



Safe, sustainable and productive staffing

**An improvement resource
for the deployment of nursing
associates in secondary care**

This document was developed on behalf of the National Quality Board (NQB).

NQB provides co-ordinated clinical leadership for care quality across the NHS on behalf of the national bodies:

- NHS England
- Care Quality Commission
- NHS Improvement
- Health Education England
- Public Health England
- National Institute for Health and Care Excellence
- NHS Digital
- Department of Health and Social Care

For further information about the NQB, please see:

www.england.nhs.uk/ourwork/part-rel/nqb/

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Summary

The National Quality Board (NQB) publication [*Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing*](#) (2016) outlines the expectations and framework within which decisions on safe and sustainable staffing should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis.

This improvement resource focuses specifically on the deployment of nursing associates in secondary care, which includes: acute adult and children inpatients (including emergency departments) and outpatients; mental health inpatients and outpatients; learning disability inpatient and outpatients, and community care for all these specialty areas. It aligns with Commitment 9 of [*Leading change, adding value*](#) – ‘We will have the right staff in the right places and at the right time’ (NHS England, 2016) – and should be read with NHS Improvement’s Use of Resources framework.

It is designed to be used by all those involved in clinical establishment setting, approval and deployment – from the ward/care area manager to the board of directors. Although the National Institute for Health and Care Excellence (NICE) staffing guidelines¹ predate the nursing associate role, they are a useful benchmark and have helped inform its development.

¹ <https://www.nice.org.uk/guidance/sg1>

Recommendations

For decision-making in determining how to deploy nursing associates, this resource recommends:

1.	As with all new roles, adopt a systematic approach using an evidence-informed decision-support tool triangulated with professional judgement and comparison with relevant peers.
2.	Take staffing decisions in the context of the wider senior registered multi-professional team.
3.	Consider safer staffing requirements, workforce productivity and financial viability as an integral part of the deployment process.
4.	Ensure there is a local dashboard to assure stakeholders about safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.
5.	Ensure the organisation is familiar with Nursing and Midwifery Council standards of proficiency and with individual nursing associate competencies.
6.	Ensure there is an appropriate escalation process in cases where issues arise because of deployment.
7.	Investigate staffing-related incidents, their impact on staff and patients and ensure action and feedback.
8.	Develop guidelines to ensure that staff are aware of the rationale for deployment, the role's risks and benefits, and process for escalating concerns.
9.	Complete a full quality impact assessment before there is any substantial skill-mix change or deployment of a new role.

1. Introduction

The current challenges faced by the NHS provider sector – increasing demand for services, an ageing population, financial constraints and workforce supply and retention issues across many healthcare professions and disciplines – are likely to remain for the foreseeable future. At the same time, the NHS is striving to develop new models of delivery that are more patient-centred, that enable treatment and care to be provided at home and closer to home, including more self-care, and that are financially sustainable.

Healthcare professionals' ability to adapt and innovate is critical to achieving high-quality care in the right place and at the right time. By modernising, we can shape a workforce fit for purpose for the next decade and beyond and demonstrate positive outcomes and experience for those we care for.

The context outlined above has led to the development of new roles in the healthcare sector, including assistant practitioner, physician's assistant, physician's associate and nursing associate. Unlike the other new roles, the nursing associate is regulated by the Nursing and Midwifery Council (NMC).²

The nursing associate (NA)³ role is designed to bridge the skills gap between the healthcare support worker (HCSW) and more senior regulated professional and provide a new route into the registered nurse (RN) pathway. The regulated professional⁴ will continue to be the primary assessors and prescribers of care while NAs deliver and adapt care, contributing to assessment within agreed parameters (see Section 5 below).

There are considerable opportunities and benefits in deploying the NA. Some of the opportunities and benefits will come unexpectedly, others will be intentional and planned. This improvement resource will describe how best to plan the deployment of this new role and integrate it into the healthcare workforce.

² <https://www.nmc.org.uk/standards/nursing-associates/how-we-will-regulate-na-profession/>

³ This is separate to the certified nursing assistant role, which is non-registered.

⁴ For example: registered nurse, occupational therapist, social worker or similar.

We have designed this improvement resource for use by all those involved in clinical establishment setting, approval and deployment – from the ward/care setting manager to the board of directors. It focuses on safe deployment of the role and does **not** go into detail about staffing uplift, education, use of agency staff, recruitment or retention.

2. The nursing associate role

The NA role is a new generic nursing role, created to bridge the skills gap between healthcare support workers and regulated professionals. The outline concept was set out in *The shape of caring review (raising the bar)* published in March 2015 by Health Education England (HEE). It was seen as offering a range of benefits working alongside more senior regulated professionals helping to improve patient care.

HEE originally led the development of the role and piloted it in 35 test sites across England. The NMC has consulted on and published its regulatory process and relevant skills and proficiencies.⁵ We will now work with others to demonstrate its impact.

