

Our staff consultation on the restructure

May 2016

FOR INTERNAL CIRCULATION ONLY

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Our staff consultation on the restructure

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1. Introduction

This consultation document contains the proposed changes to NHS Improvement's organisational structures and the proposed ways in which staff will be transitioned to them. The proposals have been approved by the NHS Improvement Executive Committee and also considered by trades unions and employee representatives ahead of publication. The consultation period starts on Monday 16 May and closes on Tuesday 14 June 2016 at 5pm.

The proposals in this consultation document have a clear purpose: they take an organisation-wide view about the structures we need in order to deliver the best support we can for patients and providers. The proposals are not intended to address the impact on each individual member of staff. Once this consultation stage is finished, we will start the process of filling posts, proposals for which are described in Filling of Posts Guidance in **Appendix A3**. At that point, staff will be informed about what it means for them as individuals.

A limited number of redundancies are expected as a result of the proposed restructure. In part, this is because a large number of roles across our organisation are already vacant.

How to feed back during the consultation period

Each of the directorates will be invited to a meeting with its Executive Director, or one of its senior team, between 16 and 20 May, providing all staff with an opportunity to find out about the consultation process, the proposed new structures and how we will transition to them. This session will be an ideal opportunity to ask questions before staff feed back their views.

To ensure we consult effectively on ways to minimise the impact of potential redundancies and that we receive useful feedback on the proposals, we have developed the following questions to frame the consultation. Please use these in your response:

1. Do you agree with the proposed structure for your directorate?

(a) yes (b) partially or (c) no

If the answer is (b) or (c), what don't you agree with?

What different structure (or part of a structure) would you propose?

2. Do you agree with the proposed transition arrangements for your directorate?

(a) yes (b) partially or (c) no

If the answer is (b) or (c), what don't you agree with?

What different transitional arrangements would you propose?

3. Do you agree with the proposed process for "Filling of Posts" set out in the Guidance document?

(a) yes (b) partially or (c) no

If the answer is (b) or (c), what don't you agree with?

What different process would you propose?

4. Do you have any additional comments?

5. Is there information missing that you need before responding to the consultation?

Each of our Executive Directors will nominate a 'go to' point of contact within their directorate, for staff to feedback to. Staff can also give their feedback to their employee/trades union representative or their HR contact.(see **Appendix A4** for contact details). Your nominated point of contact and employee/trades union representative will collate feedback on a regular basis which will be reviewed by the Executive Team and considered before the proposals are finalised.

Once the consultation period has closed, and feedback will be considered all staff will be given a summary of the key themes which have arisen and how they have been taken into account, together with any changes to the proposals that have been made. During the consultation process staff will also receive updates in Inside Improvement.

2. NHS Improvement's role

NHS Improvement's purpose is better health, transformed care delivery and sustainable finances. We will realise this through leadership of the sector and by supporting providers and local health systems to improve. In what is undoubtedly a challenging time for the sector, we will support providers to continually improve and drive up standards, delivering consistently safe, high quality care.

The challenges facing the system require a truly joined-up approach and increased partnership across the sector. We are committed to working closely with CQC, NHS England and other partners, including professional regulators, at national, regional and local levels. We will replicate this cross-functional way of working within NHS Improvement as well.

Bringing together the Trust Development Authority (TDA) and Monitor, Patient Safety including the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams; was a result of shared consensus among healthcare leaders and NHS providers. As a new organisation, we are still developing. We will ensure that the changes are not disruptive to the sector, and will continue to support providers to deliver improvements at pace and scale.

At NHS Improvement we have a unique opportunity to make a real difference to people's lives, by supporting providers and local health systems to improve for the benefit of patients. We want to enable all providers to take control and provide the best possible care to their local communities.

Our staff are highly professional with the expertise, skills and knowledge to make a lasting impact across the NHS and they are vital to NHS Improvement's success.

3. Rationale for change

It will soon be a year since the Secretary of State for Health announced the creation of NHS Improvement and in recent months we have worked hard to establish our new organisation.

We have many ambitions ranging from helping the sector deliver outstanding patient care, to reducing deficits and supporting the transformation needed to ensure long-term sustainability. The scale of this task should not be underestimated – and neither should the urgency and importance of getting this right.

At the same time, NHS Improvement, like all government departments and other arm's-length-bodies, is under pressure to make cost savings, a pressure that is expected to continue.

