GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

CTM UHB Care Group Delivery Model

Implementation Document

June 2022

Contents

Part 1 - Introduction – Strategic Vision & Case for Change

Introduction

This Implementation document describes the changes to the current operating model as well as provide an indication on how this new delivery structure will function in the future. Included within this is the 'ways of working', guided by the design principles, which aims to set the tone for how a model will work in practice. All staff groups will be required to play a role in ensuring the organisation functions both in line with our values as well as with the principles set out below.

The document has been prepared with the help of key staff who will be impacted by the changes as well as by wider staff that will not be impacted. This engagement has been led by the Executive Directors of the Health Board to ensure that each professional area of the organisation has received suitable input and support ahead of the release of this document for formal consultation. This engagement has been vital in constructing the delivery model; ensuring what works effectively now is retained as well as improving on areas where change is required to meet the current and future challenges.

The past two years has been an unprecedented time for the Health Board. Due to the hard work of all staff, the organisation has been able to meet the challenges posed of it. The work of the Integrated Locality Group teams has been paramount in this effort. The dedication and hard work by the ILGs has and continues to be immensely appreciated throughout the organisation. The organisation needs to ensure it takes forward the positive learning and dedication seen over the past two years in order to move to the best operational model to respond to the challenges we now face. There will be elements and ways of working of the ILG model that are to be kept such as a Group Locality Meeting. This is to ensure that we continue the theme of integrated care and maintain a locality focus within the Health Board. Additionally we want to ensure that our busy clinical hospital sites are fully supported and there is local ownership to ensure a high quality of service is delivered. In this sense the organisation can ensure that it learns lessons from previous reviews, such as the Professor Andrews Report on Care in Princess of Wales and Neath Port Talbot Hospitals, published in 2014.

Any organisational change is disruptive and requires staff to work closely together to meet the needs of the organisation, whilst still operationally running clinical and non-clinical services. The objective of this change is to reduce the disruption as much as possible. Therefore despite this change being treated as a full organisational change process, in line with national guidance, the changes are not as far reaching as the operating model restructure back in 2019/2020. It should be reinforced that this model is not 'going back to the way things were' before COVID and indeed much of what is currently in place and is working effectively is to remain unchanged.

Scope of this OCP

This document will set out what will change, specifically outlining the changes from Integrated Locality Groups, running a variety of services in a geographic area, to a whole-CTM 'Care Group' structure, focussing on specific aspects of healthcare delivery. It will also outline as clearly as possible what will not change, in order to provide clarity and to reduce uncertainty.

This OCP does not alter the composition of the Clinical Service Groups (CSGs), however it is proposed that there will be a further stage of revision to the operating model in the future which will include the CSGs in its scope. The current CSGs that exist now will continue as part of this OCP and fall under one of the above appropriate Care Groups. This is where the control and coordination of delivering and improving these services will be held. As required, there will be operational adaptions to ways of working now.

Rationale for the change

There are a number of related rationale for the changes. The Executive Team with support from the wider Board and Welsh Government have set the direction of travel to move to a 'Care Group' structure across the whole of CTM. This direction of travel was endorsed at the CTM Board in March 2022. The key rationale for this is outlined below:

- Developing the 'One-CTM' agenda and to further embed Bridgend within the Cwm Taf Morgannwg University Health Board.

- Bringing the Health Board together in its vision and ways of working opposed to being split into separate groups, which can create inequality of access for patients.

- Feedback received internally and externally about the performance of the current operating model.

- The impact of COVID and the aftermath – The planned care recovery effort requires a centralised coordination of response as a unified Health Board.

- The regionalisation agenda in Wales and the wider UK – Not just a focus on Health Board-wide working but also working regionally with other Health Boards for the benefit of patients.

- CTM2030 - Clinical Services Strategy – As this strategy continues to evolve the Health Board needs to ensure there is the flexibility for key changes to take place as an output of the work.

- Better alignment and opportunities with Local Authorities for joint working and shared ambition for joint funding posts. Continue to nurture relationships and taking this further with even closer working in the future.

Principles & ways of working

The following are a set of principles guiding the ways of working of the delivery model. These help to set expectations of how CTM should be operating and the way the organisation will work:

- **Designed to enable an effective response to post-pandemic recovery**

Being aware the NHS has just gone through a significant event with COVID, this has caused multiple direct and indirect impacts for the health of our population. We need to ensure that everything we do is geared towards recovering as efficiently and safely as possible. Leaders and staff should be encouraged to bring new ideas to maximise the quality and performance of our services.

- **Ensuring quality is at the heart of everything we do**

The organisation has invested significant time and resource into improving the quality and safety of services and continuing to promote this agenda. The Health Board must maintain the focus and look at ways to strengthen this further. Central improvement functions such as iCTM will enable the Health Board to lead and teach improvement methodologies for the benefit of services. Priority areas of focus will need to be constantly reviewed to ensure the right resources are being directed at the right areas and at the right time.

- **Equity of service and access for all citizens of CTM**

The current operating model poses question around the equity of access and resulting differences in performance across the Health Board. The model needs to evaluate activity with a whole-CTM lens and ensure the patients with the highest clinical need are prioritised to avoid a 'postcode lottery'.

- **Clarity in expectations and accountability for decision making and delivery**

The model needs to ensure, as much as possible, that it is clear who is responsible for what areas of operational delivery within the organisation and at every level. This will empower individuals and supporting teams to be able to make decisions within their remit and know where and how to escalate when additional support or advice is required. The model will include site leadership, with clear roles and responsibilities, and will be defined as we work through the ways of working.

- **Streamlined management structures and decision making**

Linked to the above point, being clear on management structures, both clinically and operationally, will ensure swift and effective decision making. The Health Board should avoid, as far as possible, situations where it is not clear which team is responsible for which areas and avoid duplication or triplication as far as possible.

- **Empowering front line clinical services**

All clinical services across primary and secondary care need to be able to deliver effectively with clinical staff operating at 'the top of their licence'. To do this they not only need to be empowered by having the support and structures around them but they need to be able to champion their ideas for improvement, working in an organisation where good practice can be shared.

- **Designed to facilitate and support working across sites and with neighbouring Health Boards**

If local issues cannot be solved with local solutions then CTM needs to be able to think in a whole Health Board way to coordinate resource effectively. Additionally, there is an ever growing emphasis for regional working across traditional Health Board boundaries. The organisation needs to work towards key single points of contact to represent services at national forums and to do this to bring about transformation working with the resources of other organisations.

- **Aligning localities with local authority boundaries to facilitate integration of health and social care**

In order to ensure a close link up with Local Authorities the boundaries of our current localities need to mirror the LA boundaries. Noting that there will always be cross boundary discussions within and out of the CTM area, aligning these boundaries will begin to increase the close working and cooperation with Local Authorities. In time this relationship could involve funding joint posts to help the integration effort.

- **Clear two-way expectations between corporate support and Care Groups**

Clinical and operational managers at all levels within CTM need to be clear on what falls under their managerial responsibility and where they can access help and support to fulfil their leadership duties. This 'deal' between operational and corporate colleagues is set out later in chapter 8 of this document. This sets out the expectations in terms of what support corporate business partners will provide and what Care Groups and others can expect. In turn this relationship will be clear on the areas under the control of managers and where there should

not be an assumption that corporate services will perform these duties for them.

Next Steps

In accordance with the Organisational Change Policy (OCP) for Wales, the Health Board will work in partnership with its trade union colleagues, to ensure a smooth transition to the revised delivery model. However, any process will be based on the key principles of OCP and will therefore follow:

Slotting-In – Applies where a post is substantially unchanged (e.g. the scope of the role remains unaltered and it matches `two thirds' or more of an existing job description and person specification) and there is only one candidate or equal numbers of posts and candidates, who currently undertake this role. In this circumstance the post would not be advertised and the individual(s) whose post(s) meets the criteria would be slotted into the post(s).

Prior Consideration – Applies where a post is substantially unchanged (e.g. the scope of the role remains unaltered and it matches `two thirds' or more of an existing job description and person specification) and there is more than one potential candidate.

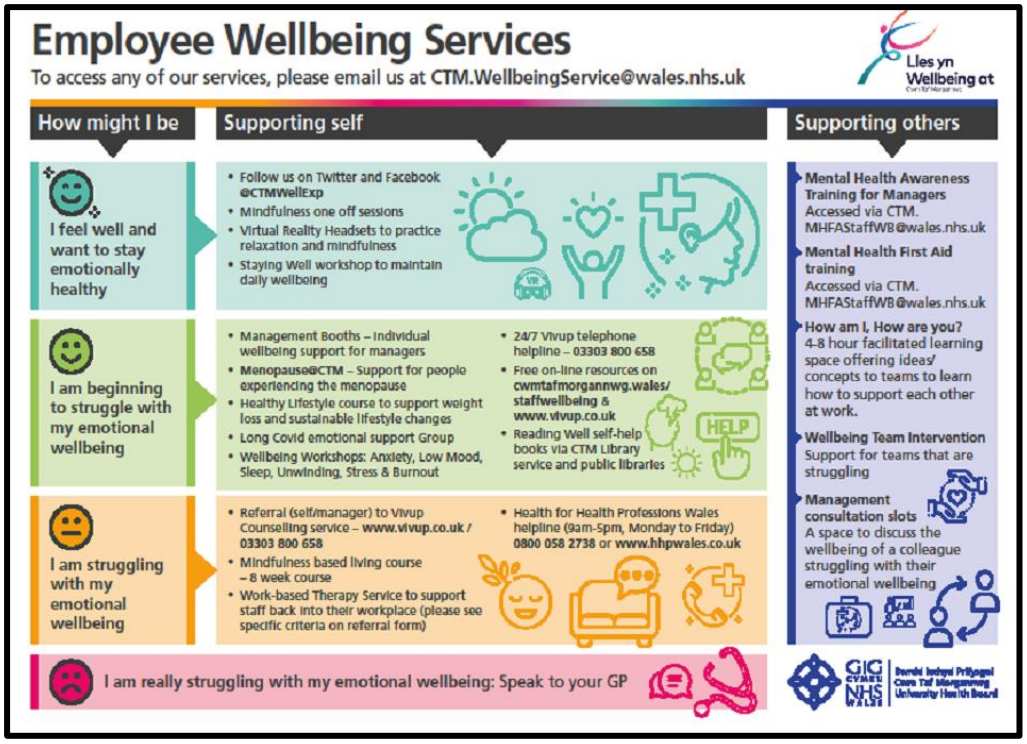
Restricted Competition – Where a post is considered to be new or substantially changed, it should be filled in the first instance by restricting competition to staff affected by the changes, provided the criteria of the person specification is met.

Selection Process - Where appointment to a post is subject to **prior consideration** or **restricted competition**, an interview will be the minimum selection process requirement. The process of selection will be carried out by reference to the relevant job description and person specification.

The CTM employee wellbeing service has a wide range of resources available to support all staff experiencing organisational change. We are aware that for some of us change can come with uncertainties and talking about how you feel is not always an easy thing to do.

Please visit the wellbeing sections on our intranet here: https://cwmtafmorgannwg.wales/staffwellbeing or e-mail CTM.WellbeingService@wales.nhs.uk

The Employee Wellbeing Team are also able to provide bespoke support to staff impacted by the change process. Support could be provided either on a one to one or group basis depending on individual needs and preferences.


Employee Wellbeing Services
To access any of our services, please email us at CTM.WellbeingService@wales.nhs.uk
Lles yn Wellbeing at
How might I be
Supporting self
Supporting others
I feel well and want to stay emotionally healthy
• Follow us on Twitter and Facebook @CTMWellExp
• Mindfulness one off sessions
• Virtual Reality Headsets to practice relaxation and mindfulness
• Staying Well workshop to maintain daily wellbeing
I am beginning to struggle with my emotional wellbeing
• Management Booths – individual wellbeing support for managers
• Menopause@CTM – Support for people experiencing the menopause
• Healthy Lifestyle course to support weight loss and sustainable lifestyle changes
• Long Covid emotional support Group
• Wellbeing Workshops: Anxiety, Low Mood, Sleep, Unwinding, Stress & Burnout
• 24/7 Vivup telephone helpline – 03303 800 658
• Free on-line resources on cwmtafmorgannwg.wales/staffwellbeing & www.vivup.co.uk
• Reading Well self-help books via CTM Library service and public libraries
HELP
I am struggling with my emotional wellbeing
• Referral (self/manager) to Vivup Counselling service – www.vivup.co.uk / 03303 800 658
• Mindfulness based living course – 8 week course
• Work-based Therapy Service to support staff back into their workplace (please see specific criteria on referral form)
• Health for Health Professions Wales helpline (9am-5pm, Monday to Friday) 0800 058 2738 or www.hhpwales.co.uk
I am really struggling with my emotional wellbeing: Speak to your GP
Mental Health Awareness Training for Managers
Accessed via CTM. MHFAStaffWB@wales.nhs.uk
Mental Health First Aid training
Accessed via CTM. MHFAStaffWB@wales.nhs.uk
How am I, How are you?
4-8 hour facilitated learning space offering ideas/ concepts to teams to learn how to support each other at work.
Wellbeing Team Intervention
Support for teams that are struggling
Management consultation slots
A space to discuss the wellbeing of a colleague struggling with their emotional wellbeing
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Part 2 - Current Position

The CTMUHB Management Board approved the establishment of Integrated Locality Groups (ILG) in December 2019, which were granted specific powers, authority and freedom to act. This went into operation in April 2020 when COVID was beginning to impact the NHS.

The original design principles of the model were:

- Empowering People.
- Community Leadership and Involvement.
- Clinically Led, Community Focused Services.
- Learning and Innovating for Continual Quality Improvement.
- Robust, Simplified and Safe Decision Making.

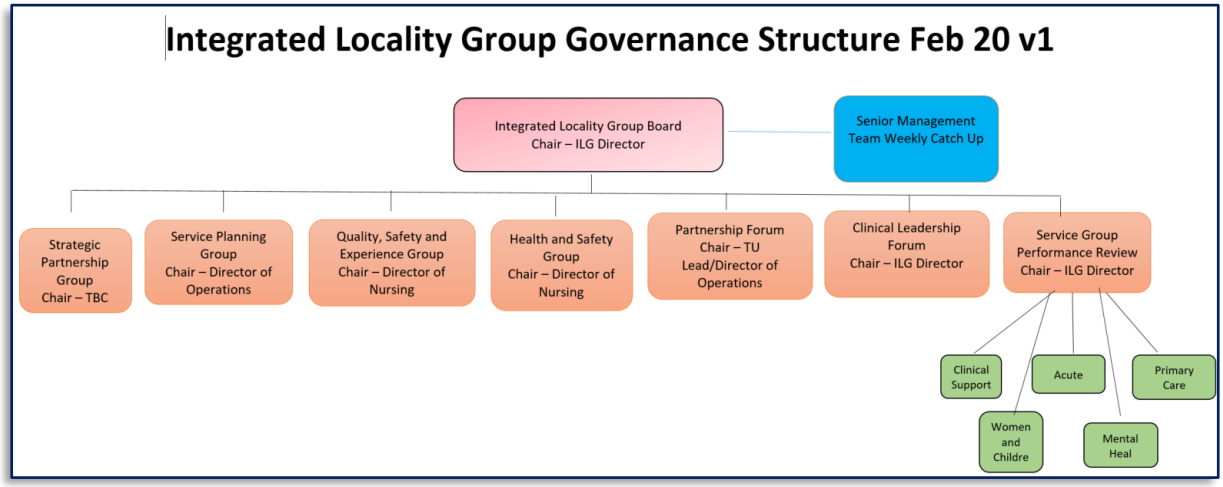
Three Integrated Locality Groups were set up each serving a population of 125-185,000 with a strategic and operational focus. These are Merthyr & Cynon, Rhondda and Taff Ely and Bridgend.

There are certain tweaks / subtleties within the current model between ILGs - e.g. RTE 'host' Pathology and Radiology for CTM as a whole.

The ILG triumvirate (Group Director, Ops Director, Nurse Director) is supported by corporate resource which are dedicated staff including those from Workforce and OD, Information, Finance and Planning. There is also an 'arm's length' level of communication and engagement support from the corporate Communications and Engagement Team.

Clinical Service Groups sit within each ILG and run service areas. A triumvirate leadership model is also adopted within each CSG. All 3 acute hospitals have site clinical and non-clinical leadership including a Head of Nursing and Acute Service General Managers.

The original internal ILG Governance structure diagram is shown below outlining original plans for how each ILG will ensure governance.

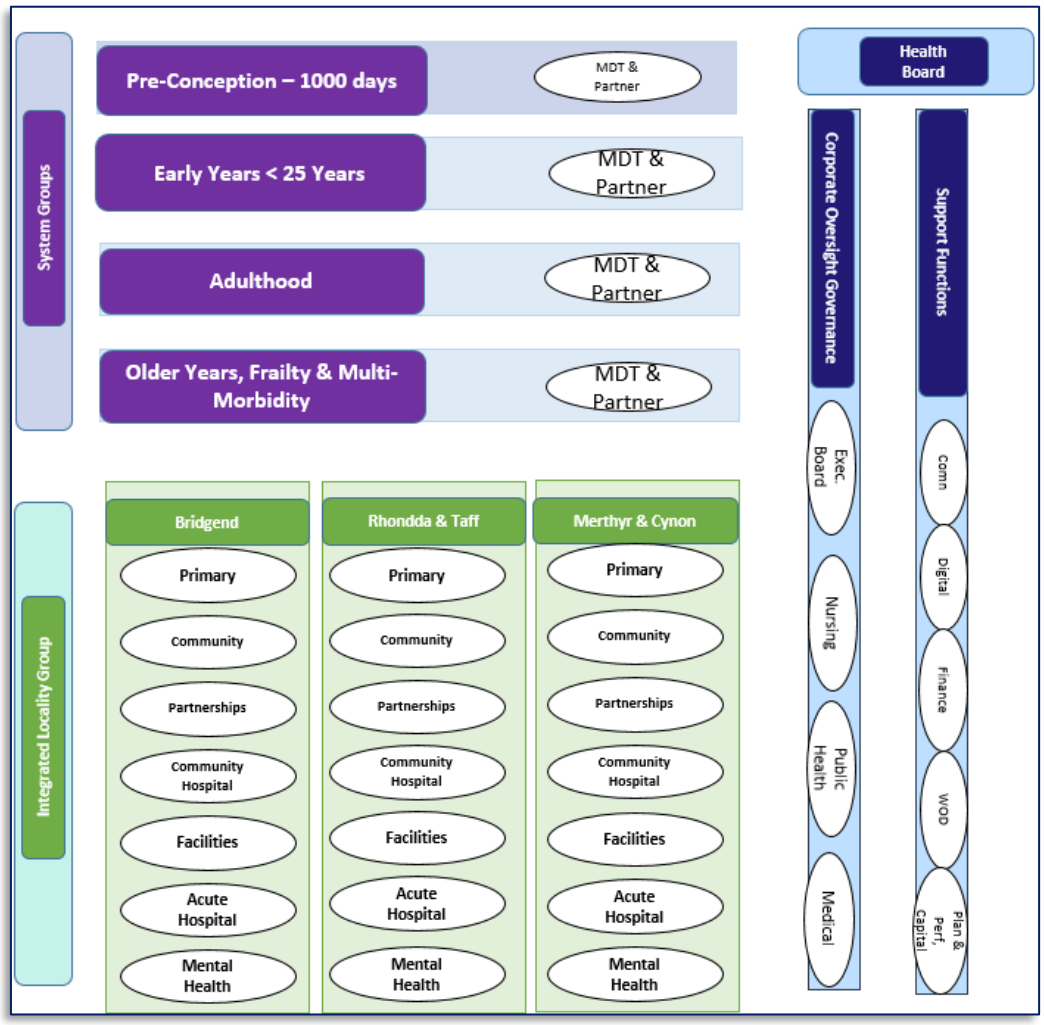


The ILG Group Directors attend what is now Strategic Leadership Group (Formerly Management Board) where decision making for the Health Board was conducted until late 2021.

The Chief Operating Officer meets with the ILG team on a weekly basis and conducts performance reviews each month. In addition to this, the COO chairs a weekly Senior ILG meeting which on a rotational basis is also attended by Executive Team colleagues.

The ILG Nurse Directors and Operations Directors both report into the Group Director who in turn reports into the COO. There is a professional link between the Nurse Directors and the Executive Director of Nursing. There are forums to ensure a close working between professional groups.

For a detailed description of the current operating model as set out in December 2019 please use the intranet to access this document. The original structural diagram for the current model is set out below:



Part 3 – Care Group Structure

The core component of the change to the current operating model is the move to a 'Care Group' structure from an ILG one. Unlike ILGs, which are responsible for planning and delivering multiple services across primary and secondary care, as well as hosting individual service areas, the Care Groups will be more focussed and specialised and run these services across the whole of CTM. This model is in line with neighbouring Health Boards and many English Trusts, however many elements of the current model will remain.

The proposal is to have the following six clinical Care Groups:

- Planned Care Group
- Unscheduled Care Group
- Children & Families Care Group
- Diagnostics, Therapies and Specialities Care Group
- Mental Health Care Group
- Primary & Community Care Group

The following sections of this document will go into more detail about the composition and purpose of these groups but at a summary level each group will be led by a senior management team. This team, supported through professional leads, as well as underpinned by corporate business partners, will focus on coordinating the services under their control across the whole of CTM. This OCP does not propose to alter the composition of the Clinical Service Groups (CSGs), however it is proposed that there will be a further stage of revision to the operating model in the future which will include the CSGs in its scope. The current CSGs that exist now will continue as part of this OCP and fall under one of the above appropriate Care Groups. This is where the control and coordination of delivering and improving these services will be held. As required, there will be operational adaptions to ways of working now.

The Care Group structure will be supported by 2 overarching programme boards, one focussed on urgent and emergency care and the other on planned care recovery, which will ensure coordinated cross care group interaction.

The specific roles within the Care Groups will be outlined both in the following sections and within the specific Nursing and Medical sections, however at a summary level, each Care Group will continue to have a triumvirate leadership model, or other similar set up dependant on the nature of the Care Group.

Please see the overall organogram below outlining the key aspects of the Care Group structure.

Proposed Clinical Care Group Structure

Please note, corporate business partner support to Care Groups is outlined in chapter 8

Care Group	Planned Care Group	Unscheduled Care Group	Children & Families Care Group	Diagnostics, Therapies & Specialties Care Group	Mental Health & Learning Disabilities Care Group	Primary & Community Care Group
Leadership Team roles	**Triumvirate Leadership Team** • Group Service Director • Group Medical Director • Nurse Director	**Triumvirate Leadership Team** • Group Service Director • Group Medical Director • Nurse Director	**Triumvirate Leadership Team** • Group Service Director • Group Medical Director • Director of Midwifery	**Leadership Team** • Group Service Director • Group Medical Director • Nurse Director leadership provided by Planned Care Nurse Director	**Leadership Team** • Group Service Director • Group Medical Director • Nurse Director	**Leadership Team** • Group Service Director • AMD For Primary and Community • Nurse Director leadership provided by MH&LD Nurse Director
Summary of role of **Group Service Directors** in structure	**Care Group Role** - The Service Director, will lead the Group and deliver high level operational and strategic leadership to the care group and provide a high quality, cost effective patient care within resources available, provide strong non clinical leadership to manage and support the delivery of clinical services, ensure clear communication of UHB values, vision, priorities and expectations to enable the teams to deliver high quality services, be responsible for managing the complex nature of the Group and ensure strategic plans are delivered, undertake planning which ensures safe, high quality and efficient delivery of the day to day operational management, be responsible for delivering against the legal, risk and governance agenda in the Group. **Locality Role** - Deliver high level strategic oversight to their designated locality					
Summary of role of **Nurse Directors** in structure	**Care Group role** - Professional accountability for professional leadership, quality governance and people's experience for a designated Care Group, reporting into the Executive Director of Nursing's office. **Locality role** - Proposed that each Nurse Director maintains a locality leadership role in addition to their Care Group responsibilities. The locality part of the role will comprise of several aspects incl. taking a lead for a designated locality where there are cross-cutting professional / quality issues and interdependencies across CSGs. Act as a collegial point of contact for external oversight bodies where locality cross cutting issues need to be addressed. Be the key contact on behalf of the Care Group for locality public engagement for example with local authorities and third sector teams. Nurse Director's will also retain site based strategic leadership responsibility. ***For more detail on the Nursing & Midwifery model please see chapter 5 – Nursing & Midwifery***					
Summary of role of **Group Medical Directors** in structure	**Care Group Role** - This proposed role would be designed for a Doctor who remains clinically active to Work closely with leadership team – Operational and Nurse Leaders, Oversee medical aspects of Care Group activity, Provide Medical Leadership of the group, Support for clinical departments and teams within the Care Group. Within Primary and Community Care Group this will be delivered by the AMD for Primary and Community, as the role currently does now. **Medical Leadership at acute site level** - There are no proposed changes to the current model with reference to acute site medical leadership on our three DGH sites. ***For more detail on the Medical model please see chapter 7 – Medical Focus – Key roles and responsibilities***					
Scope of Care Group	Draws together all specialties which are focused on the provision of services with planned and pre-arranged appointments, operations or treatments in a range of settings ***For a detailed list of what clinical specialties are included please see Chapter 3a***	Draws together all specialties which are focused on the provision of health services which cannot be foreseen to a significant degree in advance of contact with the relevant healthcare professional ***For a detailed list of what clinical specialties are included please see Chapter 3b***	The Children & Families Care Group draws together all specialties which are focused on the provision of health services for women, men and children, including Maternity Services ***For a detailed list of what clinical specialties are included please see Chapter 3c***	Developed to recognise that the services within it provide input across the entire Health Board: planned and unscheduled care, women and children's services, mental health, primary and community care. A diverse and multi-professional workforce delivers these services, comprising healthcare scientists (HCS), medics, nurses, allied health professionals (AHP), and pharmacists. ***For a detailed list of what clinical specialties are included please see Chapter 3f***	It is proposed that all services currently provided by the Child and Adolescent Mental Health Clinical Services Group and the three adult Mental Health Clinical Services Group transfer to the responsibility of the Mental Health and Learning Disabilities Care Group. ***For a detailed list of what clinical specialties are included please see Chapter 3e***	Draws together core primary care provision incl. four practitioner services; medical; dental; community pharmacy and opticians. These practitioners are independent of the Health Board and the services are contracted by the Health Board to deliver their defined service areas. Community Services cover a breadth of areas, including some nursing services and others with a much more MDT focus. All services currently provided by the three Primary and Community Clinical Services Group will form part of the proposed Primary and Community Care group. ***For a detailed list of what clinical specialties are included please see Chapter 3d***

Part 3a – Planned Care Group

Introduction

The Planned Care Group draws together all specialties which are focused on the provision of services with planned and pre-arranged appointments, operations or treatments in a range of settings including inpatient, outpatient and day case environments.

The Group will use appropriate clinical governance and management structures to ensure that the service is safe, effective and efficient and of the highest quality, with routine audit and opportunities for the spread of learning. Improved clinical outcomes and patient experience will be important.

This Group concerns mainly with the acute sector, the community and primary care elements are considered elsewhere in this document.

Scope of what's included within this Care Group

The following will be included within the Care Group – at present this is not an exhaustive list.

Orthopaedics	General Surgery inc Breast, Colorectal, Upper GI	Diabetes and Endocrinology	Pre-operative Assessment
Cancer Services & Tracking	Urology	ENT	Oral Maxillo-Facial Surgery
Rheumatology	Vascular Services	Dermatology and Dermatology Day Unit	Endoscopy
Critical Care inc Outreach (ICU & HDU)	Anaesthetics inc Acute Pain & Chronic Pain	Theatres inc Emergency, Trauma and CEPOD	Ophthalmology, Orthoptics & Optometry
Gastroenterology inc GI Cancer and Endoscopy and Day Unit	Outpatients inc Nursing Staffing	Neurology and neurophysiology	Nephrology
Cardiac Services inc Cardiac Catheterisation Lab and CPU Adult Congenital Heart Defect Service Satellite Clinic and Cardiac Rehabilitation CPEX Service			

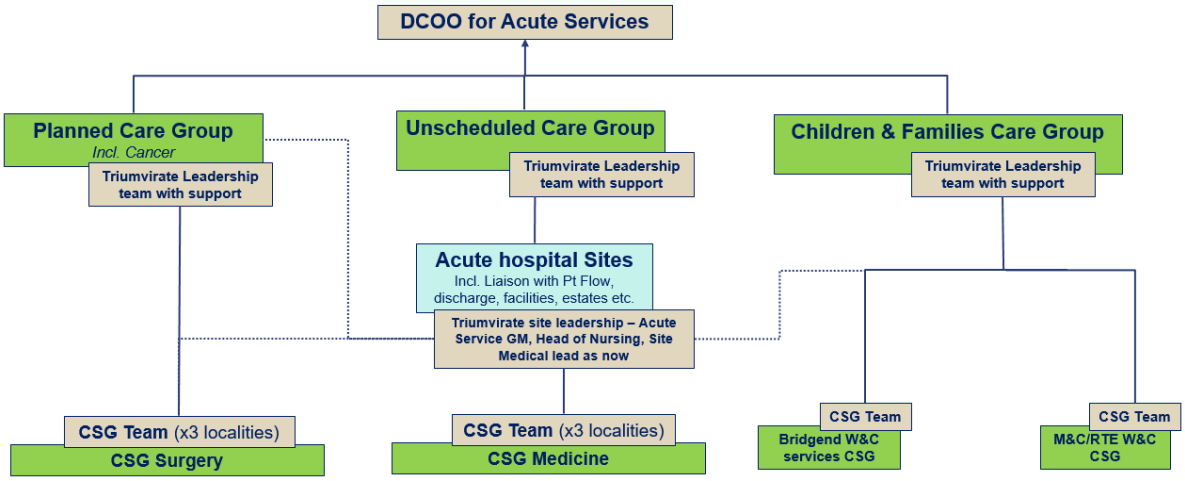
Roles / Titles of Leadership Team & Key Responsibilities

Leadership Team

Role	Key Responsibilities
Group Service Director	The Service Director will lead the Care Group, working closely with the Nurse and Medical Directors, will: • deliver high level **operational and strategic leadership to the care group and strategic oversight to their designated locality**; • provide a high quality, cost effective patient care **within resources available**; • provide **strong non clinical leadership** to manage and support the delivery of clinical services; • ensure **clear communication** of UHB values, vision, priorities and expectations to enable the teams to deliver high quality services; • be responsible for managing the complex nature of the Group and **ensure strategic plans are delivered**; • **undertake planning** which ensures safe, high quality and efficient delivery of the day to day operational management; • **be responsible for delivering** against the legal, risk and governance agenda in the Group.
Group Medical Director	The Group Medical Director, working closely with the Nursing and Service Director, will: • be responsible for the delivery of **high quality and high performing services**, within budget for an agreed level of activity; • **provide strong clinical leadership and direction** for the Care Group, ensuring that this supports the fulfilment of the UHB's vision and strategic aims; • ensure that all colleagues are aware of and signed up to the UHB's **clinical strategy**; • ensure that all **professional and accountability issues for medical staff** are in place.
Group Nurse Director	The Nurse Director, working closely with the Medical and Service Director, will: • provide assurance to colleagues that robust **processes and systems of governance and risk management** are in place

Role	Key Responsibilities
	• ensure the implementation of the **corporate nursing agenda** is shared with all colleagues and embedded in the day to day operational work; • ensure the **appropriate staff are in place** and that training is encouraged; • **ensure fundamentals of care are delivered and that clinical competence is maintained** and developed to maximise the patient experience, safety and quality.

Organogram – showing linkage with acute hospital site and key CSG teams



National responsibilities within Care Group

For Cancer Services across the UHB:

- Cancer Update Meeting with WG
- Cancer Operational Manager Group meeting with WCN
- Cancer Operational Manager PTL meeting with WCN
- Monthly VCC pathway collaboration meeting

Additionally:

- Planned Care Programme National Orthopaedic Board
- Planned Care Programme National General Surgery Board
- Planned Care Programme National Ophthalmology Board
- Clinical Orthopaedic Strategy Clinical Reference Sub Group
- National Planned Care Programme – Dermatology – represent the Health Board alongside Associate Clinical Director
- National Endoscopy Programme – attend alongside other Health Board representatives
- WICIS (all Wales ITU information system) National project representation

Part 3b – Unscheduled Care Group

Introduction

The Unscheduled Care Group draws together all specialties which are focused on the provision of health services which cannot be foreseen to a significant degree in advance of contact with the relevant healthcare professional

The Group will use appropriate clinical governance and management structures to ensure that the service is safe, effective and efficient and of the highest quality, with routine audit and opportunities for the spread of learning. Improved clinical outcomes and patient experience will be important.

This Group concerns mainly the acute sector, the community and primary care elements are considered elsewhere in this document.

Scope of what's included within this Care Group

The following will be included within the Care Group as follows – at present this is not an exhaustive list.

