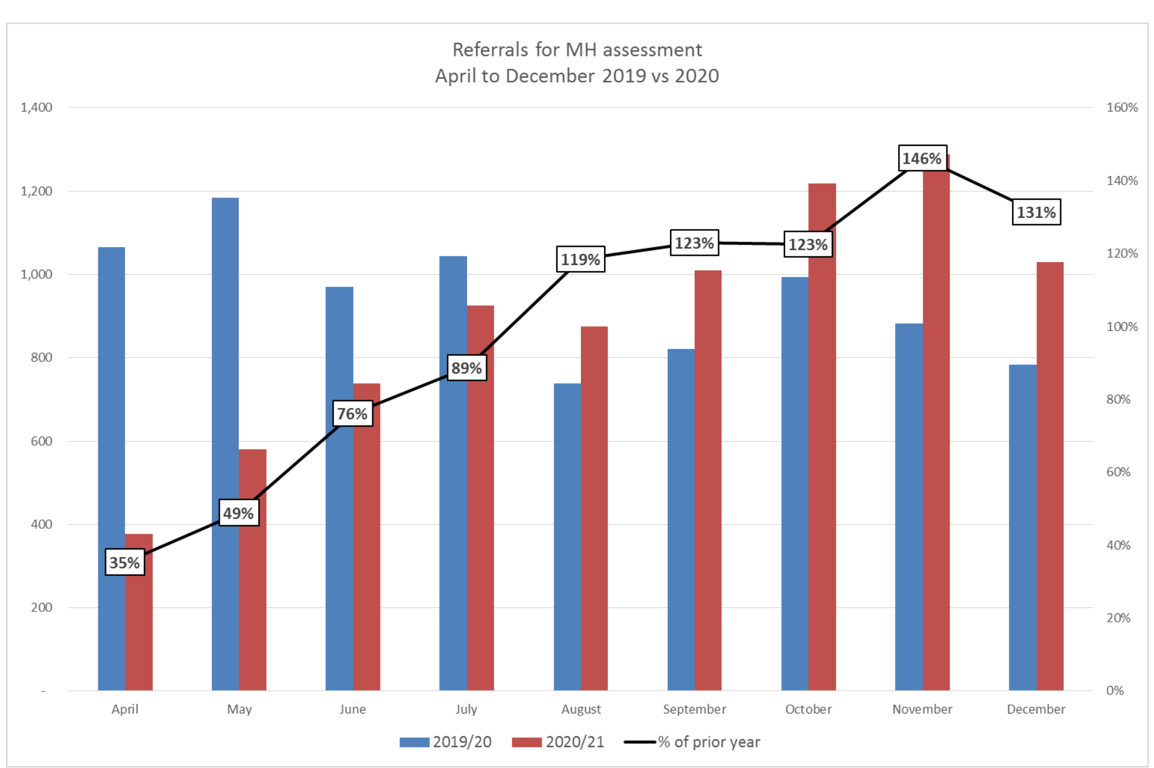
Sustainability and Recovery plans are in place for Optometry and Dental services, who are facing similar challenges related to contract obligations and IP&C considerations. A small number of Optometry practices have not seen a return to normal/average activity following the routine recall of patients attending practices and the return of routine domiciliary services.

Welsh Government wrote to all Health Boards in December 2020 advising of the Covid-19 vaccination roll-out, a review and update of the SOP, 2020/2021 quarter four arrangements and support. The communication outlined measures in 2020/2021 quarter four and detailed planning and requirements to join contract reform in 2021/2022.

Mental Health

Mental Health also experienced an initial decline in referral volumes. However the planning assumption was that we anticipated a lag between the onset of Covid-19 and an increase in demand for Mental Health services. From May onwards, the service started to see an immediate recovery of referral demand and from August 2020 onward this has been at unprecedented levels, remaining at extremely high levels. Figure 8 illustrates the impact of Covid-19 on referrals for Mental Health Assessments.

Figure 8: Referrals for Mental Health Assessments (Impact of Covid-19 & Recovery)



The response of the Mental Health Services has been to increase the volume of Mental Health Assessments and since September 2020, the Health Board Mental Health service has been operating in excess of pre-Covid levels consistently. Figure 9 illustrates the response to Covid-19 by the Mental Health Assessment teams.

Figure 9: Mental Health Assessments (Impact of Covid-19 & Recovery)

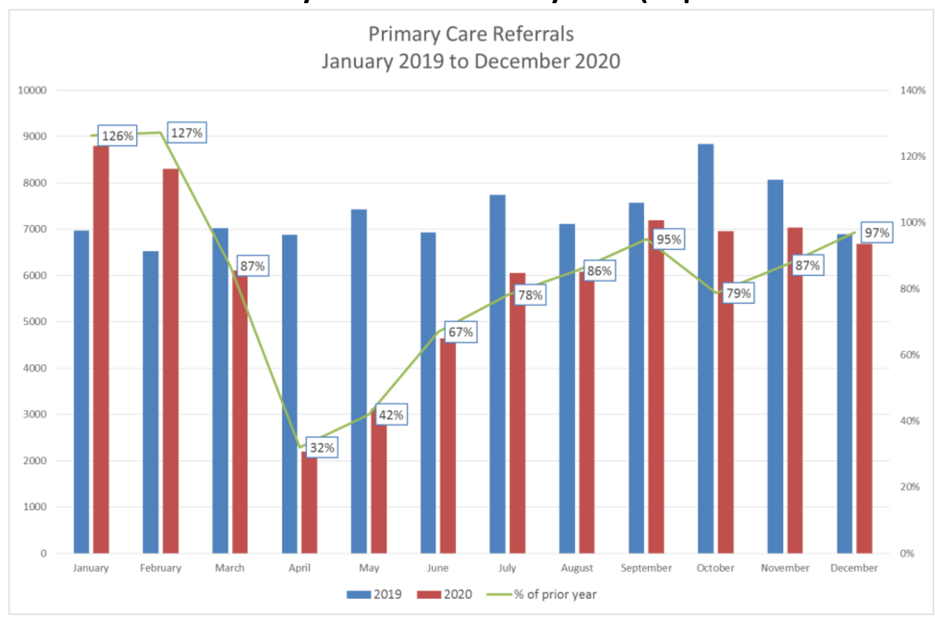
MH assessments
April - December 2019 vs 2020

600
500
400
300
200
100
-
140%
120%
100%
80%
60%
40%
20%
0%
84%
67%
97%
75%
81%
113%
131%
109%
105%
April
May
June
July
August
September
October
November
December
2019/20
2020/21
% of prior year

c) Services where they may be suppressed demand due to Covid-19

The decline in referrals for services was severe and whilst recovery has been steep, referrals remain below pre-Covid levels. The assessment of what level of this demand will recover and what level of demand has been “suppressed” but will return continues to be monitored on a weekly basis. Figure 10 illustrates the impact of Covid-19 on referrals from primary care to secondary care.

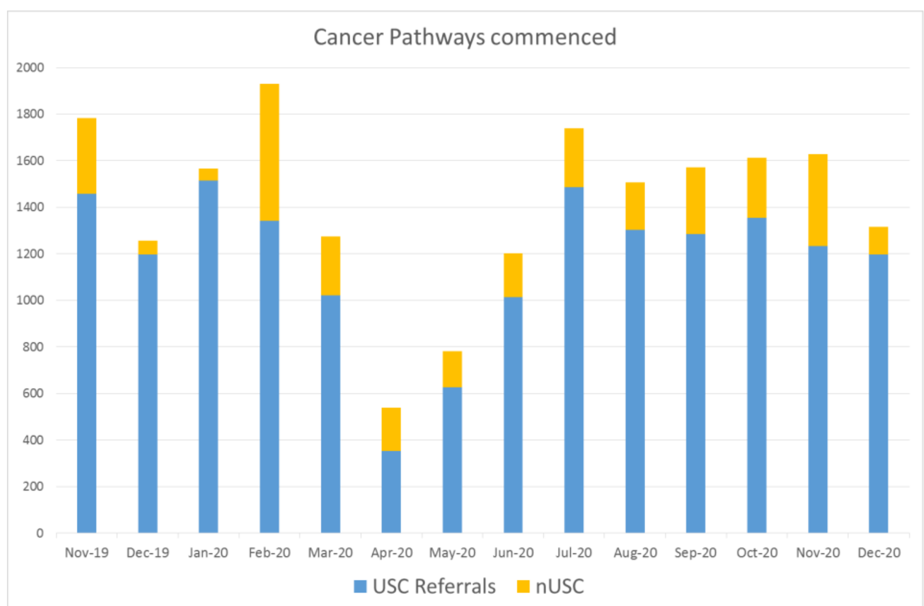
Figure 10: Referrals from Primary Care to Secondary Care (Impact of Covid-19 & Recovery)



Referrals into Hospitals from Primary Care were significantly reduced as a result of Covid-19. Volumes started to decline in March and reached its lowest point (32%) in April 2020. Activity recovered to 95% by the end of September 2020.

Figure 11 illustrates the impact of Covid-19 on the volumes of Cancer Pathways commenced in response to referrals received.

Figure 11: Cancer Pathways (Impact of Covid-19 & Recovery)



Cancer services were maintained throughout Covid-19 with the Health Board continuing to maintain essential services including diagnostics and treatments for urgent including cancer patients. There was a decline in referrals during this period, but the recovery of cancer referrals to “normal” levels was evident by July 2020. However, it is not possible to assess with any degree of accuracy the impact of the months of March to June when referrals for cancer were noticeably reduced.

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

Risk Prioritisation

For new referrals, there are established Clinical Risk measures in Ophthalmology which are monitored by the Health Board and reported to Welsh Government on a monthly basis. In addition, each clinical department and specialty reviews its referrals and uses clinical judgement to determine the relative priority (Urgent/Routine) and identifies the most suitable option in terms of face to face appointments or virtual outpatients.

The Health Board is taking part in national working groups under the National Planned Care Programme Board, coordinated by Welsh Government, which is proposing a national standardised and evidence based approach to risk prioritisation.

As part of our Covid-19 response, the Health Board adopted the Royal College of Surgeons criteria for prioritising surgical treatments. The Health Board undertook an exercise in Quarter three of 2020/21 to classify all of the patients on existing Inpatient & Daycase waiting lists using the Royal College of Surgeons urgency criteria.

Additional Capacity

Internal capacity

Whilst the creation of designated amber and green zone elective surgical capacity has not created additional capacity, it has enabled continuation of elective work at higher levels than in the first wave. The creation of a Protected Elective Surgical Unit (PESU) at University Hospital of Wales has enabled higher volumes of surgical treatments to be delivered throughout the second wave in comparison with the first wave.

Independent Sector (Outsourcing)

Due to the Covid-19 pandemic, the Health Board has an ongoing requirement for additional capacity to ensure the continuing delivery of essential services and the recovery of planned care in particular. The use of independent sector capacity is a core part of the Health Board's plan for both stability and recovery within and following the pandemic period and will support the reduction in backlog of patients waiting for treatment.

Cardiff and Vale Health Board was the highest user of the Independent Sector National Contract, which was funded by Welsh Government and coordinated by the Welsh Health Specialised Services Committee (WHSSC) from April 2020 onwards.

10,074 patients (of the 20,872 treated in the Independent Sector across Wales from April to December 2020) were seen and treated in Spire Cardiff by Health Board staff during this period. 43% of surgical cases were Cancer cases with the remaining 57% urgent surgery. Over 90% of Outpatients were for urgent Ophthalmology treatments, Clinical Haematology and Breast Cancer patients.

Using NHS facilities (Insourcing)

Insourcing is a tried and tested approach to maximise the use of NHS premises and equipment to deliver extra clinical capacity, outside of when they are normally in use. The Health Board has traditionally used such approaches during periods of high demand and from January 2021, a contract has been in place to support additional capacity in Endoscopy, a fundamentally important area of diagnostics supporting urgent care and particularly Cancer services. This is currently delivering between 200-300 cases per month for the Health Board.

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?

Cardiff and Vale Health Board has continued to communicate with patients and patient groups through the usual channels including through Primary Care, Community Health Councils and the Medical Advisory Group. Long waiting patients have been contacted by letter to validate waiting lists, however, there has been no explicit communication regarding predicted waiting times or delays to procedures or treatments due the uncertainty created by the continuing effects of the pandemic.

The Health Board recently undertook a significant communications exercise as part of the introduction of the CAV24/7 model for urgent care to ensure people we able to access urgent care in the most appropriate fashion. The evaluation of this identified that 91% of the population of Cardiff and Vale were reached, with useful learning regarding the most effective advertising mediums and use of the CAV website. This will be used to inform future communications exercises.

The Keeping Me Well Covid-19 Rehabilitation Model was launched in May 2020. The remit includes;
Cohort 1: People recovering from Covid-19
Cohort 2: People with Paused Planned Care
Cohort 3: People who have avoided accessing health services
Cohort 4: People who are socially isolated or part of a shielding group
The resources associated with this model include the ‘Keeping Me Well’ website and app – www.keepingmewell.com. The website includes information and links to support regarding, Covid-19, preparing for treatment and recovery, rehab support, children’s services and resources related to self-care and caring for others. The app compliments the website and has been developed to support patients with a range of rehabilitation needs, including as a result of the Covid-19 pandemic.

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

It would not be prudent at this stage to be specific about the length of time it will take to return to pre-pandemic waiting times.

Our key dependencies in respect of planned care include the following:

- Progression of the Covid-19 pandemic
- Time to recover to 100% levels of activity
- Backlog capacity plans
- Issue of forecasting deferred / suppressed demand

Elective Demand, Activity & Waiting Lists

The indirect impact of the pandemic on health services has been profound. Elective activity reduced to 25% at the peak of the first wave and despite some recovery, elective capacity remains at around 70% of pre-Covid levels. This has led to an unprecedented increase in the number of long-waiting patients, rising from 1,747 to 37,434. This has occurred despite the UHB protecting 'Essential' services throughout the pandemic, the extensive use of the independent sector (more than the rest of Wales combined), and the establishment of 'green zones' which allowed the Health Board to continue to deliver higher levels of elective operating than in the first wave and maintain safe operating despite the higher levels of Covid-19 in the second wave.

