NHS Improvement

Developing workforce safeguards

Supporting providers to deliver high quality care through safe and effective staffing

October 2018

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

Foreword

The NHS is proud of the care and services it delivers to communities across England. At the centre of this important work are the staff who support patients, service users and clients from hospital wards to their own homes. Recent reports have highlighted the continuing challenges facing the supply and retention of the NHS's workforce. Demand for healthcare staff continues to exceed supply, despite increases. Staff have risen to this challenge. They continue to provide outstanding care as they develop flexible approaches to their roles, improving efficiencies and maximising their impact on patients' and service users' lives. Innovative ways of working have been introduced to achieve this, alongside new roles and development of existing ones. This is a challenging time, but one that brings significant opportunities for workforce development.

However, we recognise that these ongoing pressures require health systems and boards to make tough decisions to ensure services achieve best outcomes at a time of financial challenge. Boards must ensure that this does not have an adverse impact on the quality of care, as well as patient, service user and staff experience.

This document has been developed by system leaders to highlight policy that supports organisations to use best practice in effective staff deployment and workforce planning. It offers advice on governance issues related to redesigning roles and responding to unplanned changes in workforce, and it describes NHS Improvement's role in helping providers achieve high quality, sustainable care by assessing the effectiveness of workforce safeguards annually. As a result, it includes new recommendations on workforce safeguards to strengthen the commitment to safe, high quality care in the current climate.

Ruth May
Executive Director of Nursing
NHS Improvement

1. Introduction

This document is designed to help trusts manage common workforce problems. It contains new recommendations to support them in making informed, safe and sustainable workforce decisions, and identifies examples of best practice in the NHS. It was developed with sector leaders and frontline staff and builds on the National Quality Board's (NQB) guidance.[1,2]

From now on we will assess trusts' compliance with the 'triangulated approach' to deciding staffing requirements described in NQB's guidance. This combines evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time (see Appendix 1). It is based on patients' needs, acuity, dependency and risks, and trusts should monitor it from ward to board.

To assess trusts' compliance with this, we will use information collected through the Single Oversight Framework (SOF). We will also ask trusts to include a specific workforce statement in their annual governance statement (for more details, see Section 7: NHS Improvement's yearly assessment).

By implementing this document's recommendations and strong, effective governance, boards can be assured that their workforce decisions will promote patient safety and so comply with the Care Quality Commission's (CQC) fundamental standards, our Use of Resources assessment and the board's statutory duties. We recognise that further work is necessary to develop a consistent approach to safe staffing levels across all clinical workforce groups. We particularly need to develop evidence-based tools for assessing the impact of variations in acuity and dependency on medical, allied health professional (AHP) and other non-nursing clinical staff groups.

In addition to following our recommendations, we urge senior leaders to consider their organisation's wider culture. Evidence shows that an organisation's leadership is the single biggest influence on culture: paying attention to it will make success in implementing the recommendations more likely.

[1] NQB (2013) *How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability*. https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

[2] NQB (2016) *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing*. https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

2. Recommendations

NQB's guidance states that providers:

- **must** deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively
- should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
- **must** use an approach that reflects current legislation and guidance where it is available.

Meeting NQB's expectations helps providers comply with CQC's fundamental standards on staffing – for example, in the well-led framework[3] – and related legislation.

In support of the NQB expectations, we will ensure that trusts take the required action to ensure that these principles are in place. Therefore:

1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.

2. Trusts must ensure the three components (see Figure 1 below) are used in their safe staffing processes:

   – evidence-based tools (where they exist)
   – professional judgement
   – outcomes.

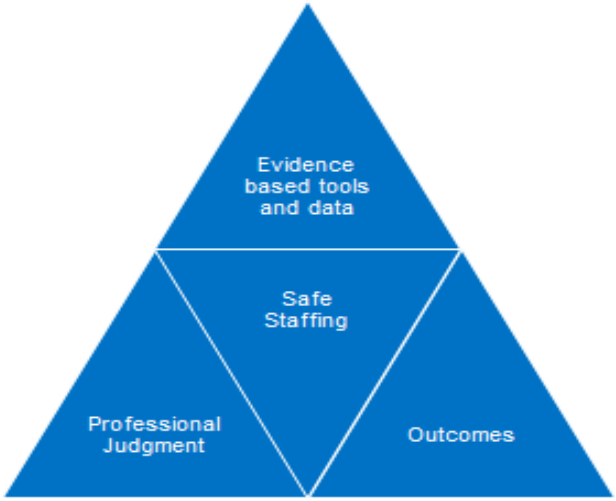
   We will check this in our yearly assessment.

3. We will base our assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.

[3] https://www.cqc.org.uk/files/inspection-framework-nhs-trusts-foundation-trusts-trust-wide-well-led

4. We will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.

Figure 1: Principles of safe staffing



5. As part of this yearly assessment we will also seek assurance through the SOF, in which a provider's performance is monitored against five themes.

6. As part of the safe staffing review, the director of nursing and medical director **must** confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

7. Trusts **must** have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.

For more details on our yearly assessment, see Section 7.

NQB guidance contains further principles boards **must** follow:

8. They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard.[4] Trusts should report on this to their board every month.

[4] https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf Section 3

9. An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance[5] and NHS Improvement resources. This must also be linked to professional judgement and outcomes.

10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.

11. As stated in CQC's well-led framework guidance (2018)[6] and NQB's guidance[7] any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.

12. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.

13. Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.

14. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.

[5] https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf
[6] http://www.cqc.org.uk/sites/default/files/20180130_9001100_well-led_Trust-wide_inspection_framework_NP_v4.pdf
[7] NQB (2012) *How to quality impact assess provider cost improvement plans* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212819/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf

3. Effective workforce planning

Effective workforce planning is vital to ensure appropriate levels and skills of staff are available to deliver safe, high quality care to patients and service users.[8,9]

Establishment setting must be done annually, with a mid-year review, and should take account of:

- patient acuity and dependency using an evidence-based tool (as designed and where available)
- activity levels
- seasonal variation in demand
- service developments
- contract commissioning
- service changes
- staff supply and experience issues
- where temporary staff have been required above the set planned establishment
- patient and staff outcome measures.

It is important that all stakeholders, including commissioners, are sighted on all recommendations to maintain or change establishments. Stakeholders should understand the rationale behind such recommendations and their anticipated impact.

Our annual planning process supports this assessment and includes monthly returns to identify trusts' progress and inform wider strategic workforce planning.

[8] http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/
[9] https://www.hee.nhs.uk/our-work/workforce-strategy

What a workforce plan should do

An effective workforce plan should be multidisciplinary, evidence-based, integrated with finance, activity and performance plans, and directly involve leaders and managers of the service. You may find our workforce planning toolkit helpful (see page 15).

A good workforce plan will:

- be constructed from robust plans focused at clinical service-line level that draw on available evidence –particularly the Getting It Right First Time (GIRFT) programme – describing 'what good looks like'
- ensure multidisciplinary workforce numbers are evidence-based, while considering specific system and organisational requirements
- ensure staffing capacity and capability are sustainable and sufficient to provide safe and effective care to patients and service users, taking account of any predictable patterns of variation in demand
- take account of financial restraints by setting an accurate and achievable staffing budget agreed by clinicians and the finance department
- minimise or negate the need for expensive agency staff by effectively planning the workforce needed for service requirements[10]
- inform and be informed by an organisation's clinical strategy, business cases and efficiency plans
- encourage leaders, managers and staff to work collectively on the workforce planning process, which should be informed by comprehensive staff engagement
- include a comprehensive QIA where there is any workforce transformation or redesign including a change in skill mix and/or the introduction of new roles (eg physician associates, nursing associates, ACPs)
- set the standard for expected staffing levels – encouraging transparency and enabling staffing decisions to be based on evidence
- be formulated by multidisciplinary teams and consider the whole service and the workforce required to deliver the activity, at the required quality standards; from a financial perspective, this should include realistic calculations of workforce 'headroom' for all professional groups and support workers, and consider likely

[10] https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/

staffing costs such as a percentage of parental or study leave, to avoid overspending when such leave is required

- promote a proactive rather than reactive approach to staffing because workforce planning is a continuous process and should be continually monitored and reviewed.

