Trust Board Paper S

To:	**Trust Board**
From:	**Kate Bradley, Director of Human Resources**
Date:	**26 September 2013**

Title:	Implementation of the Clinical Management Group Structures

Author/Responsible Directors:
Kate Bradley, Director of Human Resources /Richard Mitchell, Chief Operating Officer

Purpose of the Report:
To provide an update on the progress being made, and project arrangements in place in relation to the introduction and implementation of the new Clinical Management Group (CMG) structure across UHL.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	√	Ratification	

Summary / Key Points:
The purpose of this paper is to provide an update on the work that has been completed and that continues in relation to the implementation of the new CMG structure from the beginning of October 2013. Detailed work commenced following the Trust Board decision on 28 August 2013 and a project plan covering each of the key work-streams was created. Members of the Executive Team were assigned a lead role for the relevant work-stream and this group have met twice weekly to ensure work is completed and that decisions and actions are reviewed appropriately and taken forward.

Attached as **Appendix 1** is an abridged copy of the project plan which indicates the key elements of the work. As indicated the management of change process has been divided into three phases and phase one is nearing completion.

Phase One
Phase one involved determining the content of the job descriptions for the CMG senior management team, completing benchmarking with other similar NHS Trusts, having these evaluated and then initial and final discussions taking place between colleagues who are currently in a Divisional or CBU role. It is anticipated that the CMG senior management structures will be populated by week commencing 30 September 2013.

Having considered the organisation's requirements, individuals' experience and skill set and taking into account individuals' preferences where appropriate, we are in the process of confirming with colleagues the CMG role that they will move in to. Where it is necessary and appropriate, for example in the nursing work-stream, a selection of processes will be held 26/27 September to determine who will move into CMG Head of Nursing roles. In this work-stream it is worth noting that there are a number of opportunities for promotion into the CMG Head of Nursing roles. Work has continued to determine the most appropriate management team structure to report to the CMG senior management team and this will be discussed with CMG leads as soon as is practical.

Phase Two and Three
Work where appropriate has commenced on phases two and three, for example, the production of draft job descriptions for the posts reporting into CMG roles. When the CMG teams are in place, there will be a finalisation of the sub-structures and we can start to discuss with colleagues where they might move to.

It is anticipated that if there are redundancies as a result of the move to CMGs this will be small in number and where possible colleagues would be redeployed to suitable alternative employment.

Recommendations:
The Trust Board is asked to note the contents.

Strategic Risk Register	**Performance KPIs year to date**
A comprehensive risk assessment has been produced and is attached at appendix 3.	N/A

Resource Implications (eg Financial, HR)
Managerial, Human Resources, Finance, Communications.

Assurance Implications
As per Appendix 3

Patient and Public Involvement (PPI) Implications

Equality Impact - A due regard assessment has been completed and is attached at Appendix 4.

Information exempt from Disclosure
Yes

Requirement for further review?
Updates will be provided through Executive Team.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MEETING: **TRUST BOARD REPORT**

DATE: **26 SEPTEMBER 2013**

REPORT BY: **KATE BRADLEY, DIRECTOR OF HUMAN RESOURCES/ RICHARD MITCHELL, CHIEF OPERATING OFFICER**

SUBJECT: **IMPLEMENTATION OF THE CLINICAL MANAGEMENT GROUP STRUCTURES (CMG's)**

1.0 INTRODUCTION

1.1 The purpose of this paper is to provide an update on the work that has been completed and that continues, in relation to implementation of the new CMG structure from the beginning of October 2013. Detailed work commenced following the Trust Board decision on 28 August 2013 to move from the current structure of three Clinical Divisions and 12 Clinical Business Units to seven Clinical Management Groups.

1.2 A detailed project plan covering each of the key work-streams was created and members of the Executive Team were assigned a lead role for the relevant work-stream. This group have met twice weekly since the end of August to determine next steps, ensure work is completed and that any subsequent decisions and actions are agreed and taken forward appropriately. **Appendix 1** is an overview of the project plan and in addition **Appendix 2** is a copy of the template highlight report which is completed for each work-stream and used at the bi-weekly meetings. Please note sensitive data has been removed from the project plan for reasons of confidentiality.