However, despite the reduction in activity, the longer-term impact on waiting times is less clear-cut. The fall in activity has been broadly matched by a reduction in referrals, consequently the total number of patients waiting has increased by 5%.

However the latent demand in the population is probably significant. For most services the lack of referrals is unlikely to reflect a change in the true health needs of the population - more likely the demand has simply been supressed by the pandemic. As the pandemic recedes it is reasonable to assume this demand will resurface and therefore, added to normal demand, the total referred demand may significantly exceed pre-Covid levels for many months.

A key question therefore, in planning the recovery, is how much latent demand exists in the population, in which services, and over what timescale will this present. There is no data or precedent to inform the answer to this question and as a result the Health Board has to consider a range of scenarios. Nonetheless, few (if any) services in the NHS had surplus capacity prior to the pandemic and therefore once demand in a service consistently exceeds 100% it will require sustained action to avoid waiting lists growing. It can therefore be anticipated that additional capacity will be required for most services on a 'semi-recurrent' basis.

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?

Improvement initiatives

- CAV convention approach, using our shared learning from Canterbury Health (New Zealand) and adapted for Cardiff and Vale, is our proposed model for review of all of our services. This is based on integrated working across Primary and Secondary care, clinically led and delivered via the development, agreement and compliance with evidence based Clinical Pathways.
- Supporting this approach is the continued investment and development of Data Driven Demand Modelling and analytics across all of our Health Board Operational planning and management.
- See on Symptoms and Patient Initiated Follow Up pathways are being rolled out at greater pace to reduce unnecessary 'follow up' outpatient appointments, ensure timely follow-ups for those meeting the criteria for an appointment and create capacity to see more 'new' outpatients more quickly
- Virtual tools and techniques are being adopted across more areas to increase the capacity of our clinical workforce to see more patients more quickly and safely. This includes Virtual outpatient clinics using video technology, telephone consultations and virtual reviews by Consultants of patient referrals, notes and diagnostics which can support quicker decision making and more joint management between primary and secondary care. The creation of a "Virtual Village" for expansion of Virtual Consulting at University Hospital Llandough forms part of our plans.
- Advice & Guidance tools and technologies are being used to expand options for primary care referrers to seek advice and guidance and both improve the quality of referrals to secondary care but also to where possible reduce the volumes of referrals and support management of more care and treatment in primary care, including the promotion of self-care and management by patients.
- Additional capacity via both Insourcing and Outsourcing to the Independent Sector will be an important continuing element of the Health Board response to clearing the backlog of planned care treatments. The Health Board has already included within its 2020/21.
- CAV24/7. Introduction of a 'phone first' triage system for people requiring urgent care. Operates 24 hours a day 7 days a week to signpost people to the most appropriate medical help (not necessarily EU). Calls are taken by a call handler who will escalate in the case of a life threatening emergency. Non- life/limb emergencies are logged for a clinician call back within 20 mins (urgent) or 60 mins (less urgent). A referral is then made to the most appropriate service; people requiring attendance at EU or MIU are given a timeslot for attendance.

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?

Our response to question 4 sets out some elements and uncertainties which will affect the rate at which waiting times can reduce. The following are all factors when considering this:

- *Workforce* – Our staff remain our most important asset, and as a Health Board we are very aware of the exceptional pressures and demands which Covid-19 has placed on our people, in addition to the challenges the NHS faces and has faced throughout the past year and current Winter period. It is a point worth noting that there are now around 550 more people working for the UHB in medical, nursing and general areas compared to last year. In addition, the Board has invested in specific targeted initiatives focussed on retaining people to the UHB which is starting to deliver tangible improvements. Operational challenges remain around meeting winter and Covid-19 pressures, and a weekly taskforce is in place to discuss issues.

  Our immediate workforce priorities include a specific focus on expansion of our Theatre staffing groups. The Board has recently approved a major recruitment plan for our Peri Operative Directorate to recruit both experienced and newly qualified Nurses /Operating Department Practitioners to support our Operating Theatres. This includes a UK wide and internal recruitment process.

- *Essential services* – we have continued to maintain all essential services throughout the pandemic and we anticipate this will remain the case throughout 2021/22.

- *Green zones and resuming non-Covid activity* - we have done a great deal of work to develop *protected elective surgical units* at both UHW and UHL and this has enabled us to safely increase the volume of surgical activity undertaken, even during the deteriorating Covid-19 position over the past few months. There has been some reduction during January, in order to re-direct nursing staff to open additional Covid-19 treatment areas, but elective admissions remain at around 70% of pre-Covid levels. In addition our outpatient activity is currently running at 80% of pre-Covid levels (including virtual activity) and endoscopy at 85%. Our planning assumption therefore is that we will be able to maintain elective activity at above 70% of pre-Covid levels at all pathway stages, even in the event of a large third wave. As set out in our Q3/Q4 plan when Covid recedes to low levels we expect to be in a position to increase surgical activity to at least 80% of pre-Covid activity and clearly as the requirement for additional IP&C measures diminish we anticipate we will return to pre-Covid levels and beyond.

- *Independent sector* – A key contributor to us maintaining essential services and resuming elective activity, as described above, has been our extensive use of the independent sector. It is clear that continuing this into 2021/22 will be critical to ourselves and NHS Wales securing sufficient staffed capacity to begin the long post-Covid recovery.

- *Backlog* – The number of patients waiting over 36 weeks peaked at the end of November at nearly 40,000 breaches (an 18-fold increase) but has in fact begun to reduce over December and January. 60% of this increase is at stage one, new outpatients. In contrast the total RTT waiting list has grown by only 4.5%, reflecting the sharp reduction in referrals. For this reason we anticipate the backlog is only part of the story and our recovery planning will also need to consider the latent demand across our population, see below.

- *Mass Vaccination programme* – We have an existing mass vaccination plan in place, aligned to the national strategy, and in the past two weeks we have completed a 14-day 'sprint' to identify and review options for a much more rapid deployment of the vaccine should sufficient supplies become available. Vaccination is of course the route out of the pandemic and the rate at which we are able to vaccinate our population is informing our scenario planning for Covid, and in turn our post-Covid recovery.

- *Covid scenario planning* – the profile of Covid prevalence will, at least initially, be the primary determinant of the level of elective activity we are able to undertake. As part of our planning for 2021/22 we are continuing our approach from Q3/Q4 and developing three broad scenarios: Covid best-case, Covid worst-case and Covid central scenario. These will be used to ensure we can continue to respond to all eventualities and inform our understanding of the implications of these scenarios on finance, workforce and delivery of services (including recovery).

- *Latent demand* – The critical element in understanding the scale, and therefore the timescales, for post-Covid recovery is the extent to which there is unmet demand across our population that will resurface as health care demand at a later date. We know, for example, that we have undertaken 16,000 fewer surgical procedures over the past 12 months compared to the previous year. Some of this demand will have been addressed in other ways or naturally resolved, but it is likely a significant proportion will require some form of health care support over the coming years. We have the ability to analyse this by specialty and procedure and will over the coming months be taking a service-by-service approach to understand the implications of, and potential options for, this latent demand.

- *Increased Population Need* – In addition to the existing backlogs, plus latent demand, there is an expectation that the broader health, economic and social effects of the pandemic may be profound and long-lasting. We are therefore expecting the consequences of this may present as additional demand for health care services at some stage - it is likely for example that we will see an increase in demand for mental health services and there are some indications this has already begun.

Given the range of possible trajectories for Covid-19 and the uncertainty with latent demand, our planning work is predominantly taking the form of scenarios and understanding the implications of these on the recovery profile.

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?

The UHB is in dialogue with Welsh Government regarding the strategic direction of the recovery programme. To date there is no detail yet confirmed on the overall resource envelope or the share of that allocated to Cardiff and Vale. We have emerging plans on our intended approach and some specific proposals to increase capacity in some key areas, including endoscopy, radiology and ophthalmology; all of which aligns to the UHB's strategic direction and developing clinical strategy.

We have already reintroduced endoscopy in-sourcing and approved, at risk, the commission of a MRI scanner into the first six months of next year. In addition we are proceeding to 'over-recruit' theatre staffing in recognition that this is typically the rate-limiter to increasing surgical activity and in the anticipation that central funding will be available for this purpose. Over the medium-term we have a number of capital-dependent schemes in progress to increase physical capacity in key areas, aligned to our strategy, in particular endoscopy expansion at UHL and increased theatre provision.

We continue to work with our neighbouring Health Boards to align our planning and identify opportunities for regional working. This is being led through our South East Regional Planning forum that is constituted of Directors and Assistant Directors of Planning, Medical Directors and appropriate operational leadership.

Vivienne Harpwood, Cadeirydd / Chair

Carol Shillabeer, Y Prif Weithredwr / Chief Executive

16th February 2021

HT/SP/CS

Dr Dai Lloyd MS
Chair, Health, Social Care and Sport Committee
Welsh Parliament
Cardiff Bay
Cardiff
CF99 1SN

Sent via Email to: SeneddHealth@senedd.wales

Dear Dr Lloyd,

Evidence Submission from Powys Teaching Health Board to the Health, Social Care and Sport Committee Inquiry into the impact of COVID-19 on health and social care in Wales

1. I am pleased to provide this written evidence to contribute to the Committee's inquiry in response to the letter received on 20th January 2021 which sought responses on the matter of the impact of the pandemic on waiting times.

Context

2. Powys Teaching Health Board (PTHB) serves a population of approximately 133,000 people, in an entirely rural County with no major conurbations and no District General Hospitals (DGH) in its own borders.

3. The provision of healthcare for the residents of Powys is therefore complex, with significant cross border interdependencies. The health board is both a commissioner and a direct provider of healthcare. The issue of waiting times for the Powys population is set in this context of multiple providers across England and Wales.

Further detail is provided below on the specific Committee Lines of Enquiry.

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

4. As noted in the context above, Powys has a complex network of provision and the areas of pressure are not solely in one provider but across providers in England and Wales.

5. The majority of Powys patients waiting times are dependent on the delivery of neighbouring providers all of whom are continuing to manage the ongoing response to the pandemic and make difficult decisions in relation to the subsequent impact on service capacity.

6. In addition, whilst the pandemic itself has not impacted as strongly in Powys as other areas, the wider socio-economic impact is significant in this rural area. Residents are experiencing the same set of restrictions on their social and economic lives with greater isolation, and a lower income and employment base. Initial analysis points to effects on the population of Powys over a very long period ahead and this has a consequential impact on health and well-being pressures.

7. The health board has a unique role as a commissioner as well as a provider of healthcare. It has a strong community based model which has played a crucial role in supporting flow across the DGH systems in both England and Wales during the pandemic.

8. The health board also has a shared long term Health and Care Strategy, 'A Healthy, Caring Powys', which is building and strengthening this community model of care. This work is even more important in the context of the pandemic, as a cornerstone for longer term renewal and recovery.

9. Our approach to addressing the challenge of waiting times is therefore in development as a holistic, strategic and operational programme of work which will be set out in more detail in our Annual Plan 2021/22.

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

10. All new referrals and existing referrals continue to be risk manage; this provides the most rapid and equitable care possible during the current period.

11. The health board has a clear 6 step approach to developing the organisation's priorities for 2021/22 and the formulation of the Annual Plan that underpins delivery.

12. A programme of renewal will be core to the Annual Plan. This is work that requires a depth of time, resource and consideration to fully explore the problem and target solutions. This will include value based approaches and careful assessment of relative risks, priorities and system impacts of any choices that are made.

13. It is already known that the impact of the pandemic is being experienced differentially by some groups in our communities, in Powys, and in Wales, as it is globally. It is this differential that will help form underlying principles for renewal and recovery.

14. The health board will be taking an approach, with partners locally, regionally and nationally, to ensure the challenges of equity and access for vulnerable groups are thought through and written into the design of the next year and beyond.

15. A focus on renewal and recovery is the key feature of partnership working, in particular the Regional Partnership Board. A draft plan has been developed and approved by the RPB which cover a range of schemes with particular expansion and emphasis on children, given the disproportionate impact on children and young people. The work of other partnerships is also key: Public Services Board, Mid Wales Joint Committee for Health and Care and other regional, cross border and national collaborations are key to our future strategy.

16. The key elements of the system working between primary and secondary care will be the wider impact of the unprecedented level of waiting times in terms of quality and safety, including:

    - shared decision making and to keep patients informed
    - risk stratification
    - investigation and response to a much higher volume of concerns
    - review of harm

17. 'A Healthy, Caring Powys' has an emphasis on collaboration not only between statutory partners for health and care but with an aim of connecting communities to improve resilience and well-being. This includes a recognition of the importance of the third sector as a first line of support for many communities. This whole system approach is critical to fully understand the roots as well as the more prominent branches of the problem now faced by our populations

18. The health board will develop its approach in line with national policies and positions to uphold equity and the principles of the NHS and to communicate and engage with communities to understand the situation, the options and the way forward.

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?

19. As noted above, the health board has a strong community based model which has been further strengthened during the pandemic. All health board essential services have continued to be delivered throughout the pandemic, albeit at reduced levels of capacity in the service, due to the requirements of infection prevention and control measures. Primary and Community teams involve health, social care and third sector professionals in case reviews and management.

20. Individual conversations with those most at risk or with the most complex needs are held on a daily basis through the Primary and Community teams including specialist nurses and therapists, to discuss their conditions and options. This may include well-being support, pain management or alternative local services for those people waiting for care.

21. For the wider population, a Communications Plan has been implemented focused on the promotion of access to healthcare, particularly in response to the significant change in the behaviour of the population in the first wave of the pandemic, which saw a reduction in people presenting in primary care and other access points.

22. The health board website has also been used as a portal for information on access routes to specific services and to explain any changes in the ways in which people are able to contact teams or the ways in which services may be delivered.

23. As noted above, for the majority of care pathways these will be dependent on the arrangements in neighbouring DGH providers, who are also providing tailored communications to their patients depending on the speciality and the current status of that service provision.

24. The health board established a 'DGH Log' in the early stage of the pandemic to ensure service status was tracked and communicated to stakeholders including the Community Health Council and key stakeholders.

