Appendix 1 – Planned Care Recovery Documents

1. Elective Care Recovery Portfolio Board: Terms of Reference

1.0 Introduction

The purpose of this document is to define the terms of reference for the Elective Care Recovery Portfolio Board.

As the impact of the Covid pandemic becomes clearer, the Health Board have commenced detailed planning and (where appropriate and according to changing Infection and Prevention Control guidance) restarting of elective activity.

To oversee the development, implementation and delivery of plans for the restart of elective activity the Elective Care Recovery Portfolio Board (the Portfolio Board) has been convened.

2.0 Remit and Responsibilities

This multi-disciplinary Portfolio Board is responsible for the leadership, influence and support to drive the elective care recovery programmes of work forward and will deliver in line with the Health Board's operational objectives to:

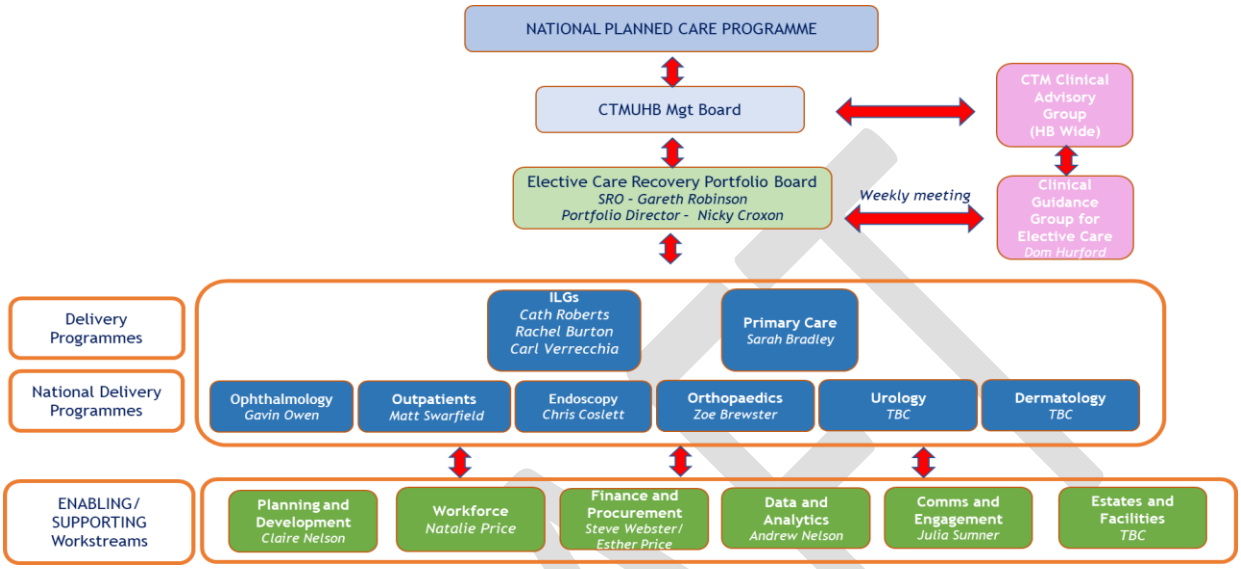
- Improve quality, safety and patient experience.
- Protect and improve population health.
- Ensure that the services provided are accessible and sustainable into the future.
- Provide strong governance and assurance.
- Ensure good value based care and treatment for our patients in line with the resources made available to the Health Board.
- Develop a motivated and sustainable workforce.
- Carry out a thorough evaluation throughout this portfolio.

The Portfolio Board will meet weekly initially to agree detailed activities and to support the development and implementation of the associated Recovery Plan (the plan). The Portfolio Board will also monitor delivery via a combination of highlight reports and associated trackers. Once per month, when closed down financial and activity is available a dedicated session will be held to review the signed off positions (ie tracking of activity benefits and drawn down financial position). Furthermore, a written report will be provided to the CTM Health Board Management Board each month.

Each ILG will be represented by a member of the Senior ILG Team (Director of Operations or equivalent). In addition, the Portfolio Board will include key representatives from all parts of CTM UHB required to help deliver the final plan. Co-ordinated by the Portfolio Director, this team will support the development of the ILG and overall CTM UHB recovery plan.

3.0 Work stream & Governance Structure

The programme work stream and reporting structure is illustrated below. As the portfolio develops and matures the work streams and delivery programmes may be subject to change. Any substantial changes will be detailed in a future iteration of the terms of reference.