The NMC's standards of proficiency set out what all NAs will know and be able to do at the point of registration. Like other registered professionals, NAs can develop extra skills and knowledge before and after registration, and their practice is not limited to their initial competences. They can contribute more to patient care if they have received appropriate training and there is relevant clinical governance.

As registered professionals, NAs are individually accountable for their own professional conduct and practice. They will be expected to uphold the NMC Code, to work within their scope of practice and to raise concerns where needed. They will renew their registration via the usual revalidation process.

As with all new roles, there has been substantial debate and discussion about the NA's place in the multidisciplinary team and the aligned scope of professional practice and accountability. The HEE test sites use case studies to describe the role's potential benefits and outcomes and show that NA skills and proficiencies not only help to meet patients'/clients' needs but free more senior professionals to work to the full extent of their licence.⁶

⁵ <https://www.nmc.org.uk/standards/nursing-associates/standards-for-nursing-associates/>

⁶ www.hee.nhs.uk/our-work/nursing-associates/nursing-associate-trainee-case-studies
[www.hee.nhs.uk/sites/default/files/documents/Phase%201%20OPM%20Evaluation%20Report%20\(002\).pdf](http://www.hee.nhs.uk/sites/default/files/documents/Phase%201%20OPM%20Evaluation%20Report%20(002).pdf)

In time, as the evidence base develops around the new role, we may see the NA undertaking other activities, and this will be monitored through further iterations of the NA deployment resources. In the meantime, we are continuing to collate and examine the evidence as the role matures.

3. Safe staffing and NQB expectations

This improvement resource outlines a systematic approach for identifying the organisational, managerial and other factors that support safe deployment of the nursing associate as part of an effective clinical team. It supports deployment of the nursing associate and is aligned to Commitment 9 of *Leading change, adding value: a framework for nursing, midwifery and care staff* (2016).⁷ Although the NQB expectations predate the NA role, the principles of ensuring safe, effective, caring, responsive and well-led care on a sustainable basis apply to the deployment of the role.

This improvement resource is structured according to the expectations in the NQB guidance outlined in the diagram on the next page. It provides an opportunity to remind all NHS provider organisations of the expectations described in the NQB (2013 and 2016)⁸ guidance and reiterated, for example, in the NQB sector-specific improvement resources published on the NHS Improvement website.⁹

⁷ <https://www.england.nhs.uk/ourwork/leading-change/>

⁸ NQB 2013 'How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability.'

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

NQB 2016 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing'

<https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf>

⁹ https://improvement.nhs.uk/search/?q=safe+staffing&page_type=52&=Filter+results

Figure 1: NQB’s expectations for safe, sustainable and productive staffing (2016)

Safe, Effective, Caring, Responsive and Well-Led Care		
<p>Measure and Improve</p> <ul style="list-style-type: none"> - patient outcomes, people productivity and financial sustainability - - report investigate and act on incidents (including red flags) - - patient, carer and staff feedback - 		
<ul style="list-style-type: none"> - Implementation Care Hours per Patient Day (CHPPD) - - develop local quality dashboard for safe sustainable staffing - 		
Expectation 1	Expectation 2	Expectation 3
<p>Right Staff</p> <ul style="list-style-type: none"> 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers 	<p>Right Skills</p> <ul style="list-style-type: none"> 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention 	<p>Right Place and Time</p> <ul style="list-style-type: none"> 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

NQB guidance, particularly pertinent to the deployment of new roles such as the nursing associate, states that providers:

- **must** deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure they can meet people’s care and treatment; the skills of the staff must therefore be matched to the needs of the patient
- should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe always
- **must** use an approach that reflects current legislation and guidance where it is available.

Implementing the NQB expectations will help ensure providers comply with the Care Quality Commission's (CQC) fundamental standards around staffing – for example, in the Well-Led Framework¹⁰ – and related legislation.

Using the NQB expectations does not restrict the deployment of the nursing associate, which can be done widely across health and care settings. The expectations make it clear that the patient's needs are paramount, and matching patient needs with the skills and competencies of the practitioner is essential. This deployment must be monitored and reviewed according to NQB guidance.

¹⁰ https://www.cqc.org.uk/sites/default/files/20180921_9001100_trust-wide_well-led_inspection_framework_v5.pdf

4. Right staff

The nursing establishment is defined as the number of registered nurses, nursing associates and healthcare assistants who work in a ward, department, care setting, or team. The skills and capabilities of the nursing family must be carefully considered to ensure that the right person is delivering the right care to the right patient at the right place and time. Using an evidence-based tool, such as the safer nursing care tool and acuity and dependency tools, can assist this.

Understanding the proficiencies of each role at the point of registration will help with safely deploying the NA. The NMC has summarised its standards of proficiency for both the RN and NA role as shown in Table 1 below.

