Sustaining a Safe & Quality Workforce

Nursing & HR Event

Tuesday 23 September

Welcome

- Caroline Waterfield

  Assistant Director of Employment Services

  NHS Employers

   @NHSE_Caroline

Safe staffing

- Ruth May

  Director of Nursing

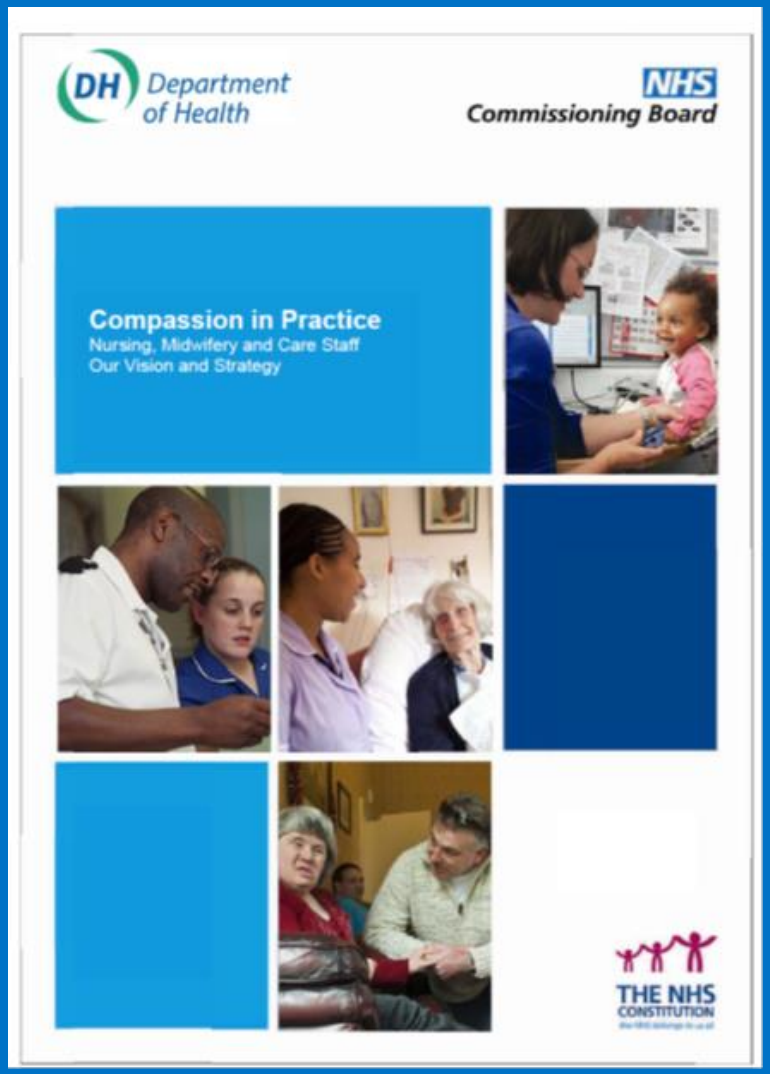
  NHS England

  @RMayNurseDir

Overview of Safer Staffing Workstream

Ruth May
Regional Chief Nurse
NHS England (Midlands & East)

23 September 2014

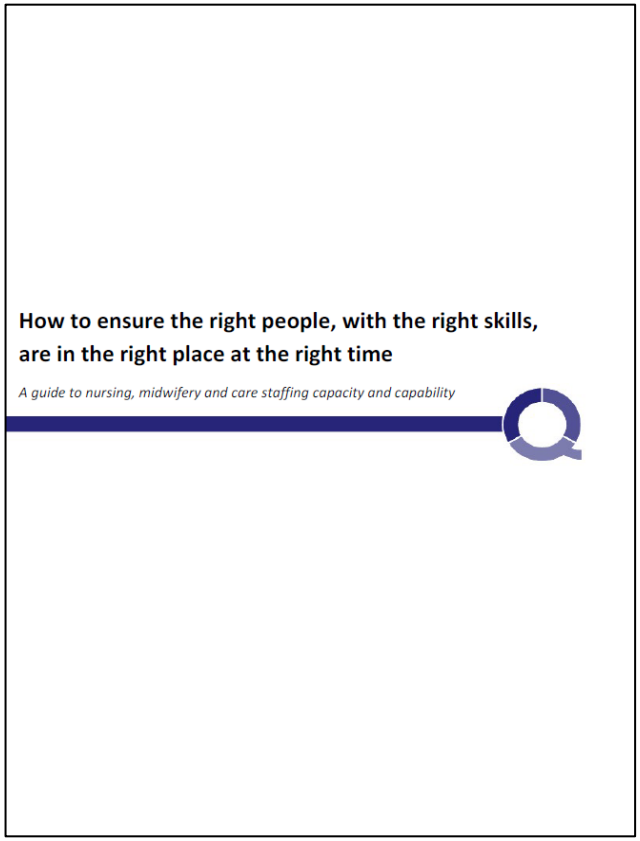


Action Area 5:
'ensuring we have the right staff, with the right skills in the right place'

Workforce Planning Tools

- Safer Nursing Care Tool Guidance and Multipliers updated in July 2013. Available at: http://shelfordgroup.org/resource/chief-nurses/safety-nursing-care-tool
- Safer Nursing Care Tool for Acute Admission Units launched May 2014. Available at: http://shelfordgroup.org/resource/chief-nurses/aau-safer-nursing-care-tool
- Work in progress to develop Safer Nursing Care Tool for Children's In-Patient Wards / A&E / Elderly Care
- IPAD-APP in development to record SNCT acuity and dependency scores at the bedside and generate local reports – proof of concept stage
- Birthrate Plus - RCM published updated guidance in autumn 2013
- QNI have undertaken a review of existing tools for District Nursing
- Staffing in Mental Health Guidance in draft – publication imminent
- Literature review undertaken – currently consulting on themes relating to safe staffing in LD care

National Quality Board Guidance



Available at:
http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

Good Practice Guidance

National Quality Board guidance published on 19/11/13

Includes ten expectations and twenty case studies

Six themes –

- Accountability and responsibility
- Evidence-based decision making
- Supporting and fostering a professional environment
- Openness and transparency
- Planning for future workforce requirements
- Role of commissioning

Work in progress with CQC regarding the monitoring of implementation of the expectations

Accountability and Responsibility

1. Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability.
2. Processes are in place to enable staffing establishments to be met on a shift-to-shift basis.

Evidence-Based Decision Making

3. Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability.

Supporting and Fostering a Professional Environment

4. Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.
5. A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments.
6. Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.

Openness and Transparency

7. Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.
8. NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.

Planning for Future Workforce Requirements

9. Providers of NHS services take an active role in securing staff in line with their workforce requirements.

The Role of Commissioning

10. Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.

Hard Truths

Department of Health response to the Francis Inquiry Hard Truths. The Journey to Putting Patients First; includes the requirement for that:

'from April 2014, and by June 2014 at the latest, NHS Trusts will publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery staffing will be published every month; and every six months Trust boards will be required to undertake a detailed review of staffing using evidence based tools'.

First published 24th June 2014 and monthly thereafter

NICE Guidelines on Safe Staffing

- Francis Report and Berwick Review identified role for NICE
- NICE will produce evidence-based guidelines on cost-effective safe staffing levels for the NHS
- NICE will quality assure any associated practical tools to support safe staffing
- 1st topic focussed on nursing staff in adult wards in acute settings

NICE Guidelines on Safe Staffing

http://www.nice.org.uk/guidance/SG1/chapter/introduction

http://www.nice.org.uk/guidance/sg1/resources/sg1-safe-staffing-for-nursing-in-adult-inpatient-wards-in-acute-hospitals10

Final guidelines were published 15 July 2014.

From August 2014 NICE will publish guidance on safer staffing levels for:

- Accident and Emergency units
- Maternity units
- Acute in-patient paediatric and neonatal wards
- Learning Disability in-patient units
- Learning Disabilities in the community
- Community nursing teams
- Mental health in-patient settings
- Mental Health community units

Safer Staffing: Contact Hours Pilot

14 Trusts completed and returned the data

They are:

1. Basildon and Thurrock University Hospitals NHS Foundation Trust
2. Bradford Teaching Hospitals NHS Foundation Trust
3. Central Manchester University Hospitals NHS Foundation Trust
4. Mersey Care NHS Trust
5. Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
6. Salford Royal NHS Foundation Trust
7. Sheffield Teaching Hospitals Foundation Trust
8. The Royal Surrey County Hospital NHS Foundation Trust
9. The Royal Wolverhampton Hospitals NHS Trust
10. University College London Hospitals NHS Foundation Trust
11. University Hospitals Birmingham NHS Foundation Trust
12. University Hospitals Coventry and Warwickshire NHS Trust
13. University Hospital of North Staffordshire
14. Western Sussex Hospitals NHS Foundation Trust

Safer Staffing: Contact Hours Pilot

- Elderly care ward used across all organisations
- Data collected:
  - Day and night at the weekend; and
  - Day and night weekday.

- Initial data demonstrates averages between:
  - 50 – 70% time spent on “direct care”;
  - 25 -35% on “indirect care”; and
  - 10 – 15% on “non-patient care”.

- Both “Direct” (e.g. hygiene, medication)and “Indirect” (handover, communication with relatives) care are value adding.

Safer Staffing: Contact Hours Pilot

- Aim for guidance to be completed for November 2014
- Key points to be included:
  - Clear indication that it can be used as a tool to inform the 6 monthly review of staffing requirements;
  - Supported by staff who undertook the review;
  - Contribution to patient care by others should be recognised; and
  - Impact of other factors on ability to deliver care.
  - Ability for CQC to test principles within regulatory regime
- Align with key stakeholders
- Currently aligning results with the Safer Nursing Care Tool database consisting of 100+ wards across England.

Next Steps

- Developing indicators for staffing standard include collaborative working with:
  - Providers
  - TDA
  - NICE
  - CQC

- Shadow reporting

  - January – March

- Go live, Spring 2015

Ruth May

Regional Chief Nurse

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Follow me on twitter
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NICE Guidance

- Val Moore

  Guidelines Implementation Programme Director

  National Institute for Health & Care Excellence

  @valmooreatpb

NICE National Institute for Health and Care Excellence

NICE guidelines on safe staffing

Val Moore, Guidelines Implementation Programme Director

To cover

- NICE's approach and guidance development process
- Newly published guidance on safe staffing of adult wards in acute hospitals
- Feedback so far from the field

Safe staffing guidance for the following settings

:

- adult inpatient wards in acute hospitals –July 2014
- maternity settings – January 2015
- accident and emergency settings – May 2015
- acute in-patient paediatric and neonatal wards
- mental health in-patient settings
- learning disabilities in-patient setting
- mental health community setting
- learning disabilities in the community
- community nursing care settings

Process overview

Key stages of guideline development:

- Independent Safe Staffing Advisory Committee
- Evidence reviews
- Economic modelling
- Consultation and testing

Endorsement of tools:

- Separate process

What the NICE guideline on safe staffing on adult inpatient wards in acute hospitals will do for you

Board procedures

Approaches for **registered nurses** to determine their ward's nursing staff requirements

A practical guide for **senior nurses** to set ward nursing staff establishments

Lists **'red flag events'** which indicate an immediate need for additional staff

Methods for **nursing managers/Matrons** to monitor and evaluate that wards are adequately staffed for patients' needs

General approach

Organisational & managerial factors

Staff factors

Patient factors

Environment factors

Ward/unit staffing requirement

Safe nursing indicators

'Red flags'

General approach

Patient factors

Staff factors

Environment factors

Activity relates to patient needs

Ongoing requirements:

- **Routine**, eg simple conditions, minimal assistance required
- **Additional needs** (20-30mins per activity), eg iv medication
- **Significant care needs** (>30 mins per activity), eg parenteral nutrition
- **1 to 1 care**, eg constant monitoring

Key messages from the new guidance include…

Safe nursing indicators

- **Patient reported:**
  - Meeting patients' nursing care needs
  - Provided pain relief
  - Communication with nursing team
- **Safety outcomes:**
  - Falls
  - Hospital acquired pressure ulcers
  - Medication errors

- **Staff reported:**
  - Missed breaks
  - Nursing overtime
- **Nursing staff establishment:**
  - Planned, required and available staff
  - Temporary or agency staff ('Hard truths')

‘Red flag’ alerts

To enable ward staff to indicate an immediate need for additional staff, e.g.

- Any unplanned omission or delay in providing patient medication
- Any patient vital signs not assessed as ordered
- ‘intentional rounding’ not completed as ordered
- Less than 2 registered nurses present

Safety outcomes and nursing care

Few if any safety outcomes relate primarily to nursing care, but few if any safety outcomes are not at least partly influenced by nursing care

Which are linked?

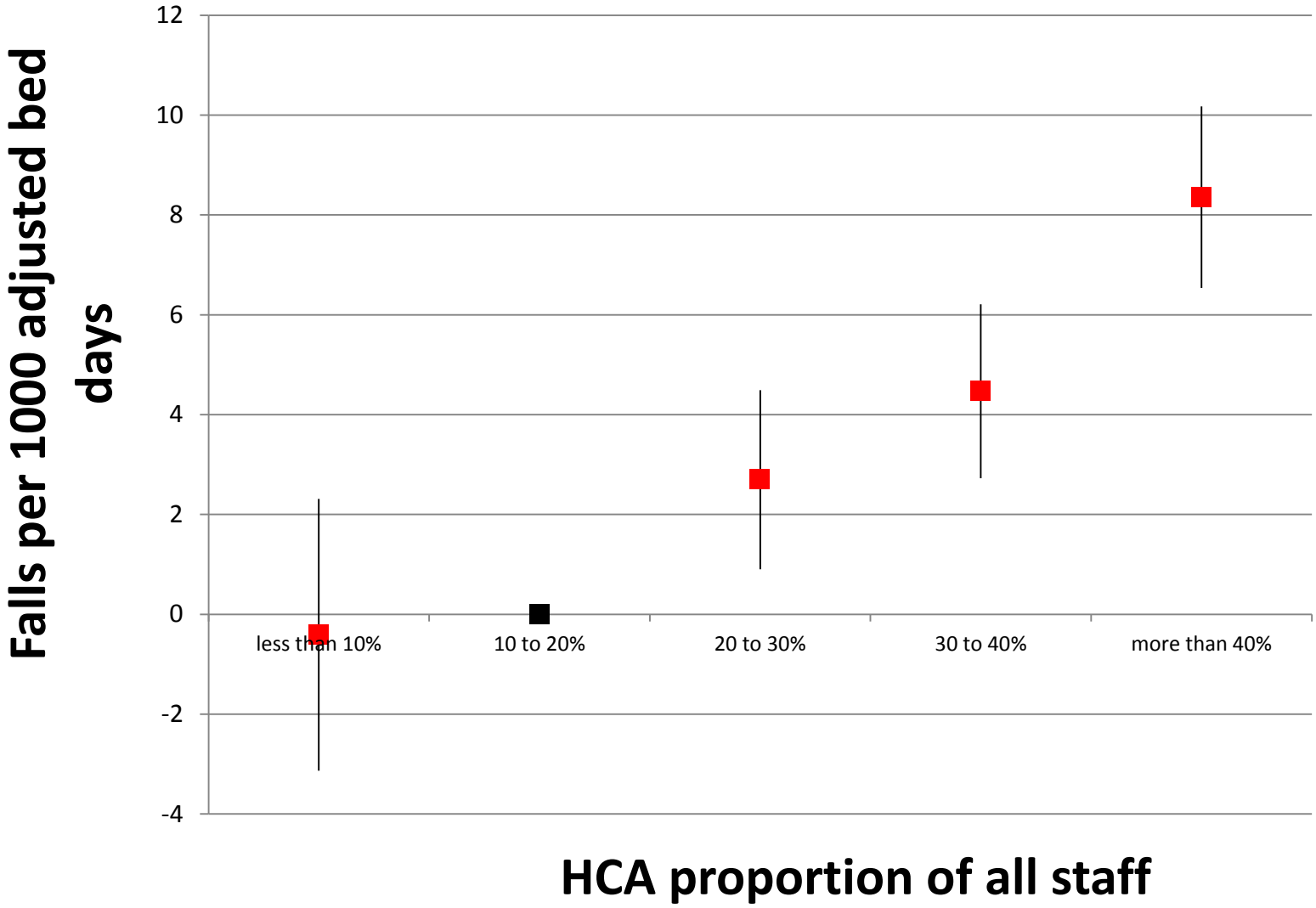
- Pressure ulcers?
- Falls?
- Healthcare associated infection?
- Medication administration error?
- Venous thromboembolism?
- Deterioration not recognised?
- Failed discharge?
- Diagnostic error?