4.0 Procedural Arrangements

Quorum – The meeting will be regarded as quorate when attended as a **minimum** by

- Senior Responsible Office or Chair
- 2 delivery programme leads,
- 1 finance representative,
- 1 National Delivery Programme lead.
- 1 Enabling/Supporting work stream lead.

Chair – Portfolio Director (or nominated deputy).

Attendance – Most meetings will be conducted virtually.
Appropriate deputies may be sent when members are unable to attend. These deputies must be briefed and provided with the documentation relevant to the meeting by the group member.

Secretariat – Provided by Programme Management Office

Frequency of meetings – Initially Weekly. This will be adjusted in line with portfolio requirements

Reporting

The Chair shall:

- Report formally to the Senior Responsible Office on the Portfolio Boards activities. This includes updates on activity, written reports as well as the presentation of detailed plans ; and

- Bring to the Executive Board's attention via the SRO any significant matters under consideration by the Portfolio Board.

6.0 Review

These Terms of Reference will be reviewed as significant issues arise.

Date	29/06/2021
Author	Nicky Croxon
Version	0.2
Status	Second Draft

2. Planned Care Recovery Portfolio Board agenda/ documents-

The following is an example agenda which has been used in the Planned Care Recovery Portfolio Board-

Agenda

- Apologies received from: Rachel Burton, Nicola Milligan, Esther Price, Chris Coslett
- Showcase trackers
  - Workforce
  - Finance
  - Activity
- Discussion re paediatrics
- Programme Highlight Reports
  - Escalations for action only
- Outstanding actions
- AOB

The following is an example of a highlight report which has been presented to Board, each work stream presents a highlight report weekly at the Planned Care Recovery Portfolio Board-

Primary Care Schemes: Shared Care*Glaucoma//Dental Urgent Access*

KEY CELL OBJECTIVES:

- Development/implementation of primary care pathways to provide assessment/treatment to 'low risk' patients identified by hospital services as appropriate to receive care in a primary care setting, pathways will support reduction of hospital waiting times/provide care closer to home\utilising skills of primary care practitioners.
- Provision of Urgent Dental Care within required timescales.

GOOD STORIES:

MOS scheme stood down as backlog addressed. Funding transferred to support additional in hours for dental sessions. This has commenced, this enables timely access to dental care for patients that do not have access to a regular dentist.

OVERALL RAG

AMBER

STATUS UPDATE/ ACTIONS TAKEN by Workstream:

Workstream	Status Update	RAG
1. Glaucoma	• 5 x further practices in process of having PSBA links set up, anticipated 2nd practice to go Live end July/Aug • Support documentation to be developed to provide optometrists on scheme with guide to support. • Zeiss to be granted 'code of connection' to CTM Systems – (IT leading) • Viewing PC required for specsavers- discussions with IT required on how this can be supported	GREEN
3. Dental Urgent Access	• 14 x practices to provide additional in hours access sessions /Rota confirmed- new sessions commenced 15.06.21 • Additional OOH triage/treatment sessions yet TBC and included into existing rotas • Engagement required with 111/OOHs service to devise new rotas when additional OOH sessions agreed	AMBER

KEY METRICS:

Measure		RAG			
Target no. of patients identified to be assessed in primary care	No of assessments Undertaken: (Specsavers Merthyr) 15 May/June	No of assessments: (Mountain Ash)	No of assessments: (Davies and Jones Porth)	No of assessments Davies and Jones (Talbot Green)	No of assessment (Bridgend practice TBC)
5,500	40 x assessed 9 x booked in 31 x waiting VR in HES	Go Live due Aug	Go Live date TBC	Go live date TBC	Go live date TBC

ESCALATIONS/DECISIONS TO BOARD:

RISKS/ISSUES:

Risks/Issues	Description & Mitigation	RAG
Risk 1 –IT/Zeiss support	Glaucoma: Draft documentation being written to support practices during/after going live with scheme	GREEN
Risk 2- Patient experience	Confusion for patients in charge of pathway. Communication to patients agreed.	Amber

3. Recruitment tracker-

The following provides an example of the recruitment tracker that is being implemented to track and monitor recruitment against the Planned Care recovery schemes-