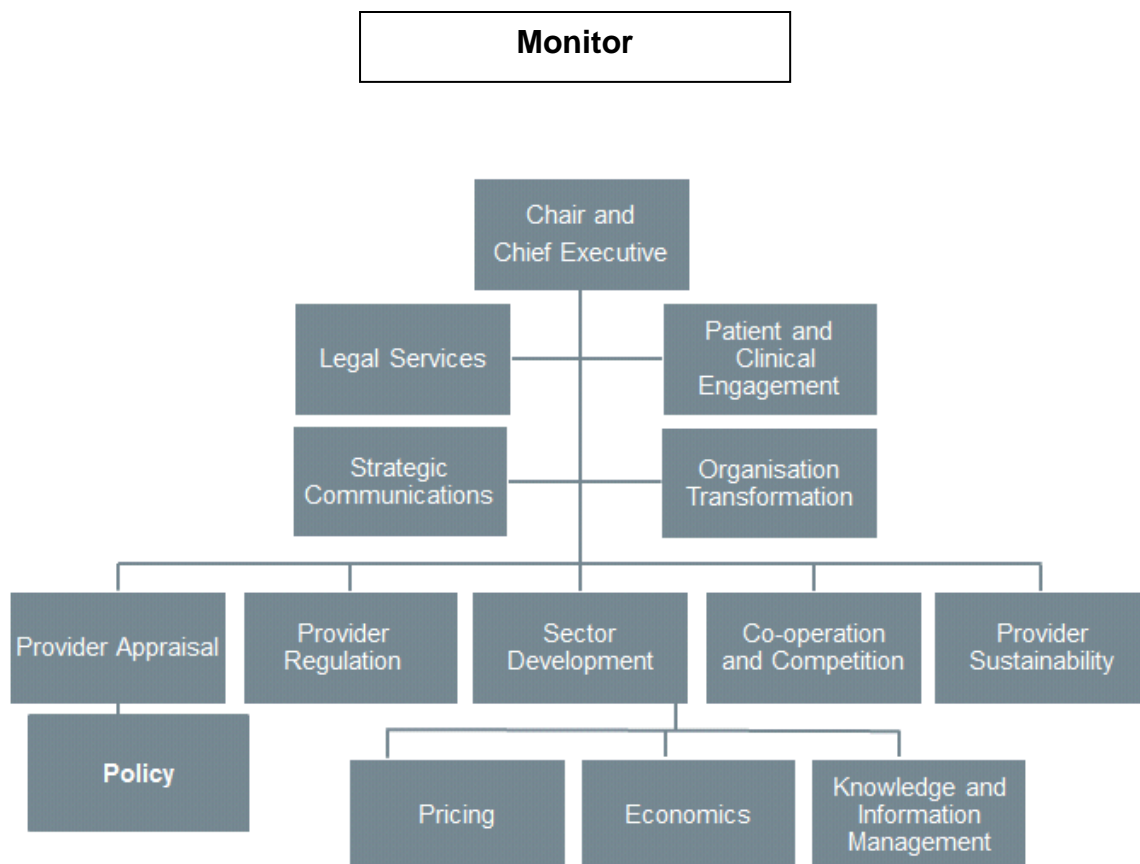
As a result, significant organisational change within NHS Improvement is needed. We need to integrate our people, resources and responsibilities to reflect our vision and purpose, and the priorities which will be set out shortly in our business plan. Our aim must be to build an effective and cost-efficient organisation which is able to adapt to the current and future demands on it. NHS Improvement will have a strong regional focus. This reflects our broader aim to work alongside providers and to rely on our relationships with the front line in individual trusts. There will be a strong centre, however, ensuring consistency, framing national policy, and providing intensive support for the most challenged trusts. The central teams will be a source

of expertise, developing good practice, and working flexibly according to the needs of the sector.