Falls: what the evidence shows

- The following variables increase fall rate:
  - Medical wards
  - Larger wards
  - Bays
  - Patient turnover

- The following variables decrease fall rate:
  - Higher proportions of RNs

Skill mix and falls



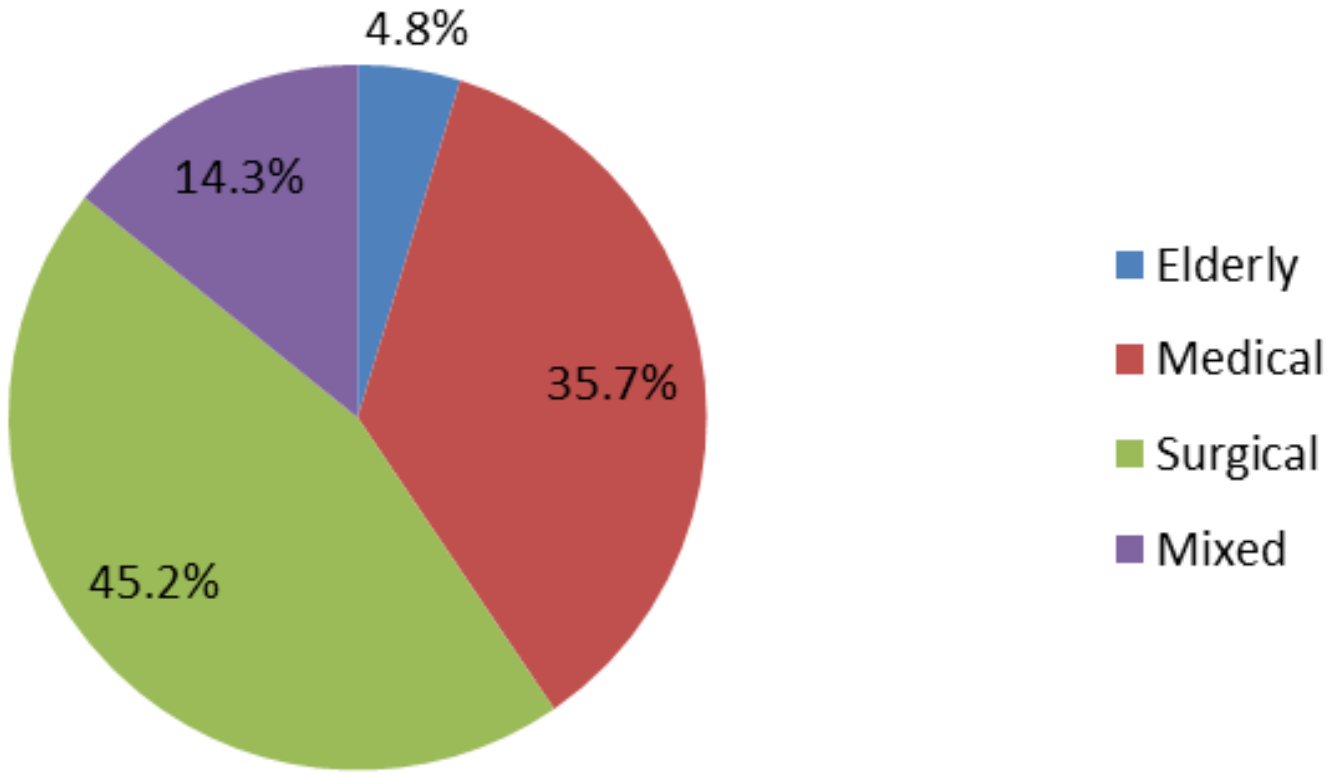
Hierarchy of activities left undone

Because of lack of time

	% left undone (all cases)	Pts/RN (day) Left undone (all)	Pts/RN (day) Not left undone (all)	% of those who left at least one task undone
5. Comfort/talk with patients	66			76
6. Educating patients and family	52			61
11. Develop or update nursing care plans/care pathways	46			54
1. Adequate patient surveillance	34			40
10. Adequately document nursing care	33			39
3. Oral hygiene	28			33
13. Frequent changing of patient position	28			33
12. Planning care	27			32
8. Administer medications on time	22			26
2. Skin care	21			24
9. Prepare patients and families for discharge	20			23
7. Treatments and procedures	11			13
4. Pain management	7			8

Source: KCL RN4CAST Survey 2012

Field testing ward types (n=94). Feedback on professional judgement and acuity scores from the SNCT



Public consultation themes

46 orgs commented – plus from individuals

- Issues raised include:
  - Guideline vs a tool
  - The wider workforce
  - Student nurses and specials
  - Establishment vs immediate requirements
  - *Use of nursing hours per patient day – tables popular*
  - *1 to 8 ratio*
  - *Registered nurses and HCAs*
  - *Outcomes and red flags*

The minimum ratio question

- The guideline recommends tailoring staffing requirements to patients' needs on the ward.
- It states: *"There is no single nursing staff-to-patient ratio that can be applied across all acute adult inpatient wards. However, take into account that there is evidence of increased risk of harm associated with a registered nurse caring for more than 8 patients during the day shifts….*

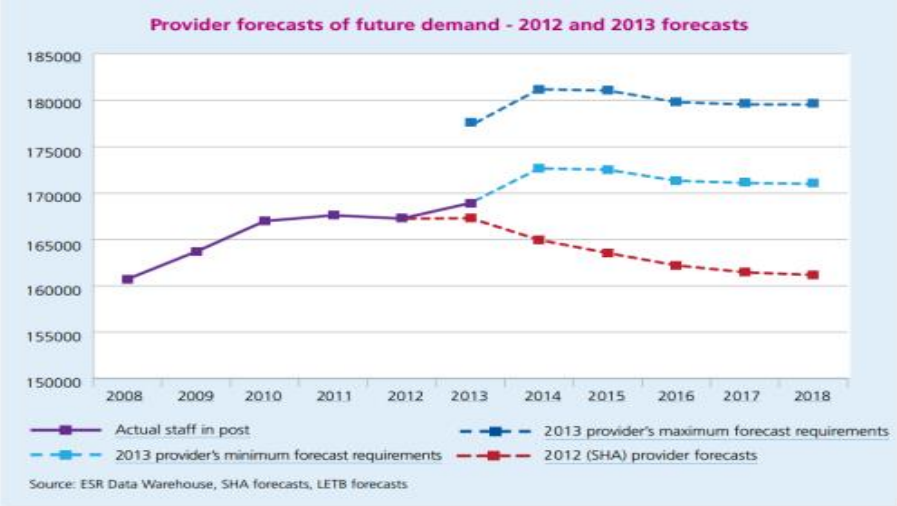
  - closely monitor nursing red flag events

  - perform early analysis of safe nursing indicator results

  - take action to ensure staffing is adequate to meet patients' needs"

Assessing the impact

- How many registered nurses (FTE) are currently employed in adult inpatient wards in acute hospitals?
- How is this figure likely to change in the future?
- Cost impact?
- Potential benefits?



Costs and implementation

These guidelines will help hospitals deliver high quality care that meets patients' needs

Safer care costs less in the long run

The guidance is well received – you are already doing much of this

Shared learning on implementation

"I think it's user-friendly, I think it encompasses what nursing care is about because it breaks down activities of daily living and includes the extra things we do on the ward"

Senior Sister

"None of it told us anything new which was the disappointing part"

Senior Nurse

"I think that it's a very important document NICE has given out from a nursing point of view"

Registered Nurse

"It was really good to look at all the evidence and research in one place and for that to have been done for us; so yes that was really valuable and to have some dialogue around that …really useful"

Matron

Endorsing published tools

- Assess whether decision support toolkits are in line with NICE recommendations
- Focus on content of the tool
- Field-testing assessment for topic 1 to compare the guideline and the SNCT tool
- Future process will involve external expert opinion and internal assessment a agreed criteria
- Open application process

Summary

- First of a number of NICE guideline in safe staffing
- Challenges relate to lack of evidence and data
- Likely to be associated costs and savings
- Prioritising nurse staffing is only one element – work on whole team staffing models also required
- **Aim is to ensure safe care for patients – not just a focus on numbers**

Refreshments & Networking

Nursing Return to Practice

- Janice Stevens

  Managing Director

  Health Education West Midlands

   @stevens_jan

Developing people for health and healthcare

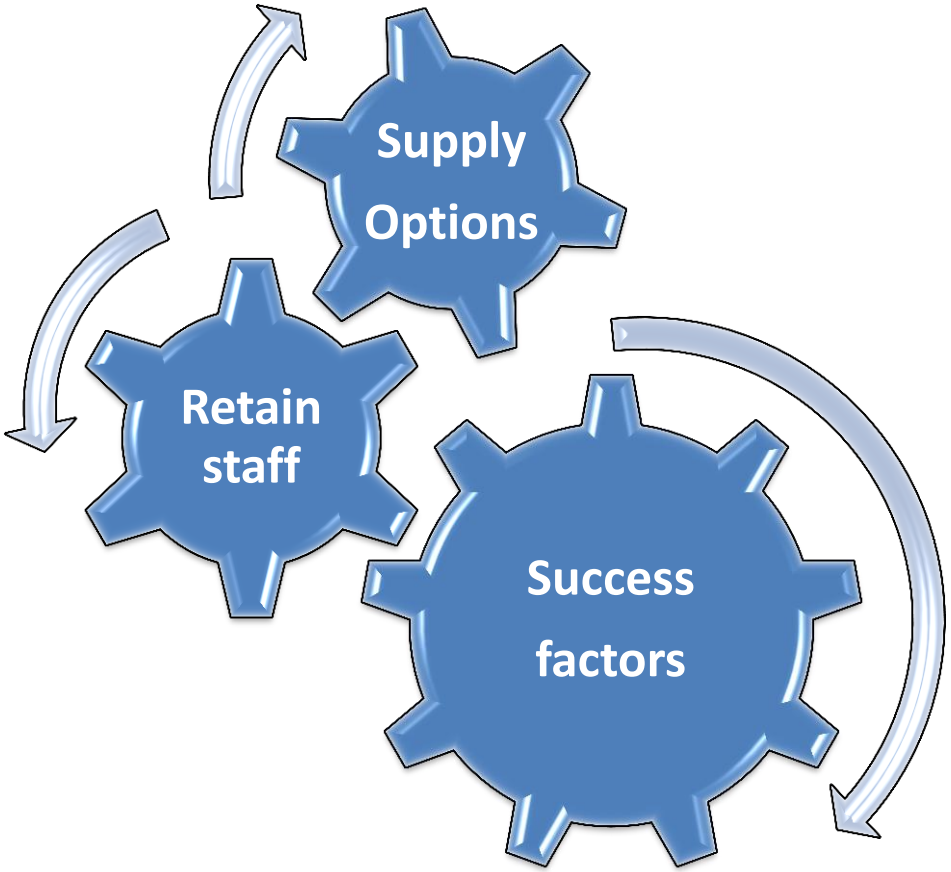
Growing our nursing numbers..

Janice Stevens CBE

NHS
Health Education England

Growing & maintaining our nursing workforce

Health Education England



Why Nurses leave

Health Education England

international literature review identified

- Pay and the cost of living
- The changing nature of the job
- Not feeling valued
- Employment opportunities
- Flexibility of working patterns
- Stress and burnout

Action

NHS Employers producing good practice examples of addressing issues

- What is your attrition
- Where, when, why
- What action are you taking
  - Flexible working
  - Supervision
  - Appraisal & PDP

Supply Options

Health Education England

Health Education England

International Recruitment

- NMC Changes - beyond EU
- NHS Employers – good ethical recruitment practices
- EURES
  - Pilot in West Midlands
  - Recruitment in EU countries without using an Agency

Back to nursing
Understanding the challenges

Health Education England

- Stakeholder Engagement has been integral to the programme and we have significant commitment from key partners across the Country.

- We have undertaken the following:

  - Focus Groups to inform phase 1 review
  - West Midlands evening forum – February 2014
  - Launched at HEE Conference – 15 May 2014
  - Growing Nursing Numbers Call to Action Events – Leeds 16 June 2014, London 24 June 2014
  - All LETBs visited in June/July 2014 by programme leads
  - West Midlands Placement and Preceptorship event – 11 July 2014
  - Regular teleconferences and communication with LETB RTP Leads.