1.3 A key area of focus has been the production of a comprehensive risk assessment to ensure that any potential risks created or exacerbated by the introduction of CMGs are identified and actions to mitigate against these risks are taken. A copy of the risk assessment is attached as **Appendix 3**.

2.0 BACKGROUND

2.1 Executive Directors had been considering the benefits of reviewing the current Clinical Divisional structure prior to the submission of the August Trust Board paper. The two main drivers to the proposed change were a reduction to the current multi-tiered layers of management and the size and complexity of the Divisions particularly the Acute and Planned Care Divisions.

2.2 If was felt that by moving to seven CMGs it would facilitate and enable management colleagues to have:-

- an improved operational grip of the services and a simpler, clinically rational, structure with fewer layers
- Improved clinical engagement
- Enhanced ability to deliver UHL objectives and collaborate with CCG colleagues
- Smaller management units with improved operational grip and clearer management accountability
- Less variations in size of management units
- More "doable" leadership roles
- CBUs are not split, reducing disruption/risk

3.0 CURRENT POSITION

3.1 Ahead of the August Trust Board meeting, a meeting was held to which all Divisional and CBU colleagues were invited to commence the discussion about the move to CMGs. Following this meeting an email communication was sent to all staff and at the September Chief Executive briefings the move to the new CMG structure was discussed. Generally the feedback was been very positive and colleagues, both those is a management position in the current structure and those working at service level, have supported the rationale for the changes. The change has been discussed at both the LNC and JSCNC and informal updates provided to the Chairs of both these forums.

3.2 During the end of August and the beginning of September individual meetings were held with all colleagues who are affected by the move to CMGs. Following these meetings letters have been sent to colleagues informing them of the nature of change and confirming where possible the role they will be moving into from early October 2013.

3.3 The decision regarding the most appropriate role for colleagues in the new structure have been made through discussion with colleagues, the organisation requirements, experience and skill sets of colleagues and individuals' preferences.

4.0 PROJECT ARRANGEMENTS

4.1 In order to manage this change we have adopted a project management arrangement and have separated the change into key phases. There are three key phases and where possible we have worked on these concurrently:-

Phase One:	Establishing Senior CMG Team (Director, Manager, Lead Nurse)
Phase Two:	Establishing CMG Support Team
Phase Three:	Establishing service teams into the new CMG structures

5.0 PROJECT PLAN

5.1 A project plan has been developed providing timescales relating to Phase One, Two and Three and detailing specific work-streams as part of each Phase. To an extent the roll-out requires completion of phases in order to fully assess implications and to engage the newly appointed teams who will be integral in setting their service management arrangements.

5.2 There are eight key work-streams which form part of the project planning. Each work stream is responsible for defining affected staff, posts and processes dependant on the staff group.

5.3 These work-streams are:

Medical	Lead - Kevin Harris/HR Support - Joanne Tyler-Fantom
Nursing	Lead - Carole Ribbins / HR Support - Clare Blakemore
Operational	Lead - Richard Mitchell/HR Support - Emma Stevens
Quality	Lead - Moira Durbridge / HR Support - Nicola Junkin
Education	Lead - Carole Ribbins / HR Support - Nicola Junkin
Finance	Lead - Simon Shepherd / HR Support -Tina Larder
Human Resources	Lead - Kate Bradley/ HR Support -Emma Stevens
Research and Development	Lead - David Hetmanski/ HR Support -Tina Larder

6.0 WEEKLY MONITORING

6.1 A bi-weekly update meeting is held with the relevant work-streams leads and HR support, overseen by the Chief Operating Officer and Director of Human Resources. A highlight report is provided for each work stream in the highlight report template format as attached in **Appendix 2** which is updated weekly.

7.0 ACTION AND ISSUE LOGS

7.1 Action logs are produced as an output of the bi-weekly meetings and to record progression and decision making. An Issue log has been developed and is maintained as a central record to ensure for all issues arising out of the changes are captured and managed appropriately.