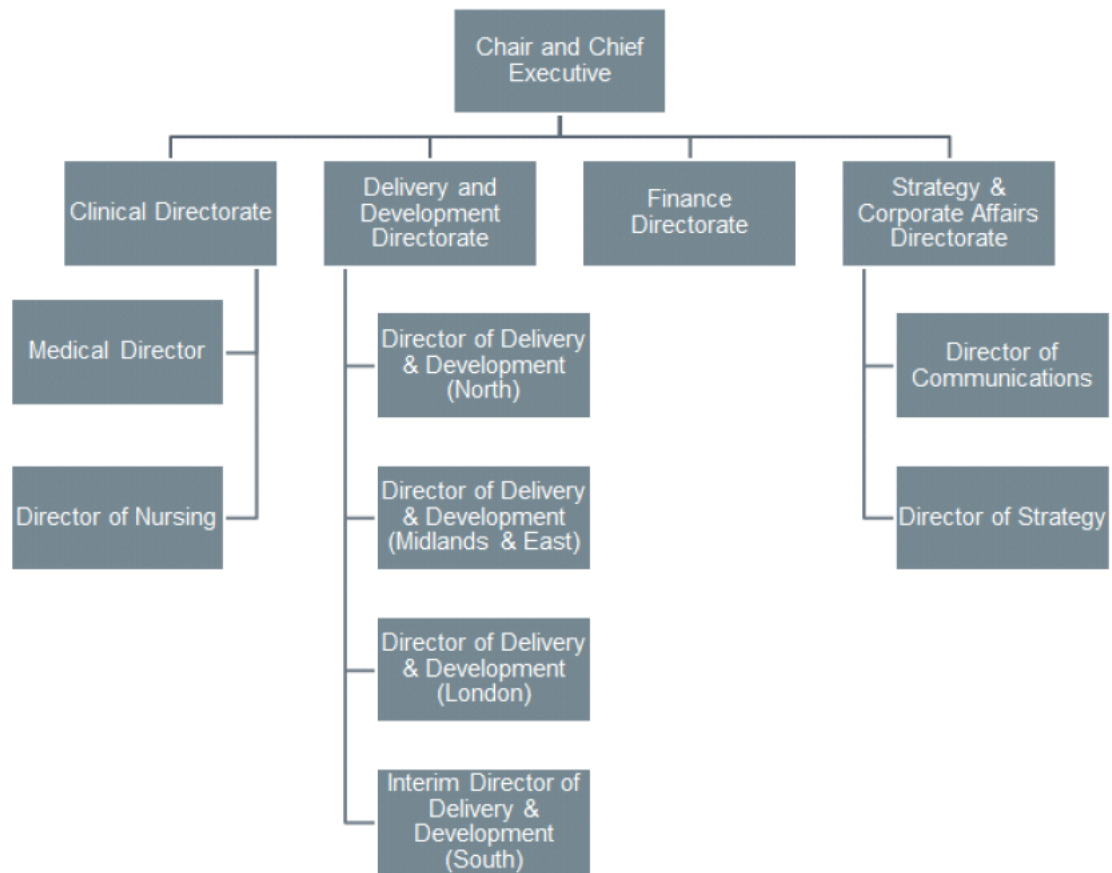
While the organisations are fully integrated into one operating structure, Monitor and TDA remain as the two legal entities which will employ staff.

4. Existing structures

The top-line structures for Monitor and TDA were:



NHS TDA (including Patient Safety, ACT and ISTs)



These NHS Improvement directorate structures were introduced on 1 April 2016:

Nursing	Resources	Regulation	Regions
<ul style="list-style-type: none"> Professional leadership of Nurses & Midwives Deputy Chief Nursing Officer Patient experience Infection prevention and control Workforce policy End of life care Mental health services Maternity services Allied Health Professionals Clinical engagement Quality improvement support Nursing and Midwifery revalidation 	<ul style="list-style-type: none"> Financial management Carter review implementation Professional leadership Internal finance Pricing Data & Analytics Digital strategy Internal risk management Corporate IT Support on provider planning process 	<ul style="list-style-type: none"> FT assessment & authorisation New Organisational Models Co-operation and Competition Transactions Interventions, including Financial Improvement Team Oversight Regulatory policy Licensing Legal & Governance 	<ul style="list-style-type: none"> Relationship management Assessment and diagnosis Delivery of support for improvement Organisation and system sustainability National operational priorities Co-ordination of local networks Leadership support & appointments
Medical	Corporate Affairs	Strategy	Improvement
<ul style="list-style-type: none"> Professional medical leadership Quality improvement Patient safety Special Measures Cancer services NHSI lead with CQC Clinical engagement Medical revalidation Caldicott Guardian 	<ul style="list-style-type: none"> Trust chair and NED appointments Private office Human Resources Organisation Development Stakeholder engagement Estates Corporate Issue Resolution Communications 	<ul style="list-style-type: none"> NHSI Corporate strategy NHSI business plan Annual provider planning Provider policy Sector strategy Strategy for Vanguard and New Care Models Economics 	<ul style="list-style-type: none"> Improvement methodology development and promotion of best practice Developing improvement capabilities Specialist support teams (eg ISTs and ACT) Talent management Leadership development

Existing staff from each of the employing organisations were aligned to one of these new directorates based on current roles and functions.

5. Factors influencing the new organisation design

The proposed directorate structures have been designed in a period when the organisation is still establishing itself, working on its objectives for 2020 and its 2016/17 business plan. We recognise that the organisation will need to adapt continuously, responding to the new operating model (once finalised and implemented), any future statutory changes, and, of course, the needs of providers. The aim of our proposals is to build NHS Improvement in a way that makes it fit for delivering what is required today and also able to respond to changing requirements in the future.

The key features of the new operating model that underpin the organisation design are set out in **Appendix A1**.