25. The health board participates in the system arrangements and resilience forums in the main provider geographies for the Powys population to ensure the needs of Powys residents are built into their planning and communications. The main provider systems by scale of use are Shropshire, Telford and Wrekin, Herefordshire and Worcestershire and Dyfed Powys / wider NHS Wales.

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

26. The time needed is determined both by external factors in relation to the pandemic but also to structural considerations across health and care. If the system operates in the same way as it did prior to the pandemic that is likely to be a slower route to recovery. The route to renewal can be quickened by innovations, collaboration and technologies already being forged during the pandemic.

27. As a provider the service capacity has held up well, and essential services have been maintained, albeit a 30% capacity reduction in some areas. More broadly, Health Boards and Trusts (England and Wales) have reduced elective activity to prioritise urgent and emergency care. The impact and timeframes across systems are not fully clear at this stage.

28. The health board has carried out initial analysis of demand and capacity and the associated trajectories over time and is conducting further work to ensure this is fully understood. The assessment is by necessity whole system and population focused, informed by an understanding of the latest evidence regarding impact on health and wellbeing. PTHB has commissioned specific pieces of work to provide this intelligence.

    - Population Healthcare Demand Trends: A desktop review of evidence is being finalised on the impacts of the pandemic on population healthcare demand in Powys including new forms and patterns of demand and inequalities.

    - Strategic Demand and Capacity analysis: this is being commissioned in partnership between health and care to provide a detailed analysis of impacts and opportunities.

    - Commissioned Services: Systematic tracking and analysis of commissioner demand and capacity including neighbouring health boards in Wales and English systems.

    - PTHB Provider Demand and Capacity Planning: local operational tracking and planning including acute flows across the system.

29. This analysis work has demonstrated that significant changes in demand were seen in 2020, in Powys as they were nationally across Wales and the rest of the UK.

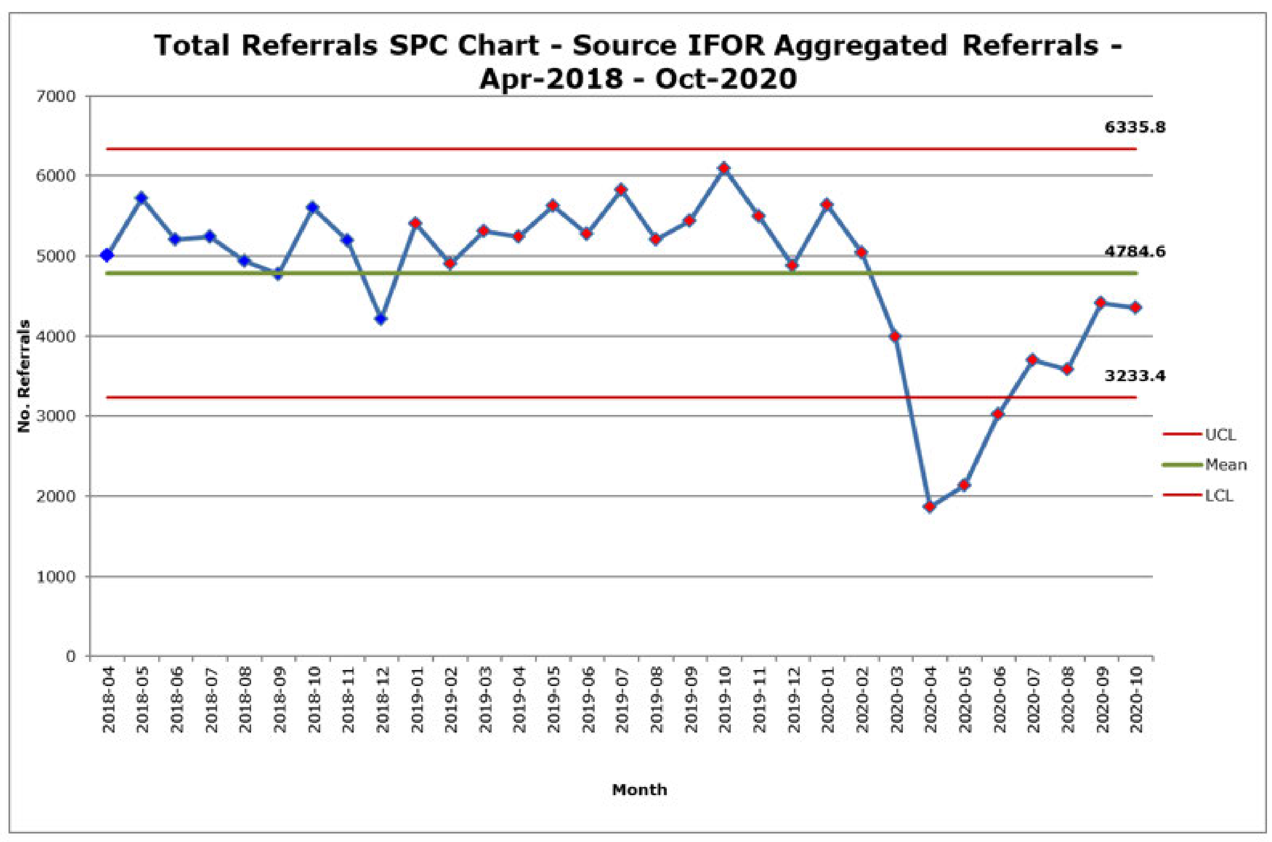
30. In the health board, as a direct provider, the use of primary and community care including community hospitals was significantly reduced as demand behaviour changed in the first wave of the pandemic Spring / Summer 2020.

31. A comprehensive communications and engagement programme was implemented to mitigate these reductions in demand and to ensure that residents understood that services were open and accessible.

32. Demand had gradually been increasing in the Autumn 2020 and Table 1 below (management information) demonstrates the pattern to the beginning of November 2020 which is the latest available data. Referral counts had returned to 92% of the mean.

33. Preliminary data for November and December 2020 is showing another wave of reduction in line with the timing of the second wave of the pandemic and the decisions being made by both providers and in terms of population behaviours at this time.

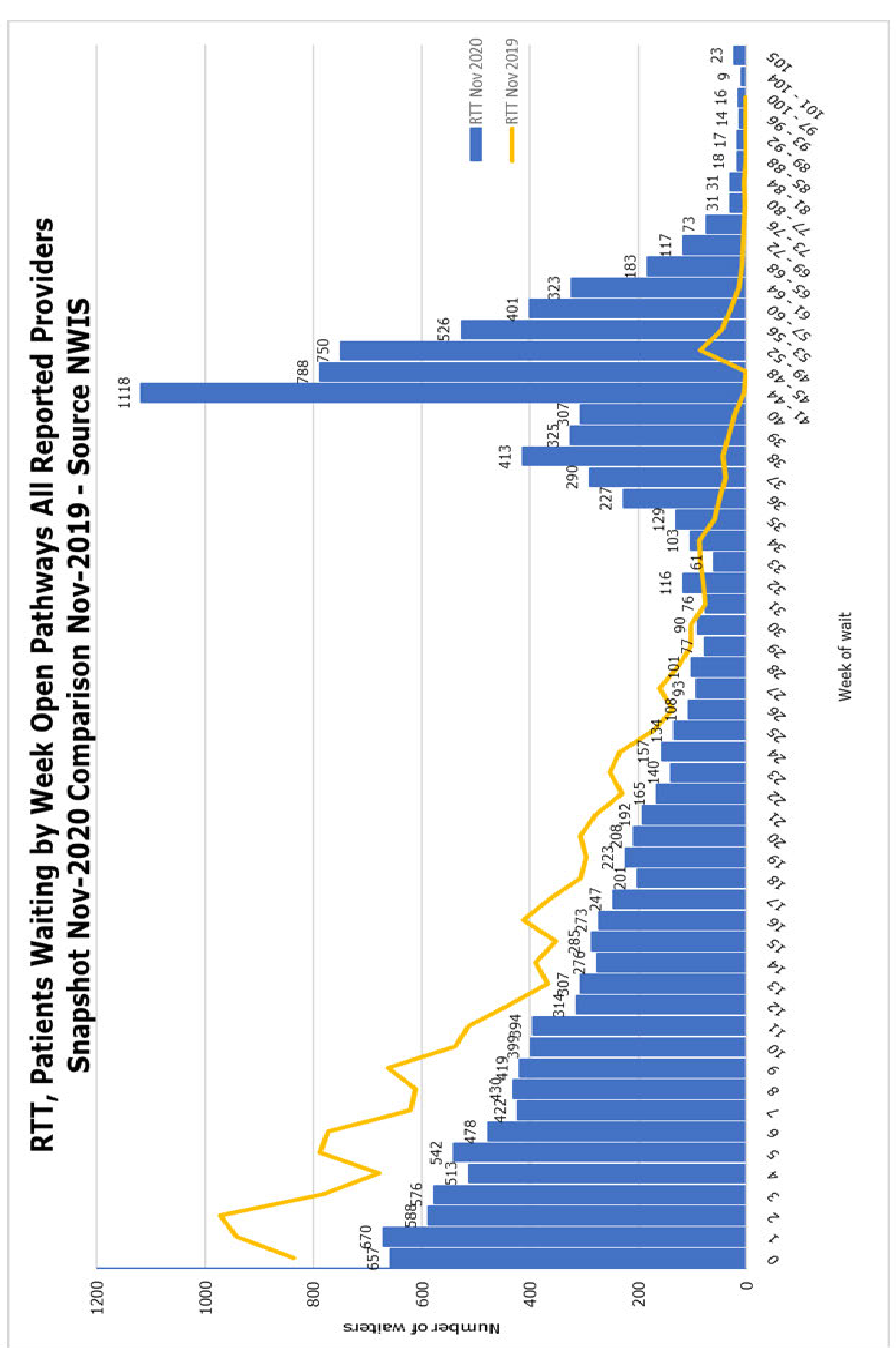
Table 1: Total Referrals (Apr 2018 – Oct 2020)



34. Table 2 below (management information) outlines the pattern of waiting times for all reported providers (PTHB provider, English and Welsh HB/Trust providers) at the November 2020 snapshot.

35. This shows the impact of national service suspensions during the first wave of the pandemic. Second wave/winter impacts are expected with a similar but potentially not as pronounced second cohort of impact resulting from service contraction/suspension.

36. Table 2: Referral to Treatment across all reported providers, Snapshot November 2020



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?

37. There have been significant innovations to date and these are being appraised and evaluated constantly as part of the response to the pandemic and the requirements for infection prevention and control, mitigation of nosocomial spread, physical space restrictions and social distancing. This will be a core part of the health boards Annual Plan 2021/22 and longer term renewal as part of 'A Healthy Caring Powys'.

38. For example, the digital rollout in Powys has seen significant acceleration of new ways of working and alternative service delivery, enabling healthcare to continue to be delivered across all essential services throughout the pandemic.

39. Virtual appointments have been embedded into practice where appropriate, including the roll-out of "Attend Anywhere" across our services. In many cases, the use of virtual methods of delivery facilitated even greater numbers of users supported and across a greater geography, with none of the usual travel and transport difficulties that can be experienced in a very rural County. In some cases where group work was delivered, this exceeded the contracted levels of activity across providers, at no extra cost, providing greater value and leverage of public monies.

40. Virtual delivery does not fully meet the needs of all clients such as those providing support for mental health or advocacy. In these cases the organisations have reinstated face to face support where it is safe and appropriate to do so, with some new measures and changes in the use and flow of physical spaces.

41. The third sector has also played a significant role, with an increase in activity, groups and volunteers as well as an increase in clients. The Community Connectors model was expanded to support multi-disciplinary case reviews and case management.

42. A pathway for 'Long COVID-19' has also been developed in line with NICE Guidance. This will provide access for any individual with on-going signs and symptoms or with Post-COVID-19 Syndrome.

43. Further areas are being assessed as part of the analysis of demand and capacity noted earlier. This is highlighting not only particular specialities as areas of both challenge and opportunity but also the importance of diagnostics as a critical enabler.

44. Similarly, the approach to outpatients and follow up appointments are key points in the several patient journeys across pathways which present opportunities for modernisation nationally and locally. This is

part of the health boards approach and will be given specific and detailed consideration.

<u>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?</u>

45. The ongoing challenge and uncertainty of the pandemic is the primary factor.

46. Significant capacity and resource is currently being directed to the Covid-19 Vaccination programme which is a significant priority for NHS Wales, and the Covid Prevention and Response Programme, which has a number of components including Test, Trace and Protect.

47. The balance of delivery between covid and non covid healthcare, the risk of an overwhelmed system, a fatigued workforce and the wider societal impacts of the pandemic represent a significant and ongoing challenge. Addressing these 'Four Harms' will require a continual appraisal and rebalancing of priorities through the year.

48. There remain significant unknowns in relation to the course of the pandemic, and a need for a 'fluid' approach as recommended by Welsh Government in the Planning Framework for 2021/22. This will be reflected in the health boards Annual Plan.

49. Key transformation programmes will continue to be taken forward, in line with the balance of delivery noted above, reshaping and refocusing against the emerging learning and intelligence. This includes flagship partnership programmes such as the North Powys Well-being Programme, Powys Workforce Futures and the Powys Well-being Plan within which we are setting the Innovative Environments framework.

50. The key partnerships in Powys including the Regional Partnership Board and Public Services Board have begun to re-establish and reframe these key programmes and areas of work in line with our shared ambition for 'A Healthy Caring Powys' and are providing crucial spaces for wider reflection and learning across the region.

51. The response to the pandemic still requires the greatest amount of effort across all sectors, communities and individuals. It is also forging innovations that will be part of the solutions within longer term strategy, as the whole system learns and evolves.

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

52. The health board is awaiting confirmation of the allocation to support recovery activity in 2021/22 having been informed that it will be subject to a separate funding allocation.

53. As a provider and commissioner, the health board will utilise the funding in line with our Annual Plan priorities and the agreed approach to 'Planning Ahead' (the Boards strategic priority for renewal and recovery). This will include further assessment of demand and capacity across provider plans internally and externally to understand the position and identify and cost robust activity and capacity plans.

