

Report Title	NHSI Workforce Safeguards – Trust Assessment		
Sponsoring Executive	Raffaella Goodby – Director of People and Organisation Development		
Report Author	Raffaella Goodby – Director of People and Organisation Development		
Meeting	Trust Board	Date	7 th February 2019

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

In October 2018 NHSI launched a Workforce Safeguards toolkit https://improvement.nhs.uk/documents/3320/Developing_workforce_safeguards.pdf to direct Trusts to ensure that there are appropriate safeguards in place, that support NHS boards to make informed, safe and sustainable workforce decisions. NHSI will assess our compliance yearly

The executive team have undertaken an initial assessment of our compliance against the workforce safeguards toolkit. This demonstrated that we are largely compliant in the nursing workforce indicators undertaking nearly all of the recommended actions in the toolkit. It was felt there is more work to do to triangulate all of the data we have, to take a clear view on whether we are productive or not. This is evident in the ‘non nursing’ staff groups. The People and OD directorate, will ensure that they are scanning and looking ahead, identifying responses and actions and closely monitor any action plans.

The board are invited to discuss:

- The executive’s assessment of assurance against the workforce safeguard indicators
- The actions suggested which signal a change to a more proactive approach led by the People and OD Directorate.
- Delegate the monitoring to the bi-monthly People and OD committee, with relevant items being escalated to the Trust Board.

2. Alignment to 2020 Vision *[indicate with an ‘X’ which Plan this paper supports]*

Safety Plan	X	Public Health Plan		People Plan & Education Plan	X
Quality Plan	X	Research and Development	X	Estates Plan	
Financial Plan	X	Digital Plan		Other <i>[specify in the paper]</i>	

3. Previous consideration *[where has this paper been previously discussed?]*

None

4. Recommendation(s)

The Trust Board is asked to:

- DISCUSS** and **ACCEPT** the executive assessment against NHSI workforce Safeguards
- DELEGATE** the monitoring to the bi-monthly People and OD committee, with relevant items being escalated to the Trust Board.

5. Impact *[indicate with an ‘X’ which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register	X	Risk 114				
Board Assurance Framework	X	BAF 8 BAF 9				
Equality Impact Assessment	Is this required?	Y		N	X	If ‘Y’ date completed
Quality Impact Assessment	Is this required?	Y		N	X	If ‘Y’ date completed

NHSI Board Indicator:

1) Using local quality and outcomes dashboards that are discussed in public board meetings, and nationally agreed quality metrics published at provider level

Strengths:

- There are clear indicators in place for Nurse staffing, based on NICE guidance, that ensures the NQB (National Quality Board) recommendations are embedded in the recommended establishments.
- Regular consideration is given to nursing establishment based on acuity and dependency data, and establishments are flexed to meet the need of the patients, under professional advice of Chief Nurse or their representative.
- Quality metrics are monitored regularly through the Performance Management Committee, chaired by the Chief Executive, the Clinical Leadership Executive, and ultimately at the Public Trust Board each month.
- Staffing and recruitment metrics are detailed in the recruitment trajectory for hard to fill posts, monitored at Public Trust Board.
- Nursing Safe Staffing presented monthly to Board in CEO report appendix
- The Trust's Quality Plan has been developed in both Public and Private Board Meetings, and contains metrics around quality outcomes.
- Non executives have some involvement in GIRFT sessions, which detail quality metrics associated with productivity
- The board is sighted on financial restraints and understands rational for setting an accurate and achievable staffing budget agreed by clinicians, operational managers and executive.

Gaps:

- There is not a systematic approach to determining the number of staff and range of skills required to meet the needs of patients using our services, for non nursing roles.
- Lack of clear productivity data, such as job plans that are based on to production plan, and outcomes, is not regularly reviewed at board level.
- Outcome data is not regularly triangulated across the Trust or reviewed at board level
- Model Hospital and GIRFT data is not routinely reviewed at board level and not currently embedded in change or improvement methodology.