Understanding the Challenges

Health Education England

- Nursing Return to Practice: Review of the current landscape
- Growing Nursing Numbers: Literature review on nurses leaving the NHS
- Principles of Growing Nursing Numbers: Slide Deck
- NHS Qualified Nurse Supply and Demand Survey - Report produced for the Health Education England Nursing Supply Steering Group

The literature highlighted RTP Myths

Health Education England

- RTP nurses left due to poor performance issues
- RTP nurses all want to work part-time and won’t be flexible around shifts
- RTP nurses require more support from Trusts
- RTP nurses can't cope with the 'new NHS', the faster pace, higher level of decision making, sicker patients
- RTP nurses often leave after completing the course

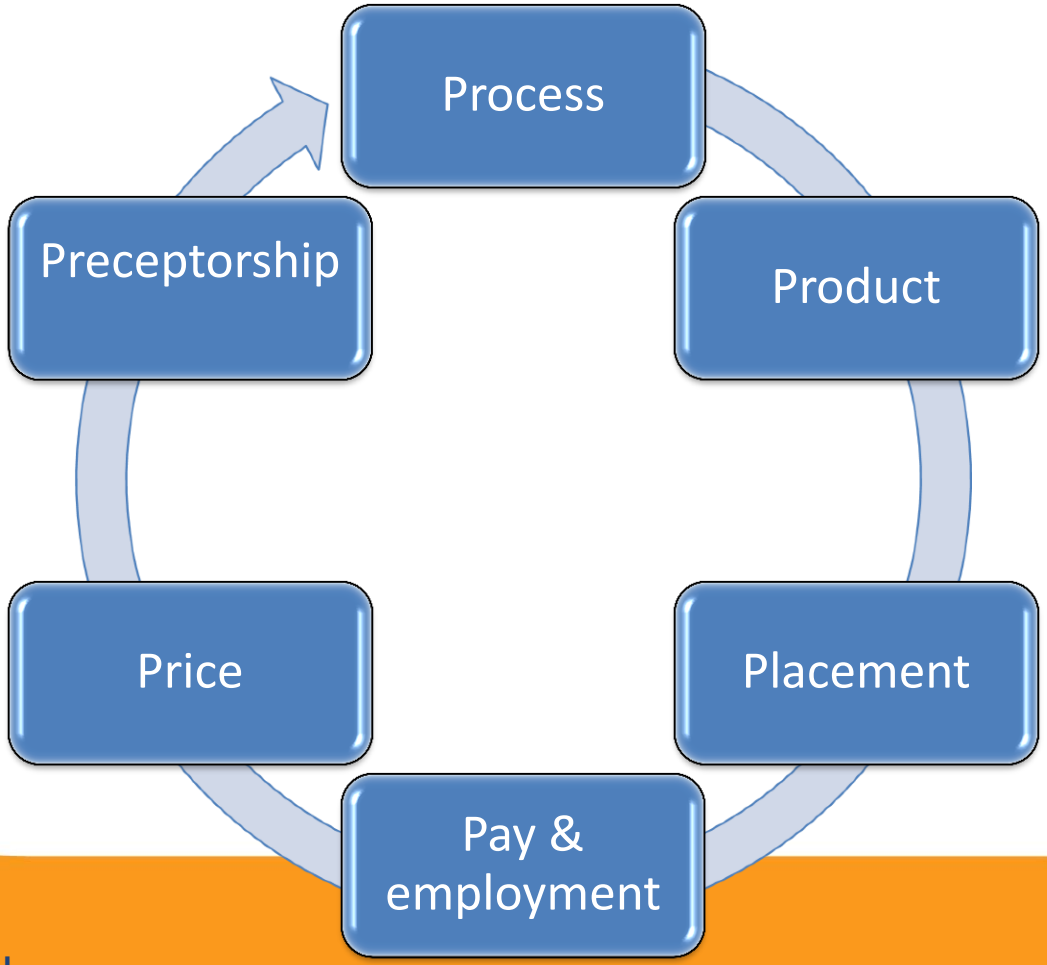
Benefits of RTP

Health Education England

- Low attrition rates
- Local nurses wanting employment with their clinical placement provider at the end of the course
- Often nurses with many years of previous experience
- Often more mature nurses who bring wider experiences
- Unlikely to go on career break, and more likely to work until retirement
- More cost effective than training a nurse from scratch

6 P's

Health Education England



Health Education England

Come Back Campaign

come back

come back to your career

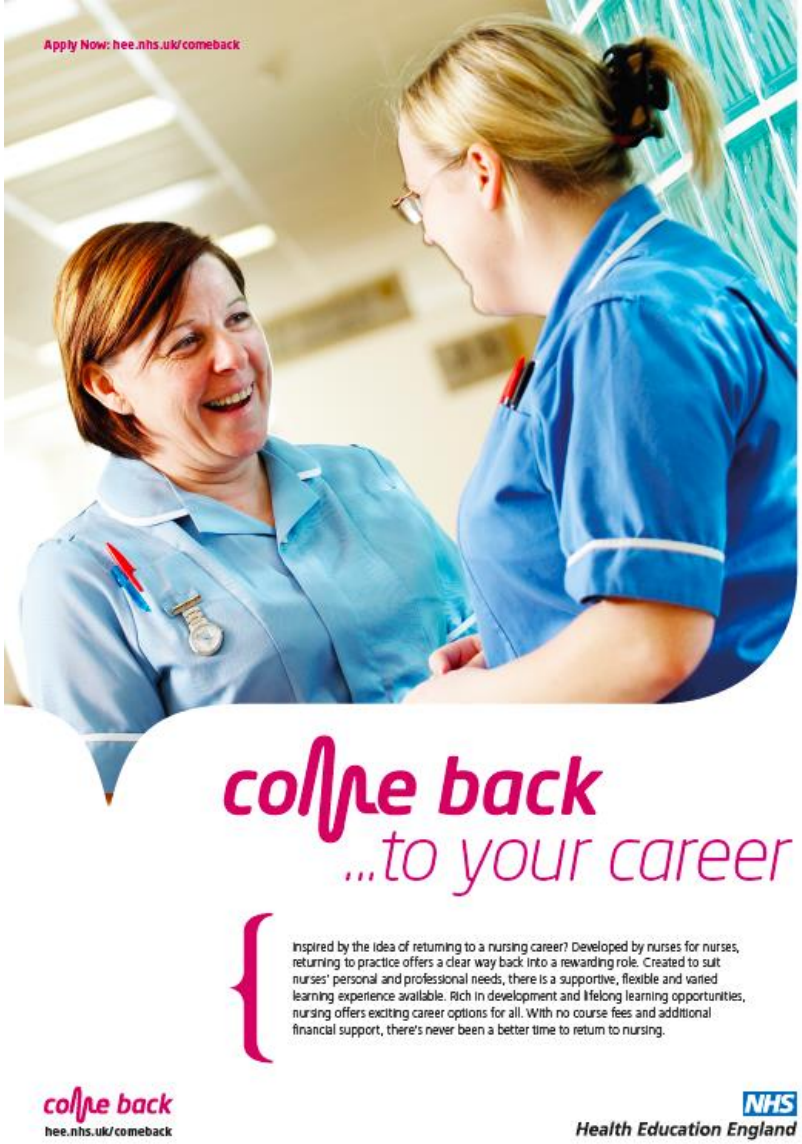
come back to care

come back to nursing

www.hee.nhs.uk

The Campaign….

- Driven by social media
- Designed by nurses, for nurses
- Successful stories leading campaign
- Campaign toolkit ready for 24th
  - Videos, posters, web banners etc
- Launch 29th September



Web pages…

www.hee.nhs.uk

Contacts and Further Information

Health Education England

- All papers available at:

http://hee.nhs.uk/work-programmes/nurse-return-to-practice/

- Self assessment toolkit available at:

http://learning.wm.hee.nhs.uk/resources/rtp

- NMC overseas guidance:

http://www.nmc-uk.org/Documents/Registration/Information%20for%20applicants%20-%20overseas%202014.pdf

- The campaign will be found (from 29 September) at:

http://hee.nhs.uk/comeback

Alison Pope, **Programme lead** 0121 695 2381, Alison.Pope@wm.hee.nhs.uk

Revalidation

- Jon Billings

  Director of Strategy

  Nursing & Midwifery Council

  @BillingsJon

Revalidation: The story so far

Jon Billings, Director of Strategy

23rd September 2014

Revalidation

- Proposed model for revalidation
- Consultation process, current status and key messages to date
- Plans for testing and implementation
- Timescales for all of the above

Basis for Revalidation

- The revalidation model has been developed in line with our current legislative framework;
- Revalidation will be built on the existing 3 year renewal cycle;
- Nurses and midwives will continue to be required to complete 450 practice hours;
- Nurses and Midwives will need to complete the required CPD.

The revalidation model

A nurse or midwife will be required to declare they have:

- practised for 450 hours during the last three years;
- followed requirements on continuing professional development (CPD);
- obtained confirmation from a third party about the reliability of the their declaration and (based on information available) the absence of unaddressed concerns about fitness to practise; based on local appraisal processes
- demonstrated that they are using practice related feedback to reflect on their practice;
- Selective audit to drive engagement and understand risk.

Consultation Part one

Online survey (January to March) on the revalidation model and the Code:

- Focused on operational aspects of the model, gathering intelligence on how it will work across all settings;
- and gauged initial views on the content of the revised Code;
- Outcomes informed draft revised Code and revalidation development;
- Promoted through NMC and stakeholder communication channels;
- Supported by extensive stakeholder engagement.

Consultation part 1

Confirmation and appraisal

- Majority prefer a NMC registered nurse/midwife who is overseeing their work to confirm;
- Where not managed by a registrant, support also for addition of a peer registered nurse/midwife who has worked alongside them, another UK regulated health professional who has insight into their practice;
- Almost all respondents said they receive an appraisal with a majority feeling it is the best way of obtaining confirmation.

Consultation part 1

Third party feedback

- Strong support for peers (registered nurses/midwives), patients and service users and other colleagues
- Also support for relatives and carers

Continuing professional development (CPD)

- Clear support for certificates and work-based scenarios (reflective accounts) as evidence

Consultation part two

- Started 19 May and closed 11 August 2014;
- Considered draft revised Code and revalidation;
- Consisted of an online consultation survey and qualitative consultative methods, including deliberative workshops, focus groups and online forums with:
    - nurses and midwives
    - patients and the public
    - seldom heard groups

Consultation Outcomes: The Code

The draft revised Code has generated considerable debate. Key issues include:

- Application: ensuring it addresses all scopes of practice, not just direct patient care roles.
- Tone: including positive language to support the professionalism agenda
- Length/relevance: enabling registrants to use the Code to revalidate against their own practice so they don't attempt to apply aspects which don't relate to their scope of practice.

Early Implementer Draft Plan

Launch: early 2015

Purpose: test the process, testing the tools, testing the model and engaging employers

Outcomes: will inform the model, guidance, supporting information and NMC/employer systems and processes

Proposed timescales

December 2014: publication of revised Code

January 2015: publication of draft guidance for revalidation

Spring/Summer 2015: revalidation – pilot and testing

Autumn 2015: Council decision on model and roll out

End of 2015: revalidation launch

Nursing & Midwifery Council

Thank you

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Twitter #revalidation

Workshops

Capsticks

- Jacqui Atkinson
  Partner
  Capsticks

- Joanne Burrows
  Lawyer
  Capsticks

Capsticks
The Healthcare Business Inside Out

Duty of Candour

NHS Employers: Sustaining a Safe and Quality Workforce

Jacqui Atkinson, Partner

23 September 2014

Themes for today

1. Current sources of the duty of candour
    1. Background
    2. Contractual duties
    3. Current legal obligations
    4. Professional obligations
    5. Guidance and other sources
2. Forthcoming changes

    The Care Act/Statutory Duty of Candour
3. Dealing with conflicts regarding the Duty of Candour

Current sources of the duty of candour

Duty of Candour – Background
What is candour?

- Francis:

"The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

Current sources
Contractual duty of candour (1)

- Service condition 35 – duty to provide information verbally and in writing within set timeframes where moderate or severe harm or death has occurred
- **Inform within (at most) 10 working days of the incident reported on local systems**
- **Initial notification must be verbal**
- **An apology must be given**
- **An explanation must be offered**

Current sources
Contractual duty of candour (2)

- **Tip**: keep documentation ‘factual’. If staff are preparing reports, they should avoid speculation and keep to the facts. Write with an expectation that someone else will see it and that you will have to justify what you have written!
- See 2014/15 NHS Standard Contract Updated Technical Guidance from NHS England.

Current sources
Contractual obligations (3)

- There are a range of actions available to commissioners where a provider breaches the contractual requirement:
  - requiring a direct written apology and explanation for the breach to the individual(s) affected from the provider's chief executive;
  - publication of the fact of a breach prominently on the provider's website;
  - notification to CQC by the commissioner.
- nationally set consequence - recovery of the cost of the episode of care or £10,000 if the cost of the episode of care is unknown.

Current sources
Legal obligations (1)

- Care Quality Commission 2009 Regulations
  - requirement to notify the CQC of the death of a service user or of allegations of patient injury or abuse.
  - obligation on every NHS trust to send to the CQC, if requested, a summary of complaints and responses.
- Monitor
  - may require any NHS healthcare provider to submit information it considers necessary for its regulatory functions.
  - licences contain two general conditions governing the provision and publication of information by licensees. (General Conditions 1 and 2).

Current sources
Legal obligations (2)

- Requirements under HSE legislation – “RIDDOR” to report to HSE certain deaths, injuries and dangerous occurrences.
- Further obligations to provide under information law requirements and as part of disclosure in legal proceedings

Current sources Professional obligations

- GMC and NMC have explicit requirements in their professional codes for candour if a patient suffers harm.
  - GMC – Good Medical Practice (Updated 2014) – para 55
  - NMC – Code – para 54-5
  - HCPC – Standards – obligation 2.

Current sources
Guidance and standards

- NHS Constitution:

"The NHS … commits … when mistakes happen, to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively."

- *Being Open* policy and guidance
- NHSLA guidance *"Apologies and Explanations"*
- NHSLA has never declined cover where an apology has been given.

Forthcoming changes

(1) The Care Act 2014

- Given Royal Assent 14 May 2014
- Places a specific duty on the Government to include a Duty of Candour on providers registered with the Care Quality Commission (under clause 81).

(2) The Statutory Duty of Candour

- Proposed addition to the requirements for registration with the Care Quality Commission (CQC) in order to introduce a statutory Duty of Candour on all providers registered with the CQC.
- Public consultation on Duty of Candour Regulations closed on 25 April and public consultation on CQC guidance closed on 5 September 2014
- Subject to any changes arising from public consultation, draft regulations envisage commencement date of 1 October 2014 for statutory Duty of Candour
- Overseen by CQC

(2) Statutory Duty of Candour Envisaged regulations

- Envisaged to apply to any unintended or unexpected incident that occurs in respect of a service user during the provision of services, or is suspected to have occurred, in respect of a service user that could/appears to have resulted (in the reasonable opinion of a healthcare professional) in moderate or severe harm or death (i.e. notifiable safety incidents).
- Underpinning guidance from the CQC sets out what providers could do to meet the requirements in the Regulations (draft)
  - **Moderate harm:**

    (a) a moderate increase in treatment ("*a return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care)*");

    (b) significant, but not permanent, harm, or

    (c) prolonged psychological harm (28 days +); ;

(2) Statutory Duty of Candour Envisaged regulations

- **Severe harm:** permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage related directly to the incident (and not a natural cause of the service user's illness or underlying condition)

(2) Statutory Duty of Candour Envisaged regulations

- Providers (and registered managers from 2015) will be required:
- to act in an open and transparent way with service users and their representatives, as regards care and treatment (generally); and
- as soon as reasonably practicable after becoming aware of a notifiable incident, to:
  - notify the service user (or someone lawfully acting on their behalf) that the incident has occurred. This notification must include an apology ("expression of sorrow or regret" in respect of the incident) and must be in person by a representative of the health service body;
  - provide a truthful account of all the facts known as at the date of the notification

(2) Statutory Duty of Candour Envisaged regulations

- provide all information directly relevant to the incident;
- advise and if possible agree with the service user what further enquiries are appropriate;
- provide reasonable support to the service user;
- follow the personal notification with a written notification informing the service user of the original notification, enquiries undertaken and the results of any further enquiries along with an apology;
- keep a written record of all meetings and correspondence with the service user;
- if a service user doesn't want to correspond/meet with the Trust, keep a record of attempts to contact/speak to them.

(3) Statutory duty of Candour Envisaged Regulations

- Offence for Trust to fail to comply with duty of candour – fine if convicted (£2,500) on provider even if breach is by a member of staff
- Triggers:
  - failure to be open and transparent
  - not quick enough notification to service user; or
  - notification does not cover requirements in regulation 3;
- Defence if can prove that they took all appropriate steps and exercised all due diligence to ensure that the provision in question was complied with.