8.0 RISK ASSESSMENT

8.1 A risk assessment has been undertaken if the impact and implications of the move to CMGs and has considered the implications and short and long term risks associated with the changes. This is a dynamic document that is reviewed as the implementation of the change continues. This is attached as **Appendix 3.**

9.0 DUE REGARD

9.1 In order to ensure that the move to CMGs does not adversely affect a member of staff with a protected characteristic we have undertaken a Due Regard of the proposed change process. Please find a copy of this attached as **Appendix 4.**

9.2 A Due Regard assessment will be undertaken for all work-streams and on completion of the move to CMGs, we will review the longer term position to ensure that this change has not had a detrimental impact on any particular group of staff with a protected change.

10.0 FINANCIAL

10.1 From the onset of this change we have been clear that the financial costs of the current structure were not in themselves a reason for the change to CMGs. That said we are keen to ensure that the overall cost envelope is not increased as a result of the change.

10.2 Financial implications are being considered as each work-stream is developed and as the structures are finalised to monitor an on-going basis the costs. At the end of each phase this will be reviewed and validated and a full evaluation will be completed at the end of the entire process.

10.3 Work is being undertaken to ensure that the budgets of the existing CBU's are being brought together in preparation for the CMG structure.

11.0 COMMUNICATIONS

11.1 We have continued to communicate details of the move to CMG through the Chief Executive Briefings, the Trust Board Report, FAQ's published on Insite, use of the Promo Box to signpost staff to more details and through emails to all staff. This range of communication will continue.

12.0 GOVERNANCE ARRANGEMENTS

12.1 We will review policies and procedures to ensure the new CMG structure is reflected in these to ensure appropriate reporting, monitoring and management processes are in place in the new structure.

12.2 We will agree an appropriate performance management framework to ensure that relevant and comprehensive governance arrangements are in place including reporting to the Executive Team and confirm and challenge processes. This will be vital for the purposes of CIP management and developing CIP plans for 2014/15.

13.0 SUPPORT AND DEVELOPMENT

13.1 It is anticipated that if there are redundancies as a result of the move to CMGs this will be small in number and where possible colleagues would be redeployed to suitable alternative employment.

13.2 We have arranged a contract with Right Management who specialise in supporting individuals through role change should this be appropriate for an individual. Access to this coaching and personal development is being agreed through the various work-stream leads and the Director of Human Resources.

14.0 LISTENING INTO ACTION (LIA) EVENT

14.1 In order to ensure that we learn from the current structure and capture what has worked well and how we can continue this in the new structure, we have arranged a LIA session on 30 September 2013 to discuss the changing structures with Divisional and CBU teams, members of corporate team and individual members of staff from all levels in the Trusts. Feedback will be evaluated and shared widely two weeks after the event to ensure capture, progression and learning of the discussions and agreed outcomes.

15.0 CONCLUSION

15.1 The move to the new structure is going well. The appointment of CMG Medical Leads, CMG Managers and CMG Lead Nurses will be completed by week commencing 30 September 2013. We are still on target for an early October start.

APPENDICES

Appendix 1 – Project Plan
Appendix 2 – Workstream Weekly Highlight Report Template
Appendix 3 Risk Assessment
Appendix 4 – Due Regard Assessment

Appendix 1

University Hospitals of Leicester NHS
NHS Trust

Project Overview for the Implementation of the Clinical Management Structure.

Monitoring body (Internal and/or External):	Executive Team
Executive Sponsor:	Director of HR
Operational Lead:	Emma Stevens
Frequency of review:	Weekly
Date of last review:	16th September 2013

Ref	PHASE	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	1	Define senior CMG posts within new structures	Exec Lead	HR support	End of August	CMG Groups defined as: • Cancer, Haematology GI Medicine and Surgery • Emergency and Specialist Medicine • Musculoskeletal and Specialist Surgery • Professional Services, Imaging, Medical Physics and Empath • Cardiac, Renal and Respiratory • Critical Care, Theatres, Anaesthesia, Pain and Sleep (ITAPS) • Women's and Children's	5
2	1	Define senior posts within new CMG structures to include Banding rationale / deputy roles if applicable.	Exec Lead	HR support	29th Sept	Executive lead to meet with HR support to define and to ET for final sign off of detailed structure roles.	4
3	1	Draft and evaluate JDs for senior CMG posts	Exec Lead	ES/KB	29th Sept	To formal AfC evaluation panel 4th Sept: • CMG Manager - RM • CMG Deputy Manager - RM • Head of Nursing - CR • Deputy Head of Nursing - CR • Corporate Nurse Role - CR • CIP role – RM	4

