| AGENDA ITEM |
|---|
| 6.6 |

| CTM BOARD |
|---|

| CTM OPERATING MODEL – RECONFIGURATION PROPOSAL |
|---|

| | |
|---|---|
| **Date of meeting** | (31/03/2022) |
| **FOI Status** | Open/Public |
| **If closed please indicate reason** | Not Applicable - Public Report |
| **Prepared by** | Richard Morgan-Evans, Chief of Staff |
| **Presented by** | Paul Mears, Chief Executive |
| **Approving Executive Sponsor** | Chief Executive |
| **Report purpose** | FOR APPROVAL |

| **Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)** | | |
|---|---|---|
| **Committee/Group/Individuals** | **Date** | **Outcome** |
| (Insert Name) | (DD/MM/YYYY) | Choose an item. |

| **ACRONYMS** | |
|---|---|
| | |

## 1. SITUATION/BACKGROUND

1.1 The current Integrated Locality Group operating model has been in operation formally since April 2020. It was implemented after a Health Board-wide restructure led by the former interim Chief Executive of CTMUHB in 2019/2020.

1.2 In August 2021 it was agreed by the Executive Team that it would begin to engage with stakeholders and review the current operating model at CTM. When the current model was established in 2020, it was done so with the intention of conducting such a review into its effectiveness after a period of time had passed.

1.3 There have been a range of issues and feedback raised by various staff concerning the functioning of the current operating model throughout CTM. We have also received feedback from several sources in government and regulators raising questions about the effectiveness of the current operating model. Most recently, in early March Welsh Government wrote to the Health Board stating an expectation to 'conclude the review of the organisational structure, and in particular to take a view on the future of the current ILG arrangements.'

1.4 This formal and informal feedback has raised the question of whether the model in its current form is fit for purpose given the challenges facing the Health Board post-pandemic and the ambitions of the Health Board emerging in the corporate strategy.

1.5 The review and engagement work over the past six months has focussed on elements of strategy, structures, leadership, skills and resources and culture. The discussions and feedback throughout this work showed that, although there was a great degree of support to try and make the model work, the reality has resulted in staff unsure as to the current organisational priorities. There has been a strong feeling shared that the model does not allow for a 'One CTM' or collaborative approach to delivering healthcare that is equitable across the three local authority areas.

1.6 Some of the mechanisms and structures originally designed to ensure a common and joined up approach have unfortunately not achieved the original goals. For example the System Groups. Whilst now providing a hugely positive input to the clinical services strategy work, have not able to ensure services are working together across different ILG areas on a week by week basis. The sheer scale of this task is not one that would have been realistically deliverable with the limited capacity designed into the System Group structure.

1.7 The structural set up of an organisation is not the only factor to ensure performance success, however the current structure has been described by some stakeholders as 'fractured'. This has meant that the fault lines can at times either slow down Health Board-wide progress or prevent it altogether. Additionally there can be numerous 'hand offs' and duplication of effort resulting in delays or differences in the quality and style of the output.

1.8 Due to the global pandemic, Covid has dominated the work of the organisation since the operating model was introduced. The Health Board now has a significant challenge to recover from the pandemic including the significant challenge of the backlog of elective activity. Equally we need to continue to improve the quality and safety of care and deliver significant transformation of services to ensure clinical and financial sustainability. This all needs to be delivered as well as continuing the progress in responding to targeted intervention and special measures in maternity and neonatal services.

1.9 Following extensive discussions with the management team, the consensus is that the current operating model will not enable to us to respond to the challenges we face and there is a need to revise the model to ensure we are in the best place to deliver the required improvements.

## 2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 There are a number of reasons as to why the Health Board is proposing altering its operating model at this time:

- **Feedback to date** – As described in the previous section, there has been a range of feedback discussed showing that the current model has not been delivering at a great enough pace for the patients in CTM. Although our staff have been working incredibly hard, the way the organisation has structured itself has meant that its ability to respond, improve, engage, intervene and deliver services has been hindered as a result.

- **The challenges of post-covid** – Over the past two years the pandemic has caused a significant backlog of elective surgery which is continuing to grow. In order to clear this backlog, whilst managing the ever growing demand of unscheduled care pressures, the Health Board needs to centralise its effort to create economies of scale. It cannot continue to work in locality or hospital-specific silos but needs to take advantage of all its capabilities and match resource against capacity. By having a centralised / 'One CTM' model it will enable this to start to take effect.