In Bridgend ILG, Service Level Agreement / Long Term Agreement, management/interface for: • COPD Early Discharge Team • Pulmonary Rehab • Neurology • Neurophysiology	Care of the Elderly incl. in Bridgend the Community Acute Care Team and Frailty	Major trauma	Patient Flow Teams
Rapid Diagnostic Unit, Medical Day Units - planned	Ambulatory Care Day Unit including Venous Thromboembolism (VTE) Service	Emergency Departments and MI Units – urgent primary care centres	Ambulatory Falls Service
Acute Medicine / Acute Medical Unit	Discharge Lounges	Sports & Exercise Medicine	AESU
Trauma	Stroke	Respiratory incl. lung cancer	SDEC

Roles / Titles of Leadership Team & Key Responsibilities

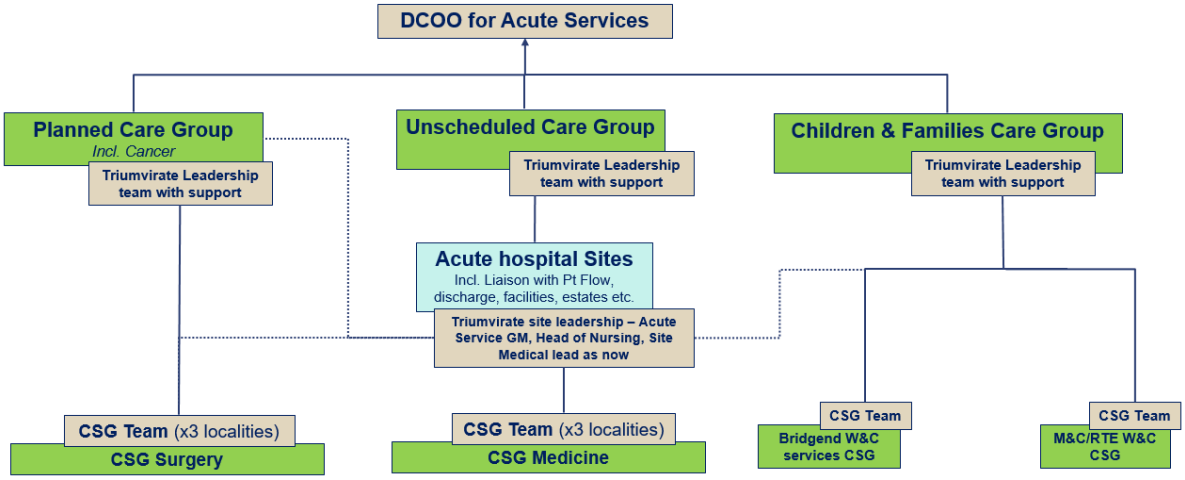
Leadership Team

Role	Key Responsibilities
Group Service Director	The Service Director will lead the Care Group, working closely with the Nurse and Medical Directors, will: • deliver high level **operational and strategic leadership to the care group and**

Role	Key Responsibilities
	strategic oversight to their designated locality; • provide a high quality, cost effective patient care **within resources available**; • provide **strong non clinical leadership** to manage and support the delivery of clinical services; • ensure **clear communication** of UHB values, vision, priorities and expectations to enable the teams to deliver high quality services; • be responsible for managing the complex nature of the Group and **ensure strategic plans are delivered**; • **undertake planning** which ensures safe, high quality and efficient delivery of the day to day operational management; • **responsible for delivering** against the legal, risk and governance agenda in the Group.
Group Medical Director	The Group Medical Director, working closely with the Nursing and Service Director, will: • be responsible for the delivery of **high quality and high performing services**, within budget for an agreed level of activity; • **provide strong clinical leadership and direction** for the Care Group, ensuring that this supports the fulfilment of the UHB's vision and strategic aims; • ensure that all colleagues are aware of and signed up to the UHB's **clinical strategy**; • Ensure that all **professional and accountability issues for medical staff** are in place.
Group Nurse Director	The Nurse Director, working closely with the Medical and Service Director, will: • provide assurance to colleagues that robust **processes and systems of governance and risk management** are in place • ensure the implementation of the **corporate nursing agenda** is shared with all colleagues and embedded in the day to day operational work; • ensure the **appropriate staff are in place** and that training is encouraged;

Role	Key Responsibilities
	• **ensure fundamentals of care are delivered and that clinical competence is maintained** and developed to maximise the patient experience, safety and quality.

Organogram - showing linkage with acute hospital site and key CSG teams



National responsibilities within Care Group

National Programmes include:

- All Wales Stroke Thrombectomy Group – attend alongside other Health Board representatives
- National Stroke Group – attend alongside other Health Board representatives
- Cardiology Network Meetings – attend alongside other Health Board representatives
- NHS Wales national 6 goals of Urgent Care and SDEC representation

For Cancer Services across the UHB:

- Cancer Update Meeting with WG
- Cancer Operational Manager Group meeting with WCN
- Cancer Operational Manager PTL meeting with WCN
- Monthly VCC pathway collaboration meeting

Part 3c – Children & Families Care Group

Introduction

The Children & Families Care Group draws together all specialties which are focused on the provision of specific health services for women, men and children, including Maternity Services.

The Group will use appropriate clinical governance and management structures to ensure that the service is safe, effective and efficient and of the highest quality, with routine audit and opportunities for the spread of learning. Improved clinical outcomes and patient experience will be important.

This Group concerns mainly the acute sector, the community and primary care elements are considered elsewhere in this document.

Scope of what's included within this Care Group

Neonatology and Special Care	Acute Paediatrics	Acute Paediatric Outpatients	Ante Natal Services
Midwifery inc Labour Ward	Gynaecology	Obstetrics	Fertility
Colposcopy Services	Pregnancy Advice Service	Hysteroscopy	Uro-Gyneacology
Integrated Sexual Health inc GU Services and HIV	Early Pregnancy Unit	Gynaecology Assessment Service	Neurodevelopmental Disorder
Community Paediatrics	Community Childrens Nursing	Continuing Healthcare	Community Midwifery
Specialists Nursing	Special Schools	Community Gynaecology	Paediatric Surgery Responsibility to also run a Paediatrics Surgical Board within Children & Families Care Group

Roles / Titles of Leadership Team & Key Responsibilities

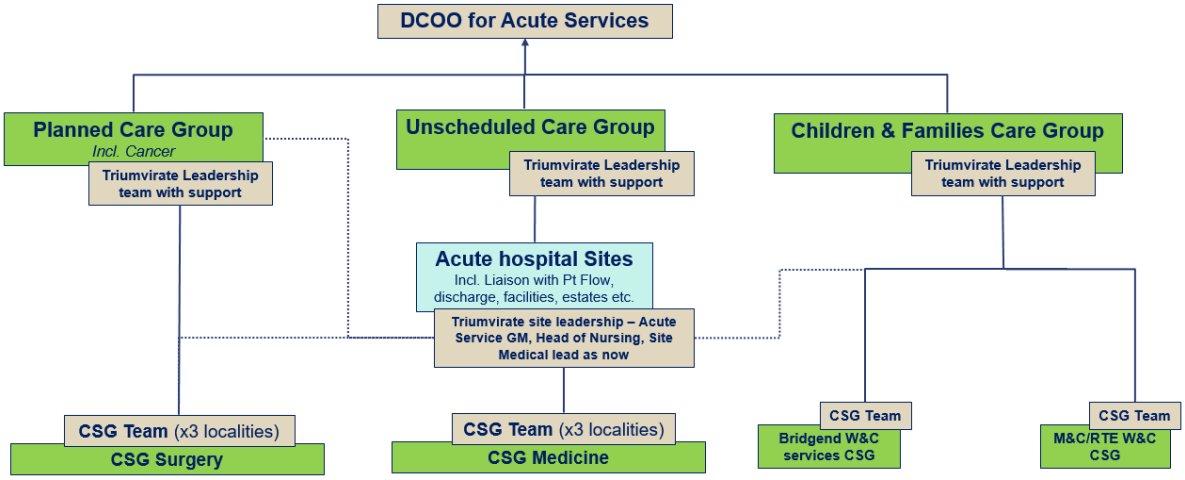
Leadership Team

Role	**Key Responsibilities**
Group Service Director	The Service Director will lead the Care Group, working closely with the Nurse and Medical Directors, will: • deliver high level **operational and strategic leadership to the care group and**

Role	Key Responsibilities
	strategic oversight to their designated locality; • provide a high quality, cost effective patient care **within resources available**; • provide **strong non clinical leadership** to manage and support the delivery of clinical services; • ensure **clear communication** of UHB values, vision, priorities and expectations to enable the teams to deliver high quality services; • be responsible for managing the complex nature of the Group and **ensure strategic plans are delivered**; • **undertake planning** which ensures safe, high quality and efficient delivery of the day to day operational management; • **be responsible for delivering** against the legal, risk and governance agenda in the Group.
Group Medical Director	The Group Medical Director, working closely with the Nursing and Service Director, will: • be responsible for the delivery of **high quality and high performing services**, within budget for an agreed level of activity; • **provide strong clinical leadership and direction** for the Care Group, ensuring that this supports the fulfilment of the UHB's vision and strategic aims; • ensure that all colleagues are aware of and signed up to the UHB's **clinical strategy**; • ensure that all **professional and accountability issues for medical staff** are in place.
Director of Midwifery	The Head of Midwifery, working closely with the Medical, Nursing and Service Director, will: • provide assurance to colleagues that robust **processes and systems of governance and risk management** are in place • ensure the implementation of the **corporate nursing agenda** is shared with all colleagues

Role	Key Responsibilities
	and embedded in the day to day operational work; • ensure the **appropriate staff are in place** and that training is encouraged; • **ensure fundamentals of care are delivered and that clinical competence is maintained** and developed to maximise the patient experience, safety and quality.

Organogram – showing linkage with acute hospital site and key CSG teams



National Responsibilities within Care Group

For Cancer Services across the UHB:

- Cancer Update Meeting with WG
- Cancer Operational Manager Group meeting with WCN
- Cancer Operational Manager PTL meeting with WCN
- Monthly VCC pathway collaboration meeting

Also:

- Gynaecology Planned Care Board
- Women's Health Implementation Group
- GIRFT for Gynaecology service
- Peer reviews
- HIW assurance
- HEIW assurance
- Independent Maternity Services Oversight Panel (IMSOP) including across Neonates
- Healthy Child Wales
- All Wales Neurodevelopmental Disorder improvement
- All Wales Networks (e.g. Neonatal)
- Transitional Implementation from Children to Adult Services
- Bridgend Youth Justice Service (BCBC Local Authority)

Part 3d – Primary & Community Care Group

Introduction

Within core primary care provision, there are four practitioner services; medical; dental; community pharmacy and opticians. These practitioners are independent of the Health Board and the services are contracted by the Health Board to deliver their defined service areas. It is that the Primary and Community Care Group encompasses responsibility for all four service areas.

The key role of primary care services is to:

- Provide a first point of contact with healthcare services;
- Offer continuity of care (diagnosis, prescribing and care management);
- Provide a universal service, co-ordination of care 24 hours a day, 7 days per week across primary, secondary and social care systems; and
- Improve the health of the population through health promotion and primary prevention.

Primary care services are grouped into 8 clusters based around localities, these are Cynon North, Cynon South, Merthyr North, Merthyr South, Rhondda North, Rhondda South, Taff Ely North, Taff Ely South, Bridgend West, Bridgend North and Bridgend East Cluster. The latter is a not for profit social enterprise consortium of GPs and known as the 'Pen y Bont Federation'.

Community Services cover a breadth of areas, including some nursing services and others with a much more MDT focus. All services currently provided by the three Primary and Community Clinical Services Group will form part of the Primary and Community Care group.

In managing community services, it is this Care Group takes the operational lead on Community / Health Parks Site / Hospitals management & development.

Two other significant areas of responsibility for this Care Group include cluster development and Continuing Healthcare as both are intrinsically linked to how we deliver services listed below for our population.

Scope of what's included within this care Group

Primary Care Contractors - contracting & negotiation, development & improvement

- General Medical Services (GMS),
- General Dental Services (GDS) &
- General Ophthalmic Service (GOS)
- General Dental Services (GDS)

Other Primary & Community Care Services:

- Urgent primary care access (Out of Hours)
- Dental Teaching Unit

- Community Dental Services
- Patient Education Programme
- Inverse care programme
- Primary care support unit (salaried GPs & managed practice)
- Prison Healthcare Service (from Dec 22)
- Home Oxygen Service
- Specialist Palliative Care (SPC)

- Community Teams / Services

    - Community Wellbeing & Therapy Team
    - District Nursing
    - Vaccinations and Immunisations Team
    - Integrated Network Teams
    - Health @ Home (Rhondda/Merthyr only)
    - Community Resource Team (Bridgend only)
    - Lymphoedema Services (Rhondda/Merthyr, Service Level Agreement for Bridgend)
    - Health Visiting
    - School Nursing

- Tissue Viability Service (Rhondda/Merthyr, SLA for Bridgend)

    - Parkinson Clinical Nurse Specialists (Rhondda/Merthyr, Medicine for
    - Bridgend)
    - Advanced Care Planning Nurses
    - Wound Care' Lindsey Leg Clubs

- Palliative Care Service inpatient & Community services

- Continuing Health Care for adults
- Community / Health Parks Site Management & Development
- Community Hospitals Sites, Wards & Administration, includes outpatients in Maesteg
- Cluster Development so cluster clinical leadership and management support and development.

Roles / titles of leadership team & key responsibilities

The Deputy COO for Primary, Community and Mental Health will lead the Care Group managerially on behalf of the Chief Operating Officer. They will be supported by a Director of Nursing for Primary, Community and Mental Health. There will be two Care Groups and the details of these are set out below:

- Primary & Community Care Group
- Mental Health and Learning Disabilities Care Group

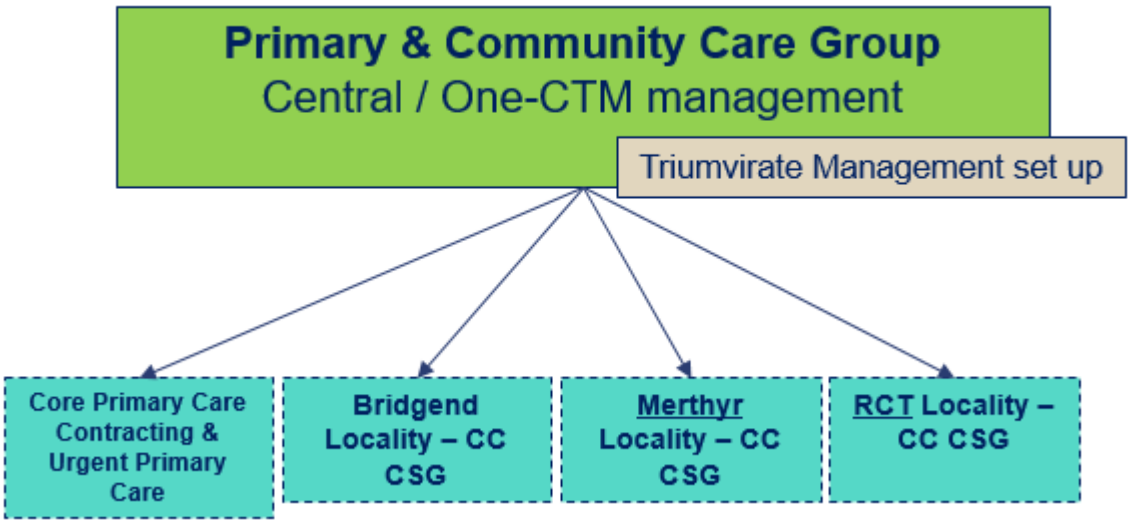
The Primary and Community Care Group will be led by the following roles:

- Group Service Director – Will lead the Care Group
- AMD for Primary and Community
- Group Nurse Director (shared with Mental Health)

Further work up is needed to ensure strong leadership input and alignment of wider therapies professions to this care group.

Detailed roles and responsibilities across a range of competency areas will be outlined in individual job descriptions as per the OCP process.

Organogram



National responsibilities within Care Group

- PC medical Directors Group
- Dental Directors Group
- Directors of Primary Care
- Heads of Primary Care
- Dental Contract Reform Oversight Group
- Strategic Programme for Primary Care
- Prisons Oversight Group
- National End of Life Care Board
- All Wales District Nursing Forum
- All Wales District Nursing Strategic Oversight Board
- All Wales District Nursing Senior Nurse Peer Group
- All Wales Band 4 Development Group

Miscellaneous points

The relationship of cluster development with other aspects of Primary Care, Community, mental Health and Local Authority working has never been more important with the strong focus on Accelerated Cluster Development. Cluster

management and development will take place within Localities that mirror the Local Authority footprints.

Part 3e – Mental Health Care Group

Introduction

All services currently provided by the Child and Adolescent Mental health Clinical Services Group and the three adult Mental Health Clinical Services Group transfer to the responsibility of the Mental Health and Learning Disabilities Care Group.

Adult Mental Health services has a multidisciplinary workforce of approximately 680 whole time equivalent (WTE) staff including nurses, psychiatrists, psychologists, occupational therapists, administration staff and medical staff. In addition to this Child and Adolescent Mental Health Services has approximately 300 staff.

The Care Group will also take responsibility for the Mental Health and Learning Disability Continuing Health Care working through integrated governance with Primary and Community Services Care group.

The Care Group proposes it will initially continue to provide its own Outpatient and Medical Records functions as per current arrangements but will consider mainstreaming opportunities with the wider Health Board systems and teams. There is also an administrative team to deliver the legal requirements of this mental Health Act on behalf of the Board.

The care group continues to lead on providing a full array of mental health services across five hospital sites and a range of community sites. In addition to this there is a wide range of Service Level Agreements (SLAs) with Voluntary Sector organisations as well as a number of outsourcing funded arrangements. The Care Group continue to manage this with oversight and support from the central teams.

Please refer to the section outlining the Diagnostics, Therapies and Specialities Care Group for full details but it is worth noting in this section explicitly that Mental Health Psychology will be directly managed through the Mental Health and Learning Disability Care Group. The Head of Psychology will hold professional accountability for Art and Music Therapists working within mental health services. Occupational therapists will be directly managed within the Diagnostics, Therapies and Specialties Care Group, with robust communication systems in place to ensure effective delivery services.

Swansea Bay University Health Board provides CTM Learning Disability services. The leadership of the commissioned services will sit within this care group supported by key central departments. The driving of improving the health experiences of people with a learning disability – addressing key health inequalities will remain with the Director of Nursing as per current arrangements.

Scope of what's included within this care Group

- Older Adult MH Wards
- Adult MH Wards
- Rehabilitation Units
- Ty Lydiard

- Community Teams
    - Adult Community Mental Health Teams
    - Older Adult community Mental Health Teams
    - Children & Young People community Mental Health Teams
    - Forensic Nursing Team
    - Crisis Resolution Home Treatments
    - Local Primary Mental Health Services and PC MH Team
    - Arc Day Opportunities
    - Outreach & Recovery Teams
    - Community Drug & Alcohol Teams
    - Memory Assessment Services
    - Older Adult Day Services
    - Care Home In reach and Stay & Support Services
    - Veterans Service
    - Perinatal Service
    - Early Intervention Service
    - Eating Disorder Service
    - Integrated Autism Service – Adults
    - Psychology Services – provided across Cwm Taf Morgannwg (excluding Health Psychology)
    - Wholes Schools Approach Services

- Acute Hospital Psychiatric Liaison Services
- Continuing Healthcare Commissioning Quality Assurance Team
- Mental Health Act administrator
- Medical records
- As the Health Board continues its focus to align and standardise processes and services, a review of the Medical Records services for Mental Health will take place alongside a review of the wider Medical Records function to explore opportunities for alignment of working practices. This review will take place once the initial consultation process has been concluded.

Roles / titles of leadership team & key responsibilities

The Deputy COO for Primary, Community and Mental Health will lead the care group managerially on behalf of the Chief Operating office. They will be supported by a Director of Nursing for Primary, Community and Mental Health. There will be two care groups and the details of these are set out below:

- Primary & Community Care Group
- Mental Health and Learning Disability Care Group

The Mental Health & LD Care Group will be led by the following roles:

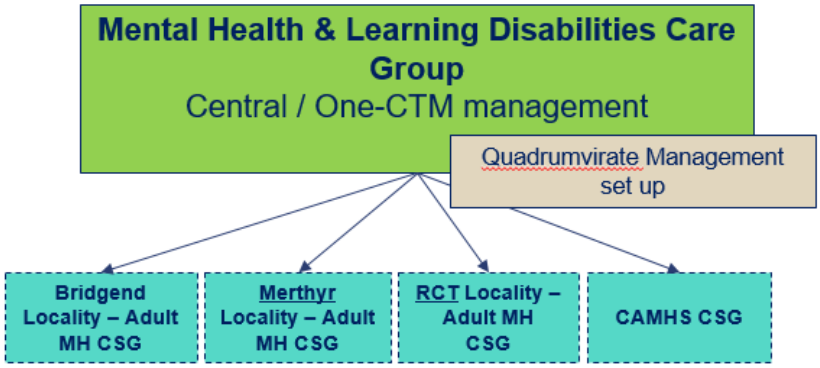
- Group Service Director – Will lead the Care Group
- Group Medical Director
- Group Nurse Director (shared with Primary & Community Care Group)

There will also be a Head of Psychology leadership role on a sessional basis

Further work up is needed to ensure strong leadership input and alignment of wider therapies professions to this care group.

Detailed roles and responsibilities across a range of competency areas will be outlined in individual job descriptions as per the OCP process.

Organogram incl. reporting lines



National responsibilities within Care Group

- Mental Health Network Board & Subgroups incl.
  - CAMHS subgroup
  - Eating disorder subgroup
  - Adult Services subgroup
- National Mental health Partnership Board
- All Wales Senior Nurse Advisory Group (Mental Health)
- Crisis Concordat
- National Learning Disability Implementation and Assurance group Meeting
- Mental health Act Managers Forum
- CYP Regional Partnership Boards
- CAMHS All Wales Leads Meeting (run via the CAMHS Network in PHW)
- National Psychological Therapies Committee

Part 3f – Diagnostics, Therapies and Specialties Care Group

Introduction

Our Diagnostics, Therapies and Specialties Care Group has been developed to recognise that the services within it provide input across the entire Health Board: planned and unscheduled care, Children & Families services, mental health, primary and community care. A diverse and multi-professional workforce delivers these services, comprising healthcare scientists (HCS), medics, nurses, allied health professionals (AHP), and pharmacists.

Grouping these services in this way ensures visibility, the ability to maintain strength of voice across the Health Board, and offers robust oversight and assurance of performance, quality and governance. The resilience of services is increased through the ability to be flexible in response to demand and capacity fluctuations. Our colleagues benefit through strengthened inter-professional connections, organisational proximity to professional leads, and increased opportunities for portfolio careers.

As members of the Diagnostics, Therapies and Specialties Care Group deliver services across the Health Board, effective communication and robust working relationships with all other care groups is of paramount importance.

The Care Group structure aligns with key national strategies and programmes of work, providing a single point of contact and economies of scale. Examples include the national frameworks for AHPs and HCS, the Statements of Intent for Pathology and Imaging, and the National Clinical Framework, amongst others.

Scope of what is included within this Care Group

The following services are included within the Diagnostics, Therapies and Specialties Care Group:

DIAGNOSTICS

- Radiology
- Pathology
- Audiology
- Respiratory Physiology
- Cardiac Physiology

ALLIED HEALTH PROFESSIONS (AHP)

- Physiotherapy
- Occupational Therapy
- Speech and Language Therapy
- Podiatry and Orthotics
- Nutrition and Dietetics
- Health Psychology

CLINICAL SUPPORT

- Medical Devices
- Clinical Engineering
- Medical Illustration
- Equipment and Medical Device Transfer
- HSDU

PHARMACY – incl. all medicines management

Roles / titles of leadership team & key responsibilities

The Diagnostics, Therapies and Specialties leadership team provide operational and professional leadership to colleagues working within the care group. They are responsible for activity, performance and governance of the services they oversee. Reporting operationally to the Deputy Chief Operating Officer, these are senior roles and all of the leadership team work closely with colleagues within the group and across all other care groups to support the delivery of high quality services. The leadership team are required to work in partnership with all other care groups due to the pan-CTM nature of the services they lead.

There is no Nurse Director within the leadership team due to the small number of nursing colleagues working within the care group. Nurses working within the Care Group will receive professional support and oversight from the Nurse Director within the Planned Care Group.

The Chief Pharmacist will receive professional support and oversight from the Medical Director. The Clinical Director for AHPs will receive professional support and oversight from the Director of Therapies and Health Science. Professional leads for HCS continue to be professionally accountable to the Director of Therapies and Health Science.

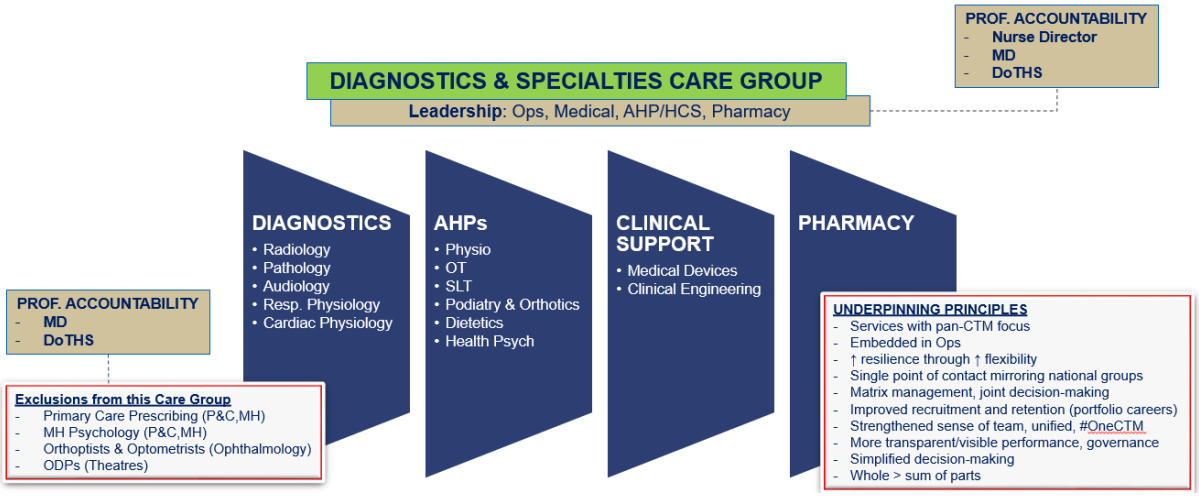
The leadership team will comprise of:

- Group Service Director – Care Group Lead
- Group Medical Director
- Group Nurse Director (Provided by Planned Care Nurse Director)

There will also be the following roles contributing to the Senior Leadership Team:

- Clinical Director for Allied Health Professions
- Chief Pharmacist

Organogram



Addition – *Please note that this Care Group will also include responsibility for the HSDU service*

National responsibilities within Care Group

Groups that we have representatives on or Chair

- National Pathology Network Board
- National Imaging Programme Board
- LINC Programme Board
- RISP Programme Board
- Healthcare Science Network Meeting
- Audiology Standing Specialist Advisory Group
- All Wales Pathology Workforce and Education Group
- All Wales Imaging Workforce and Education group
- All Wales Point of Care Testing Strategy Board
- All Wales Pathology Quality and Regulatory Compliance Group
- National Digital Cellular Pathology Programme
- National Pathology Operational Managers Group
- Strategic Programme for Primary Care
- National Planned Care Programme
- All Wales Allied Health Professions Committee
- National Joint Professional Advisory Committee

Miscellaneous points

Contact has been made with other NHS providers within Wales and England, where this structure has been found to be effective.

Part 4 – Facilities Structure

Since the formal consultation began it has been subsequently decided not to progress with the original proposals around the centralisation of Facilities at this time. Therefore the current arrangement and management of the Facilities function across the Health Board will remain as it is currently. If in the future there is an aspiration to reconfigure the service, this will be conducted as part of a separate OCP. The exception to this are the services that are being moved into the Diagnostics, Therapies and Specialities Care Group.

Part 5 – Nursing & Midwifery

Introduction and outline of the Nursing structure at CTM

The Nursing and Midwifery profession is enabled to consistently deliver safe, effective, high quality person centred care reflecting the health needs of local communities, underpinned by the professional standards within the Nursing & Midwifery Code of Practice and the delivery of the Chief Nursing Officer (CNO) for Wales priorities 2022-2024.

Nursing & Midwifery Code of Practice

The Code sets out common standards of conduct and behaviour for those on the NMC register. This provides a clear, consistent and positive message to patients, service users and colleagues about what they can expect of those who provide nursing or midwifery care.

The Code of Practice has four key principles:-

- Prioritise people
- Practice effectively
- Preserve safety
- Promote professionalism and trust

The Chief Nursing Officer (CNO) for Wales has developed in collaboration with stakeholders five key priorities for 2022-2024. These were launched in April 2022.

- Leading the profession - invest in and develop nurse and midwife leaders at all levels in health and social care through dedicated leadership programmes;

- Workforce - close the vacancy gap and attract, recruit and retain a motivated, skilled workforce;

- Making the professions attractive - inspire people to enter the nursing and midwifery professions as the most attractive healthcare career choice in Wales;

- Improving health and social care outcomes - deliver equitable, good-quality, person-centred care; and

- Professional equity and healthcare equality - create a nursing and midwifery workforce that reflects the population it serves and addresses inequalities

The locality based nursing leadership structure under the current model, has reaped significant benefits in terms of place based integrated nursing care delivery across the life span of local populations. This integrated nursing team under the leadership of a locality nurse director has also benefitted from a reduction in 'hand offs' of patient care to multiple different teams and has fostered excellent working relationships across the different branches of nursing within each locality.

Each Nurse Director maintains a locality leadership role in addition to their Care Group responsibilities within a set of key design principles, which can be found below.

Nursing leadership at each component of this operating model will encompass the following design principles:

- To involve, engage and provide evidence based person-centred care to our communities and local populations
- To work as one Nursing and Midwifery team across the care groups with a locality focused professional leadership model
- A commitment to multi professional cross boundary working with all agencies
- To remain professionally curious and always seek ways to continually improve
- To seek to uphold the standards within the NMC code whilst encompassing, advocating and enabling our health board values and behaviours to be upheld
- To enable clear lines of responsibility / quality assurance / reporting mechanisms from point of care delivery to Board level

Nursing Leadership within Care Groups

Each Nurse/ Midwifery Director will have professional accountability for professional leadership, quality governance and people's experience for a designated Care Group, reporting into the Executive Director of Nursing's office.

The Planned Care Nurse Director role will provide professional leadership support to the nurses working within the Diagnostic, Therapies and Specialties Care Group.

The locality part of the role will comprise of several aspects.

- Take a lead role for a designated locality where there are cross-cutting professional / quality issues and interdependencies across CSGs.
- Act as a collegial point of contact for external oversight bodies where locality cross cutting issues need to be addressed.
- Be the key contact on behalf of the Care Group for locality public engagement for example with local authorities and third sector teams.
- Nurse Director's will also retain site based strategic leadership responsibility.

The Nurse/Midwifery Directors will continue to lead strategic pieces of work on behalf of the Executive Director of Nursing at both local and national level, whilst maintaining the strong established links with all stakeholders and strategic partners across the localities.

Nursing leadership within the Community Care / Primary Group & the Mental Health Care Group

A designated Head of Nursing will be responsible and accountable for nursing care delivery / quality governance within the Primary & Community Care Group and Mental Health Care Group (which includes a Head of Nursing for CAMHs). As with the acute sites, all Heads of Nursing will work as part of an integrated Care Group leadership team.

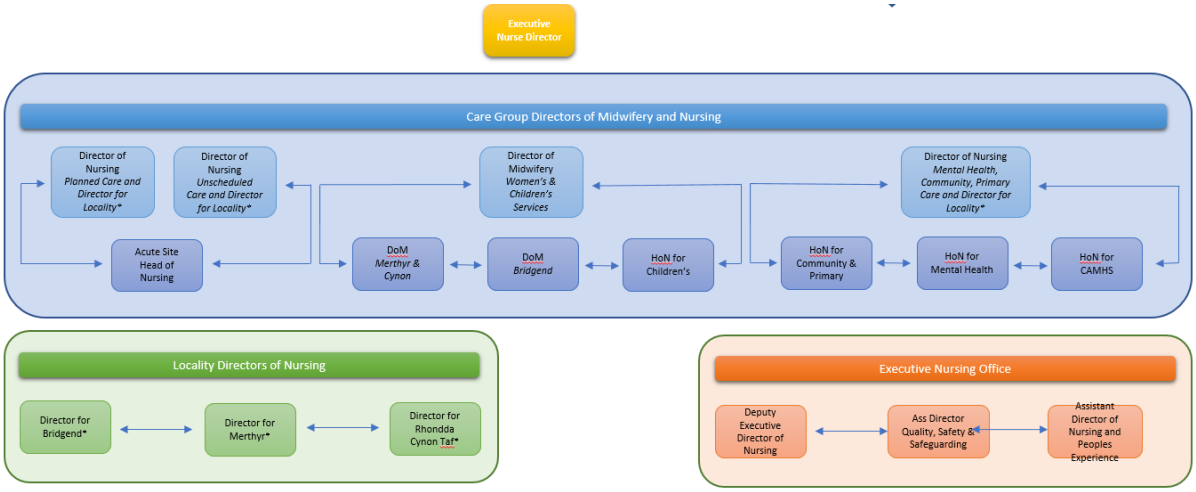
Nursing / Midwifery leadership within the Children & Families Care Group

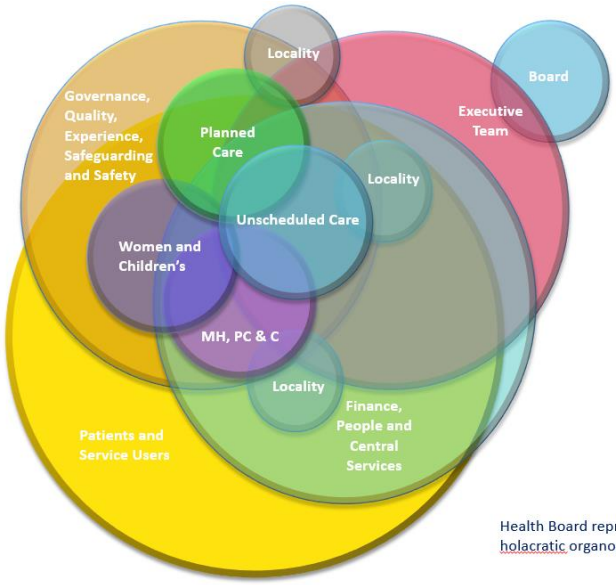
The Director of Midwifery will be professionally accountable for professional leadership, quality governance, peoples experience within the Children & Families care group. There will remain a designated Head of Midwifery in place at each obstetric unit with the Head of Midwifery at Prince Charles Hospital taking accountability for midwifery services on the Royal Glamorgan site. The Head of Nursing for Children's services will also report into the Director of Midwifery.