(4) Statutory Duty of Candour
CQC Draft Guidance

- Must have regard to guidance issued by CQC regarding duty of candour (the final version of this guidance has not yet been published)
- CQC can move directly to prosecution without a warning notice if non-compliance
- Trust must be able to demonstrate that it has systems in place to know about notifiable safety incidents

(4) Statutory Duty of Candour
CQC Draft Guidance

- Where the Trust becomes aware that staff have not acted in accordance with the requirements placed on them by the duty, the Trust must refer individuals concerned to their regulator/body, police etc
- It is important to keep the service user up to date on any developments
- If Trust staff identify that a notifiable safety incident occurred at a different provider – the Trust must work with the other provider to identify who is best placed to notify the service user and ensure this happens.

(5) Statutory Duty of Candour
What to do now

- Ensure you have in place robust and easy to use processes and systems to ensure openness and transparency with service users
- Check policies and update them/write them if not in place already
- The duty applies to organisations but it is expected that to enable the organisation to meet its duties, staff will need to be appropriately trained

(5) Statutory Duty of Candour
What to do now

- Individual regulatory bodies are updating their guidance to members – ensure you know what they say
- Ensure senior staff are comfortable in apologising for incidents
- Ensure full records of implementation are kept and regular audits of compliance take place
- MUST show learning from incidents where the duty applies.

Dealing with conflicts regarding candour

Conflicts between Duty of Candour and investigations

- NHSLA will not decline cover where an apology has been made
- A factual account is not an admission of liability
- Engage with policy leads at commercial insurers now – obtain clarity on what would constitute an admission which may void the policy.
- Liaise further with NHSLA

Q&A and Thank you!

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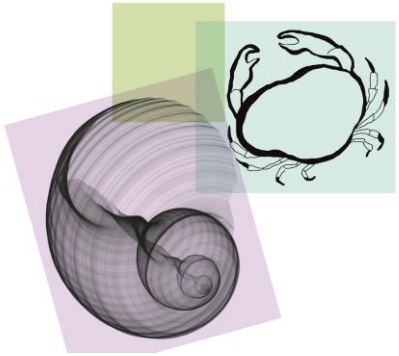

Fit and Proper Person Test

NHS Employers: Sustaining a safe and quality workforce

Joanna Burrows, Lawyer

23 September 2014

Themes for today

- Background
- New requirements
- New Regulations
- Grounds for Unfitness
- Monitor Licence Conditions
- Draft CQC Guidance
- Points to consider

Background

- Francis Inquiry raised concerns about fitness of directors at Mid Staffs Hospital
  - Recommendation 79
- The public has the right to expect that those in leading NHS positions are fit and proper persons
- New registration requirement that all directors of providers registered with the CQC must meet a fit and proper person test

New requirements

- Original aim in force 1 October 2014 but likely to be mid November (presently in draft form)
- Applies to all board level positions - directors and “equivalents”:
  - executive directors
  - non-executive directors
- Chair of Board responsible for ensuring all directors meet the new requirements
- Regulations do not apply to a person if any of the grounds of unfitness apply

New Regulations (1)

- To be a fit and proper person, must meet **all** of the following:
  a) be of good character
  b) have the qualifications, skills and experience necessary for the office or position
  c) Be capable by reason of their health… of properly performing tasks intrinsic to their office or position
  d) not have been responsible for, privy to, contributed to or facilitated any misconduct or mismanagement (whether unlawful or not) in the course of discharging functions relating to their office or position previously
  e) Not be prohibited from holding the office or position

Grounds for Unfitness (1) – Schedule 1 of Regulations

A person will be deemed unfit if:

- within the preceding 5 years has been convicted in the UK of any criminal offence (or elsewhere if committed in the UK would be a criminal offence), and
- been sentenced to a sentence of imprisonment (suspended or not) for a period of not less than 3 months (without the option of a fine), and

on appeal the conviction has not been quashed nor the sentence reduced to a sentence other than a sentence of imprisonment, or sentence of imprisonment of less than 3 months (suspended or not)

(NB. A person deemed unfit on one of the above grounds may apply in writing to the CQC to remove the prohibition)

Grounds for Unfitness (2) – Schedule 1 of Regulations

The person will be deemed unfit if:

- is an undischarged bankrupt
- is subject to bankruptcy restrictions
- has made a composition or arrangement with creditors and has not been discharged in respect of it
- is included in the children's or adults' barred list under Section 2 Safeguarding Vulnerable Groups Act 2006 (and equivalent in Scotland/Northern Ireland).

Monitor Licence Conditions

- Condition G4 – fit and proper persons
  - Trust shall not appoint as a Director any person who is unfit except with the approval in writing of Monitor
  - Trusts will ensure provision in contracts permitting summary termination in event of Director being / becoming unfit person
- Unfit person test:
  - In the preceding 5 years has been convicted of a criminal offence and sentenced to imprisonment of 3 months or more
  - Is an undischarged bankrupt
  - Has made an arrangement/composition with creditors and has not discharged it
  - Subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986
- Similar provisions for "body corporate"

What if an Individual no Longer Meets the Requirements for a Fit and Proper Person?

The Trust must:

- take necessary and proportionate action to ensure the office/position is held by an individual who meets the requirements, and
- inform the relevant regulator (if appropriate)

(Draft CQC Guidance)

CQC Guidance (draft)

- Must make all “reasonable effort” to assure yourself about an individual who would come under the FPPR
- If the Trust allows an “unfit” person to be a director or equivalent, or stay in that role, the CQC may question the Trust’s overall fitness to operate
- No prosecution offence but CQC can take other action if breach, e.g. conditions on licence/remove individual
- Regularly review and audit compliance with these Regulations
- Regularly review fitness of directors or equivalent
- Regulators are informed as necessary

Points to consider

- Set up robust recruitment processes to ensure all relevant individuals are assessed under the new criteria, including those already in place
- Have clear records of all information gathering / decision making
- Consider changes to contracts of employment:
  - Make it a condition of continuing employment that they remain a fit and proper person
- Have a clear process for dealing with interim cover arrangements
- Build into recruitment processes at board level
  - An expectation that Chair or other senior person will personally sign off all board-level appointments
- Have clear process for dealing with any concerns raised
  - whistle-blowing complaints

Q+A and Thank you!

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Workshops

Princess Alexandra Hospital NHS Trust & NHS Professionals

- Anne Challinor
  Director of Client Relations & Business Development
  NHS Professionals

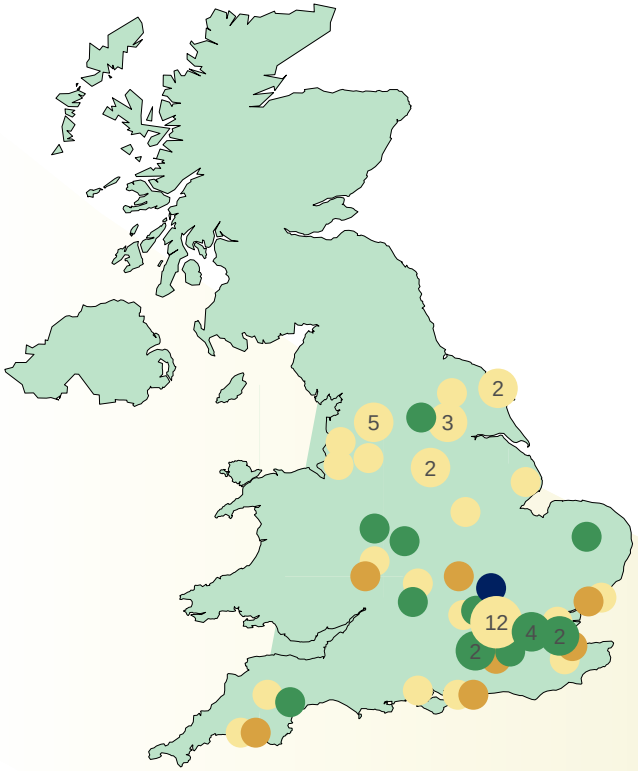
- Anne O'Brien
  Clinical Governance Director
  NHS Professionals

Sustaining a Safe & Quality Workforce

The Princess Alexandra Hospital NHS Trust

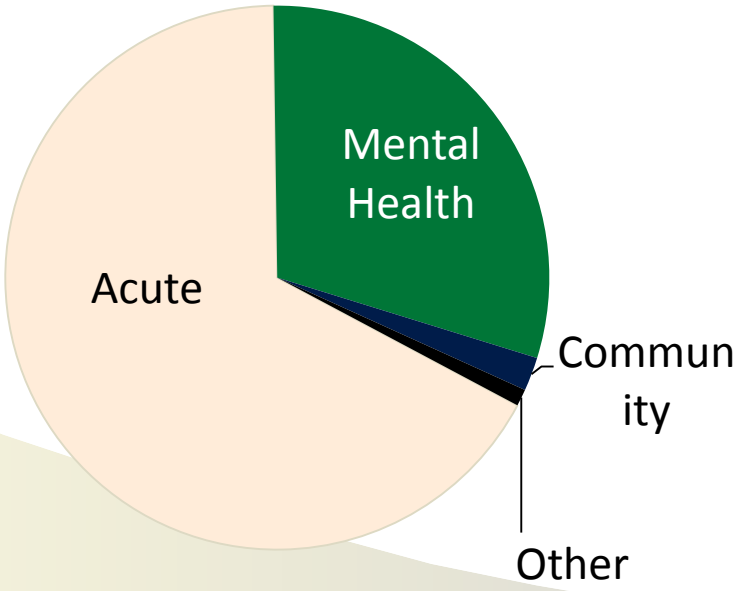
Gloria Barber, Princess Alexandra Hospital, Harlow
Anne Challinor, Client Service Director, NHS Professionals
Anne O'Brien, Clinical Governance Director, NHS Professionals

NHS Professionals – National Coverage



	# of clients*
Acute	39
Mental health	16
Community	7
Other	1
Total	**63**

£370m Revenue (2013/14) by Trust Type

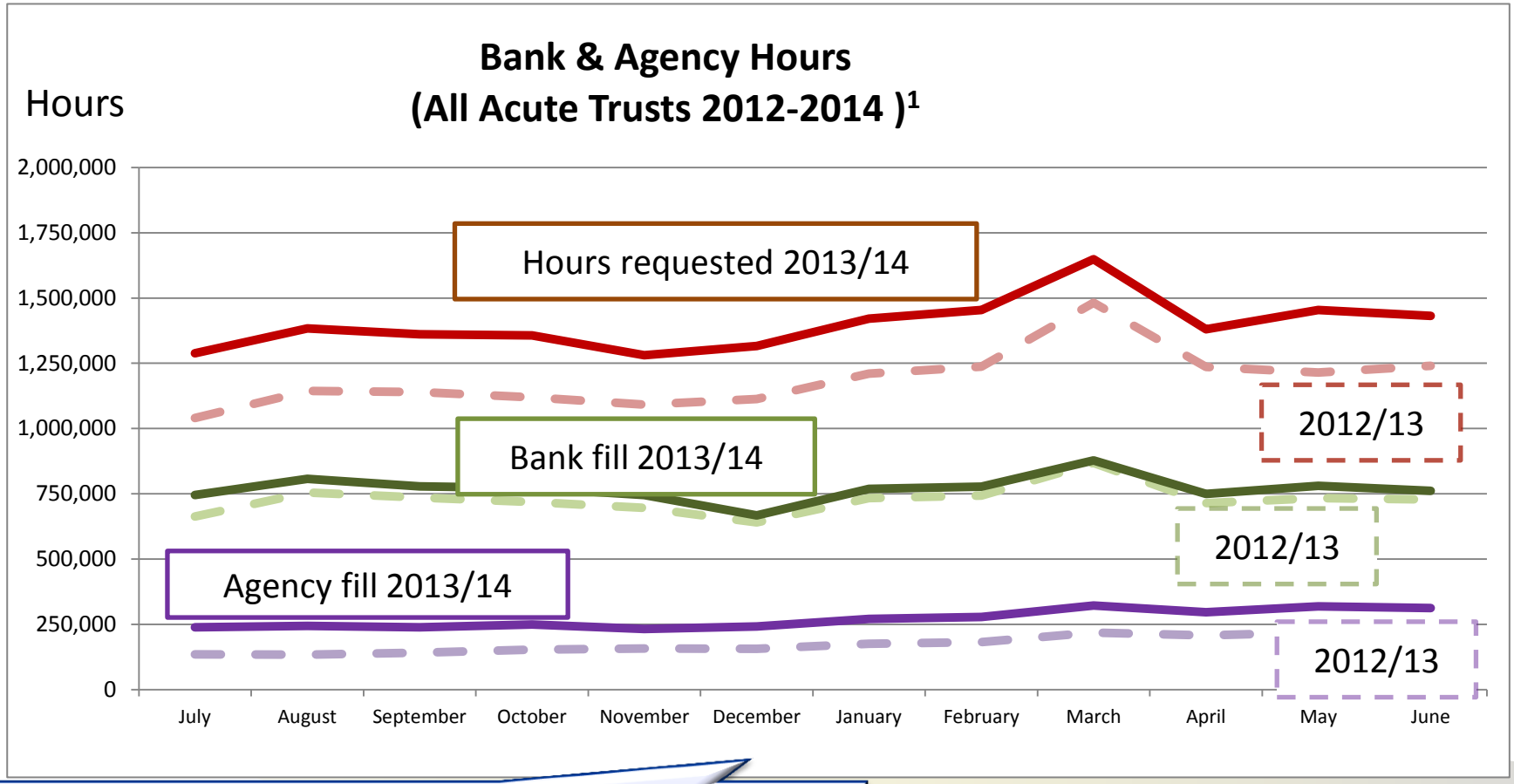


NHS Professionals – Validated Contribution to Cost Savings

Area of Saving	Annual savings made for our existing 60+ clients
Employment On-costs	£20m
Agency tiering and cascade **	£4m
Demand visibility and control **	£82m
Migration of Agency to Bank	£30m
Overtime conversion	£31m
Bank payroll processing	£1m
Agency invoice accuracy **	£4m
Release of internal Bank costs	£18m

- **Includes data based on Industry standard benchmarks from Hackett and NHS Business Services authority

What's happening in the market?