Given the significant financial challenge in the NHS, NHS Improvement must also demonstrate that, it understands that it must be as cost-effective as possible. Therefore, NHS Improvement will continually focus throughout the period of the spending review on implementing better ways of working and delivering greater efficiency. We expect this of the providers we oversee, so we have to also do it ourselves.

The total funded number of roles NHS Improvement had approved for 2015/16 was 1,244 full time equivalents (FTE). (FTE means posts measured as full time equivalents which accounts for job shares and part-time posts). This figure was the baseline to calculate what savings the proposed new structures promised to make.

The proposed number of roles in the new structure for NHS Improvement reduces to 1113.1 FTE (excluding the Chief Executive role). However, we have already reduced recruitment or filled roles temporarily over the last few months. As a result permanent staff numbers are about 100 FTEs fewer than this figure. This picture does vary across individual directorates and regions.

There are teams where the number of current staff appears the same or fewer than the proposed established headcount. However, the new roles may be designed differently from the current posts and may require different skills. We set out in section 6 of this paper our assessment of whether it will be possible to appoint the current number of staff in each team either by “slotting in” or by “ringfenced” competition: these are the two processes for transitioning individuals which we explain in section 6.

Overall, and as previously stated, we expect only a small number of redundancies as a result of our transition to the new structures during 2016.

6. Proposed directorate structures and transition proposals

This section provides an overview of each directorate, its headcount, and its proposed approach to transitioning people to the new structure. You should read this in conjunction with the set of structure charts available via the link in **Appendix A2** and the Filling of Posts Guidance in **Appendix A3**.

The short introduction to each directorate is included for context only, as the remit of the new directorates is now agreed. However, the structure charts and the processes proposed for the transition form part of the consultation process.

Usually, staff will be moved across to the new structure by one of two proposed methods called slotting in and ringfencing.

Slotting in: here you are confirmed into a post similar to your current post and where you are the only contender (or there are fewer contenders overall than the number of roles). This typically applies when the old and new roles are at least 70% the same in terms of job content, responsibility, grade, status and requirement for skills, knowledge and experience.

Ringfencing: here you are considered for a post which is typically more than 50% similar to your current post in terms of content, responsibility etc and/or where there is more than one contender for the role. A selection interview will be used to appoint an individual to the role.

6.1 Regional Directorates

The four Regional Directorates (North, Midlands and East, South and London) will play a key role in building strong relationships within local health economies. This is critical to the success of NHS Improvement in supporting providers to deliver high quality patient care.

The regional teams will provide a geographic lead for the delivery of key operational performance standards and will identify and implement improvement opportunities. These initiatives will be aligned to the requirements of individual providers within the context of the wider local health economy in which they operate. Regional teams will drive and enable quality, financial and service improvements in order to achieve a sustained level of success.

A critical internal relationship will be how regions interact with NHS Improvement's Regulation Directorate on the management and support of our most challenged organisations. While the regional teams will maintain NHS Improvement's day-to-day relationships with individual providers, regional and central regulation colleagues will work as part of matrix teams with other multi-disciplinary colleagues such as the regional finance and quality teams. They will work together to identify and apply

locally appropriate interventions to achieve the required levels of performance improvement in specific organisations and/or health systems.

Regional Directorates will work closely with colleagues in NHS England to develop a shared analysis with providers and local health economies on the performance challenges and solutions for the short and long-term. This will support the implementation of Sustainability and Transformation Plans. In light of this, we plan to move to a single operating/oversight model for foundation and NHS trusts as soon as this is agreed in the next three to six months.

Proposed new structure 353 FTE

Principles for structure design

We propose that:

- Each local health economy will have a core sub-regional team (led internally by a Delivery and Improvement Director). They will draw in regional specialist expertise and resource focusing on problem areas as appropriate eg working in a matrix way with finance, quality teams and colleagues from the central regulation function.
- Regional subject matter experts will have a 'dotted line' relationship to their central colleagues eg with the Director of Finance and Medical Director Teams. Their line management will sit within each region.
- Sub-regions will mirror NHS England's areas, to enable close working with our national partners. For example, posts will be either the same (or largely the same) and there will be collaborative regional governance arrangements.
- Capability for regulatory oversight will be considered in the appointment of the teams to provide development support, at a broad level and on an individual basis.

Transition proposals

The following principles are proposed:

- Regional staff will be considered for roles within the directorate they are currently aligned to.
- Existing staff will not be required to relocate, but provider-facing colleagues will be expected to spend time in the regional offices close to their provider(s) in accordance with the role they do.
- Staff will be selected for posts in the new structure through the slotting in and ringfencing principles in **Appendix A3**.

In some regions there may be enough positions to accommodate all our current staff, although this is not necessarily the case elsewhere. Suitability for roles will be reviewed against an individual's current grade, skill set and areas of expertise and in line with the Filling of Posts Guidance.