There will be no change to the reporting lines of both the senior / lead nurses and midwives.

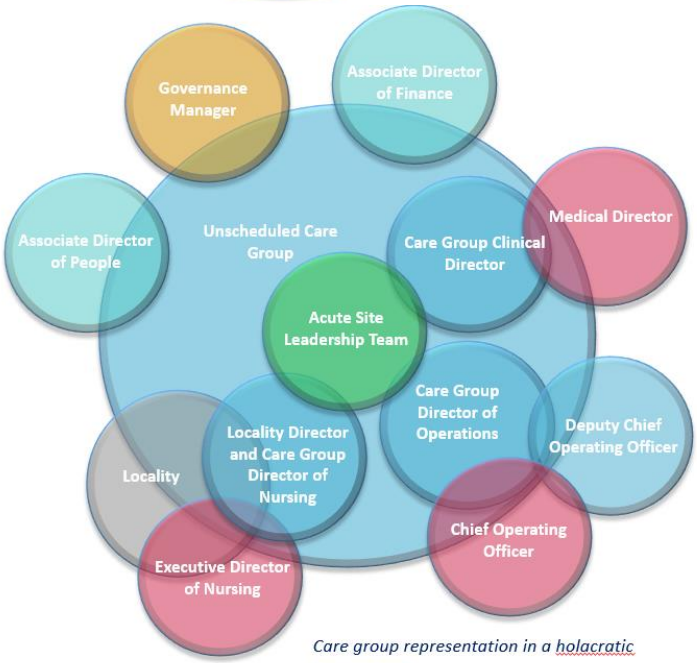
Nursing Leadership at acute site level

A designated Head of Nursing will be responsible and accountable for care delivery within the planned and unscheduled care groups for each acute site. They will also act as an interdependency and interface between care groups which may be geographically located on their specific acute hospital site e.g. paediatrics/ maternity services/ mental health services .The Head of Nursing at each acute hospital site will work as part of the acute site based triumvirate with the general manager and medical director.





Health Board representation in a holacratic organogram.



Care group representation in a holacratic organogram.

Part 6 – Quality & Safety / Putting Things Right

Quality & Safety in the model – outline of key structures and responsibilities

Purpose:

The people who use our services, wherever they live, can expect no variation in approach to care and resources within our health board. To provide a consistent, equitable function across the Health Board in respect of Quality Governance, Patient Safety, People's Experience and Putting Things Right, the current ILG Quality Governance roles and responsibilities will be re-aligned in order to provide a centrally managed team structure with a focus on effectiveness, performance and equitable distribution amongst the Care Groups. The centralisation of the functions will provide greater flexibility and mobilisation to services where greater support is required in order to respond to acuity fluctuations and need.

The model will also support a central cohort of professional and technical expertise to support our services in responding to complex issues. The services within the '**Quality & Safety Central Team'** will work hand in glove with the Care Groups and Clinical Service Groups to ensure a quality service from the outset, but when things do go wrong, lessons are learnt and acted on swiftly and our patients and families are supported appropriately.

Changes required:

The Care Group operating model will mean changes will be required to the current Quality Governance & Assurance Framework, PTR policies, with necessary changes to aligned systems, processes and pathways. This includes monitoring systems and audit processes to provide assurance of patient safety, learning and quality of care across the organisation.

Each Care Group will benefit from an assurance, escalation and risk framework, clearly demonstrating how this links to the overarching governance framework for point of service to Board assurance. Similarly, a shared model of a multi-disciplinary panel to quality assure and recommend closure of all care group incident and complaint investigations that will provide consistency of approach, robust analysis and drive quality and learning.

A Care Group Quality & Safety Forum, modelled on the current ILG function will enable each group to seek assurance from their clinical service groups and ensure that their services are safe, effective, efficient, equitable, timely and person centred. Each Care Group Q&S Forum will report upwards to a Health Board Wide Quality Assurance Group, which in turn will provide assurance to the Board via the Quality & Safety Committee as well as providing performance information to other executive, sub-committee and Board groups.

Alignment of current ILG based Quality Governance roles will be required to meet the specification of the function in order to function successfully as one organisation.

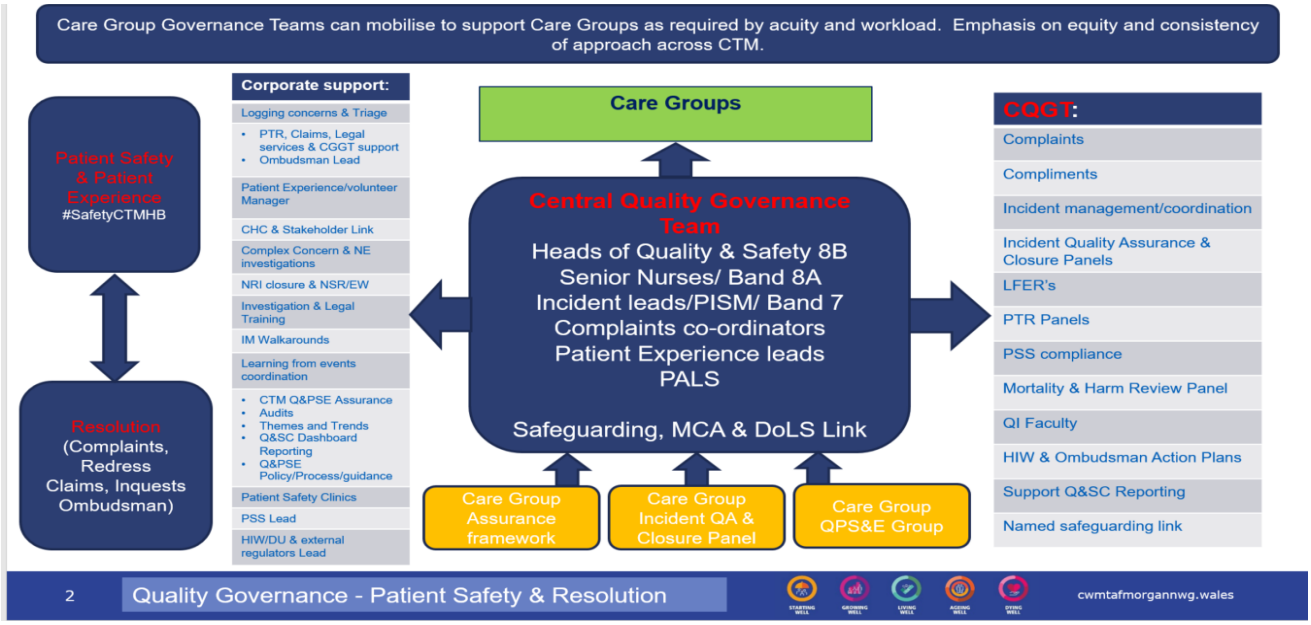
People:

There will be a focus on demonstrable improvement in effectiveness, performance and equity of service provision across the Care Groups. People may have to re-locate or work in different ways to ensure there is parity of service provision to the care groups, under a centralised structure. It is recognised that a locality-based presence will be required of roles that require timely patient contact such as PALS, concern resolution and colleague interface. Therefore, the experience and skills of those who currently provide these functions within the ILG operating model will bring significant value to a centralised system and will be crucial to the success of good quality, safe and effective services.

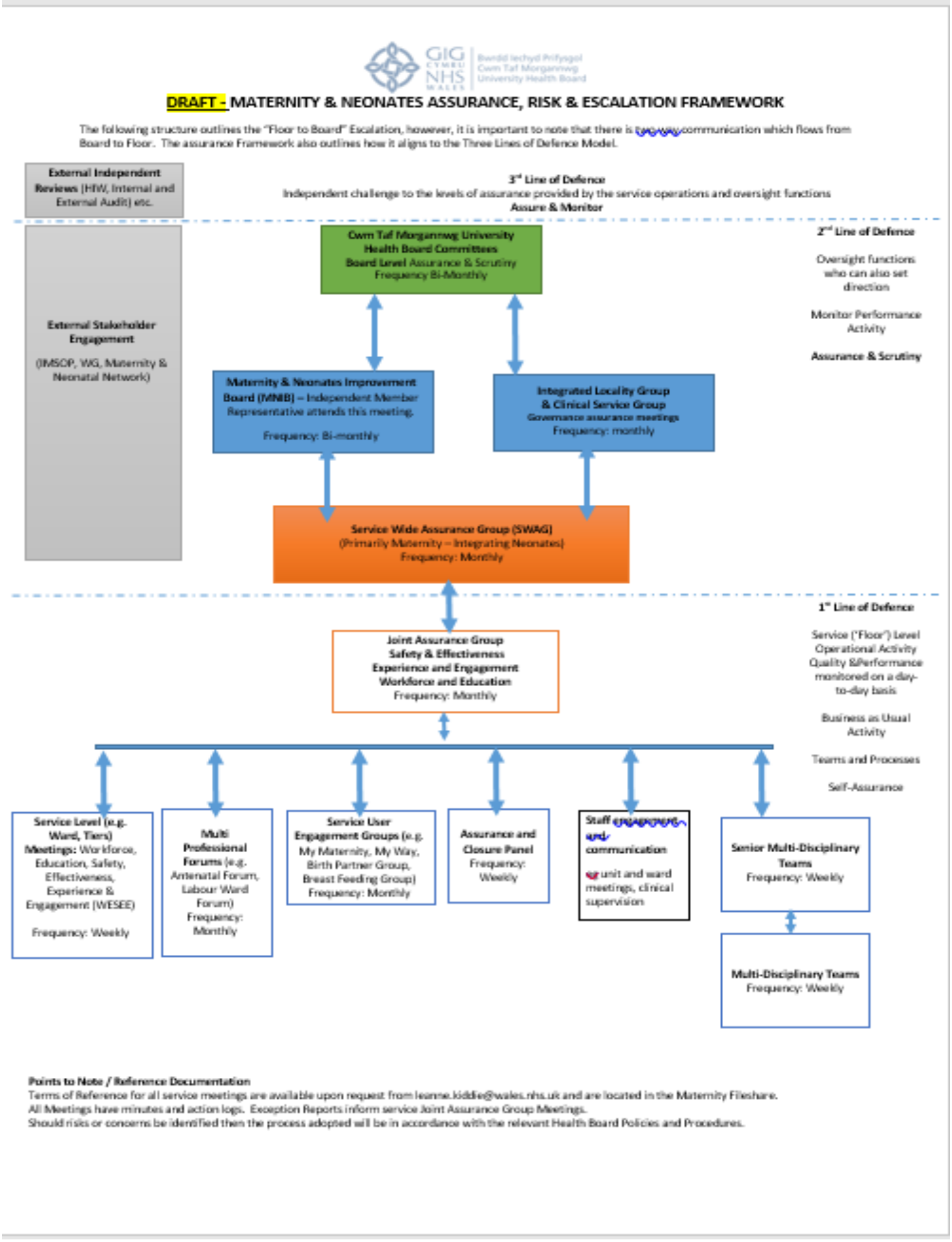
The model proposes a Central Quality Governance Team which supports each of the Care Groups with a similar model to manage and optimise patient safety incident management and investigation, complaints, compliments, and Putting Things Right regulations work, patient experience, mortality and harm reviews, patient safety solutions, external action plan reviews, quality improvement and faculty advocates. Care Group Quality Governance teams will be centrally managed in order to maintain equity and consistency and strengthen resilience. The current executive and senior leadership team supported by the central patient safety team and the concerns and legal services team, will retain their core functions to provide pan-organisational strategic direction, leadership and oversight in compliance with legislation and regulation, quality planning, quality improvement, quality control and assurance, and in managing risk.

The central **Datix** function will transfer from Health & Safety into the Central Resolution Team with no further changes to the function or interaction with Clinical Service Groups.

Model of centralised Quality Governance (Patient Safety & Resolution)



Example of a Care Group Assurance Framework model:



RESOLUTION (Complaints, Redress & Legal)

Executive Lead – Director of Corporate Governance

Responsible Officer – Assistant Director of Concerns & Claims

In accordance with the Health Board's commitment to openness and transparency, and the introduction of the Duty of Candour in 2023, where concerns have been identified, it may be necessary to consider formal resolution.

Formal resolution may involve;

- Responding to an informal, or formal written complaint;
- Responding to the Public Service Ombudsman;
- Offer of financial redress;
- Other legal resolution such as a legal claim (personal injury/medical negligence);
- Engaging with HM Coroner, including responding to Section 28 Reg 28 Reports

Complaints (including Ombudsman), Putting Things Right (PTR), Legal (Redress, Claims & HM Coroner Inquests) and Datix will be primarily led, coordinated and managed by the Central Resolution Team.

The Central Resolution Team will retain professional and technical expertise in managing, advising and training on systems, processes and quality assurance in relation to complaints, PTR redress, legal and the Datix information management system.

The following provides a summary of the role of the Central Resolution Team and is intended as a guide, with SOPs and guidance documents in place to provide more detail. These will be updated to reflect the changes following the changes to the operating model being agreed.

	CENTRAL	CARE GROUP
PTR Complaints	• Work with Patient Care & Safety on Investigations to ensure early learning in the Care Groups • Triage – Single Point of Entry, Categorisation Acknowledgement & Referral to SPOC in relevant Care Group • Policies • Processes • Complaints training (inc. communications) • Trend & theme analysis • Data/business intelligence (from Datix) • Specialist advice • Management of complex complaints	• Investigate and respond to complaints, engaging with relevant health professionals ensuring breach of duty and causation is considered. Linking with Central Resolution team for advice when required • Ensuring PTR targets are met • Work within the remits of Health Board policies and procedures

	CENTRAL	CARE GROUP
	• Quality Assurance on content and style of complaints/PTR responses ensuring patients and families receive robust responses in a sensitive and appropriate manner • Central point of contact & management of all Ombudsman Cases	
PTR Redress	• Work with Patient Care & Safety on Investigations to ensure early learning in the Care Groups • Full management of redress cases arising from concerns (incidents/complaints) • Lead on determining BoD, Causation and Quantum & seeking appropriate authority • Work in conjunction Clinical Service Groups to draft correspondence detailing outcome/decision on behalf of the Care Group to ensure regulation compliance • Contribute to the completion of LFERs to support improved patient safety, experience and process of reimbursement from WRP • Completion & submission of Case Management Reports to support WRP reimbursement • Engagement with WRP, L&R, PSOW	• Ensure timely completion of LFERs to support improved patient safety, experience and WRP reimbursement • Following on from concern investigation, engage with Resolution team to confirm BoD, causation and quantum and determine whether Redress is required
Claims	• Work with Patient Care & Safety on Investigations to ensure early learning in the Care Groups • Instructing legal advice • Full management of claim including seeking relevant authority for admissions and financial implications in accordance with the Scheme of Delegation • Contribute to the completion of LFERs to support improved patient safety, experience	• Ensure timely completion of LFERs to support improved patient safety, experience and WRP reimbursement

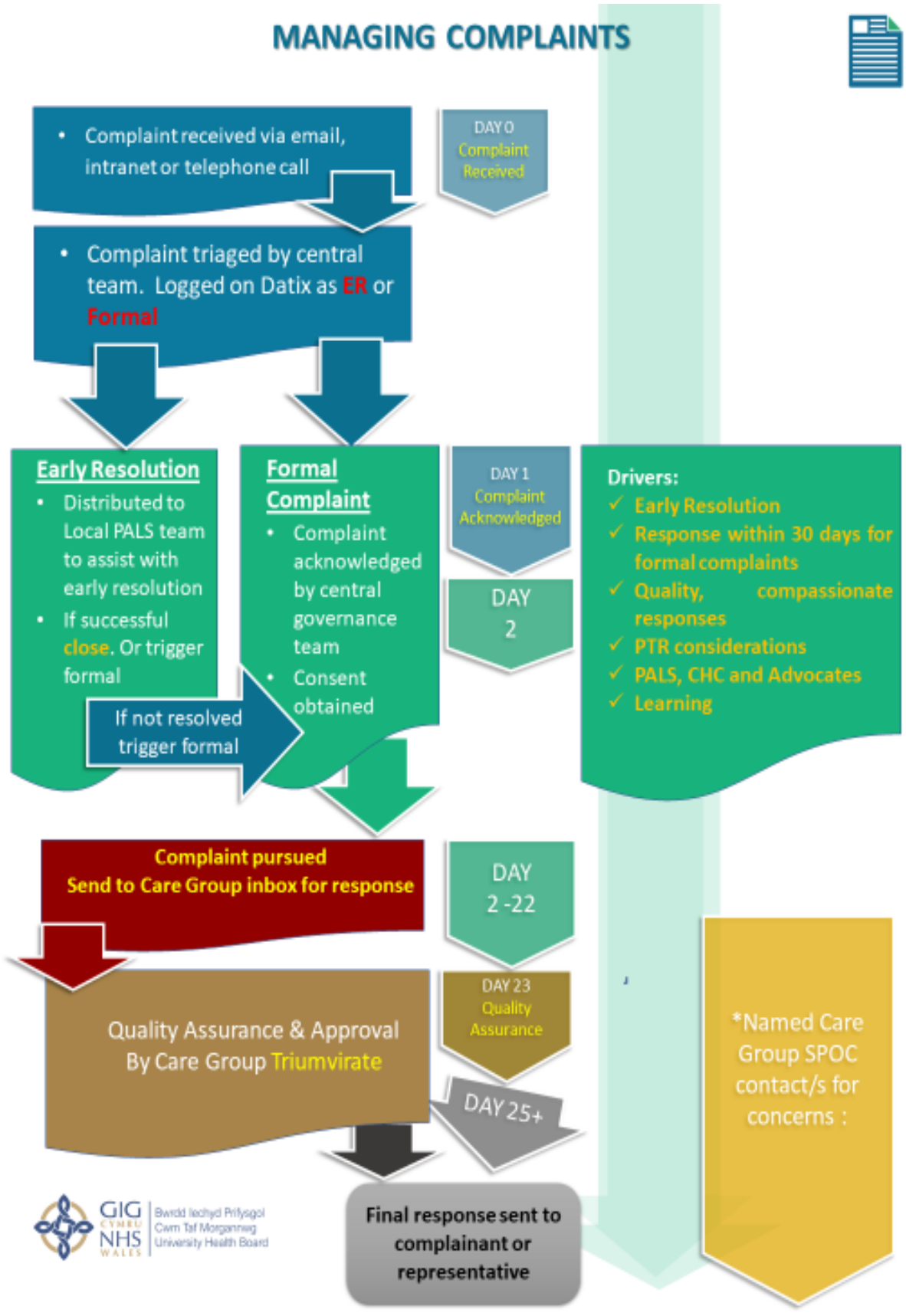
	CENTRAL	CARE GROUP
	and process of reimbursement from WRP to support WRP reimbursement where cases exceed £ excess • Completion & submission of Case Management Reports to support WRP reimbursement where cases exceed £ excess • Management and response to ad hoc legal queries	
HM Inquests	• When requests come in via Resolution Legal team, notify relevant Care Group Governance team in order to obtain statements • Legally review and advising on draft statements • Advise on referral to ensure appropriate statements are gained from HB staff • Support HB staff through statement drafting, preparedness for Inquest and subsequent debrief • Trend and theme analysis including flags for potential Regulation 28 implications • Link with Communications & Engagement to ensure reputational management on any cases with potential media attention • Managing Regulation 28 response to HM Coroner	• Obtain statements from appropriate members of staff, ensuring appropriate administrative and governance support is provided • Send Statements onto the Resolution Legal team for review and submission • Lead on development of responses to Regulation 28 in conjunction with Central Resolution Legal Team

Roles & key responsibilities

Assistant Director of Concerns/Claims oversees the Concerns & Claims functions, sets policy and standards and ensures quality assurance of all aspects of resolution.

Together with the AD Concerns/Claims, Care Group leads will attend and report on agreed metrics to the Health Board's Quality Assurance Group (to be established) which in turn provides assurance to the Senior Leadership Team and Q&S Committee of the Board.

Managing Complaints within Care Groups:


MANAGING COMPLAINTS
• Complaint received via email, intranet or telephone call
DAY 0 Complaint Received
• Complaint triaged by central team. Logged on Datix as ER or Formal
Early Resolution
• Distributed to Local PALS team to assist with early resolution
• If successful close. Or trigger formal
If not resolved trigger formal
Formal Complaint
• Complaint acknowledged by central governance team
• Consent obtained
DAY 1 Complaint Acknowledged
DAY 2
Drivers:
✓ Early Resolution
✓ Response within 30 days for formal complaints
✓ Quality, compassionate responses
✓ PTR considerations
✓ PALS, CHC and Advocates
✓ Learning
Complaint pursued
Send to Care Group inbox for response
DAY 2 -22
Quality Assurance & Approval By Care Group Triumvirate
DAY 23 Quality Assurance
DAY 25+
*Named Care Group SPOC contact/s for concerns :
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board
Final response sent to complainant or representative

Quality, Safety & Safeguarding

Executive Lead – Executive Director of Nursing, Midwifery & Patient Care

Responsible Officer – Assistant Director of Quality, Safety & Safeguarding

Introduction

Quality in health care is defined as:

- the effectiveness of health services,
- the safety of health services, and
- the experience of individuals to whom health services are provided [Health and Social Care (Quality and Engagement) (Wales) Act 2020]

The importance of understanding the components of quality are fundamental to addressing improvements in health care delivery. These are detailed by the Institute of Medicine (IOM, 2001) as safety, timeliness, effectiveness, efficient, equitable and person-centred; providing a valuable framework to evaluate and advance quality of care.

Policy & Guidance

The Welsh Government articulated a vision in 'A Healthier Wales' (Welsh Government 2018). The focus of services shifts towards prevention, reiterating the philosophy of 'Prudent Healthcare' and the Quadruple Aim. The core values that underpin the NHS in Wales are:

- Putting quality and safety above all else: providing high value evidence based care for our patients at all times
- Integrating improvement into everyday working and eliminating harm, variation and waste
- Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales
- Working in true partnerships with partners and organisations and with our staff
- Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively

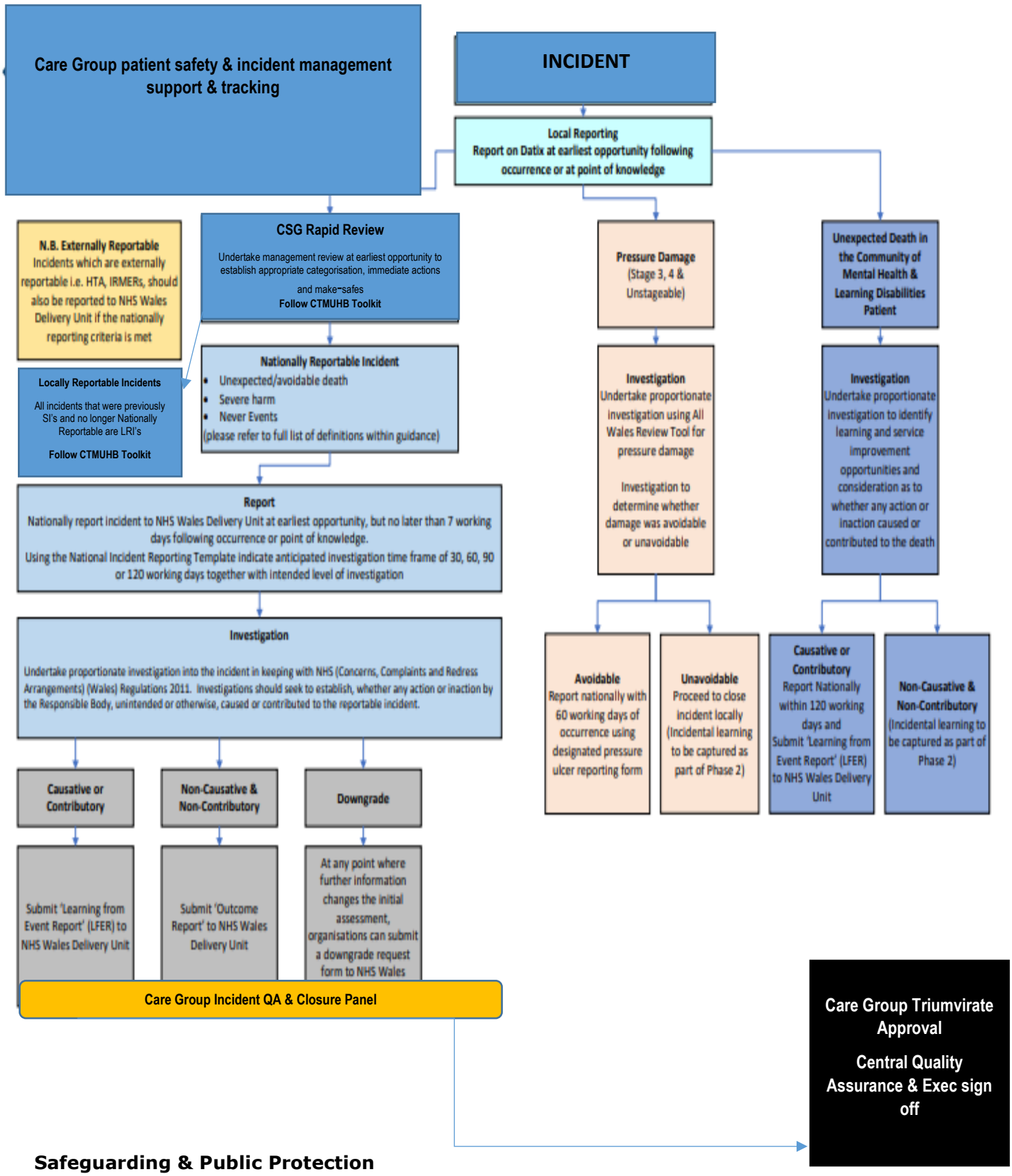
These core values are supported by the good governance principles outlined in the Citizen Centred Governance Principles (2010) and Putting Things Right guidance, 2013.

	CENTRAL	CARE GROUP
Incidents	• Complex investigations • Never Events • Tracking & Incident audit cycle	• Make Safe & prevention • Incident reporting

	CENTRAL	CARE GROUP
	• Early Warning QA • Translating policy into practice • Patient Safety Clinics • RCA/investigation training • Patient Safety Clinics • Pan organisational themes and trends • Standardisation & consistency • Targeted Intervention & Support to Care Groups • Links with QI • Q&S Dashboards/assurance reporting to Boards & committees • DU interface • NRI Closures & sign off • Pan organisational support to Falls & PD panels • PSS lead • Quality Assurance Group	• Work within the incident management framework • Rapid reviews • EW, NE, LRI & NRI reporting and investigation • MDT approach • Ensuring investigation timescales are met • Assurance & Closure Panels with standardised TOR • SMART action planning • Falls & PD panels • Themes & trends • Learning • PSS compliance • Care Group quality dashboard reporting • Work within the remits of Care Group and CTM assurance framework, Health Board policies and procedures • Q&S Forum with standardised agenda
Learning	• Learning Framework • Listening & Learning Forum • Learning for events coordination • Patient Safety Clinics • @SafetyCTMHB	• Support a learning culture • Mortality & Harm review panels • Learning Events
External regulators interface	• Conduit for external quality & safety reviews, inspections, actions and compliance. • External stakeholder relationship leads for DU, HIW, CHC & stakeholders • IM walkabouts	• Take action as required. • Timely progression, updating and monitoring of external recommendations and actions
QI Faculty	•	• Care Group Representative

Safeguarding & Public Protection	• CTMSGB & Sub group representation • Community Safety Partnership • Youth Justice Board • MAPPA Lead • MARAC coordination • DoLS & MCA Lead • Risk management Workforce support • Safeguarding & PP Training • VAWDASV • Prevent, Contest & Counter Terrorism • Serious Offender Lead • Suicide Prevention Lead • Unaccompanied Asylum Seekers Lead • Looked After Children's Services • Cwm Taf MASH • Bridgend MASH • IMHA Lead • Policies into Practice • Safeguarding Supervision & Support • Court attendance support • Care Group Direct public protection nurse link	• Safeguarding is everyone's business • Recognition & response to Safeguarding • Duty to report & Referrals • Involvement in safeguarding reviews, investigations and Learning Events. • Action and compliance with recommendations. • Participation in Operational Groups.

Managing incidents in Care Groups



Safeguarding & Public Protection

Each Care Croup will have a safeguarding, MCA and DoLS link to provide advice, support and information. There will be a pan organisational Adult Operational Safeguarding Group and a Children's Operational Safeguarding Group, chaired by the Head of Safeguarding and reporting to the Safeguarding Executive Group.

Part 7 – Medical Focus – Key roles & responsibilities

Intro and outline of the Medical structure at CTM

The medical model in the organisational delivery model will be key in providing medical leadership and oversight as part of the Care Group structure. The following section outlines the role of the Care Group Medical Lead

Overarching summary of this role within Care Group Structure

Group Medical Director:

- Session allocation: 6 sessions – Consultant, GP of SAS Doctor
- Support for leadership development in SPA

This role would be designed for a Medic who remains clinically active to:

- Work closely with leadership team – Operational and Nurse Leaders
- Oversee medical aspects of Care Group activity
- Provide Medical Leadership of the group
- Support for clinical departments and teams within Group

Medical Leadership within Care Groups (detail)

The following components break down the role of medical leadership within the Care Group Level:

Quality
Complaints / Concerns / Incidents

- Accountable, with Group Nurse Director, for final versions to be signed and delivered or copied to Executives or representatives

- Colleagues to do the reports accountable for completion, accuracy and implementing changes and recommendations Including: LEFR, Serious Incidents, Never Events, Coroner, Ombudsman reports

- Responsible for implementing regulation 28s, as well as Coroner and Ombudsman recommendations and requirements.
  Provide reassurance and evidence of compliance with regulations as required

- Accountable, with triumvirate, for group meeting target response times

Governance

- Accountable for Medical Governance activity within specialities of Group.
  - Meetings occurrence and attendance by permanent team members
  - Compliance with CTM agreed governance processes
  - Sharing of learning themes across acute sites and community
- Develop Dashboards, alongside Group triumvirate, for metrics used to provide evidence of Groups performance.

- Dashboards will be same from Clinical site meetings (CDs level) to CTM committee level

Improving Care

- Accountable for primary secondary care interactions relevant to specialties within group
- Accountable for maintaining and driving standards of care within specialty
- Sign off approval of all guidelines and policies related to activities of Group.
- Send report to MD Manager for any policies and guidelines approved, to be logged as CTM policy.
- Accountable for guidelines / policies being implemented and adhered to, Clinical Specialty Directors (CDs) are responsible for this.
- Nominate a representative to join Mortality Review stage 3 review
- Ensure medical engagement form Group for Stage 1 and 2 Mortality review process

Professional Standards

- Responsible for initial investigation of concerns regarding doctors within group
- Delegate to CD or Site Leads as appropriate
- Initial discussions to gather information / address issues as able and escalate as needed
- Responsible for reporting serious concerns to Deputy MD for Prof Standards

Workforce

- Accountable for Medical workforce recruitment strategy and implementation
- Accountable for Job Planning within all Group Specialties
    - Standardised Job Planning across each specialty
    - Oversee SPA activity across specialty

Finance

- Operate within financial budget
- Develop business cases with Triumvirate and CDs to develop service
- Supported by Financial Business partnering team to deliver service within budget

Activities and Outcomes

- Accountable alongside Group operations lead and Nurse Director for Group activity and outcomes
- Provide regular reports to Executives and CTM committees
- Provide action plans and strategy to meet targets set and future development of services

Reporting to

- The Care Group Medical Director will operationally report to the Group Service Director. There will be a professional reporting line through to the Executive Medical Director's office, including the Deputy Medical Director.