54. In previous years funding has been allocated on a provider basis in Wales and we would seek to ensure that the appropriate commissioning allocation for the Powys population is fully included in any provider plans, given the unique arrangements for this part of the Welsh population. This will ensure that health board can agree appropriate levels of activity and funding for the Powys resident population share of that funding.

55. The health board is taking a whole system and value based approach to Planning Ahead, as noted above, building on the innovations and collaboration forged during the pandemic to accelerate capacity and speed of delivery and maximise the use of funding provided.

I hope this provides a useful overview of our approach. Please do let me know if the Committee requires any further information.

Yours sincerely

Carol Shillabeer
Chief Executive

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.

Senedd Cymru
Pwyllgor Diwylliant, y Gymraeg a Chyfathrebu

—

Welsh Parliament
Culture, Welsh Language and Communications Committee

Yr Arglwydd Dafydd Elis-Thomas

Y Dirprwy Weinidog Diwylliant, Chwaraeon a Thwristiaeth

Dyddiad | Date: 9 Chwefror 2021

Pwnc | Subject: Gwaith dilynol ar effaith COVID-19 ar chwaraeon

Annwyl Dafydd,

Ers dechrau pandemig COVID-19, mae'r Pwyllgor Diwylliant, y Gymraeg a Chyfathrebu wedi trafod llawer o oblygiadau COVID-19 i feysydd o fewn eich portffolio gweinidogol. Mae hyn wedi cynnwys ein **hadroddiad cychwynnol ar yr effaith ar chwaraeon yng Nghymru** a gyhoeddwyd ym mis Mehefin 2020. Ym mis Ionawr 2021, gwnaethom gytuno i ailedrych ar y maes gwaith hwn a chymryd tystiolaeth gan yr unigolion a sefydliadau a ganlyn:

- Brian Davies, Chwaraeon Cymru;
- Victoria Ward, Cymdeithas Chwaraeon Cymru;
- Jonathan Ford,Cymdeithas Bêl-droed Cymru (CBDC);
- Marcus Kingwell, EMD UK;
- Steve Phillips, Undeb Rygbi Cymru (URC).

Rydym yn ddiolchgar iawn i bawb a helpodd y Pwyllgor gyda'i waith. Mae'n bwysig pwysleisio o'r dechrau, oherwydd yr amser cyfyngedig sydd ar gael i'r Pwyllgor ar hyn o bryd, nad oeddem yn gallu edrych yn ehangach ar chwaraeon eraill sydd, heb os, â rhan bwysig mewn cymunedau lleol a'n bywyd cenedlaethol. Yn lle hynny, rydym yn gobeithio codi rhai o'r materion sy'n gyffredin i'r sector cyfan.

Mae **trawsgrifiad o'r sesiwn ar gael ar ein gwefan**. Yn dilyn y sesiwn, cytunodd y Pwyllgor i ysgrifennu atoch gyda nifer o gwestiynau, canfyddiadau ac argymhellion a nodir yn yr atodiad isod.

Hefyd, rwy'n anfon copi o'r llythyr hwn at Dai Lloyd AS, Cadeirydd y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon.

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Yn gywir,

Bethan Sayed.

Bethan Sayed AS

Cadeirydd y Pwyllgor Diwylliant, y Gymraeg a Chyfathrebu

Atodiad

Effaith y pandemig ar gyfranogiad a gweithgarwch corfforol

Nodwyd bod effaith y pandemig a mesurau'r cyfyngiadau symud yn drychinebus ac yn ddinistriol i chwaraeon yng Nghymru.[1] Dywedodd Brian Davies o Chwaraeon Cymru fod effaith mesurau'r cyfyngiadau symud presennol yn barlysol, yn enwedig ar lawr gwlad.[2] Dan y cyfyngiadau lefel pedwar presennol, gwaharddir yr holl weithgareddau chwaraeon, heblaw am nifer fach iawn o rai elitaidd. Heblaw am chwaraeon proffesiynol (megis rygbi, pêl-droed a phêl-rwyd) amcangyfrifodd Mr Davies mai dim ond tua 200 o athletwyr yng Nghymru sydd â goddefeb o reoliadau'r cyfyngiadau symud.[3]

O ran gweithgaredd corfforol, mae **ymchwil gan Chwaraeon Cymru** yn awgrymu bod y pandemig, i raddau, wedi atgyfnerthu a dwysáu'r tueddiadau presennol. Canfu arolwg Chwaraeon Cymru fod y cyfranogiad cyffredinol mewn chwaraeon a gweithgarwch corfforol yng Nghymru wedi cadw at yr un lefelau yn fras yn ystod cyfnod y cyfyngiadau symud, er nad oes chwaraeon strwythuredig. Fodd bynnag, roedd plant, oedolion hŷn (55 oed a hŷn) a'r rhai o gefndiroedd economaidd-gymdeithasol is yn tueddu i gymryd rhan mewn llai o chwaraeon a gweithgarwch corfforol yn ystod y cyfyngiadau symud nag roeddent wedi o'r blaen.

Cytunodd Victoria Ward o Gymdeithas Chwaraeon Cymru a Brian Davies o Chwaraeon Cymru fod y pandemig wedi gwaethygu'r bwlch anghydraddoldebau presennol o ran gweithgarwch corfforol.[4] Yn yr un modd, dywedodd Marcus Kingwell o EMD UK fod effaith y pandemig wedi bod yn niweidiol iawn i fenywod. Dywedodd Mr Kingwell y canlynol:

> "[…] within group exercise, which is pretty much the most popular physical activity that women take part in, 80 per cent of the participants are female. So, with restrictions on that—and I fully accept them in level 4, by the way—it disproportionately impacts women. And if we look back through the history of sport and physical activity in an organised manner, there's been significantly more barriers to female participation across the board, and those are starting to return."[5]

Pan gynhaliwyd ein sesiwn dystiolaeth, roedd y cyfyngiadau lefel pedwar yng Nghymru yn cyfyngu ar unigolion i ymarfer corff yn yr awyr agored, unwaith y dydd ac ar eu pen eu hunain yn unig, gydag aelodau o'u cartref neu swigod cymorth. Dywedodd Victoria Ward o Gymdeithas Chwaraeon Cymru y byddai'n croesawu addasiad i'r rheoliadau hyn sy'n caniatáu i fwy nag un aelwyd ymuno â'i gilydd ar gyfer ymarfer corff yn yr awyr agored a fyddai'n ein gwneud yn gyson â gwledydd eraill Prydain. [6] Yn yr adolygiad tair wythnos diweddaraf o reoliadau coronafeirws ar 29 Ionawr,

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[1] Senedd Cymru, Cofnod y Trafodion, paragraffau 91, 92, 98
[2] Paragraff 8
[3] Paragraff 10
[4] Paragraffau 28 ac 31
[5] Paragraff 147
[6] Paragraff 73

cyhoeddodd y Prif Weinidog y byddai'r rheoliadau'n cael eu diwygio i ganiatáu i hyd at ddau berson o ddwy aelwyd wahanol ymarfer corff gyda'i gilydd.[7]

Mae'r pandemig yn parhau i gael effaith fawr ar draws y sector ac ar bob lefel. Mae arwyddion parhaus bod effaith y pandemig ar gyfranogiad a lefelau gweithgarwch corfforol yn anwastad ar draws cefndiroedd economaidd-gymdeithasol a demograffig gwahanol. Rydym hefyd wedi clywed pryderon wrth wneud ein gwaith o ddydd i ddydd am yr effaith y mae diffyg gweithgareddau corfforol a chwaraeon yn ei chael ar blant a phobl ifanc a'r niwed y mae hyn yn ei gael ar eu hiechyd corfforol a meddyliol a'u llesiant.

Argymhelliad 1) Dylai Llywodraeth Cymru weithio gyda Chwaraeon Cymru ac eraill i gynnal rhagor o ymchwil ar effaith y pandemig ar lefelau cyfranogiad mewn gweithgarwch corfforol ar gyfer grwpiau sydd â nodweddion gwarchodedig er mwyn llywio gwaith cynllunio a llunio polisi ar ôl y pandemig. Mae'n rhaid i'r ymchwil hon gynnwys asesiad o'r effaith ar gyfranogiad menywod, y gymuned BAME, ac ar blant a phobl ifanc.

Fel y nodwyd yn y dystiolaeth – mae cyfyngiadau lefel/haen pedwar gwahanol yn gymwys yng Nghymru, yr Alban a Lloegr o ran ymarfer corff yn yr awyr agored a chlywodd y Pwyllgor alwadau am edrych ar y rhain eto.

Rydym yn croesawu penderfyniad y Prif Weinidog i ganiatáu i ddau berson o ddwy aelwyd wahanol ymarfer corff gyda'i gilydd (ar yr amod y gwneir pob ymdrech i gadw pellter cymdeithasol) yn ogystal ag eithriad ar gyfer mynd gyda phlant dan 11 oed. Yn ein barn ni, dylid cadw'r eithriad hwn hefyd mewn cyfyngiadau symud lefel pedwar yn y dyfodol.

Er bod yn rhaid rhoi blaenoriaeth i fynd i'r afael â'r pandemig – mae manteision amlwg i iechyd y cyhoedd (iechyd corfforol a meddyliol) i weithgarwch corfforol ac ymarfer corff. Ar hyn o bryd, gwaherddir popeth heblaw am gyfres fach iawn a chyfyngedig o weithgareddau ac (yn ychwanegol at y pryderon mewn perthynas â'r grwpiau penodol uchod) mae hyn yn cael effaith negyddol sylweddol ar unigolion a'r sector cyfan.

Argymhelliad 2) Pan fydd amodau (o ran rheoli'r feirws) yn caniatáu, mae'n rhaid i Lywodraeth Cymru sicrhau bod campfeydd, lleoliadau chwaraeon a lleoliadau ymarfer corff eraill (gan gynnwys dosbarthiadau ymarfer corff grŵp sy'n cwrdd yn yr awyr agored) ymysg y blaenoriaethau wrth lacio'r cyfyngiadau symud.

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[7] Datganiad Ysgrifenedig, Datganiad Ysgrifenedig: Adolygiad o Reoliadau Diogelu Iechyd (Cyfyngiadau Coronafeirws) (Rhif 5) (Cymru) 2020 – 29 Ionawr 2021

Canllawiau a'r cynllun rheoli coronafeirws

Roedd rhanddeiliaid yn gefnogol i'r cynllun rheoli coronafeirws newydd a gyhoeddwyd ym mis Rhagfyr 2020 sy'n amlinellu'r gweithgareddau gwahanol a ganiateir ar draws y pedair lefel rhybudd yng Nghymru.

Cytunodd Chwaraeon Cymru, EMD UK, URC ac CBDC fod lefel yr ymgysylltiad â Llywodraeth Cymru wedi bod yn dda.[8] At hynny, roedd Jonathan Ford o CBDC a Marcus Kingwell o EMD UK am gymryd mwy o ran yn agweddau manwl canllawiau yn y dyfodol. Yn benodol, nododd Mr Ford fod datgysylltiad weithiau rhwng trafodaethau a'r polisi yn y pen draw wrth iddo gael ei lunio a'i gyfleu'n ehangach. Cyfeiriodd Mr Ford at enghraifft y terfyn 30 person ar weithgareddau yn yr awyr agored (a oedd ar waith o'r blaen yn ystod haf 2020) gan ddweud ei fod yn ymddangos yn ffigur mympwyol a gafodd ei ddefnyddio ar draws cymdeithas ac na chafodd ei greu drwy ymgynghoriad o gwbl.[9]

Mae'r Pwyllgor yn croesawu'r lefelau ymgysylltu da rhwng y sector, Llywodraeth Cymru a swyddogion ar lefelau uwch ac yn disgwyl i hyn barhau dros y misoedd nesaf. Fodd bynnag, wedi hynny, rydym wedi cael gwybodaeth sy'n awgrymu nad yw gwybodaeth bob amser yn rhaeadru o'r lefelau uwch i'r lefel llawr gwlad mewn modd effeithiol ac amserol. Felly, rydym yn disgwyl i bob ymdrech gael ei gwneud i sicrhau y caiff canllawiau a gwybodaeth eu lledaenu'n effeithiol gan Lywodraeth Cymru a chyrff perthnasol i'r lefel llawr gwlad pan fydd newidiadau'n digwydd yn y dyfodol.

O ran canllawiau yn y dyfodol, nodwn fod y rheol ynghylch hyd at 30 o gyfranogwyr ar gyfer ymarfer corff yn yr awyr agored yn parhau i fod ar waith yn y cynllun rheoli coronafeirws newydd ar draws lefelau rhybudd dau a thri. Mae hyn yn codi i 100 o gyfranogwyr ar lefel rhybudd un.

Argymhelliad 3) Byddem yn croesawu mwy o fanylion ynghylch sut y penderfynwyd ar 30 fel uchafswm. Er mwyn ein galluogi i wneud hyn, dylai Llywodraeth Cymru gyhoeddi'r dystiolaeth wyddonol y mae'r rheol hon yn seiliedig arni. At hynny, dylai Llywodraeth Cymru amlinellu pa asesiad y mae wedi'i gynnal o'r effaith y bydd terfyn 30 person yn ei chael ar ailddechrau gweithgareddau chwaraeon, yn enwedig ar lawr gwlad.

[8] Paragraffau 17, 111, 112, 113
[9] Paragraff 112

Gwylwyr a chwaraeon gwylwyr

Mae cyfyngiadau COVID-19 ers dechrau'r pandemig yng Nghymru wedi gwahardd yr holl wylwyr rhag mynd i ddigwyddiadau chwaraeon yn ffisegol. Heb os, mae effaith economaidd niweidiol ar chwaraeon gwahardd gwylwyr - a'r refeniw y maent yn dod ag ef - wedi bod yn ddwys.[10]

Pwysleisiodd Jonathan Ford o CBDC a Steve Phillips o URC bwysigrwydd sefydlu map ffyrdd clir i wylwyr ddychwelyd yn ddiogel i ddigwyddiadau chwaraeon (ar draws pob lefel o'r gêm). Esboniodd Mr Ford y canlynol:

> "It's having a little bit more clarity so that people can see that there's light at the end of the tunnel. At the moment, there's no light at the end of the spectator tunnel, and we would just like to have some assurances that there is a plan going to be put in place, and if things go according to plan, which we appreciate that everything changes, but if they go according to plan and the vaccination roll-out works and the numbers come down and we go down the scales, it will be increased. If people can understand that, they can start putting their business models back in place. At this moment in time, the business model is broken without match-day attendances and without the additional spend, and we just need to try and find that solution, otherwise people are looking back at me and I cannot be the bank, unfortunately; we only have so much money and we are looking at survival ourselves."