Status key:									
	5	Complete	4	On track	3	Some delay – expect to completed as planned OR implemented but not fully embedded	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Ref	PHASE	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
						• Operations Role - PW	
4	**1**	Validate bench marking data with comparable Trusts	KB/ES	CB	By 6th Sept	Grid formulated - Trusts approached - Notts, Sheffield, John Radcliffe, Leeds, UCLH, Addenbrookes.	5
5	**1**	Each workstream to confirm staff in scope for Phase 1 and 2 and opportunities for staff. • Medical Workstream - KH • Nursing Worksteam - RO • Operational /Managers Workstream - RM • Quality Workstream - MD • Finance Workstream – AS/SS • HR Workstream – KB/ES • R&D - David Hemanski • Education - Carole Ribbins Confirm processes and timescales to be applied for each work stream.	KH RO/CR RM MD AS KB	CB – Nursing NJ – Quality NJ - Education JTF – Medical ES – Managers Operational TL – Finance	By 1st Sept By 29th Sept	**PHASE 1 (Senior CMG teams)**: Pool A – Current Post holders Eligible to Apply for Phase 1 (not Director post) • HoN / HoM • Lead Nurses • HR Leads (post holders to be defined by function) • Finance Leads (post holders to be defined by function) • Divisional Managers • CBU Managers (8D only) Medical Pool – Current Post holders eligible for CMG Directors: • Divisional Directors • Deputy Divisional Directors • CBU Medical Leads **DEPENDANT ON FINAL PHASE 1 MAPPING** **PHASE 2**: • CBU Managers (8C) • Remaining Lead Nurses • HR Support Teams • Finance Support Teams • Quality Teams • Deputy CBU Managers / 8B Service Managers Medical Pool – Current Post holders eligible for Deputy CMG Directors • Deputy Divisional Directors	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned OR implemented but not fully embedded	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Ref	PHASE	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
						• CBU Medical Leads • Heads of Service Draft list being verified by HR. Defines staff in and out of scope.	
6	**1**	Agree notification letters for Phase 1pool for each workstream.	Exec Leads	HR Leads / Director Leads	1st September	Letters individualised and sent according to specific workstream.	5
7	**1**	At risk of redeployment letters to be hand delivered. Inform Phase 1 pool of their options. **30 days commences.** Workstream leads to schedule individual discussions with individuals affected for phase 1 staff	Exec Leads	HR Leads / Director Leads	By 29th Sept	Individual discussions to be scheduled with worksteam leads – schedules being arranged by workstreams. Discussions to take place throughout September.	4
8	**2**	Initial meeting to agree Phase 2 structures for each CMG with Exec Leads.	Exec Leads	HR Leads / Director Leads	By Mid October	To take place when CMG teams appointed.	4
9	**ALL**	Risk Assessment and Equality Impact Assessment.	Exec Lead	Deb Baker /Pete Clever	By 1st Oct	Risk Assessment completed. On completion of the change a full due regard will be undertaken to ensure that the implementation of the new structure has not had a detrimental affect on any particular staff group.	4
10	**ALL**	Financial costings	AS	SS	Ongoing	Costings have been considered as part of the programme of work and at the end of the process a final overall evaluation of the costs pre and post will be produced.	4
11	**2**	Where applicable, draft and agree JDs (phase 2 roles)	Exec Leads	HR Leads / Director Leads	By 1st October	JD's to AFC panel in October.	4
12	**1**	Cost any pay protection requirements for Phase 1.	Exec Leads	HR Leads / Director	30th September	12 months pay protection will be applied where applicable as per UHL policy.	4