Where staff members wish to change role or regions in the future structure, the Executive Directors propose that:

- Staff can apply for roles outside their region if roles remain unfilled after all suitable staff from the other regional team have been considered for them.
- Staff members are free to apply for future vacancies as advertised within NHS Improvement eg following the conclusion of the wider restructuring process.
- Any transfer to a different region or directorate must be agreed with the respective Executive Directors, specifically the notice/transition period required to ensure continuity of service to providers is maintained.
- Where backfilling of a post is required in future (eg replacing a leaver), the Executive Director may change the location base of the post to meet operational needs at the time.
- To support potential internal moves and career opportunities, HR will continue to maintain the mobility database to establish if there are suitable voluntary moves, for example, noting where colleagues are willing and/or able to work in a different location.

6.2 Improvement Directorate

The Improvement Directorate is responsible for developing the organisation-wide approach to improvement and the use of evidence based improvement methodologies. This includes the provision of expert input and advice on the support offerings available to the NHS in areas such as emergency, elective and mental health care and quality improvement approaches for example application of the Virginia Mason methodology within the NHS and measurement for improvement/improvement analytics.

The directorate provides development support to providers, most notably at board level, by leading programmes and developing tools in areas such as strategy and the development of cultures for delivering high quality care within providers.

The Improvement Directorate is leading the development and delivery of the national strategy for leadership development and improvement, working closely with other national bodies to build up expertise and capacity in quality improvement. Within this work, the directorate is supporting the national approach to talent management across the NHS in England.

Through the Advancing Change and Transformation (ACT) Academy the directorate develops and delivers a range of training tools and programmes in Quality Improvement and Transformational Change.

The directorate has functional teams covering programme management, emergency care improvement, elective care improvement and mental health improvement, improvement and leadership development, operations and administration plus team support.

Proposed new structure 99.8 FTE

Transition proposals

The Improvement Directorate brings together the existing expertise across Monitor and NHS TDA as well as the Advancing Change Team, the Emergency Care Intensive Support Team and the Elective Intensive Support Team.

Given NHS Improvement's focus on improvement and the commissioning of additional improvement support, the target headcount has been increased above the original establishment. However the fixed permanent headcount is being reduced, with additional posts being provided through additional programme funding from NHS England. This potential funding is currently estimated at 20.4 FTE across Improvement, Emergency Care and Elective/Mental Health, with the fixed permanent headcount being 79.4 FTE. If the proposed funding changes, corresponding adjustments will be made to the temporary posts. Programme funding changes will not be subject to consultation.

There will be a number of unfilled posts that will be advertised in accordance with the Filling of Posts guidance. In addition there are a number of secondments in place across this team, which will be reviewed in accordance with existing policy.

The ACT Academy also has a significant pay budget available for contract staff. It is proposed that, once the operating model is finalised, a future review will consider whether it is more cost effective to convert this into additional headcount within this directorate or another part of the organisation.

6.3 Regulation Directorate

The Regulation Directorate will design and implement solutions to resolve the most complex problems faced by the most distressed NHS providers and local health economies, in a way that supports improvement across the sector. In addition to this, it will oversee the appraisal and authorisation of NHS foundation trust applications, provide support on transactions, the development of new care models and patient choice. The directorate will encompass the work of Monitor's Transformation and Turnaround team, the Provider Appraisal team, Sustainability and Solutions Development team, Legal team (including the Secretariat), Co-

operation and Competition team, and some members of the Distressed Finance team, and some former TDA staff who worked on transactions.

The Directorate will work closely with NHS Improvement's regional teams to ensure consistent application of the regulatory regime at a local level, such as investigating possible licence breaches at foundation trusts and – where it is agreed that a provider is operating in breach of its licence – agreeing remedial actions.

While the Regulation Directorate will have extensive accountabilities around the consistency and coherence of NHS Improvement's regulatory activities, it will not carry out all the work at the front line itself. It is expected to support only the most challenged providers directly with intensive support. Outside this, the Regional teams will identify underlying issues that are emerging with individual providers, with a view to preventing their deterioration. Similarly, where the Regulation Directorate has already intervened and a provider is on the road to recovery, the Regional team will work to ensure this is sustained.

Proposed new structure 177.6 FTE

Transition proposals

A number of regulatory policy decisions are yet to be made which will affect decisions on resourcing. In the meantime, vacancies arising within the new structure will not be automatically backfilled and recruitment requirements will be reviewed on a case-by-case basis, enabling the directorate to manage its headcount through attrition where appropriate. This will support the directorate in meeting savings requirements and in continuing to align its resources to required ways of working.