Esboniodd Jonathan Ford o CBDC fod cymysgedd o dimau proffesiynol a lled-broffesiynol sy'n chwarae yn uwch gynghrair Cymru yn golygu na all uwch gynghrair Cymru weithredu ar hyn o bryd. Ychwanegodd URC fod hyn yn wir hefyd ar gyfer uwch gynghrair rygbi Cymru.[11]

O ran Twrnamaint y Chwe Gwlad yn 2021, esboniodd Steve Phillips o URC y cynhelir y tri thwrnamaint (twrnameintiau'r menywod hŷn; y dynion hŷn; a'r un dan 20 oed) ar yr un pryd fel arfer, ond na fyddai hyn yn bosibl gyda'r protocolau coronafeirws ynghylch cyfleusterau, profion ac ati. Esboniodd Mr Phillips mai eu bwriad bellach oedd cynnal pob twrnamaint ar wahân ac yn ei dro.[12]

Mae'r sector cyfan i'w ganmol am y ffordd y mae wedi gweithio i sicrhau y bu modd cynnal rhai gweithgareddau chwaraeon, sydd weithiau'n cynnwys ebyrth personol gan y bobl sy'n cymryd rhan yn y chwaraeon eu hunain. Mae enghreifftiau nodedig o weithgareddau chwaraeon wedi cynnwys ailddechrau'r gynghrair bêl-droed broffesiynol a Chwpan Cenhedloedd yr Hydref yn ddiogel yn ddiweddar.

Nodwn fod cymysgedd o glybiau proffesiynol a lled-broffesiynol sy'n chwarae mewn cynghreiriau chwaraeon pwysig fel uwch gynghreiriau rygbi a phêl-droed Cymru yn golygu

[10] Paragraffau 66, 102, 158
[11] Paragraffau 95 ac 96
[12] Paragraff 143

bod y cynghreiriau hynny'n segur ar hyn o bryd. Mae hyn yn wahanol i'r nifer fach o glybiau pêl-droed proffesiynol sy'n chwarae yng nghynghrair bêl-droed Lloegr.

Pan aeth y Pwyllgor ati i ailedrych ar COVID-19 a chwaraeon, un o'r meysydd allweddol o ddiddordeb i ni oedd ailddechrau chwaraeon gwylwyr yn ddiogel. Yn ystod yr hydref, Cymru oedd yr unig wlad yn y DU i wahardd gwylwyr rhag mynd i ddigwyddiadau chwaraeon mewn ffordd gyfyngedig. Mae'r ffaith bod sefyllfa iechyd y cyhoedd ar draws y DU wedi dirywio mor sylweddol yn y cyfamser yn brawf o'r gwaith anodd y mae Llywodraeth Cymru a'r sector wedi'i gael o ran ymateb i bandemig anrhagweladwy sy'n newid yn gyflym.

Argymhelliad 4) Dylai Llywodraeth Cymru amlinellu ei barn am:

- ***yr amodau a fyddai'n galluogi treialu digwyddiadau chwaraeon gwylwyr diogel;***
- ***y berthynas rhwng y rhaglen frechu a gwylwyr yn dychwelyd i ddigwyddiadau chwaraeon;***
- ***manylion unrhyw ymgysylltiad y mae'n ei gael â chlybiau Cymru sy'n chwarae yng nghynghrair bêl-droed Lloegr i sicrhau syniadau cydgysylltiedig;***
- ***diweddariad ar yr amserlenni presennol y mae'n gweithio tuag atynt yn hynny o beth.***

Mae'r Pwyllgor yn nodi'r penderfyniad i ohirio twrnamaint menywod y Chwe Gwlad yn 2021 ac mae'n disgwyl i bob ymdrech gael ei gwneud i sicrhau y gellir cynnal y twrnamaint yn ddiweddarach eleni.

Cyllid

Mae cymorth ariannol i'r sector wedi bod yn hanfodol er mwyn dod drwy'r gwaethaf o'r pandemig. Amlinellodd Chwaraeon Cymru sut y dyrannwyd £22.7 miliwn mewn cyllid hyd yn hyn mewn ymateb i bandemig COVID-19.[13] Dywedodd Mr Davies y canlynol:

> "the Be Active Wales fund has been the primary source for community clubs et cetera to apply, but we've also supported governing bodies, and some governing bodies have also allocated some of that resource down to that level of their membership. We've allocated around about £2.2 million of the Be Active Wales fund, and that has all gone to community grass-roots organisations. I'd have to dig out the exact stats, but it's something like around about 900 supported applicants, who would all be different entities. Football has been a big beneficiary of that, but that's what you'd expect; there are far more football clubs than any other type of clubs at grass-roots level. So, around about £2.2 million has gone, through the Be Active Wales fund, and we've supported governing bodies, not only with protected funding they would have had annually, but

[13] Paragraff 51

also £2.5 million worth of additional funding for, primarily, grass-roots activity that they're responsible for."[14]

Ar yr un pryd, rhybuddiodd Victoria Ward o Gymdeithas Chwaraeon Cymru, er bod Chwaraeon Cymru wedi gwneud gwaith gwych o ran cael arian allan i gymunedau, fod y cyllid hyd yn hyn yn fach mewn termau cymharol ac na fyddai'n gwrthbwyso'r gostyngiad mewn incwm y mae'r sector yn ei wynebu.[15]

Yn yr un modd, dywedodd CBDC fod y cyllid drwy'r Gronfa Cymru Actif a'r Gronfa Gwydnwch Chwaraeon yn rhaff achub, ond rhybuddiodd y byddai angen mwy o arian i sicrhau y gall y clybiau pêl-droed (bron 1,000 ohonynt) oroesi. Tynnodd Mr Ford sylw hefyd at ffynonellau cyllid eraill roedd ei gamp wedi elwa arnynt, gan gynnwys FIFA a'r Loteri Genedlaethol.[16]

O ran yr effaith ar ymarferwyr unigol yn y sector, pwysleisiodd Marcus Kingwell o EMD UK y **bylchau mewn cymorth,** yn enwedig i'r rhai sy'n hunangyflogedig.

Ar 25 Ionawr, cyhoeddodd Llywodraeth Cymru **Gronfa Diogelu Chwaraeon Gwylwyr** gwerth £17.7 miliwn. Mae mwyafrif helaeth y Gronfa hon (£13.5 miliwn) wedi'i ddyrannu i Undeb Rygbi Cymru gyda'r tri phrif faes nesaf – pêl-droed, criced a rasio ceffylau – yn cael rhwng £1,000,000 a £1,500,000 yr un. Dywedodd Llywodraeth Cymru fod y cyllid hwn "yn seiliedig ar y dybiaeth nad yw gwylwyr yn debygol o ddychwelyd mewn niferoedd sylweddol cyn yr haf".[17]

Mewn ymateb i'r pandemig hwn, mae Llywodraeth Cymru wedi dyrannu pecyn cymorth cyllid digynsail i'r sector ac mae'r Pwyllgor yn canmol y ffordd y mae'r sector wedi gweithio gyda'i gilydd i ddosbarthu'r cyllid hwn.

O ran cymorth i'r hunangyflogedig, clywsom am fylchau yn y cymorth a ddarperir ac, er gwaethaf taliadau £1,500 untro – y mae croeso mawr iddynt – o'r Gronfa Gweithwyr Llawrydd Chwaraeon, mae'n amlwg bod pobl hunangyflogedig yn wynebu cyfnod hirfaith arall heb fynediad at incwm. At hynny, rydym yn deall y gall meini prawf gwahanol a gymhwysir i Gam 2 ei gwneud yn anoddach i rai pobl hunangyflogedig hawlio (***gweler gwybodaeth ychwanegol gan EMD UK***).

Argymhelliad 5) Dylai Llywodraeth Cymru ymateb i bryderon EMD UK ynghylch Cam 2 o'r Gronfa Gweithwyr Llawrydd Chwaraeon. Yn benodol, effeithiolrwydd trefniadau i gefnogi pobl hunangyflogedig yn y sector.

Rydym yn croesawu'r cyllid i gefnogi chwaraeon gwylwyr yng Nghymru ac yn cytuno, tra gwaherddir gwylwyr rhag mynd i ddigwyddiadau, y dylai Llywodraeth Cymru barhau i'w cefnogi. Nodwn y dyrannwyd cyfran helaeth o'r cyllid hwn i Undeb Rygbi Cymru a byddem yn croesawu mwy o fanylion am y rhesymeg dros hyn.

[14] Paragraff 55

[15] Paragraff 59

[16] Paragraffau 157 - 158

[17] Llywodraeth Cymru, Datganiad Ysgrifenedig, 29 Ionawr 2021

Argymhelliad 6) O ran y Gronfa Diogelu Chwaraeon Gwylwyr, dylai Llywodraeth Cymru:

- ***roi mwy o fanylion am y rhesymeg y tu ôl i ddyrannu cyfran helaeth o'r Gronfa i rygbi'r undeb;***
- ***cadarnhau a yw'r cyllid hwn wedi'i ailddyrannu o wariant yn rhywle arall neu a yw'n arian newydd;***
- ***cadarnhau'r amserlenni ar gyfer gwneud penderfyniad mewn perthynas ag unrhyw gyllid ychwanegol a grybwyllir yn y datganiad ysgrifenedig ar 29 Ionawr 2021;***
- ***cadarnhau a oes amodau wedi'u hatodi i'r cyllid a ddarperir i gyrff llywodraethu, os felly, sut y bydd Llywodraeth Cymru yn sicrhau y caiff cyllid ei ddosbarthu'n deg ymhlith haenau a lefelau gwahanol o weithgarwch –*** yn enwedig y lefel llawr gwlad.

Clywsom bryderon o'r blaen ynghylch cynaliadwyedd ariannol ymddiriedolaethau hamdden o gofio'r gostyngiad estynedig mewn incwm y maent wedi'i wynebu. Pa asesiad y mae Llywodraeth Cymru wedi'i gynnal o gynaliadwyedd ariannol ymddiriedolaethau hamdden, a pha gymorth ariannol sydd ar gael i helpu'r ymddiriedolaethau y mae arnynt ei angen i oroesi'r pandemig?

Adferiad ar ôl y pandemig i'r sector

Wrth edrych ymlaen at adferiad ar ôl y pandemig, cytunodd rhanddeiliaid y gellid gwneud mwy i gysoni polisi chwaraeon a gweithgarwch corfforol ag iechyd y cyhoedd yn y dyfodol.[18]

Esboniodd Brian Davies fod Chwaraeon Cymru wedi bod yn rhan o drafodaethau ar adferiad COVID ar lefel uchel, ond yr hoffai ef a'r sector gael rôl fwy hanfodol ynddynt.[19] Yn benodol, rhybuddiodd Mr Davies fod cydnerthedd y sector yn y dyfodol yn gysylltiedig ac mai'r hyn nad ydynt am ei wneud yw canolbwyntio ar un peth yn fwy na'r llall, ac yn sicr nid rhywun elitaidd ar draul chwaraeon cymunedol.[20]

Roedd hon hefyd yn thema allweddol yn **ein hadroddiad blaenorol** pan wnaethom alw am fwy o gydweithrediad rhwng y sectorau iechyd a chwaraeon wrth gynllunio ar gyfer adferiad ar ôl y pandemig.

Mae ail don y pandemig wedi golygu bod gwaith cynllunio ar gyfer adferiad ar ôl y pandemig wedi'i ohirio am y tro. Fodd bynnag, mae datblygiadau calonogol ar y gorwel, gan gynnwys cyflwyno rhaglen frechu dorfol.

Dylai Llywodraeth Cymru sicrhau bod adferiad ar ôl y pandemig yn rhoi pwyslais cryf ar fuddion chwaraeon a gweithgarwch corfforol.

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[18] Paragraffau 182, 183, 184

[19] Paragraff 36

[20] Paragraff 44

Argymhelliad 7) Byddem yn croesawu diweddariad ar waith cynllunio Llywodraeth Cymru ar gyfer adferiad ar ôl y pandemig i gynnwys:

- ***manylion ar sut mae'n ymgysylltu â'r sectorau chwaraeon ac iechyd i sicrhau dull cydgysylltiedig o lunio polisïau;***
- ***goblygiadau cyflwyno rhaglen frechu dorfol ar gyfer amserlen adferiad COVID-19;***
- ***pa wersi y mae wedi'u dysgu o'r pandemig am fuddion iechyd ataliol gweithgarwch corfforol. A fydd y profiad hwn yn arwain at newid sylweddol yn y maes hwn ac, os felly, sut y caiff hyn ei gyflawni?***

Senedd Cymru
Y Pwyllgor Deisebau
—
Welsh Parliament
Petitions Committee

Dai Lloyd AS
Cadeirydd y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Senedd Cymru
Tŷ Hywel
Bae Caerdydd
CF99 1SN

10 Chwefror 2021

Annwyl Dai

Deiseb P-05-812 Dylid gweithredu canllawiau NICE ar gyfer trin Anhwylder Personoliaeth Ffiniol

Mae'r Pwyllgor Deisebau wedi bod yn trafod y ddeiseb uchod, yn ddiweddaraf yn ein cyfarfod ar 26 Ionawr.

Gwnaethom drafod gohebiaeth lle nododd y Gweinidog Iechyd a Gwasanaethau Cymdeithasol, er nad yw'n orfodol i sefydliadau'r GIG ddilyn canllawiau clinigol a luniodd y Sefydliad Cenedlaethol dros Ragoriaeth mewn Iechyd a Gofal (NICE), y byddai Llywodraeth Cymru yn disgwyl i bob sefydliad ystyried canllawiau perthnasol NICE. Hefyd, nododd y Gweinidog fod NICE ac Arolygiaeth Gofal Iechyd Cymru (AGIC) wedi llofnodi Memorandwm Cyd-ddealltwriaeth yn ddiweddar ac yn archwilio opsiynau i ystyried gweithredu canllawiau NICE yn fwy systematig fel rhan o'r broses arolygu.