Table 1: RN and NA standards of proficiency summary

Platform	Nursing associate	Platform	Registered nurse
1	Be an accountable professional	1	Be an accountable professional
2	Promoting health and preventing ill health	2	Promoting health and preventing ill health
3	Provide and monitor care	3	Assessing needs and planning care
		4	Providing and evaluating care
4	Working in teams	5	Leading and managing nursing care and working in team
5	Improving safety	6	Improving safety
6	Contributing to integrated care	7	Co-ordinating care

**Points in black are areas of similarity; points in red are where roles differ.*

This shows that NAs will have a broad range of competencies and skills specifically developed to meet a range of care needs for patients. They will need to achieve these competencies before registration with the NMC. To obtain the best value from staff, employers will also want to be aware of any extra skills and knowledge they acquire, before and after registration.

These competencies should therefore be considered when assessing patients' needs so that the required need is matched with the appropriate skills. If this results in a different skill mix, then robust governance processes and professional judgement need to be applied to ensure that quality and safety are maintained. There should be an ongoing monitoring process to ensure that action can be taken if required.

Professional judgement will be vital to the future innovative development of the role and to determining what additional skills organisations wish their NAs to undertake. Additional skills will require additional training and development.

Governance

In the context of increasing demands on healthcare, new models of service delivery, and the gap in workforce supply, the introduction and development of new roles, new ways of working in existing roles and changing the skill mix of clinical teams will continue to be necessary.

- The introduction of any new role or new ways of working in current roles will open new career pathways and when planned effectively will contribute to securing safe and sustainable care. Care will be provided by staff with the appropriate skills, competence, values and behaviours.
- Identifying and managing the potential benefits and risks posed by the introduction of new roles and skill mixes across healthcare, requires strong and effective governance arrangements from the front line to the board. As detailed in Section 4.2.2, best practice and NQB guidance¹¹ dictate that a quality impact assessment (QIA) must be completed for all significant skill-mix reviews and service changes.

¹¹ National Quality Board (2012) *HOW TO: quality impact assess provider cost improvement plans*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/212819/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf

Governance arrangements

Robust and effective governance is fundamental to deploying the NA. It must give the provider board confidence about their capacity to maintain and continually improve the delivery and quality of their services and patient experience. This section should be read in conjunction with NHS Improvement's recent publication *Developing workforce safeguards*,¹² which discusses in greater detail governance arrangements when making staffing decisions.

The provider board should have the necessary assurance to support the deployment of the role, ensuring the trust has strong and effective governance frameworks for this change. Trusts must have a clear focus and process from the front line to the board, making sure their tactical and operational systems address strategic needs and have a consistent approach to monitoring and improvement.

Section 4.2.1 discusses what is meant by a systematic and structured approach to workforce change, and Section 4.2.2 discusses the process of assessing the potential impact on quality (normally defined by a QIA), as part of provider governance processes.

4.1.1 Taking a structured and systematic approach to deploying new roles

A structured and systematic approach entails:

- Understanding and articulating the reasons for introducing the role. For example: is the role to be deployed to one clinical area/specialty, clinical pathway or more? What are the opportunities and challenges? What are the potential risks and what are the mitigating actions to be taken?
- Identifying which staff group(s) are affected. This is likely to include HCSWs, RNs in all fields and other clinical and non-clinical staff. An appropriate executive lead to sponsor and to advise on changes should be identified. Consideration should be given to the impact on patients, service users and carers.

¹² <https://improvement.nhs.uk/resources/developing-workforce-safeguards/>

- Agreeing a process or framework to work through the challenges, opportunities and risks.
- Taking account of financial restraints by setting an accurate and achievable staffing budget agreed by clinicians and the finance department. This may include considering possible cost pressures associated with deploying the NA or any new role.
- Clear and robust governance systems and processes that can provide checks and balances through the workforce changes and seek the necessary assurance at all levels from the front line to board level. This requires an effective governance structure where the appropriate committee(s) have responsibility for, and a focus on, workforce, quality, risk and finance. This reflects CQC's 'well-led' requirements.

4.1.2 Quality impact assessments

There are considerable opportunities and benefits in deploying this new role. Some of the opportunities will come unexpectedly and require a prompt and reactive response; others will be planned and will enable a more considered and proactive response. The points outlined below are provided to encourage and support a structured systematic approach to planning, implementing and monitoring while deploying the role to ensure quality and safety for patients and service users, and to provide the necessary assurance to your board, commissioners and regulators.

As part of the governance processes, trusts are expected to assess the potential impact on quality (normally by completing a QIA) ahead of introducing NAs.