The planning cycle

Plans are typically initiated in accordance with NHS Improvement and Health Education England (HEE) cyclical timescales. However, we recommend that workforce plans are regularly reviewed as workforce or operational issues are identified. They must take account of the six-monthly establishment reviews and the annual establishment re-set identified in NQB's guidance.[11] Plans will typically be aligned to the business planning cycle. However, an effective workforce plan should also be revised 'as and when' needed when a change is identified. It should reflect the workforce position based on service need at any time. It is vital that managers and clinical leaders are involved in developing the plan whatever prompted it, so it is effectively informed and aligned to the clinical strategy and stakeholders' support is sought.

Approach to workforce planning

We recommend a two-step approach to workforce planning. First, take account of actual staffing levels and second, understand the gaps and what is required to close them, supported by a workforce planning model. A range of data sources can help with this:

- **The electronic staff record** (ESR) provides information on contracted whole-time equivalents (WTEs), headcount, leave (sickness, maternity, adoption and annual) and turnover information. ESR can also be used to project when staff will reach pensionable age and forecast the potential impact of the number of staff who could retire.
- **Evidence based decision support tools** that demonstrate patient acuity and dependency aligned to staffing resource requirements. These can provide robust establishment recommendations when used according to their guidance.

[11] https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

- **E-rostering systems** provide evidence to detail workforce utilisation including leave trends and types of staff utilised (bank, agency, substantive). We recommend using these systems for all staff groups.
- **Electronic job-planning systems** provide evidence of available clinical capacity across the seven-day working week. We recommend using these systems for all clinical staff not working a 24/7 shift system.
- **Financial systems** provide information on planned and actual substantive workforce costs and establishments. They also provide details on the historical use of temporary staffing.

Case study: Safe staffing for occupational therapy

Needs assessment: The joint North West Allied Health Professional Project Group identified these issues:

- difficulties associated with cross-site cover in a large organisation
- concerns about the consistency of allocating staff resources in line with clinical need as opposed to historical staffing levels
- forward planning of leave and cover to avoid crisis management
- staff awareness of pressures in the whole service
- ability to clinically reason staffing levels required for an existing service.

Aims and objective: The initial aim was to agree safe staffing levels within the occupational therapy team, enabling effective management, planning of safe levels of care and to escalate concerns when safe staffing levels were not met.

Method and approach: Physiotherapy colleagues shared their existing annual leave planner. On further development, the occupational therapy team devised a principle locally for a simple, single patient pathway caseload:

Clinical time needed for an average patient x the number of patients + an uplift to account for non-clinically related time = how much staff time you need to safely manage the needs of that patient group

Non-clinical time uplift = 15% (based on national benchmark)

Vacancy uplift = 23% (based on trust current value)

For more complex teams, the patient pathways were split and added together to produce a whole-time equivalent calculation for the whole team.

Results and evaluation: Tools were developed and updated through joint working with local physiotherapy colleagues.

- As the annual leave planning tool is visual and updated by the teams, the team leaders and wider teams have a much better understanding of service pressures as a whole.
- Planning for leave is done with team leaders and is regularly reviewed to avoid crisis management of shortages.
- Safe staffing levels are reviewed monthly and cross-checked against activity data. This has resulted in some changes, with staff being reallocated in line with clinical need.
- The calculator can be used to compare staffing requirements pre and post-service initiatives.

Key learning points:

- Comparison across localities between expected and actual clinical need allowed a quality check on the typical estimated acute patient pathway being around 2.5 to 3 hours for occupational therapy.
- Highlighted the need to incorporate time working as ‘doubles’, when two clinicians are working with a patient.
- Highlighted the need for the tool to be used for specific condition-related pathways (eg weight management) as well as general caseload pathways (eg acute surgery).

Next steps:

1. Pilot tools across additional North West sites and include dieticians and speech and language colleagues, to:

   - investigate the possibility of predicting typical patient pathways in some areas with more data comparisons available
   - fine tune the tool to work for other professions
   - develop more examples of how the tools can be put into practice.

2. To work with IT teams to develop the tools so they are more user-friendly and easier to share.

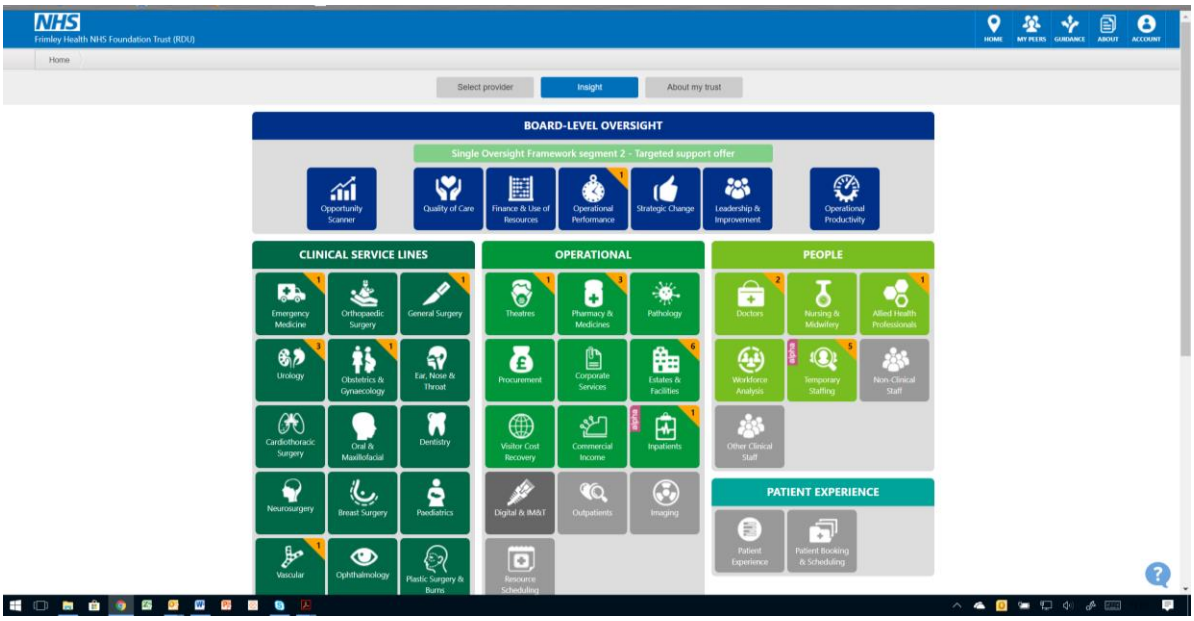
NHS Improvement's Model Hospital[12] is a digital information service that enables trusts to compare their productivity, quality and responsiveness to identify and realise productivity opportunities by tackling unwarranted variation. Its datasets are drawn from providers' returns and other data held by arm's length bodies, displayed in a format that allows benchmarking and peer comparison.

The Model Hospital holds a wealth of workforce data (see Figure 2 below) that can and should be used for workforce planning:

- care hours per patient day (CHPPD) and cost per care hour (CPCH) help identify and benchmark typical nursing and care staff utilisation in various specialty settings
- further metrics are under development for other elements of the workforce – for example, clinical hours to contact (CHtC) and cost per contact for non-ward based settings.

[12] https://improvement.nhs.uk/resources/model-hospital/

Figure 2: Model Hospital compartment screenshot



Better workforce planning and avoiding agency usage

The NHS workforce strategy[13] highlighted significant workforce shortages and an over-reliance on temporary solutions such as locums and agency staff.