Actions to address:

- Proactive use of NHSI's Model Hospital data. The datasets in model hospital are drawn from provider returns across the UK, and compare productivity, quality and responsiveness data. This gives information on workforce data which can be used for workforce planning, including Care hours per patient per day (CHPPD) and clinical hours to contact (CHtc) data, and cost per contact for non ward based settings.
- Review of Job Plans linked to productivity data, led by Medical Director
- Review of evidence based acuity tools (e.g guidance from professional bodies) to ensure the Trust is up to date with their response. Record these in a central place (hosted by People and OD) and support professional groups to deliver on action plans. **March 20**
- Information team to work with key stakeholders to link up quality **outcomes** with the metrics contained in the IQPR. **Oct 19**

NHSI Board Indicator

2. Developing metrics for patient and service user outcomes, staff experience, people productivity and financial sustainability

Strengths

- Friends and family test metrics linked with Nursing metrics
- IQPR inclusive of friends and family test responses and metrics
- Quality Plan contains quality improvement metrics, developed through Trust Board and updates presented through board committees
- Complaints, compliments and Purple Point metrics and outcomes discussed at board committees and Public Trust Board
- YourVoice metrics regularly monitored at People and OD Committee and at Public Trust Board.
- Launch of WeConnect involving board, to understand, measure and improve staff experience
- Financial sustainability metrics regular discussed at Finance and Investment Committee (FIC) and Public Trust Board

Gaps:

- Although the IQPR contains all of the data points detailed in the NHSI toolkit, outcome data for staff and patient experience is not triangulated. e.g. FFT data alongside patient outcome data
- People productivity metrics are not clearly sighted at the board
- Medical staff job planning is not clearly sighted at the board
- Productivity metrics visibility variable. Board have good oversight of Imaging productivity, ED Dashboards and theatre utilisation, but this should be improved for other areas
- Model Hospital metrics or GIRFT data are not regularly monitored at board level

Actions to address:

- Proactive use of NHSI's Model Hospital data. The datasets in model hospital are drawn from provider returns across the UK, and compare productivity, quality and responsiveness data. This gives information on workforce data which can be used for workforce planning, including Care hours per patient per day (CHPPD) and clinical hours to contact (CHtc) data, and cost per contact for non ward based settings. (March 2020)
- Review of Job Plans linked to productivity data, led by Medical Director and achieved through PDR objective setting 19/20. (Oct 19)
- Chief Nurse, Medical Director and Director of People and OD to bring regular updates through the bi monthly People and OD Board Committee, on people productivity.

NHSI Board Indicator

3. Comparing performance against internal plans, peer benchmarks and the NHS Experts' views, taking account of any underlying differences

Strengths:

- Clinical Groups are held to account through bi monthly Group Reviews, including review of clinical group IQPR metrics and performance metrics
- Good use of GIRFT in clinical areas
- Internal plan monitoring is through TPRS (for CIP Plans) and monitored through local programme management offices (PMO's) closely overseen by Chief Operating Officer
- Clear Board oversight of Mortality Metrics, presented by Medical Director
- Regular Board oversight of ED performance comparable to peers, on a daily and weekly basis
- Good oversight of financial performance compared to peers, overseen by Finance and Investment Committee with monthly discussion at Public Trust Board.
- Evidence of collaboration with other Trusts, for example of A&E Locum price negotiation
- Examples of best practice for NHS in Recruitment, Safety Plan and End of Life Care

Gaps:

- Comparisons and 'best practice', are not integrated in to any process improvement methodology. E.g. when a change is proposed, there is a checklist that ensures national toolkits are considered, and organisations in the top quartile of performance are researched and contacted.
- Good practice visits are currently limited and not built in to local processes
- Limited use of Model Hospital Data, this needs to be more proactive
- Limited use made of national toolkits for improvements

Actions to address:

- People and OD will recruit an OD Transformation Manager. This individual will take ownership of ensuring that national workforce toolkits, or workforce guidance from professional bodies are regularly reviewed, a central repository will be developed, and this individual will work proactively with local clinical leaders to ensure that a robust response is developed and monitored.
- For example, if the Royal College of Paediatrics issues workforce guidance, People and OD will take ownership of identifying the new guidance, working with Women and Child Health to ascertain whether the Trust is compliant, and then work with clinical groups to monitor our response.
- Regular updates will be brought to the People and OD Board Committee and other committees or Board where appropriate.

NHSI Indicator

4. Supporting and engaging staff to remove barriers to help their productivity and ensure their time is used in the best way possible to provide direct or relevant care or care support.

