**Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Effaith yr ôl-groniad o ran amseroedd aros ar bobl yng Nghymru sy'n aros am ddiagnosis neu driniaeth**

**This response was submitted to the Health and Social Care Committee consultation on the impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment**

**WP 09**

**Ymateb gan: | Response from: Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board**

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## *Health and Social Care Committee – Senedd Cymru*

## *Inquiry into the impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment*

### *EVIDENCE RESPONSE OF CARDIFF AND VALE UNIVERSITY HEALTH BOARD*

Introduction

1. The UHB welcomes the Committee's inquiry into the impact of waiting times backlog on people in Wales. Alongside a clear focus on reducing waiting lists, the UHB is keen to continue to improve on its approach to supporting people whilst they experience delays in accessing planned care as a result of the covid-19 pandemic ("the pandemic").

2. Significant improvements had been made in Cardiff and Vale UHB in terms of the Referral to Treatment (RTT) 26- and 36-week target (Table 1) before the pandemic through a combination of pathway transformation, efficiency gains and capacity expansion. In terms of 26 week waits, whilst performance was consistently sustained at around 87%, this was still below the Welsh Government target of 95%, illustrating that the elective care system was not in balance on a sustained basis before the pandemic.

3. Tables 1-3 illustrate the impact that the pandemic and the ensuing loss of capacity has had on waiting list backlogs. Addressing the backlog and improving access to planned care for patients and communities is a priority for the UHB, although it presents significant operational challenges as recovery is set against the backdrop of the ongoing pandemic, the infection, prevention & control (IPC) measures required to reduce risks for patients and the availability of workforce to support the totality of service requirements (recovery, response and vaccination).

4. Essentially, covid-19 increases the costs of providing normal NHS services and meeting performance targets. The pandemic reduces the service's productivity while increasing the backlog for physical health and mental health services. The pandemic has also exacerbated issues such as mental ill-health, an unsustainable social care system and workforce supply.

5. The pandemic continues to impact across all parts of the health and social cares system. There are three broad categories where the UHB experiences pressures from the pandemic:

    - Services where the UHB has had to reduce its levels of activity in order to reprioritise resources for the covid-19 response,
    - 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,

- Services where demand was suppressed and whether there may be unmet demand which is now emerging as pandemic extends over a prolonged period of time

6. Underpinning all of these service areas is the impact of the pandemic on our workforce, both in terms of their wellbeing in the face of enduring and sustained pressures in all three service areas and in terms of workforce capacity.

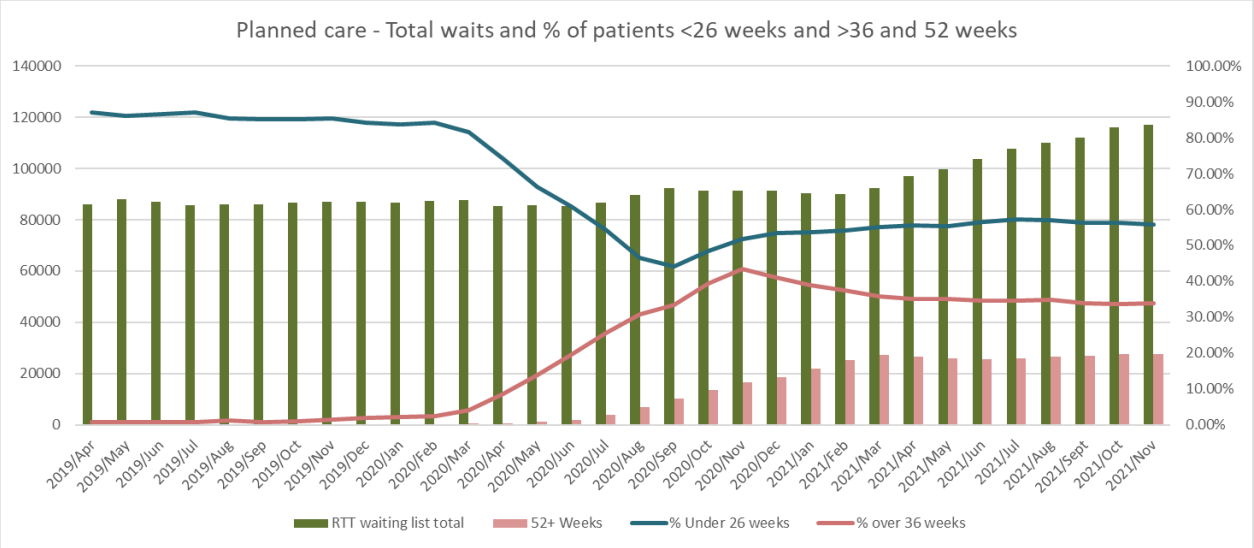
7. Specific responses to the questions are set out below.