- **Developing regional services** – In order to ensure the best possible services for patients in Wales there are a number of discussions under way with neighbouring health boards to enable regional working across multiple sites and organisations. This has

the possibility to create regional centres of excellence for the benefit of wider populations. If the Health Board is to engage with this agenda, maximise this opportunity, it needs to firstly ensure it is able to work as one unified Health Board. This 'One CTM' working and mind set is important in ensuring all corners of CTM feels a part of the bigger team offering.

- **CTM2030 Clinical Services Strategy** – As our clinical services strategy continues to evolve the organisation needs to remain agile to adapt the Health Board structure to deliver the strategy over the coming months and years. More integrated ways of working across the whole of CTM, including working with Local Authority partners, will be a feature of how CTM will need to work and engage to deliver this strategy.

## 3. KEY MATTERS FOR ESCALATION TO BOARD/COMMITTEE

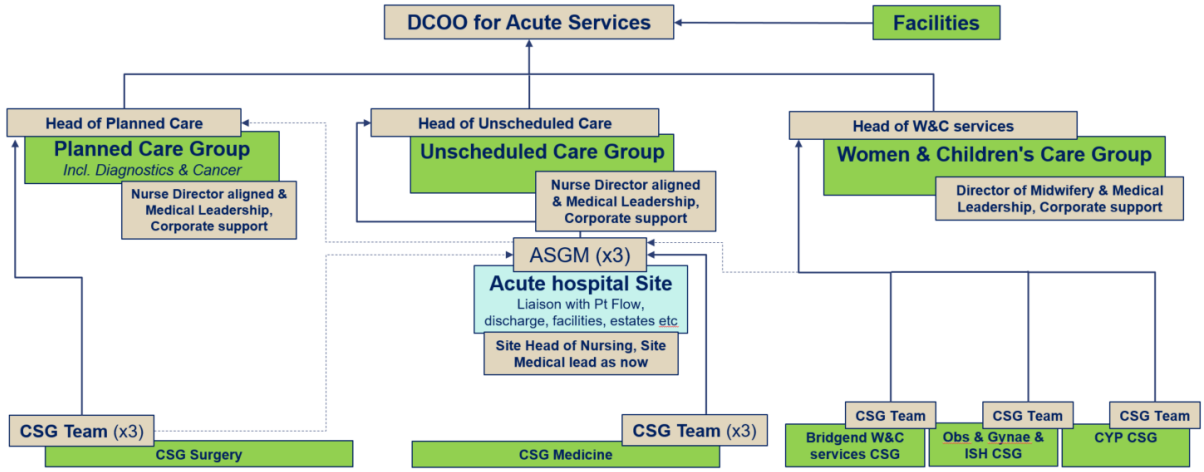
3.1 This section provides a summarised outline structure and key aspects of the proposed future model. Some of these elements have not been finalised at this time. This provides a proposed direction of travel that will be developed further in detail, if accepted by the Board.

3.2 The naming of various groups / functions and their exact compositions will be further defined over the coming weeks to ensure the right support is provided from a central corporate viewpoint as well as provided to the various Care Groups.

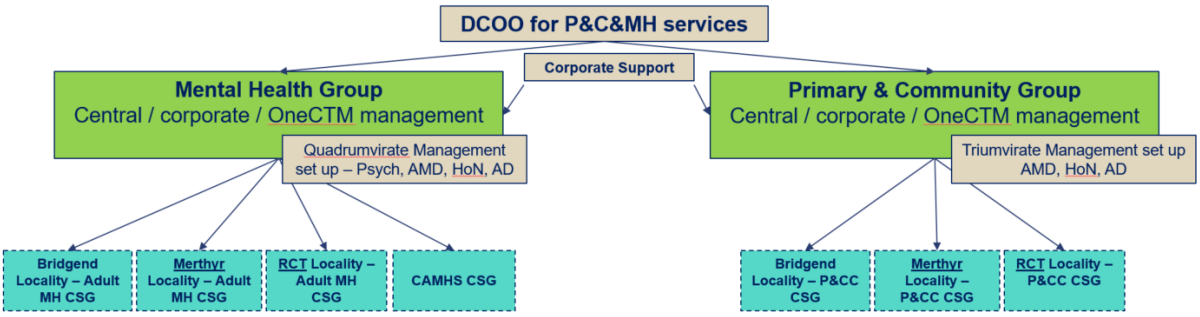
3.3 It is proposed that the reconfiguration of the operating model is conducted in two phases. The first phase, outlined below, will focus on setting up the overarching Care Groups and defining their related support and functioning. The second phase will use the expertise of the Care Group staff to define how best to structure the Clinical Service Groups. This will look to replicate the whole-CTM focus as set up with Care Groups, focussing in on specific specialities to cover across CTM.