Status key:									
5	Complete	4	On track	3	Some delay – expect to completed as planned OR implemented but not fully embedded	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Ref	PHASE	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
				Leads			
13	**1**	Consultation with Phase 1 pools. Agree posts Confirmation / notice letters to be sent. Agree date of change.	Exec Leads	HR Leads / Director Leads	30th September	Within individual discussion with executive lead.	4
14	**1**	Where applicable agree selection processes for overlapping preferences / HoN role.	Exec Leads	HR Leads / Director Leads	13th September	Selection processes 20th Sept and 26/27th Sept.	4
15	**2**	Each workstream to confirm Phase 2 structures and any vacancies open to Phase 2 pool. Agree any selection processes for Phase 2.	Exec Leads / CMG Leads			In conjunction with newly appointed CMG teams	4
16	**2**	At risk of redeployment letters to be sent. Inform Phase 2 pool of their options. **30 days commences.**	Exec Leads / CMG Leads			As part of MOC processes	1
17	**2**	Consultation forums / individual discussions arranged. Selection and agreement of posts. Agree date of change.	Exec Leads / CMG Leads			As part of MOC processes	1
18	**2**	Cost any pay protection requirements.	Exec Leads / CMG Leads			Ongoing as part of individual workstreams – To be evaluated at the completion of each phase and fully assessed on completion	1
19	**2**	SAE options reviewed for unsuccessful applicants.	Exec Leads / CMG Leads			As part of MOC processes	1
20	**3**	Review impact of Phase 3 pool of unsuccessful Phase 2 staff. Each workstream to confirm staff in scope				Senior CMG teams to formulate plan, to include Matrons, Service Managers, Ops Managers, finance, business analysts, HR, Education Teams.	1

Status key:									
5	Complete	4	On track	3	Some delay – expect to completed as planned OR implemented but not fully embedded	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Ref	PHASE	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
		for Phase 3 and opportunities for staff. • Medical Workstream • Nursing Worksteam • Operational Workstream • Quality Workstream • Finance Workstream • Education Workstream • HR Workstream • R&D					
21	**3**	Where applicable, Phase 3 to express interest in new CMGs in order of preference					1
		COMMUNICATION PLAN					
22	**ALL**	Meeting 15th August with Divsional teams				Complete	5
23	**ALL**	Slides disseminated to teams			16th Aug	JA circulated slide set – 16th Aug.	5
24	**ALL**	Communicate FAQ's			By 13th Sept	To be available on Intranet w/c 9th Sept	5
25	**ALL**	Agree ongoing CMG comms	MW			Agreement for frequency of updates	4
26	**ALL**	Agree Trust wide comms	MW			Insite page in development	4
27	**ALL**	LIA EVENT re CMG's	KB/Bina Kotecha	Michelle C	30th Sept	Scehduled to take place on 30th Septemeber	4
28	**ALL**	Development and Support	KB/Bina Kotecha		Ongoing	Access to coaching through Right Management / Individual Development plans are being reviewed through discussions against roles requirements and expectations	4
29	**ALL**	**GOVERNANCE FRAMEWORK** Review policies and procedures to ensure the new CMG structure is reflected in	ALL	ALL	30th October	Review of policies and procedures – schedule required Review of meeting frameworks i.e ET, C&C	4

5

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned OR implemented but not fully embedded	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Ref	PHASE	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
		these to ensure appropriate reporting, monitoring and management processes are recorded. Agree an appropriate performance management framework.					

Key to initials

ET	Executive Team	HR	HR Support
KH	Kevin Harris	ES	Emma Stevens
CR	Carole Ribbins	JTF	Joanne Tyler-Fantom
RM	Richard Mitchell	CB	Clare Blakemore
MW	Mark Wightman	TL	Tina Larder
AS	Andrew Seddon	NJ	Nicola Junkin
KB	Kate Bradley	VS	Victoria Solley
PW	Phil Warmsley	MW	Mark Whiteman

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned OR implemented but not fully embedded	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Appendix 2

Workstream Highlight Report /Update

Workstream	
Executive Lead	
HR Support	
Date	

Activity	Lead	Update	Timescale	Status
Pool of staff confirmed for Phase 1				
Structures agreed				
Posts confirmed				
JD's evaluated and finalised				
Banding/ salary implications considered				
Holding letters				
Process being applied/ discussion / selection				
Consultation letter				
Offer letters				
Phase 2 activity – as above				
Phase 3 activity - as above				
Outstanding Issues				
Next key steps				