Yn sgil hyn, gwnaethom gytuno i ysgrifennu atoch i ofyn a yw'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon wedi gwneud gwaith craffu ar weithredu canllawiau NICE yng Nghymru, neu a fyddai hwn yn faes y byddech yn ystyried argymell bod angen efallai i'ch pwyllgor olynol edrych arno eto yn y Chweched Senedd.

Hefyd, wrth ysgrifennu atoch, cytunodd y Pwyllgor i gau'r ddeiseb ar hyn o bryd.

Mae rhagor o wybodaeth am y ddeiseb, gan gynnwys gohebiaeth gysylltiedig, ar gael ar ein gwefan: https://busnes.senedd.cymru/ieIssueDetails.aspx?IId=21491&Opt=3.

Os oes gennych unrhyw ymholiadau, cysylltwch â thîm clercio'r Pwyllgor drwy'r cyfeiriad e-bost uchod, neu drwy ffonio 0300 200 6454.

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Yn gywir

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Eitem 4.3

Senedd Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

—

Welsh Parliament
Health, Social Care and Sport Committee

Janet Finch-Saunders AS
Cadeirydd
Y Pwyllgor Deisebau

12 Chwefror 2021

Annwyl Janet

Deiseb P-05-812 Dylid gweithredu canllawiau NICE ar gyfer trin Anhwylder Personoliaeth Ffiniol

Diolch am eich llythyr dyddiedig 10 Chwefror ynghylch y ddeiseb uchod. Yn y llythyr hwnnw, roeddech yn ceisio gwybodaeth ynghylch a yw'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon wedi gwneud unrhyw waith craffu ar weithredu canllawiau NICE yng Nghymru.

Mewn ymateb i'r cwestiwn yn eich llythyr, gallaf gadarnhau bod y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yn ystyried canllawiau NICE lle bo hynny'n berthnasol yn ystod ein gwaith craffu, er enghraifft mewn perthynas â gwaith y Pwyllgor ar **wasanaethau endosgopi** yn 2019, neu'r gwaith ar **strategaeth genedlaethol ddrafft Llywodraeth Cymru ar ddementia** yn 2017.

Yn ein hadroddiad etifeddiaeth, rydym yn disgwyl cynnwys amlinelliad o'r materion y bydd ein Pwyllgor olynol yn y Chweched Senedd o bosibl yn dymuno eu hystyried. Byddwn yn cynnwys cyfeiriad at awgrym y Pwyllgor Deisebau mewn perthynas â gweithredu canllawiau NICE yng Nghymru.

Diolch i chi am ymgysylltu'n gyson â'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon ar y materion trawsbynciol hyn.

Yn gywir,

Dr Dai Lloyd AS

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Cadeirydd y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Eitem 4.4

Senedd Cymru
Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
—
Welsh Parliament
Health, Social Care and Sport Committee

Vaughan Gething AS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

Julie Morgan AS
Y Dirprwy Weinidog Iechyd a Gwasanaethau Cymdeithasol

29 Ionawr 2021

Annwyl Weinidogion

Diolch i chi am ddod i gyfarfod y Pwyllgor ddydd Mercher i drafod effaith COVID-19 ar y sector gofal cymdeithasol a gofalwyr di-dâl.

Yn anffodus, roedd nifer o faterion nad oeddem yn gallu ymdrin â hwy yn llawn yn yr amser a oedd ar gael, felly mae'r Aelodau wedi gofyn i mi ysgrifennu atoch ynghylch y materion hyn. A allwch roi'r canlynol i ni:

1. Manylion unrhyw ymrwymiadau ariannol pellach dros y tyor hwy y mae Llywodraeth Cymru yn bwriadu eu gwneud i gefnogi'r sector, yn benodol i sicrhau bod cartrefi gofal yn parhau i fod yn hyfyw;

2. Gwybodaeth am sut mae Llywodraeth Cymru yn bwriadu gwella mynediad at ofal seibiant i ofalwyr di-dâl yn ystod y pandemig;

3. Eich barn ynglŷn â'r dystiolaeth y mae'r Pwyllgor wedi'i chlywed gan randdeiliaid ynghylch pryderon y gallai'r ffaith bod defnyddwyr gwasanaeth a gofalwyr di-dâl wedi 'ymdopi' gyda llai o wasanaethau gofal a chymorth ffurfiol yn ystod y pandemig gael ei ddehongli fel arwydd bod angen llai o ymyrraeth arnynt gan wasanaethau cymdeithasol yn y dyfodol;

4. Manylion unrhyw fesurau pellach rydych chi'n eu hystyried i hwyluso ymweliadau â chartrefi gofal a sut y byddwch yn asesu effaith mesurau fel llogi podiau ar gyfer ymweliadau diogel;

5. Mae'r Pwyllgor yn nodi bod £250,000 wedi'i ychwanegu at y gronfa cymorth gofalwyr gwerth £1 miliwn. Fodd bynnag, gan fod hon yn dod i ben ym mis Mawrth 2021, a allech roi eglurhad o ba gymorth fydd ar gael ar ôl mis Mawrth i ofalwyr sy'n ei chael hi'n anodd yn ariannol;

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6. Mae'r Pwyllgor yn nodi bod rhai gwasanaethau cymorth i ofalwyr ifanc wedi gallu symud ar-lein yn ystod y pandemig a bod y cerdyn gofalwyr ifanc yn cael ei lansio. A yw Llywodraeth Cymru yn cymryd unrhyw gamau pellach i gefnogi gofalwyr ifanc neu roi seibiant iddynt, yn enwedig y rhai nad ydynt yn gallu mynd i'r ysgol ar hyn o bryd;
7. Gwybodaeth am sut mae gwaith cynllunio Llywodraeth Cymru ar gyfer adferiad ar ôl COVID-19 yn ystyried y goblygiadau ar gyfer gofal cymdeithasol o ganlyiad i:
    - Oedi o ran cynnal asesiadau ac adolygiadau dementia yn ystod y pandemig; a
    - Anghenion a allai godi o ganlyniad i COVID hir.
8. Y diweddaraf ynglŷn â chyflenwadau cyfarpar diogelu personol ar gyfer y sector gofal cymdeithasol. Yn benodol, unrhyw gamau y mae Llywodraeth Cymru yn eu cymryd i sicrhau bod cyflenwad priodol a chynaliadwy o gyfarpar diogelu personol ar gael i ddiwallu anghenion ym maes gofal cymdeithasol o hyn allan.

Byddai'n ddefnyddiol pe gallech ymateb erbyn **15 Chwefror 2021** i helpu i lywio adroddiad y Pwyllgor ar y mater hwn.

Yn gywir

Dr Dai Lloyd AS
Cadeirydd y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Vaughan Gething AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Julie Morgan AS/MS
Y Dirprwy Weinidog Iechyd a Gwasanaethau Cymdeithasol
Deputy Minister for Health and Social Services

Dr Dai Lloyd AS
Cadeirydd y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Senedd Cymru
Bae Caerdydd
Caerdydd
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15 Chwefror 2021

Annwyl Dai,

Diolch i chi am eich llythyr dyddiedig 29 Ionawr. Yn unol â'ch cais, rydym wedi nodi isod ein hymateb i'r materion nad oeddem yn gallu ymdrin â nhw'n llawn yng nghyfarfod diweddar y Pwyllgor.

Manylion unrhyw ymrwymiadau ariannol pellach dros y tymor hwy y mae Llywodraeth Cymru yn bwriadu eu gwneud i gefnogi'r sector, yn benodol i sicrhau bod cartrefi gofal yn parhau i fod yn hyfyw.

Mae gofal cymdeithasol yn flaenoriaeth i Lywodraeth Cymru. Mae Llywodraeth Cymru wedi parhau i roi iechyd a gofal cymdeithasol ar frig y blaenoriaethau ar gyfer cyllideb 2021-22. Awdurdodau lleol sy'n ysgwyddo'r cyfrifoldeb statudol dros ddarparu gwasanaethau cymdeithasol. Mae Llywodraeth Cymru yn rhoi cyllid i'r cyrff hyn drwy'r Grant Cynnal Refeniw; mae cyfanswm o £176m ychwanegol wedi'i ddyrannu i'r setliad llywodraeth leol yn y Gyllideb Ddrafft ar gyfer 2021-22.

Y tu hwnt i'r buddsoddiad craidd hwn, mae gan Lywodraeth Cymru gyllidebau canolog i gefnogi'r sector gofal cymdeithasol a meysydd cysylltiedig. Mae'r rhan fwyaf o'r cyllidebau hyn o fewn y MEG Iechyd a Gwasanaethau Cymdeithasol. Mae Llywodraeth Cymru yn buddsoddi £431 miliwn ychwanegol mewn iechyd a gofal cymdeithasol yn 2021-22.

Byddwn yn parhau i fuddsoddi yn y Gronfa Gofal Integredig am flwyddyn arall gyda chyllideb refeniw o £89m yn 2021-22. Rheolir y Gronfa drwy Fyrddau Partneriaeth Rhanbarthol, gan ddod â gwasanaethau iechyd a chymdeithasol ynghyd i gyflenwi gwasanaethau ar sail anghenion dinasyddion.

Ac ystyried y pwysau sylweddol sy'n wynebu'r sector o ganlyniad i'r pandemig mae'r grant Cynaliadwyedd y Gweithlu Gofal Cymdeithasol wedi cael ei gynyddu o £40m i £50m yn y gyllideb ddrafft ar gyfer 2021-22. Ar hyn o bryd, mae swyddogion yn

adolygu’r meini prawf sydd ynghlwm wrth y cyllid hwn i sicrhau ei fod yn parhau i gefnogi ein hamcanion strategol sy’n ymwneud â chynaliadwyedd y gweithlu.

Gwnaethom weithredu’n gyflym i roi’r cymorth ariannol angenrheidiol i Awdurdodau Lleol i’w galluogi i dalu am gostau ychwanegol darparu gofal yn ystod y pandemig drwy’r Gronfa Galedi, a thrwy ddefnyddio’r dull hwn rydym wedi darparu dros £88m i’r sector hyd yma. Yn ogystal â chefnogi costau staff ychwanegol a darpariaeth gyffredinol drwy godiad cyfradd safonol, roedd hyn hefyd yn cynnwys elfen i gefnogi Awdurdodau Lleol i ymateb i bwysau ar sefydlogrwydd y farchnad i ddarparwyr yn eu hardaloedd er mwyn sicrhau bod y ddarpariaeth yn parhau yn ystod y pandemig. Roeddem hefyd wedi darparu £22.4 miliwn cychwynnol i gefnogi Byrddau Iechyd Lleol gyda gofal iechyd a chymorth ar gyfer gofal iechyd parhaus hyd at ddiwedd mis Medi 2020 ac, ers hynny, rydym wedi ymestyn y ddarpariaeth hon gyda £22.4m arall ar gael tan ddiwedd y flwyddyn ariannol. Ar hyn o bryd, mae’r Gronfa Galedi, a’r cymorth ychwanegol i Fyrddau Iechyd Lleol, yn dod i ben ddiwedd mis Mawrth ond rydym yn cydnabod y pryderon a godwyd am hyn gan bartneriaid yng nghyd-destun pandemig sy’n parhau.

Dywedodd y Gweinidog Cyllid yn y gyllideb ddrafft y byddwn yn adeiladu ar y nifer fach o ddyraniadau ar gyfer ymateb i Covid dros yr wythnosau nesaf ac yn y Gyllideb derfynol, unwaith y gallwn wneud asesiad gwell ynglŷn â’r ffordd orau o dargedu cyllid yn 2021-22. Yn benodol, ystyried pa gyllid ychwanegol sydd ei angen i gefnogi’r GIG a llywodraeth leol wrth iddynt chwarae rhan flaenllaw yn ein hymateb i’r pandemig.

Bydd yr angen am gefnogaeth barhaus ar gyfer gofal cymdeithasol i oedolion yn cael ei ystyried ochr yn ochr â phwysau eraill ar lywodraeth leol yn y cyd-destun hwnnw.

Manylion am sut mae Llywodraeth Cymru yn bwriadu gwella mynediad at ofal seibiant i ofalwyr di-dâl yn ystod y pandemig.

Mae awdurdodau lleol yn parhau i ddarparu ystod o gymorth i ofalwyr di-dâl (gofalwyr) yn unol â’u dyletswyddau statudol o dan Ddeddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014, gan gynnwys sicrhau bod gofalwyr yn gallu cael asesiad o anghenion gofalwyr. Rydym yn disgwyl i awdurdodau lleol barhau i ddiwallu anghenion gofal a chymorth pobl yn ogystal ag anghenion gofalwyr. Mae seibiant i ofalwr yn angen cymwys, ond rydym yn deall yr effaith y mae’r pandemig wedi’i chael ar ddarparu gwasanaethau cymorth lleol wyneb yn wyneb.

Rydym yn disgwyl i ddarpariaeth yn y gymuned ynghyd â mathau eraill o ddarpariaeth gael eu hail-agor cyn gynted â’i bod yn ddiogel gwneud hynny. Mae awdurdodau lleol a’r trydydd sector wedi bod yn hyblyg o ran datblygu ffyrdd eraill o gynnal cyswllt a darparu mathau o seibiant, fel galwadau ffôn cadw mewn cysylltiad a gweithgareddau ar-lein. Fe wnaethom roi £50k ychwanegol i Gofalwyr Cymru i gynnal eu sesiynau cymorth seicolegol MeTime ar-lein, ac mae’r rheiny wedi bod yn boblogaidd. Mae cymunedau a byrddau iechyd lleol hefyd wedi bod yn greadigol ac wedi datblygu dulliau gweithredu amgen; er enghraifft, yn Rhondda Cynon Taf maen nhw wedi defnyddio cyllid o’n dyraniad £1m i Fwrdd Iechyd Lleol Cwm Taf o Gronfa Gofalwyr y Bwrdd Iechyd Lleol i ddarparu’r Prosiect Cefnogi Gofalwyr. Mae wedi bod yn darparu amrywiaeth o weithgareddau, gweithdai a digwyddiadau cymdeithasol er

mwyn helpu i fyw yn ogystal â gofalu, defnyddio'r cyfryngau cymdeithasol i roi cyngor; dosbarthu pecynnau i atal diflastod; gweithgareddau ar-lein fel dosbarthiadau cadw'n heini; gweithdai ar bynciau fel rheoli gorbryder eich plentyn; bwyd a hwyliau gyda maethydd; a phethau hwyl fel rhith-nosweithiau tecawê.