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

NQB published a 'how to' guide¹³ in 2012, which outlined best practice guidance in applying QIA to efficiency and transformation plans. This guidance remains valid and can be extended to using QIAs for deploying NAs. The key aspects are:

- There is a clear governance structure surrounding the plan to deploy the nursing associate, acceptance and monitoring of implementation and impact.
- The plan must be assessed according to the potential impact on all aspects of quality, including impact on patient/service user experience or patient/service user safety.
- The plan must be developed with clinicians. It must have a clinical sponsor, or a consultation that has been held with clinicians. The board must sign off all schemes for significant skill-mix changes, and a formal management of change process must be followed.
- The plan must also ensure that services are provided in a financially sustainable manner and should measure the financial impact of the NA role where possible in conjunction with other roles in the same setting.
- Measures of quality and early warning indicators are identified for the initiative and are monitored before (baseline), during and after implementation. A clear process for escalating concern, undertaking mitigating action, identifying positive outcomes to quality and patient experience to the director of nursing must be in place.
- The board is aware of, and understands, the ongoing impact of the plan; it monitors financial, operational, and quality outcomes as appropriate.

From the outset, providers should subject all plans to ongoing assessment for their potential impact on quality and patient experience. These assessments must include identification of negative consequences so that they can be eliminated or mitigated and positive outcomes so that they can be shared and celebrated. The minimum

¹³ National Quality Board (2012) *HOW TO: quality impact assess provider cost improvement plans*. www.gov.uk/government/uploads/system/uploads/attachment_data/file/212819/How-to-Quality-Impact-Assess-Provider-Cost-Improvement-Plans-.pdf

components for this QIA are patient/service user safety, clinical outcomes, patient/service user experience and staff experience.

- To be assured, a board will require confirmation that all plans for deployment have been systematically assessed for their impact on quality.
- The board needs to ensure that the quality assessments are of sufficient robustness and have captured all foreseeable risks and benefits. Risk scores should be attributed to each risk using a standard five-by-five risk matrix, which should be consistent with the organisation's risk management policy
- The board must be assured of the quality and comprehensiveness of the assessment.
- Key performance indicators and other quality measures, both long and short term, should be identified and monitored pre and post-implementation.
- Identify the mitigating actions necessary to avoid any negative impact on quality.

5. Additional considerations

Professional judgement

Staffing decisions based solely on professional judgement – the expert opinion of clinical staff – are considered subjective and may not be transparent, but professional judgement remains an essential element of staffing decisions. For this reason, we advocate a cross-checking approach, which uses a decision support tool in conjunction with clinical quality indicators and professional judgement/scrutiny.

Just as RNs have a range of experience and abilities that inform clinicians' local deployment decisions about the right mix of staff, the same is true for NAs. Deployment decisions are local clinical judgements about the capabilities of the individual RNs and NAs available. Just as RNs have both limitations as well as capabilities that define their scope of safe practice, so too will NAs. Deployment decisions should be about how best to manage the limitations of both and make the most of the abilities of both. They should provide growth and development for all to practise safely to the best of their abilities in the interest of patients.

The Department of Health and Social Care is commissioning evaluative research on the NA role that, in time, will provide an evidence base for deploying the NA. In the meantime, it is important to apply professional judgement to deploying the role, using available information and evidence and ensuring staffing decisions meet CQC requirements. This information and evidence should include the NMC's standards of proficiency, HEE case studies, CQC guidance and available research evidence.

Comparing staffing levels with peers

Peer comparisons can act as a platform for further enquiry. While you need to exercise caution, comparing staffing with peers can act as a 'sense check', particularly of assumptions and professional judgements. Benchmarking can also help stimulate the sharing of best practice.

Care hours per patient day (CHPPD) provide a useful metric for making these comparisons. CHPPD gives a picture of the total ward care workforce and will be split between RNs, nursing associates and healthcare support workers (see box below).

Care hours per patient day =	Hours of registered nurses alongside Hours of nursing associates and Hours of healthcare support workers
	Total number of inpatients (midnight census) ¹⁴

While the summary CHPPD measure includes all care staff, the RN hours must always be considered in any benchmarking alongside quality care metrics (Griffiths et al 2016b) to assess the impact on patient outcomes. The nursing associate will be on a separate line on the data and therefore will be seen publicly. This is an example of a ward (split between RN and HCSW):

www.nhs.uk/Services/hospitals/Services/Service/DefaultView.aspx?id=195266

The Model Hospital dashboard makes it possible to compare with peers using CHPPD. Finding peers that are close comparators is important, as aspects such as patient acuity, dependency, turnover and ward support staff will differ. You should take account of local factors – eg patient specialty make-up – as well as differences in the accuracy and completeness of data collection, and environment (hospital, community, patient home settings, etc).

¹⁴ Midnight census: definition (approximating 24 patient hours by counts of patients at midnight).

Right skills

Decision-makers should consider the skill mix required to deliver services as safely, efficiently and effectively as possible. Clinical leaders and managers should be supported to deliver high quality, efficient services, and staffing should reflect a multiprofessional team approach. Clinical leaders should use the workforce's competencies to the full, introducing and supporting the development of new roles where they identify a need or skills gap in line with national policy.