G	Complete	A	On track	R	Needs urgent action

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UHL RISK ASSESSMENT FORM				**Local Ref. No.**	
Title of risk (i.e. There is a risk of/that… resulting in…)	There is a risk that the restructure to seven Clinical Management Groups may, in the short-term, adversely impact upon quality and performance targets				
Division/Directorate	***Operations***	***Unit***	***All***	***Site***	***All***
Department/Ward	***All***	***Date of Assessment***	***16/09/2013***	***Assurance Source*** (Refer to Datix for reference)	***Risk Assessment***

Description of the risk: List the causes **and the** consequences **of the risk** (Copy & paste to add rows where necessary)

Currently the UHL is organised around 3 clinical divisions; Women's and Children's, Planned Care and Acute Care. The two larger divisions are equivalent in their size, complexity, staff numbers and budgets to large District General Hospitals but they do not have the same clinical, nursing and operational management resource that a large DGH has.

It is proposed that the three Divisions and 12 Clinical Business Units are disestablished and are replaced with seven Clinical Management Groups (CMGs).

The seven proposed CMGs are:

- Cancer, Haematology, GI Medicine and Surgery
- Emergency and Specialist Medicine
- Musculoskeletal and Specialist Surgery
- Professional Services, Imaging, Medical Physics and Empath
- Cardiac, Renal and Respiratory
- Theatres, Anaesthesia, Pain and Sleep, (ITAPS)
- Women's and Children's (the same as the current Division)

Please note that these are only working titles.

The new structure will provide three key benefits:

1. A simpler structure with fewer layers will support improved working from the Executive Team through to service provision and vice versa. Management visibility will improve with increased clinical engagement and quicker and more effective decision making.

2. Smaller management units, in terms of income, expenditure and staff numbers which will support improved operational 'grip' and clearer management accountability.

3. Improved parity between the comparative size of the units. Currently Women's and Children's is 40% the size of the Acute Care Division. In the proposal, the smallest CMG is 60% the size of the largest CMG.

The proposal is to secure the CMG Management senior posts by the beginning of October and then to work with these teams to ensure their structures are effective to meet the CMG's needs. Any structural changes beneath the CMG management level would follow the UHL Management of Change Policy and consultation would take place with staff and Staff Side. Timescales are subject to review in the light of consultation requirements.

Causes (hazard)	**Consequence** (harm / loss event)
Clinical Divisions are equivalent to large DGHs but they do not have the same clinical, nursing and operational management resource.	Divisional staff may be unsure of their reporting lines and governance structures and therefore may be dips in performance as new structures 'bed-in', in particular around perceived 'lower priority' issues (e.g.,) incident reporting and complaints reporting

	timescales.
The current management structure does not support effective working nor the level of operational grip required to manage a complex, multi-site, tertiary, teaching Trust.	Information held on Trust reporting databases will require migration to take account of the changes (e.g. Datix: risk register, complaints, claims, incidents, e-UHL, etc.
	Requirement to update UHL policies/ procedural documents to reflect changes.
	Short-term additional staff stress and potential for increased short-term sickness in the management teams of the existing Divisions and CBUs, as well as those staff who interface with Divisions and CBUs (e.g. Corporate Directorates).

Controls in place: List what processes are already in place to control the risk (Copy & paste to add rows where necessary)

The vast majority of staff will be unaffected by this change in terms of day to day working. Effective communication of rationale and changes within and external to clinical divisions (e.g. CEO meetings with divisional managers and divisional staff, local team meetings, briefings in Trust magazine, messages on InSite, UHL PC desktop messages, media briefings).
Performance monitoring against KPIs in place via normal mechanisms.
Role descriptions have been produced for the CMG roles detailed in the structure. Local managers to support staff through change through established HR processes.

Current Risk Rating (with the controls listed above in place)

Risk subtype: Consequence descriptor: select highest score for Datix (Delete subtype if not applicable)	Consequence (C)	x	Likelihood (L)	=	Current Risk Rating
Patients (mismanagement of patient care with long-term effects)	4	x	1 (i.e. probability <0.1%)	=	4
Quality (treatment or service has significantly reduced effectiveness)	3	x	2	=	6
HR (short-term low staffing level that temporarily reduces service quality) (<1 day)	1	x	3	=	3
Statutory (critical report)	4	x	2	=	8
Reputation (media coverage)	2	x	2	=	4
Business (key objectives not met)	4	x	2	=	8

Action Plan ***List of actions that can be taken to further control the risk*** **(Copy & paste to add rows where necessary)**