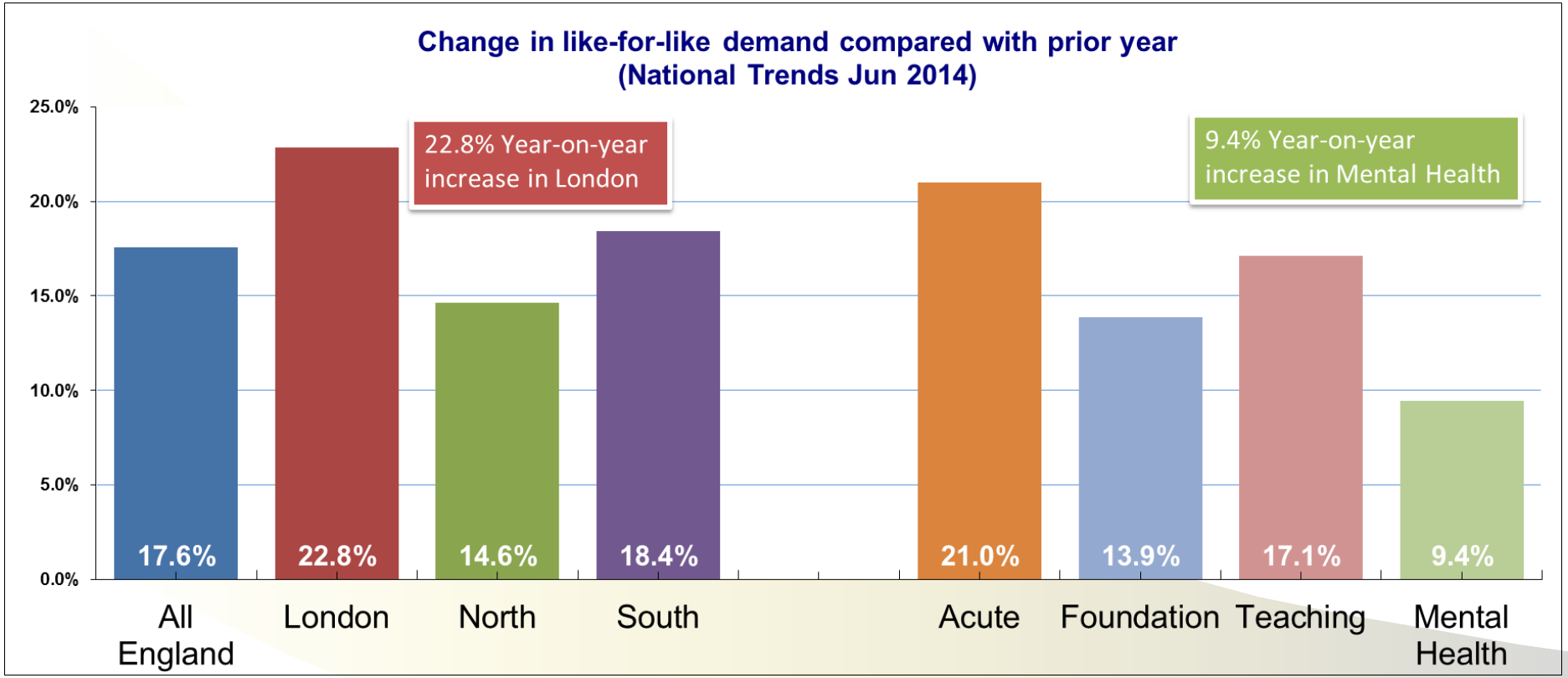


"The CfWI projects that the adult nursing supply is likely to remain largely static while demand for nurses increases by 10%" [2]

1 Source: National Trends: NHS Professionals, 2014

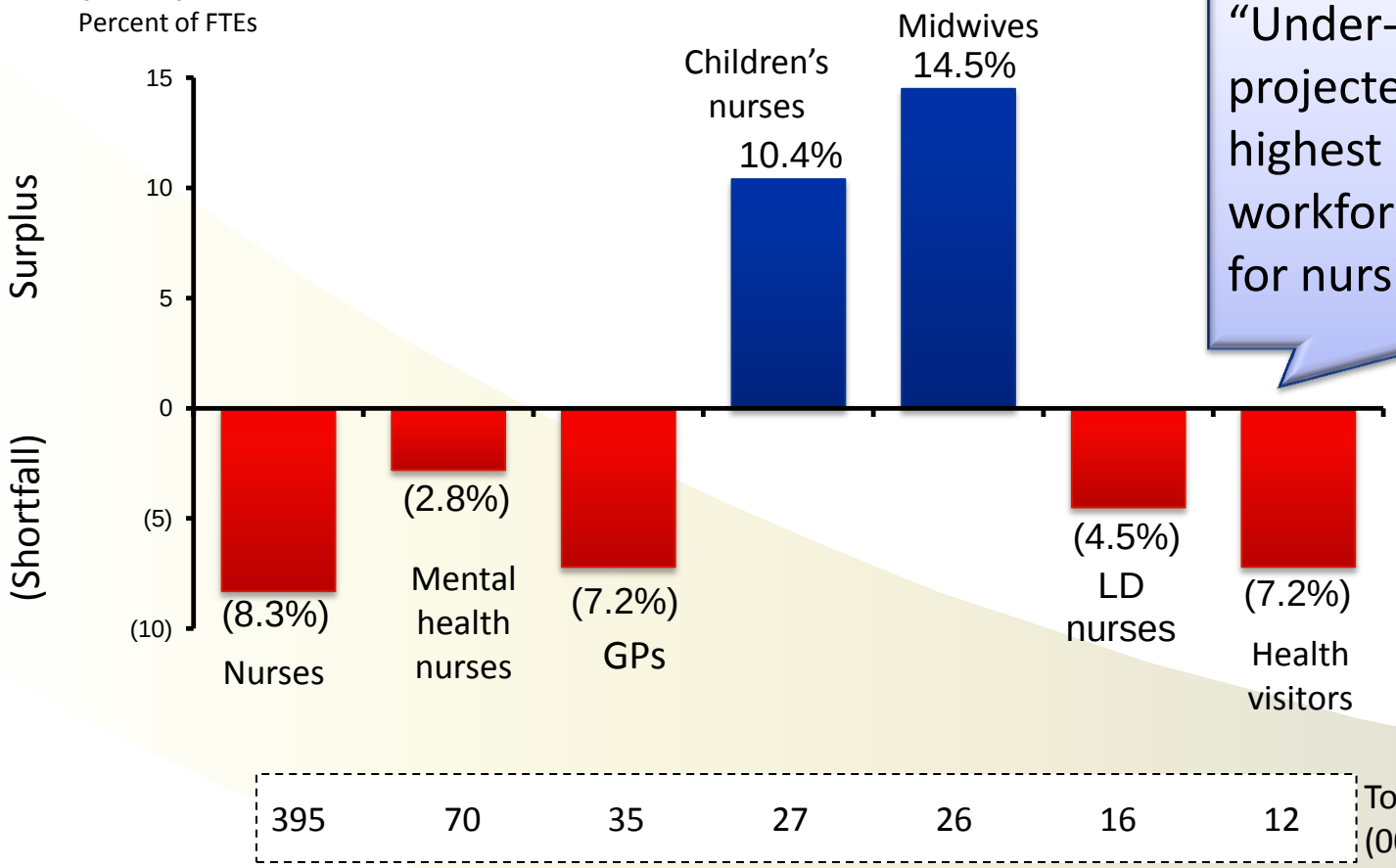
2 Source: Laing & Buisson: Flexible Staffing in Health & Care 2013

Like-for-like growth in demand



Market Dynamics - Supply Constraints

Projected difference in FTE supply and demand (2016)



"Under-supply is projected … and the highest risk of workforce shortages is for nursing staff."[1]

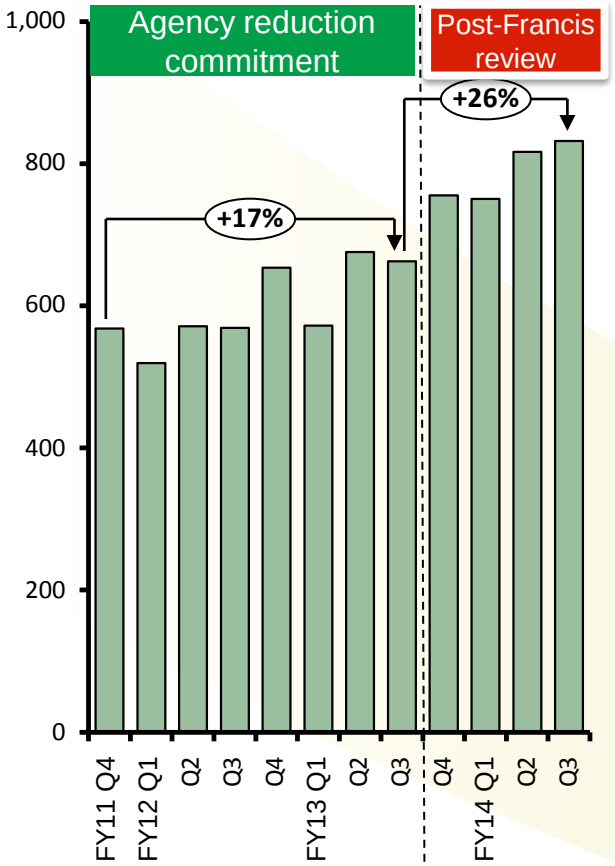
Source: 1:Centre for Workforce Intelligence; Laing and Buisson (2013)

Market Dynamics – Our Experience

NHS Professionals

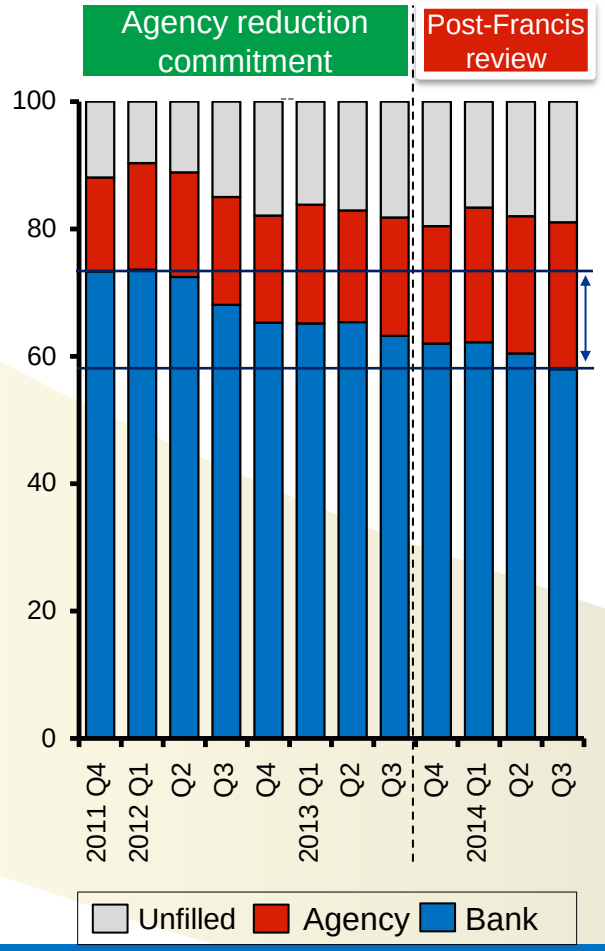
NHSP shift requests (Q4 FY2011 – Q4 FY2014)

Thousands of shifts



Bank shift status (Q4 FY2011 – Q3 FY2014)

Percent



Bank Filled hours **increased by 16%** while fill rate has **fallen by 15%**

- Francis report impact – significant increase in temporary staff demand
- Demand increase constrained by availability of market supply
- This supply-demand mismatch has also constrained nursing banks' ability to fill shifts leading to increased agency use

About Princess Alexandra Hospital…

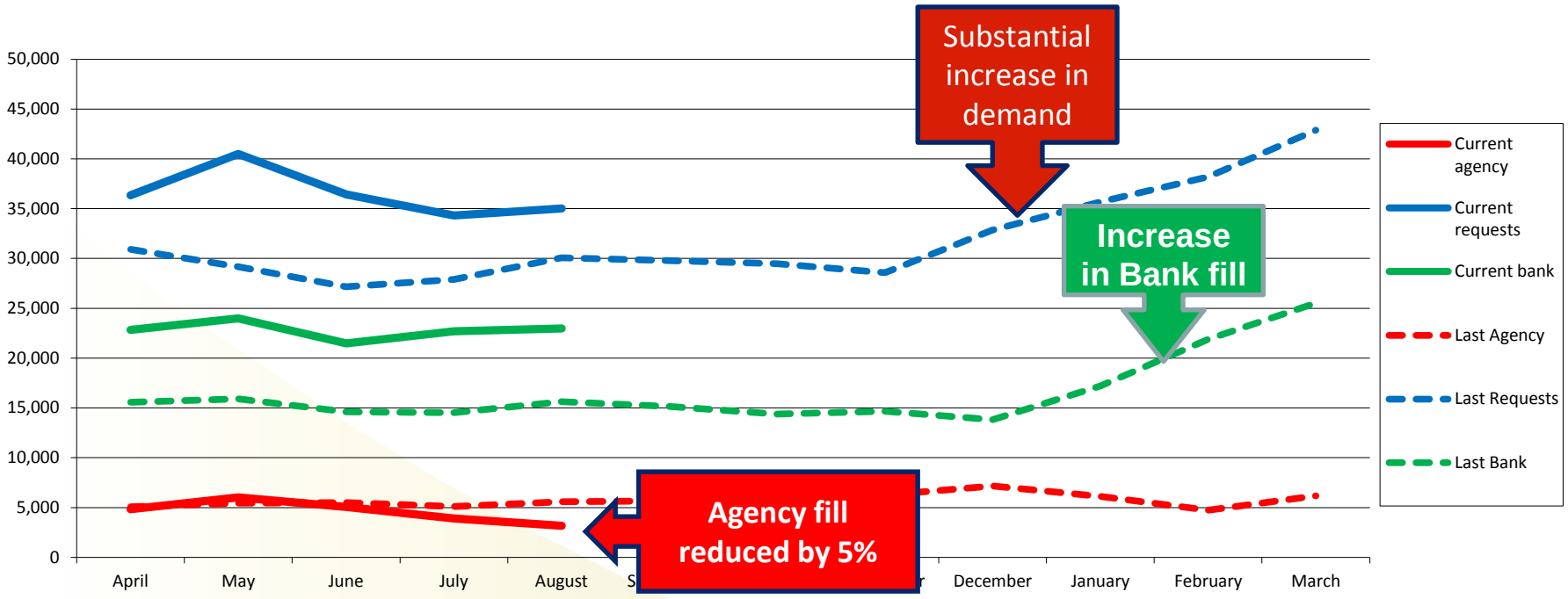
- Local District General Hospital
- Population of 285,000
- CQC concerns raised about staffing numbers 2012
- 41% reduction in complaints 2011-2012
- NHS Professionals client since 2008

What's happening at PAH?

Consider our options?