Role of nursing associates within a healthcare team

Nursing associates in healthcare settings will work closely with RNs, healthcare support workers, nurse specialists, nurse consultants and a range of other healthcare professionals. The following steps should be considered in determining who is best placed to safely meet the patients' care needs. To use the workforce efficiently and effectively it is important to identify the skills needed to deliver the care required and deploy the right staff to deliver that care.

Nursing associates will have a range of skills, knowledge and abilities. Their skills and proficiencies should be used to the fullest degree. This will enable them to successfully work within their competencies, bridge the skills gap between healthcare support workers and regulated professionals, and improve patient care. The needs of the patient are always paramount when determining what level of practitioner is required to care for them.

Leadership

The ward sister/charge nurse/team leader role is critical in ensuring the delivery of safe and effective care in care areas; they are responsible for ensuring staffing meets locally agreed levels. This post-holder is also responsible for setting the culture of compassionate care and teamworking.

The successful deployment of the nursing associate will depend (at least in part) on the commitment and understanding of the local leaders. Local leaders will require

educating about the role and how it can best be used and have an opportunity to discuss any concerns about implementation. As leaders are key to promoting understanding of the role and myth busting, organisations should ensure they are adequately prepared before deployment.

6. Measure and improve

Trusts should collect service-level and organisation-level metrics to monitor the impact of staffing levels, changes to skill mix and introduction of new roles on the quality of patient care, experience and outcomes, the use of resources and on staff themselves.

The aim is to continuously improve patient outcomes and use of resources in a culture of engagement and learning.¹⁵ Although there is little evidence of the impact of deploying the nursing associate, evidence-informed ward-based metrics may focus on:

- patient outcomes (eg infections, falls, pressure ulcers, suicide rates)
- patient incidents (eg medication administration errors, failure to escalate, restraint policy initiations)
- patient and staff experience (eg patient and staff survey, Friends and Family Test)
- staffing data (eg appraisal, retention, vacancy, sickness)
- process measures (eg hand hygiene, documentation standards)
- training and education (eg mandatory training, clinical training)
- financial impact of the role where possible in conjunction with other roles in the same setting.

These matrices will inform future evidence on the impact of the NA deployment within the workforce

¹⁵ <https://www.kingsfund.org.uk/publications/leadership-engagement-for-improvement-nhs>

Measure patient outcomes, people, productivity and sustainability

It is important to identify the aspects of quality that are linked to safe staffing in all care settings. The literature highlights that falls and medication errors are strongly linked to staffing (NICE evidence review, 2014),¹⁶ with other areas including omissions in care, missed or delayed observations and failure of observation policies.

Report, investigate and act on incidents

Trusts should follow best practice guidance in the investigation of all patient safety incidents, using root cause analysis¹⁷ for serious incidents.¹⁸ As part of this systematic approach to investigating incidents, providers should consider staff capacity and capability, and act on any issues and contributing factors identified.

Where nursing associates are deployed, NHS providers should consider reports of the 'red flag' issues suggested in NICE guidance,^{19,20} and any other incident where a patient was or could have been harmed,²¹ separately from other areas of routine risk management of patient safety incidents.

¹⁶ <https://www.nice.org.uk/guidance/sg1/chapter/2-Evidence>

¹⁷ <https://improvement.nhs.uk/resources/root-cause-analysis-using-five-whys/>

¹⁸ <https://improvement.nhs.uk/resources/serious-incident-framework/>

¹⁹ www.nice.org.uk/guidance/SG1

²⁰ www.nice.org.uk/guidance/ng4

²¹ <https://improvement.nhs.uk/resources/national-quarterly-data-patient-safety-incident-reports/>

All incidents must be reviewed alongside other data sources, including local quality improvement data (eg for omitted medication),²² clinical audits²³ or locally agreed monitoring information, such as delays or omissions of planned care.

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https://www.safetythermometer.nhs.uk/index.php?option=com%20_content&view=article&id=3&Itemid=10

²³ <http://www.hqip.org.uk/national-programmes/>

7. Snapshots from pilot sites

7.1 Cheshire and Wirral Partnership NHS Foundation Trust

Avril Devaney, Director of Nursing, Therapies and Patient Experience, says:

“At the Cheshire and Wirral Partnership pilot, each trust committed to identifying potential permanent posts by the end of the first year of training. We majored on person-centeredness and reviewed skill mix to maximise the potential of having a new role that encompasses biopsychosocial skills to achieve the best outcomes for patients. This is as relevant to acute care settings as it is to mental health, learning disability and community settings. Consideration was given to the function of teams, delegation and supervision arrangements. Once teams had been identified, then these became the final placements for the trainees. The trusts will be carrying out a full quality impact assessment on the role during this final placement to gain assurance that these are, indeed, the best settings before making the final decision on deployment.”