## Backlogs and waiting times

**1. What is the current position on backlogs and waiting times within your health board? How were trends in waiting times changing before the emergence of COVID-19, and what effect as COVID-19 had on waiting times?**

8. Table 1 demonstrates the impact the pandemic has had on numbers of patients waiting, % compliance against RTT waiting time targets and the growing volume of long waiting patients. Prior to the pandemic, the overall number of patients waiting for outpatient review or treatment was relatively stable with compliance against RTT at approximately 87% of patients treated within 26 weeks with a small percentage of patients waiting over 36 weeks. Patients waiting excessively long (i.e. over 52 weeks) was consistently low. As a consequence of the pandemic, the position in terms of overall volume of patients waiting, compliance against RTT and long waiting patients has deteriorated. The 36-week and 52-week waits are predominantly driven by the specialities of Ophthalmology, Orthopaedics, General Surgery, Dental, Dermatology, Urology and Gynaecology with the majority of patients in those specialities currently waiting for an initial outpatient appointment.

Table 1 - Referral to Treatment Times (RTT): Total size of waiting lists and % of patients waiting <26 and <36 weeks.

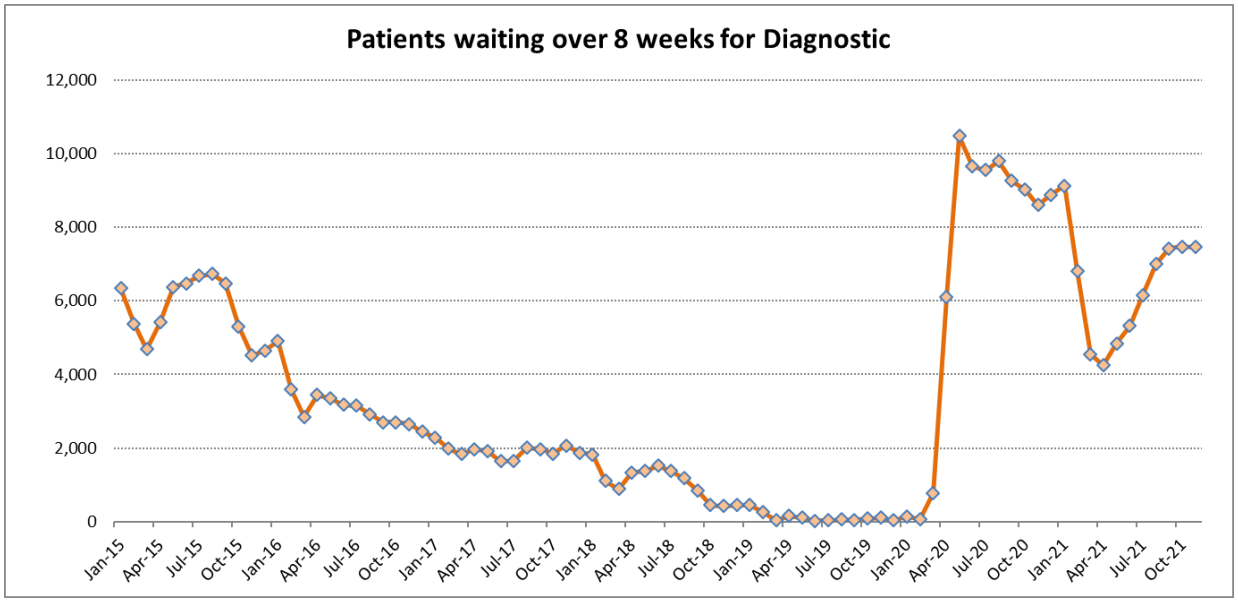


Diagnostics

9. Table 2 demonstrates that pre-pandemic, the diagnostic performance position for the UHB was consistently good, with less than 25 patients waiting over 8 weeks across all specialities and modalities in the months leading up to the pandemic.