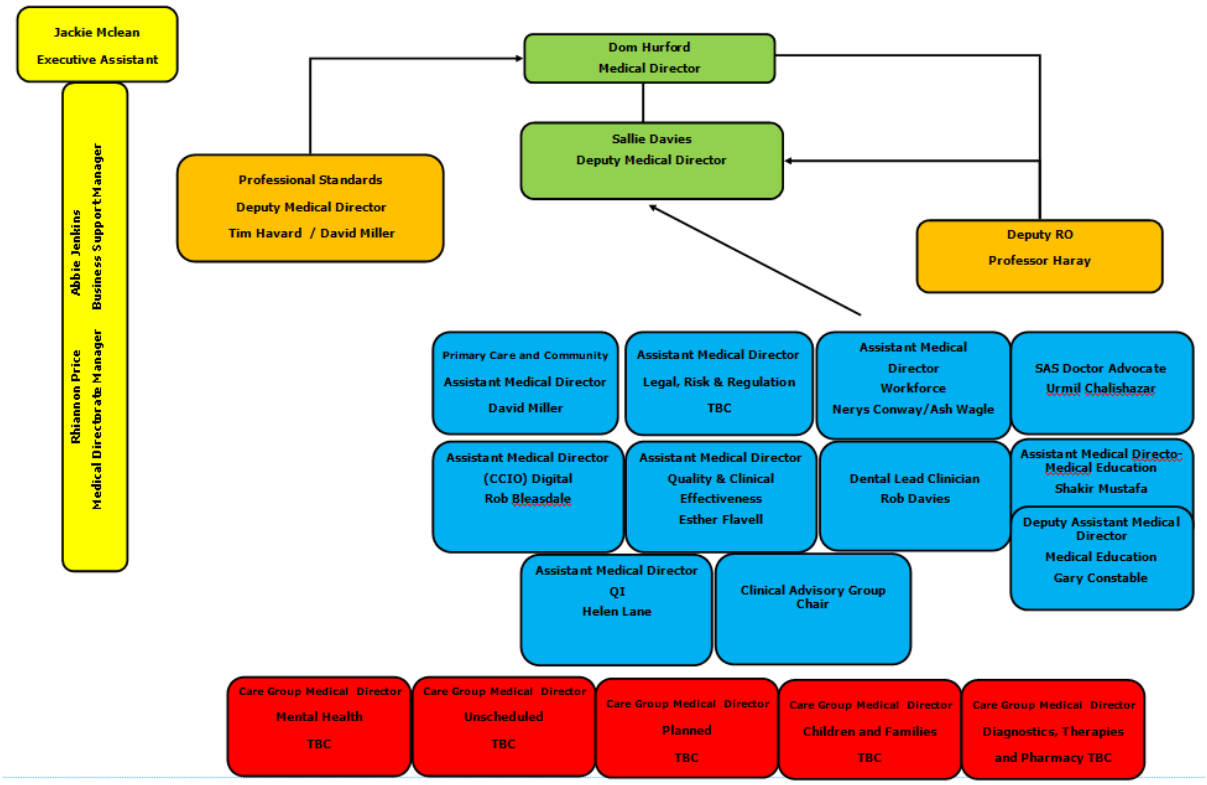
- Different aspects of the post will require reporting to different leads (see attached a flow chart)
- Activity and Outcome reports to Deputy COO / MD Manager on agreed regular basis
- Provide reports for CTM committees relevant to areas within Group, notably:
    - Quality and Safety (Governance and patient safety issues)
    - People and Culture (Workforce and Job Planning)

Support in post

- Would enter the appointee onto the CTM "Inspire" development programme
- Regular sessions with Deputy Medical Director and Medical Director, to review actions and situations
- Invitation to join AMD sessions for support and feedback

Medical Leadership at acute site level

There are no changes to the current model with reference to acute site medical leadership on our three DGH sites.



Part 8 – Corporate support to Care Groups outline

Corporate specialist support to the future Care Groups is key to ensure the Groups have access to the support required to underpin their responsibilities. The following section outlines the 'business partner' support set up from all the key corporate specialisms. This may adapt and evolve over time to ensure the needs of the organisation are met as new tools, technologies and ways of working are developed.

In the future ways of working, the organisation needs to ensure it is clear with the offer of how corporate staff can and should be expected to support operational teams and different levels. The principle of this will need to ensure that managers are clear on what their responsibilities are and where they can seek specialist corporate support.

1. **Finance** support structure

The **current** finance structure includes four business partnering teams (circa 40 WTE) which support the following service areas:

Service area	**Finance lead for business partnering team**
Bridgend ILG	Assistant Director of Finance
RTE ILG	Assistant Director of Finance
Merthyr Cynon ILG	Assistant Director of Finance
Delivery Executive and Corporate directorates	Head of Finance

The finance structure to support the new Care Groups is as follows. Further work is needed to agree the distribution of the 40 WTE staff across the four new business partnering teams and work is underway to ensure this is conducted:

Service area	**Finance lead for business partnering team**
Planned Care Group Diagnostics, Therapies & Specialties Care Group	Assistant Director of Finance
Unscheduled Care Group Children & Families Care Group	Assistant Director of Finance
Mental Health Care Group Primary & Community Care Group	Assistant Director of Finance

Facilities plus all Corporate directorates	Head of Finance

Reporting - The Assistant Directors of Finance are currently managerially responsible to the ILG Directors of Operations. The proposal under the new model is that managerial responsibility will revert back to the Deputy Director of Finance.

2. Planning support structure

The core planning/transformation team is very small; with the bulk of the planning capacity having been disseminated into ILGs; a band 8b and a band 7 to each.

A workshop held in April with the relevant individuals established the need to re-centre the team in order to improve CTM strategic and tactical planning, with a clear hand-off to operational planning, providing guidance and support as appropriate.

Scope of the Planning function

- Strategy into Action
- Aligning Plans
- Challenge evidence
- Monitoring and Evaluation
- Regional and National working
- Stakeholder Engagement and consultations
- Partnerships
- Provide coherent responses - plans and letters
- Emergency Planning

Roles & key responsibilities

The team will work as a unit, with mutual support, skills development and cross cover. However there will be a **first amongst equals 'Business partner' allocation to each care group**, the level of resource being commensurate with the needs.

Examples of activities may include (not exhaustive):

Planned Care:

- Identification of priorities
- Planned Care recovery – strategic and tactical programme planning
- Link with Strategy groups and national programme re evidence base and pathway development
- Regional collaborations
- Support business case development
- Assurance re delivery
- Manage regional SLAs and impact of new pathways
- Clear supportive hand-off to operational delivery
- Manage implications of Swansea Bay disaggregation
- IMTP process

Unscheduled Care:

- Identification of priorities
- Ensure links to WG programmes
- Link with Strategy groups and national programme re evidence base and pathway development
- Support business case development
- Assurance re delivery – e.g. SDEC
- Manage regional SLAs and impact of new pathways
- Clear supportive hand-off to operational delivery
- Manage implications of Swansea Bay disaggregation
- IMTP process

Diagnostics, Therapies and Specialities – As above

Primary and Community – as above plus

- Support community development planning and link to RPB – specifically the Health and Social Care Integration programme operationalisation

Mental Health & LD – as above

Children & Families – as above plus Flying start SLA, weight management service.

Reporting

- AD Transformation (8D)
    - 3x Band 8b planning lead (from current ILGs)
    - 3x Band 7 planner

This team will be integrated with the existing core planning team.

Some of the example relationships of these roles included below (please note this is not a Job description but provides a summary of key priority areas):

8b	7
Key relationship is with Deputy COO and Head(s) of designated Care Group	Key relationship is with CSG Managers
Developing strategy – 1 to 3 years	Supporting service transformation and development
Innovation, research and benchmarking, outward looking	Reporting, monitoring and evaluation of service developments
Ensuring plans are aligned to WG, clinical and organisational strategy	Co-ordinating evidence and data collection to support service redesign and evaluation
Ensuring plans are integrated - across providers and enablers (finance, workforce, IM&T, quality etc)	Developing project plans for service redesign and developments

8b	7
Developing major business cases, eg for national level funding	Support the care group with the development of funding bids
Providing advice and quality assurance for departmental business plans	Providing advice and quality assurance for departmental business plans
Representing the health board in regional and national developments	Represent planning in departmental forums
Leading stakeholder engagement and communication over major service change and developments	Undertaking Equality Impact Assessments for any proposed service change and developments
Leading option appraisal exercises	Supporting option appraisal exercises
Leading the development of the 3 year plan for designated care group, and delivery plans	Support CSGs to develop their 3 year plans and delivery plans
Contributing to the development of the CTM 3 year plan / UHB	Monitoring implementation of the 3 year plan for the designated care group
Working in partnership with local authority, third sector and other key partners to develop joint plans	Liaise with partners in the development and implementation of joint plans
Leading the commissioning / review of relevant third sector and partnership SLAs	Monitor implementation of relevant third sector and partnership SLAs
Preparing planning related reports for Board / committees as required	Preparing planning related reports

National responsibilities within this Professional Group

Support as appropriate to the following:

- South and Central Wales Planning group
    - Orthopaedics
    - Vascular (Implementation)
    - Ophthalmology
    - Diagnostics, including community diagnostic hubs
    - Pathology
    - AOS implementation
- Swansea Disaggregation group
- ADOPS
- Planned Care recovery programme
- Others as appropriate over time

Miscellaneous points

Members of the team will also be involved in development work across the organisation to improve the planning skills of operational managers and others for whom this would be a benefit.

3. <u>Communications and Engagement</u> support structure

An unofficial 'account management' model has been adopted during the course of the 'ILG' operating model to provide more localised communications and engagement support to each of the three ILGs, where members of the Communications and Engagement team are allocated to each of the ILGs, in addition to the core communications and engagement work they undertake for the Health Board.

This model has aimed to ensure consistency of communications and engagement support standards aligned to corporate and strategic priorities.

The change to a Care Group model would not fundamentally change the communications and engagement work. Instead of 'ILG' accounts, the operating model changes would work on a 'Care Group' account basis.

The 'Care Groups' would need to be responsible for their respective operational communications (in the same way the ILGs are currently) although use the technical expertise of the Communications and Engagement Team for more specialised PR matters.

The Communications and Engagement roles would remain within Communications and Engagement Team and 'allocated' to each Care Group on a rotational basis with overarching assurance and accountability sitting within the Communications and Engagement Team.

This approach will ensure that the Corporate Centre has an awareness of trends and the sharing/learning that is related to issues that are specific to a locality and speciality and vice versa.

This arrangement also presents an attractive recruitment, retention and succession planning offer for PR talent.

All work undertaken by the Communications and Engagement team would continue to be based on an organisational Health Board-wide priority basis and based on capacity within the team at any given time through a standardised request route.

4. **Quality & Safety Support** – See Q&S section for detail of this model

5. Central Corporate Governance

Executive Lead – Director of Corporate Governance

Responsible Officer – Assistant Director of Governance & Risk

Introduction:

The remit of the Central Corporate Governance Function includes the following key areas of activity:

- Corporate Governance and Board Business
- Information Governance
- Risk Management

The **Central Corporate Governance Functions** primary role is to manage and support the statutory Board Business of the organisation and ensure that the Health Board is operating in accordance with its Standing Orders.

The proposals to the operating model include the re-alignment of Quality Governance to provide a centrally managed team structure with a focus on effectiveness, performance and equitable distribution amongst the Care Groups. As a direct result of this, the resource currently in the ILGs will be focussed on central management in the changes to the operating model and therefore coordination and support of the Central Quality Governance Team will incorporate the on-going responsibility for the management of the organisational risk register.

The table below articulates how Information Governance and Risk Management will work in partnership with the Care Groups:

	CENTRAL	CARE GROUP
Risk Management	• Professional Specialist Advice – Risk Management • Provide Training in relation to Risk Management and Board and Committee Education. • Set systems, processes, standards and policies in relation to Risk. • Lead on the Board Assurance Framework with the strategic risk owners. • Produce the Organisational Risk Register that is received at Board and Committee meetings based on risks that have been considered to have met the threshold for escalation. • Represent the Health Board on National Groups such as the Risk Management Community of Practice, Board Secretary Network. • Provide opportunities and bespoke targeted sessions as required in relation to risk. • Establish and maintain a system for "Service to Board Escalation for risk". • Provide expert advice and peer review for risk and support timely, robust and compliant returns for the BAF and Organisational Risk Register and other areas of activity as required.	• Escalate organisational risks that meet the threshold for escalation to the Organisational Risk Register / Board Assurance Framework. • Contribute to developments in Risk Systems, Policies and Procedures. • Support the risk culture within the organisation – ensuring risk is used as a dynamic tool to support decision making and is visible in local management meetings. • Engage in the Annual Audit on Risk Management and support the completion of any associate recommendations / learning. • Attend training on Risk Management Training

	CENTRAL	CARE GROUP
Information Governance	• Professional Specialist Expert Advice in managing, advising and training on all aspects of Information Governance, including Freedom of Information Act, Data Protection Act and General Data Protection Regulations. • Provide Core Statutory & Mandatory Training in Information Governance and on the Welcome Day Induction • External Partnership Management with Welsh Government, Information Commissioners office, Audit Wales and Digital Health Care Wales • Set standards and policies relation to Information Governance • Complete the Health Boards IG Toolkit • Undertake Audit – NIIAS • Represent the Health Board on National Groups such as IGMAG. • Provide regular training opportunities and bespoke targeted sessions as required. • Provide expert advice upon complex SAR's, DPIA's and FOI's to support timely, robust and compliant responses. • Provide the reports for the Health Boards Digital & Data Committee and Information Governance Group • Support incident investigation and learning from concerns and ensure Health Board wide learning.	• Attend training and maintain compliance on Information Governance Training • Investigate IG Incidents • Investigate NIIAS alerts when escalated in relation to "Own access" and "Home relations" access • Provide the management / operational response to FOI's and requests for information under DPA legislation within set timescales to maintain compliance. • Initiate timely development of DPIA's for any new services/projects where data will be shared and share with the IG team at an early stage to ensure sign off. • Provide information upon request to support Board and Committee reporting. • Support the completion of the IG Toolkit on a timely basis. • Engage in audits e.g. ICO inspections

Roles & key responsibilities

Assistant Director of Governance & Risk oversees the Information Governance and Risk functions, sets policy and standards and ensures quality assurance of all aspects.

Together with the Assistant Director of Governance & Risk, Care Group leads will attend and report on agreed metrics to the Health Board's Strategic Leadership Group, Information Governance Group, Board Committees and Board as appropriate.

6. Information Team support

The Data Intelligence team oversees the strategies and associated applications, infrastructure and tools used by Cwm Taf Morgannwg University Health Board for the analysis of its business data and information. An efficient, supportive intelligence service should be able to provide historical, current, and future (predictive) views of business operations to support effective decision-making and activity/performance monitoring.

The Data Intelligence team is committed to providing best-in-class information, statistics, analysis, capacity and demand and forecasting through the development of data warehousing and business intelligence services. The services aim to provide the Health Board with the information to make informed decision and operational efficiency/excellence to improve experience and outcomes for the patients and communities it serves.

Each Care stream requirements are met from a collaborative and complimentary set of skills within the Data Intelligence team.

Scope of what's included within this Professional Group

The data intelligence team will support each of the care groups by delivering the following services:

- Data Management, Data Quality, Warehousing, and Analytics
    - Implementing tools and techniques for the efficient acquisition, organisation, secure storage, patient/donor linkage, data quality/integrity and interpretation of data.

- Data Intelligence
    - Delivering and publishing information through reports, and self-service intelligence tools. Ensuring the right technology is utilised.

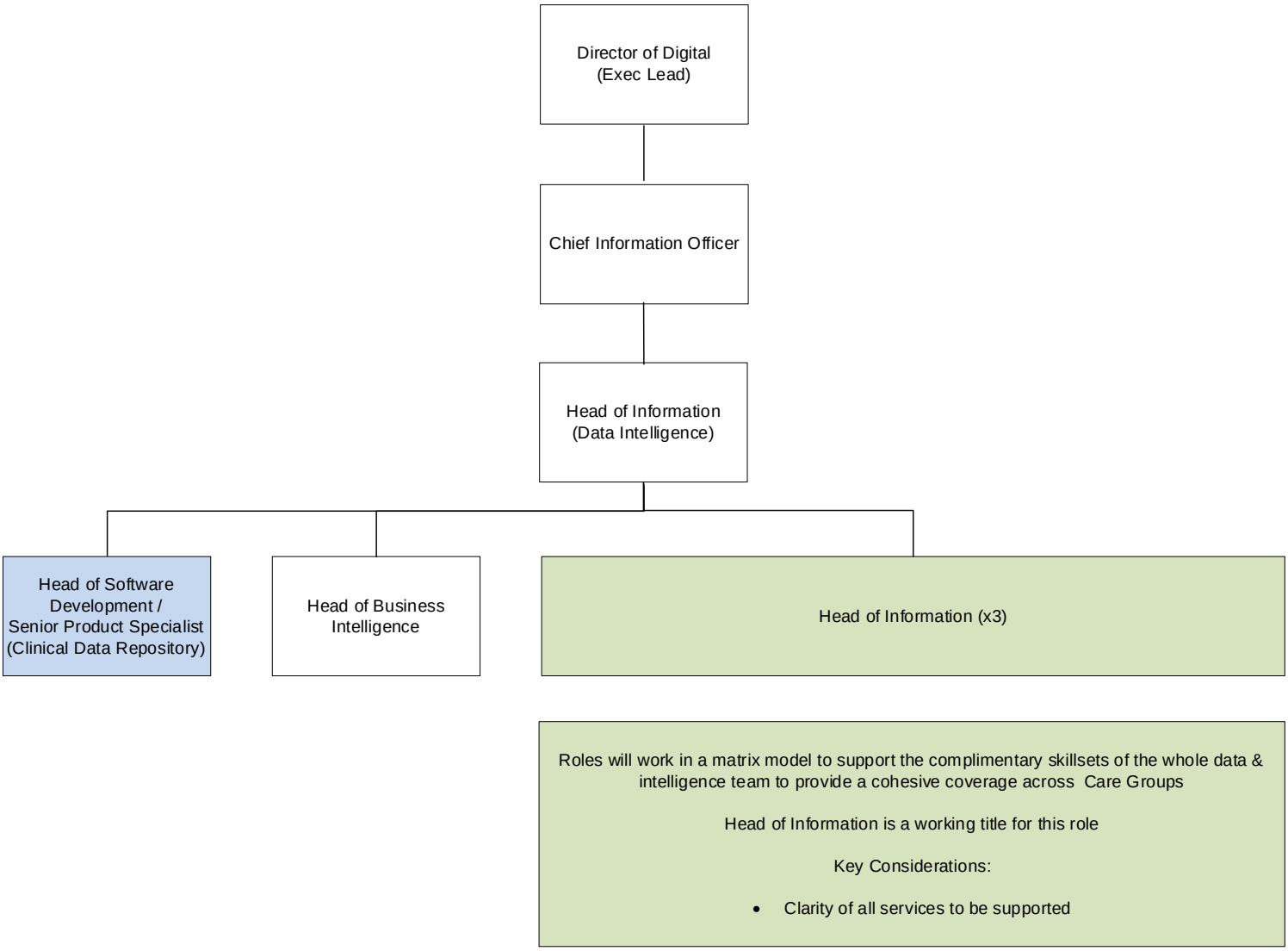
- Data Governance and Information Training
    - Develop and implementation of processes and procedures for data capture, storage and dissemination. The development of data dictionaries, training and documentation so that information and business intelligence tools provided can be effectively utilised to deliver the information required.

Roles & key responsibilities

Job Descriptions will be amended to reference the Care Group Model. Given the proposal is a minor change in terms of alignment, the majority of the Job Description will remain unchanged.

These roles will actively support and participate in all aspects of the data intelligence team, providing expertise in their relevant fields:

- Modelling the data appropriately so that it is a true reflection of service delivery
- Monitoring and improving the quality of the data held within the key critical systems
- Ensuring the consistent definition and publication of the required indicators through the agreement and ongoing refinement of analysis methodologies
- Supporting the development and populating a range of new 'self-service' dashboards and reports
- Supporting Service Improvement and Service Redesign e.g. through statistics and mathematical modelling
- Complying with current and new national data standards and submission requirements
- Undertaking benchmarking against comparable organisations both in terms of operational services and the Data function
- Aligning and incorporating national products and programmes of work, for example the National Data Repository (NDR)
- Providing support, guidance, and expertise in Information for the Health Board's strategic programmes
- Undertaking broader triangulation, drive-time predictive analysis, forecasting, capacity and demand and the inclusion of additional data sets such as weather, population projections
- The ability to innovate and embrace new technologies and techniques
- Maintaining support for ad-hoc requests and new priorities whilst seeking to deliver the above



Green boxes represent transferred roles - Blue box represents existing vacancy

Note: This transfer of staff does not mitigate the additional capacity & capability required within the current Data Intelligence team

National or All Wales responsibilities within this Professional Group

The leads within the Data Intelligence team represent the organisation at various national groups. It is envisaged, as senior members of the data intelligence team that the Heads of Information for each of the care streams would also support these national groups as required and in agreement with the Head of service.

7. People Business Partnering and People Services Structure

The current Workforce and OD structure includes four Business Partnering teams which support the following service areas and operational workforce support is devolved across each service area.

Service area	Workforce and OD lead for business partnering team
Bridgend ILG	Head of Workforce and OD
RTE ILG	Head of Workforce and OD
Merthyr & Cynon ILG	Head of Workforce and OD
Executive and Corporate directorates	Assistant Director of Policy, Governance and Compliance

As part of this restructuring, the Workforce and OD Directorate is renamed the People Directorate to ensure consistency with the job titles of the Executive Director for People and Deputy Director for People. Given this, the job titles of other roles within the operational workforce structure will change to ensure consistent nomenclature.

Each Head of People (HoP) will support two Care Groups with two HoPs supporting Acute Services and 1 HoP supporting Primary and Community and Mental Health Services and that each of these roles will have a Deputy Head of People. The business partner support for Executive and Corporate services will remain unchanged and be provided by Assistant Director of Policy, Governance and Compliance.

In the new model the operational support will be centralised to provide a professional people services function which will be led by a new Head of People Services. This new post will be created through skill mix change and use of existing vacancies. This post will drive the delivery of modern people focused services underpinned by professional standards and enable an agile, flexible response to project work, capability building and relationship management with line managers. This post holder will also provide Business Partner support to Estates and Facilities teams.

*The Head of People for Mental Health and Primary Community Care will be expected to engage with Local Authority and Primary Care colleagues.

The People structure to support the new Care Groups is as follows:

Care Group and wte	People lead for business partnering
Planned Care Group Diagnostics, Therapies & Specialties Care Group (3,495.42wte)	Head of People
Unscheduled Care Group Children & Families Care Group (3170.7wte)	Head of People
Mental Health Care Group Primary & Community Care Group (2,490.47wte)	Head of People*

Care Group and wte	People lead for business partnering
Executive and Corporate directorates (823.28)	Assistant Director of Policy, Governance and Compliance
Estates and Facilities (1085.08)	Head of People Services

While the current ILG Head of Workforce and OD role currently report to the ILG Operational Director, in the new structure the line management reporting line is to the Deputy Director for People.

Scope of what's included within this Professional Group

The Head of People role will provide professional, strategic leadership and expert contribution on the strategic change agenda and development to inform decision making within the Care Groups:

- People focus to business decisions
- Drive culture change
- Strategic, future facing workforce planning
- Operational workforce resource plans
- Workforce Efficiency and Productivity
- Role redesign
- Credible, confident professional leaders
- Curious for improvement and new ways of working
- Coach and Relationship builder

The Head of People Services will be responsible for ensuring

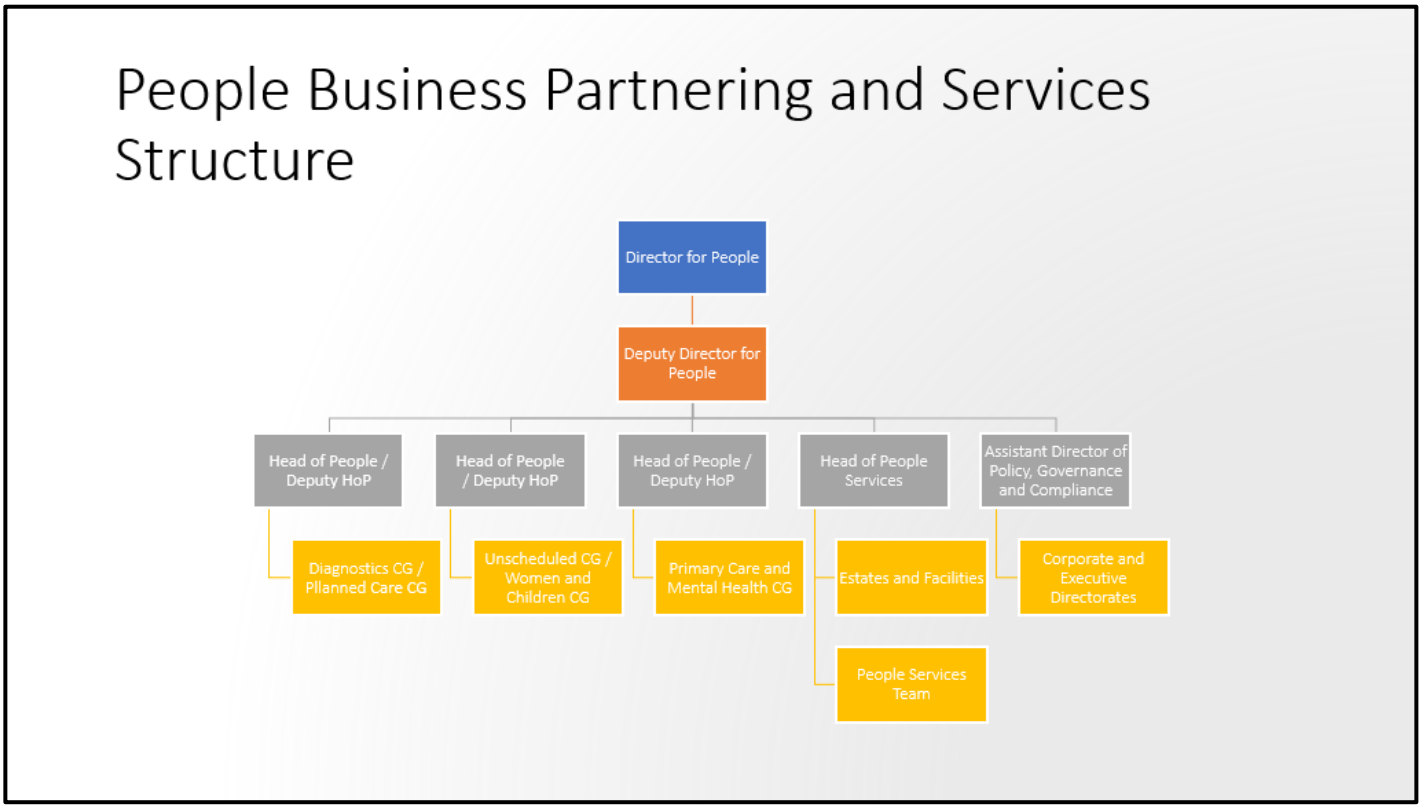
- Customer/People focus
- Employee Engagement lens to workforce processes
- Agile and flexible service provision
- Modern and evidenced based people management practices
- Commissioning process for support for project work
- Capability building in line management
- Professional confidence
- Excelling at the fundamentals
- Curious for improvement and new ways of working
- Line manager coaching

The implications of the new People Business Partnering and Support Services structure will be reviewed for other parts of the Directorate. However, it is intended that closer working is enabled across OD, Wellbeing, Education and Development, ESR and Medical Personnel and Efficiency teams as communities of expertise are developed.

The roles and key responsibilities will map to the Professional Principles of the Chartered Institute of Personnel and Development (CIPD) Profession map.

The organogram only reflects the People Business Partnering and People Services element of the structure.

The structure of the People Services team to be shared in due course.



Part 9 – Strategy Groups – Role & Function

The Strategy Groups were established as Systems Groups in 2020. The Systems Groups were originally designed to bring colleagues, patients and partners together to have a view across the whole health board. The work of the Systems Groups had an aim to improve the quality of service whilst reducing the risk of duplication or a lack of consistency which could inadvertently be a by-product of taking a Locality view.

The System Groups were designed to be clinically led, supported by expertise in public health, planning, analytics, project management, workforce planning and financial development. The System Groups were designed for partners, including local authorities, volunteers, third sector and patients to be actively involved.

It was originally stated that as the System Groups were designed to be highly transformational, it was expected they would 'mature, evolve and develop over time with the end formation being different to the starting point.' Therefore the movement to Strategy Groups to directly support the CTM2030 Clinical Strategy development is a welcome evolution and one that has already taken place.

There are no changes to the way the Strategy Groups currently function or how they are staffed in this operating model. These groups will continue to play an ever important and evolving role in the organisation.

This new evolution into Strategy Group over the course of 2021 into 2022 shows that they remain a critical component of turning CTM2030 into action, by overseeing how the Health Board plans and delivers improvements to the health outcomes for our population.

There groups are organised into the 4 separate groups of:

- Born Well
- Growing Well
- Living Well
- Ageing Well

In addition there is a dying well group, which works to describe good end of life care planning and delivery. It has important interfaces across the strategy groups. The dying well group has to be strategic, however we will ensure that we are clear about correct involvement and debate on EOL elements of all strategic pathway development.

Each Strategy Group has several subgroups addressing priority health needs including:

- Healthy weight
- Young people's mental health
- Respiratory
- Diabetes
- Heart disease
- Elective pathways
- Stroke
- Frailty
- Dementia

The Strategy Groups and their subgroups are collaborations of clinicians from across the range of public health, preventative, primary, secondary and tertiary care, supported by part time senior experienced clinicians and managers who are full time. Their aim is to understand the most important aspects of shortfalls in health outcomes and to work with all relevant partners to identify how Health Board activities should change to better shape the experiences of patients. There is also a very close working relationship with Value Based Healthcare activities.

Given the new orientation of this operating model the System Group unique focus is that of the citizen and attention will be on whole pathways and the vertical alignment of services for effective and seamless care.

Drawing on best evidence, local experience and local opportunities, outputs include:

- model care pathways
- savings and investment proposals
- policies for access to treatment and care

- partnership agreement

Part 10 – Performance, Finance & Governance

At the beginning of this document the design principles set out the expectations around ways of working in the day to day operational running of the Health Board. The aspiration of the model is to ensure clarity of responsibilities and accountabilities which will then empower individuals to ensure quick and safe decision making. What this means is, unlike the current model, where there can be uncertainties around responsibilities, the Health Board wants to move to a model that ensures a clear governance chain no matter what part of the CTM geography is being discussed. The current arrangement of internal 'hosting' of certain smaller services by geographically based ILGs will no longer be required as all services will be able to sit within a relevant Care Group.

Scheme of Delegation & Standing Financial Instructions

Over the following weeks, in line with the operating model, the Health Board's formal Scheme of Delegation and Standing Financial Instructions will be required to be updated by relevant leads. There was an aspiration set out by the Executive Team in August 2021 to ensure that any future updates of these formal documents are clear and useable so that they support staff in understanding the organisational boundaries. This is important as it ensures decision making, including decisions with financial implications, is being conducted at the most appropriate levels and that staff are not put in a position where they are not sure what they can and cannot do.

Performance

As a summary statement, performance in the model will be focussed at Care Groups who will coordinate the relevant Services through CSGs. This is in contrast to the current model where performance is often categorised by ILG. This move will ensure that what Welsh Government track and hold the organisation to account on is the same as how we internally view performance. As an example, performance against elective surgical activity will be focussed CTM-wide and the Planned Care Group will be the entity responsible for managing this. This is in line with the majority of CTM's neighbours.

There will be a specific focus on Performance Management for the organisation over the coming weeks to ensure appropriate structures are established to robustly monitor, control, escalate and clearly display performance across all areas up to Health Board Executive and wider Board level. This will then enable the organisation to work more seamlessly with Welsh Government on tracking and managing performance. This work will not impact the Care Group structure, as outlined in this consultation document, but rather it will complement it by allowing clear guidance on the tools, support and ways of working within operational

performance management. This is an aspect of work that is required to take place to ensure the Health Board's 'Performance function' is aligned to that of neighbouring Health Boards and allows informed decisions to take place effectively.

Governance

The current senior governance structures, including the weekly Executive Leadership Group (ELG) and the wider monthly Strategic Leadership Group (SLG), are not proposed to change at this time. It is expected that the SLG will be a forum that has and will continually adapt and evolve to ensure longer-term strategic discussion takes place, in a protected way and involving wider senior staff within the Health Board.

Specific Care Group Governance forums / mechanisms / reporting expectations will be defined in time as the model becomes finalised. This will be directed by the Chief Operating Officer with the developing wider Performance framework. The governance set up will take into account both what is working effectively now whilst also ensuring that any stipulated or formal meeting and reporting requirements are streamlined, value-adding and ensuring there is support and challenge at all levels of service and operational delivery as required.

Part 11 – Misc.

Location of work

In the current ILG model, due to the fixed geographic nature of the structure there are ILG HQ offices located at Keir Hardie University Health Park (for M&C ILG), Dewi Sant Hospital (for RTE ILG) and Glanrhyd Hospital (For BILG). In the future model those triumvirate staff working in each Care Group will have a 'whole-CTM' focus and therefore will not be limited to one local authority area. Therefore current office space will be deemed a shared space for those Care Group and support staff required to operate at different locations in the Health Board.

The Health Board, over the coming months, will look to further define its working practices but the option of digital first / working from home set up will remain as it does now. The future strategy of our estate will influence how we adapt our current non-clinical office space to accommodate a greater flexibility of where people want and need to work.

In the immediate future those impacted members of staff will be allowed to keep their contractual home base as it is, or if required, have the option to change their home base in agreement with their line manager.

Appendix 1 – Consultation Feedback

The following section outlines the questions and comments received during the four week formal consultation. The majority of this feedback was received via the MS Forms link. However feedback was also received through emails. Where appropriate these have been included in the below.