UIN	Status	Specialty	Group	Description	Recruitment : FTE and banding	Additional Hours & Overtime: FTE	Assurance Level	Target date in post	Estimated date in post	Comments	Mitigating Actions	Assumed months	FYE	PYE
RTE 3		Urology	Additional sessions	Virtual FUNB Clinics (12 sessions)								6	£ 8,604.00	£ 4,302.00
RTE 4		Urology	Additional sessions	Theatre Backfill 50 sessions								6	£ 35,850.00	£ 17,925.00
RTE 5		Gastroenterology	Additional sessions	JH & DK WLI new urgent sessions 13th, 20 & 27th March & assumed 1 Saturday session each per month thereafter for 5 months								6	£ 10,754.56	£ 5,377.28
RTE 6		Pharmacy	Recruitment: Other Health Professionals	Dedicated Pharmacist to Green ward area Band 7								6	£ 49,068.00	£ 24,534.00
RTE 7		General Surgery	Recruitment: Medical Staff	Medical clean ward cover								6	£ 32,000.00	£ 16,000.00
RTE 8		General Surgery	Recruitment: Medical Staff	New Anaesthetist for additional theatre activity including new including backfills etc. (Locum as interim)								6	£ 168,000.00	£ 84,000.00
RTE13		Diabetes	Recruitment: Medical Staff	Extension of current locum contract (April - Oct 21)								6	£ 136,578.00	£ 68,289.00
RTE14		COTE	Additional sessions	Parkinson's newFUP WLI's 6 sessions (March 21)								3	£ 6,300.00	£ 3,150.00
				Locum consultant appointed for 6 months (01.03 - 31.08.21) to release										

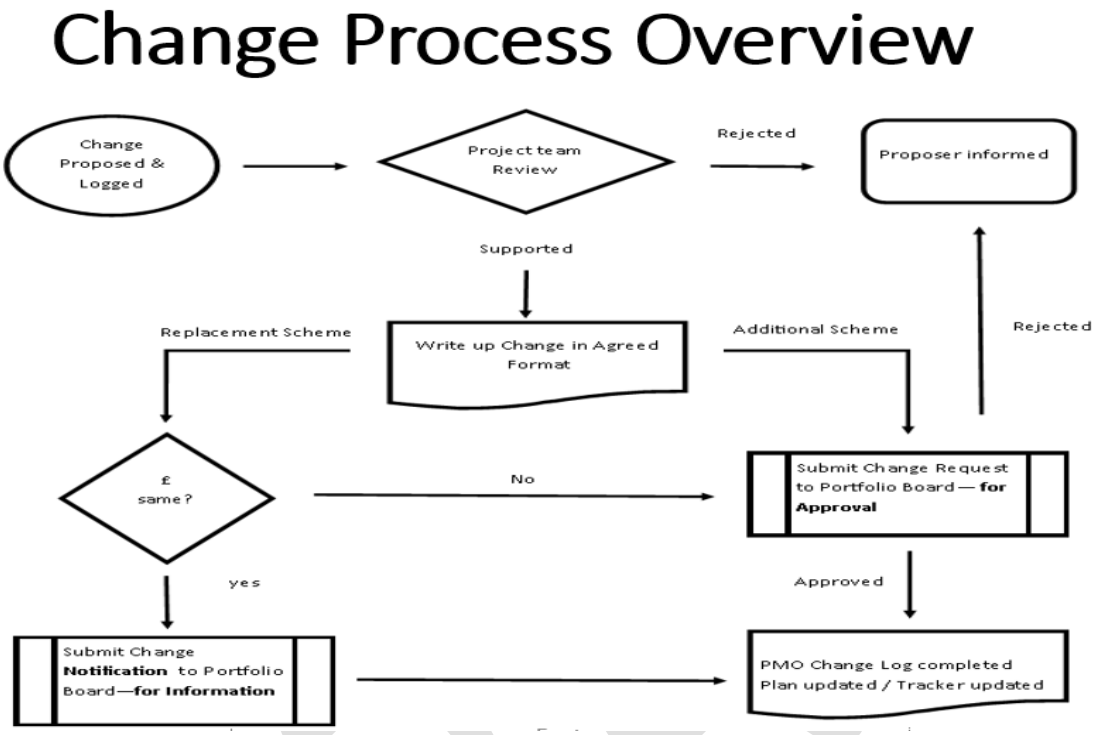
4. Finance tracker-

The following provides an example of the finance tracker that is being implemented to track and monitor expenditure against the Planned Care recovery schemes-