Recruit substantive staff	• Wherever possible
Build the bank	• Yes, as part of the Trust workforce
Grow your own	• Training programmes for unqualified

Shift Fill Performance – Nursing Hours



Current YTD Month & Year	Net Hours Requested	NHSP Filled Hours	% NHSP Filled Hours	Agency Filled Hours	% Agency Filled Hours	Overall Fill Rate	Unfilled Shifts	% Unfilled Hours
Jun-14	36,417	21,472	59.0 %	5,062	13.9 %	72.9 %	9,883	27.1 %
Jul-14	34,322	22,690	66.1 %	3,895	11.3 %	77.5 %	7,737	22.5 %
Aug-14	35,020	22,970	65.6 %	3,164	9.0 %	74.6 %	8,885	25.4 %
Total:	**105,758**	**67,132**	**63.6 %**	**12,121**	**11.4 %**	**75.0 %**	**26,505**	**25.0 %**

Recruitment Initiatives

NHS Professionals

International Recruitment

- Direct
- Indirect
  - 30 EU nurses
  - 26 en route

Grow your own

- Care Support Worker Development Programme
  - 15 in place
  - +15 this month

Working within our means

NHS Professionals

Business as usual

- Work within reasonable fill expectations,
- Be realistic about what temporary staffing can fill,
- See *NHS Professionals* nurses as part of the workforce,
- Insist on **all** agency via the one NHSP platform;
  - stay on framework,
  - control governance risk,
  - manage cost

Escalation & contingency

- Plan for contingencies,
- Frequent touch points,
  Escalation pool

Crisis management

- Recall Substantive staff

Questions

NHSP: Clinical Governance Strategy

The following four principles underpin our CG strategy:

- **1**. Clinical governance is integral to all our activities, processes and procedures.
- **2**. NHS Professionals is a transparent, open and learning organisation where incidents are fully investigated to prevent recurrences and ensure that people are dealt with fairly and appropriately.
- **3**. NHS Professionals works collaboratively with client Trusts to protect patients and improve their care.
- **4**. NHS Professionals continues to lead thinking on all aspects of clinical governance

Clinical Governance Principles

To ensure that clinical staff who enter the flexible staffing market and are placed in patient care through NHS Professionals, are fit for purpose and deliver safe care

To ensure that appropriate flexible workers are placed to fulfil requests from client Trusts for staff, and that those workers are, and remain, competent practitioners in whom Trust managers can have confidence

These clinical governance aims underpin our principles:

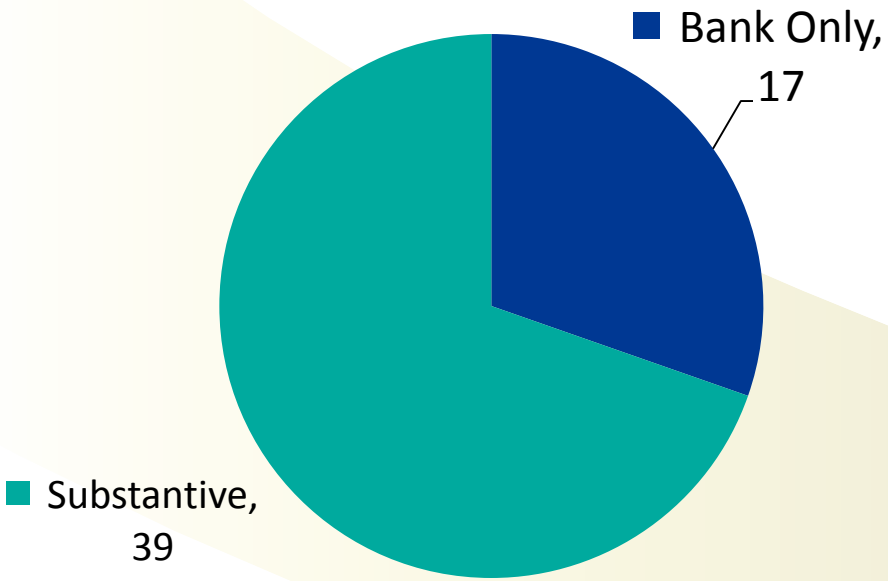
To assist client Trusts achieve their clinical governance objectives and assessments by demonstrating the quality assurance of NHS Professionals' services

To implement recommendations from National Reports

NHSP Recruitment statistics

85% of bank workers are reported as "good" or "excellent"

Every single day of the year,
NHSP recruits 56 people, on average



0.15% of bank workers are reported as "poor" or "require support"

Sustaining a Safe & Quality Workforce

The Princess Alexandra Hospital NHS Trust

NHS Professionals

Workshops

- Andrea Field

  Associate Head Nurse Corporate Nursing

  Heart of England NHS Foundation Trust

Case study – Our journey towards assuring safe staffing at HoEFT

Andrea Field –Associate Head Nurse

HoEFT in a nut shell!

- 3 main sites – 1,700 beds
  - Birmingham Heartlands
  - Solihull
  - Good Hope
- Solihull Community Services
- 11,500 staff
- £700 million turnover

NHS | HEART of ENGLAND NHS Foundation Trust

Pride Passion Professionalism

The case study

Based around our adult inpatient areas

Part One:

- How did we know what our staffing levels were?
- How did we know how these compared to the establishment?
- The first step to electronic data
- The system now
- What it tells us and what we use it for

Part Two:

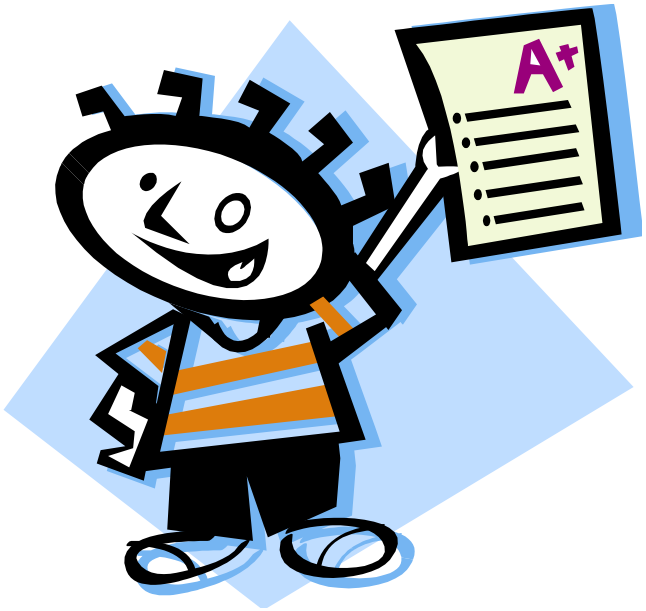
- The 2014 establishment review methodology
- What is it based on?
- What comparators are we using?
- What is it showing us so far, the capacity and capability debate

A starter for ten…..

Spend a few minutes considering the following questions for your organisation:

- **How do you know your staffing is safe today?**
- **How will you prove it tomorrow?**
- **Do you know what resource you need to meet the acuity and dependency of the patients in your care?**
- **Do you use other indicators as part of a review of safe staffing?**

What we knew before August 2013….



- We had paper, held by one person that showed today's position (if you could read it after all of the alterations!)
- It did not relate to what we needed as no one really knew for certain what this was
- There was no indication of mitigation or management of risks that could be followed at the time or after the event

The first steps to change…

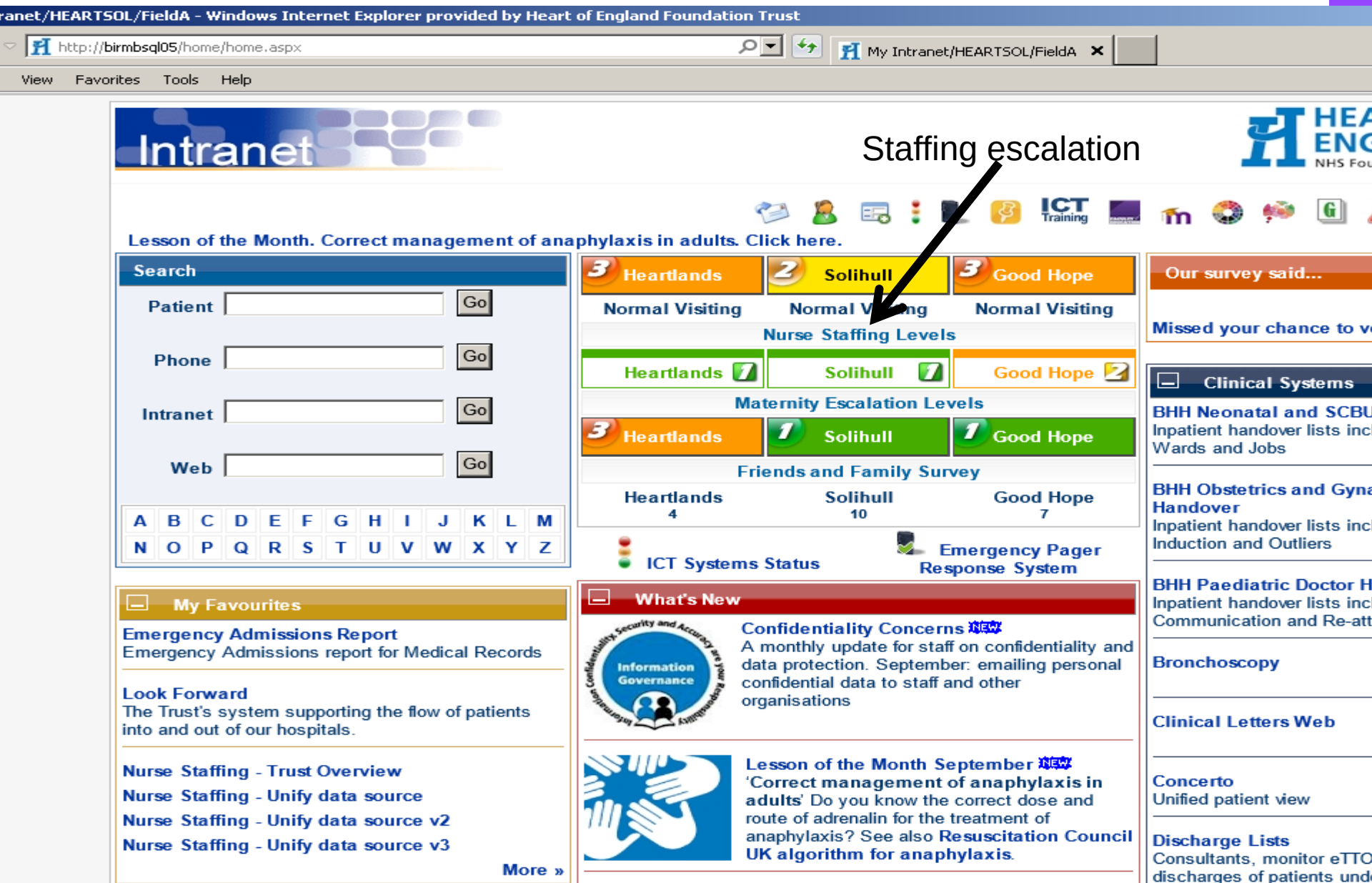
We got rid of the paper….

Oh no ….. this was not popular……but we persevered…

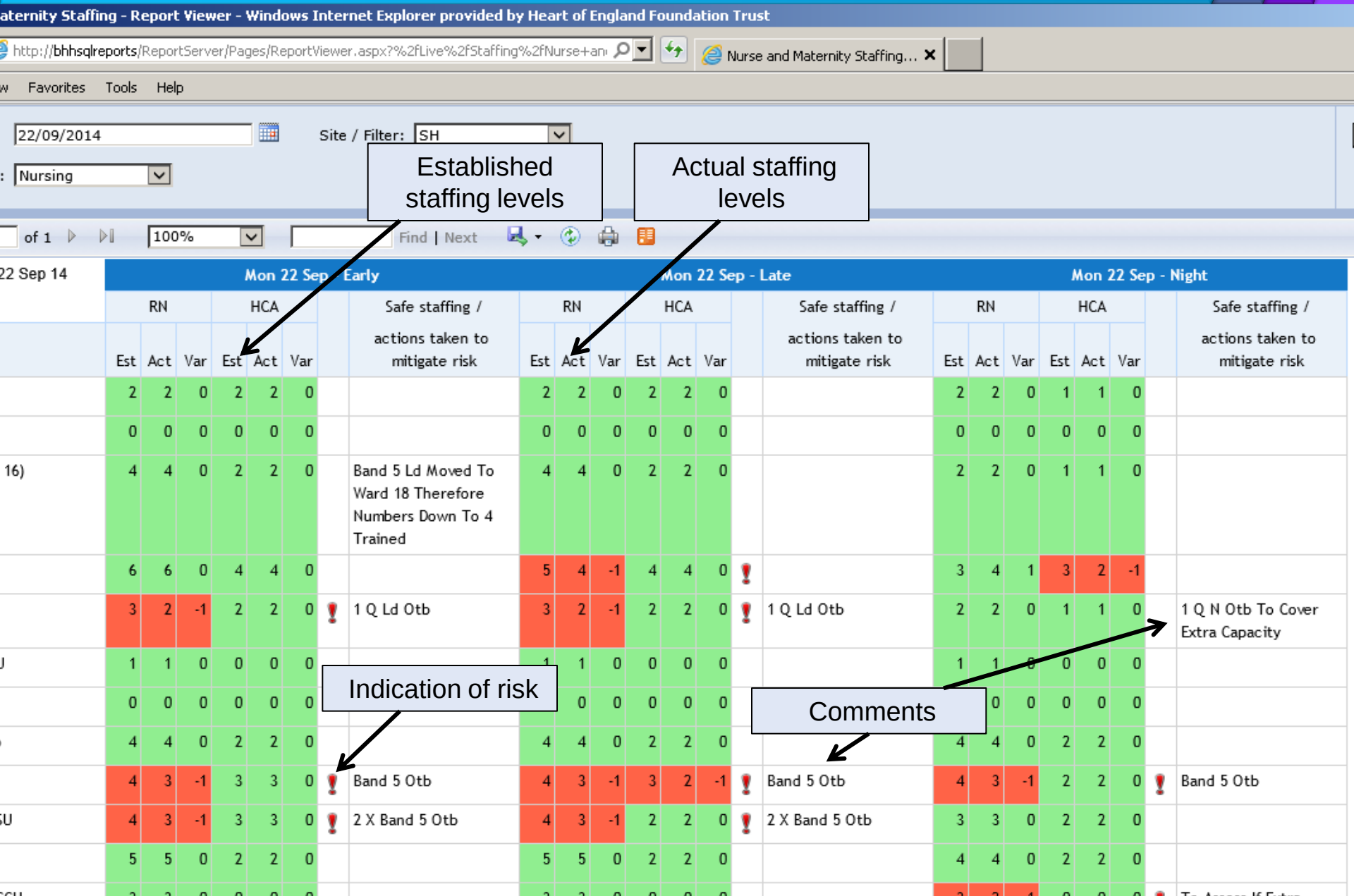
Then we made it live and electronic…

- Live on the Intranet
- Agreed established staffing numbers on E-rostering templates
- Updated as changes occur
- Indication of safe staffing levels including where risks have been mitigated
- Staffing escalation alongside capacity escalation on the Intranet home page
- Information directly uploads and populates our monthly UNIFY reports

Screen shot – the homepage



Screenshot of live staffing



22 Sep 14	Mon 22 Sep - Early								Mon 22 Sep - Late								Mon 22 Sep - Night							
	RN			HCA				Safe staffing / actions taken to mitigate risk	RN			HCA				Safe staffing / actions taken to mitigate risk	RN			HCA				Safe staffing / actions taken to mitigate risk
	Est	Act	Var	Est	Act	Var			Est	Act	Var	Est	Act	Var			Est	Act	Var	Est	Act	Var		
	2	2	0	2	2	0			2	2	0	2	2	0			2	2	0	1	1	0		
	0	0	0	0	0	0			0	0	0	0	0	0			0	0	0	0	0	0		
16)	4	4	0	2	2	0		Band 5 Ld Moved To Ward 18 Therefore Numbers Down To 4 Trained	4	4	0	2	2	0			2	2	0	1	1	0		
	6	6	0	4	4	0			5	4	-1	4	4	0	!		3	4	1	3	2	-1		
	3	2	-1	2	2	0	!	1 Q Ld Otb	3	2	-1	2	2	0	!	1 Q Ld Otb	2	2	0	1	1	0		1 Q N Otb To Cover Extra Capacity
U	1	1	0	0	0	0			1	1	0	0	0	0			1	1	0	0	0	0		
	0	0	0	0	0	0			0	0	0	0	0	0			0	0	0	0	0	0		
	4	4	0	2	2	0			4	4	0	2	2	0			4	4	0	2	2	0		
	4	3	-1	3	3	0	!	Band 5 Otb	4	3	-1	3	2	-1	!	Band 5 Otb	4	3	-1	2	2	0	!	Band 5 Otb
SU	4	3	-1	3	3	0	!	2 X Band 5 Otb	4	3	-1	2	2	0	!	2 X Band 5 Otb	3	3	0	2	2	0		
	5	5	0	2	2	0			5	5	0	2	2	0			4	4	0	2	2	0		