Mae ein Cyllid Gofal Integredig hefyd yn darparu cymorth uniongyrchol i brosiectau sy'n galluogi gofalwyr i fanteisio ar gyfleoedd seibiant a helpu i wella llesiant y gofalwyr eu hunain. Yn 2020-21, roedd gwariant uniongyrchol y Bwrdd Partneriaeth Rhanbarthol ar ofalwyr yn £8.9m. Rydym yn disgwyl y bydd hyn yn cynyddu yn 2021-22 gyda gofalwyr, gan gynnwys gofalwyr ifanc, yn parhau i fod yn grŵp blaenoriaeth o fewn y rhaglen ariannu. Mae'r Cyllid Gofal Integredig felly'n helpu i gyflawni'r tair Blaenoriaeth Genedlaethol ar gyfer Gofalwyr, gan gynnwys "Helpu i fyw yn ogystal â gofalu".

Gan edrych ymlaen at y darlun ehangach o sut mae gofalwyr yn dymuno cael cymorth seibiant priodol ac amserol, mae swyddogion wrthi'n dadansoddi mwy na 80 o ymatebion i'n hymgynghoriad cyhoeddus er mwyn datblygu cynllun cenedlaethol newydd ar gyfer gofalwyr. Cafodd cwestiynau penodol am seibiant a gwyliau byr eu cynnwys yn y ddogfen ymgynghori ac rydym yn ystyried y safbwyntiau hyn ac enghreifftiau o arferion da. Mae ein Grŵp Cynghori'r Gweinidog ar Ofalwyr hefyd wedi bod yn trafod seibiant fel mater allweddol ar gyfer gofalwyr, a byddan nhw'n gweithio gyda ni i weld beth yw'r ffordd orau i sefydliadau'r sector cyhoeddus, y sector preifat a'r trydydd sector ddarparu seibiant a / neu wyliau byr, i ofalwyr o bob oed.

Eich barn ynglŷn â'r dystiolaeth y mae'r Pwyllgor wedi'i chlywed gan randdeiliaid ynghylch pryderon y gallai'r ffaith bod defnyddwyr gwasanaeth a gofalwyr di-dâl wedi 'ymdopi' gyda llai o wasanaethau gofal a chymorth ffurfiol yn ystod y pandemig gael ei ddehongli fel arwydd bod angen llai o ymyrraeth arnynt gan wasanaethau cymdeithasol yn y dyfodol.

O ran y pecynnau gofal cymdeithasol sydd ar gael, hyd yma, yr wybodaeth rydym yn ei chael yw nad yw awdurdodau lleol a darparwyr yn lleihau pecynnau'n systematig. Fodd bynnag, mae'r mesurau diogelu ehangach sydd wedi bod yn angenrheidiol er mwyn cyfyngu ar drosglwyddo'r feirws wedi cael effaith ar sut mae pobl yn cael gafael ar ofal a chymorth. Rydyn ni'n gwybod bod rhai pobl yn dewis gwneud newidiadau eu hunain, oherwydd pryder ynghylch caniatáu i weithwyr gofal ddod i mewn i'w cartrefi a'r risg o haint yn gysylltiedig â hynny. Mae eraill wedi dewis manteisio ar allu teulu neu berthnasau sydd ar ffyrlo, sy'n gallu darparu'r gofal y mae ei angen o fewn y teulu.

Er gwaethaf yr heriau hyn, gwyddom fod unigolion, darparwyr gofal ac awdurdodau lleol wedi bod yn gweithio gyda'i gilydd i ystyried a dod o hyd i atebion eraill er mwyn parhau i ddarparu gofal a chymorth. Os bydd unrhyw un sydd â chynllun gofal a chymorth yn credu bod ei les corfforol neu emosiynol wedi cael ei effeithio'n andwyol yn sgil gostyngiad neu newid yn y gwasanaethau a ddarperir, dylai gysylltu ag adran gwasanaethau cymdeithasol yr awdurdod lleol i drafod hyn ac, os oes angen, i ofyn am adolygiad o'i gynllun gofal a chymorth.

O’r cychwyn cyntaf, mae ein disgwyliadau wedi bod yn glir. Rhaid i awdurdodau lleol gydymffurfio â’u gofynion statudol cyn hired a chyn belled ag y bo hynny’n bosibl. Dim ond os yw hyn yn hanfodol er mwyn cynnal y lefel uchaf bosibl o wasanaethau y dylid rhoi unrhyw newidiadau ar waith, a rhaid i unrhyw newidiadau fod yn rhai dros dro yn unig, yn rhai y gellir eu cyfiawnhau oherwydd amgylchiadau lleol na ellir eu hosgoi, a’u stopio ar y cyfle cyntaf posibl. Mae ein canllawiau statudol yn datgan: rhaid i ofal a / neu gefnogaeth unigolion ddychwelyd i’r trefniadau y cytunwyd arnynt cyn gynted ag y bo modd; ni ddylai’r cyfrifoldeb fod ar unigolion na’u teuluoedd/gofalwyr i sicrhau bod eu gofal a’u cefnogaeth yn cael eu hadfer; ac mae angen i awdurdodau lleol sefydlu trefniadau a rhoi gwybod i’r rhai y bydd hyn yn effeithio arnynt ynglŷn â sut y caiff hyn ei wneud.

Manylion unrhyw fesurau pellach rydych chi'n eu hystyried i hwyluso ymweliadau â chartrefi gofal a sut y byddwch yn asesu effaith mesurau fel llogi podiau ar gyfer ymweliadau diogel.

Mae cyfyngiadau ar ymweliadau â chartrefi gofal wedi bod yn un o ganlyniadau anoddaf y pandemig hwn. Mae’r angen i gydbwyso hawliau pobl a chefnogi eu llesiant â’r awydd i amddiffyn pobl sy’n byw mewn cartrefi gofal rhag y risg o haint yn parhau i fod yn heriol iawn. Mae amrywiolyn newydd y feirws yn ychwanegu at yr her honno ac rydym yn dal i geisio deall ei heffaith. Ein safbwynt ni yw bod yn rhaid i ni, gyda’n gilydd, wneud popeth o fewn ein gallu i helpu pobl i weld eu hanwyliaid mewn ffordd sydd mor ddiogel â phosibl. Byddwn yn parhau i adolygu’r sefyllfa a byddwn yn addasu ein cyngor a’n harweiniad os bydd angen.

Mae Cynllun Rheoli Coronafeirws Llywodraeth Cymru yn rhoi canllawiau ar beth mae pob lefel rhybudd yn ei olygu ar gyfer ymweliadau â chartrefi gofal. Rydym wedi diweddaru ein canllawiau ymweld cenedlaethol manwl ar gyfer darparwyr cartrefi gofal (a gyhoeddwyd ar 1 Chwefror), i’w gwneud yn gyson â’r lefelau rhybudd ac i roi manylion ychwanegol ynghylch defnyddio podiau ymwelwyr yn ddiogel. Rydym yn gobeithio y bydd hyn yn rhoi mwy o eglurder i bawb – unigolion a’u teuluoedd, darparwyr ac awdurdodau lleol – nawr ac wrth i’r cyfyngiadau lacio.

Wrth ddatblygu ein canllawiau i ymwelwyr, buom yn gweithio’n agos iawn gyda’n grŵp ymwelwyr rhanddeiliaid sy’n cynnwys cynrychiolwyr o swyddfeydd y Comisiynydd Pobl Hŷn a’r Comisiynydd Plant yn ogystal â chynrychiolwyr eraill o’r sector, gan gynnwys Iechyd Cyhoeddus Cymru.

Byddwn yn gwerthuso effaith ein rhaglen beilot gwerth £3 miliwn ac rydym yn hapus â lefel y diddordeb a’r ymgysylltiad yn y cynllun hwn hyd yma. Erbyn hyn, rydym wedi dod o hyd i gyfanswm o 101 o bodiau i ymwelwyr drwy’r rhaglen ac mae 93 pod wedi’u gosod mewn cartrefi gofal ledled Cymru. Mae’r rhaglen beilot yn cynnwys hyd at £1 miliwn sydd ar gael drwy’r gronfa galedi i gefnogi darparwyr sy’n dewis llogi eu podiau eu hunain ar gyfer ymwelwyr. Mae ceisiadau am gyllid yn cael eu hasesu fel y'u derbynnir.

Mae'r Pwyllgor yn nodi bod £250,000 wedi'i ychwanegu at y gronfa cymorth gofalwyr gwerth £1 miliwn. Fodd bynnag, gan fod hon yn dod i ben ym mis Mawrth 2021, a allech roi eglurhad o ba gymorth fydd ar gael ar ôl mis Mawrth i ofalwyr sy'n ei chael hi'n anodd yn ariannol.

Un agwedd ar gymorth i ofalwyr di-dâl yw budd-daliadau lles, lle mae ganddynt hawl i'r rhain. Pan wnaethom sefydlu ein Cronfa Gynghori Sengl, roeddem yn mynnu bod darparwyr yn gwirio hawl i fudd-daliadau lles i bawb a oedd yn defnyddio eu gwasanaeth, waeth beth oedd eu problemau cyfredol. Yn ystod y flwyddyn gyntaf, roedd y canolfannau cyngor ynghylch budd-daliadau a gyflawnir drwy'r Gronfa Gynghori Sengl wedi helpu pobl yng Nghymru i hawlio dros £34 miliwn o incwm ychwanegol drwy fudd-daliadau lles. Mae'r incwm ychwanegol hwn yn helpu i godi pobl allan o dlodi, i leddfu eu pwysau ariannol ac, yn bwysig iawn, i roi hwb i wariant mewn economïau lleol ledled Cymru.

Fodd bynnag, gwyddom fod angen gwneud mwy i gyrraedd y grwpiau hynny sy'n methu'n gyson â hawlio budd-daliadau lles, gan gynnwys gofalwyr. Felly, mae partneriaid Cyngor a Mynediad y Gronfa Gynghori Sengl yn cynnal cynlluniau peilot 'Profi a Dysgu' yn chwe ardal y Gronfa, ac yn darparu negeseuon wedi'u teilwra a chymorth i annog y grwpiau sy'n lleiaf tebygol o hawlio'r holl gymorth ariannol y mae ganddynt hawl iddo i fanteisio ar hyn. Dechreuodd y cynlluniau peilot ym mis Hydref 2020 a byddant yn dod i ben ym mis Mawrth 2021, a bydd y gwersi a ddysgwyd yn cael eu rhannu. Yn ystod y 3 mis cyntaf, cyrhaeddodd y cynlluniau peilot 601 o bobl a'u cynghori ynghylch mwy na 1,600 o faterion yn ymwneud â'u hawl i fudd-daliadau lles a'u helpu i gael incwm ychwanegol o oddeutu £1m y flwyddyn. Bydd yr hyn a ddysgir o'r cynlluniau peilot yn cael ei rannu'n eang ddechrau mis Mai, ac yn helpu pobl o grwpiau allweddol, fel gofalwyr, i barhau i hawlio'r holl gymorth ariannol y mae ganddynt hawl iddo.

Mae'r pwysau ariannol ar ofalwyr wedi cynyddu yn ystod y pandemig ac er bod grantiau bach i ofalwyr a theuluoedd unigol yn gallu rhoi rhywfaint o ryddhad i'r rheini sy'n gymwys, fel drwy'r Gronfa Gofalwyr, neu grantiau cymorth awdurdodau lleol, ein cyllid i gefnogi systemau a darparu gwasanaethau yw'r brif ffordd o gefnogi gofalwyr nawr ac yn y dyfodol. Rydym yn parhau i ddarparu adnoddau sylweddol i awdurdodau lleol i'w galluogi i ddarparu'r gwasanaethau a'r gefnogaeth y mae eu cymunedau'n dibynnu arnynt. Yn ogystal â'r Setliad, mae Cronfa Galedi Llywodraeth Leol yn dal ar gael i gefnogi awdurdodau lleol gyda'r costau ychwanegol o ymateb i'r pandemig.

Mae cyllid ar wahân gan Lywodraeth Cymru i ofalwyr yn canolbwyntio ar ddarparu ychwanegoldeb i wasanaethau statudol, ac rydym yn darparu £2.6 miliwn dros dair blynedd (2020-23) i Gofalwyr Cymru, Fforwm Rhieni a Gofalwyr Cymru Gyfan, Ymddiriedolaeth Gofalwyr Cymru ac Age Cymru, drwy ein Cynllun Grant Gwasanaethau Cymdeithasol Cynaliadwy ar gyfer y Trydydd Sector. Nod y pedwar prosiect yw darparu ystod o gefnogaeth i ofalwyr o bob oed yn ogystal â gweithio gyda staff iechyd a gofal cymdeithasol i wella ymwybyddiaeth o'r materion sy'n effeithio ar ofalwyr, a sut i gefnogi gofalwyr yn well. Hefyd, mae ein £1m o gyllid blynyddol i fyrddau iechyd lleol ar gyfer gofalwyr wedi cael ei ddefnyddio yn ystod

2020-21 i helpu gofalwyr sy’n cael trafferth gyda phwysau cynyddol y pandemig, ac rydym yn ystyried y cyllid hwn ar gyfer 2021-22 ar hyn o bryd. Yn olaf, fel y nodwyd uchod, mae gofalwyr yn parhau i elwa ar brosiectau o dan y Gronfa Gofal Integredig ac yn 2020-21 rydym wedi buddsoddi refeniw o £89m a chyfalaf o £35m yn y Gronfa honno. Gan adeiladu ar lwyddiant hyd yma, rydym yn buddsoddi yn y Gronfa Gofal Integredig am flwyddyn arall gyda chyllideb refeniw o £89m yn 2021-22.