	Phasing of Plan			Annual Plan	1.0		2.0		3.0		4.0	
ID	Scheme	CSG	Specialty		Plan	Forecast or Actual	Plan	Actual	Plan	Forecast or Actual	Plan	Forecast or Actual
				£k	£k	£k	£k	£k	£k	£k	£k	£k
1	3 Super Weeks x2		Flexi	45.00								
2	New cancer backlog	General Surgery	Breast	22.00					3.67	3.67	3.67	3.67
3	Virtual FUNB Clinics (12 sessions)	General Surgery	Urology	4.30			0.72		0.72	1.43	0.72	0.72
4	Theatre Backfill 50 sessions	General Surgery	Urology	17.93	2.99		2.99		2.99	2.99	2.99	2.99
5	JH & DK WLI new urgent sessions 13th, 20 & 27th March & assumed 1 Saturday session each per month thereafter for 5 months	General Surgery	Gastroenterology	5.38	1.08		1.08		1.08	1.08	1.08	1.08
6	Dedicated Pharmacist to Green ward area Band 7	Pharmacy	Pharmacy	24.53					4.09	4.09	4.09	4.09
7	Medical clean ward cover	General Surgery	General Surgery	16.00	2.67		2.67		2.67	2.67	2.67	2.67
8	New Anaesthetist for additional theatre activity including new including backfills etc. (Locum as	General Surgery	General Surgery	84.00				2.12	14.00	0.00	14.00	14.00
10	Potential for Saturday OPD clinics	General Surgery	General Surgery	16.50	2.75		2.75		2.75	2.75	2.75	2.75
11	General Surgery weekend day case lists - fortnightly (9mths) 35 sessions	General Surgery	General Surgery	45.00							7.50	7.50
13	Extension of current locum contract (April - Oct 21)	Acute Medicine	Diabetes	68.29	11.38		11.38	11.38	11.38	0.00	11.38	11.38
14	Parkinson's new/FUP WLI's 20 sessions (March 21)	Acute Medicine	COTE	3.15	1.05		1.05		1.05	1.50	0.00	1.50

5. Service change process-

The following diagram describes the process for any proposed changes to the agreed Planned Care Recovery schemes-



6. Planned Care Recovery Portfolio– DRAFT Equality Impact Assessment

Introduction
The aim of this document is to provide a high level impact equality impact assessment enable project leads to ensure that the re-set of services complies with Equality legislation by meeting the needs of each of the protected groups under the Equality Act 2010.

Full consideration should be given to the negative experience of different groups during the Covid crisis and every effort should be made to improve their access and experience in the future provision of services.

The multi-disciplinary Planned Care Recovery Portfolio is responsible for the leadership, influence and support to drive the associated programmes of work forward and will deliver in line with the Health Board's operational objectives to:

- Improve quality, safety and patient experience.
- Protect and improve population health.
- Ensure that the services provided are accessible and sustainable into the future.
- Provide strong governance and assurance.
- Ensure good value based care and treatment for our patients in line with the resources made available to the Health Board.
- Develop a motivated and sustainable workforce.
- Carry out a thorough evaluation throughout this portfolio.

The Portfolio Board oversees the detailed activities to support the development and implementation of the Elective Care Recovery Plan. The Portfolio Board will also monitor delivery.

Equality Impact Assessment –

Section 1 – Preparation		
1.	**Title of Policy/service**	Planned Care Recovery Portfolio
	Is this a new service or an existing one? This is a service review.	Choose an item.
2.	**Service Aims and Brief Description**	Review of current services to enable re-start following Covid pandemic. Short, medium and long term plan
3.	**Who Owns/Defines the Service?** -	The Planned Care Recovery Portfolio Board
4.	**Who is Involved in undertaking this EqIA?**	Michael Dickie, Head of PMO Paul Williams, Programme Manager Liz Jenkins, EDI Manager

Section 1 – Preparation		
5.	**Other Policies and Services** -	This programme is relevant to the Integrated Medium Term Plan. It covers all services delivered by the health board.
7.	**What might help/hinder the success of the policy/service?**	Managers' commitment (due to time constraints etc.) and understanding of the process.
8.	**Is the policy/service relevant to "eliminating discrimination and eliminating harassment?"**	The re-started services will identify and take account of potential barriers for protected groups under the Equality Act 2010 and aim to address them. This will be particularly relevant in relation to the outsourcing of services, the move to remote consultations and access arrangements (telephone and Attend Anywhere), digitisation generally and relocation of services. It will be essential to avoid indirect discrimination where some protected groups are unable to access new systems and locations.
9.	**Is the policy/service relevant to "promoting equality of opportunity?"**	We will ensure that our services are accessible to different groups. The needs and issues in relation to each protected group are considered later in this document. We will endeavour to address existing barriers wherever possible.