Strengths:

- Engagement events are regularly held, e.g T&O Safety Summit, ED Listening in to Action Events, Falls Summit, with purpose of supporting staff to remove barriers to help their productivity
- Imaging are good example of board oversight and support to improve productivity.
- Chief Nurse proactive oversight on establishment reviews, use of focussed care, unannounced 4am visits are good practice
- Strong executive oversight of rostering improvements, closely linked to financial improvements.
- Proactive programme of developing Band 4 nursing workforce, enabling nursing colleagues to work within the maximum of their practice
- Freedom to Speak Up Guardians are well utilised and linked to the Board
- Your Voice surveys, WeConnect surveys to identify and resolve barrier and regularly reviewed at the Board
- Learning from incidents is strong, good culture of incident reporting with issues resolved and monitored at CLE and Board Committees. WeLearn programme developed at Board.

Gaps:

- Linking up examples of engaging staff with patient outcomes and subsequent improvements made to productivity.
- More scrutiny of complaints and compliments needed linked to staff experience and engagement data
- Staff productivity links to PDR objective setting is variable

Actions to address:

- Friends and Family Test roll out, led by Chief Nurse, will link to nursing dashboards, and set patient outcomes alongside this data. E.g. falls linked to staff experience, and patient experience metrics (October 2019)
- Ongoing use of Listening in to Action events, Safety Summits as a learning tool (March 2020)
- Implementation of WeLearn to share best practice across organisation (October 2019)

NHSI Board Indicator

5. Using national good practice checklists to guide improvement action, as well as taking account of knowledge shared by top performers

Strengths:

- Use of WHO checklist, regularly used and reported to Board and learning shared
- Some visits to other areas of excellence, e.g. Wigan, EPR Trusts, clinical best practice Good use of Nursing best practice models. E.g. safer staffing, good discharge, golden patient, red to green, ten before ten, NICE guidance
- Learning and sharing through local STP forums
- National Awards for best practice, e.g. Safety Plan, Equality Awards

Gaps:

- National good practice checklists are used intermittently and action plans are not monitored in one place. Use of toolkits is not embedded in to improvement methodology and best practice visits are limited.
- Under developed 'learning from others' and implementing resource toolkits at present. This will be integrated (for workforce issues) in to the People and OD Directorate from Q1.

Actions to improve:

- Proactive use of NHSI's Model Hospital data. The datasets in model hospital are drawn from provider returns across the UK, and compare productivity, quality and responsiveness data. This gives information on workforce data which can be used for workforce planning, including Care hours per patient per day (CHPPD) and clinical hours to contact (CHtc) data, and cost per contact for non ward based settings.
- Review of Job Plans linked to productivity data, led by Medical Director
- Review of evidence based acuity tools (e.g guidance from professional bodies) to ensure the Trust is up to date with their response. Record these in a central place (hosted by People and OD) and support professional groups to deliver on action plans. **March 20**
- Information team to work with key stakeholders to link up quality **outcomes** with the metrics contained in the IQPR. **Oct 19**
- *Actions repeated from elsewhere, as repetitive indicator*

<p>NHSI Indicator</p> <p>6. Use evidence based decision support tools</p>
<p>Strengths:</p> <ul style="list-style-type: none"> • Good use of CHPPD in nursing workforce • Nursing dashboards scrutinised at Performance Management Committee • UNITY based on evidence based tools • Widespread use of GIRFT, involving executive and board members
<p>Gaps:</p> <ul style="list-style-type: none"> • Focus on model hospital data and evidence tools needed for 19/20 • Evidence based tools should be built in to improvement methodology and workforce change processes • Evidence based tools need to be more visible in non nursing workforce
<p>Actions to address:</p> <ul style="list-style-type: none"> • Proactive use of NHSI's Model Hospital data. The datasets in model hospital are drawn from provider returns across the UK, and compare productivity, quality and responsiveness data. This gives information on workforce data which can be used for workforce planning, including Care hours per patient per day (CHPPD) and clinical hours to contact (CHtc) data, and cost per contact for non ward based settings. • Review of Job Plans linked to productivity data, led by Medical Director • Review of evidence based acuity tools (e.g guidance from professional bodies) to ensure the Trust is up to date with their response. Record these in a central place (hosted by People and OD) and support professional groups to deliver on action plans. March 20 • Information team to work with key stakeholders to link up quality outcomes with the metrics contained in the IQPR. Oct 19 • Actions repeated from above as repetitive