Action Plan	Assigned to	Start date	Due date	Completed date	Cost £
Trust reporting and information Databases to be migrated to ensure data previously assigned to Clinical Divisions is assigned to the correct CMG	Operations / Corporate Directorates / CMGs				
Continued monitoring and review of performance and proposals for more effective working, when necessary, to be managed at CMG director level and via cross-CMG meetings with outcomes reported to Trust Senior Committees (ET, TB etc)	CMG Directors		Oct 13		
CMG structures to be developed and vacancies to be recruited in to	CMG Directors		Oct 13		
LIA workshops to ensure colleagues have the opportunity to share their thoughts on what has worked well in the current structure so we can build on the strengthens going forward	ET		Sept/Oct 13		

Target Risk Rating (with the proposed actions listed above in place)

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Risk subtype: Consequence descriptor (Delete subtype if not applicable)	Consequence (C)	x	Likelihood (L)	=	Target Risk Rating
Patients (mismanagement of patient care with long-term effects)	4	x	1 (i.e. probability <0.1%)	=	4
Quality (treatment or service has significantly reduced effectiveness)	3	x	2	=	6
HR (short-term low staffing level that temporarily reduces service quality) (<1 day)	1	x	2	=	3
Statutory (critical report)	4	x	2	=	8
Reputation (media coverage)	2	x	2	=	4
Business (key objectives not met)	4	x	2	=	8

Risk Assessment Approval ***(prior to the entry being input on to Datix)***

Risk Assessor name	Richard Mitchell, COO	**Signature**		**Date**	16/09/13
Line Manager name		**Signature**		**Date**	
NOTE: This Risk Assessment form must be approved by the clinical division / corporate directorate board prior to being entered on to the Datix risk register					
Approved by Division / Directorate: name		**Signature (to confirm)**		**Date**	

Risk Review Details

1st Review Date	

Scoring Guidance:

Consequence score (impact of cause / hazard) and example of descriptors					
Risk Subtype	**1**	**2**	**3**	**4**	**5**
	Insignificant	**Minor**	**Moderate**	**Major**	**Extreme**
PATIENTS (Consequence on the safety of patients physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which Consequences on a small number of patients	Mismanagement of patient care with long-term effects Increase in length of hospital stay by >15 days	Incident leading to death Multiple permanent injuries or irreversible health effects An event which Consequences on a large number of patients
INJURY Consequence on the safety of staff or public physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to death Multiple permanent injuries or irreversible health effects
QUALITY Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/ service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
HUMAN RESOURCES (Human resources/ organisational development/ staffing/ competence)	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
STATUTORY (Statutory duty/ inspections)	No or minimal Consequence or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
REPUTATION (Adverse publicity/	Rumors Potential for public	Local media coverage – short-term reduction in public confidence	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days	National media coverage with >3 days service well below

reputation)	concern	Elements of public expectation not being met		service well below reasonable public expectation	reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
BUSINESS (Business objectives/ projects)	Insignificant cost increase/ scheduled slippage	<5 per cent over project budget Scheduled slippage	5–10 per cent over project budget Scheduled slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
ECONOMIC (Finance including claims)	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
TARGETS (Service/ business interruption)	Loss/interruption to service of >1 hour	Loss/interruption to service of >8 hours	Loss/interruption to service of >1 day	Loss/interruption to service of >1 week	Permanent loss of service or facility
ENVIRONMENT (Environmental Consequence)	Minimal or no Consequence on the environment	Minor Consequence on environment	Moderate Consequence on environment	Major Consequence on environment	Catastrophic Consequence on environment

How to assess likelihood:

When assessing 'likelihood' it is important to take into consideration the controls already in place. The likelihood score is a reflection of how likely it is that the risk described will occur with the current controls. Likelihood can be scored by considering:

- The frequency (i.e. how many times will the adverse consequence being assessed actually be realised?) or
- The probability (i.e. what is the chance the adverse consequence will occur in a given reference period?)

Likelihood and Risk score

The risk score is calculated by multiplying the consequence score by the likelihood score.