Section 1 – Preparation		
10.	**Is the policy/service relevant to "promoting good relationships and positive attitudes?"**	By taking account of the needs of each group and setting standards, this will encourage good relationships. Training will be provided in order to increase staff understanding.

Section 2. Impact
All service EIAs must take account of national and local population data and other information in relation to relevant organisations (e.g. partners, Third Sector organisations etc), staff groups, individuals etc. **The following general considerations should be addressed as part of the overall approach but also by individual services:** Digital systems and risk of exclusion. Attend Anywhere – consider traditional alternatives for those who may be digitally excluded but promote use of interpreters on calls and other benefits. A specific EIA should be undertaken for this – possibly an overall one for remote consultation. Phone consultation – positive to avoid travel etc. for many groups but not suitable for Deaf, speech impaired etc. Promote 3 way interpretation and face to face appointments with interpretation support. Text and remind has proved problematic for some groups and a specific EIA should be undertaken for this. Accessible appointments – being able to receive appointment letters in large print or electronically, not having to phone as part of partial booking etc. are all of fundamental importance going forward. Accessible buildings – we need to ensure that all of our Primary and Secondary Care premises are accessible to people with physical, sensory and/or learning disabilities including autism and dementia. Accessible information – communications, websites and promotional material must be bilingual, available in different formats and languages. Easy Read should be offered wherever possible. *Please check out the guidance on our EIA SharePoint Page.*
Do you think that the policy/service impacts on people because of their age? (This includes people of any age but typically focusing on children and young people up to 18 and older people over 60) Old age often intersects with disability e.g. sensory loss (particularly hearing), mobility problems. Digital exclusion is a greater risk so it is important in particular to ensure there are alternatives where required for older people who may not use modern technology e.g. for on-line appointments, virtual visiting etc.

Telephone appointments – consider alternatives for those who cannot communicate effectively by phone.

Accessible buildings and signage – can patients access buildings, rooms, facilities, is signage clear and understandable, are there hand rails and resting points (seating etc) in each of our buildings.

Accessible appointments, communication and information – availability of different formats and fonts for all of our written correspondence. Are comms undertaken in different formats without over reliance on one type of media e.g. posters in waiting rooms should be supplemented by recorded messages or staff communication.

Increased or more challenging travel – provision of help with transport for groups less likely to own or drive cars.

Do you think that the policy/service impacts on people because of their disability? (This includes sensory loss, physical disability, learning disability, some mental health problems, and some other long term conditions such as Cancer or HIV)

All services must consider how people with a range of disabilities will be potentially affected. This could include mobility in terms of access to different sites, people with sight loss or learning disabilities being able to negotiate new surroundings, people with hearing or communication difficulties being able to access telephone based services or intercom systems. The booking of appointments particularly in Primary Care is particularly challenging. The provision of interpreters is essential for British Sign Language Users and appointments should not be made for Deaf people 'out of hours' i.e. on evenings or weekends when interpreters would be unlikely to be available. Add language line info here

Digital exclusion – identify alternatives to on-line interpretation and telephone contact as above where necessary. Text and remind can prove particularly challenging for people with sensory loss

Accessible buildings account must be taken of accessible signage which takes account of RNIB requirements, areas must be well lit, trip hazards avoided etc. Quiet areas should be available for people with autism and their individual needs considered when attending appointments.

Accessible appointments, communication and information – appointment letters must be available in accessible formats e.g. e-mail, large print, audio, Braille, Easy Read etc. Alternatives must be offered in communications e.g. reliance on one type of media risks excluding some groups. The use of hearing equipment must be encouraged and interpretation resources fully utilised and use of family members for interpretation actively avoided (link to leaflet)

Increased or more challenging travel – some groups have particular challenges with public transport e.g. if they rely on guide dogs who will have learned specific routes.