<p>NHSI Board Indicator</p> <p>7. Use r-rostering and job planning tools to support efficient and effective staff deployment</p>
<p>Strengths:</p> <ul style="list-style-type: none"> • Integrated Trust Bank that operates nurse, AHP, doctor, admin and all posts. • E-rostering in place for nursing consistently, and some facilities staff.
<p>Gaps:</p> <ul style="list-style-type: none"> • Job planning and rotas are managed locally within clinical groups for doctors, and other staff groups. • Some rotas and rosters are paper based, mostly for doctors and AHP's.
<p>Actions to address:</p> <ul style="list-style-type: none"> • Consideration could be given to regional bank and workforce planning to address skill gaps. (March 2020) • Consideration of electronic rostering tools for all professional groups. Must be post UNITY as technical implications (March 2020) • Job plans electronically linked to production plan and productivity outcomes (March 2020)

NHSI Board Indicator

- 8 Any workforce review and assessment and 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, AHP's, healthcare and scientists and the wider workforce is needed too**

Strengths:

- Quality impact assessments are reported at the Trust Board and board committees and signed off by Chief Nurse and Medical Director and recorded and monitored centrally. When workforce changes are proposed, over 25% usually change or are adjusted to reflect feedback on quality and safety from different staff groups
- All workforce review processes are in partnership with Staffside, presented at Quality Committee and Trust Board regularly.
- Good representation of nursing and midwifery safeguards reported at board level.
- All staff groups are reviewed during QIA workforce process, including consultation with LNCC and JCNC and involvement of multi disciplinary stakeholders.
- When undertaking workforce change, bi weekly meetings with multi disciplinary leaders to ensure that risks, issues and impact is known across clinical groups.
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Gaps:

- AHP workforce planning has made a very strong start, needs further support to fully roll out.

Actions to address:

- Continued scrutiny of workforce changes and full involvement of Chief Nurse and Medical Director in Quality Impact Assessments of Workforce Changes
- Close management of workforce change, that spans professional groups, so impact on quality and safety is understood
- Monitor through People and OD Board Committee, and the Board.

9.NHSI Board Indicator

It is vital that the board see 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 info

Strengths:

- The board see data from nursing and midwifery tools in committees and the Board
- Clinical groups consider and respond to tools available at a local level, with support from relevant clinical executive
- Board have scrutinised working hours, and impact on quality of care, at Public Trust Board meetings.
- Hours worked is monitored and reported for Bank Workers at a central level
- Safe Hours Guardian in place for Junior Doctors, with regular reports to the Trust Board.

Gaps:

- The board do not scrutinise diary cards and it is unclear what value this would add.
- There is a lack of information on our staff who may be working hours at other organisations through an agency and the impact on their working hours, and quality of care.

Actions to address:

- The People and OD Committee plan to review WTD reporting in Q1 and Q2 2019/20
- Ongoing scrutiny of bank hours worked through the rostering team
- Review of evidence based acuity tools (e.g guidance from professional bodies) to ensure the Trust is up to date with their response. Record these in a central place (hosted by People and OD) and support professional groups to deliver on action plans. **(March 20)**
repeated action

NHSI Board Indicator

10. A clear link between the quality outcomes, operational and financial performance, and patient, service user and staff experience on 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 financial performance, so they can oversee and monitor how these areas are independent

Strengths:

- The executive felt that all of this data is available and reported through CLE and Board committees, including Performance Management Committee with reports to the Trust Board,

Gaps:

- Data is not triangulated in to outcomes, as the NHSI toolkit suggests
- Actions as per other items, repetitive indicator

NHSI Board Indicator

11. Boards must assure themselves that robust governance systems and processes around staffing systems and processes around staffing and related outcomes are embedded to ward or service level. This may include formally reviewing or adding QIA's to org. policy. Ultimate decisions should sit with the Chief Executive

Strengths:

- Chief Executive accountability is clear in reporting, and annual returns and governance statement
- Board have oversight of ward metrics, and regularly visit clinical front line areas to test out assumptions in person
- Board members fully involved in 'mock inspections' and scrutinise data and assessment criteria in person

Gaps:

- The executive felt that although we are data rich on all of the metrics regarding our workforce, that we still don't know fully whether we are a productive workforce based on the NHSI assessment metrics
- We are not efficiently looking at outcome or experience data alongside the performance metrics, to draw conclusions and focus our resources effectively

Actions to address:

- Summary of all actions noted above
- Organisation change policy has recently being reviewed, inclusive of Quality Impact Assessments. Ensure that this is embedded in future workforce changes.
- Actions as per above, as repetitive indicator.