Some temporary staffing options are important so the workforce can be flexible to service demands, but the NHS's over-reliance on locum and agency solutions is unsustainable and may affect service continuity and quality.

Our agency reduction programme[14] helps trusts reduce costs and ensure that internal bank systems are first choice. Effective rostering of substantive staff should maximise productivity and reduce demand for temporary staffing.

In the short term, we expect effective workforce planning to have a positive impact on quality of care and patient, service user and staff experience, while ensuring financial resources are used efficiently. Longer term, accurate plans will help predict the numbers of healthcare workers required to meet future demand and supply. This aligns with our Use of Resources assessments.[15] Trusts have already made progress: for example, spending on bank staff now exceeds agency spend.

[13] https://hee.nhs.uk/our-work/workforce-strategy
[14] https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/
[15] https://improvement.nhs.uk/improvement-hub/finance-and-use-resources/

Workforce planning toolkit

Our workforce planning toolkit[16] identifies five components of workforce planning, as well as the characteristics and processes of effective workforce planning.

- **Leadership:** Is there an executive sponsor, such as the director of workforce, and are internal and external stakeholders involved?
- **Technology:** What systems are there to assist with workforce planning and assess performance against the plan?
- **Information, method and governance:** Is workforce planning based on evidence? Is planning supported by applying a workforce planning model?
- **Engagement and integration:** To what extent are staff involved in workforce planning? How is this integrated/cross-checked with other aspects of planning including activity and finance?
- **Strategy:** Is short, medium and long-term horizon-planning included? Have future scenarios been considered within the local health and care systems, including sustainability and transformation partnerships or integrated care systems?

The toolkit complements other workforce planning resources and enables self-assessment against typical workforce planning requirements. It will promote discussion at a senior level to identify factors such as culture and leadership that underpin effective workforce planning. It covers the factors we use to review workforce plans and includes links to other workforce planning resources. Some of our other toolkits – such as the pathology toolkit essential services laboratory template[17] – also help with workforce planning.

[16] https://improvement.nhs.uk/resources/operational-workforce-planning-self-assessment-tool/
[17] https://improvement.nhs.uk/documents/2366/Template_structure_for_ESL_blood_sciences_RE03.pdf

4. Deploying staff effectively

This section contains advice on trust boards' responsibilities for making sure staffing arrangements are safe, sustainable and productive. It also considers emerging roles such as nursing associates, physician associates and ACPs, who will be integral to the future NHS workforce.

Useful guidance

NQB's guidance[18] explicitly requires trusts to meet three expectations – deploying the right staff with the right skills at the right place and time (see Appendix 1). These set the foundations on which any workforce plan should be based, while not ignoring other organisational development needs such as values and behaviours.

In addition, the Cavendish report[4] highlights that well-performing organisations use their workforce as a strategic asset. This underlines the need to deploy the workforce effectively and efficiently: it accounted for 63% of trusts' costs on average in 2017/18.

Boards should also take account of guidance from bodies such as royal colleges. For example, in July 2018 the Royal College of Physicians published *Guidance on safe medical staffing*.[19] This recommends standards for medical staffing in acute settings. It aims to help those planning and organising core medical services to calculate how many doctors and related personnel they need to provide timely and effective care.

We have developed sector-specific evidence-based workforce improvement resources for:[20]

- adult inpatients
- urgent and emergency care
- maternity
- mental health and learning disability

[18] NQB (2016) *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing*. https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf
[19] https://www.rcplondon.ac.uk/projects/outputs/safe-medical-staffing
[20] https://improvement.nhs.uk/search/?q=safe+staffing&page_type=52&=Filter+results

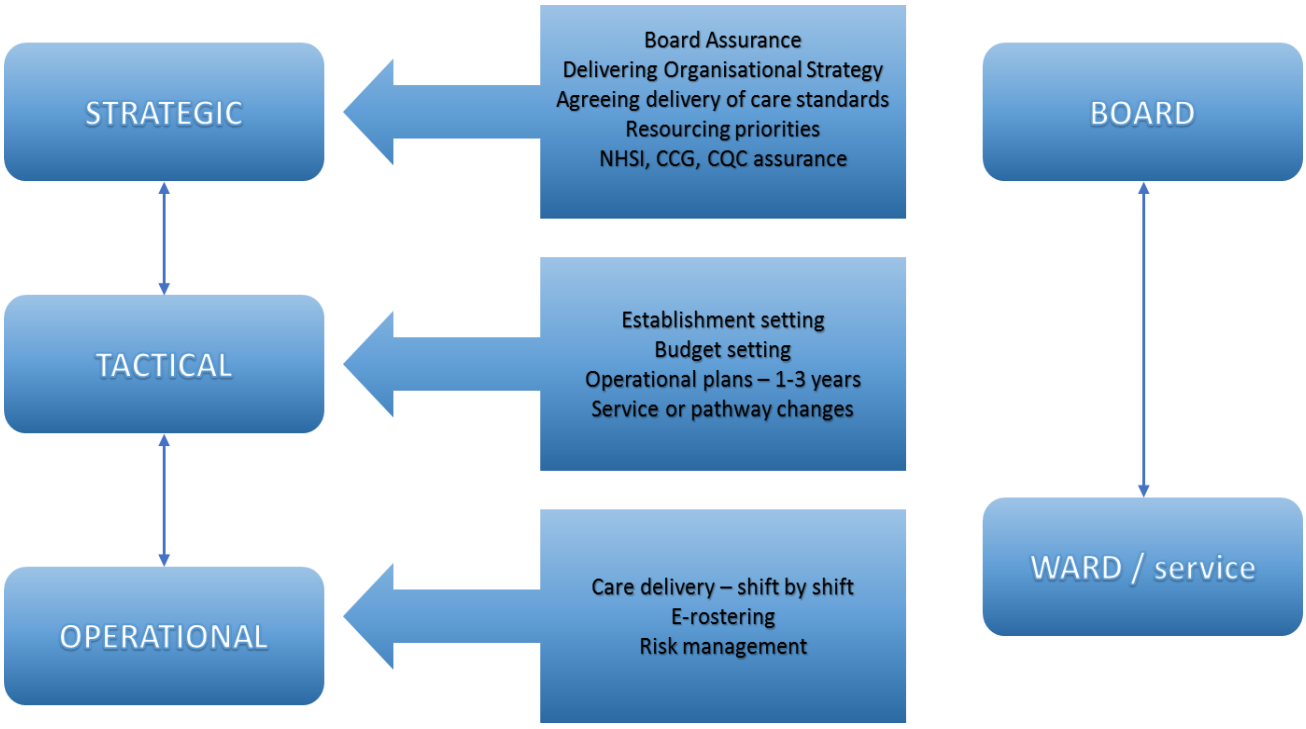
- district nursing
- children and young people
- neonatal
- pathology.

Board reporting

It is critical that boards oversee workforce issues and grasp the detail of any risk to safe and high quality care. NQB highlighted that boards are accountable for ensuring their organisation has the right culture, leadership and skills for safe, sustainable and productive staffing. While ultimate responsibility for safe staffing rests with the chief executive, boards are also responsible for proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care. This also reflects CQC's 'well-led' requirements.

Trusts must have a clear focus and process from the front line to the board, making sure their tactical and operational systems address strategic needs (see Figure 3).

Figure 3: Ward-to-board model for workforce safeguards



Boards need to collaborate with their local health and care system, specialist networks, commissioners and other providers to ensure the best possible care and value for patients, service users and the public. This may mean making difficult decisions about resourcing as local sustainability and transformation plans are developed and agreed.

So it is critical that boards review workforce metrics, quality and outcome indicators, and productivity measures monthly – as a whole and not in isolation from each other – and there is evidence of continuous improvements across all these areas. To best assign workforce resources and improve outcomes, boards must implement NQB's 2016 guidance and the Carter recommendations,[21] and use information from the Model Hospital or other data sources.