Mae'r Pwyllgor yn nodi bod rhai gwasanaethau cymorth i ofalwyr ifanc wedi gallu symud ar-lein yn ystod y pandemig a bod y cerdyn gofalwyr ifanc yn cael ei lansio. A yw Llywodraeth Cymru yn cymryd unrhyw gamau pellach i gefnogi gofalwyr ifanc neu roi seibiant iddynt, yn enwedig y rhai nad ydynt yn gallu mynd i’r ysgol ar hyn o bryd.

Nodwyd yr anghenion a’r materion sy’n effeithio ar ofalwyr ifanc, a gofynnwyd sawl cwestiwn ynghylch sut i wella cymorth a chefnogaeth i ofalwyr ifanc ac oedolion ifanc sy’n ofalwyr, fel rhan o’n hymgynghoriad cyhoeddus a ddaeth i ben yn ddiweddar i ddatblygu cynllun cenedlaethol newydd ar gyfer gofalwyr. Roedd hyn yn cynnwys cynnig am bedwaredd flaenoriaeth genedlaethol newydd i ofalwyr a fyddai’n canolbwyntio ar ofalwyr mewn addysg a gofalwyr cyflogedig. Mae swyddogion wrthi'n dadansoddi’r ymatebion.

Fodd bynnag, ers dechrau’r pandemig, rydym wedi bod yn gweithio gyda sefydliadau gofalwyr cenedlaethol, gan gynnwys Ymddiriedolaeth Gofalwyr Cymru, i ddeall sut yr effeithir ar ofalwyr ifanc. Roeddem yn falch o weithio gydag Ymddiriedolaeth Gofalwyr Cymru, Fferylliaeth Gymunedol Cymru ac eraill i ddatblygu canllawiau ac adnoddau i helpu pob gofalwr i gael gafael ar feddyginiaeth ar gyfer y rheini maen nhw’n gofalu amdanynt. Hefyd, fel dysgwyr agored i niwed, mae gofalwyr ifanc yn dal yn gymwys i ddefnyddio lleoliadau dysgu ochr yn ochr â phlant gweithwyr allweddol. Hyd yn oed cyn y pandemig roeddem yn gwybod bod yr ysgol yn darparu math o seibiant o’r rôl ofalu i lawer o ofalwyr ifanc. Rydym yn parhau i’w hannog i gysylltu â’u hawdurdod lleol i drafod eu hanghenion fel dysgwyr agored i niwed, ac o dan Ddeddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) mae gan ofalwyr ifanc hawl i gael asesiad o anghenion gofalwyr. Tra eu bod gartref, mae amrywiaeth eang o sefydliadau wedi darparu gweithgareddau i’w helpu i gael rhyw fath o seibiant. Mae ein cyllid £1m ar gyfer byrddau iechyd lleol a phartneriaethau gofalwyr wedi cael ei ddefnyddio mewn sawl ffordd gan y partneriaethau hyn i gefnogi prosiectau gofalwyr ifanc. Mae enghreifftiau’n cynnwys dosbarthiadau coginio ar-lein a danfon “pecynnau lles”.

Fodd bynnag, gwyddom fod angen ystod eang o fecanweithiau cymorth i helpu pob person ifanc, gan gynnwys gofalwyr ifanc, yn enwedig gydag anghenion emosiynol ac iechyd meddwl. Yn 2020, gwnaethom gynhyrchu Pecyn Cymorth Iechyd Meddwl Pobl Ifanc a gallant gael gafael ar gymorth drwy wasanaeth llinell gymorth CALL, a gwefan a llinell gymorth MEIC. Ar 1 Chwefror, cyhoeddodd y Gweinidog Iechyd Meddwl, Llesiant a'r Gymraeg y bydd £9.4 miliwn ychwanegol ar gael yn benodol i gefnogi plant a phobl ifanc yng Nghymru, a bydd y cyllid ychwanegol yn cydnabod yr effaith y mae bod i ffwrdd o’r ysgol a rhwydweithiau cefnogi rheolaidd wedi’i chael ar bobl ifanc yn ystod y pandemig. https://gov.wales/pledge-support-youth-extra-ps94m-investment-children-and-young-people-mental-health-services

Gwybodaeth am sut mae gwaith cynllunio Llywodraeth Cymru ar gyfer adferiad ar ôl COVID-19 yn ystyried y goblygiadau ar gyfer gofal cymdeithasol o ganlyniad i:

- ***Oedi o ran cynnal asesiadau ac adolygiadau dementia yn ystod y pandemig; ac***
- ***Anghenion a allai godi o ganlyniad i COVID hir.***

Mewn perthynas ag Asesiadau Dementia, bydd Llywodraeth Cymru yn parhau i fuddsoddi £10m i gefnogi'r gwaith o weithredu Cynllun Gweithredu Dementia 2018-22 y flwyddyn nesaf, gyda'r rhan fwyaf o'r cyllid hwn (dros £9m) yn cael ei ddyrannu i Fyrddau Partneriaeth Rhanbarthol. Rydyn ni'n cydnabod y bydd y pandemig wedi effeithio ar wasanaethau ac felly, ar y cyd â'r Grŵp Goruchwylio Gweithrediad ac Effaith ym maes Dementia, rydyn ni'n adolygu ein cynllun gweithredu presennol i ystyried pa gamau pellach sydd angen eu cymryd.

Hefyd, yn y gyllideb ddrafft ar gyfer 2021/22 rydym yn cynnig darparu hyd at £3m o arian ar gyfer gwella gwasanaethau er mwyn cefnogi gwasanaethau asesu'r cof a'r cymorth cofleidiol hanfodol i sicrhau bod pobl yn cael eu cefnogi wrth iddynt fynd drwy'r broses hon o gael eu hasesu a chael diagnosis.

Yn fwy cyffredinol, rydym yn parhau i ddysgu mwy am COVID hir o ymchwil a phrofiadau pobl. Gwyddom fod pobl yn cael ystod o anawsterau tymor hir ac er bod pob person yn wahanol, mae'r rhain yn cynnwys blinder, diffyg anadl, poen a phroblemau cardiaidd, resbiradol, gwybyddol a niwrolegol. Rydym yn defnyddio dull mwy personol yng Nghymru i ddiwallu anghenion penodol yr unigolyn oherwydd bod ystod mor eang o effeithiau yn gysylltiedig â COVID.

Mae'r Sefydliad Cenedlaethol dros Ragoriaeth mewn Iechyd a Gofal (NICE) wedi datblygu canllawiau clinigol, a gyhoeddwyd ar 18 Rhagfyr 2020: https://www.nice.org.uk/guidance/NG188.

Mae'r canllawiau'n ymdrin â chanfod, asesu a rheoli effeithiau hirdymor COVID-19 ac mae'n defnyddio'r diffiniadau clinigol canlynol:

- **COVID-19 aciwt**: arwyddion a symptomau COVID-19 am hyd at bedair wythnos.
- **COVID-19 parhaus symptomatig**: arwyddion a symptomau COVID-19 am bedair i 12 wythnos.
- **Syndrom ôl-COVID-19**: arwyddion a symptomau sy'n datblygu yn ystod neu ar ôl haint sy'n gyson â COVID-19, ac yn para am fwy na 12 wythnos ac nad ydy diagnosis arall yn gallu eu hegluro.

Yn ogystal â'r diffiniadau o achosion clinigol, mae NICE yn cydnabod bod *'COVID hir'* yn cael ei ddefnyddio'n aml i ddisgrifio arwyddion a symptomau sy'n parhau neu'n datblygu ar ôl COVID-19 aciwt, hy mae'n cynnwys COVID-19 parhaus symptomatig a syndrom ôl-COVID-19.

Cyhoeddwyd Datganiad Ysgrifenedig ar 20 Ionawr yn rhoi'r wybodaeth ddiweddaraf am gamau yng Nghymru i gefnogi pobl sy'n dioddef effeithiau tymor hirach COVID 19: https://gov.wales/written-statement-longer-term-effects-covid-19.

Hefyd, mae'r Grŵp Cyngor Technegol wedi cyhoeddi papur ar 3 Chwefror o'r enw '*Covid Hir – beth ydyn ni'n ei wybod a beth sydd angen i ni ei wybod*?' sy'n dwyn ynghyd dystiolaeth ac ymchwil diweddaraf y DU a rhyngwladol i gefnogi polisïau a gweithredu lleol: https://llyw.cymru/y-grwp-cyngor-technegol-covid-hir?_ga=2.155353787.1807395496.1612862720-2107173052.1588868234. Mae'r papur yn nodi rhagor o gwestiynau ymchwil pwysig i ddeall a monitro effaith COVID hir ar unigolion a gwasanaethau yng Nghymru, ac i ddatblygu llwybrau gofal effeithiol. Bydd angen adolygu'r rhain yn barhaus wrth i anghenion tystiolaeth gael eu diwallu drwy astudiaethau ymchwil parhaus ac yn y dyfodol, ac wrth i feysydd angen newydd ddod i'r amlwg.

Mae effaith yr effeithiau tymor hwy hyn yn effeithio ar bob claf a gwasanaeth ac mae'n ystyriaeth mewn cynlluniau adfer. Rydyn ni eisiau i bobl sydd â syndrom ôl-Covid allu cael mynediad at y rhan fwyaf o'r gwasanaethau sydd eu hangen arnyn nhw – boed hynny'n asesiadau, diagnosis, triniaeth ac adsefydlu – mor agos i gartref â phosibl neu drwy wasanaethau o bell, a dim ond yn gorfod teithio am wasanaethau mwy arbenigol, y mae'n rhaid eu darparu mewn ysbyty aciwt.

Mae adsefydlu yn elfen hanfodol o ofal i bobl sy'n gwella o COVID-19. Mae hefyd yn hanfodol i grwpiau o bobl y mae'r pandemig yn effeithio arnynt yn anuniongyrchol, gan gynnwys y rheini sydd â dementia. Mae hyn yn cynnwys pobl y cafodd eu gofal ei ohirio, y rheini a allai fod wedi gohirio gofyn am gyngor ynghylch problem iechyd, a'r rheini y mae'r cyfyngiadau symud wedi effeithio arnynt, fel y rheini sydd wedi cael eu hynysu neu wedi bod yn gwarchod.

Mae gweithwyr proffesiynol perthynol i iechyd a chydweithwyr wedi bod yn gweithio'n greadigol ac yn gyson i sicrhau bod gwasanaethau'n cael eu darparu'n rheolaidd lle bo hynny'n bosibl drwy gadw mewn cysylltiad â'u cleifion heb anghenion brys, er mwyn rhoi cyngor i'w helpu i ymdopi. Mae gweithwyr proffesiynol perthynol i iechyd wedi rhoi llawer o bethau arloesol ar waith, fel cynnal sesiynau neu grwpiau adsefydlu ar-lein, defnyddio Attend Anywhere ar gyfer ymgynghoriadau, a darparu cymorth seicolegol drwy ymgynghoriadau fideo er mwyn darparu'r cyngor a'r gofal yn ddiogel pan nad ydynt yn gallu gweld pobl wyneb yn wyneb.

Y diweddaraf ynglŷn â chyflenwadau cyfarpar diogelu personol ar gyfer y sector gofal cymdeithasol. Yn benodol, unrhyw gamau y mae Llywodraeth Cymru yn eu cymryd i sicrhau bod cyflenwad priodol a chynaliadwy o gyfarpar diogelu personol ar gael i ddiwallu anghenion ym maes gofal cymdeithasol o hyn allan.

Buom yn gweithio mewn partneriaeth â Phartneriaeth Cydwasanaethau GIG Cymru ac rydym wedi datblygu cynllun strategol ar gyfer caffael cyfarpar diogelu personol. O ganlyniad i'r gwaith hwn mewn partneriaeth, rwy'n falch o gadarnhau bod ein sefyllfa o ran cyfarpar diogelu personol yn parhau i fod yn sefydlog. Cedwir y rhan fwyaf o'r eitemau a argymhellir mewn stoc sy'n ddigon i bara am gyfnod o 24 wythnos a bydd hynny'n wir am bob eitem erbyn diwedd y mis hwn.

Rydym hefyd wedi helpu i hwyluso cytundeb lefel gwasanaeth ar gyfer darparu cyfarpar diogelu personol rhwng Partneriaeth Cydwasanaethau GIG Cymru a

Chymdeithas Llywodraeth Leol Cymru. Mae'r cytundeb hwn yn darparu ar gyfer parhau i gyflenwi 100% o'r cyfarpar diogelu personol a argymhellir ar gyfer gofal cymdeithasol, a fydd yn parhau i gael ei ariannu'n llawn gan Lywodraeth Cymru. Mae'r cytundeb lefel gwasanaeth ar waith tan ddiwedd mis Awst 2021.

Rydym yn parhau i ddilyn y canllawiau Atal a Rheoli Heintiau mewn perthynas â defnyddio cyfarpar diogelu personol mewn lleoliadau iechyd a gofal cymdeithasol – mae'r canllawiau hyn yn cael eu defnyddio ledled y DU ac yn seiliedig ar y dystiolaeth a'r data diweddaraf. Cafodd y canllawiau Atal a Rheoli Heintiau eu hystyried yn ddiweddar yng ngoleuni'r amrywiolyn newydd ac nid yw ein sefyllfa o ran cyfarpar diogelu personol wedi newid yn y canllawiau sydd newydd gael eu cyhoeddi. Bydd y canllawiau, ac o ganlyniad ein sefyllfa o ran cyfarpar diogelu personol, yn cael eu hadolygu'n gyson wrth i ragor o dystiolaeth a data fod ar gael.

Gobeithio bod yr wybodaeth uchod yn ddefnyddiol i chi wrth baratoi adroddiad y Pwyllgor.

Yn gywir

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Eitem 7

Mae cyfyngiadau ar y ddogfen hon

Eitem 8

Mae cyfyngiadau ar y ddogfen hon