Promotion of Easy Read and dementia friendly and autism friendly resources.
Does the policy impact on people because of their caring responsibilities? Do you think that the policy/service impacts on people because of their caring responsibilities? I.e. would it affect their ability to care for somebody who is primarily dependant on them? This could include family members but not necessarily. E.g. if a children's service is relocated, how would that impact on the parents' ability to care for other family members. The relocation of services can particularly impact on carers if there is increased distance and difficulty of journey and increased travel time if the service is no longer local.
Do you think that the policy/service impacts on people because of Gender reassignment? (This includes all people included under trans* e.g. transgender, non-binary, gender fluid etc.) All services should ensure gender neutral literature, language, images, files, forms etc This includes gender neutral job titles and asking patients how they want to be addressed. Reflection of same sex relationships in also relevant. Greater sensitivity in some services e.g. maternity or paediatrics if trans* people are pregnant or parent, and Sexual Health. Lots of information on working with Trans* patients is available in the Trans* Toolkit. Consideration must be given to gender neutral facilities particularly in new builds or refurbishments. Care must be taken to use names and pronouns correctly and to avoid 'dead naming' particularly if previous records are used. Consideration must be given to when a service treats men and women differently or separately (e.g. single sex bays on a ward) how will Trans*individuals are included? Each service must ensure that Trans* individuals maintain privacy and the right to gender expression. Is language gender neutral and are specific provisions made for their needs.
Do you think that the policy/service impacts on people because of their being married or in a civil partnership? Impacts in this area are rare, but it can intersect with gender discrimination. Whether an individual is married or not should not impact any aspect of the way they are treated. This is an issue of 'due regard'.
Do you think that the policy/service impacts on people because of their being pregnant or having recently had a baby? (This applies to anyone who is pregnant or on maternity leave, but not parents of older children)

Impacts in this area are rare, but it can intersect with gender discrimination. Whether an individual is married or not should not impact any aspect of the way they are treated. This is an issue of 'due regard'.

As above, impacts in this area are rare, but again can intersect with gender discrimination. However it may be difficult to attend appointments and in many cases digital and remote services could be helpful.

It is important to also consider staff who are on maternity leave when changes are made.

Do you think that the policy/service impacts on people because of their race? (This includes colour, nationality and citizenship or ethnic or national origin such as Gypsy and Traveller Communities, Welsh/English etc.)

It is essential to consider that people might be affected as they are marginalised within communities or because of language barriers

All services should make use of interpretation services – all staff must be aware

Account must be taken of cultural sensitivity – see toolkit and consider specifics – see below where there is an inter-section with religion.

Language and imagery – is it appropriate, sensitive and understandable (Plain English), are images multi-cultural. Do services take account of colour e.g. 'flesh coloured' items, prosthetics in different colours, recording patients reactions e.g. monitoring skin responses such as rashes or turning blue.

Attention must be paid to ensuring service reach – are different communities marginalised? Does information reach them? Are there particular barriers and is a targeted approach appropriate.

Do you think that the policy/service impacts on people because of their religion, belief or non-belief? (Religious groups cover a wide range including Buddhist, Christians, Hindus, Jews, Muslims, and Sikhs as well as atheists and other non-religious groups)

Cultural sensitivity – see toolkit and consider specifics here in relation to care – could individuals be impacted because of their cultural beliefs and observations e.g. sensitivities regarding being treated by staff of a particular gender, prayer and dietary issues etc.

Language and imagery - is it appropriate, sensitive and understandable

Ensuring service reach – are different communities marginalised? Does information reach them? Are there particular barriers and is a targeted approach appropriate. Is Comms multi-faceted, could links be utilised with Third Sector organisations.
Do you think that the policy/service impacts on men and women in different ways? Services should consider whether there is a greater risk for either men or women. Women were particularly adversely affected by Covid. There could be cultural implications for some women – see section on religion.
Do you think that the policy/service impacts on people because of their sexual orientation? (This includes Gay men, heterosexual, lesbian and bisexual people) Language and imagery should encompass same sex relationships. This also applies to work-life balance policies, visitors and relationship status etc.
Do you think that the policy/service impacts on people because they speak Welsh? The Welsh Language Standards place duties on organisations in Wales to deliver services through the medium of Welsh and the following points must be considered in all services: Patient leaflets and public facing posters must be bilingual. If not please send them to ctt_welsh_translation@wales.nhs.uk The 'active offer' means that patients must be offered services in their preferred language and this must be noted in their records / digital ward screens so that they have the opportunity to communicate in Welsh. Language Line may be used for this. Welsh speaking staff should be employed in each department/ service? If not the health board's list of Welsh speakers willing to help can be found on sharepoint) – http://ctuhb-intranet/dir/WLU/Pages/Find%20a%20Welsh%20Speaker.aspx The need to increase the number of Welsh speaking staff in your department/service? Please refer to the Bilingual Skills Strategy and guidance documents.