7.2 Royal Devon and Exeter NHS Foundation Trust

Professor Em Wilkinson-Brice, Deputy Chief Executive/Chief Nurse, says:

“Our trust was fortunate enough to be part of the Wave 1 pilot sites (as part of the Devon Sustainability and Transformation Partnership), so the role of the nursing associate and the safe deployment of NAs into our workforce has been an agenda item at various committees and meetings for some time. Those discussions have enabled us to reach a point where we feel we have a considered approach to that deployment. So, we have:

- devised a scope of practice that details what the NA can do in practice, the boundaries and expectations; this has been extremely useful to ensure the current workforce are of the same understanding, which minimises risks in the workplace

- utilised the national job description (JD), with local criteria as required, which are linked to NMC standards of proficiency for nursing associates and agreed the post-holder will work to the top of their JD
- provided the trainee NA/NA with their own uniform to ensure they are recognised as an NA
- engaged with colleagues to ensure that we have robust governance procedures around additional local sign-off competency, eg around medicine management
- considered the roles we have that also support registered nurses, such as assistant practitioners (APs), to understand the differences/similarities and where each could be used most effectively; as a result, we will continue to deploy APs where the skills required are very specific – eg renal dialysis, theatres – but in other areas such as general medicine and community care, where the role is more generic and requires a greater breadth of skills, we will deploy an NA
- considered the impact that registration and regulation will bring to the NA role as opposed to other clinical support workers
- at a series of ‘star chambers’ we met senior nursing staff from all areas of our organisation. Questions were asked to clarify issues such as funded establishments, current workforce numbers including staff ratios and vacancies, future service developments, number of learners in the area and associated challenges and solutions. Data such as staff numbers, sickness and turnover was also available to provide an evidence base for the discussions. The question was asked at each meeting, would an NA add value to this area and is there infrastructure/opportunity to make it right to deploy an NA here? As is established practice at the trust, questions were asked about skill-mix opportunities, ways to do things differently and development and deployment of new roles, but always with understanding and sound knowledge and professional judgement of safe staffing ratios being upheld.

Through these processes we feel we have a plan that will safely deploy the NA into our clinical workforce from January 2019.”

References and additional resources

Aiken L et al (2011) The effects of nurse staffing and nurse education on patient deaths in Hospitals with different nurse work environments. *Med Care* 49 (12): 1047-1053.

Aiken L et al (2018) Hospital nurse staffing and patient outcomes. *Revista Medica Clinica Las Condes* 29(3): 322-327.

Boorman S (2009) *NHS health and well-being: final report.*

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/pr od_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108907.pdf

Dall'Ora C, Ball J, Recio-Saucedo A, Griffiths, P (2016) Characteristics of shift work and their impact on employee performance and wellbeing: a literature review. *International Journal of Nursing Studies* 57: 12-27.

Dall'Ora C, Griffiths P (2017a) Nursing shift work in hospitals: what are the effects on patient and employee outcomes? Health Work Evidence Briefs 2, University of Southampton.

Dall'Ora C, Griffiths P (2017b) Flexible nurse staffing in hospital wards: the effects on costs and patient outcomes. Health Work Evidence Briefs 3, University of Southampton.

Department of Health (2016) *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations.*

<https://www.gov.uk/government/publications/productivity-in-nhs-hospitals>

Equality Act 2010: guidance.

<https://www.gov.uk/guidance/equality-act-2010-guidance>

Griffiths P, Ball J, Drennan J et al (2014) *The association between patient safety outcomes and nurse/healthcare assistant skill mix and staffing levels and factors that may influence staffing requirements* (NICE evidence review). University of Southampton Centre for Innovation and Leadership in Health Sciences.

Griffiths P, Dall'Ora C, Ball J (2017) Nurse staffing levels, quality and outcomes of care in NHS hospital wards: what does the evidence say? Health Work Evidence Briefs 1, University of Southampton.

Griffiths P, Ball J, Drennan J et al (2016a) Nurse staffing and patient outcomes: strengths and limitations of the evidence to inform policy and practice. A review and discussion paper based on evidence reviewed for the National Institute for Health and Care Excellence safe staffing guideline development. *Int J Nurs Stud* 63: 213–225.

Griffiths P, Ball J, Murrells T, Jones S, Rafferty AM (2016b) Registered nurse, health care support worker, medical staffing levels and mortality in English hospital trusts: a cross-sectional study. *BMJ Open* 5: e008751.

Hamilton J, Verrall T, Maben J, Griffiths P et al (2014) One size does not fit all: a qualitative content analysis of the importance of existing quality improvement capacity in the implementation of Releasing Time to Care: the Productive Ward™ in Saskatchewan, Canada. *BMC Health Services Res* 14: 642.

Hayes LJ, O'Brien-Pallas L, Duffield C et al (2012) Nurse turnover: a literature review – an update. *Int J Nurs Stud* 49(7): 887–905.