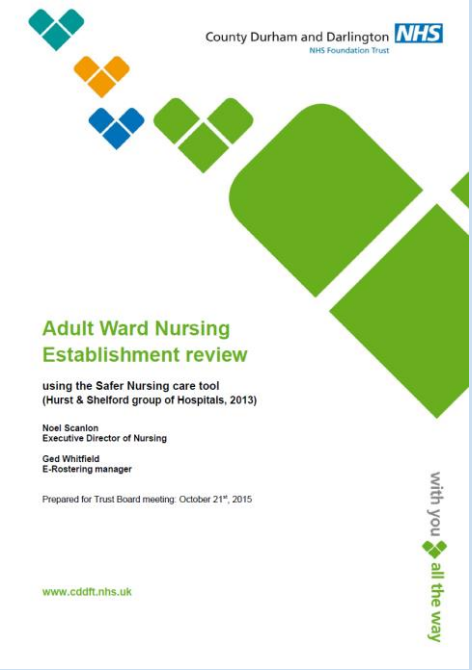
This includes:

- using local quality and outcomes dashboards that are published locally and discussed in public board meetings, and nationally agreed quality metrics published at provider level
- developing metrics for patient/service user outcomes, staff experience, people productivity and financial sustainability
- comparing performance against internal plans, peer benchmarks and the NHS experts' views, taking account of any underlying differences
- supporting and engaging staff to remove barriers to their productivity and ensure their time is used in the best way possible to provide direct or relevant care or care support
- using national good practice checklists to guide improvement action, as well as taking account of knowledge shared by top performers
- using evidence-based decision support tools (where available and appropriate)
- using e-rostering and e-job planning tools to support efficient and effective staff deployment
- reconciling the ESR and finance ledger every month.

[21] http://www.nhsemployers.org/news/2016/02/carter-report

Case study: County Durham and Darlington NHS Foundation Trust

County Durham and Darlington NHS Foundation Trust, like many trusts, has taken a comprehensive approach to safe staffing. This approach is aligned with NQB's guidance and evidence-based practice, and it includes publicly displaying information reports and data.



Key elements of the trust's detailed reporting of the adult inpatient establishment review are:

- understanding and analysing the wider workforce market and operational demands
- use of evidenced-based tools and professional judgement
- clear link to quality indicators
- clear action on areas that do not comply or require investment or review.

https://www.cddft.nhs.uk/quality-and-safety/reports,-policies-monitoring/safer-staffing.aspx?style=highcontrast

From working with providers, we suggest further best practice on the following areas at board level.

- Any workforce review and assessment and the safeguards reported should cover all clinical groups, areas and teams. Nursing/midwifery is the most often represented group at board level, but a focus on medical staff, AHPs, healthcare scientists and the wider workforce is needed too.
- Reports need to cover all areas, departments and clinical services.

- It is vital that the board sees the actual data from the tools used, such as the Safer Nursing Care Tool, BirthRate Plus and other European working-time directive reporting such as diary cards and exception-reporting information. This should be clearly cross-checked with other data such as ratios, fill rates and CHPPD.
- A clear link should be made between the quality outcomes, operational and finance performance, and patient, service user and staff experience in the ward, department or area. Boards must ensure that intelligence on patient, service user and staff experience is explicitly linked with metrics on quality outcomes, operational and finance performance, so they can oversee and monitor how these areas are interdependent.
- Boards must assure themselves that robust governance systems and processes around staffing and related outcomes are embedded down to ward or service level. This may include formally reviewing or adding processes such as QIAs to organisational policy. Ultimate responsibility for governance around staffing decisions should rest with the chief executive.
- Chairs and chief executives should ensure that time is allocated at board meetings or similar to discuss and agree clear actions in response to the data, and they should identify the key performance indicators (KPIs) to measure success and adverse outcomes.

Boards must assure themselves that an effective response to 'areas of concern' is described and consistently implemented. Escalation processes for ward, service or professional group should be activated if risks associated with staffing continue or increase, or mitigations prove insufficient, so that safety and care quality are maintained.

New and developing roles

Skill-mix changes that modify funded establishments to develop new roles or new ways of working within existing roles – for example, nursing associates or apprenticeship frameworks – must be informed by a comprehensive assessment using evidenced-based tools and a QIA. They must be signed off at executive sign-off level (see Section 5: Governance considerations: redesigning roles and skill mix). We expect risks to be recorded on local and corporate risk registers (depending on severity) as well as the QIA, to enable regular monitoring. Trusts must have measures that are routinely assessed against KPIs to ensure safety and effectiveness.

Nursing associate

The nursing associate role was created to bridge the gap between unregistered healthcare support workers and registered nurses – creating a further entry point into registered nurse training – and to provide additional support in clinical practice. The role will help provide high quality person-centred care across health and social care settings.

We are working to ensure that this role is effectively and safely introduced into healthcare workforce establishments. We plan to publish guidance to support decision-making in their deployment in early 2019.

Maternity support worker

The maternity support worker (MSW) role bridges the gap between healthcare support workers and registered midwives. MSWs should be recruited and trained as employees specific to maternity care, not as general healthcare assistants. This will require MSWs to complete of a formal competency-based education programme. MSWs support midwives in providing high quality, personalised, safe care across the pregnancy and postnatal care pathway.

Physician associates

Physician associates are healthcare professionals with a generalist medical education who work alongside doctors, physicians, GPs and surgeons providing medical care as an integral part of the multidisciplinary team. Physician associates have been practising in the UK for 10 years, so are relatively new members of clinical teams. They practise medicine in collaboration and through supportive working relationships with a dedicated clinical supervisor (a consultant), so they always have access to someone senior who can discuss cases with them, give advice and attend to patients if necessary. They are trained to perform various tasks including diagnosis, treatment, complex medical procedures and taking medical histories. Physician associates are working in primary and secondary care across at least 20 specialties throughout the UK.

Supervision of a qualified physician associate resembles that of a doctor in training or trust-grade doctor in that the physician associate is responsible for their actions and decisions. However, the clinician who is ultimately responsible for the patient is the consultant.

At present there is no regulatory body for physician associates. However, the Department of Health and Social Care consulted on this in 2017 and the results are awaited.[22]

As physician associates are already in practice, trusts must ensure they have safeguards to support safety and care quality. Any proactive skill-mix changes that modify funded establishments to develop physician associate roles must be based on a comprehensive assessment using evidenced-based tools, a QIA and executive sign-off. The Royal College of Physicians has published guidance on physician associate roles for employing organisations.[23]

It is critical that trusts ensure all physician associates fulfil continuing professional development requirements, receive appropriate clinical supervision, fulfil recertification requirements when needed and retain membership of the Physician Associate Managed Voluntary Register. We will monitor this at trust level, advising as required.

Advanced clinical practitioners

Advanced clinical practice can be undertaken by a nurse, midwife, pharmacist or AHP who has completed additional training and has experience in areas such as health assessment, diagnosis and prescribing. Once trained through an accredited university programme, they can be deployed in many clinical settings to manage patient pathways. ACPs can work independently or alongside medical and other clinical staff. They can see and treat a range of simple to complex clinical problems in a range of settings and clinical areas.

The advanced clinical practice role has developed in the NHS for several years, although without specific standards. We worked with HEE over 18 months to develop a standardised multiprofessional framework for advanced clinical practice in England (2017),[24] building on best practice examples in the regions and internationally. The framework defines a new beginning for this innovative work solution for the NHS.

As with any new care model, trusts must ensure they have safeguards to support safety and care quality. Skill-mix changes that modify funded establishments to develop ACP roles must be based on a comprehensive assessment, including a full QIA and executive sign-off.