10. At the start of the pandemic and as a consequence of the reduction in diagnostic activity, there was a significant spike in the number of patients waiting over 8 weeks, largely driven by patients waiting for radiology. This position has gradually improved through the implementation of service specific recovery plans. The recent rise in long waiting patients is driven by increased pressure on ultrasound and echocardiograms as the pent-up demand for services has started to filter through into the service. A number of additional recovery interventions have been initiated in these services to improve access and bring performance in line with the improvements made in other diagnostic services.

Table 2 – Number of Patients waiting > 8 weeks for diagnostics




**2. What is the anticipated size of the backlog and the pent-up demand from patients who require diagnostics or treatments? Are patients having to wait longer for some specialties than others, and if so, why?**

11. Demand and activity for planned care continues to recover towards pre-pandemic levels. As at end of November 2021, referrals from primary care into secondary care have returned to over 90% of pre-pandemic levels. Outpatient activity, a quarter of which is undertaken virtually, is now 94% of pre-covid levels for new outpatients.

12. The overall RTT waiting list continues to increase from 92,286 in March 2021 to 117,002 in November 2021. There were 39,782 patients waiting over 36 weeks as at end of November 2021.

13. Until such time as activity exceeds pre-covid levels, the waiting list and backlogs will continue to grow. The UHB has, through its recovery plan, continued to grow levels of elective inpatient and daycase activity from 70% of pre-covid levels in June 2021 to around 85% at the end of December 2021. The plans and ambition are to continue that increase in activity levels until end of 2021/22 and into 2022/23 although this is subject to operational pressures and impact of the omicron wave as well as clear funding for the continuation of recovery schemes.

14. There is still a degree of uncertainty regarding the pent-up demand, with variations in the volume and acuity of presenting patients.

15. Size and lengths of wait do vary across specialties, as they did pre-pandemic. In addition, there are variations in returning demand depending on services (for example mental health demand is over 100% compared to pre-pandemic and other specialties are yet to hit 100%). Services are using clinical prioritisation (as per questions 6 & 7) to ensure that the most urgent patients are seen.

Support Services

**3. What services (for example mental health and wellbeing support, pain management support, social prescribing etc) are in place to support people who are waiting for diagnostics and treatment? Given the scale of the current backlogs, how accessible are such support services?**

16. The UHB has a number of services and approaches in place to support patients who are waiting to access planned care.

17. A key part of this approach has been our Prehab2Rehab work. This project promotes an innovative behavioural change approach to health messaging and 'pre-habilitation' style advice for patients on the inpatient waiting list. The aim is to provide robust self-management advice to educate, support and inform patients about general health and well-being whilst they wait (and prepare) for their elective operation. During an initial 12-month period from March 2020, 3135 eligible patients were identified and sent 'nudges' through text promoting healthy behaviour. The majority of the patients who responded, found all the nudges useful and informative, with a health behavioural change reported by 40-72% of people who received each nudge.

18. An important aspect of the Prehab2Rehab project is the https://keepingmewell.com website, developed by a multi-disciplinary team of health professionals at the UHB. Services signpost patients on waiting lists to resources on this website. To improve accessibility, directorates such as general surgery have included links to the website as QR codes on their letters to waiting patients, as seen below.


19. Consistent with the Health Board's approach to pre-habilitation, orthopaedic patients at the early stages of waiting are contacted to join the 'Living Well' programme which advises patients on pain management through medication and health and wellbeing advice including smoking cessation and dietetics. Following pre-assessment, patients are managed by multi-disciplinary teams including occupational therapists and physiotherapists for the 'Prepare Well' programme. Patients are offered a weekly session for 6 weeks which includes an educational element and exercise as part of a group session.

20. Occupational therapists are also assessing the longer waiting patients who have not yet been pre-assessed to join the Prepare Well programme. The Living Well and Prepare Well programmes are not yet at capacity so there is no barrier to access and the programmes are considered as being accessible when the patients have been invited to join.

21. Establishing clear lines of communication is an important part of supporting patients once they are on the waiting list as demonstrated by our cardiothoracic team. Patients who are waiting for cardiothoracic surgery are reviewed by Nurse Specialist Case Managers and provided with contact details for the team. Patients are also given a letter with a clear process on who to contact if they experience a change in symptoms. Contact details are also provided for the secretary of the consultant responsible for their care.