Our UNIFY data

			Day						Night					
Ward Type	Site		RN Day Est hrs	RN Day Act hrs	%	HCA Day Est hrs	HCA Day Act hrs	%	RN Night Est hrs	RN NIght Act hrs	%	HCA Night Est hrs	HCA Night Act hrs	%
Nursing	BHH		1162.5	1248	107.4%	775	737.5	95.2%	1069.5	977.5	91.4%	356.5	356.5	100.0%
Nursing	BHH		1782.5	1763.5	98.9%	1162.5	1122.5	96.6%	1069.5	1069.5	100.0%	713	632.5	88.7%
Nursing	BHH		2170	2172.17	100.1%	1395	1325	95.0%	1426	1299.5	91.1%	713	632.5	88.7%
Nursing	BHH		2325	2270	97.6%	775	650	83.9%	1426	1391.5	97.6%	356.5	402.5	112.9%
Nursing	BHH		1937.5	1840.25	95.0%	1162.5	1497.5	128.8%	1426	1403	98.4%	713	977.5	137.1%
Nursing	BHH		1550	1643	106.0%	775	962.5	124.2%	1069.5	1035	96.8%	713	805	112.9%
Nursing	BHH		1550	1540	99.4%	1007.5	987.5	98.0%	1069.5	943	88.2%	356.5	724.5	203.2%
Nursing	BHH		2095	1882.5	89.9%	1550	1630	105.2%	1713.5	1610	94.0%	1288	966	75.0%
Nursing	BHH		850	940.5	110.6%	387.5	380	98.1%	782	759	97.1%	356.5	345	96.8%
Nursing	BHH		1162.5	1138	97.9%	775	705	91.0%	1069.5	989	92.5%	356.5	356.5	100.0%
Nursing	BHH		1162.5	1174	101.0%	775	860	111.0%	713	713	100.0%	713	874	122.6%
Nursing	BHH		1782.5	1919.5	107.7%	1162.5	1235	106.2%	1426	1380	96.8%	1069.5	1081	101.1%
Nursing	BHH		1937.5	1729.5	89.3%	1162.5	1272.5	109.5%	1426	1196	83.9%	713	701.5	98.4%
Nursing	BHH		1550	1616.48	104.3%	775	1182.5	152.6%	1069.5	1012	94.6%	356.5	931.5	261.3%
Nursing	BHH		1937.5	1968	101.6%	1162.5	1027.5	88.4%	1069.5	1035	96.8%	356.5	333.5	93.5%
Nursing	BHH		775	925	119.4%	0	12.5	#DIV/0!	713	862.5	121.0%	0	0	#DIV/0!
Nursing	BHH		1782.5	1578	88.5%	1007.5	920	91.3%	1069.5	1023.5	95.7%	713	713	100.0%
Nursing	BHH		1550	1692.25	109.2%	775	732.5	94.5%	1000.5	1000.5	100.0%	356.5	356.5	100.0%
Nursing	BHH		1937.5	1925	99.4%	0	100	#DIV/0!	1782.5	1748	98.1%	0	34.5	#DIV/0!
Nursing	BHH		1875	2019.5	107.7%	1125	1745	155.1%	1380	1414.5	102.5%	690	1322.5	191.7%
Nursing	BHH		2155	2122	98.5%	1525	1210	79.3%	1403	1207.5	86.1%	1069.5	1127	105.4%
Nursing	BHH		4417.5	4002	90.6%	1550	1497.5	96.6%	3634	3231.5	88.9%	1138.5	1012	88.9%
Nursing	BHH		1550	1509	97.4%	1550	1460	94.2%	1426	1184.5	83.1%	713	874	122.6%
Nursing	BHH		1212.5	945.75	78.0%	800	717.5	89.7%	736	667	90.6%	736	655.5	89.1%

Our RAG rating is: under 90% Red, 90-94% amber, 95% and over green, the site Head Nurses then provide monthly exception reports for any areas that are below 95% to the Chief Nurse. These figures include the SWS hours as stated in the UNIFY guidance

The 2014 establishment review

- Today's focus will be on the Trust's adult inpatient review
- Methodology based around the recommendations in the NICE safe staffing guideline (2014) and the 'Right People, Right Skills, Right Place, Right Time' (NQB 2013) document
- Methodology:
  - % compliance with established versus actual staffing
  - Acuity results 2012, 2013 and 2014
  - Avoidable pressures sores
  - Number of falls
  - Nursing metrics scores
  - Professional judgement – challenge and confirm

What is it showing us so far

No of beds on ward	Total Q & HCA with 20%	% compliance Est vs actual Jun-Aug 2014 QUAL UNIFY DATA	Acuity Results 2012	Acuity Results 2013	Acuity Results 2014	% patients with acuity level 1b+	Avoidable pressure sores 07/13 to 07/14	Average fall rate 07/13 to 07/14 per 1,000 occupied bed days	Average nursing metrics score 10/13 to 08/14
21	27.09	96%	no data	19.84	13.09	N/A	0	2.37	
29	40.54	91%	36	34.5	38.66	2%	8	15.54	
32	38.40	93%	32.45	37.17	46.87	13%	6	15.16	
30	41.21	93%	36.2	32.85	32.89	5%	9	7.02	
31	38.40	91%	NA	49.29	47.09	13%	4	15.85	
31	46.80	88%	no data	no data	38.87	3%	2	6.95	
29	35.03	96%	33.19	31.54	30.76	N/A	2	8	
29	35.03	99%	37.42	32.05	36.72	8%	16	7.67	
28	39.21	1%	30.77	32.69	33.46	N/A	3	6.03	

Staffing at 99% compliance yet patient care indicators are showing red and amber scores.

Staffing at 88% compliance but with less red and amber patient care indicators

Is it a Capacity or Capability issue?

- Right People, Right skills, Right Place, Right Time (2013) states that numbers are not enough
- We are seeing from our initial results that higher compliance with established and actual staffing levels does not necessarily equate to better patient care outcomes
- The Capability and Capacity debate is forming part of our professional support and challenge when we look to recommending actions to the Board
- Previously we reported whether we needed more staff, this time we will consider do we need more staff or better skilled staff?

And to end…..

Spend a few minutes considering the initial questions that we looked at, have you got any ideas now how you may change you practices and therefore your responses?

- How do you know your staffing is safe today?
- How will you prove it tomorrow?
- Do you know what resource you need to meet the acuity and dependency of the patients in your care?
- Do you use other indicators as part of a review of safe staffing?

Thank you for taking part
Any questions?

Workshops

- Lara Walsh
  Programme Officer
  NHS Employers

Using values to sustain a quality workforce

NHS Employers

NHS Employers

NHS
Health Education England

Work Psychology Group
Thinking differently

Session outline

- NHS Employers VBR Project overview
- Values Based Recruitment: What, how and why
- Tools & resources
- Case studies example of good VBR practice
- Action plan
- NHS Employers Partner Network

The VBR Team

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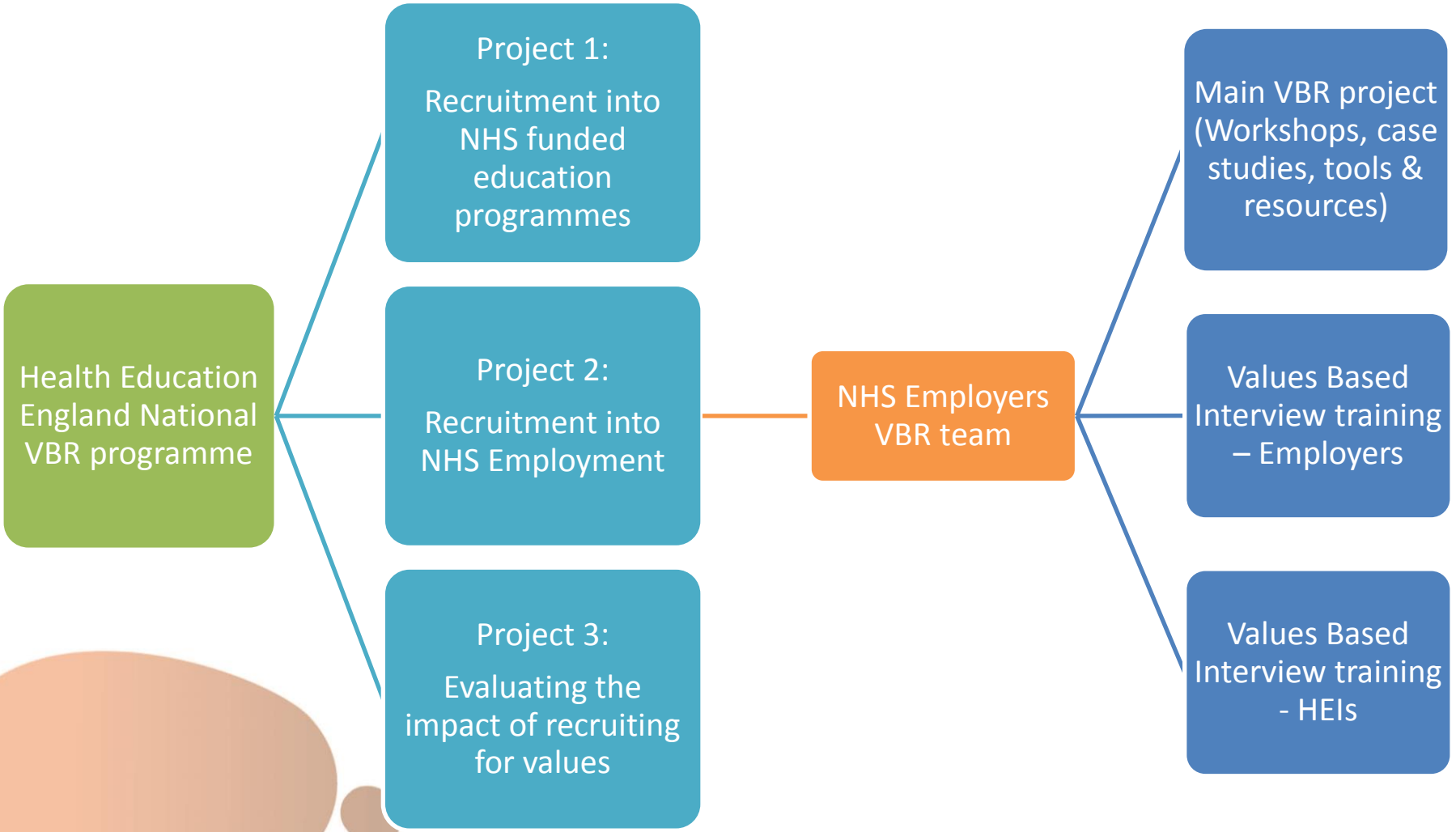
National VBR Programme



NHS Employment Journey – A Continuum of Values Based Employment

NHS Constitution

Recruitment | **Post selection**

Values Based Recruitment
(Values tested at multiple assessment points)

Attracting Candidates	Pre-selection	Selection	Post Selection	Entry into Employment & Beyond
Values of **NHS Constitution** marketed to prospective candidates (students, trainees and employees), including use of NHS Careers Service.	Values based short-listing criteria. Pre-selection tools to assess values.	Use of selection tools, methods and approaches to assess values.	Evidence of values in education, training, development and organisation culture.	Embedding values in organisation processes and continuous learning and professional development.

Values Based Environment

Values Based Employment Systems

Culture & Leadership

Education, Training & Continuous Development

What is recruiting for values?

- Employers seek to recruit staff with values that fit with their organisation
- Approach to help attract and select students, trainees and employees, whose personal values and behaviours align with the values outlined in the NHS Constitution

How?

- Throughout the whole recruitment process & beyond
- Pre-screening assessments; values based interviews; assessment centres

Why recruit for values?

Activity – 10 minutes

Discuss at your table:

Reasons why NHS organisations should recruit for values

If you are already doing so, please share your experiences

Feedback

One reason why to the main group

National VBR framework

HEE are launching a national values based recruitment framework aim October 2014. The framework will:

- provide a common set of evidence-based national VBR principles and standards against each stage of the recruitment process (attraction, screening/shortlisting, selection and induction);
- provide guidance and access to resources to successfully recruit in HEIs, NHS employers and LETBs and to prepare organisations for VBR;
- provide easy access to a toolkit of resources and evaluated techniques;
- access to good practice and case studies;
- provide a way in which to show adherence with the Mandate for VBR

Recruitment Stages

Stage	Good practice requirements for VBR	
Attraction	• Marketing materials, websites and job descriptions and person specifications include specific reference to the NHS Constitution / Local Values. • Local values (where they exist) are mapped to those of the NHS Constitution.	 Evidence of involvement of patients and public in some stage of the recruitment process. 
Screening/ Shortlisting and/or Selection	• Situational Judgement Tests (SJTs). • Structured interview undertaken by a Panel including at least one interviewer trained for Values Based Interviewing skills using values based questions – which may occur at a point within a wider selection process. • Selection Centres.	
Post selection	• Providing feedback to unsuccessful candidates if requested. • Embedding the NHS Constitution in induction processes.	
Professional and regulatory standards are integral to the overall selection process.		

Review of selection methods

Selection Method for VBR	Reliability	Validity	Candidate acceptability	Cost (to the organisation)	Promotes diversity	Susceptibility to coaching
Traditional Interviews	Low	Low	High	Moderate to high	Low	High
Structured Interviews e.g. competency-based, situational, multi-mini interviews	Moderate to high	Moderate	High	Moderate to high	Moderate	Moderate
Group Interviews	Low	Low	Moderate	Moderate	Low	High
Personal statements	Low	Low	High	Low to moderate	Low	High
References	Low	Low	High	Low to moderate	Low	N/A
Situational judgement tests	High	High (only if based on a robust psychometric methodology)	Moderate to high	Low to moderate	High	Low to moderate
Personality testing	High	Moderate	Low to moderate	Low to moderate	Moderate	Moderate to high
Selection centres using work samples e.g. group exercise, written/in-tray task, presentations, interactive exercises	Moderate to high	High (only if exercises are used in combination based on a multi-trait, method approach)	High	High	Moderate	Moderate

Values in the NHS Constitution

WORKING TOGETHER FOR PATIENTS

Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

RESPECT AND DIGNITY

We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

EVERYONE COUNTS

We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

COMMITMENT TO QUALITY OF CARE

We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

COMPASSION

We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

IMPROVING LIVES

We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

Our Values – The 6C's

Care	Compassion	Competence	Communication	Courage	Commitment

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THE NHS CONSTITUTION
the NHS belongs to us all

NHS
Health Education England

Health Education England

THE NHS CONSTITUTION
the NHS belongs to us all

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Recruiting for values – is your organisation ready?

Working towards embedding values driven behaviour

This is a readiness checklist to help you get the most out of your recruiting for values programme, and to make sure that the future and current NHS workforce is selected against the values of the NHS Constitution.