[22] https://consultations.dh.gov.uk/workforce/regulation-of-medical-associate-professions/
[23] http://www.fparcp.co.uk/employers/guidance
[24] https://www.hee.nhs.uk/sites/default/files/documents/Multi-professional%20framework%20for%20advanced%20clinical%20practice%20in%20England.pdf

We have developed plans with HEE and NHS England so that the ACP model is developed and applied consistently. In particular, we intend:

- by 2019 to ensure the framework is used throughout the acute, mental health, learning disability, community, primary care and ambulance sectors
- to ensure workforce planning through sustainability transformation partnerships (STPs) and integrated care systems (ICSs), via local workforce action boards, optimises the development and funding of ACP roles
- by the end of 2018 to assess the implementation of the framework and adherence to principles and practice
- by the end of 2018 to provide system and trust-level support to implement roles effectively and safely
- by the end of 2018 to agree timescales with higher education institution representatives to align ACP course curricula to the new framework
- to work with the Department of Health and Social Care and professional regulators to advance discussions on regulating ACPs
- to work with the devolved nations to provide further alignment of advanced clinical practice.

5. Governance considerations: redesigning roles and skill mix

Increasing demands on healthcare and the gap in workforce supply mean introducing new roles and changing the skill mix of clinical teams will continue to be necessary across nursing, medical, AHPs, healthcare scientists and all other staff groups.

This creates opportunities to change the composition of the current health service workforce. Some will come unexpectedly and require a prompt and reactive response; others will be planned and enable a more considered and proactive response. In either case, this guidance is designed to encourage and support you to take a structured systematic approach to planning, implementing and monitoring new roles or changes to skill mix.

When planned effectively, new roles and skill-mixes will contribute to securing safe and sustainable care. But identifying and managing the potential risks they pose requires strong and effective governance arrangements from the front line to the board.

Governance arrangements

Effective governance gives boards confidence about maintaining and continually improving both the delivery and quality of their services, despite rising demand, cost pressures, advancing science, changing expectations, tough economic circumstances and the complexity of the healthcare system.

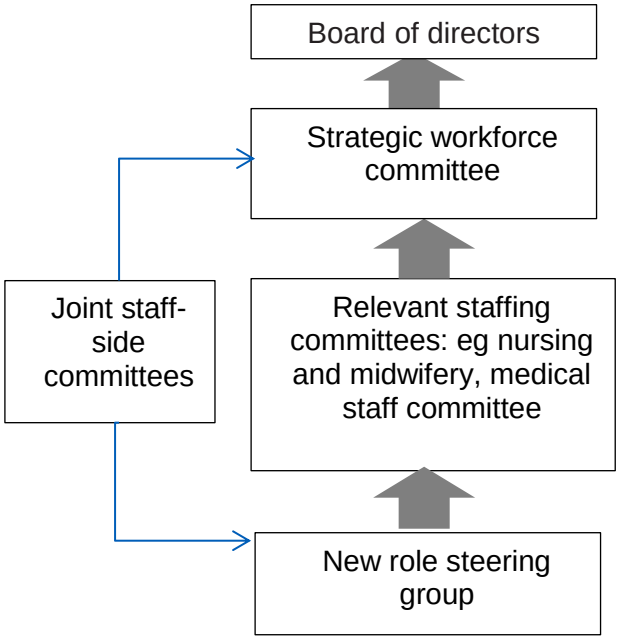
Boards should have the necessary assurance to support any proposed changes to skill mix that go beyond traditional professional boundaries and/or national guidance[25] or regulatory frameworks (see Figure 4).[26] They must ensure they have strong and effective governance frameworks and a systematic and structured approach to workforce changes.

[25] Such as NHS Improvement's *Safe staffing for nursing in adult inpatient hospitals* (2017) and the Royal College of Physicians' *Guidance on safe medical staffing* (2018).

[26] Such as, but not limited to, CQC regulations 12(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; and 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed;

This is important to protect patient and service user safety and maintain a positive patient, service user and staff experience: some new roles do not have an extensive evidence base or statutory registration requirements. They may lack recognition from other clinicians, patients, service users, commissioners and regulators, or from developing care systems such as STPs and ICSs.

Figure 4: Example of governance route for approving and supporting new roles



Information required to provide assurance up through the governance structure

Provide assurance to each committee, at each stage of the work, which you understand and can describe:

a) the workforce challenge
b) what is needed from the new roles
c) the remit of any new role
d) the competencies required and how they will be acquired
e) how the new role(s) will be costed, assessed and monitored
f) the measures to ensure the new roles are fit for purpose and deliver what was expected
g) any risks identified through the quality impact assessment
h) lines of accountability for the new roles
i) the supervision arrangements in place.

Taking a structured and systematic approach to workforce change

A structured and systematic approach to workforce change entails:

- **Understanding and articulating the staffing challenge:** is it anticipated to be short or long-term? Is the challenge confined to one clinical area/specialty, clinical pathway or more? What opportunities and innovative or collaborative solutions are available to address the challenge? What are the potential risks and what are the mitigating actions taken so far?

(2) (a) Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

- **Identifying the staff group(s) affected:** this may include clinical and non-clinical staff who therefore should be involved in exploring solutions. Identifying an appropriate executive lead to sponsor and advise on changes. Consideration of the impact on patients, service users and carers, who should also be involved in any significant workforce changes.
- **Agreeing a process or framework** to work through the challenges, opportunities and risks.
- **Governance systems and processes** that provide checks and balances during the workforce changes and seek the necessary assurance at all levels. This is based on an effective governance committee reporting structure, where the committees are responsible for, and focus on, workforce, quality, risk and finance.

The Nuffield Trust, commissioned by NHS Employers, published practical guidance[27] for reshaping the workforce, drawing on the literature and interviews with stakeholders. The report cites examples where new roles have been developed, and where staff developed skills and took on responsibilities in response to service need or gaps in staff capacity. These include ACPs, support workers and associate practitioners.

It identified important lessons for organisations seeking to redesign their workforce:

- be realistic about the time and capacity needed to support change
- create a receptive culture for change
- support transformation with a strong communication and change management strategy
- build roles on a detailed understanding of the work, staff skills and patient/service user needs
- invest in the team, not just the role
- develop and invest in a training capability
- build sustainability for new and extended roles
- evaluate change
- adopt a systematic approach to workforce development and change.

[27] www.nuffieldtrust.org.uk/research/reshaping-the-workforce-to-deliver-the-care-patients-need

Case study: implementing ACPs at Sheffield Teaching Hospitals NHS Foundation Trust

Needs assessment: Critical care was one of the first areas to realise it faced a workforce shortage and put together a proposal to fill the gap. It produced a comprehensive plan and mapped patient need to clinical competencies.

Raising awareness: The trust raised awareness internally through intense communications, staff meetings and handbooks.

Supporting systems: The trust has a robust mentorship and supervision programme for its ACPs. Each has a consultant supervisor who signs off the trainee as they go through the programme, and a mentor who acts as a second port of call if the supervisor is unavailable.

Training: The trust has standardised training requirements for ACPs. They take two to three years to complete the postgraduate diploma from the Master's degree in advancing professional practice at Sheffield Hallam University. Once in substantive posts, ACPs are supported and expected to complete the full Master's degree programme. Most trainees are supernumerary, which the trust has found to be the most effective way of training them.

The trust has a formal partnership with Sheffield Hallam University. It worked with the university to tailor the course modules and recruit students with the right aptitude and values. The trust supplements the university's modules with in-house training modules, for which trainees can receive academic credit if required.

Sustainability: In the longer term, it was felt that it would become clear where in the hospital ACPs could add value, and their position there would be sustained.

Buy-in to the roles: Medical champions in each department have increased the 'buy-in' from others, and many consultants are willing to act as supervisors and mentors. This buy-in has continued at all levels of the hospital. Board approval for project plans and proposals has been sought at each stage.

Comprehensive business cases and potential savings from avoiding agency costs helped ensure board-level support.

Note: this is a synopsis of a case study taken from the Nuffield Trust report (2016).

Another effective and systematic tool when implementing new roles and ways of working is the Calderdale Framework.[28] Its founders offer trusts training and support when using this approach.