Health Education England (2015) *Mind the gap*.

https://www.hee.nhs.uk/sites/default/files/documents/Mind%20the%20Gap%20Report_0.pdf

Health Education England (2017) *HEE quality framework 2017/2018*.
https://www.rcpe.ac.uk/sites/default/files/files/hee_quality-framework.pdf

Health Education England. Recipe for workforce planning.
<https://recipeforworkforceplanning.hee.nhs.uk/>

Heslop et al (2013) *Confidential inquiry into premature deaths of people with learning disabilities (CIPOLD) final report*. University of Bristol.
<http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf>

Healthcare Quality Improvement Partnership. National quality improvement programmes.
<http://www.hqip.org.uk/national-programmes/>

Institute for Healthcare Improvement. Transforming care at the bedside.
<http://www.ihl.org/engage/initiatives/completed/tcab/pages/default.aspx>

Mental Capacity Act 2005, c.9.
<http://www.legislation.gov.uk/ukpga/2005/9/contents>

National Patient Safety Association. Root cause analysis (RCA) investigation.
<http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/>

NHS Safety Thermometer.
<https://www.safetythermometer.nhs.uk/>

NHS Employers. Health and wellbeing.
<http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing>

NHS Employers. E-rostering.

<http://www.nhsemployers.org/your-workforce/plan/agency-workers/reducing-agency-spend/e-rostering>

NHS Employers. Raising whistleblowing concerns.

<http://www.nhsemployers.org/your-workforce/retain-and-improve/raising-concerns-at-work-and-whistleblowing>

NHS Employers. Flexible working.

<http://www.nhsemployers.org/your-workforce/retain-and-improve/managing-your-workforce/flexible-working>

NHS Employers (2013) *Guidelines on prevention and management of sickness absence*.

<http://www.nhsemployers.org/case-studies-and-resources/2013/11/guidelines-on-prevention-and-management-of-sickness-absence>

NHS England. Safe staffing.

<https://www.england.nhs.uk/ourwork/safe-staffing/>

NHS England (2015) *Serious incident framework: supporting learning to prevent recurrence*.

<https://improvement.nhs.uk/resources/serious-incident-framework/>

NHS England (2016) *Leading change, adding value: a framework for nursing, midwifery and care staff*.

<https://www.england.nhs.uk/ourwork/leading-change/>

NHS England (2017) *Allied health professions into action. Using allied health professionals to transform health, care and wellbeing*.

<https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf>

NHS Improvement (2018) *Developing workforce safeguards*.

<https://improvement.nhs.uk/resources/developing-workforce-safeguards/>

NHS Improvement. NHS partnership with Virginia Mason Institute.

<https://improvement.nhs.uk/resources/virginia-mason-institute/>

NHS Improvement. National quarterly data on patient safety incident reports.

<https://improvement.nhs.uk/resources/national-quarterly-data-patient-safety-incident-reports/>

NHS Improvement. Safe sustainable and productive staffing: case studies.

<https://improvement.nhs.uk/resources/safe-sustainable-and-productive-staffing-case-studies/#acute>

NHS Improvement (2016) *Reducing expenditure on NHS agency staff: rules and price caps*.

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

NHS Improvement (2018) *Nursing and midwifery e-rostering: a good practice guide*.

<https://improvement.nhs.uk/resources/rostering-good-practice/>

NICE (2014) *Safe staffing for nursing in adult inpatient wards in acute hospitals: Safe Staffing Guideline [SG1]*.

<http://www.nice.org.uk/guidance/SG1>

NICE (2015) *Safe midwifery staffing for maternity settings: NICE guideline [NG4]*.

<https://www.nice.org.uk/guidance/ng4>

Nursing and Midwifery Council (2015) *Raising concerns: guidance for nurses and midwives: guidance for nurses and midwives on raising concerns*.

<https://www.nmc.org.uk/standards/guidance/raising-concerns-guidance-for-nurses-and-midwives>

Nursing and Midwifery Council (2018) *Standards of proficiency for nursing associates*.

<https://www.nmc.org.uk/standards/nursing-associates/standards-for-nursing-associates/>

National Quality Board (2016) *How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability*.

<https://www.england.nhs.uk/ourwork/part-rel/nqb/>

Reed C (2016) It's time to call on the A-team. *Health Service Journal* 126 (6377): 18-19.

Royal College of Nursing (2011) *Making the business case for ward sisters to be supervisory to practice*.

<https://www.rcn.org.uk/professional-development/publications/pub-004188>

Royal College of Nursing (2015) *Stepping in, stepping out, stepping up. Research evaluating the ward sister supervisory role (REwardSS). A survey to provide baseline activity in relation to ward sister/charge nurse supervisory roles*.

<http://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2016/february/005026.pdf>

Royal College of Nursing (2016) *Improving patient outcomes by improving staff health and wellbeing*.