22. Services also signpost waiting patients to appropriate support from the third sector. This is an important aspect of the Mental Health services' approach to supporting patients on waiting lists. Letters sent to patients waiting for Mental Health

treatment include a section signposting patients to suitable charities such as Cardiff and Vale Action for Mental Health, Mind and Beat (a specific eating disorder service).

23. Wellbeing support is also provided through CAVUHB's own Recovery College. The Recovery College provides free educational courses to patients (and staff) on a range of topics covering mental health, physical health and wellbeing. Patients who are waiting are signposted to the website where support is easily accessible Recovery College - Cardiff and Vale University Health Board (nhs.wales). Expansion of this service has been funded from the WG recovery monies.

24. In primary care, there are examples of effective social prescribing which supports patients with their wider lifestyle choices and behaviours which offers significant support, advice and intervention for patients waiting to access secondary cares services.

**4. How are you working with care services and/or the third sector to support patients and their carers and families?**

25. The UHB is engaging with the British Red Cross on the establishment of a "Cardiff & Vale Waiting Well Support Service". This service will support patients on waiting lists for elective treatment through the provision of practical and emotional support, signposting and supported referral in order to help people maintain their independence and improve their ability to better self-manage. Support could take a number of forms, for example welfare telephone support whilst waiting for face to face support / face to face support with follow up welfare telephone support / only welfare telephone support, etc. and would be dependent on individual needs and preferences. It is also anticipated that, by making service users more aware of the support available within their communities and helping them connect to this pre-admission, they will be helped to increase their personal resilience to be able to manage post-discharge. The intention is to establish this service before the end of the March 2022. This service will work alongside the occupational therapy support to long waiting patients referred to above.

26. Many of the services and interventions set out in relation to question 3 include signposting to services and support offered by the Third Sector.

Capacity and resources

**5. What are your views on whether the health board has the capacity and resources required to deal with the current backlog, including the right number of staff with the right skills mix?**

27. Whilst ongoing improvements to elective care had been achieved across the UHB, the NHS has been unable to consistently and sustainably keep pace with the growing demand for elective care prior to the pandemic. This was due a combination of factors such as the non-recurrent nature of funding streams (e.g. RTT monies), insufficient capacity across all parts of the pathway and the competing pressures with the

unscheduled care system. Covid-19 has made the situation considerably more difficult with significant disruptions to elective care.

28. As well as the number of patients in hospital with covid-19, the need to separate/stream patients based on their covid-19 status and to implement social distancing measures has had significant consequences for hospital capacity. Protecting patients and staff with extra infection prevention and control measures has increased the time needed to deliver key diagnostic and treatment procedures, reducing productivity and efficiency in terms of loss of economies of scale. In addition, UHB staff having to take time off work due to covid-19, through sickness or self-isolation, has limited the workforce available to provide care.

29. Furthermore, the planned care system does not exist in isolation from the unscheduled care system which supports the urgent and emergency needs of patients. The workforce often spans both systems, particularly for medical staff and in times of escalation (due to demand increases or capacity shortages in beds/workforce), decisions are taken on risk-based approach as to the redeployment of staff across both systems. In Wales, during the pandemic, the Local Choices Framework provides the basis for this.

30. Therefore, it is too simplistic to consider the capacity to address the backlog in isolation from dealing with some of the systemic demand and capacity issues across health and social care.

31. In terms of the specific question, the UHB has welcomed the investment during 2021/22 provided to support recovery plans. This has been deployed in a number of ways that ultimately support increases in capacity or reduction in demand. In the short to medium term, confirmation of revenue monies over a number of years would improve the UHB's ability to grow the workforce as it is more attractive for staff to apply for permanent positions rather than short term fixed posts.

32. Commissioning additional capacity from the independent sector does provide additional capacity both in term terms of physical resources and workforce, particularly in specialist skill areas such as diagnostics (endoscopy, radiology) and theatres. These solutions enable a flexible and timely approach to providing capacity for a finite period of time to address backlogs. The challenge is the availability of capacity in the independent sector as the whole of the NHS across the UK seeks to access these options.

33. For the longer term there needs to be a national workforce and commissioning plan in place that delivers sufficient skilled workforce across all professions that recognises the changing shape and expectations of the workforce as well as the required skills and capacity required. This will require long term commitments and therefore investment into education and training commissioned places. These need to be underpinned by support for capital investment plans that seek to increase physical capacity such as endoscopy suites and theatres.