No.	Feedback	Response (where applicable)
1	Is it possible please for further clarification regarding the proposed Women & Children's Care Group? In the current ILG structures there are two Clinical Service Groups for Women and Children's Services (Bridgend; Merthyr Cynon - which also covers RTE). Is the organogram indicating that there will be three CSGs - one for Bridgend W&C; one for Obs, gynae and ISH; one for CYP? Does this mean that Bridgend Women and Children CSG will remain but that Merthyr Cynon Women and Children CSG to be split in to Obs, Gynae and ISH; and CYP?	As part of this OCP consultation there will be no adjustment to the current CSG set up. So the current layout and structure of the CSGs will stay the same but report up into the relevant Care Groups.
2	The document refers to there being a further stage of revision to the operating model in the future which will include the CSGs in its scope - is there any further detail as to what this entails and implications for the CSGs?	At this time there is no further information aside to confirm that once the Care Group structure is put in place the organisation will consider how best to configure a potential structure for the current CSGs to ensure they work effectively with the Care Groups. The knowledge and experience of Care Group and wider staff will be utilised in this effort.
3	Despite being listed as a service in 'Part 3f – Diagnostics, Therapies and Specialties Care Group', there are no specific roles as to what 'Pharmacy' will fulfil, with reference to Pharmacy a mere five times through the document - two of which referring to a person, the Chief Pharmacist. Once again, it seems as if	Thank you for the response. You raise a number of points here. Directly related to the Med Management points we have had

No.	Feedback	Response (where applicable)
	Pharmacy / Medicines Management have been considered as an after-thought, and is illustrated as such on the organogram on page 30. As a Pharmacist who is employed within CTMUHB, it's clear that the Organisation do not understand the intricacies of Medicines Management and the principles that underpin our behaviours and actions. An example of such was during the very early stages of the COVID-19 pandemic when colleagues were asked to 'create space' and 'move drugs' to the designated COVID-positive wards. There are strict principles which need to be adhered to, such as safe storage and monitoring, which other colleagues in CTMUHB seemed to have little consideration for. This illustrates a 'laissez-faire' attitude and is quite concerning when patient safety is paramount, and could be compromised due to ad-hoc actions and poor planning. Additionally, Pharmacy is defined as either; 'a shop or hospital dispensary where medicinal drugs are prepared or sold. ("the local pharmacy")'; or, 'the science or practice of the preparation and dispensing of medicinal drugs. ("courses in pharmacy"). Both of the above have little relevance to what functions are expected from 'Pharmacy' in this document, and clarity would be appreciated to truly define what is expected from the Medicines Management Directorate. There needs to be a clear and explicit vision as to how the Medicines Management Directorate can assist in achieving the long-term vision for CTMUHB from the Board, and not left to the decisions of those within Departments. Having spoken to other Pharmacists in neighbouring Health Boards, it seems that CTMUHB have been lingering in the Dark Ages for quite some time, not solely impacting on expenditure, but clinical governance and	an in depth summary from Brian Hawkins (Chief Pharmacist). The structure and organisation of Pharmacy remains integral to all services and even though it is being placed as part of a wider Care Group operationally it will still act across all areas and interact as it currently does. The Pharmacy service and Med Management will be overseen by the Chief Pharmacist and senior team to ensure safe high quality service and care. In all matters related to Pharmacy they will give the guidance and direction that is needed. At all Care Group meetings where Pharmacy are involved then they will be represented at the first discussions and not as a second thought. This is being built into the operational structure of the new Care Groups.

No.	Feedback	Response (where applicable)
	simply not supporting our patients in the way that is delivered just a few miles away. Medicines Management are a very under-utilised Directorate and there are many great people that work within. Please engage with us, allowing us to fulfil our professional capability.	
4	Can Orthoptics be added to the Part 3a – Planned Care Group table of included professions together with ophthalmology and optometry? We are currently excluded from AHP group and I have raised this with the DoTHs and was assured that we would fall under Planned care management with input from DoTH professionally. However we now appear to have been missed of this table as a whole profession. While I appreciate that this table is stated as 'not and exhaustive list' to omit a whole professional group is unsatisfactory.	Please be assured that specific conversations have been held within the Executive team regarding the fact that Orthoptics will be best sited within the Planned Care Group. We will ensure that the table is updated to read: Ophthalmology, Orthoptics and Optometry. You are correct to state that professional accountability sits with the DoTHS. Orthoptics membership will be key within the soon to be formed AHP and HCS Professional Leadership Forum. Please accept our apologies that this important group of professionals was omitted from the table – this was an error.
5	Hello, Orthoptics has been missed off from Part 3A – Planned Care Group table of included professions together with ophthalmology and optometry, I'm sure it's just a typo. Thank you,	Please be assured that specific conversations have been held within the Executive team regarding the fact that Orthoptics will be best sited within the Planned Care Group. We will

No.	Feedback	Response (where applicable)
		ensure that the table is updated to read: Ophthalmology, Orthoptics and Optometry. You are correct to state that professional accountability sits with the DoTHS. Orthoptics membership will be key within the soon to be formed AHP and HCS Professional Leadership Forum. Please accept our apologies that this important group of professionals was omitted from the table – this was an error.
6	When will individual staff be advised of their role within the new Operating Model, who they will be reporting to and their base. Is this up for negotiating/discussion or will staff simply be slotted into various posts? As you can appreciate this is a very unsettling time for staff and not only am I feeling fairly anxious about the change but would like to support the staff I manage as they too are feeling anxious.	Following the consultation period and the release of the agreed Care Group Delivery implementation model, affected staff will be contacted and the transition to the new model will begin. The principles of which will follow the process as outlined in the All Wales Organisational Change Policy.
7	I'd like to ask for clarity around lines of reporting. It is explicitly stated as an aim that "[t]he Health Board should avoid, as far as possible, situations where it is not clear which team is responsible for which areas." From a medical point of view, I think this is currently far from the case. The current proposal includes, for example, Trauma under one care group and Orthopaedics under another. For Medicine, endocrinology, gastroenterology and neurology are separate to the rest of medicine in terms of which care group they	This phase of the operating model reconfiguration is looking at the senior structure to manage overarching Care Groups. The next phase, as referenced in the introductory section of the document, will focus on the CSG and speciality level to ensure the model is best structured. All

No.	Feedback	Response (where applicable)
	fall under. At the same time, it is stated that the existing CSG/directorate structures will remain the same, and "[t]he current CSGs that exist now are proposed to continue as part of this OCP and fall under one of the above appropriate Care Groups." At the same time as this, there is a local hospital leadership team, which are also not planned to change. I really am not clear on how the above examples would fit within the proposed model, if the CSGs are remaining the same. The 'organogram' which is referenced does not really provide clarity - so my question is - how can you have different parts of the existing CSGs under different care groups? It seems to directly contradict the bit about ensuring clarity of responsibility. How can a Medicine CSG keep endocrinology, but then endocrinology sits under a different care group to the Medicine CSG? Along with this comment, there is no mention of the roles and responsibilities of the site leadership team - while these roles exist now they are much less well defined than the current CSG structure, and seem quite different across different sites - at least from a medical point of view. We have been told in our all consultants meeting (and prior to this) there will be 'lead CDs' for each speciality, but this isn't mentioned in the consultation document. Again, this will be important to the medical body, as my expectation at least would be that at the end of this consultation period reporting lines and responsibilities for each role will be completely transparent. At the moment a potentially key part of the medical team isn't mentioned - so will the responsibilities of a 'lead CD' and 'hospital medical director' be clarified? Will 'lead CD' be a single role, or triumvirate in nature? Again, the same question, would a lead CD for Trauma and Orthopaedics report to Scheduled or Unscheduled care - or both? Who line manages them? Thank you - I can see the positives, but as at current, the CSGs don't line up well at all with the care groups, and unless explicitly explained is going to cause very unclear lines of reporting, governance and assurance. It would also be	comments relating to this level will be taken on board when this separate process is underway. To expand on this area further. With any model there needs to be lines drawn as to which specialty sits where for a funding stream. Sometimes this is clear cut but in other areas it is a grey area where the specialty has multiple areas to its role and as such is not easily categorised. In these cases no matter where the specialty sits it is where they interact that matters - to enable this each Care Group will be set up so all decisions being made need to involve those it impacts upon. To use an example - Critical Care (sitting in the Planned Care Group) would need to interact with Unscheduled Care Group for all matters it is involved with (ED & acute medicine) therefore Critical Care will need to be part of the Unscheduled Care Group discussions for any decision to be made and agreed. Appreciate this is not ideal but it is more complex to have one specialty sitting under more than

No.	Feedback	Response (where applicable)
	helpful, given note is given to the need for a review of CSG structure at some point, to put some timescales on this.	one care group for funding. So a Quorate at all meetings approach is easier to resolve these issues. There is a need for certain issues to remain on site to be resolved locally – e.g. bed management, offloads of Ambulances and where the patient flow moves to, discharge planning with Social Services - are but a few areas. The role of a Clinical Site General Manager will deal with a number of these matters. Also Head of Nursing roles will continue to ensure and maintain high levels of nursing care on all sites. The Medical Site leadership will have a lot of cross over with Care Groups and the responsibilities will be set our very clearly in the Job Descriptions for these posts in due course. When the Care Groups are established to CSG level will then begin to analysed. The approach could be for a unified specialty approach across CTM. As such a proposal is that there could be Strategy CDs who would represent all specialties (on all 3

No.	Feedback	Response (where applicable)
		sites) at meetings and set the direction and plans as well as set the standards and plans for the specialty. Each of the 3 sites will have a Site CD who deals with the matters specific to that site - welfare, job planning, rota issues, collating that groups views and disseminating Specialty CDs / Care Group plans, and more. The responsibilities and accountability of these roles will be set out in full detail in the Job Descriptions. Each will involve interaction with the Site MD as well.
8	1. Critical Care sits under Planned care in the document. This is inappropriate, as there are very few planned patients coming to any of our units. It should be either be in Unscheduled or Specialist services, ideally alongside with anaesthetics, as medical workforce is heavily intertwined. Potentially a separate CSG alongside surgery and medicine? As discussed in the Critical Care Planning group there is a desperate need for the service to become 1 across CTM, with dedicated management support, which recognizes the service's unique position and needs. Critical Care Network representation should be included alongside other networks into the document. 2. It is not entirely clear from the document how the CSGs will stay in place with the introduction of the care groups. There are currently 3 site CSGs, which are slightly different by site, how would this be amalgamated into 1? What would be the role of the CSGs? How would this look from a specialty point of view, is it envisaged that each specialty would have an UHB lead/CD? Where would this person sit in the structure? The medical structure in general is not very clear form this document.	ITU is currently placed within the Planned Care Group to ensure coterminosity with Anaesthetics. The next phase of the Operating model reconfiguration will investigate an option for a single CSG for ITU / Anaesthetics. This CSG layer is not part of this OCP but all comments will be considered and taken forward for the next phase in due course. Major Trauma involves MT liaison with the MTC as part of being a member of the major trauma network, therefore this is seen as

No.	Feedback	Response (where applicable)
	3. Surgery CSG is quite appropriately currently called Surgery, Anaesthetics, Critical Care and Theatres, which should be kept if it is envisaged to stay as it is? 4. Trauma and Major Trauma are separate under Unscheduled Care Group. CTM has got no Major Trauma Centre, so these should join under Trauma? 5. Endoscopy and Dermatology sits under Planned, but the national responsibility lies within Unscheduled in the document? 6. Could the WICIS (new All-Wales ITU information system) implementation be included in the plan with other national projects?	separate from our own Trauma service. Thank you for the comments around national responsibilities for Endoscopy and Dermatology. These will be re-aligned within the Planned Care Group. WICIS (all Wales ITU information system) National project will be added to the national responsibilities.
9	diagnostics, therapies and specialties care group contains both cardiac and respiratory physiology which sits well alongside the other professions within this care group Please could I ask for clarification to the following : our services are also mentioned within the unscheduled care group - the vast majority of our services are planned / scheduled and we are already in the appropriate care group please could I confirm what is the reasoning for duplication ? Within the diagnostics, therapies and specialties group the suggested leadership team does not seem to show representation for the healthcare sciences at clinical director level so we have potential to have a disparity of representation which could impact on our professional voice being heard , as well as the operational management structures and reporting not mirroring the document highlights As this group contains a large number of professions all with their own accountability and governance arrangements it is understandable 'There is to be no nursing director within this group' - however there appears to be prof accountability to a nurse director - is this to support any nursing colleagues working within any of these specialties ?	This duplication is an error. Please be assured that it is proposed that our Cardiac and Respiratory Physiologists sit within the Diagnostics, Therapies and Specialties Care Group. It is envisaged that grouping our Healthcare Science professions in this way will strengthen the visibility and voice of these important professions across CTM. Thank you for outlining your thoughts regarding the leadership team for the Diagnostics, Therapies and Specialties Care Group (DTS). The proposal is to have a group Medical Director,

No.	Feedback	Response (where applicable)
		group Operational Director, Chief Pharmacist, and Clinical Director for AHPs within the leadership team. The proposed leadership structure for DTS ensures that existing professional leadership roles for AHPs and Pharmacists are included within the leadership structure. I understand your views and recognise that there isn't a Clinical Director for Healthcare Scientists (HCS), or equivalent. This is the case within CTM's current structures and I do not believe that there is a similar role elsewhere in Wales. I hear your concerns regarding disparity and the voice of HCS professions and this was one of the key drivers to the development of a proposed Care Group in which all of these professions are co-located. The proposed operating model suggests that the Healthcare Scientists continue to be ultimately professionally accountable to the DoTHS. CTM has invested significantly in strengthening the professional leadership for our HCS through their recent substantive

No.	Feedback	Response (where applicable)
		appointments to the DoTHS and ADoTHS posts, and I hope that you agree with the benefits of this structure. I am in the process of establishing a professional leadership forum for AHPs and HCSs. This forum will ensure that the clinical leaders for each of our professional groups will have a forum in which they can engage with peers and have a direct communication route to Board-level, through the DoTHS. The Clinical Directors for Radiology and Pathology will continue their close working relationships with our HCS working in these areas and represent their views within the DTS leadership team. Closer links with the CD for AHPs via the professional leadership forum will result in improved understanding of the invaluable roles of our HCS and facilitate the CD for AHPs to also represent our HCS. I appreciate that there is a view that we should have a CD for HCS but this is not a post that is currently being considered within the proposed CTM operating model. I very much value the

No.	Feedback	Response (where applicable)
		advice and contributions of our healthcare science leaders and please be assured that this will continue to be the case. There are a small number of nurses who would work within this proposed Care Group. They will receive their professional leadership from the Nurse Director in the Planned Care Group as there will be no Nurse Director specific to the proposed DTS leadership structure. I hope that this helps to clarify the thinking.
10	I am struggling to see any meaningful references to Health, Safety & Fire within this document. The Team is not fit for purpose due to a lack of investment since the formation of CTMUHB. The evidence is there for all to see in relation to organisational compliance with statutory training. How can having one Manual Handling Trainer for 16,000 staff be ok or justified or in the worst case scenario, defended. The H, S & F Dept has not really seen any significant investment since Cwm Taf NHS Trust which is surprising when staff numbers have increased from 8000 to nearly 16,000 (Remembering the H, S & F Team are also responsible for the training of Bank, Overseas and Agency staff as well as our substantive staff). It would be fundamental for staff health, patient safety and organisational excellence to see a greater emphasis being placed on the proactive development of this Department so that it can manage its workload more effectively and efficiently for all, instead of being completely drowned in work and having to continuously prioritise worst cases. Currently quality is suffering due to the quantity of work now required to support our Health Board from the mountains of Merthyr to the beaches of Porthcawl both in our hospitals	Many thanks for providing your comments on this matter. Unfortunately the Consultation Document was unable to reference every single function within the Health Board, but to assure you that the Health, Safety and Fire function will continue to sit under the leadership of the Executive Director for People. It should be noted that despite no reference to the Team or its function, the Health Board places a high importance on the Team and the support its function provides to

No.	Feedback	Response (where applicable)
	and communities. What is currently in place is not working and should be seen as a threat to the organisation as an external inspection will bring about a tremendous amount of corrective actions and cost pressures at a time when our financial position and staff are at the most vulnerable they have been since I joined Pontypridd and Rhondda NHS Trust in 1997 as a Nursing Student.	ensure compliance in these matters. Whist some parts of the Health, Safety and Fire Team have seen some investment and expansion over the last few years, it is acknowledged that in other parts there are possible resource improvements that may be required. These will be discussed between the Director for People and the Head of Health, Safety and Fire following the implementation of the new and agreed structure.
11	I support the proposed change from ILG's to Care Group Structures. Please can the following be clarified? 1) does paediatric surgery (which is listed in the women's and children's care group) include all the subspecialties (i.e. dental, general, urology, orthopaedics, ENT)? 2)and therefore, will the non-specialised paediatric orthopaedic surgery service specification (that was approved by the NHS Wales collaborative executive group and due to be published on the Collaborative website) recommendations be included within the scope of the" planned care group for Orthopaedics" or the "women and children care group"? 3) whether the care group structure will facilitate the end of the SLA/LTA that Bridgend have with Morriston so healthcare equity can be provided for all the kids in CTMUHB (or will this be dealt with before the ILG's change to Care groups)?	Sub specialities will run and be managed from their overarching specialty Care Group. There is an overarching coordination piece for Paediatrics. It is proposed that a Paediatrics Surgical Board is run by the Children & Families Care Group to take responsibility for national guidance.

No.	Feedback	Response (where applicable)
	4)what is the timeframe for converting to this delivery model and during this timeframe, will there be a delay in general recruitment / service development?	
12	Many thanks for your help with the re-design plans for the structures. I have looked at the consultation document and would like to raise a few points, I do hope that's ok • After page 10, there is a landscape page with the proposed structures in diagrammatic form, I agree with the management structure in terms of group medical director and group operations director, but fail to see how there is a space professionally for group nurse director. Whether this is historical relating to triumvirates I am not sure?, but if the shoe was on the other foot, would a therapist or a healthcare scientist be welcomed as a strategic leader in a group of nurses. As according to this diagram, that is what is being proposed. Apologies if this sounds rather blunt, but I am really not seeing the benefit, would a HCS or a therapist be better placed to provide leadership in this care group ? in the narrative on this page there is reference to professional leadership, in this context a nurse would not fit well in this structure I believe. • At the bottom of this page there is reference to scope of care group and nurses and doctors get mentioned. However, in reality how do doctors and nurses fit into this care group? And from which departments? • Page 15, in the early paragraphs there is again reference to nurses and doctors, then the document narrative goes on to list the specific departments that might fit into the care group – whilst I appreciate that there may be medics working out of radiology or pathology and there could be some nurses embedded in these departments, but given the ratio of nursing input versus HCS and therapists for example, I fail to see how a nurse director is required again • In the continuing text, there is a phrase that says "there is no nursing director in this care group" or words similar to that, but this contradicts the landscape overview page (after page 10) and my comments above, this should be clarified	Thank you for taking the time to review the consultation document and provide comments and feedback – this is really helpful. Your points are very much welcomed and I have responded to each one in turn. Thank you for outlining your thoughts regarding the leadership team for the Diagnostics, Therapies and Specialties Care Group (DTS). The proposal is to have a group Medical Director, group Operational Director, Chief Pharmacist, and Clinical Directors for AHPs within the leadership team. The omission of the CD for AHPs and Chief Pharmacist in this diagram is an oversight. The proposed leadership structure for DTS ensures that existing professional leadership roles for AHPs and Pharmacists are included within the leadership structure. As is the case currently, the Healthcare Scientists within the group have a professional line of accountability and leadership via the DoTHS and

No.	Feedback	Response (where applicable)
	The leadership team is stated • "The leadership team is proposed to comprise of: • Group Operations Director • Group Medical Director • Clinical Director for Pathology • Clinical Director for Radiology • Clinical Director for Allied Health Professions • Chief Pharmacist " • However, from an operations point of view, there is no clinical director for healthcare sciences or such like, how would this work clinically as it appears that audiology, clinical engineering, medical illustration, cardiac and pulmonary physiology doesn't have the same reporting structures as others and this could perpetuate a disparity in ops management and "air time". Essentially, who would represent us in the group from an ops point of view? For equity there should be a similar role representing the smaller professional groups like those that I have already mentioned. I agree entirely with the proposal for this care group, but feel strongly around the smaller professional groups will not have enough professional "grunt" as they are not represented in the leadership team and feel that this really needs addressing	ADoTHS. There are a small number of nurses who would work within this proposed Care Group. They will receive their professional leadership from the Nurse Director in the Planned Care Group as there will be no Nurse Director specific to the proposed DTS leadership structure. I hope that this helps to clarify the thinking. We have doctors and nurses working within our pathology and radiology services, hence their inclusion in this section for completeness. It is not proposed to have a Nurse Director role specific to DTS but there will be a link to the Planned Care Nurse Director for professional support to the nurses working within DTS. I understand your views and recognise that there is not a Clinical Director for Healthcare Scientists, or equivalent. This is the case within CTM's current structures and I do not believe that there is a similar role

No.	Feedback	Response (where applicable)
		elsewhere in Wales. I hear your concerns regarding the voice and visibility of our smaller professions and this was one of the key drivers to the development of a proposed Care Group in which all of these professions are co-located. I am pleased to note from our recent conversations that you are in agreement with the many benefits of this proposed grouping. The proposed operating model suggests that the our Healthcare Scientists continue to be ultimately professionally accountable to the DoTHS, with close allies and advocates in the other CD roles. CTM has invested significantly in strengthening the professional leadership for our HCS through their recent substantive appointments to the DoTHS and ADoTHS posts and I hope that you have already felt the benefits of this structure. We are in the process of establishing a professional leadership forum for AHPs and HCSs. This forum will ensure that the clinical leaders for each of our

No.	Feedback	Response (where applicable)
		professional groups will have a forum through which they can engage with peers and have a direct communication route with the Board, through the DoTHS. The Clinical Directors for Radiology and Pathology will continue their close working relationships with our HCS and represent their views within the DTS leadership team. Closer links with the CD for AHPs via the professional leadership forum will result in improved understanding of the roles of our HCS and facilitate the CD for AHPs to also represent our HCS. I appreciate your view that we should have a CD for HCS but this is not a post that is currently being considered within the proposed CTM operating model. As you know, I very much value your advice and contributions as one of our most senior healthcare science leaders so please be assured that this will continue to be the case.
13	Main comment would be the lack of restructure beneath the leadership teams, I've raised my concerns before that unless you have for example 1 General Manager managing collective services across the HB rather than having them location based, so for example 3 managers across 3 sites, this really isn't going to be as effective.	It is proposed that there will be a phase 2, as referenced in the introduction of the document, which will look at the CSG and speciality layer to ensure that is

No.	Feedback	Response (where applicable)
	Having worked at large multisite organisations, the services aren't site specific they are service specific, having to deal with 3 different managers and three different clinical leads won't actually help, so the restructure appears a little superficial. Clearly the devil is in the detail but I would strongly support the restructuring of the 8c's to ensure that we have general managers managing HB wide services not site services, also I would say this is a very expensive model and makes for weaker governance. I also don't really understand why Public Health isn't in this structure? And also I don't think any comment on where all the infrastructure posts within the ILG's go, planning, PI leads etc. I might have missed it, I was reading fairly quickly.	best structured for the Care Group model. Public Health is not impacted by this OCP and therefore is not included in this document. Impacted corporate areas are referenced as part of chapter 8 of the document.
14	Medical illustration are also sitting in the wrong group. I believe we should come under scheduled care. As the vast majority of our workload is ophthalmology and dermatology with ward (POVA /NAI imaging) possibly coming under unscheduled. Please could I ask that we are moved.	Given that the service provided by Medical illustration Services is between Unscheduled and Scheduled care Groups the view remains that the service best fits in the Diagnostics, Therapies and Specialities Care Group. This Group has been developed to recognise that the services within it provide input across the entire Health Board and as a diverse & multi-professional workforce delivering care. Grouping these services in this way ensures visibility, the ability to maintain strength of voice across the Health Board, and offers robust oversight and assurance of

No.	Feedback	Response (where applicable)
		performance, quality and governance.
15	1. Women and Children's Care Group - could we consider moving away from gender based titles. our service group will be maternity and gynaecology. Could we consider renaming it - Children & Families? 2. within this care group the CSG teams aren't quite right, within the consultation, Bridgend W&C has been singled out. Please could consideration be given to the three CSGs being 'Maternity & Gynaecology', 'Community CYP', (inc Health Visiting and School Nursing, Continuing Care) ,'Acute CYP' (neonates and paediatrics) 3. within the new family care group structure Integrated Sexual Health seems an outlier and doesn't fit. Please could consideration be given for ISH to move to PCIC as it no longer fits with the profile? Pregnancy Advisory, EPAU, Emergency Gynae should stay as gynaecology out patient services but ISH should sit within PCIC as it's a service for men too.	Thank you for the feedback. From this feedback it has been decided that Women & Children's Care Group will be renamed Children & Families Care Group. In terms of moves of certain services between Care Groups, this will be considered over time, noting that there will be a phase two of the operating model restructure.
16	AESU does not fit into this as it straddles both elective (surgery) and ED (staffing and support staff). It differs from acute medicine as consultants have both acute and elective components to job plan. How will it fit into the proposed structure?	AESU will sit under the Unscheduled Care Group as part of the Same Day Emergency Care offering. It is recognised that this will require effective job planning with the surgical CSG to ensure capacity is made available.
17	I am very supportive of these changes, I always felt that this was the most logical way to deal with the challenges facing the HB. It is worth noting however that just as the issues with the ILG structure were caused by silo working and not developing/supporting a collaborative leadership culture, this remains a danger in the new structure unless we are really clear about the importance of matrix working. Perhaps setting 'demonstrate how you are supporting the other workstream triumvirates?' as a primary objective for each triumvirate leadership team might set the scene... just a thought.	Thank you for the comments. With regards to the USC Care Group section not mentioning the national 6 goals work or SDEC, these will be put into the final document.

No.	Feedback	Response (where applicable)
	Sadly there is no mention in the background of the unscheduled care group of the '6 goals for urgent and emergency care' which would have helped frame the content (I accept this consultation was out before the formal launch of the 6 goals - but the 6 goals work has been out there for the past 6 months.) No mention of same day emergency care (SDEC) (I would say this in my current role I know!) - again I realise there is different nomenclature in use across CTM but using national nomenclature might help pull the different services together. The lack of reference to SDEC and its core specialties (medicine/surgery/frailty) also mean that surgery is divorced to an extent from unscheduled care, with its focus firmly in planned care, even though we all know that getting unscheduled care (in particular surgical SDEC) functioning well is a key enabler for scheduled care recovery. Introducing SDEC as an element of the unscheduled care work, and listing under it the disparately named and variously organised elements might bring better structure to what the HB is trying to achieve. for what its worth though, very supportive	
18	to raise a few queries in relation to the Primary Care and Communities group - 1. the triumvirate has now expanded to 5 managers, it remains to be inequitable in terms of roles and grades (2 x directors, 2 x assistant directors and 1 x head of nursing), this does not allow for parity and partnership working. 2. could the nursing structure below the triumvirate be detailed as to have one head of nursing pan CTM communities and primary care would be a very significant sized portfolio. 3. the document details the nurse directors are each responsible for a locality, would this mean there would be 3 nurse directors over the communities portfolio 4. the leadership group includes the triumvirate staff but excludes the head of nursing and then includes the director of nursing	1 & 2 – Initial discussions are underway with regards to the nurse leadership model within the community and primary Care Group. Those potentially affected will have plenty of opportunity to help shape any future model. 3 – The Nurse Directors will be professionally accountable for delivery within their designated Care Group and will be provide strategic nursing support to a locality when cross cutting issues / themes emerge.

No.	Feedback	Response (where applicable)
		4 – The HoN will form part of the leadership group.
19	This is a paragraph I do not understand. Dying well is an aim for us all and is within the CTM 2030. The idea that dying well has a limited focus is short sighted. It is about flow, diagnosis, risk, patient experience. At the moment we are facing a catastrophe of domiciliary care. Those illesst and frailest cannot get home even to die. Look at complaints, ombudsman's report. Dying is neither peripheral nor limited in scope. But the in reorganisation we have note this. Part 9 – Strategy Groups – Role & Function The Strategy Groups were established as Systems Groups in 2020. The Systems Groups were originally designed to bring colleagues, patients and partners together to have a view across the whole health board. The work of the Systems Groups had an aim to improve the quality of service whilst reducing the risk of duplication or a lack of consistency which could inadvertently be a by-product of taking a Locality view. The System Groups were designed to be clinically led, supported by expertise in public health, planning, analytics, project management, workforce planning and financial development. The System Groups were designed for partners, including local authorities, volunteers, third sector and patients to be actively involved. It was originally stated that as the System Groups were designed to be highly transformational, it was expected they would 'mature, evolve and develop over time with the end formation being different to the starting point.' Therefore the movement to Strategy Groups to directly support the CTM2030 Clinical Strategy development is a welcome evolution and one that has already taken place. 51 There are no proposed changes to the way the Strategy Groups currently function or how they are staffed in this proposed operating model. These groups will continue to play an ever important and evolving role in the organisation.	Thank you for the input - In addition there is a dying well group, which works to describe good end of life care planning and delivery. It has important interfaces across the strategy groups. The dying well group has to be strategic, however we will ensure that we are clear about correct involvement and debate on EOL elements of all strategic pathway development.

No.	Feedback	Response (where applicable)
	This new evolution into Strategy Group over the course of 2021 into 2022 shows that they remain a critical component of turning CTM2030 into action, by overseeing how the Health Board plans and delivers improvements to the health outcomes for our population. There groups are organised into the 4 separate groups of: ☐ Born Well ☐ Growing Well ☐ Living Well ☐ Ageing Well In addition there is a dying well group, however given the limited focus of this group it is not supported by the same infrastructure. Each Strategy Group has several subgroups addressing priority health needs including: ☐ Healthy weight ☐ Young people's mental health ☐ Respiratory ☐ Diabetes ☐ Heart disease ☐ Elective pathways ☐ Stroke ☐ Frailty ☐ Dementia	
20	I don't understand what is being proposed for child health services. It's not clear what the structure is. I am also assuming that this has been put together before the coordinated response from paediatrics was received? Dr Dom Hurford was contacted about this following a meeting of our paediatric leads. Thanks.	Thanks for the comments - this consultation model was designed to get the ball rolling on discussions. As such it was not a model that was worked through in detail with the specialties - it was a starting point by which teams could comment upon. Paediatrics are one of the groups that took this on and formulated an overall

No.	Feedback	Response (where applicable)
		vision of their future structure but not all specialties did this. The Consultation model was there to start discussions. The premise of a Children's and Family Care Group is based upon models very common across the UK. As with all specialties once lines start to be drawn and categories are formed it highlights the multiple interactions a team has and not all teams sit cleanly within a Care Group. To mitigate this any decision that affects Paediatrics in another Care Group must include that Group in its discussions in order to be Quorate and have its decisions agreed (one example here could be Paediatric Surgery and Planned Care group allocation of theatre space). The Paediatric plan put forward has raised a lot of excellent points that need to be incorporated into the model and structure and has been exceptionally useful. Not all Specialties can sit on their own - as the structure would be not only very difficult to oversee from a governance perspective but also financially impossible to deliver. Appreciate that finance is one

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		area that the Paediatric team are concerned about and they would have a financial partner to support the budget needs to the team. We need time to explore how the proposed Paediatric model would fit.
21	Paediatric clinicians view on CTMUHB proposed Care Group Delivery model Consensus of Community Paediatrics and all Inpatient Paediatric / Neonatal units, June 2022 **Key points:** • There should be an independent, autonomous children's services care group consistent of three acute sites and community paediatrics • There should be a paediatric leadership group with responsibility for these four components and accountability directly to CTMU board • There should be strong local leadership to address operational problems • There should be the same emphasis for community paediatrics as for inpatient units • CAMHS services, therapies and public health nursing should be integrated in this model • The department will be led based on principles of compassionate leadership and trust • We will continue to build on present effective joint working between maternity and neonatal services through strong collaborative team approach • We will focus on programmes of prevention incorporating child and YP/ family and community engagement	Paediatrics and Community coming together makes a lot of sense as it consolidates the specialty. The Paediatric plan put forward has raised a lot of excellent points that need to be incorporated into the model and structure and has been exceptionally useful. Not all Specialties can sit on their own - as the structure would be not only very difficult to oversee from a governance perspective but also financially impossible to deliver. Appreciate that finance is one area that the Paediatric team are concerned about and they would have a financial partner to support the budget needs to the team. We need a bit of time to explore how the proposed Paediatric model would fit. The integration of Paediatrics across CTM as one specialty is something that will be worked through in

No.	Feedback	Response (where applicable)
	Rationale: • Address child health inequalities across the whole of CTMU more efficiently • Address the tidal wave of mental health problems in children and young people in close working relationship with CAMHS • Outcomes framework as ratified by the early years board will be a central pillar of the paediatric structure • A strong focus on patients and family experience with children's rights embedded in this approach • Integrate and strengthen therapy provisions for inpatient and community care • Consolidate and strengthen paediatric / neonatal pathways • Strengthen and create new pathways across primary, secondary and community / home care • Create integrated models with partners in the 3rd sector • Capture accurate data in all paediatric units including community • Use this data to develop strategic planning • Have control over a budget allocated specifically to paediatric, neonatal and CAMHS services • Use and pool resources across the whole of CTMU making services more streamlined, efficient and equitable • Develop new workforce models including ANP, ANNP, PA • Strengthen QI, audit and research	detail when the CSGs are re-structured. We will of course be involving you at that point too.
	As a current Planning and Partnerships manager I am intrigued to understand how my base and area of work will change. I am keen to know if I will be working in one specific area and if I will have an opportunity to express an interest in which area I move to; or will we as planners be pooled together and be allocated projects - if this happens how will the allocation process work, to ensure workload is shared fairly.	This will be undertaken via a collaborative process with all planners. We had an initial meeting to discuss the best ways of organising and agreed that a business partner model will work, the need to identify current tasks to either be handed to ops or to

No.	Feedback	Response (where applicable)
	For me, I would preference being placed in a specific area so that I could get to know that specific care group, its staff and its operating model, as this would be more beneficial to the service I provide as a planner. It would also allow me to build effective relationships with partners. I also wonder when we will know more and when changes will take place. The work behind potentially handing over current planning would benefit from forward planning and initial conversations.	be retained in planning and how we might split areas of work. We will continue the discussion together on who does what based on skills, knowledge, aptitude and preferences.
22	This document doesn't really clarify how the current model feeds into the proposed one. It has been mentioned but I am afraid I do not understand what you mean. What experience will the nurse lead for the Primary care group have of general practice? Will the primary and community care group be working alongside the pan cluster planning group to ensure GP is not pulled in different directions? I presume that both these groups will be guiding Clusters with regards to services that they feel the area needs? I would be grateful for clarity on these matters. Many thanks	Yes P&CC groups will be working alongside pan cluster planning groups to progress the ACD agenda under P&CC. The organisation will ensure all leadership roles have relevant and value-adding experience.
23	I am a clinical lead for Cardiology and this proposed model was discussed at our weekly Consultant/senior Nurse/Manager meeting today; all have been asked to respond separately. (You may also have on record my previous response to the delivery model of services that was requested when CTM was created). I appreciate that an understanding of all clinical specialties is challenging but there was a general criticism when we discussed the document sent that the proposal shows a lack of understanding of our specialty- Cardiology (and other clinical specialties) based on the wording applied and specifically the posting of 'cardiac services' within the Unscheduled Care Group.	Thank you for the comments. Cardiology will now sit under the Planned Care Group. As part of phase 2 there is an aspiration to run Cardiology as one single service across CTM.