To ensure the Regulation Directorate has maximum flexibility to deploy its resources, it will adopt new ways of working, principally more use of multi-disciplinary project-based teams. To support this it is proposed that the current Provider Appraisal, Transformation and Turnaround, and Sustainability and Solutions Development and those individuals working on transactions are brought together into a single team which can be utilised in a more flexible way. This will support the changing needs of providers and other parts of NHS Improvement. Therefore, it is expected that roles will not change radically, but the ways of working and the resourcing of specific projects and interventions will be adjusted. While the majority of roles are expected to be filled by slotting in, there may potentially be some roles filled by ringfencing, subject to outcomes of senior appointments in the team. The title of the Appraisal and Restructuring team may change as a result of feedback received during the consultation.

The structure and work of both the Legal team and the Co-operation and Competition team are not expected to change at this time, (although the permanent directorate for the co-operation and competition policy roles is being considered). Therefore, it is proposed that roles are filled by slotting in at this point. However, it is

envisaged that we will explore a number of different ways of working in order to make the best use of resources and skills within these two teams and respond to changing priorities across the sector.

While it is proposed that the structure and remit of the current Operations and Performance team remain similar to its current form, we are considering the Independent Providers and Investigations team joining it. This would preserve these two teams as discrete functions, rather than dispersing their staff across the Appraisal and Restructuring team. Further work will be undertaken during the consultation to establish if this is the most appropriate approach.

It is proposed therefore that the majority of roles in these teams will be filled by slotting in, although roles may potentially be ringfenced at director level, and within the Operations team. There are expected to be a small number of vacant posts which will be advertised in accordance with the Filling of Posts guidance.

6.4 Resources Directorate

The Resources Directorate brings together core teams essential to the day-to-day running of NHS Improvement and supporting the wider sector.

The directorate has responsibility for ensuring NHS Improvement meets all of its statutory financial duties and responsibilities, including developing the financial strategy and financial performance framework for the NHS, and providing expert advice. Our statutory responsibilities also cover pricing and the National Tariff, and national leadership of areas such as the Carter Review.

The Resources Directorate will also manage the informatics and analytics function of NHS Improvement to develop and share robust data infrastructures that the organisation can rely on, and will work with other national bodies to ensure that the data requirements of NHS organisations are proportionate. This function includes information technology support, data, and the development of an analytics hub providing a single picture of how the sector and individual trusts are performing. This will also help support NHS Improvement's understanding of how far trusts have adopted a quality improvement approach. The pricing and financial strategies for the sector will be underpinned by new developments in costing.

The current functional teams are finance, internal finance, informatics and analytics, technology, pricing, programmes and business management. The national finance team will be based in our London and Taunton offices.

Proposed new structure 229 FTE

Transition proposals

Because the organisation has minimised recruitment activity and the directorate has removed appropriate vacant posts, the current substantive headcount is close to the target headcount proposed.

Finance

In moving to the new finance structure it is proposed that the majority of roles will be filled by slotting in, although there will be a small reduction in the number of roles to create further efficiencies and reflect the fact that we are moving to a regional model. There may be a need to ring fence the reduced number of roles. Two areas - Capital and Cash and Sector Reporting - have been identified where there are more candidates than roles and therefore it's proposed that roles will be filled by ringfencing. The proposed structures indicate that there may be some unfilled posts within the Financial Planning and Strategic Finance teams and any vacancies will be advertised in accordance with the Filling of Posts Guidance.

Pricing

The proposed structure creates an opportunity to align the various pricing processes better, to both support efficient ways of working including greater joint working. In the structure there are defined responsibilities for the development of the annual tariff and fulfilment of statutory duties.

Where there are no significant changes proposed in the structure it is expected that existing staff will slot into roles. The changes mean that we expect to have a reduced number of director level posts, therefore these posts are likely to be filled by ringfencing.

The Costing area is expected to be mainly unchanged with the addition of a few new functions including Costing Audits and Enforcement. Most roles will not change and will be filled by slotting in; however, we are proposing to introduce new manager roles to support these new functions.

Pricing Strategy encompasses the remit of the previous Development Team and has some proposed new functions such as local pricing rules. There are expected to be a small number of posts at lead and manager level which are likely to be filled by ringfencing.

Pricing Regulation's role is to oversee and direct our regulatory policy and method, including the National Tariff. It is likely that the lead and manager roles will be filled by ringfencing.

Pricing Analysis will manage the tariff model and the inclusion of various inputs into it. Although two specialist lead responsibilities remain unchanged, lead and manager roles are expected to be available for staff whose skill set is more aligned to the technical elements of tariff development.

Within the Operations function, it is proposed to include three areas: Resource Management; Programme Management (including Tariff Editing); and Clinical and Sector Relations.

It is proposed that Partnerships and Clinical and Sector Relations are brought together as one team, to support efficiencies and reduce any duplication. Within this area there are fewer manager roles proposed, and therefore they are expected to be filled by ringfencing.