 New CTUHB Bilingual Skills Strat  Clickthrough Guide v3.pptx Language Line may also be used to access Welsh interpretation: Add language line info here
The Welsh government has introduced a new Socio-economic duty effective from April 2021. This places a legal responsibility during strategic decision making to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. Digital exclusion is a greater risk so it is important in particular to ensure there are alternatives where required for older people who may not use modern technology e.g. for on-line appointments, virtual visiting etc. There could also be increased reliance on public transport which could be problematic in reaching alternative destinations e.g. if services are out-sourced. There is also a risk of social marginalisation, less access of uptake of services balanced against greater need (inverse care law) and this must be considered in promotion and accessibility of services. There could also be issues with regard to access to info, literacy levels etc so correspondence and patient information should take account of this. There is also a higher risk of disability or life limiting illnesses – see section above.

Section 3 Outcome	
Summary of Assessment: **Please summarise Equality, diversity and inclusion issues of concern and changes that will be made to the service development accordingly.**	In general the planned care recovery programme will be focused on returning the health board to pre Covid activity levels and waiting times. Many working practices will be unchanged from Pre Covid times and but it is recognised that in order to achieve this that there a number of new ways of working such as video consultations and increased utilisation of the private sector. In preparing this EIA it was recognised that there are large number of small and large scale interventions and schemes which will contribute to the service developments to deliver CTMUHB's planned care recovery plans. All projects and workstreams within the programme will receive this document with the intention it is used as a signpost to best practice. The programme approach adopted does not preclude the need for individual service developments to consider equality, diversity and inclusion issues and the expectation of the programme is that there is an appropriate reflection in the formation of the detailed plans. • Digital exclusion is recognised as an issue and therefore the use of technology to support remote consultations will have a separate EIA. • The validation of waiting lists (initially 52 weeks waiters) will be accompanied by a detailed report highlighting issues and potential mitigations. This report will be considered as part of the go/no go discussions. It is CTMUHB's understanding that although waiting list validation is a key Welsh Government strategic policy driver with that there are no existing EIA's across Wales to benchmark against. Therefore on basis of a go decision for the activity a full

	EIA will be undertaken as a joint endeavour with primary and secondary care clinical colleagues. • Where there is a physical relocation of services a full EIA conducted as part of the service design planning. • The communications plan for the programme will include how hard to reach groups will be communicated with. • The communication strategy for the programme will aim to deliver key messages across a number of delivery channels to ensure message reach.
Please indicate whether these changes have been made.	The changes detailed above are in development and an update on implementation will be included in a later iteration of this report.
Please indicate where issues have been raised but the service development has not been changed and indicate reasons and alternative action (mitigation) taken where appropriate.	Additional travel time will be limited as far as possible for there will be occasions where our resident will be asked to travel outside of the CTMUHB boundaries to receive care, for example surgery conducted at a private provider. However to mitigate every effort will be made to ensure pre –assessment and after care activity is provided as close to home as possible. CTMUHB have from an early stage in the programme worked with WAST to assess the impact on all schemes within the programme service related to the recovery of planned services. Weekend working – provision of BSL translation services are of limited supply and only available Monday – Friday in normal office hours. Deaf patients will therefore offered appointments within core business hours.

	In recognition that at the time of writing many of the plans for elective care recovery are in the development stages the programme will undertake engagement events with a wide range of stakeholders including CHC's Third Sector as the detailed planning progresses.
Who will monitor this EIA and ensure mitigation is undertaken	The EIA will be monitored by the Planned Care Recovery Programme Director and mitigation actions will be undertaken following consideration by the Planned Care Recovery Programme Board.
Approved by Equality Team **To be held on Re-set document site**	**Yes/No** **Signed ……..** **(Equality Manager / Officer)** **Date……** **Actioned Yes/No**