No.	Feedback	Response (where applicable)
	Whilst a proposal to unify cardiac services across 3 sites is welcomed, our work (much like cancer services) spans 'planned', 'unscheduled' and 'diagnostics, therapies and specialties' groups (with a smaller less well defined role in primary/community care). I would therefore favour, a stand alone directorate/organisational team (cf. the 'cancer operational group') for cardiac services (as is found in most UHB/Trusts). Being positioned in the 'unscheduled care group' does not reflect the majority of cardiac service work and pursuing this proposed model I would advise placing cardiac services in 'scheduled care' and importantly with cardiology diagnostic services. This should be supported by a cardiology operational group.	
24	in the diagram for the HR teams the hosted organisation such as WHSSC and NCCU are not shown. Would this fall to the Executive Corporate business partner?	Strategic advice will be provided by the business partner support for Executive and Corporate teams which currently sits with the Assistant Director of Policy and Compliance. Operational expertise will be provided by the People Service Team.
25	What does the people services structure look like?	The People Services structure will be led by Head of People Services and comprise expertise at bands 5, 6 and 7. The job descriptions for these roles are being finalised to be shared with the team over the next month during several engagement events with colleagues who are affected by the new model.

No.	Feedback	Response (where applicable)
26	Part 3b – Unscheduled Care Group There are a number of services which appear here but are not 'unscheduled' in nature. 1. Pulmonary rehabilitation 2. Cardiac rehabilitation 3. Sport and exercise medicine My feedback is that the above services should sit in diagnostics, therapies, specialities care group due to the purpose of these services (therapeutic). There is no mention of AHP leadership within this care group, therefore if the services aren't moved, will appropriate AHP leadership be added to the roles/leadership? Please can we confirm that 'major trauma' in the unscheduled care group includes the operational management of the AHPs? Women's and Children's care group – given that unlike our other AHPs, paediatric AHPs do not work across other care groups, are we going to suggest they actually move to this care group? Part 3d – Primary & Community Care Group There is reference to specialist palliative care – can we confirm if the AHPs will be operationally managed in this care group? As with paeds, the physios don't cover any other care group/service so could be appropriate? Community wellbeing & therapy team & Community resource team (Bridgend) – we have some concerns about the clinical governance related to the physios in these services – I can't see any reference to AHPs in the leadership roles If this is going to remain in this care group – how do we get an AHP in a leadership role in this care group? We were under the impression that these staff who move to the diagnostics/therapies/specialties care group	Thank you for taking the time to review the consultation document and provide comments and feedback, this is very much welcomed and really helpful. Your feedback has been carefully considered by Executive leads. The Diagnostics, Therapies and Specialities Care Group has been developed to recognise that the services within it provide input across the entire Health Board and has a diverse & multi-professional workforce delivering care. Grouping these services in this way ensures visibility, the ability to maintain strength of voice across the Health Board, and offers robust oversight and assurance of performance, quality and governance. Consideration will be given to the services that you and others have recommended move across to the Diagnostics, Therapies and Specialities Care Group, as where appropriate the intention of this operating model is to keep AHPs together and not separate therapy teams.

No.	Feedback	Response (where applicable)
	This is mentioned a few times: Further work up is needed to ensure strong leadership input and alignment of wider therapies professions to this care group. Do we have any more information?	I understand the importance of AHP leadership and the value that this brings to the organisation. The proposal is to have a group Medical Director, group Operational Director, Chief Pharmacist, and Clinical Directors for AHPs within the leadership team. The omission of the CD for AHPs and Chief Pharmacist in the original diagram was an oversight. The proposed leadership structure for DTS ensures that existing professional leadership roles for AHPs and Pharmacists are included within the leadership structure. As is the case currently, the Healthcare Scientists within the group have a professional line of accountability and leadership via the DoTHS and ADoTHS. There are a small number of nurses who would work within this proposed Care Group. They will receive their professional leadership from the Nurse Director in the Planned Care Group as there will be no Nurse Director specific to the proposed DTS leadership structure.

No.	Feedback	Response (where applicable)
		The DoTHs portfolio is currently in the process of establishing a professional leadership forum for AHPs and HCSs. This forum will ensure that the clinical leaders for each of our professional groups will have a forum through which they can engage with peers and have a direct communication route with the Board, through the DoTHS. The Clinical Directors for Radiology and Pathology will continue their close working relationships with our HCS and represent their views within the DTS leadership team. Closer links with the CD for AHPs via the professional leadership forum will result in improved understanding of the roles of our HCS and facilitate the CD for AHPs to also represent our HCS. I appreciate your view that we should have a CD for HCS but this is not a post that is currently being considered within the proposed CTM operating model.
27	My role in the new structure I am currently a PA for an ILG. Under the proposed new operational model there are no ILG's and I do not fit into the new operational model. I am very	Thank you for your comments and feedback.

No.	Feedback	Response (where applicable)
	happy in my current role and team and it is causing me great anxiety and stress in where I am going to be placed and really doesn't promote our values and behaviours. I have put my all into this role and have loved being part of an amazing and dedicated team and not having a role in this new structure has made me feel absolutely worthless. Please can you confirm what you have planned for me and if I need to look for another job. Reason for the change in model Please can you confirm if feedback around the current model from Consultants has been taken from different specialities across the three ILG's? RTE have maintained a green pathway throughout the pandemic and seem to support other ILG's with no extra resource e.g. the ED boundary change. Have you considered the people in management making these decisions in the other ILG's and how they work rather than just change the model? Would this not just have the same problems with management staff who are underachieving staying at the same level with different titles? Fourth Care Group With the discussions of having a fourth care group, this will need another set of 'Heads Off' staff. How can this be justified when we need more nursing/admin staff to get the work done to provide services to our communities? Team working What is the Local Authorities feedback on this new model? Throughout the last 2 ½ years I have developed a large number of good working relationships which has opened up communications with different specialities, both on the Acute sites and in the Community. How will this improve by changing to Care Groups? How will this improve patient care?	Following the consultation period and the release of the agreed Care Group Delivery implementation model, affected staff will be contacted and the transition to the new model will begin. The principles of which will follow the process as outlined in the All Wales Organisational Change Policy. Feedback around the current operating model have been received from a variety of staff groups over the past 8 months. Feedback has come in a variety of forms and provided to a number of senior members of the Health Board. Fourth Care Group - The Care Group proposed structure is outlined in the Consultation document. This proposed structure does not alter the current set up / provision of the CSG level. There is no additional staffing proposed.

No.	Feedback	Response (where applicable)
28	My response predominantly concerns Radiology. I think the Diagnostics, Therapies and Specialties Care Group is a good model bringing together a wide range of support services. I would be concerned regarding the structure below the leadership team as there does not appear to be a defined structure to each of the professions. I assume that Radiology will have a Head of Profession to mirror similar structures with AHPs. Radiology does not currently have that post in place and hasn't for a few years. If so, I assume this 'Head' post will work like a Directorate Manager also with budgetary responsibility for the service. I am not sure that this will give the best structure for the whole of Radiology across the sites. If this is the case then there needs to be appropriate management teams below the Head of Profession - many of the other professions appear to have Heads, Deputies and Assistants (I think) in place. Radiology structure will need investment. There is a danger that the Clinical Directors in the leadership team become overly operational unless the relationship between the leadership team and the heads/service leads is managed carefully. There needs to be care regarding the smaller services within the model to ensure that they are not swallowed up by the larger services. It is important that they have an appropriate voice.	Thank you for taking the time to review the consultation document and provide comments and feedback, this is very much welcomed and really helpful. Your feedback has been carefully considered by Executive leads and your support of the proposed model welcomed. The Diagnostics, Therapies and Specialities Care Group has been developed to recognise that the services within it provide input across the entire Health Board and has a diverse & multi-professional workforce delivering care. Grouping these services in this way ensures visibility, the ability to maintain strength of voice across the Health Board, and offers robust oversight and assurance of performance, quality and governance. As you've pointed out there does need to be robust structures below the proposed leadership team and this will need to be worked through in due course. The DoTHs portfolio is currently in the process of establishing a

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		professional leadership forum for AHPs and HCSs. This forum will ensure that the clinical leaders for each of our professional groups will have a forum through which they can engage with peers and have a direct communication route with the Board, through the DoTHS. The Clinical Directors for Radiology and Pathology will continue their close working relationships with our HCS and represent their views within the DTS leadership team. Closer links with the CD for AHPs via the professional leadership forum will result in improved understanding of the roles of our HCS and facilitate the CD for AHPs to also represent our HCS.
29	thanks a lot for putting the document about the new structure I have few comments: a) In regards to sexual health 1. Sexual health services are provided to both men and women and not just women 2. Sexual health services need to be close to the area of residency which will be easily achieved if under primary care 3. Sexual health services will no more be commissioned by Swansea and the want Bridgend to be responsible and as we know Bridgend has no capacity for that and diverting the services to MC will be too far for the population and will extremely affect the quality of care and patients' expectations while if delivered	Thank you for the suggestions and comments here - agreed Sexual Health is non-gender based, as such it would still sit well under the Children and Family Care Group. We understand the Primary Care aspect to this however delivery of the service to be run from a central Care Group is an easier way to manage the service. There are aspects as you say that are

No.	Feedback	Response (where applicable)
	under primary care, the services will be closer to them through the primary care settings 4. HIV services needs to be more centralised owing to the low number of health care professionals providing that service as well as the high need for that service. If it is centralised this will help the cross cover and maintain the service while though the year 5. Sexual health is mainly nurse led and this will allow the easy cover through the primary care group b) In regards to the new structure: 1. the diagram is not clear and most likely wrong as I heard about the structure as in Bridgend it is one care group for W&C but in RGH/PCH it is one for obstetrics and one for children 2. The diagram didn't take in to account the relation of Gyn to planned and unplanned care which is critical to is in order to deliver the service in both scheduled and unscheduled Gyn 3. In the narrative it is not clear the role of CD and group medical director and what autonomy the CD will have 4. The flow of money is not clear in the one CTM structure and this can lead to inequality in service provided across the CTM as we have two different population demographics and needs and accordingly having one budget with two competitors will not be fair 5. The relation between diagnostics and the other three care groups is not clear 6. While everywhere in England going toward the ICS approach and we were a head of the game, i am sorry but i cannot see that integration in the new structure 7. Where is the integration with primary care and social care in that structure 8. The reporting system for approval is getting more layers which means more delay in getting things sorted and done which will lead to more frustration in the system	still under SBUHB but in time will become integral to CTM and a central oversight of this gives a stronger governance approach. It needs to essentially be thought of as a CTM-wide service and not in terms of diverting to Hospital X from Hospital Y. If one site or area does not have the capacity how do we create the capacity to deliver it closer to home? That is where a Care Group can oversee a whole service plan.

No.	Feedback	Response (where applicable)
	The current Facilities operating model was developed between 2012 and 2018 and is based on a 'hub and spoke' model with the Hub centralised services policy, risk management and governance oversight and management of a number of Facilities central services namely CPU, Clinical Engineering, CTM wide Environmental management, Transport, Waste, Security, Switchboard, General Offices, Car Parking, Grounds and Gardens, staff residences and the Laundry that support CTM wide. The Facilities spoke delivery units support the front line clinically led ILGs with Porter, Catering and Housekeeping services. Facilities is centrally positioned in Clinical Service Operations and remains so in this proposed new model however line management of the Facilities spokes was moved to the ILGs when the ILG operating model was created in April 2020. As Assistant Director of Facilities I provide professional leadership to the Facilities ILG management teams and meet and support them on a regularly basis which has been the case in particular during the pandemic and to date. Both the Facilities central hub and the ILG Facilities management teams are of a view that they feel disconnected from their Facilities central hub colleagues and that splitting the Facilities team management in two has not been a success for them in support, operationally and on a professional level. They feel that the ILG clinical leads have an uphill patient care challenge coming out of the pandemic and for the foreseeable future and would benefit from a release of management time, space and that Facilities can offer improved support to the ILGs if the hub and spoke went back to Facilities hub and spoke line management rather than the current professional dotted line support. This is a model that worked well following Bridgend transition and before the ILG clinical lead model was introduced and is one that is an industry standard. I know that some of the Facilities management team have expressed their view about a proposed change on this forum.	Thank you for the comments.

No.	Feedback	Response (where applicable)
	I agree with the views that have been expressed by my ILG and hub Facilities colleagues and would fully support a change back to the original Facilities hub and spoke operating model and I would be comfortable to take on this previous responsibility I had prior to the ILG operating model in April 2020. It is my view that the Facilities ILG teams at ILG would benefit from Facilities leadership and line management support not just professional dotted line support. This in no way meant as a disrespect to the ILG site clinical leads, but I do feel that my ILG clinical colleagues have an uphill climb out of the pandemic and enough patient and clinical matters to resolve every day and for the foreseeable future and that the Facilities team and I would be better placed to support the COO, D/COO's and ILG clinical leads in this revised delivery model being proposed. With regard to OCP if this proposal was to be taken forward it would mean a lift and shift of ESR and budgets and would have no impact on the Facilities management or Facilities staff at ILGs or at the Facilities central hub. With this in mind my question is has any thought been given to changing the Facilities management arrangements to enable ILG clinical leads more management time and space by reverting back to the original Clinical Services Operations COO lead Facilities hub and spoke line management model?	
30	From an Environment, Waste and Fleet management perspective, the split of facilities has not been a successful move, and has put further operational and professional weight and pressure on to the department which is already stretched with limited staff. There is a very disjointed management system in place currently, and it is very difficult to reach decision making with ILG clinical leads who are more furnished with clinical decision making as opposed to facilities management, with no disrespect meant to the ILG site clinical leads, who I know are extremely	Thank you for the comments

No.	Feedback	Response (where applicable)
	stretched clinically also following the pandemic, and have pressures of their own in ensuring exasperated waiting lists are managed. For ISO 14001 Reporting, Duty of Care and Regulatory decision making within my Environment, Waste and Fleet services department, it is my view that Facilities should revert back to its original reporting structure of COO lead facilities. With that being said, I would fully support a prompt revert back to the original Clinical Services Operations structure with front line Facilities Management Leadership support from our Assistant Director of Facilities, Russell Hoare.	
31	Thank you for the opportunity to comment on the proposed care delivery group model. Overall I am disappointed that the organisation is again reorganising service delivery and would have advocated a settling down period given the difficulties experienced with the COVID pandemic over the last two years and that would have given the ILG model time to fully develop and embed. As a CSG Manager my biggest concern is the suggestion that we move from running services in a geographic location to focussing on specific aspects across CTM. Whilst i can appreciate the advantages in theory, in reality this is very difficult to deliver operationally. One of the benefits of the ILG model has been the ability to be based on one site and to develop close working relationships with the clinical teams. We will lose some of this if we move back to delivery across a number of sites. I completely disagree with the statement that the proposal does not alter the composition of the CSGs and regardless of where I would sit as an individual I feel that the role will have changed significantly. Planned care group - what is meant by cancer services? Does rheumatology include DEXA services? Gastro has a significant unscheduled element and should	Any proposed changes for CSGs will be as part of phase 2. This will be a separate OCP. Cancer Business unit will sit within the Planned Care Group in its coordination role. Thank you for the remainder of your comments

No.	Feedback	Response (where applicable)
	be with unscheduled care? Endoscopy - why here and not with other diagnostics? Neurophysiology is a diagnostic. Unscheduled care group - why is Bridgend treated differently again? Sports & exercise medicine should sit with planned care. Cancer is mentioned a number of times and it is not clear where it will sit. Cardio Pulmonary & Respiratory diagnostics is called various things throughout the document and sits in a number of care group - can this be clarified. Rapid diagnostic clinic is not listed - with cancer in planned care or in unscheduled care - it is not clear. Clinical haematology currently sits with pathology although most people who agree it should sit with the medical inpatient services - if we do not address this long standing issue now then we have missed an opportunity. In the current model the operational CSGs have lost corporate support from the business partners and I am not sure that the proposed changes will improve this situation with roles moving into the central teams and becoming more distant from the delivery arm of the organisation. Budgetary responsibility needs to be very clear in the new model as the ILG model has led to confusion and decision making without discussion with the budget holder who is then held to account to any overspend. In conclusion I feel that the focus of the organisation will move away from recovery post COVID and this will be a distraction for the next 6-12 months at a time when our focus should be on delivery of services to meet the needs of our patients. Reorganisation is never the answer to challenges within the system and having worked under a number of operating models they all have strengths and weaknesses.	
32	I am writing with regard to the proposal for Facilities within the new structure. I feel that being split as an overall team and also being split between the three	Thank you for the comments

No.	Feedback	Response (where applicable)
	regions has not benefited Facilities operationally and with regard to professional support. ILG responsible leads are under great pressure to support the clinical service groups and the day to day patient flow, by returning ILG Facilities to it's original position reporting to Assistant Director of Facilities will lessen the pressure on ILG leads to provide support to ILG Facilities. I mean no disrespect to the ILG Leads and this view is not meant as a criticism but as an acknowledgment that there is a great deal of work required to recover from the Pandemic for all service groups to include Facilities as a whole and Facilities are best supported entirely by the professional lead reporting to the deputy COO and COO in providing the best responsive service to the ILG Leads and clinical service groups.	
33	I am a consultant cardiologist and most of my work and that of my consultant colleagues is scheduled care. It therefore makes most sense that we are placed in the scheduled care group and not the unscheduled care group. Furthermore, the rest of cardiology services including cardiac physiology and all cardiac diagnostics is predominantly scheduled care and not unscheduled care. We have previously lobbied for the proposal that all cardiology services should be in its own directorate under scheduled care. We would numerically be a large number of staff, operating one of the most complex patient pathways, using expensive infrastructure (eg three catheterisation and pacing labs) and with a sizeable budget. This is the only way that we will achieve true multisite working and push forward complex cardiology business proposals.	Thank you for the comments. Cardiology will now sit under the Planned Care Group. As part of phase 2 there is proposed aspiration to run Cardiology as one single service across CTM, subject to engagement and consultation.
34	The issues we are facing are not the result of a flawed structure, they are the result of a flawed culture. Changing the structure just reshuffles the same people into different roles with different remits. It does not change the people or the culture. I applaud the intention to limit the number of tiers between front line and exec decision makers with accountability and authority to act. However, my observation is that these same decision makers are already fully aware of front line issues but do not seem to have the ability, power or credibility to act.	Thank you for the comments. The organisation will ensure that the new structure aims to add greater value and negate some of the issues you raise in your comments. As part of our ongoing escalation status, we will continue

No.	Feedback	Response (where applicable)
	It is not clear how this restructuring will address this. Many (?all) of the tiers that have been put in place between front line and exec level are necessarily there to absorb the work of an overly bureaucratic organisation. These same tiers will inevitably re-emerge in the new structure as various 'deputy' and 'assistant' posts unless stifling red tape is removed.	to keep a focus on our development across leadership and culture, trust and confidence and Quality and Governance.
35	It is proposed in this document that health visitors and school nurses will come under the women and children's care group. As both these specialties come under the umbrella of Specialist Community Public Health Nursing (SCPHN) and have very close working relationships with general practice, would it be more appropriate for these disciplines come under primary care and community. It is also worth noting that health visitors and school nurses are housed in premises that are managed by primary care and community.	Thank you for your feedback. We can confirm that Health Visitors and School Nursing will remain in the Primary and Community Care Group
36	i feel the wording of the care group for Therapies and diagnostics doesn't make strong enough the clinical director/clinical pharmacist leadership, i would like to see them on same level as Nurse and Ops director, for parity. Also Page 12-MH services also include SLT & dietetics-this is often missed. thanks	Thank you for taking the time to review the consultation document and provide comments and feedback, this is very much welcomed and really helpful. Your feedback has been carefully considered by Executive leads. Please be reassured that the clinical director and clinical pharmacist will form part of the senior leadership team structure. Your comments on wording on page 12 will also be considered.
37	I am surprised and concerned that the system group 'dying well' is not being afforded the support and infrastructure of all the other systems groups in this consultant document (i.e. "clinically led, supported by expertise in public health, planning, analytics, project management, workforce planning and financial development"). This is explained in the document as "In addition there is a	Thank you for the input - In addition there is a dying well group, which works to describe good end of life care planning and delivery. It has important

No.	Feedback	Response (where applicable)
	dying well group, however given the limited focus of this group it is not supported by the same infrastructure." This approach contradicts the emphasis that palliative and end of life care is being given elsewhere (1). Palliative and end of life care is "everybody's business" (2,3). Around 30% of adult inpatients in hospitals are in their last year of life (4), for example. With insufficient infrastructure to support 'dying well' the focus and priority on this area will head backwards, and would make this health board very much an outlier compared to elsewhere in Wales. (1) NHS Health Collaborative Groups. End of Life Care. https://collaborative.nhs.wales/implementation-groups/end-of-life-care/ (2) Ilora Finlay: Making end-of-life care everybody's business. The King's Fund, 2016. https://www.kingsfund.org.uk/audio-video/ilora-finlay-end-life-care (3) David Oliver. End of life care in hospital is everyone's business. BMJ 2016; 354 doi: https://doi.org/10.1136/bmj.i3888 (4) Clark, D Armstrong, M Allan, A Graham, F Carnon, A Isles, C Imminence of death among a national cohort of hospital inpatients. Palliative Medicine, 2014, 28 (6). 474-479. ISSN 0269-2163 (doi:10.1177/0269216314526443)	interfaces across the strategy groups The dying well group has to be strategic, however we will ensure that we are clear about correct involvement and debate on EOL elements of all strategic pathway development.
38	The role of the Acute Services General Manager has the potential to change focus considerably as a result of the consultation. This has pros and cons. The role of the ASGM lacks detail within the consultation document. It is featured within the organogram as part of the triumvirate for "triumvirate site	Thank you for your feedback

No.	Feedback	Response (where applicable)
	leadership" with a combination of hard line management into the CSG medicine and dotted line management into other roles however is not mentioned within the proposed clinical care group structure. Further discussions have clarified that it is not featured within the Clinical Care Group structure as CSGM positions will report directly to the Group Operations Director roles. It has been suggested direct reporting into the Deputy COO which would be sensible given the above. The current role is multifaceted and combines a senior clinical service group manager position with oversight and responsibility and operational management hospital wide. This includes line management and financial management of a significant portfolio of Clinical Service Group functions within the Medicine/Emergency Medicine and Surgery, Anaesthetics, Critical Care and Theatres areas. Operational management of core facilities functions is also part of the remit of the ASGM however this is not clear in the document whether it would now move corporately or remain devolved – we would support this remaining devolved. The focus of the role would therefore change from direct management of clinical services to an influencing and co-ordinating function. Patient Flow would be an integral part of the role and could be widened to include discharge liaison teams. Due to the change in ILG operational director role, there would be a need for functions currently sitting at this level to be devolved down to Acute Site level which can site with the ASGM role including Health, Safety and Fire, Business Continuity planning, Strategic planning, local partnership forums etc. which would be possible due to the removal of clinical service group management.	

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	Further discussions have been held regarding the inclusion of Emergency Medicine within the portfolio however there would need to be clinical buy in and rationale for why EM would be treated differently to any other service group. The role of the Head of Nursing and Clinical lead for each of the acute sites would need to align to this portfolio to ensure aligned governance, portfolios etc Lines of Accountability The lines of accountability within the consultation document need further clarity and at some points appear to conflict. Nursing The Head of Nursing is defined as "being responsible and accountable for care delivery within the planned and unscheduled care groups for each acute site". This is in direct comparison with the responsibility of the Medical Lead and ASGM as described in the document as they do not have management accountability or budgetary responsibility for the care groups. Does this role hold responsibility without budgetary accountability as this would sit within the Care Group structure? The document also states that a Nurse Director would also hold a locality leadership role alongside a Care Group which has a potential for lack of clarity of reporting lines/accountability. When taking an example of "Who is responsible for the nursing care on ITU within either DGH." The document states that it would be the Head of Nursing. In terms of reporting lines, this sits within the planned care group so could be assumed to be to the nurse director of the planned care group but there is also nurse director with site responsibility. This needs to be clearly articulated within the final structural document to avoid confusion.	

No.	Feedback	Response (where applicable)
	Medical Leadership Page 37 states no change to the medical leadership model on DGH sites however this is now changed. The role of the Medical Leadership post requires clarification as there is no direct line management of Clinical Directors. Is the role now a coordination	
39	Finance Team – key considerations and risks highlighted through a documented submission	Attached in the final part of this appendix
40	a) I fully support and agree with the rationale for establishing the Diagnostics, Therapies & Specialties care Group. This aligns with the future strategic direction of the WG, in recognising the contribution of diagnostics to the NHS service delivery. It will (hopefully) help ensure future involvement of and investment in these services as the NHS changes, through the improved visibility. b) My key comment is as follows: The Diagnostics, Therapies & Specialties care Group has a significant number of the Healthcare Science (HCS) workforce within many of the clinical specialties identified, to include Pathology (which consists of Microbiology, Cellular Pathology, Haematology/ Blood Transfusion, Point of Care Testing and Clinical Biochemistry), Audiology, Cardiac physiology, Respiratory physiology, Clinical engineering and Psychologists. I note that the HCS work force is the only professional work force that does not have representation of its professional group on the leadership team. I note that consideration was given for nursing representation on the leadership team, but this has not been included because of the small number of nursing colleagues working within this care group. May I suggest that the reverse could apply for the HCS work force and that consideration should be given for this group to have representation, in light of the significance of the HCS workforce in terms of numbers and contribution to the work of this care group. May I respectfully suggest that it would be beneficial for there to be a HCS as a member of the leadership team, to provide the necessary professional input to the high level strategic discussions of this care group. This aligns very closely to the work at WG, through the Health Science Network promoting Healthcare scientists, their	Thank you for taking the time to review the consultation document and provide comments and feedback, this is very much welcomed and really helpful. Your feedback has been carefully considered by Executive leads and your support of the proposed model welcomed. Please be assured that Health Care Scientists are a valued profession within CTM and your point regarding inclusion on the senior leadership team noted. The DoTHs portfolio is currently in the process of establishing a professional leadership forum for AHPs and HCSs. This forum will ensure that the clinical leaders for each of our professional groups will have a forum through which they can engage with peers and have a direct communication

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	roles, contribution and leadership opportunities across the NHS (please see attached Framework, supported by the then Health Minister). I think CTMUHB has an opportunity to lead by example and demonstrate full inclusivity through inclusion of a HCS as a member of the Leadership team. c) Has Endoscopy been considered as an additional "Diagnostics" service that could potentially sit within this group, because Endoscopy works very closely with the other diagnostic specialties, notably Pathology and Imaging. d) A minor point but there are a number of important Groups not included on Page 17 that you may wish to include in any future documents: Healthcare Scientists are also members of: i) Welsh Scientific Advisory Group (WSAC) (directly advises the Chief Scientific Advisor for Health) ii) Clinical Biochemistry Standing Specialist Advisory Group iii) Microbiology Standing Specialist Advisory Group iv) Haematology / Blood Transfusion Standing Specialist Advisory Group(s) v) Cellular Pathology Standing Specialist Advisory Group	route with the Board, through the DoTHS. Thank you for highlighting that endoscopy is a service that could be included in this care group and for highlighting additional national groups both of which are helpful points for consideration.
41	I am emailing on behalf of all of the Palliative Medicine Consultants in CTM. Below is our formal response to the consultation surrounding the Health Board restructure. We would be grateful for your consideration and response. Currently Specialist Palliative Care (SPC) in its entirety sits within Community and Primary Care, hosted by the RTE ILG. The health board's three specialist palliative care teams (based in Bridgend, Rhondda/Taf Ely, and Merthyr/Cynon) already work in an integrated and seamless way between hospital/secondary care and community/primary care, with each of the three having hospital, community and specialist inpatient unit teams. This has allowed collaborative working, with job plans across those three areas for medical staff, and the ability to respond flexibly to demands in different parts of the service by having a combined integrated workforce. The community, hospital, and inpatient units	Thank you for your feedback. However it has been discussed in depth and concluded that SPC best fits within the Primary and Community Care Group.

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	for each SPC team should remain managed together in any new organisational structure. Specialist palliative care is a small specialty (with just 4.7 WTE Palliative Medicine consultants for the whole health board, for example). One advantage of being small, is that the three SPC teams can be managed within the same part of the health board structure, with many advantages afforded from this, particularly around joined up working and providing an equivalent SPC offer, regardless of where a patient lives in the health board. It is proposed in the consultation document, that SPC continues to be managed within Community and Primary Care. Having read the document, the SPC consultant body would argue strongly that the service provision of SPC fits better within the Unscheduled Care Group for a variety of reasons as follows:- 1) The document clearly states that the "Unscheduled Care Group draws together all specialties which are focused on the provision of health services which cannot be foreseen to a significant degree in advance of contact with the relevant healthcare professional". This is exactly the nature of the work of the SPC service. Our patients across all settings have rapidly changing and unpredictable conditions. As such, our minimum national standards require that all urgent referrals are seen within 48 hours, and non-urgent cases within 10 days. In reality our team are often asked to see patients within a period of just hours, including in the out of hours period. There are multiple areas where our expertise is needed quickly; catastrophic symptoms, family distress and new cancer and non-malignant diagnoses. In addition, our multiprofessional community teams operate as virtual consultant led wards, responding quickly and actively to prevent acute admissions, supporting patients to remain at home for end of life care, or facilitating a more appropriate admission directly to a SPC bed. Our consultant led SPC hospital teams are integral to acute flow in the DGHs, helping to facilitate rapid	

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	discharges home, and organising timely transfer of appropriate patients to our three SPC units, especially within POW and RGH, where our SPC units are on site and transfers can be easily facilitated. Our three SPC units are responsive in taking urgent admissions when needed, including in the out of hours period. Thus we have developed strong and close working relationships with the clinical leads across the Unscheduled Care Group, and feel very much that we belong as part of this wider team. 2) We are an active training specialty, responsible for the training of an F1, F2, academic F2 and VTS trainee, and a palliative medicine registrar, the majority of whom are also on acute medical on call rotas. Palliative Medicine becomes a Group 1 specialty from August 2022, with our trainees being dual accredited in General Medicine. We need to be able to support our registrars onto the acute medical on call rotas, working closely with our GIM colleagues to provide a combined training approach. This training would be better facilitated as part of the Unscheduled Care Group, by managers experienced in supporting medical trainees. 3) We have aspirations for further service development. We want to increase our front door presence and thus have a greater influence and impact in this area, in terms of clinical decision making and preventing admissions. There is a huge need for the development of joint working with specialties such as respiratory and cardiology in order to improve advance care planning and end of life care for patients with non-malignant life limiting illnesses. We want to develop our Clinical Nurse Specialist skill mix, including the introduction of ANPs and nurse prescribing. Being situated within the Unscheduled Care Group would provide the best opportunity for fulfilling these aspirations. As a service we are currently remotely managed by a HB derived structure, that is neither based locally or really understands the acute nature of the SPC services that we deliver. We would welcome this restructure as an opportunity	

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	to change this and to be managed within a Care Group who understand the nature of our work and what we do at a local level.	
42	General Observations Positives of the ILG model This was a positive move fro Primary and Community Services as it was the first time we had regular integrated meetings of clinical staff from primary care such as GP's in the same room / meetings as our acute care colleagues. They had started to understand each other and their pressures more and were showing far more mutual respect. Acute clinicians started to understand the cluster working and projects and were interested in joint working. the cluster work did not feature un their thinking prior to this The flow conversations between the acute site and the community hospital was much improved and again the understanding of what a community hospital should offer was understood. We had done joint work with our acute colleagues on defining the strategy for the community hospital wards based on a point prevalence audit across both sites. This joint work in this way had never happened before as there was always an us and them culture. Despites some problems of hosted services we had managed to integrate Specialist Palliative Care as a hosted service fro CTM within RT ILG. They were able to speak with one voice and we were able to report on a once from CTM basis to WG and the national end of life board. We maintained our relationships with RCT LA and the 3rd sector in RCT, although I appreciate this was difficult for them when they had to cove off Cynon in a differ ILG. Negatives of ILG's The geographical spread of the hosted service CTM wide is difficult to manage to show a presence on all 3 units and they sometimes felt isolated from their own acute sites and colleagues.	Thank you for you substantial contribution which is much appreciated. Your points have been shared with the wider Executive Team for consideration as part of this process.