<https://www.rcn.org.uk/>

Royal College of Nursing and Warwick University (2015) *A survey to provide baseline activity in relation to ward sister/charge nurse supervisory roles*

NHS England Publications Gateway Reference 04505

<https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2016/01/rcnri-report-supervisory-roles-survey-dec15.pdf>

The Trust Special Administrators of Mid Staffordshire NHS Foundation Trust (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.*

<http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffpublicinquiry.com/>

Simon M, Ball J, Drennan J et al (2014) *Effectiveness of management approaches and organisational factors on nurse sensitive outcomes* (NICE evidence review).
University of Southampton Centre for Innovation and Leadership in Health Sciences.

The King's Fund (2012) *Leadership and engagement for improvement in the NHS: together we can.*

<https://www.kingsfund.org.uk/publications/leadership-engagement-for-improvement-nhs>

The Shelford Group (2013) *Safer nursing care tool implementation resource pack.*

http://shelfordgroup.org/library/documents/130719_Shelford_Safer_Nursing_FINAL.pdf

Glossary

Capability: competence/skills/experience of the individuals within the care team.

Capacity: size of the care team relative to their workload and ability to manage it.

Ward establishment: the number of registered nurses and healthcare assistants and/or allied health professionals funded to work in a ward, department or hospital. This includes all staff in post, as well as unfilled vacancies or vacancies being covered by temporary staff. Ward establishments are usually expressed in whole-time equivalents.

Healthcare assistants (HCAs): work under the supervision and guidance of a registered nurse and are also known as nursing assistants, healthcare support workers (HCSWs) or nursing auxiliaries.

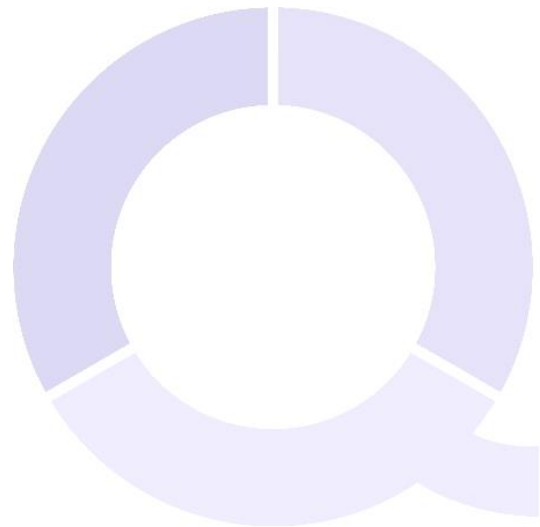
Patient acuity: how ill the patient is, their increased risk of clinical deterioration and how complex their clinical care needs are. This term is sometimes used interchangeably with 'patient complexity' and 'nursing intensity' (NICE 2014).

Patient dependency: the level to which the patient depends on nursing/AHP care to support their physical and psychological needs and activities of daily living, such as eating and drinking, personal care and hygiene, mobilisation, mental health.

Workforce planning: aims to ensure organisations strategically plan to have sufficient staff (clinical and non-clinical), with the appropriate skills, to meet the current and future needs of their population (HEE, *Recipe for workforce planning* <https://recipeforworkforceplanning.hee.nhs.uk/>).

Steering group members

Name	Title
Kathryn Halford (Chair)	Chief Nurse, Barking, Havering and Redbridge University Hospitals NHS Trust
Stephanie Aitken	Deputy Director of Nursing, Royal College of Nursing
Susan Aitkenhead	Director of Nursing – Professional Development, NHS England
Ann Casey	Clinical Workforce Lead, NHS Improvement
Natalie Cullen	Education Policy Manager, NHS Workforce, Education, Modernisation and Funding, Department of Health and Social Care
Avril Devaney	Director of Nursing, Therapies and Patient Partnership, Cheshire and Wirral Partnership NHS Foundation Trust
Samantha Donohue	Senior Nurse Manager – Transformation, Health Education England
Dr Jacqueline McKenna MBE	Director of Nursing – Professional Leadership, NHS Improvement
Toni Meyers	Project Manager, NHS Improvement
Carolyn Morrice	Chief Nurse, Buckinghamshire Healthcare NHS Trust
Mark Radford	Director of Nursing Improvement, NHS Improvement
Paul Reeves	Head of Nursing – Education and New Roles, NHS Improvement
Robyn Swain	Programme Lead, NHS Employers
Sue Tranka	Chief Nurse, Ashford and St Peter's Hospitals NHS Foundation Trust
Emma Westcott	Assistant Director, Strategy and Insight, Nursing and Midwifery Council



Contact:

NHS Improvement

Wellington House

133-155 Waterloo Road

London

SE1 8UG

0300 123 2257

enquiries@improvement.nhs.uk

improvement.nhs.uk

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