Prioritisation

**6. Which services have you prioritised in terms of tackling the backlog?**

34. The UHB has adopted a risk-based approach to prioritisation. At the start of the pandemic, the Royal College of Surgeons developed a set of clinical guidelines to aid decision making in terms of surgery with procedures categorised as priority 1 (emergency surgery), priority 2 (operate within a month), priority 3 (operate within 3 months) and priority 4 (operate > 3months).

35. In order to maintain elective surgery for the highest risk patients, including cancer (priority 2 and 3), the UHB took steps to initiate a Protected Elective Surgical Unit early on in the pandemic called the 'green zone'. This is in effect a 'hospital within a hospital' and we have been very successful in maintaining elective surgical activity for the most clinically urgent patients and now have a stable waiting list position for those patients categorised as priority 2 and priority 3.

36. In terms of priority 4 patients (operate > 3months), we have secured additional capacity at St Joseph's Hospital to begin to deal with the backlog of less clinically urgent patients waiting for treatment. Capacity at St Joseph's has been determined through discussions with the team at St Joseph's and local Health Board clinicians in terms of the range of services that are able to be provided within that facility. This includes some renal procedures, general surgery, urology, ENT, OMFS and orthopaedics.

37. Through our Recovery and Redesign programme, we have secured capital funding to increase capacity for our ophthalmology service (to reduce cataract waiting times) and have commissioned two mobile theatres to undertake high volume cataract operating; these theatres are due to become operational from the start of February 2022.

38. The UHB has also prioritised diagnostics and endoscopy. The diagnostic part of the pathway is critical for many patients as part of their cancer diagnosis. We have therefore invested Welsh Government funding into short term additional capacity to reduce waiting times for high volume diagnostics such as non-obstetric ultrasound and echocardiography. In terms of endoscopy, we have recruited additional staff to increase capacity within the service to undertake additional lists at weekends and equipment to enable us to increase the throughput on lists during the week. We have also procured a mobile endoscopy unit which we are expecting to be commissioned from Spring 2022. These plans are in line with National Endoscopy Programme's priorities.

**7. How are you prioritising people on waiting lists, for example in respect of clinical need and time waiting? Has any consideration been given to taking other factors into account, for example population group or deprivation? Given your local population, what implications might such an approach have?**

39. As noted in the response to question 6, the UHB has adopted a risk-based approach to prioritisation. Patients on waiting lists are prioritised according to clinical need and urgency. However, some of the additional capacity we have secured at St Joseph's for example, was specifically to enable us to start to offer treatment to the longest waiting patients and so prioritisation of those patients has been based on time waiting. Similarly, the additional capacity commissioned through the mobile operating theatres for ophthalmology will enable us to start treating the longest waiting patients for cataract procedures.

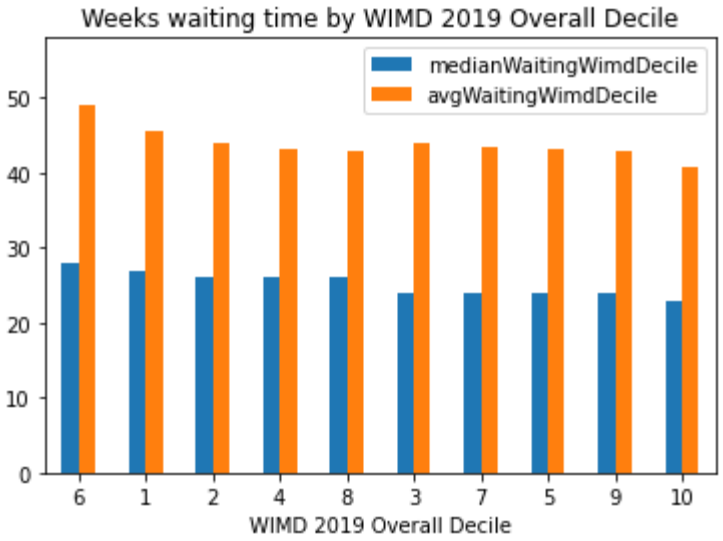
40. The UHB has also embarked on a validation exercise to establish whether patients still require an appointment or whether their symptoms have deteriorated which may indicate the need for an earlier appointment. Initially, we have contacted patients who have been waiting over 52 weeks for a new outpatient appointment, in January we will commence writing out to patients who are waiting for a follow up appointment and in April, we will write out to patients waiting over 52 weeks for treatment.