It is proposed that Pricing Analysts will operate as a resource pool under a Resource Manager, and the roles are expected to be filled by slotting in. However, there may be a number of vacant posts which will be filled in accordance with the Filling of Posts Guidance.

It is proposed that all Programme Managers and Project Managers operate as a resource pool within the Operations function, and they will manage programmes of work through matrix management. This means that there will be fewer posts, and these will be filled by ringfencing; however we expect other suitable alternative roles will be available.

The Technical Editor posts are not proposed to change and one role is currently vacant.

Given the extent of changes in the Pricing function, there is expected to be a reduced need for administration support.

Given the specialist nature of the roles and the transferrable skills of the existing Pricing team, all roles will be filled by ringfencing. It is expected that even with the changes and reductions the majority of existing staff will have opportunities within the team.

Informatics and Analytics

The Information Analyst team of five roles, previously part of Monitor, has been integrated into the wider Informatics and Analytics team, led by a Director of Informatics and Analytics. The structure of the combined team is largely unchanged, as the functionality will continue to be required and developed by NHS Improvement. Therefore, it is expected that the majority of roles will be filled by slotting in, and there may be a limited number of roles at line management level filled by ringfencing.

Technology and Data

The Technology and Data team's core function remains largely unchanged with the exception that the analytics function is proposed to move to the Informatics and Analytics team. The data management function is proposed to expand to incorporate team members transferring in from the Informatics and Analytics team. The two teams will work closely together to deliver the information needs of the business.

Role changes have been identified where there is a need to better align to NHS Improvement's strategic needs; and some efficiencies have been made within the new structure.

The most significant changes are proposed in the Delivery and Operations team. In order to support the required technology changes that underpin NHS Improvement's objectives, it is likely that short-term resource will be brought in to manage specific projects.

It is proposed that the number of roles currently supporting projects and governance be reduced in size in order to focus on overall contractor commissioning, benefits management and improving operational efficiency. As a result, there will be a reduced number of roles across the team and these are likely to be filled by ringfencing,

To create greater efficiencies the proposed structure includes a reduced number of roles at administration and managerial level. These will be filled by ringfencing.

There will be a reduced requirement for web solutions and SharePoint developer roles and therefore at least two posts are proposed to be removed from the structure.

In addition, the Information Governance team, previously within TDA, will transfer to the Technology and Data team, and will be largely unchanged due to the discrete nature of its activities. Therefore, for the majority of roles it is proposed the structures will be filled by slotting in.

Procurement and Risk Management

Procurement and Risk Management are part of the structure and posts are likely to be filled by slotting in and ringfencing.

6.5 Nursing Directorate

The Nursing Directorate provides strategic input on nursing and midwifery issues at a national level, to NHS Improvement's Board and to partners across the healthcare system. The directorate will provide professional nursing, midwifery and allied health professional leadership to providers.

Working closely with the Medical and Regional Directorates, the Nursing Directorate will develop and manage relevant clinical engagement activities across NHS Improvement's operations. Priority areas for the directorate are:

- professional leadership and development to nurses, midwives and allied health professionals across the provider sector
- infection prevention and control
- workforce policy
- mental health
- maternity and children's services
- patient experience.

In conjunction with the Improvement and Medical Directorates, the Nursing Directorate will also have a quality improvement and efficiency function that will drive forward change to help enhance the quality of patient care in trusts.

Proposed new structure 34.1 FTE

Transition proposals

The Nursing Directorate brings together the existing expertise across both Monitor and NHS TDA into one integrated directorate. Specialist teams will be established to provide the necessary focus and support to regional teams and trusts. These teams are proposed to be:

- Nursing: leading on patient experience, professional development, and infection prevention and control
- Improvement: leading on workforce matters and delivering a programme of quality improvement projects

- Maternity and children's services
- Mental Health
- Allied Health Professionals
- Business operations.

Because the organisation has minimised recruitment activity, and additional substantive staff have not been brought into the directorate, the current headcount is well below the target headcount. Therefore no reductions are needed and it is proposed to fill a number of roles from the existing team by slotting in or ringfencing. There will be a remaining number of unfilled posts, which will be advertised in accordance with the Filling of Posts Guidance.

Joint appointments

Discussions have been underway to consider new ways of working to strengthen system leadership at a regional and local level. The emphasis on balancing organisational-led planning with joined-up placed-based planning has significant implications for the way arm's-length bodies work together to plan, assure and deliver the nine must do's of the planning guidance and the creation of local Strategic Transformation Plans. In particular, this will require ever-increasing collaboration and alignment between NHS Improvement and NHS England, removing unnecessary fragmentation and duplication. One way to support this is to consider the potential to make some joint appointments which would:

- provide clear system leadership to the NHS
- deliver system wide objectives and accountabilities whilst ensuring that institutional ones can also be delivered
- reduce areas of interface and promote collaboration
- reduce fragmentation and duplication of activities and maximise use of resources
- create attractive roles.