Assessing risk and impact on quality

As part of the governance process, trusts must assess the potential impact on quality before service changes or where there is any substantial workforce transformation, including the introduction of new roles (eg physician associates, nursing associates, ACPs). This is normally done by completing a QIA.

QIAs systematically assess and record the likely impact on quality and safety of an activity or policy. They focus on assessing the impact on patients, service users and staff. This involves anticipating, monitoring and measuring the consequences of activities and making sure that, as far as possible, any negative consequences are eliminated or mitigated.

NQB's 'how to' guide[29] outlines best practice on applying a QIA to efficiency and transformation plans. This guidance can be extended to using QIAs in relation to workforce changes. The key aspects are:

- There is a clear governance structure surrounding the development of the scheme, acceptance and monitoring of implementation and impact (positive and negative).
- Initiatives are assessed according to their potential impact on all aspects of quality (including patient/service user experience or patient/service user safety).
- Initiatives are developed with clinicians and have a clinical sponsor, or clinicians have been consulted. The medical director and director of nursing scrutinise and sign off all schemes. Schemes are modified (or rejected) because of staff

[28] Smith and Duffy (2010) www.calderdaleframework.com/the-framework
[29] NQB (2012) *How to: quality impact assess provider cost improvement plans* www.gov.uk/government/uploads/system/uploads/attachment_data/file/212819/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf

concerns, and there should be clear routes for staff to raise concerns at the outset and on an ongoing basis.

- Measures of quality and early warning indicators are identified for each initiative and are monitored before (baseline), during and after implementation; mitigating action and/or escalation to the medical director or director of nursing is taken where necessary (including stopping or reversing the scheme).
- The board is aware of, and understands, the ongoing impact of schemes in place; monitoring of financial, operational and quality outcomes as appropriate.

Trusts must adopt a similar approach for introducing new roles or skill-mix changes. From the outset, all such proposals must be subject to ongoing assessment for their potential impact on quality. The minimum elements for this QIA exercise are patient/service user safety, clinical outcomes, patient/service user experience and staff experience.

To be assured, a board will require confirmation that all proposals for changing the workforce have been systematically assessed for their impact on quality. Many will be familiar with completing and reviewing QIAs as a normal part of their efficiency and transformation arrangements, and they will have seen how QIAs support considered and proportionate decision-making.

A model QIA template is shown in Appendix 2. Trusts should tailor it to meet their structures and governance arrangements.

The board must ensure that the quality risk assessments are of sufficient quality and have captured all foreseeable risks. Risk scores should be attributed to each risk using a standard 5 × 5 risk matrix, which should be consistent with the organisation's risk management policy.

The board must be assured of the quality and comprehensiveness of the risk assessment. It must also ensure there is a way to identify the cumulative impact of smaller or less risky schemes to ensure the risk does not increase.

For all schemes, long and short-term KPIs and other quality measures should be identified and monitored before and after implementation. Identify the mitigating actions necessary to avoid any negative impact on quality.

Case study: using QIAs in governance for efficiency and transformation

We have helped trusts make improvements in governance and the 'well-led' domain. This has revealed many examples of 'what good looks like' when using QIAs for efficiency and transformation schemes, which can be applied to plans for workforce changes and introducing new roles. Typically:

- staff undertaking QIAs need training
- QIAs must assess all the domains of quality (including staff impact)
- QIAs require appropriate depth and must include foreseeable risks
- the risk matrix must be the same as the trust's 5 × 5 risk matrix
- risks must be adequately discussed and realistic, with clear thresholds for escalation to the medical director/director of nursing
- holding vacancies/removing posts should be subject to a QIA
- the cumulative impact of workforce schemes across pathways/professional group should be recognised
- KPIs and other quality indicators – short and long-term and including staff and patient/service user feedback – should be identified for all schemes, and tolerances set
- KPIs need to be sensitive enough to identify the impact of the specific scheme
- where generic indicators are used, and a change is noted, evidence is needed to identify if the workforce change has caused the impact
- the quality data – eg complaints, harm events, serious incidents, patient/service user and staff experience – must be cross-checked
- risks should be recorded on local/corporate risk registers.
- Use soft intelligence, including service user and staff feedback, to enhance knowledge/support assurance.

6. Responding to unplanned workforce challenges

Boards must review workforce metrics, quality and outcome indicators, and productivity measures monthly and receive a comprehensive staffing report every six months (NQB 2016).

We recommend that, given day-to-day operational challenges, trusts have dynamic staffing risk assessments and escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in the risk assessments. For example, the Royal College of Physicians (2018) recommends audit topics and standards for medical personnel are subjected to scrutiny to ensure medical care is safe, timely and effective. The National Institute for Health and Care Excellence (NICE 2014) recommends the nurse staffing level available for each shift – or at least each 24-hour period – is systemically assessed to ensure it is adequate to meet patients' nursing needs.

Should risks associated with staffing continue or increase, and mitigations prove insufficient, trusts must refer this to the executive to ensure action is taken to maintain safety and care quality.

Unplanned workforce challenges

We recognise that day-to-day operational management requires dynamic solutions to align staffing numbers to acuity, dependency and demand. However, at times staff numbers may be insufficient to meet this demand or complexity. In this case, an organisation must have a process or standard operating procedure (SOP) to recognise the risks and co-ordinate a response on a shift-by-shift or daily basis. For example, in midwifery, NICE guidance sets out the procedures services must have in place for monitoring and responding to unexpected changes in midwifery staffing requirements, including the use of specific red flags.

A staffing safeguards SOP should provide assurance from the front line to the board that safe staffing standards are being achieved and risks to quality and safety mitigated. Within this, associated thresholds need to be developed with frontline staff to inform and trigger concerns about safe staffing deployment. This includes a clear escalation

approach describing the steps that may be required to ensure safe staffing levels to meet every patient's needs on each shift.

The SOP's purpose is to help manage daily staffing levels so that the right staff and skill mix are available for safe, effective patient care.

Such an assessment may require a decision to:

- increase staffing numbers to meet patient demand
- partially or fully close a ward or service for a determined period until the issues are resolved
- temporarily reduce service delivery or take another demand-management approach to redeploy the available workforce to areas of critical need to sustain safe and adequate care delivery
- close the service, facility or model of care in the long term
- implement business continuity plans.

In such circumstances, the trust must notify NHS Improvement and NHS England (including commissioners) so they can provide support and assess the wider impact across the sector, system and care providers.

Case study: Sherwood Forest Hospitals NHS Foundation Trust

The trust devised a safe staffing SOP to support decision-making for wards and departments. It created a clear framework and escalation approach with defined measures and metrics so staff were clear about what to do and when. The key components of this fulfilled NQB and NHS Improvement's approaches to effective workforce safeguards.

Daily staffing reviews

- These include each ward's staffing and minimum staffing levels, number of agency staff and RAG rating. Reviews take place three times a day and are shared with ward sisters, charge nurses, matrons, heads of nursing, deputy and chief nurse, and silver and gold on call.

- The SOP helps manage nursing and midwifery staffing levels to ensure the right staff and skill mix for safe, effective patient care and to robustly manage staffing levels as part of the trust's operational management.

Thresholds – referred to as 'tipping points'

- The trust developed tipping points around safety levels within minimum staffing levels on each ward. These trigger a review of every ward position that breaches these levels and prompt a face-to-face discussion with the registered nurse (RN) in charge for that shift to ensure they feel 'safe' with their staffing for that shift:
  - the trust-employed RN on each shift to take charge
  - minimum of two RNs on each shift
  - ≥50% of RNs on each shift are employed by the trust
  - critical care unit has a maximum of 20% agency staff, in accordance with the specifications for adult critical care
  - no less than one RN for every eight patients
  - sudden changes in the acuity/dependency on a ward to be agreed at divisional level.