3.4 The following outline operating model structure is proposed, pending Board approval:

- **Acute hospital services delivery** – Acute operational delivery is proposed to be structured in line with the below diagram. Under the current Deputy Chief Operating Officer for acute services will be three Care Groups: Planned Care Group, Unscheduled Care Group and Women and Children's Care Group. This structuring will ensure senior clinical and management focus on specific aspects of acute service delivery whilst ensuring a commonality and control across the whole of CTM.




- **Out of hospital services delivery – Mental Health and Primary and Community Care** – Out of hospital operational delivery is proposed to be structured in line with the below diagram. Under the current Deputy Chief Operating Officer for Primary, Community and Mental Health services will be two overarching Care Groups: Mental Health Group and Primary & Community Group. As with the acute side of operational delivery, this structuring will ensure senior clinical and management focus on specific aspects of service delivery whilst ensuring a commonality and control across the whole of CTM.




3.5 All services that are currently internally 'hosted' by an ILG will be incorporated into the Care Groups above. As an example, Diagnostics will fall under the Planned Care Group.

3.6 Therapy services will be a largely centralised function sitting corporately to ensure its smaller speciality services are not spread thinly and it has the ability to support across the whole of CTM.

3.7 The locality working at primary, community and mental health services will be aligned to the local authority boundaries of RCT, Merthyr Tydfil and Bridgend. This will ensure the Health Board is aligned with social care colleagues.

3.8 **System Groups & progressing the Population Health Agenda.** The System Groups have already been positively repurposed to Strategy Groups to support the ongoing clinical services strategy work. This will ensure the organisation has firm plans over the coming years to meet the demands of our population.

3.9 The life course approach of organising the Strategy Groups is planned to incorporate a population health focus in the coming months. This will ensure the required focus on the prevention agenda is maintained no matter what operational pressures are faced. It will also ensure a focus at the required level, dependent on the stage in someone's life.

3.10 **Ways of working** – Although this paper outlines how operational service delivery will be structured, it is important to note that the ways of working in the future structure will be of paramount importance. Ensuring the structure is clear on responsibilities at every level will create an environment that enables fast-paced and safe decision making and control. Setting expectations of clinical and non-clinical leaders will not only make them feel empowered but also provide clarity around ensuring a focus on performance and improvement within their areas of control. This is an area that will be further defined over the coming weeks.

3.11 **Design Principles –** The following are an initial set of suggested draft principles of the proposed operating model. These help to set expectations of how CTM should be structured and the way the organisation will work:

- Designed to enable an effective response to post-pandemic recovery.
- Equity of service and access for all citizens of CTM.
- Clarity in expectations and accountability for decision making and delivery.
- Streamlined management structures and decision making as close to frontline clinical services as possible.
- Designed to facilitate and support working across sites and with neighbouring health boards.
- Aligning our localities with local authority boundaries to facilitate integration of health and social care.
- Clinical services as the internal customer of corporate services.

## 4. IMPACT ASSESSMENT

| | |
|---|---|
| **Quality/Safety/Patient Experience implications** | There are no specific quality and safety implications related to the activity outined in this report. |
| | |
| **Related Health and Care standard(s)** | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies please list below: |
| **Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.** | No (Include further detail below)<br><br>If no, please provide reasons why an EIA was not considered to be required in the box below. |
| | No change in policies at this time. |
| **Legal implications / impact** | There are no specific legal implications related to the activity outlined in this report. |
| | |
| **Resource (Capital/Revenue £/Workforce) implications / Impact** | There is no direct impact on resources as a result of the activity outlined in this report. |
| | |
| **Link to Strategic Goals** | Inspiring People |

## 5. RECOMMENDATION

5.1 The Board is asked to **discuss** and **approve** this report. If approval is granted then a core programme team will be mobilised to support the key Executive and senior management leads in delivering this operating model over the coming weeks, in line with professional guidance.