	← Consequence →				
Likelihood	**1**	**2**	**3**	**4**	**5**
↓	**Insignificant**	**Minor**	**Moderate**	**Major**	**Extreme**
1 Rare This will probably never happen/recur. Or Not expected to occur for years. Or Probability: <0.1%	**1**	**2**	**3**	**4**	**5**
2 Unlikely Do not expect it to happen/recur but it is possible it may do so. Or Expected to occur at least annually. Or Probability: 0.1-1%	**2**	**4**	**6**	**8**	**10**
3 Possible Might happen or recur occasionally. Or Expected to occur at least monthly. Or Probability: 1-10%	**3**	**6**	**9**	**12**	**15**
4 Likely Will probably happen/recur but it is not a persisting issue. Or Expected to occur at least weekly. Or Probability: 10-50%	**4**	**8**	**12**	**16**	**20**
5 Almost certain					

Will undoubtedly happen/recur, possibly frequently. Or Expected to occur at least daily. Probability: >50%	**5**	**10**	**15**	**20**	**25**

RISK RATING (SCORE)	*ACTION REQUIRED*
Low (1 – 6)	Acceptable risk requiring no immediate action. Review annually.
Moderate (8 – 12)	Action planned within six months; commenced within 6 months. Review in 3 months. Place on risk register.
High (15 – 20)	Action planned within three months; commenced within 3 months. Review at monthly intervals. Place on risk register.
Extreme (25)	Action planned and implemented ASAP. Review weekly. Place on risk register.

Appendix 4

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Due Regard Assessment

1.	**Describe the service/ policy change**	The move from three Divisions to seven Clinical Management Groups	
2.	**What are the aims of the service/ policy change including expected outcomes**	The two main drivers to the proposed change were a reduction to the current multi-tiered layers of management and the size and complexity of the divisions particularly the Acute and Planned Care Divisions. If was felt the by moving to seven CMGs it would facilitate and enable management colleagues to have an improved operational grip of the services. In general terms the number of posts will remain the same. Redundancies are not anticipated, however, some of the posts may be down graded but pay protection will apply. The restructuring will create some promotional opportunities. Candidates will be subject to a fair and open recruitment process. The restructuring is occurring in 3 phases.	
		Yes/No	**Comments**
3.	**Is there a possibility that one or more of the groups listed below will be <u>less</u> or <u>more</u> favourably affected by the change if so describe the likely effect:**		The ultimate aim is to maintain current workforce representation as we know that females and Black and Minority Ethnic staff are not representative at band 7 or above. As a minimum we would want the current equality profile to remain the same. However this could be an opportunity to increase representation at senior levels. This may mean applying positive action at appointment as per the Recruitment and Selection Policy. In order for this to happen a workforce profile of those staff affected at each phase needs to be produced prior to any interview or slotting in process. We need to recognise that the data for sexual orientation and disability will be inaccurate due to the low number of declarations so due regard will be assessed on gender,

			ethnicity and age. This will need to be reviewed and reported at the end of the process to ensure that the due regard process has been robustly applied.
	• Race/ethnicity	Yes	As described in section 2.
	• Age	Yes	As described in section 2.
	• Sex	Yes	As described in section 2.
	• Religion or belief	Yes	Likely not to be able to draw accurate conclusions from ESR data due to low declarations.
	• Gender Reassignment	Yes	No data available.
	• Sexual orientation including lesbian, gay and transsexual people	Yes	Likely not to be able to draw accurate conclusions from ESR data due to low declarations.
	• Maternity	No	
	• Marriage and Civil Partnership	Yes	Likely not to be able to draw accurate conclusions from ESR data due to low declarations.
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems If so what is the evidence /data :	Yes	Likely not to be able to draw accurate conclusions from ESR data due to low declarations.
5.	Which specific group do you need to speak to / involve		Staff side are actively involved. The Management of Change process will apply to all staff affected so all consultation requirements will be met.

6.	If challenged are you confident that the change and its implementation will: • Be non discriminatory • Not damage equality of opportunity • Not damage relations with the protected groups listed above	Yes	It is highly unlikely that there will be any negative equality impact providing the UHL recruitment process is adhered to. Where a reduction in workforce representation for BME and female staff is a likely consequence, positive action should be applied where appropriate

Assessment completed by: Deb

Deb Baker, Equality Manager
September 18th 2013