Risk factors

- Low risk (green) – staffing is safe. Ward teams are managing their workload. Reassess on routine walk-round.
- Moderate risk (amber) – caution: staffing is at 50% trust RN and 50% agency. Monitor staffing out of hours and ensure wards are visited regularly.
- High risk (red) – depleted: trust RN considers area to be high risk. In-hours, ensure the matron has evaluated the areas and has mitigated the risks. Out of hours, duty nurse manager to assess the risk, mitigate where able and complete incident reporting if no mitigation.

- Unmitigated high risk (black) – unmitigated: high risk that has not been mitigated adequately by the ward-based teams/matron. Head of nursing to investigate and implement mitigations.

Roles and responsibilities

- Ward sister/charge nurse – remains accountable for providing safe staffing levels to meet patient needs and service demands, and should ensure the duty roster reflects the agreed workforce model.
- Matron – responsible for ensuring each ward is safely staffed in their specialty. Where risks on rosters have been identified by the ward sister/charge nurse, the matron should try to assist in any mitigation to ensure all rosters are safe and meet patient needs and service demands, escalating any safety issues to their head of nursing.
- Heads of nursing – responsible for ensuring all wards in their division are safely staffed and all risks have been minimised. It is the head of nursing's responsibility to ensure the deputy chief nurse/chief nurse is informed.
- Chief nurse – executive director responsible for overall safe staffing on the wards and departments across the trust. It is their responsibility to report to the board on the safe staffing position.

7. NHS Improvement's yearly assessment

We are committed to supporting trusts to manage common workforce problems by making informed, safe and sustainable workforce decisions.

In accordance with NQB guidance, trusts must ensure that the three components – evidence-based tools, professional judgement and outcomes – are used in their staffing governance processes.

From now on we will actively assess trusts' compliance with this 'triangulated approach'.

Annual governance statement

The Department of Health and Social Care's group accounting manual[30] requires NHS trusts and foundation trusts to include an annual governance statement in their annual report. Paragraph 3.29 of the manual states that trusts must follow NHS Improvement's guidance on the format of the annual governance statement.

We have added a section to the annual governance statement specifically about staffing governance processes. In their response to this section, trusts will be able to describe or explain the extent of their compliance with the NQB guidance.

We will review this statement through our usual regulatory arrangements and performance management processes.

Single Oversight Framework

The SOF is designed to help trusts attain and maintain CQC ratings of 'good' or 'outstanding'.

The SOF describes how we oversee NHS trusts and foundation trusts. Their performance is monitored against five themes (quality of care, finance and use of resources,

[30] https://www.gov.uk/government/publications/dhsc-group-accounting-manual-2018-to-2019

operational performance, strategic change, and leadership and improvement capability) and helps determine the level of support we may offer them.

Within the SOF, the organisational health section contains information on monthly staff sickness, staff turnover and the volume of temporary staffing a trust uses, as well as the annual staff survey. These are high level organisational metrics that we will continue to analyse.

In addition, our assessment will review more detailed metrics (where appropriate and in line with the SOF) that are collated within individual trusts. These will be available from 'board to ward' and sourced from ESR, e-rostering and financial systems, as well as a quality dashboard reviewed by the trust board.

As described in board reporting (see Section 4), individual trusts are expected to collate and review data every month for a range of workforce metrics, quality and outcomes indicators and productivity measures – as a whole and not in isolation from each other. We also expect evidence of continuous improvements across all these areas. To optimise allocation of workforce resources and improve outcomes, boards should implement the NQB (2016) and Carter recommendations,[31] together with the information available from the Model Hospital.

This includes:

- using local quality and outcomes dashboards published locally and discussed in public board meetings, including nationally agreed quality metrics to be published at trust level
- developing metrics that measure patient/service user outcomes, staff experience, people productivity and financial sustainability
- comparing performance against internal plans, peer benchmarks and NHS experts' views, taking account of any underlying differences
- supporting and engaging staff to remove barriers to their productivity and ensure their time is used in the best way possible to provide direct or relevant care or care support
- using national good practice checklists to guide improvement action, as well as taking account of knowledge shared by top performers

[31] http://www.nhsemployers.org/news/2016/02/carter-report

- using e-rostering and e-job planning tools to support efficient and effective staff deployment
- ensuring workforce data and finance information reconcile and are regularly checked to ensure they do so.

What happens next?

Trusts unable to demonstrate satisfactory compliance with the NQB guidance – through their annual governance statement or the SOF processes – may be offered support in line with that described in the SOF. This is called segmentation and is described in Table 1 and in more detail on our website.[32]

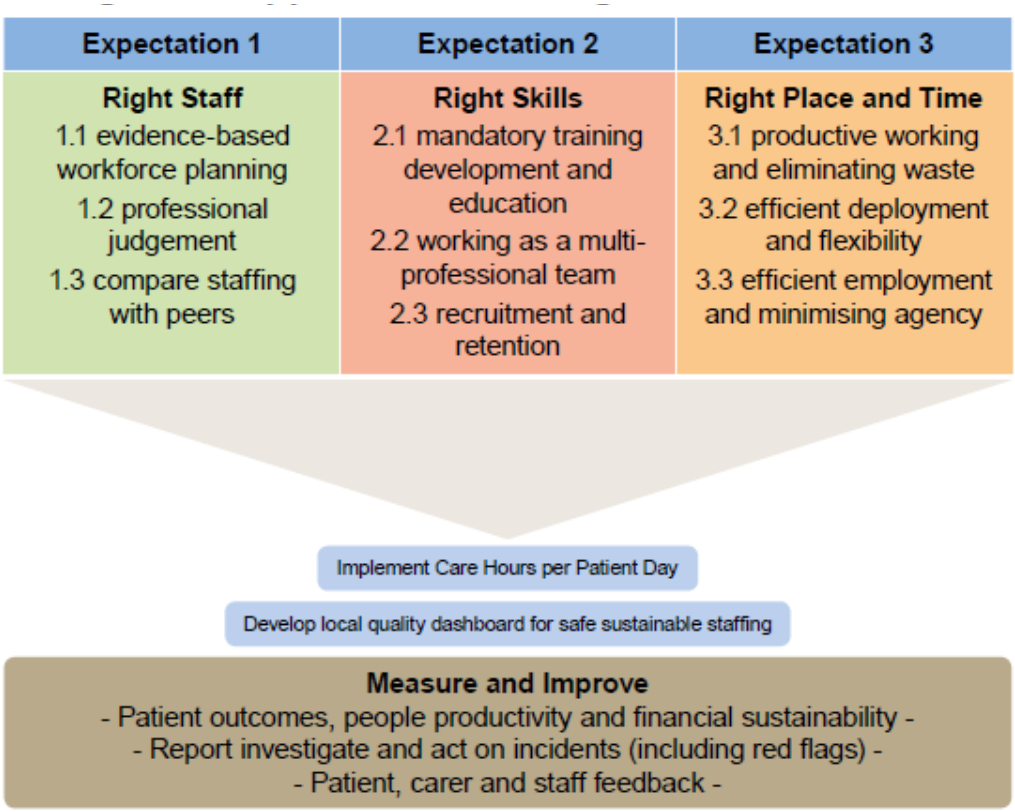
Table1: Single Oversight Framework segmentation

Segment	Description
1	Providers with maximum autonomy: no potential support needs identified.
2	Providers offered targeted support: there are concerns in relation to one or more of the themes. Targeted support has been identified that the provider can access, but they are not obliged to take it up.
3	Providers receiving mandated support for significant concerns.
4	Providers in special measures: very serious and/or complex issues.

For trusts challenged by elements of the NQB guidance, we may offer bespoke assistance aligned to the SOF segmentation so that our national and regional teams support them to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

[32] https://improvement.nhs.uk/resources/single-oversight-framework-segmentation

Appendix 1: NQB's triangulated approach to staffing decisions



For more details: https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

Appendix 2: Quality impact proforma

Name of scheme:	
Reference:	
Division:	
Indicative value of scheme:	
Saving recurrent or non-recurrent	
Proposed start date:	

Quality Impact Risks

Note: insert extra rows/leave blank rows as necessary.