No.	Feedback	Response (where applicable)
	The separation of the Primary Care Contractor Services into their own grouping didn't work as we were not kept in touch with the wider developments in primary care as we didn't sit on any groups such as the Transformation work. I am very worried that this change at such a critical time will impact on staff's Well-being. We have just gone through the toughest 2 years in the NHS we have every experienced and staff are exhausted and disillusioned. Organisational change at a time when staff are already so low feels like a bit of a 'kick in the teeth'. Despite all the reassurance everyone will now be worried about who they will be managed by, what it means for them at a time when they are already exhausted. Part 1 Page 3 The OCP does not propose to alter the composition of the Clinical Service Groups - There is no indication of when this will be reviewed although it does say it will be. Some of the wider staff changes will have big implications however ALSO the CSG's fro primary and Community will immediately be changed due to the move to the local authority boundaries. The population base for these 3 CSG's will therefore change dramatically. ie currently the populations for planning purposes are Bridgend 159k ; R/T 184k and M/C 123k if you take the Cynon out and add it to R/T..... RCT becomes 246k and Merthyr is only 61k. You will either need to move management and clinical resource from Merthyr to RCT to cover this off OR leave things managed in Merthyr. If you do not change the CSG's as noted, there would currently be a Head of Nursing (HoN) in each one as this is what is there now. the new structure proposes a Head of Nursing in the Tier above this at leadership team. You cant have 3 HoN's 1 for each CSG reporting up to the same grade a HoN at the leadership group for Primary and Community Services.	

No.	Feedback	Response (where applicable)
	Page 5 Streamlined management structures and decision making - The new structure will make this worse as it puts in another layer of management. As a CSG manager I currently report to the ILG Director of Operations who reports to the COO. In the new model, I would report to the Group Operations Director who will report to the Deputy COO who will report to the COO another layer of management. I have clearly run out of words so this is my PART 1 - I will continue on a further response !! My Second Submission as I ran out of words so PART 2 Page 6 Expectations between Corporate Support and Care Group - The key issue is the appropriate deployment of work based on the resource. There has been an 'explosion of corporate teams and roles over the last year' but none of that has made my job as a CSGM any easier in fact it has put more pressure to contact the teams, comply with requests and a feeling of expectation to engage in things that I cant find the capacity within my job to do. These teams need to be taking some work away from the CSGM's. As a CSGM I want to be driving change and developing the ideas BUT I need pairs of hands to help turn this into papers and project plans. Advice is no good to me when I don't have the capacity or local team to implement. I have currently 1 band 8A, and 2 band 6's that is the whole of my management team. These teams need to be bolstered to take the work forward but also for succession planning as with no band 7's and no 8B's when there are vacancies we don't have staff with the required skills to fill the posts. Part 3 in the document (Page 10 Again if it does not propose to change the compositions of the CSG's why has my replacement been held up since January of this year. I am retiring in June	

No.	Feedback	Response (where applicable)
	and have been pushing for a replacement to be advertised since January to have a handover. It can not be advertised because it is being considered as a joint post with the LA. We don't currently have joint posts so that will be a change and the document needs to be clear and honest about that. There is no mention of this in the document and have the LA been consulted on the changes as when I spoke to someone last week they has not seen the document. Part 3a Planned Care Group (first page no number at the bottom, pages numbers now don't flow) You should consider the Parkinson's and Movement Disorder service for CTM to be included in this grouping or even within the Unscheduled space but definitely with the 1 dedicated consultant Dr Jim Bolt CoTE medicine RT ILG. The service currently sits with MC ILG as a hosted service this should sit wherever the consultant sits. Part 3b Unscheduled Care Group Page 3 - I cant understand how Urgent Primary Care Centres would sit in the Unscheduled Care Group when they are provided by the Primary Care Independent Contractors ie the GP's. They are commissioned / some of it is managed by the Primary Care Teams and the funding is managed by that group also this should be part of that Care Group. Page 5 -Stroke is highlighted BUT not all stroke care id provided on the DGH sites. The Acute Rehab pathway for CTM is provided on Ward D4 at YCR. This component of the pathway is always forgotten for funding and resource this needs to be highlighted as a key crosscutting issue for this new are group Part 3C Women & Children Care Group page 6 Community Midwifery has been left out page 8 Cancer service is incorrect in this its a cut and paste from page 5. Children should be 'Children First' not a disorder therefore CAMHS should stay with this Care Group and not be moved to the MH & LD Care Group. This will	

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	once again lead to stigma for these young people and pathologies their problems rather than normalising them. Part 3D Page 10 it has Specialist Palliative Care Services (SPC) which is correct but should say CTM wide, further down it also says Palliative Care Services . This should come out as palliative care is everyone's business as people are supported at end of life everywhere in our organisation this Care Group will manage Specialist Palliative care as it currently stands. We should actually consider if this is the best place fro SPC to be managed in the P&C Care Group. It may be better aligned to the Unscheduled group as a hosted CTM wide service as it has significant work to do to support the acute wards and front door and the consultants may feel more affinity with their other consultant colleagues I will continue on another page.....! My Third Submission as I ran out of words so PART 3 Part 3d page 10 &11 There is no parity with the Roles in the leadership team with the other Care Groups as we only have a Head of Nursing and the others have a Nurse Director. This says something about how Primary and Community Services are valued in the organisation and also mental health and Learning Disabilities which is the same only a HoN. 90% of Health service are provided out side of a hospital bed but this is not reflected in our CTM Vision our funding or our recognition of our staff and their worth. This isn't just about parity of roles this is about a message about priorities and worth. A service that ahs been left out of the list for this Care Group is 'service provided to the Homeless' as we have a small team of mental health, substance missus and general nurses who work specifically with our homeless population across CTM. Part 3f Therapies	

No.	Feedback	Response (where applicable)
	Allied Health Professional need to be managed within the Core Group that the services are provided from they need to be part of the MDT and the budget should sit with the CSG fro that area. It doesn't work currently with them kept separately. We don't keep Nurses in a separate group, or doctors in a separate group so whey do we keep the therapists. It is very difficult with multi-disciplinary services when you have no say over the therapy resource or plans. For services like Specialist Palliative Care with small therapy resources we are often left without as they are pulled to other areas, no maternity leave cover, and no say on how the funding is spent. They need to be treated like other key professions a part of an MDT resource and managed that way. How will the links be made, who are the decisions makers, this impacts on flow form the community hospitals when we don't have the therapy resource or we differ in our urgency around flow. Part 4 Facilities Community manage many of the community estates and also the community beds / equipment. We often don't manage any of the services within the building but are accountable for the buildings. This should not be the responsibility of a Clinical Care Group, this should move to Facilities. Also the bed management ie receiving / cleaning etc and managing the transport of community beds should also sit with facilities. We have tried to be involved as much as possible in the CTM wide bed review but there is still no outcome. In RT ILG we have risks associated with this staying with us which have financial consequences to address the quality of the service . We have raised this but this should be sorted as part of this change. These services should sit under the facilities structure. Part 5 Nursing and Midwifery I have already noted my points about HoN in P&C and MH Care Groups, however there is also no parity of pay between this post and the Group Operations Director and to work as a True Partnership with this role they should be paid the same on the same grade.	

No.	Feedback	Response (where applicable)
	I have a BIG concern about the remit of the Nurse Directors as the document states that 3 of them will manage a care Group, along side this manage a DGH as well as leading on Locality. As the Locality lead they will be the contact with the LA and the 3rd sector !! this will NEVER work as a bundle or from a capacity perspective. The locality will always be last on the agenda. They also cant be the lead with the LA and the 3rd sector this needs to be done by the CSG Teams who work in that area on a day to day basis. This is just not workable and undermines the CSG's. Page 45 - Performance and Information support is lacking currently to the P&C CSG's and is a massive problem as we have no support for demand and capacity as just one example. Dedicated links need to be made available . Missing - Capital and Estates are missing and CSG's would want to know how this will support them. Sorry this was so long and in 3 submissions, as I had read it in detail I wanted to share ALL of my view so hope it helps in some way.	
43	There is a need to consider the appointment of a AMD for Cancer for the organisation in this structure – which was originally planned but the current 4 PA's were split amongst the 3 ILG's and 1 HB Lead PA. The current cancer leads struggle to impact cancer partly because of lack of time, and this impacts on other team members. In line with ABUHB and C&VUHB it is recommended we have 4 PA's of a cancer AMD. This is more in line with the new operating framework proposed and allows the HB to engage externally at a very senior level with other MD's and AMD's. The Cancer Business Unit also has a view that it is an alternative option to put Cancer Services into the Diagnostics, AHP Care Group as this has some synergy also and allows the CBU to continue to focus on Quality Assurance versus ops. There is a conflict of interest in having the same person responsible for	Cancer services are wide spread across all aspects of health - surgical, diagnostic and medical. It will still influence all areas so where it sits in many respects will not impact its delivery. By putting it in Planned care it enables a strong focus on surgical allocation of time and resources. With a strong Cancer team involving engaged Clinicians the role of an AMD for Cancer is already covered but by a group of experts in each field. Appreciate that this

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	performance and quality assurance – we have seen this with attempts to apply local rules in some cases.	model may operate elsewhere but with the strength of a Cancer team it is more MDT than on an Individual.
44	**Medical Director** Deputy (or Group) Medical Directors (4-6 sessions) • Planned Care • Unscheduled Care • Women and Children's • Medicines, Diagnostics and Therapies • Mental Health • Primary and Community **COO** Deputy (or Group) COO's • Planned Care • Unscheduled Care • Women and Children's • Medicines, Diagnostics and Therapies • Mental Health • Primary and Community **Nursing Director** Deputy (or Group) Nursing Directors • Planned Care • Unscheduled Care • Women and Children's • Medicines, Diagnostics and Therapies (AHP instead of Nursing lead) • Mental Health • Primary and Community Therefore each "Care Group" would have a triumvirate leadership team, if we need a single defined "deputy" COO then we could have group COO's for example with one of them a deputy. Site leadership • ASGM • Site CD • Head of Nursing Acute sites should report into unscheduled care group but with dotted line to planned care. Each site responsible for all patient care activity on their site, they manage wards, OPD, concerns, theatres etc though there will be collaboration and matrix working with all care groups. Benefits and additional thoughts • gives each area a strong senior HB triumvirate leadership – 1st principle is cooperation with other Care groups in line with our values. • Merging the DCOO layer and Head of Care Group layer reduces ward to board and equal access to COO and maximises information flow to exec board both operationally and clinically (number of Band 9 operational posts is reduced, preserves hierarchy and avoid downward issues with any re-banding). Also allows more expert representation to external bodies such as WG. • Each care group should have information analyst business partner alongside others – WOD, Planning, Finance. • – they should be responsible for day to day running of the site including wards etc... Observations for resolution • How does ACD work and fit in? – It is not clear how secondary care feeds in to process. • Planned and Unscheduled care needs close links with the other care groups to be effective – especially primary care and community. Should Acute site team also manage community hospitals i.e. (the places)? • Where should budgets sit? • How should CSGs be managed? Paeds, O&G, MH and Community have natural homes, Medicine and Surgery have planned and USC responsibilities. On balance, should ED, trauma, critical care, palliative care and acute medicine sit within USC, everything else should sit within Planned care. Unscheduled care sessions of clinicians should be job planned for with cooperation of planned care groups who are responsible for them. Specialities should span the whole of the HB within their respective care groups. • Should Concerns sit with site teams or centrally? A locality focus has really helped sort out the quality responses in RTE. • Strategy groups – what is their remit and what have they achieved? It is not clear and should they be included in this restructure?	Thank you for your feedback which have been shared with the wider Executive Team for consideration.
45	It is entirely inappropriate that a deliberate and explicit decision has been made not to support the 'Dying Well' system group with resources comparable to those planned for the other system groups. Given that this consultation document is to be shared widely, the risk to the organisation's reputation would seem to be significant, should this particular fact come to the attention of the media, or of one of the big national charities concerned with End of Life Care (e.g. Marie Curie, MNDA, Macmillan etc.). The attention paid to end of life care as a key cross cutting theme in the recent National Clinical Framework for Wales, makes the proposal to deprioritise end of life care within CTM even more	Thank you for the input - In addition there is a dying well group, which works to describe good end of life care planning and delivery. It has important interfaces across the strategy groups

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	interesting!!!!! Even if the organisation's reputation is not damaged by this decision, it is a completely inappropriate stance, and will have real, significant and long lasting adverse effects for the quality of end of life care experienced by our population. This will inevitably also impact adversely on family members, with a clear evidence base demonstrating that poor physical and mental health, and complex bereavement reactions are more common when a family member has witnessed poor end of life care of a loved one.	The dying well group has to be strategic, however we will ensure that we are clear about correct involvement and debate on EOL elements of all strategic pathway development.
46	As HoN for an acute site - my main feedback is to have a clearer understanding of the lines of accountability and governance. For example if ITU sits in Planned care - am I responsible for all the staff? Do they report to me? Or to the nurse director for planned care? Do the budgets sit within each care group? Not at site level? Who is ultimately responsible for governance issues? I can see the the HoN is ultimately responsible for and accountable for care delivery in the consultation document - but if they do not hold any budget or manage the staff this will make this role very difficult. Finally - having worked in ABM, and having been through the aftermath of Andrews, I am concerned about losing the local governance team who have oversight over the whole site. The new model aligns them to care groups. I also want to know that previously when working in ABM and we had specialities aligned across sites - oversight and accountability was lost as it sat within specialities rather than at site level. The local governance team have been essential in ensuring that as a triumverate we are sighted on all important issues. The Bridgend ILG model - has ultimately been very positive here. It has brought along a real sense of integration across all parts of the ILG. There is better partnership working with mental health, paediatrics and maternity and the community teams than before. I would want this to continue.	The HoN for each acute site will remain professionally accountable for both scheduled and unscheduled care services. Integrated performance will be governed through the Care Group model although there will be site specific issues that will need to be considered (e.g cleaning, estates etc). Each care group will continue to have a Head of Quality and Safety a team who will remain locally based.
47	I would suggest the Planning Business Partner model would need to be consistent with that proposed by Finance and WOD, ie dedicated 8b and band 7 planning resource to support the Care Group groupings - 1) Planned	This will be undertaken via a collaborative process with all planners. We had an initial

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	Care/Diagnostics, Therapies and Specialties; 2) Unscheduled Care/Women & Children; 3) MH / Primary & Community. This would provide the Care Groups with a consistent planning resource and would enable the planners to develop their area of expertise. As the planners will be part of the corporate planning team working alongside the Strategy Group planners, this would still enable some flexibility to assign resources where needed in line with priorities. Questions: Will the affected staff be given the opportunity to express their preferred role in the new structure or will they be assigned a role? What will the process be should more than one person express an interest in a role?	meeting to discuss ; the best ways of organising and agreed that a business partner model will work, the need to identify current tasks to either be handed to ops or to be retained in planning and how we might split areas of work. e will continue the discussion together on who does what based on skills, knowledge, aptitude and preferences.
48	Mental Health might benefit from a shift away from ILGs and into functional streams - e.g. General Adult, Old Age, CAMHS, etc. This will enable standardisation of care and equity across teams.	Thank you for the suggestions. This level of reconfiguration is not part of the scope of this OCP review but consideration will be given to these points going forward.
49	Can you explain why therapies has less time allocated to it in the management structure for mental health with the merging of CAMHS the time allocated to therapies leadership does not seem enough	Thank you for taking the time to review the consultation document on the proposed operating model. Your comment regarding the therapies leadership within the Mental Health Care Group has been noted. We have received significant feedback on the proposals for therapies leadership and would like to assure you that all comments and suggestions will be carefully considered.
50	Comments from team have been separately submitted but included; -I don't quite understand how the boundaries will be aligned with LA ones?	Please convey our thanks to your team for taking the time to

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	-Page 12-MH services also include SLT & dietetics-we often get forgotten! -Good news that the OTs in MH will be managed under Therapies -Our Care group-still sounds quite heavy on medical and nursing leadership-I think its the way its explained/written-need to put more emphasis on the Clinical Directors role in there. Will CD be on same level as Ops Director and group medical director?? -Ensure that the sharing of learning across the organizations isn't lost; this has been hugely beneficial in the ILG structure, where therapies have contributed to all 3 ILG QPSE meetings, we need to ensure this continues as so much to learn from each other. My comments are; -glad the additional Care group of Diagnostics, therapies and specialties' was added for visibility for these pan CTM services -the impact to teams on ground will be bigger than expected due to the relationships built within those local teams - there will be an impact albeit less significantly felt than at ILG director level. and it is important that that is recognised for a fragile workforce. -Agree that the 3 ILGs do not always support the one CTM vision and that financial decisions in particular have been difficult. Having worked across all ILGs there are different strengths in all 3 but the local population knowledge is important to try and keep. I am hopeful that the new structure will facilitate improved regional solutions across CTM to maximise on specialties, pool resources and improve sustainability of services. As therapists have low workforce numbers, trying to support orthopaedics and stroke care across 3 sites is not easy or the most efficient way to work. i hope that this model gives us the opportunity to have those discussions around where patients need to go within their HB to access x,y and z.	review and comment on the consultation document. The Executive Team have been very pleased to note the overwhelmingly positive response to the development of the Diagnostics, Therapies and Specialties (DTS) Care Group. Please be assured that all the comments that you have submitted will be carefully reviewed and considered. Effective communication and co-operation between our internal and external partners will be fundamental to the success of proposed operating model and integrated working across our health and social care system. As such, significant work will be undertaken to engage with key stakeholders to understand how we can retain and strengthen our successful partnerships and processes. Thank you for sharing the thoughts and comments on the proposed leadership team for the DTS Care Group. We have received significant feedback on

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	-our LA partner structure is extremely complicated - integration is key but complicated - community teams are too disparate in part due to sep funded WG projects and also shared or sep operational management of some teams with prof oversight of others - affects resilience and flexibility of some services and no one shared vision or set of objectives. anything that can improve this situation would be welcomed. -do we need a nurse director in the diagnostics, therapies and specialties care group? All 3 diagrams are different - Included in first diagram with overview of all care groups but not alluded to in subsequent text on page 16. So will we only have 2 in our leadership triumvirate or 6 Directors? Not clear how that will work? -May be that the other directors will advise the medical and ops director on pertinent issues when required as i do now in the informal quadrumvirate structure we have in M/C whilst still attending the senior ILG meetings and performance RVs etc.? -Organogram on page 17 puts these director roles clearly in the leadership group in a quadrumvirate model with i assume the med lead being either radiology or pathology , my role for AHPs , an ops director and a chief pharmacy role? Not clear sorry. -Business partners and Governance seems to have been well described. -Any opportunities for bringing some of the alternatively line managed posts under AHPs would be welcomed as we find reduced recruitment and retention in those areas we don't directly line manage eg AHP cancer lead role managed by CBU, primary care and community roles and some MH therapy roles.	this and will be carefully considering all comments and suggestions. I should point out that the inclusion of a Nurse Director for the proposed DTS Care Group in a diagram within the consultation was an error. There are a small number of nurses who would work within this proposed Care Group and they will receive their professional leadership from the Nurse Director in the Planned Care Group.

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	-in summary i am delighted that AHPs remain together in the diagnostics, therapies and specialties care group.	
51	1. Gynaecology being part exclusively of the Women and Children Care Group without any representation in the Planned Care Group. Gynaecology represents half of our activity and not being directly involved in the decision making in relation to the provision of services for treatments primarily is a worry for teh Gynaecologists. We need to be part of the decision making process in relation to inpatient and theatre utilisation, equipment for theatre and clinical setting. The Group medical directors will be responsible for delivery of services within the allocated budget for each group. What is the position in relation to covering the budgetary needs for the Gynae activity and how will the prioritisation will be made. There is anxiety amongst Gynaecologists that Gynaecology will not be a priority for the Women&Child Care Group as here, Obstetrics neonate and Paediatrics are understandingly priority. Also in the Planned care group, by having no representation we will not have a voice in the decision making again. We understand that there are collaborations and communications between groups, however as I said Gynaecology is not a little part of what we do, is basically the other half with the financial needs and implications of this. 2. In relation to the Equity of service for all citizens in the new operating model, where the activity is evaluated CTM wide and patients with high need are prioritised across the CTM to avoid 'postcode lottery'. We are in agreement that equality in service provision is a must and we thrive to provide equal care for all patients indifferent of their geographical location. Offering secondary level care to people closer to home increases patients' satisfaction. This has to be achieved by allowing secondary care level provision of services to be available in all there sites of CTM. The performance in all sites should be optimised and monitored to facilitate a good run of pathways, so it will not be needed moving patients around the sites that perform better and have a smaller waiting list.	Gynaecology will be part of the Planned Care Board and will part of the capacity planning process. There is an agreement with the second point made.
52	In the current CTM structure Clinical Engineering which includes patient bed management is part of the COO and Facilities portfolio and has been since 2011. In the proposed CTM Diagnostics and Specialities Care group structure (clinical	Thank you for the feedback

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	support) it refers to the Clinical Engineering (Medical Devices) service (which currently includes patient beds management) being part of this Care group structure? Does this proposal refer to a dotted line professional leadership structure change with the Care group or a complete transfer of line management of clinical engineering to include bed management from Facilities to this Care group structure? It also indicates in the Facilities group that patient beds equipment management which is currently an integral part of Clinical Engineering services remaining within Facilities. Without Clinical Engineering services Facilities has no resource to manage or deliver patient beds equipment services. There has been no discussion on this change to date and there is concern about this proposed change and what the impact will be on these services for Clinical Engineering, the patient beds equipment service and Facilities? It would be useful to have further clarity on this proposed change which moves Clinical Engineering services from the current Facilities portfolio and splits out beds and equipment management from Clinical Engineering services and leaves it with Facilities?	
53	I would support Clinical Engineering being placed in the proposed Diagnostics & Specialities care group with Therapies/Healthcare Sciences. It would be a better fit for the Healthcare Scientist staff group within the department and hopefully provide a stronger voice for the issues we experience and support we need to move forward as a department and staff group. Clinical Engineering/EBME has been the one service that has been tagged on to Facilities or the Operational Services department prior to that. In other organisations, we would be under a Medial Physics structure where they exist, which is much more clinically based and reflects the technical/scientific nature of the medical equipment we support for direct clinical application.	Thanks for the feedback which is duly noted.

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	There is however background supporting structure from other facilities staff members that support governance/risk/business support/back office functions which would need resolving. In terms of 'Medical Devices' will this encompass a clinical lead for Medical Devices Management groups? The term medical devices can encompass a wide range of products - disposables, implantable to re-usable medical equipment such as IV pumps/monitors that Clin Eng deal with. I think there is an error at top of page 16 of the document as below: CLINICAL SUPPORT - Medical Devices - is this Management of Medical Devices? - Clinical Engineering - Medical Illustration - Equipment and Medical Device Transfer (this I believe should be Medical Device Training?) It may also need to state Medical devices training on the organogram (page 17) rather than just medical devices under Clinical Support? Would Management of medical devices also be here? One group needs adding to the national groups of which we as a staff group have representation: Clinical Engineering PSG (Profession Specific Group) which a representative reports to the Healthcare Science Network Meeting already listed. Additionally the split of management of bed equipment to remain in Facilities would fit better as the staff dealing with bed equipment are not Healthcare Scientists, Their skill sets are completely different for managing the bed	

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	equipment and it is a specialist field in in it's own right with it's own clinical support and logistical complications. In addition there is lack of management structure to support the bed equipment service UHB wide which has been identified and needs to be addressed. It requires at minimum a dedicated B7 to manage the day to day support issues, risks, incidents, contracts and staff. The lack of support from UHB management upon highlighting the requirement and risks and expectation to absorb or manage in current structures is not acceptable for an already underfunded and struggling service that has no resilience and draining already limited Clin Eng resources to support. Beds service management has been the 'hot potato' issue being passed from pillar to post for far too long, it needs the investment, budget and correct structure to support UHB wide for the future. The equipment and patient clinical requirements have become more and more complex and varied in the last 20 years, but the support structure, budgets has not kept pace with requirements. The expansion of hospital to community care is ever expanding and creates support issues that are heavily reliant on the bed service and have to be considered. As an aside the ILG system was in my opinion destined for Silo working and limited co-operation. The previous Cwm Taf set up prior to ILG was more in tune with cross site sharing of aims/goals with the way directorates were set up. It was far easier to contact one clinical lead/directorate manager that could influence/resolve an issue, hopefully the new set up will mirror what the former CT had, incorporating all regions. With UHB wide equipment projects/standardisation it is essential that consistent approaches can be supported.	
54	Thank you for the opportunity to provide feedback on the proposed organisational delivery model. Please find comments below: 1. Scope of Care Groups - for those specialities who have been allocated to "Planned Care" and "Unscheduled Care" however have services in both care	Thanks for the feedback. Care Group alignment will be addressed in phase 2 with the status quo being maintained with current hosting arrangement.

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	groups e.g. Cardiology, Gastroenterology etc., clarity required on which leadership team have the ultimate responsibility for the services. This will be especially important when a decision to increase capacity for one care group has a direct effect on another. 2. Planned Care Group - support the inclusion of Dermatology and Rheumatology under the planned care banner due to the specialities focus. As highlighted above will need to understand the effect on Diabetes & Endocrinology and Gastroenterology due to services providing both planned and unscheduled care (GIM rota/inpatient). 3. Unscheduled Care Group - some of the services quoted are currently jointly managed across CSGs e.g. Community Acute Care Team (consultant sessions provided by Medicine CSG and rest of team managed via Primary & Community CSG). As highlighted above will need to understand the effect on Cardiology and Respiratory due to services providing both planned and unscheduled care. 4. Unscheduled Care Group - the Dermatology and Endoscopy National Programmes should sit with Planned Care Group. 5. Diagnostics, Therapies and Specialties Care Group - due to the close working relationships I would suggest that respiratory and cardiac physiology are in the same care groups as Respiratory and Cardiology (Unscheduled Care Group). 6. Future of the CSGs - it is proposed that the composition of the CSGs will not be altered in the short term. So the assumption is that the hosting arrangements will continue and the current CSG portfolios will remain the same?	
55	think there needs to be clearer explanation in around 2 key issues: 1) role, function and responsibility of the acute site team with clear reporting lines within the document - there is a significant difference between nursing responsibility in acute site model compared to medical and managerial which	Thank you for the comments - Operational Management will be direct to the DCOO in this proposed model.

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	have no direct lines accountable to them and there accountability is also not clear. 2) governance reporting structure - considering the UHB remains in TI for governance the documents seems rather "governance light" with no clear structure of reporting and also how lessons of previous reports of sharing learning between silo's are being addressed	
56	Many thanks for the opportunity to comment on the proposed operational model for CTMUHB • The document has clearly been written by a number of authors and as such language used is inconsistent and varied. This does lead to some lack of clarity for example on the future of the 'localities' and terms used such as 'Director' being used at different levels in the structure. • The narrative to date has been very much that the proposed changes will only affect the Triumvirate teams at this stage with further changes to follow if required – however the document and conversations held with ASGM / CSGM colleagues have been at odds with this, with many fundamental changes proposed that will undoubtedly have significant impact on the role profile at these levels. This needs to be addressed. • The systems groups structures should also be included in these changes as their outputs have not been clear operationally since their conception and I feel there would be merit in a renewed focus. • There has been enormous benefit in having key business partners as part of the ILG teams and I would be very supportive of continuing with this. 'Corporate support' is more often promised than delivered and when we are facing a very significant agenda the dedicated support of these colleagues is vital. • A clearer proposal around the structure of the 'cancer' team is needed, it is rather vague in the document and the UHB struggles currently with ambiguity in this area and so if nothing else the restructure should address this. • The terminology of 'Care Group' is unattractive and should be reconsidered	Thanks for the feedback, which will support the ongoing design of the model.

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	• Consistency around 'Planned or Unplanned' OR 'Scheduled and Unscheduled' would also be helpful • The role of the 'Clinical / Medical' lead for each care group is unclear and appears to be reduced. I would like to see the Medical Leadership enhanced in the document to make it clear that the services remain patient and quality focused. • There has been criticism that the current ILG model has created silo working and that the Exec team are not sufficiently sighted on pressing issues. This new model will not address either of these concerns – the silos will be cut in a different direction and with the Directors reporting to a Deputy COO (in some Care Groups but not all – inconsistent) the gap is widened between Directors and Execs. There are many skilled individuals within CTM and that we certainly have the capability to deliver however, I feel that to make these changes now is extremely unsettling for many and will serve as a distraction when all focus should be on the pressing delivery agenda. There are undoubted 'tweaks' needed to the existing model which could be undertaken relatively simply and with the backing of the majority; then a review could follow in the light of different operational leadership with the new COO and the reduced pandemic demands.	
57	• This change of model has been an exceptionally difficult message for those directly affected after more than 2 years managing the Covid pandemic and fails to recognise the value the ILGs have brought to staff, patients and their families during the exceptional pressures as a result of the pandemic. Many staff are still grieving following the staff and patients we have lost and this change fails to recognise this. • The consultation has been written by multiple authors and as such is inconsistent and unclear. This is confusing and makes it difficult to interpret the structures in each profession.. • There is inequity between the primary care/mental health care group where there is a clear tri model leading the group but in the acute care groups it	Thank you for your comments overall. We will ensure quality and governance is carefully managed going forward as part of the operating model and overall improvement work within the Health Board.

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	appears led by the deputy COO with everything being funnelled through that individual and replicating the perceived failures of the ILG model. There is therefore no clear place for the tri to sit or report • The role of the medics is unclear and the language suggests the care groups are ops led rather than clinically led – this needs to be clarified • The conversations so far have suggested only the 9 directors were directly impacted by this structural change but the implications are much wider and a number of the teams have been approached to discuss new ways of working outside of the proposed model which we had understood was for consultation at this stage – I am aware of job descriptions being written outside of those directly affected which feels unreasonable • Difficult to understand what the systems group have delivered or even how they sit in the new structure • I struggle to understand how quality/governance can be improved by being centrally managed. I would question how we can be accountable for measures when we will not be leading the team supporting the quality/governance process. I am confident the priorities of the central team will not always align with those of the care group – how will this be addressed? • There has been enormous benefit in having business partners focused on the work of the locality and I would wish this to continue as too often corporate support is withdrawn with no notice leaving the frontline teams to pick this up without additional resource. • The current ILG structure has been criticised for working in isolation, the concern is we are just splitting the structure differently which has the potential to create barriers just in a different way. • There is currently few opportunities for the localities to engage with the execs other than the COO and this is made worse by the new model where the line of contact is to the deputy COO only	
58	Hospital Sterilisation and Decontamination Unit (HSDU) There is no mention of this service in the consultation document unless it is covered under Clinical Support - Medical Devices (Part 3f). A strategic review of decontamination of medical devices within CTM was undertaken in Sept 2019 led	HSDU will sit as part of the Diagnostic and Therapies Care Group.

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	by the Director of Nursing, the options presented in this review should be considered in the delivery model.	
59	I have consulted with the clinical cabinet and have formulated the following questions: Why are CTMUHB 'restructuring' especially given this year's events in the News with Betsi Cadwaladr UHB and that Eluned Morgan Minister for Health & Social Services stated in May 2022 that restructuring at Betsi 'at this point in time is not the answer'? What options appraisals have been proposed / provided for consultation to improve on the current ILG model of operational delivery at CTMUHB? And to whom? Can the UHB divulge the specific numbers of stakeholders that were engaged with prior to the consultation document being released ie. E.g. when and how many doctors per ILG had a formal consultation on their thoughts about the functioning of the ILG's and what they would suggest for improvement? This would also apply to all other stakeholders e.g. managers, nurses, allied healthcare professionals etc. Why have the LMC not been consulted or mentioned – especially within Primary and Community Care Groups? This would appear to be a significant oversight for a restructuring document. The lines of responsibility and accountability (on a number of threads clinical and non-clinical) are unclear e.g: 1. If the Trauma and Orthopaedic CSD at site 'X' were to have a clinical incident in e.g. an orthopaedic case at site 'Y' then who would be responsible for resolution? Would it be the overarching CSD for T&O or the Planned Group Medical Director or the Acute Site Medical Director or Other? Additionally how would the governance be managed by way of PTR, immediate make safes etc.	Restructuring in CTM is for different reasons that other HBs. We were the only HB with an ILG structure and this was deemed needing to evolve, as set out in the consultation document. There was always a plan to review the ILG model at 2 years and adapt as needed. WG are in support of the proposed restructure. RESTRUCTURE CONSULTATION this Consultation Model was designed to get the discussion going rather than start from scratch. CTM cannot afford to spend a year re-designing and implementing as the need to tackle the elective backlog is significant. Being able to evolve the ILGs into a new model was to meet the issues of today in a more direct fashion. Primary Care is essentially not changing in the new model. The regional / locality model is suggested to remain in place. The Consultation Paper was produced for all colleagues to comment upon community and acute sites.