41. Analysis on was undertaken in September 2021 on the UHB's inpatient waiting list (excluding patients waiting from outside of Wales) using the Welsh Index of Multiple Deprivations (WIMD 2019). WIMD is the Welsh Government's official measure of relative deprivation for small areas in Wales, with 1 highlighting the most deprived and 10 the least deprived areas.

42. At a headline level, the analysis showed that there was no discernible positive or negative impact on inpatient lists when using the WIMD.

43. The chart below shows the median and average waiting time by (WIMD) decile.

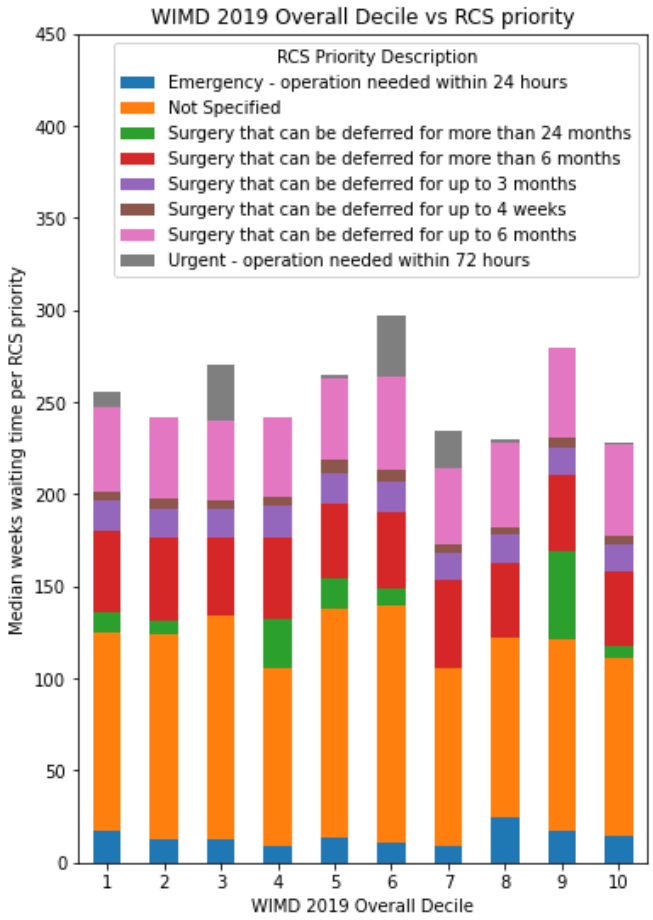
Chart 1




44. The chart shows that there is a fairly even distribution of waiting times within each WIMD decile.

45. The chart below displays the WIMD 2019 decile against the Royal College of Surgeons (RCS) prioritisation categories.

Chart 2




46. There is a fairly even distribution of RCS priorities within each WIMD decile, which suggests there are no inequalities identified.

47. At a service level, there are services we currently provide to certain sectors of the population which we have been able to maintain during the pandemic. For example, within our Specialist Services Clinical Board we have maintained services for patients with disabilities within our Artificial Limb and Appliance Service, and those from a minority ethnic background who access our Sickle Cell & Thalassaemia Service. In terms of Women's services, Obstetrics has continued throughout the pandemic. There are also a number of tertiary emergency services that we have continued to provide for patients from across South Wales, ensuring equity of access for our population, for example for patients with heart attacks, major trauma and sub arachnoid haemorrhage.

48. Working with British Red Cross (as per question 4), our intent is to use the feedback and information provided by the BRC on social circumstances to help support clinical prioritisation.

<u>Information and communication</u>

**8. How are you communicating with people who are waiting for care or treatment and what steps are you taking to ensure that people who are waiting do not feel forgotten?**

49. The UHB recognises the importance of communicating with patients who are waiting to access services and we recently responded to the Community Health Council Report “Feeling Forgotten”.

50. Across the organisation we are communicating with patients waiting for outpatient appointments through our validation team. We have revised our validation approach to not only ascertain whether appointments are still required but to collect important clinical information on symptoms and impact of condition on daily life with the aim of ensuring clinically urgent patients are seen first. This approach is being phased, starting with the longest waiting patients and moving down through the lists until we reach 26 weeks.