This checklist has been developed as part of Health Education England's Values Based Recruitment programme which aims to ensure that the NHS has a workforce not only with the right skills and in the right numbers, but with the right values to support effective team working and deliver excellent patient care and experience. Successful values-based recruitment should have a clear focus on requirements and a clear demonstration that these values are fully supported by your organisation.

Organisations who have successfully implemented and evaluated values-based recruitment practices report that there are many benefits to be gained from investing time and resources into doing VBR well, from reducing agency spend and recruitment costs, to boosting staff morale, creating a more positive work environment, and most importantly, ensuring that patients receive the best care possible.

For further information, resources and case studies, please visit the NHS Employers website and the HEE website.

VALUES AND YOUR ORGANISATION

Select

- We have values for our organisation
- Our values have been developed from those within the NHS Constitution
- We have used the NHS Employers mapping tool to demonstrate this
- Our organisation is clear about what our values mean in terms of:
  - — delivering patient care
  - — the behaviour that is expected of all staff
- Our staff are aware of our values
- Each member of staff understands what our values mean to them in their role
- We listen and engage with our staff and patients about our values and the behaviour we expect to see
- Colleagues are comfortable to address behaviour that doesn't fit with our values, with each other

NHS Employers Values Mapping Tool

VALUES, BEHAVIOURS AND ORGANISATIONAL PROCESSES

Select

- Our Board meetings and decisions are led and framed by our values
- We recruit, develop, manage and dismiss for values
- Our values and the behaviour we expect of our staff is incorporated into:
  - — Recruitment processes
  - — Induction
  - — Training and development
  - — Appraisal
  - — HR and other organisational policies
- We encourage values driven behaviour conversations between staff and teams as part of everyday activity
- We have role models at all levels of the organisations that demonstrate our values in their behaviour

Visit the NHS Employers Recruiting for Values webpages for case studies and podcasts

VALUES AND RECRUITMENT

Select

- We recruit for values
- We have developed a behaviour framework and indicators to underpin our recruitment process
- Our recruiting managers are trained to ensure we are recruiting people who align with our values and demonstrate the necessary behaviour
- We articulate our values and desired behaviours in:
  - — Job adverts
  - — Job descriptions and person specifications
  - — Shortlisting criteria/methods
  - — Interview questioning
  - — Interview assessment/scoring
- We evaluate our recruitment process and can see the return on investment to the organisation and our patients

Visit the NHS Employers Recruiting for Values webpages for case studies and podcasts

Key: Yes Need to do more work Action needed Unsure

Case Studies – Good VBR practice

VALUES BASED RECRUITMENT PROJECT
SHARING GOOD PRACTICE

Recruiting for values internationally

In recent years, Northern Lincolnshire & Goole has faced a shortage of nursing staff from the local area, leading to high vacancy rates and agency spend. In 2013, the trust took action and began a new recruitment strategy: to incorporate the principles of values based recruitment in its international recruitment activity in Spain.

Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust operates hospitals in Grimsby, Scunthorpe and Goole with a staff headcount of approximately 6,306 staff employed across the region. The trust works in partnership with the Hull York Medical School, providing comprehensive undergraduate teaching for medical students.

What problems were the trust facing?

Northern Lincolnshire & Goole faces a shortage of nursing staff in the local area, due to factors outside of their control. Their local pool for recruitment has reduced due to a decline of newly qualified nurses from the local universities. They also face competition from larger city and teaching hospitals, where newly qualified nurses often prefer to gain experience.

The trust has taken action, with several initiatives to recruit locally, such as social awareness campaigns, open information days and using established local networks. Despite their best efforts, they still continued to have a high number of vacancies and a high dependency on agency staff.

Why recruit internationally?

The trust has started to employ nurses from Spain, via a partner recruitment agency based in Madrid, to fill vacancies. As the local campaigns were not solving the staff shortage issues, the trust decided to recruit more nurses from Spain as there was interest and a large pool of nursing staff available. As nationals of an European Economic Area (EEA) country, individuals can enter the UK without any immigration restrictions which eases the process. Nurses who are trained in an EU or EEA country also have several routes to registration with the Nursing and Midwifery Council (NMC) depending on their qualification, which the trust provide guidance on.

What they did

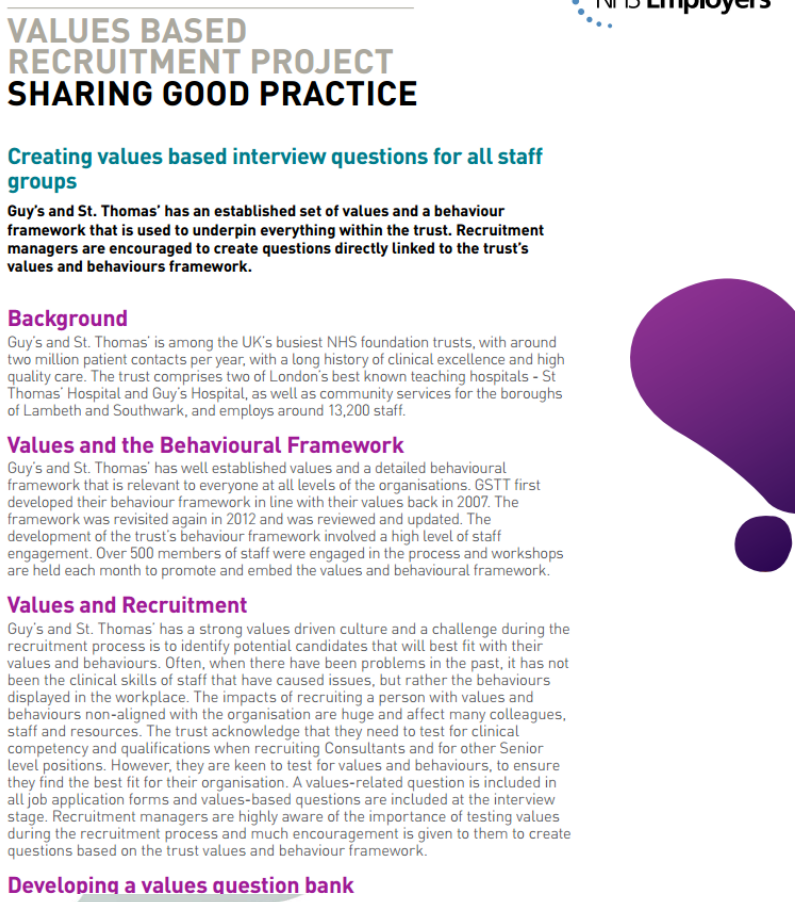
The trust faced the challenge of recruiting internationally, but also to recruit for values across different cultures. Working together with the recruitment agency in Spain, they held the first assessment centre recruitment day in Madrid in September 2013 and successfully recruited their first cohort of nurses. The trust

Northern Lincolnshire & Goole NHS Foundation Trust

- Values based assessment centres for their recruitment of nurses from Spain
- Alongside competency based
- Values throughout induction and welcome process

www.nhsemployers.org/recruitingforvalues

Case Studies – Good VBR practice



VALUES BASED RECRUITMENT PROJECT
SHARING GOOD PRACTICE

Creating values based interview questions for all staff groups

Guy's and St. Thomas' has an established set of values and a behaviour framework that is used to underpin everything within the trust. Recruitment managers are encouraged to create questions directly linked to the trust's values and behaviours framework.

Background

Guy's and St. Thomas' is among the UK's busiest NHS foundation trusts, with around two million patient contacts per year, with a long history of clinical excellence and high quality care. The trust comprises two of London's best known teaching hospitals - St Thomas' Hospital and Guy's Hospital, as well as community services for the boroughs of Lambeth and Southwark, and employs around 13,200 staff.

Values and the Behavioural Framework

Guy's and St. Thomas' has well established values and a detailed behavioural framework that is relevant to everyone at all levels of the organisations. GSTT first developed their behaviour framework in line with their values back in 2007. The framework was revisited again in 2012 and was reviewed and updated. The development of the trust's behaviour framework involved a high level of staff engagement. Over 500 members of staff were engaged in the process and workshops are held each month to promote and embed the values and behavioural framework.

Values and Recruitment

Guy's and St. Thomas' has a strong values driven culture and a challenge during the recruitment process is to identify potential candidates that will best fit with their values and behaviours. Often, when there have been problems in the past, it has not been the clinical skills of staff that have caused issues, but rather the behaviours displayed in the workplace. The impacts of recruiting a person with values and behaviours non-aligned with the organisation are huge and affect many colleagues, staff and resources. The trust acknowledge that they need to test for clinical competency and qualifications when recruiting Consultants and for other Senior level positions. However, they are keen to test for values and behaviours, to ensure they find the best fit for their organisation. A values-related question is included in all job application forms and values-based questions are included at the interview stage. Recruitment managers are highly aware of the importance of testing values during the recruitment process and much encouragement is given to them to create questions based on the trust values and behaviour framework.

Developing a values question bank

Guy's and St. Thomas' NHs Foundation Trust

Created a bank of values based interview questions that can be used for all staff recruitment

Developed with staff engagement

Based on their robust behavioural framework

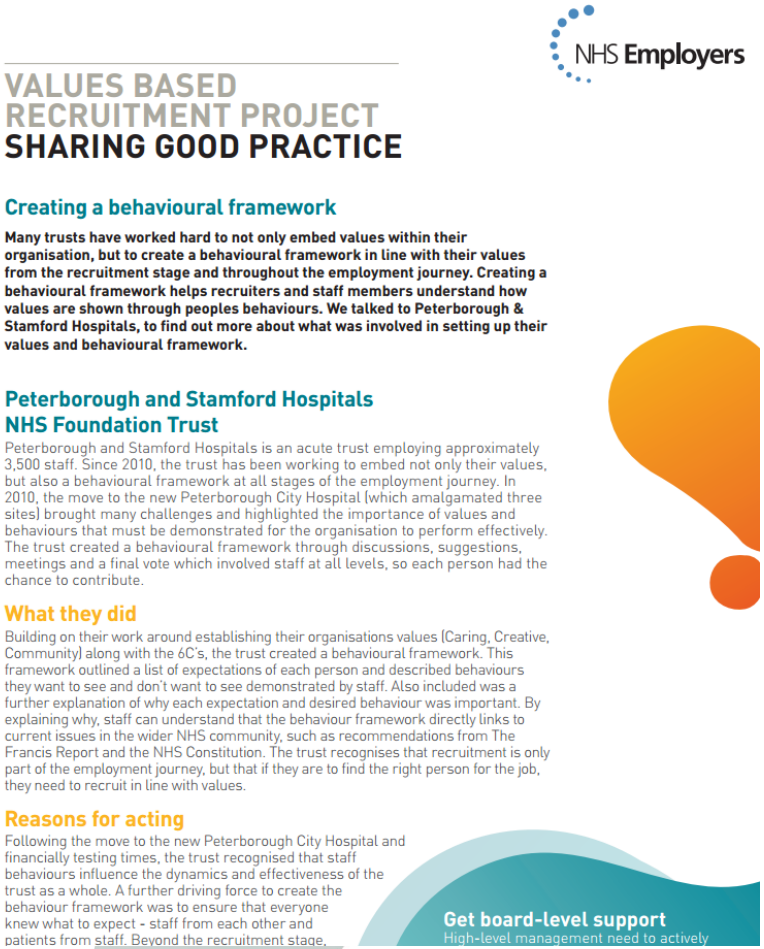
Top tips:

Leaders living the values

Staff engagement

www.nhsemployers.org/recruitingforvalues

Case Studies – Good VBR practice



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VALUES BASED RECRUITMENT PROJECT
SHARING GOOD PRACTICE

Creating a behavioural framework

Many trusts have worked hard to not only embed values within their organisation, but to create a behavioural framework in line with their values from the recruitment stage and throughout the employment journey. Creating a behavioural framework helps recruiters and staff members understand how values are shown through peoples behaviours. We talked to Peterborough & Stamford Hospitals, to find out more about what was involved in setting up their values and behavioural framework.

Peterborough and Stamford Hospitals NHS Foundation Trust

Peterborough and Stamford Hospitals is an acute trust employing approximately 3,500 staff. Since 2010, the trust has been working to embed not only their values, but also a behavioural framework at all stages of the employment journey. In 2010, the move to the new Peterborough City Hospital (which amalgamated three sites) brought many challenges and highlighted the importance of values and behaviours that must be demonstrated for the organisation to perform effectively. The trust created a behavioural framework through discussions, suggestions, meetings and a final vote which involved staff at all levels, so each person had the chance to contribute.

What they did

Building on their work around establishing their organisations values (Caring, Creative, Community) along with the 6C's, the trust created a behavioural framework. This framework outlined a list of expectations of each person and described behaviours they want to see and don't want to see demonstrated by staff. Also included was a further explanation of why each expectation and desired behaviour was important. By explaining why, staff can understand that the behaviour framework directly links to current issues in the wider NHS community, such as recommendations from The Francis Report and the NHS Constitution. The trust recognises that recruitment is only part of the employment journey, but that if they are to find the right person for the job, they need to recruit in line with values.

Reasons for acting

Following the move to the new Peterborough City Hospital and financially testing times, the trust recognised that staff behaviours influence the dynamics and effectiveness of the trust as a whole. A further driving force to create the behaviour framework was to ensure that everyone knew what to expect - staff from each other and patients from staff. Beyond the recruitment stage,

Get board-level support
High-level management need to actively

Peterborough and Stamford Hospitals NHS Foundation Trust

Created after the amalgamation of 3 hospitals into one site

Based on their local values along with the 6C's

Used in recruitment & throughout the organisation

Top tip:

Board level support

Positive praise system

www.nhsemployers.org/recruitingforvalues

VBR: Action plan

Activity – 5 minutes

Discuss in pairs or in your groups:

If you were to implement values based recruitment what actions would you take?

If you already recruit for values, are there any other actions you would take?

Individually:

Write down one action you plan to follow up in your organisation

Feedback

Linked Programmes

Organisation	Recruitment and Selection	Post selection
HEE	• VBR • NHS Careers • Pre-degree year of care	
	• Certificate of Fundamental Care	
NHS Employers	• VBR delivery partner – undertaken in context of Values Based Employment	• Do OD • Performance and appraisal systems • Care Makers (with NHS England)
NHS Leadership Academy	• Graduate Management Training Scheme and Fast Track programme recruit for values • Executive search facility	• Healthy Board guidance • Leadership programmes share set of central values based themes
NHS England	• Compassion in Practice/ 6Cs • Internal embedding and promoting of values	
NHS Equality and Diversity Council		• Leadership and Workforce identified as priority

Join the partner network

Welcome to join the NHS Employers Values Based Recruitment partner network at any stage

Email: valuesbasedrecruitment@nhsemployers.org

Website: www.nhsemployers.org/recruitingforvalues

Twitter: @NHSE_Lydia

#NHSVBR

- Partner network of in excess of 100 organisations
- Secure online space to share information & discussions
- Tools and resources: Values mapping tool, readiness checklist, shared learning: case studies, podcasts
- Values Based Interviewing – ‘Train the Trainer’ training

Thank you for listening

Closing Summary

- Caroline Waterfield

  Assistant Director of Employment Services

  NHS Employers

  @NHSE_Caroline

Thank you for attending today's event

Please take a few moments to complete the evaluation form