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	How / who would manage the potential implication for unscheduled work if e.g. consultant has to be taken off duties for a short time especially if it is at a different site. 2. A gastroenterology Consultant is asked by the Planned Care Group to undertake more Endoscopies, however this would be at the expense of their ward commitments or potentially coming off the General Medical On-call Rota (which will have its own implications). How is this resolved, by whom and who has final say? At present all paths lead to the COO – this is not practicable. It has been noted that a 'one size fits all' approach does not work based on feedback from ED colleagues. Each ED is different in terms of layout and the demographic they serve. Access to services differs between sites and there is work to do around processes. All 3 sites have staffing issues. The departments are staffed differently depending on layout and clinical need. A pan CTM staffing approach would not be conducive to this kind of working. Is the aim to continue with all 3 ED's or to adopt the original South Wales plan for CTM? Will the financial implications of having to staff ED's as per RCEM recommendations be accepted – any delays to this while considering alternatives in the context of a new restructure are potentially detrimental to patient care and safety? It is felt e.g. by O&G colleagues that sexual health would be better suited to come under primary care for a variety of reasons rather than for it to sit under Womens and Children Care Group – would this be considered from the outset or would this need to be considered once the various care groups have been set up? Clarification required on the thinking behind the care groups and the CSG's in their current state. E.g. Diabetes & Endocrinology together with Gastroenterology sit within Planned Care Group but most of the other medical specialities sit within Unplanned Care Group. Who is responsible for service delivery, governance, financial responsibility etc and who has final say when there are competing demands? Is it the Medical CSD, Acute Site Medical	ACCOUNTABILITY - There is a need for CTM specialties to work as one department across the 3 sites. Learning from incidents is needed by everyone across the HB. There will be Care Groups overseeing all activity in their areas across CTM and Strategy CDs for each Specialty who oversee the direction, plans and issues as a whole HB. Each site will have a site CD lead and a Site leadership team. If an indicate occurs in Hospital X there will be Specialty learning and Hospital learning, the Care Group will be responsible for the investigation occurring and will receive the report - they will determine if the issue is local (site specific) or broader and the Specialty as a whole need to be aware. The Governance teams will sit with the Care Groups to ensure process is followed and changes implemented as needed. ONE DEPARTMENT APPROACH Specialties will be working together much more closely, in some cases resources may be shared and cross site working will be encouraged. There may be

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	Director, Planned Group Director, Unplanned Care Group Director or COO? What would be the reporting mechanisms for this – as this is unclear with the current document.	areas where this is impractical however the idea is that there is one specialty with equity of conditions and resources.
60	I have consulted with the clinical cabinet and have formulated the following questions: Can there be greater clarity and transparency around: 1. The role and responsibilities of a 'lead CD' or 'cross site CD'. The recruitment process for this? 2. The role and responsibilities of an Acute Site Medical Director? 3. Will the roles change? 4. Will there be uniformity of these roles across the 3 sites? 5. Will the 'amount of time' and numeration dedicated for these roles be made clear. Who arbitrates the competing demands of inpatient and acute work vs planned activity? Will there be clear processed outlined together with escalation policies? There appear to be potentially more layers for 'getting approval for a change in service' with the new system based on the current documentation - why? The financial structure is unclear - we understand that this drives a number of elements that are crucial at all levels for service delivery - we would be grateful for greater clarity on this process from start to finish - including how things are resolved between competing Care Groups and timelines. Where is the integration of primary care and social care with its affiliated partners within this new proposed operating model? There needs to be explicit detail with regards to this and how this is managed between Care Groups and Acute Sites – together with lines of responsibility and accountability.	SITE LEADERSHIP -There is a need for certain issues to remain on site to be resolved locally - bed management, offloads of Ambulances and where the patient flow moves to, discharge planning with Social Care - are but a few areas. The Medical Site leadership will have a lot of cross over with Care Groups and the responsibilities will be set out very clearly in the Job Descriptions for these posts in due course. CSG level focus - When the Care Groups are established to CSG restructure will then begin to be looked at. One approach is for a unified specialty focus across CTM. As such there could be Strategy CDs who will represent all specialties (on all 3 sites) at meetings and set the direction and plans as well as set the standards and plans for the specialty. Each of the 3 sites will have a Site CD who deals with the

No.	Feedback	Response (where applicable)
	Feedback from the Paediatric teams is to restructure the care group 'Women & Children' into 2 separate groups - Women and CYP. CYP to include acute paediatrics, Neonatal services, community child health and Neurodevelopmental services and CAMHS across 3 sites. Requires structures in place for efficient joint working between maternity and Neonates. Would this be possible and what effect will this have on the function of the 3 sites – taking into account its deliverability, governance, financial impact and effect on other Care Groups and acute sites. Critical Care and Outreach have been placed within the Planned Care Group – although the significant proportion of workload comes from 'Unscheduled care activity'. In the aftermath of COVID, the ITU has become predominantly filled with increased numbers of unplanned medical and surgical admissions. The risk of being "put in the wrong box" from the start is that the needs and priorities of Critical Care services are not understood, under-appreciated and potentially lost among those of other, more appropriately-designated, "planned" services. The rationale behind this decision needs urgent clarification. Would seek clarification on how the proposed Care Group structure, and the Group Medical Director, plan to balance the needs of 3 Critical Care sites with, at present, hugely different clinical service needs, priorities and agenda? This has a significant number of inter-dependencies with other Care Groups and how the UHB delivers its care for patients. The CTM 2030 is a significant way away and the issues are now. Why is there replication with some departments in different Care Groups – e.g. respiratory & cardiac physiology are found listed in 'Diagnostics, Therapies and Specialist Care Group' as well as in Unplanned Care Group. How does this work?	matters specific to that site - welfare, job planning, rota issues, collating that groups views and disseminating Specialty CDs / Care Group plans, and more. The responsibilities and accountability of these roles will be set out in full detail in the Job Descriptions. Each will involve interaction with the Site MD as well. The Job Descriptions, time allocation and interactions between roles will be sent out when completed and during the proposed CSG structure discussions.
61	As a Team (Claims Team) we requested a meeting to go through the Consultation document - we were assured we did not need to make any comments/feedback as the changes did not affect us as a Team. Reluctantly,	The challenges described in the current ILG model are well recognised with some inconsistency with how services

No.	Feedback	Response (where applicable)
	there was a very short discussion - with the same outcome i.e. we did not need to make any comments, but here I am - making some comments. The proposed Organisation Change is exciting - as a Team with legal experience we definitely missed a trick when the ILGs were established in respect of PTR generally to ensure a consistent approach across the ILGs, and to provide basic training and support. It felt like the ILGs found their own "legal and PTR groove" with no joined up thinking, sharing, training or learning - as a Team we could/should have been pivotal in providing this support and oversight - and could/should have been working closely with the Q&S Team. I would love to see us provide more support - to ensure quality and improve CTM reputation in the legal sector - if we can get a consistent understanding of PTR, use of the correct terminology and provide support from the outset of a concerns and investigations - we will be building on a solid foundation with a view of reducing legal claims being reduced, saving costs and protecting/restoring the HB reputation. I have seen this from a different angle in the Team - I am more heavily involved in the review of investigations, exploring breach of duty discussions (legal test) with PTR in the Maternity/Neonatal world - and it has been beneficial to have some "non-clinical" input in discussions in the Closure and Assurance Panels etc. However, the Team have previously been actively dis-encouraged to forge some of these relationships. On page 25 it is not entirely clear how the Claims Team fit into the proposed model - there is no reference to Claims Investigation Officers? One of the difficulties has been that ever since I have worked in the Claims Team (March 2020) there has been no leadership, oversight or direction for the Team - which has been raised by the Team on numerous occasions, and resulted in the WRP review - but there is still no direction or leadership so it would be a real shame if this is not addressed before the changes are implemented : especially as these changes are positive, and I would not wish to see any of the negativity/toxicity impact/influence the positivity. There are some relationships that need to be repaired between the Claims Team and Governance on ILG	have approached and found their own 'legal and PTR groove' as you describe it. The proposed model aims to address that exact issue, providing a cross-health board approach to shared thinking, training and learning with greater re-aligned support and oversight from a small, but critically skilled concerns, PTR and legal workforce. The model for Quality Governance as a whole ensures the close alignment of patient safety & experience with 'resolution'. All of which are a continuum in ensuring learning to inform quality & service improvement for our patients, families and carers. Greg, as Executive Nurse, remains the CTM responsible person for PTR, working with George as Director of Corporate Governance to deliver high quality resolution when responding formally with support to concerns, incidents, claims and inquests. Greg and George both acknowledge that learning needs to be identified and acted on and recorded appropriately at the

No.	Feedback	Response (where applicable)
	There has already been a lot of talent lost from the Concerns Team - and I am not sure if anyone has asked "why"? One of the hot spots is definitely Inquests, and in particular how the investigations are carried out legal/non-clinical input when there is a potential Inquest - not just the family but for all involved, to include statements etc. I would suggest there is some non-clinical/legal input/oversight from the Claims Team before any complaint response is finalised - to check quality, terminology, together with a check all issues have been addressed - I have seen too many complaint responses after they have been sent which are either legally wrong, poorly written, not addressed concerns adequately or the PTR Regulations not considered/applied which then result in clinical negligence cases. (page 30) Same with incident investigations - consideration of "PTR" is not factored in : unless this is covered by the Closure and Assurance Panel? Every investigation needs an appropriate "PTR" response. Need to consider how communicate with family when there is a rapid review/MDT/Datix report where all care is appropriate - I raised this question last week in fact - in a case where there was a rapid review, all care was appropriate but the family were never told this investigation/review took place (page 31) I would also suggest there has to be some legal oversight as a thread through out every step which is an added layer of assurance for HB I hope this helps.	earliest opportunity to support safe and quality services, and support from the 'resolution team' across the PTR continuum will be essential in getting it right first time, noting your comment on suggesting greater involvement from the claims team in complaint drafting/responses. We have met to discuss your comments, including your concerns which have resulted in a positive view on how essential it is for us all to individually contribute to forging excellent working relationships across the Health Board in the proposed model. Leadership and direction for the team continues to develop under George's direction with a new Assistant Director of Concerns and Claims. Both Greg and George have a strong focus on oversight and assurance in the new model which is central to the support moving forward, whilst working through the challenging resource issues affecting morale and retention of team members that are not unique to any individual team or service. George

No.	Feedback	Response (where applicable)
		will be joining some Team meetings to ensure views and concerns are shared and suggestions are explored as we continue to work through the detail of the implementation.
62	I understand from the Consultation Document that this OCP does not propose to alter the composition of the Clinical Service Groups but that there will be further revisions to the operating model in the future. In the immediate term, I have some concerns with the lines of accountability, primarily from a governance, financial and performance point of view where services fall within the remit of the Medicine & ED CSG but sit within a care group other than the Unscheduled Care Group. I'd be grateful for clarification as to expectations and accountability for decision making in these instances. For the Medicine & ED CSG, does control, co-ordination and accountability for decision fall to the Unscheduled Care Group even if the specific speciality sits under the Planned Care Group? For example – Gastroenterology & Endoscopy, Dermatology, Rheumatology – all operationally managed by Medicine CSG but sit within Planned Care Group. Do the National Responsibilities remain aligned to the operational management teams (CSG) or the Care Group? e.g. Dermatology Planned Care in under Unscheduled Care Group but Dermatology is listed under Planned Care There are a number of speciality areas that are included in more than one Care Group. Can their inclusion please be clarified: Speciality Planned Care Group Unscheduled Care Group Diagnostic, Therapies & Specialties Care Group Respiratory Physiology (operationally managed by Bridgend Medicine CSG) X X Cardiac Physiology(operationally managed by Bridgend Medicine CSG) X x Cardiac Rehab (sits under Health Psychology, within Bridgend Medicine CSG) X	Thank you for your comments. Any potential duplication will be checked. The role of the Acute Services General Manager will continue to be important, just as it is now when it comes to leading the general management on each acute hospital site. As you highlight in your response, being able to ensure equity of access to all of our population based on clinical priority is paramount in the proposed model. National responsibilities will be coordinated by each Care Group. Many of these are listed within the Care Group sections of the consultation document. As outlined in the document, all CSGs and relevant specialities have been aligned under an appropriate Care Group. From a

No.	Feedback	Response (where applicable)
	(cardiac rehab) X (Health Psychology) Note - Care of the Elderly including community acute care team (Bridgend) - ACT in Bridgend is currently operationally managed by the Community CSG and not Medicine CSG (although Clinical Director has responsibilities over both). Note - CPEX is noted under unscheduled care (cardiac services) – this is an anaesthetic led service supported by the respiratory physiology team – it supports planned care activity, should this be under the Planned Care Group? Does this diagram suggest that the Medicine CSG team report to the Acute Hospital site team (whole triumvirate) or does it report to the Unscheduled Care Group as detailed in the document? Note – current Clinical Director for Care of the Elderly and Stroke (Unscheduled Care Group) also has responsibility for Community Services (Primary & Community Care Group) so will cross two Care Groups – who will they report to? Equity of service is clearly extremely important and desirable; when CTM was created it was stressed that this would be by virtue of 'levelling up' and would not result in a detrimental impact to some of our population in order to ensure a level playing field. Appreciating the significant challenges in delivering this, particularly in the aftermath of the pandemic, does this principle remain? Part 6 - Quality and Safety/Putting Things Right I strongly agree that the local presence and relationship with operational and clinical teams should be maintained to ensure effective management. Care Group Quality & Safety Forum – assurance and learning will apply across at least 3 care groups based on current CSG remit? Is the expectation that we will contribute to all? Part 10 – Performance, Finance & Governance	financial point of view, where there are historic anomalies where budgets sit for certain specialities, these will be rectified as part of the proposed second phase of the operating model revision.

No.	Feedback	Response (where applicable)
	"The current arrangement of internal 'hosting' of certain smaller services by geographically based ILGs will no longer be required as all services will be able to sit within a relevant Care Group." I am unclear what this means for the medicine CSG – e.g. Dermatology currently 'hosted' by Bridgend Medicine CSG but sits in Planned Care Group – does medicine remain operationally responsible for performance, finance and governance with accountability moving from Bridgend ILG to Planned Care Group? Or will it align to Unscheduled Care Group? What financial responsibility sits with the Care Group? Scheme of delegation – does this follow on from the Care Group responsibilities (i.e. Diabetes budget falls to Planned Care Group and Stroke budget falls to Unscheduled Care Group) or is Unscheduled Care Group financially accountable for current Medicine CSG remit entirely?	

The following part of appendix 1 outlines key considerations, risks and concerns raised by the CTM Senior Finance Team. A meeting to discuss this document was held on the 10th June. The overall aim of this document and the follow on discussions is to ensure the proposed model for this phase of the OCP is as cost neutral as possible and that the structures designed, including the roles within them, have been mapped against an existing funding source. It also highlights where, due to the current makeup of cost centres in the present model, there will be certain specialities where budgets sit in cost centres that will not be aligned with the appropriate Care Group for this phase. As part of the proposed later phase looking at the CSG level, this reconfiguration to ensure cost centres correctly match the appropriate Care Group will be analysed.

CTM UHB PROPOSED CARE GROUP DELIVERY MODEL

CONSULTATION DOCUMENT MAY 2022

COMMENTS FROM FINANCE DIRECTORATE – SENIOR MGT TEAM

1. CARE GROUP LEADERSHIP

The Consultation document identifies the following leadership posts at the Care Group level:

Post	Planned Care	Unscheduled Care	W&C	Diagnostics & Therapies	Primary & Community Care	Mental Health
Group Operations Director	X	X	X	X	X	X
Group Medical Director	X	X	X	X	X	X
Group Nurse Director/Midwifery	X	X	X	X	Joint	Joint
Head of Nursing					X	X
Head of Psychology						X
Associate Medical Director					Sessional	
Associate Dental Director					Sessional	
CD Pathology				X		
CD Radiology				X		
CD Pharmacy				X		
CD AHP				X		

At present the three ILGs each have a Director of Operations, Medical Director and Nurse Director and there are four CDs for Pathology, Radiology, Pharmacy and Therapies.

Comments:

a. Our understanding is that one of the agreed key principles of the restructure is that it must be resource neutral (or reduce costs). The above table suggests that there are a number of new posts in the new structure. A detailed mapping exercise is therefore needed to confirm that the proposed structure is resource neutral.

b. Consideration should be given to changing the title of Group Operations Director to promote clarity and consistency across the Health Board.
c. The consultation document refers to 6 sessions for Care Group leadership for the Group Medical director. Further clarification needed on how this will work with clinical sessions and SPAs.

2. NUMBER OF CLINICAL SERVICE GROUPS (CSGs)

At present we have the following CSGs within the current structures (each with 1 budgeted CSG manager or CD lead):

CSG	MC	BG	RTE	Primary Care	Medicines Mgt	Total
Surgery	X	X	X			3
Medicine	X	X	X			3
W&C	X	X				2
Clinical support			X			1
Mental Health	X	X	X			3
Community	X	X	X			3
Therapies	X					1
Primary Care				X		1
Medicines Mgt					X	1
Total						**18**

Our understanding from the Consultation document is that the new CSG model is as follows:

	Planned Care	Unscheduled Care	W&C	Diagnostics & Therapies	Primary & Community Care	Mental Health	Total
Locality based CSGs	3	3			3	3	12
BG – W&C			1				1
CYP			1				1
O&G			1				1
Primary Care					1		1
Primary Care – Prescribing and Community Pharmacy					1		1
CAMHS						1	1
Therapies				1			1
Pathology				1			1
Radiology				1			1
Medicines Mgt-excluding				1			1

Primary care prescribing							
TOTAL	**3**	**3**	**3**	**4**	**4**	**4**	**22**

Comments:

a. The increase in CSGs from 18 to 22 is due to splitting:
   - the Clinical support CSG in RTE into Pathology and Radiology,
   - the W&C CSG in MC into CYP and O&G
   - the W&C CSG in BG into W&C and CAMHS
   - Medicines Mgt between Secondary Care and Primary Care (primary care prescribing and community pharmacy)

b. The service managers will need to agree the split of the existing CSG and Medicine Mgt budgets and the resulting cost centre hierarchy by Friday 1 July in order to meet the implementation timeline noted in Section 3 below.
c. Confirmation needed that the increase in the number of CSGs does not create any additional posts or costs.
d. Further clarification is needed on the proposed CSG structure within the Diagnostics & Therapies Care Group. Our assumption is that this will include four CSGs – Pathology, Radiology, Therapies and Medicines Mgt (Secondary Care only).

3. BUDGET TRANSFERS BETWEEN DIFFERENT CARE GROUPS

Page 10 of the Consultation document states:

This OCP **does not** propose to alter the composition of the CSGs, however it is proposed that there will be a further stage of revision to the operating model in the future which will include the CSGs in its scope. The current CSGs that exist now are proposed to continue as part of the OCP and fall under one of the above appropriate Care Groups.

Notwithstanding the 'splits' noted in Section 2 above, our planning assumption is that the existing CSG budgets will ' Lift and shift ' from the current structure into the new Care Group structure and therefore there will not be any budget transfers between CSGs at this stage.

This approach is necessary in order to meet the following timeline:

- **Care Group appointments completed during July**
- **Effective date of new structure 1 August (but may be in shadow form before then)**
- **Cost centre hierarchy agreed by Friday 17 June and implemented on 1 August**
- **August Finance report – reported in new structure early Sept.**

The Consultation document includes a detailed list of what services will be included within each Care Group. It is important to note that some of these lists include services where the budget is not currently within a particular Care Group. As noted above, we are not proposing to move any of these budgets at this stage. This could form part of the next stage of revision to the operating model.

Further information on where the budgets currently sit is provided below:

3A PLANNED CARE GROUP

Which CSG currently holds the budgets for these services:	**MC CSG**	**BG CSG**	**RTE CSG**
Orthopaedics (note combined T&O)	Surgery	Surgery	Surgery
Cancer services and tracking	See comment below		
Rheumatology	Medicine	Medicine	Medicine
Critical care inc Outreach (ICU and HDU)	Surgery	Surgery	Surgery
Gastro inc GI Cancer and Endoscopy Day Unit	Medicine for gastroenterology and endoscopy, surgery for lower and upper GI surgery	Medicine for gastroenterology and endoscopy, surgery for lower and upper GI surgery	Medicine for gastroenterology and endoscopy, surgery for lower and upper GI surgery
General Surgery inc Breast, Colorectal, Upper GI	Surgery	Surgery	Surgery
Urology			Hosted in RTE Surgery
Vascular			Hosted in RTE Surgery
Anaesthetics inc Acute and chronic pain	Surgery	Surgery	Surgery
Outpatients inc nurse staffing	Surgery	Split Medicine/Surgery	Medicine
Diabetes and Endocrinology	Medicine	Medicine	Medicine
ENT			Hosted in RTE Surgery
Dermatology inc Day Unit		Hosted in BG Medicine	
Theatres inc Emergency trauma and CEPOD	Surgery	Surgery	Surgery
Neurology and neurophysiology	Medicine – but not separate cost centres	Medicine	Medicine – but not separate cost centres
Pre op assessment	Surgery	Surgery	Surgery
OMF surgery	Hosted in MCS Surgery		
Endoscopy	Medicine	Medicine	Medicine
Ophthalmology and Optometry		Hosted in BG Surgery	

Nephrology	Medicine – but not separate cost centres	Medicine – but not separate cost centres	Medicine – but not separate cost centres

Other comments:

- There are a number of budgets which sit outside of the existing Surgery CSGs. Our planning assumption is that these will remain unchanged at this stage.
- There are also a number of budgets where services are currently hosted within a particular Surgery CSG. Our planning assumption is that these will remain unchanged at this stage.
- The central budgets for Cancer services currently sits within Delivery Executive not ILGs. Our assumption is that these budgets will move. Clarification is needed on where these budgets need to be moved to in the Planned Care Group (i.e. hosted in one locality CSG or split).
- Note that the budgets for Bridgend clinic currently within the Medicine CSG in BGILG.

3B UNSCHEDULED CARE GROUP

Which CSG currently holds the budgets for these services:	**MC CSG**	**BG CSG**	**RTE CSG**
BG ILG – SLA for COPD early discharge team, pulmonary rehab, neurology, neurophysiology		Medicine but Neurology and neurophysiology also included above under planned care	
Rapid diagnostic Unit, Medical Day Units	Medicine	Medicine	Medicine
Acute Medicine/Acute Medical Unit	Medicine	Medicine	Medicine
Trauma	Surgery (combined T&O)	Surgery (combined T&O)	Surgery (combined T&O)
Care of the Elderly	Medicine	Medicine	Medicine
BGILG – Community Acute Care Team and frailty		PC & Community	
Ambulatory Care Unit including VTE service		Medicine	Medicine
Discharge lounges	Medicine but discharge liaison in PC and localities	Medicine but discharge liaison in PC and localities	
Stroke	Hosted in MC for MC and RTE (acute stroke in	Medicine	

	medicine stroke rehab in community, ESD in therapies)		
Major trauma	Surgery (combined T&O)	Surgery (combined T&O)	Not a major trauma centre
Emergency Depts and MI Units – urgent PC centres	Medicine (DE for Primary Care)	Medicine (DE for Primary Care)	Medicine (DE for Primary Care)
Sports and exercise medicine			Medicine (but not a separate cost centre)
Respiratory inc lung cancer and physiology	Medicine, but respiratory physiology also identified in the diagnostic care group	Medicine, but respiratory physiology also identified in the diagnostic care group	Medicine, but respiratory physiology also identified in the diagnostic care group
Cardiac services inc Cardiac catheterisation lab and CPU	Medicine	Medicine	Medicine
Adult Congenital heart defect service satellite clinic			
Cardiac physiology and cardiac rehab	Medicine, but cardiac physiology also identified in the diagnostic care group	Medicine, but cardiac physiology also identified in the diagnostic care group	Medicine, but cardiac physiology also identified in the diagnostic care group
CPEX service			
Patient flow teams	ILG Mgt		
Ambulatory falls service			

Other comments:

- As above for Surgery, there are a number of budgets which sit outside of the existing Medicine CSGs. Our planning assumption is that these will remain unchanged at this stage.

- There are also a number of budgets where services are currently hosted within a particular Medicine CSG. Our planning assumption is that these will remain unchanged at this stage.
- The T&O budgets are currently within the Surgery CSGs and it would be very complicated to split these budgets between the new Care Groups for Planned care and Unscheduled Care. This is not considered feasible within the timescales noted above.

3C W&C CARE GROUP

Which CSG currently holds the budgets for these services:	**MC CSG**	**BG CSG**	**RTE CSG**
Neonatology and special care	W&C	W&C	Hosted in MC
Midwifery inc labour ward	W&C	W&C	Hosted in MC
Colposcopy services	W&C	W&C	Hosted in MC
Integrated sexual health inc GU services and HIV	W&C	W&C	Hosted in MC
Community paeds	W&C	W&C	Hosted in MC
Specialist nurses	W&C	W&C	Hosted in MC
Community gynae	W&C	W&C	Hosted in MC
Acute paeds	W&C	W&C	Hosted in MC
Gynaecology	W&C	W&C	Hosted in MC
Pregnancy advice service	W&C	W&C	Hosted in MC
Early pregnancy unit	W&C	W&C	Hosted in MC
Health visiting	W&C	W&C	Hosted in MC
Special schools	W&C	W&C	Hosted in MC
Paediatric surgery			
Acute paeds outpatients	W&C	W&C	Hosted in MC
Hysteroscopy	W&C	W&C	Hosted in MC
Gynae assessment service	W&C	W&C	Hosted in MC
School nursing	W&C	W&C	Hosted in MC
Continuing Healthcare	W&C	W&C	Hosted in MC
Ante natal services	W&C	W&C	Hosted in MC

Fertility	W&C	W&C	Hosted in MC
Uro gynae	W&C	W&C	Hosted in MC
Neurodevelopmental	CAMHS	W&C	CAMHS
Community childrens nursing	W&C	W&C	Hosted in MC
Community midwifery	W&C	W&C	Hosted in MC

Other comments:

- The Neurodevelopmental budgets are currently within CAMHS and the Finance teams are working with the service managers to agree which budgets will transfer to W&C.

3D PRIMARY AND COMMUNITY CARE GROUP

Which CSG currently holds the budgets for these services:	**MC CSG**	**BG CSG**	**RTE CSG**	**Delivery Executive**
GMS, GDS, GOS, GDS				Primary Care
Urgent primary care access (Out of hours)				Primary Care
Dental teaching unit				Primary Care
Community dental				Primary Care
Patient education programme				Primary Care
Inverse care programme				Primary Care
PCSU				Primary Care
Prison Healthcare service- from Dec 22				
Home oxygen service				Primary Care
Specialist Palliative care			Hosted in RTE Localities	
Community Teams/services	PC & Community	PC & Community	PC & Community	
Tissue Viability service	Hosted in MC Localities			
Palliative care service – inpatient and Community services		Marie Curie SLA hosted in BG Localities	Hosted in RTE localities	
CHC for adults		Hosted in BILG localities		

Community/ Health Parks- site mgt and development	Localities		Localities	
Community hospitals sites , wards and administration, includes outpatients in Maesteg	Localities	Localities	Localities	
Cluster development, leadership and mgt support				Included in Other PC, not split by locality .

Other comments:

- The locality budgets are assumed to be consistent with current structure (i.e. MC, RTE and BG) and not the LA boundaries noted in the Consultation document (Merthyr, RCT & BG).
- The Community Teams previously funded through transformation currently sit within Primary care in Delivery Executive it is assumed the budgets will remain consistent with the current structure

3E MENTAL HEALTH CARE GROUP

Which CSG currently holds the budgets for these services:	**MC CSG**	**BG CSG**	**RTE CSG**
Older Adult MH wards	MH	MH	MH
Adult MH wards		MH	MH
Rehab units	MH	MH	MH
Ty Lidiard		CAMHS	
Community Teams	MH	MH/CAMHS	MH
Acute Hospital Psychiatric Liaison services	MH	MH	MH
CHC Commissioning Quality Assurance Team	MH	MH	MH
Mental Health Act administrator	MH	MH	MH
Medical records – MH	MH – but not separate	MH – but not separate	MH – but not separate

Other comments:

- The budgets for CHC (MH) are currently split across the three locality based MH CSGs. Clarification needed on how the CHC budgets will be managed in the new structure (split or hosted). Our planning assumption is that both Adult CHC and MH CHC will be hosted.
- There are also a small number of MH budgets within Delivery Executive which would need to transfer into this Care Group.

3F DIAGNOSTICS, THERPIES and SPECIALTIES CARE GROUP

Which CSG currently holds the budgets for these services:	**MC CSG**	**BG CSG**	**RTE CSG**	**Delivery Exec - Facilities**	**Delivery Exec - Medicines Mgt**
Diagnostics:					
Radiology			Hosted in RTE Clinical Services		
Pathology			Hosted in RTE Clinical Services		
Audiology			Hosted in RTE Surgery		
Respiratory Physiology	Medicine	Medicine	Medicine		
Cardiac Physiology	Medicine	Medicine	Medicine		
AHP- All	Therapies				
Clinical support					
Medical devices				Facilities	
Clinical engineering				Facilities	
Medical illustration			Hosted in RTE Surgery		
Equipment and medical device transfer				Facilities	
Pharmacy (excluding primary care prescribing and community pharmacy)					DE (not separate from PC prescribing

Other comments:

- As noted above we are assuming that the new Diagnostics and Therapies Care Group will include four CSGs- Pathology, Radiology, Therapies and Medicines Mgt (Secondary care only).
- The budgets for all of the other areas (Respiratory Physiology, Cardiac Physiology, Medical devices, Clinical engineering, Medical illustration, Equipment and medical device transfer) will remain unchanged at this stage.

3G ILG BUDGETS ABOVE CSG LEVEL

It is also important to note that there are currently circa £10m of ILG budgets that sit above the CSG level. Detailed work is ongoing to allocate these budgets to the appropriate areas.

4. **BUDGET COMPARISONS**

A summary of the draft recurrent budgets (assuming a straight 'Lift & shift ' of the existing CSG budgets) is provided below:

CSG	Planned Care	UnSch Care	PC and Community	MH	W&C	Diagnostics & Therapies	Facilities
	£m	£m	£m	£m	£m	£m	£m
Bridgend	44	43	32(inc £23m CHC)	18	21		
MC	44	38	15	49(inc £33 m CHC			
RTE	52	46	18	18			
Central Primary Care			110				
Primary Care Prescribing and Community Pharmacy			116				
CAMHs				13			
CYP					21		
O&G					28		
Pathology						24	
Radiology						22	
Therapies						23	
Medicines Mgt (excluding Primary Care Prescribing and Community Pharmacy)						25	
Facilities							40
Total	**140**	**127**	**291**	**98**	**69**	**93**	**40**

Comments:

- There is significant variation in the CSG budgets across the different Care Groups.
- It is important to note that the above budgets excludes any budget transfers that may be needed in Stage 2 for the potential changes noted in Section 3 above. These changes could move budgets from the UnScheduled Care Group to the Planned Care Group
- The £32m for the Bridgend Community CSG includes £23m for CHC on the assumption that this continues to be hosted.
- The £49m for the MC Community CSG includes £33m for CHC on the assumption that this will be hosted in MC or RTE.

5. OTHER COMMENTS

- It would be helpful to have early clarification of the scope and timing of the next stage of revision to the operating model.

Appendix 2 – Changes made to the consultation document

This section outlines any changes / edits / additions that have been made to the consultation document as a results of the comments received during the 4 week consultation period.

These changes have been made as a direct result of receiving feedback and discussions with members of staff. Where there have been suggestions for changes made in the feedback but not adopted, this has been reflected in appendix 1.

No.	Change / edit / addition	Page
1.	The following two national forum responsibilities moved from Unscheduled Care Group to Planned Care Group in line with the specialty alignment. • National Planned Care Programme – Dermatology – represent the Health Board alongside Associate Clinical Director • National Endoscopy Programme – attend alongside other Health Board representatives	14
2.	The following forum added to national responsibilities under the Planned Care Group: • WICIS (all Wales ITU information system) National project representation	14
3.	The following forum added to national responsibilities under the Unscheduled Care Group: • NHS Wales national 6 goals of Urgent Care and SDEC representation	17
4.	Cardiology services moved from Unscheduled Care Group to Planned Care Group.	12
5.	Confirmed that Medicines Management will remain as one managed entity under the Pharmacy service within the Diagnostics, Therapies and Specialities Care Group for this phase of the reconfiguration.	28
6.	Amended incorrect diagram in the consultation document to now show the correct 2 x W&C CSGs (Bridgend & M&C/RTE W&C CSGs).	Planned Care / Unscheduled Care / Children & Families sections
7.	'Operations Director' Job title for each Care Group now renamed 'Service Director' and made explicit lead for each Care Group.	Throughout
8.	'Women and Children's Care Group' change of name to 'Children & Families Care Group'.	Throughout
9.	Health Visiting and School Nursing Services moved from Children & Families Care Group' to 'Primary and Community Care Group.'	22

No.	Change / edit / addition	Page
10.	HSDU service responsibility added to the Diagnostics, Therapies and Specialities Care Group.	28
11.	Ophthalmology, Orthoptics & Optometry services reworded within Planned Care Group.	12
12.	Duplication error spotted around Cardiac and Respiratory Physiologists being sited in two different Care Groups. Confirmed these services will sit within the Diagnostics, Therapies and Specialities Care Group.	27
13.	Within the Children & Families Care Group there is an added responsibility to run a Paediatrics Surgical Board.	18
14.	AESU and SDEC added to Unscheduled Care Group responsibility	15
15.	Added in additional text around the 'Dying Well' Group based on feedback received.	63
16.	'Part 7 – Medical Focus' This section has been edited to clarify the operational and professional reporting lines for the Care Group Medical Director posts.	49
17.	Part 4 – Facilities - Since the formal consultation began it has been subsequently decided not to progress with the original proposals around the centralisation of Facilities at this time. Therefore the current arrangement and management of the Facilities function across the Health Board will remain as it is currently. If in the future there is an aspiration to reconfigure the service, this will be conducted as part of a separate OCP. The exception to this are the services that are being moved into the Diagnostics, Therapies and Specialities Care Group.	30
18.	Triumvirate overarching leadership model for each Care Group emphasized throughout the document, noting there will be additional key leadership roles that will contribute to the SLT of certain Care Groups, such as Mental Health & LD, Diagnostics, Therapies & Specialities and Primary & Community Care Group.	Throughout
19.	Medical Leadership – AMD for Primary and Community confirmed to continue to provide the Medical function for the Primary and Community Care Group in line with current role.	P.11, Part 3D