51. The development of our external facing website referred to below will be an important component of our communications with patients, carers and GPs on the prevailing position in terms of outpatients, diagnostics and treatments.

**9. Do you have any plans to publish and share information about indicative waiting time for your local population? What challenges or benefits would be associated with this?**

52. A monthly report is shared with GPs which sets out the prevailing wait times across our planned care specialities. For some services this information is shared more widely than GPs, for example, our dental and ophthalmology services share information with local dental and optometrist practices informing them of the patient wait times prior to referring patients for treatments.

53. At an organisational wide level, the UHB is accelerating the development of an external facing website that provides service level information and detail on recovery plans and progress and, where relevant, contact information for more additional information. The website will include information to signpost patients and service users to other sources of support and information on self-care. It is not anticipated that all specialties will provide specific information on how long patients will have to wait as there remain many variables. If and where possible this will be provided.

54. The main challenges of providing very specific information in terms of waiting time include:
    - The unpredictability of future demand and covid waves and decisions made in the context of the Welsh Government Local Choices Framework,
    - The level of suppressed demand in the system that will eventually materialise. What treatment will be needed by those who do is unknown and this uncertainty could have consequences for the time and funding needed to address the elective care backlog,

- Ability of NHS to scale up activity through additional workforce,
- Ability of independent sector to support with short and medium-term solutions in absence of longer-term financial commitments and/or their own workforce shortages,
- The impact of IPC guidance and controls on productivity.

Welsh Government Support

**10. What could the Welsh Government do to support health boards to tackle the backlog and ensure that people who are waiting for diagnostics and treatment get the care and support the need so that their physical and mental health does not deteriorate while they are waiting?**

55. The Welsh Government has already provided welcomed support into the challenge of recovery. Significant amounts of non-recurrent revenue monies were made available during 2021/22 to invest in recovery plans and schemes. The early confirmation of recurrent funding (£22.6m for the UHB) to support planned care sustainability has been crucial in enabling the continuation of key schemes into 2022/23 and beyond. Capital funding has also been critical in enabling some of our key plans for additional capacity. In addition, a number of the national programmes (such as Endoscopy and Outpatients Transformation) have provided valued input to targeted investment, support for benchmarking, national approach to prioritisation and sharing of good practice.

56. In terms of further support, there are some national policy positions that would support health boards even further in tackling the backlog:
    - Realism about the time it could take to bring waiting lists down to manageable levels,
    - Confirm recurrent revenue monies in recognition of the above and to enable planning across multiple years (not just in planned care),
    - Create a multi-year capital funding settlement for the NHS - continue to support recovery priorities with capital investment and a process to access capital investment that is responsive and agile.
    - Support with national communications to help manage expectations of public and stakeholders,
    - Be clear on currency and measure of recovery and not bring in targets mid-year,
    - Recognition that until a comprehensive workforce plan is delivered and the impact felt then a blended approach to NHS and independent solutions will be required,
    - Enable a degree of local determination of the nature of capacity solutions in recognition of differences in baseline capacity, workforce availability issues and geographic characteristics,
    - Recognise that recovery is not just treatments, outpatients and diagnostics but is required (and needs funding) across the whole system, including primary care and mental health,
    - Investing in workforce growth and retention is key. The NHS workforce has worked tirelessly to fight COVID-19 and protect our communities during the pandemic. As a result, there is a risk of burnout and increased numbers of staff leaving. Accelerating development of a national workforce plan with associated

commissioning of education and training in place to secure a more sustainable workforce.

## Effectiveness of the Welsh Government's Health and Social Care Winter plan 2021-2022

**11. How well are health and care services coping, including any particular pressure points and areas of concern as we move further into winter?**

57. At the time of submission (January 2022), system wide operational pressures have continued and are significant, resulting in access and/or response delays at a number of points in the health and social care system. More detail of specific service areas are as follows:

58. Essential services – The Health Board has continued to maintain all Urgent and emergency essential services, including hospital unscheduled care, primary care, cancer treatments and urgent and emergency surgery.