			Initial Asssessment				Post Mitigation				
	Y/N (If yes complete the following)	**Risk Description**	**Impact**	**L**	**C**	**Rating**	**Mitigations**	**L**	**C**	**Rating**	**KPI monitoring**
Impact on duty of quality (CQC/constitutional standards)											
Impact on pt safety?											
Impact on clinical outcomes?											
Impact on patient experience											
Impact on staff experience											

Clincal Business unit sign off (e.g division,locality)

Name	**Position/ job title**	**Signature & Date**
	Divisional Medical Director*	
	Divisional Nurse Director*	
	Divisional Operations Director*	

* or equivalent titles in the organisatoin

COMMITTEE REVIEW

	Date	Status	Comments & Date of Committee meeting
Clincal Senate / Star Chamber		Unchecked	
Quality Committee		Unchecked	
Trust Management Board		Unchecked	

Medical Director/ Chief Nurse Authorisation

By signing this section employees of the Trust are acknowledging that they have been reasonably assured that appropriate steps have been taken to ensure that this proposal will not put registration

Name	**Position/ job title**	**Signature & Date**
	Medical Director*	
	Chief Nurse*	

Appendix 3: References

National Quality Board

How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability (2013)

Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe sustainable and productive staffing (2016)

NHS Improvement

Series of improvement resources: Safe, sustainable and productive staffing:

- an improvement resource for adult inpatient wards in acute hospitals (June 2018)
- an improvement resource for learning disability services (December 2016)
- an improvement resource for the district nursing service (March 2017)
- an improvement resource for mental health (March 2017)
- an improvement resource for maternity services (June 2017)
- an improvement resource for urgent and emergency care (June 2018)
- an improvement resource for neonatal care (June 2018)
- an improvement resource for children's and young people's inpatient wards in acute hospitals (June 2018)

Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts (2017)

Care Quality Commission

Well-led trust-wide inspection framework (2018).

Combined trust-level quality and Use of Resources ratings (2018)

National Institute for Health and Social Care

Safe staffing for nursing in adult inpatient wards in acute hospitals (2014)

Safe midwifery staffing for maternity settings (2015)

Appendix 4: More resources

Culture

NHS Improvement has co-designed a culture and leadership programme with trusts, developed in partnership with the King's Fund. It provides practical support to help trusts diagnose their cultural issues, develop collective leadership strategies to address them and implement changes.

https://improvement.nhs.uk/resources/culture-and-leadership-programme-phase-2-design/

Setting appropriate staffing budgets

Establishment Genie: https://improvement.nhs.uk/resources/establishment-genie/

Finance and use of resources: https://improvement.nhs.uk/improvement-hub/finance-and-use-resources

Effective job planning for medical staff and allied health professionals

Best practice guide for consultant job planning: https://improvement.nhs.uk/resources/best-practice-guide-consultant-job-planning/

Best practice guide for AHP job planning: https://improvement.nhs.uk/resources/allied-health-professionals-job-planning-best-practice-guide/

Using agency staff

Reducing expenditure on NHS agency staff: https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps

Appendix 5: Stakeholder list

External stakeholders

Name	Role/organisation
Jane Avery	Safe Care Lead Northamptonshire Healthcare NHS Foundation Trust
Rose Baker	Associate Chief Nurse Royal Wolverhampton NHS Trust
Suzanne Banks	Chief Nurse Sherwood Forest NHS Foundation Trust
Debrah Bates	Deputy Chief Nurse (Workforce and Education) Lincoln County Hospital
Helen Blanchard	Director of Nursing and Midwifery Royal United Hospitals Bath NHS Foundation Trust
Sue Covill	Director of Development and Employment NHS Employers
Maria Croft	Director of Quality 2gether Foundation Trust
Sir Robert Francis QC	Non-executive Board Member, Care Quality Commission
Helen Inwood	Deputy Chief Nurse Royal Stoke University Hospital
Heather McClelland	Head of Nursing and Midwifery Leeds Teaching Hospital NHS Trust
Stuart Murdoch	Consultant, St James's University Hospital Leeds Teaching Hospitals NHS Trust
Clare Parker	Safe Care Lead Northamptonshire Healthcare NHS Foundation Trust
Carolyn Pitt	Lead Nurse Workforce University Hospitals Birmingham NHS Foundation Trust
Alan Robson	Department of Health and Social Care
Anna Stabler	Deputy Director of Nursing, Midwifery and AHPs North Cumbria University Hospital NHS Trust

Liz Staples	Deputy Director of Nursing Worcestershire Health and Care NHS Trust
Helen Watson	Head of Nursing Workforce Birmingham Women's & Children's NHS Foundation Trust
Hannah White	Senior HR Business Partner Dudley and Walsall Mental Health Partnership NHS Trust
Ellen Armistead	Care Quality Commission

NHS Improvement stakeholders

Name	Role
Helen Brooks	Workforce Insight Manager
Rosalind Campbell	AHP Professional Lead
Ann Casey	Clinical Workforce Lead
Joanne Fillingham	Clinical Director, Allied Health Professionals
Jennie Hall	Programme Director, Strategic Nursing Adviser
Fabian Henderson	Head of Workforce Policy & Improvement
Andy Howlett	Clinical Productivity Operations Director
Jeremy Marlow	Executive Director, Operational Productivity
Ruth May	Executive Director of Nursing
Emma McKay	Senior Clinical Lead
Toni Meyers	Project Manager
Gina Naguib-Roberts	Project Director, Partnerships
Professor Mark Radford	Director of Nursing Improvement
Paul Reeves	Strategic Nurse Advisor
Lorna Squires	Head of Quality Governance
Rebecca Southall	Quality Governance Associate
Karen Swinson	Productivity Lead
Zephan Trent	Assistant Director of Strategic Finance
David Wells	Head of Pathology Services Configuration

Appendix 6: SNCT assessment to meet criteria

1. Where the Safer Nursing Care Tool is used to set establishments the following assessment will be deployed.

2. There should be no local manipulation of the decision matrix and/or the nursing resource, or of the evidence based criteria or the figures embedded in the evidence based tool used.

Criteria	Y/N	Evidence required
Have you got a licence to use the SNCT from Imperial Innovations?	Y	Licence agreement must be signed by board and available for viewing.
Do you collect a minimum of 20 days' data twice a year for this?	Y	A minimum of two datasets of 20 days at distinct points of the year, eg January and June, must be available for review.
Are a **maximum** of three senior staff trained and the levels of care recorded?	Y	Need to see details of training and inter-rater reliability assessment of senior sister/charge nurse and two additional senior nursing staff members for each ward.
Is an established external validation of assessments in place?	Y	Must be evidence of a rota of senior staff with no direct management duties to the allocated ward for each data collection episode/written evidence that this was completed.
Has inter-rater reliability assessment been completed with these staff?	Y	All ward sisters/matrons should be trained as part of induction/management development and inter-rater reliability assessment is inbuilt.
Is A&D data collected daily, reflecting the total care provided for the previous 24 hours as part of a bed-to-bed ward round review?	Y	Must be data available showing the **daily** acuity/dependency levels for previous 24 hours for the full 20 days (minimum) at two distinct points of the year.

Are enhanced observation (specialed) patients reported separately?	Y	Enhanced care is not factored into SNCT (2013); therefore this is an additional requirement as no evidence base is included for this. How this has been assessed and included must be an additional requirement.
Has the executive board agreed the process for reviewing and responding to safe staffing recommendations?	Y	There must be a local policy setting out how (process) staffing establishments are reviewed bi-annually and reset annually, andagreed by the trust board.

Contact us:

NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

@NHSImprovement

This publication can be made available in a number of other formats on request.

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