59. Unscheduled Care - There are a combination of three factors contributing to the acute pressure we are experiencing:

- While non-covid demand has returned to previous levels (not greater than previous), bed occupancy within hospitals is extremely high. This is resulting in poor hospital and system flow resulting in delays. Our data analysis indicates that the high hospital occupancy is being driven by the inability to achieve timely discharge – as opposed to an increase in demand. This is partly being driven by the challenges in social care, including significant challenges within the domiciliary sector set against unprecedented demand; reduced access to care home beds (covid impact) and community resource capacity; and the ongoing challenge to meet the COVID 19 impact in residential and social care settings.

- The uncertainty regarding covid demand and ongoing IP&C requirements to minimise nosocomial spread results in the Health continuing to operate in an increased level of complexity – with requirements to stream and separate pathways. The emergence of Omicron has presented a significant challenge to the Winter Plans. Attendances, admissions and occupancy have risen, particularly since Christmas. The Health Board has had to be agile in rebalancing and increasing its capacity.

- Significant and sustained workforce fatigue is also a factor and, with the emergence of Omicron, both health and social care have experienced a high number of staff absences due to COVID – on top of pre-existing staffing challenges.

60. The Health Board, in conjunction with its partners, has continued to implement a range of actions – those outlined in the Integrated Winter Plan, some in the Health Board's Recovery Plan and others as part of day to day operational management. On the whole, these measures have allowed the Health Board to continue its Planned Care recovery plan at a system level. However, in January specifically, the Health Board

has reduced some non-urgent elective activity in line with the Welsh Government 'Local Choices Framework' to release staff and physical capacity to support the unscheduled care operational pressures.

61. Primary care and community services - As with other parts of the system, services continue to experience significant pressures. An increased number of practices are reporting higher escalation levels. The Health Board is also supporting a small number of practices with a range of sustainability issues and implementing plans for two practices that will not be continuing with their contract. Dental services continue to deliver 40% of pre-covid activity. Optometry has now returned to pre-covid levels. Community pharmacy has remained opened and is supporting with delivery of the mass vaccination programme.

62. Mental Health services – The demand pressures seen within physical health are reflected and further accentuated within our Mental Health services and demand for adult and children's mental health services remains significantly above pre-covid levels. There have also been similar challenges experienced with workforce fatigue and absences and an increased level of complexity for inpatients with the requirement to stream and manage covid and non-covid patients separately.

12. **What are your views on the effectiveness of this year's approach to winter planning, including the timing of the Welsh Government's winter plan and associated planning at regional/local level. Are these sufficiently joined up?**

63. It is understood that this year presents a particularly unique and challenging environment in which to plan for Winter. Historic seasonal trends have not been observed but there has been sustained operational pressure across Health and Social Care. The ongoing response to pandemic combined with continued recovery of planned care services and the emergence of additional pressures such as RSV have meant that many of the usual winter plans (beds, community resource teams, decision makers) were already been implemented far in advance of winter to address the pressures.

64. In this context, the Welsh Government's Winter Plan approach provided a high level, clear and focused view of the priorities. Initial indication was that funding for winter schemes would likely come from the existing covid response allocations. Subsequently additional funding was confirmed on 26th October via the Regional Partnership Board (RPB). Earlier confirmation of the funding, and the publication of the winter guidance, would have been valuable to allow for additional planning.

65. Winter planning was again led by RPBs and as such include contributions from the UHB, Social Care, WAST, Third Sector, etc. These proposals were developed and signed off via Joint Management Executive as such are comprehensively joined up at a local, cross sector level.

66. The system leadership response to the operational pressures has also been joined up at a local, cross sector level. In December 2021, an existing Leadership Board consisting of organisational Chairs / Leaders and Chief Executive Officers across system stakeholders such as health, local authority and the police agreed to transition to a Board/Executive level system escalation group for future meetings – in response to the system pressures. Frequency was increased to weekly.

## 13. **What lessons can be learned from this year's approach?**

67. Given this year has presented a particularly unique and challenging environment in which to plan – and specifically that at the time of this submission winter and the pandemic challenges are still ongoing – it would be helpful to take stock on the overall effectiveness of this year's approach in April / May. On a national basis, it would be helpful if this could be done in conjunction with all system partners through a winter planning review session. Lessons learnt from this should inform next year's national approach and guidance. At a local level, this review forms a critical part of the Health Board's Annual Winter Planning cycle.

68. Ahead of that, the initial view is that earlier publication of the national guidance and earlier confirmation of funding, ideally recurrent, would be beneficial.