There are a range of roles where joint appointments between NHS Improvement and NHS England could be created. In the first instance the bringing together of clinical functions has been identified as the obvious starting point. We are committed to establishing Regional Chief Nurse roles across both organisations. These will report to the Regional Directors with professional accountability to the nursing leadership across the two organisations. These will be rolled out initially in London and the South. Should any member of staff within NHS Improvement's meet the criteria for slotting in or ringfencing to these roles, then the process set out in the Filling of Posts Guidance will be followed. Likewise, a priority interview would be given to someone at risk who met the essential criteria for the role.

NHS England will be undertaking a consultation and subsequent slotting in or ringfencing process where there are individuals in post who may be affected by the decision to establish joint regional nursing roles.

NHS Improvement and NHS England are working together to ensure a fair and joint process and will work in partnership with trades unions to achieve this.

6.6 Medical Directorate

The purpose of the Medical Directorate is to provide strategic input into medical issues at national level, to NHS Improvement's Board and to partners across the healthcare system. The directorate will provide professional medical leadership to providers and, in conjunction with NHS England, to the wider NHS.

Working closely with the Nursing and Regional Directorates, the Medical Directorate will develop and manage clinical engagement across NHS Improvement's operations. Priority areas for the directorate are to:

- provide professional medical leadership to NHS Improvement medical staff, the provider sector, in conjunction with the National Medical Director of NHS England, and the wider NHS
- provide national oversight and lead on quality improvement for the provider sector
- lead on oversight and engagement across NHS Improvement to rapidly improve quality in all providers in special measures, helping them to exit special measures quickly and sustainably; whilst also overseeing intensive work with providers at risk of special measures, to help them avoid falling into it
- drive continuous improvement in patient safety
- lead on strategic service change in areas including cancer services, 7 day services, and the new junior doctor and consultant contracts
- lead strong and effective partnership working with the Care Quality Commission (CQC).

Patient Safety is part of the Medical Directorate, and gives NHS Improvement capability to drive professional leadership, partnership working and oversight in this vital area. In conjunction with the Improvement and Nursing Directorates, the Medical Directorate will have a quality improvement and efficiency function that will drive forward change to help enhance the quality of patient care in trusts.

Proposed new structure 90.4 FTE

Transition proposals

The Medical Directorate brings together existing expertise into one integrated directorate. Specialist teams are proposed to provide the necessary focus and support to other NHS Improvement directorates and providers. These are:

- Deputy Medical Director/Clinical Team
- Quality Intelligence and Insight
- Business and Operations
- Patient Safety
- Improvement Directors (trust based)

As these teams existed previously there is minimal change to the structure now they are brought together into one directorate. Therefore, it is proposed that the majority of posts will be filled by slotting in. There will be a number of unfilled posts that will be advertised in accordance with the Filling of Posts Guidance.

Future savings may be needed if, for example, programme funding reduces in the directorate. Programme funded changes will not be subject to consultation.

6.7 Strategy Directorate

The Strategy Directorate is responsible for policy and economic analysis and it contributes at system, corporate and directorate level. The directorate works closely with NHS Improvement's Board, leaders of other directorates, and with national organisations to develop national policy and strategy, and to provide clear and consistent direction in line with the Five Year Forward View.

The team provides high-level analysis and problem solving to inform the organisation's sector-wide work. The emphasis is on in-depth analysis that can translate into practical support for trusts and influence the sector in a way that drives improvements. With a single strategy to support the sector this will help ensure that NHS Improvement speaks with a coherent voice to providers

The Economics team will continue to work alongside economists embedded in other directorates, providing professional leadership across the economics profession within NHS Improvement.

Proposed new structure 54 FTE

Transition proposals

Economics was historically a Monitor function and efficiencies have been made by not filling vacancies in the existing team. Therefore, based on the proposed headcount position the existing number of roles is unchanged, and these roles are expected to be filled by slotting in.

The majority of the policy roles are now grouped into the Strategy Directorate (such as TDA policy and provider policy). In considering the most efficient model, there have been reductions in the policy advisory area across all grades, and this has been achieved by not filling vacancies. Therefore, most roles will be filled by slotting in. It is proposed to fill roles at senior policy adviser level and executive assistant level by ringfencing. There are a number of secondments, in place or planned, which are likely to mitigate displacement in the existing team.

6.8 Corporate Affairs Directorate

The Corporate Affairs Directorate brings together a number of the functions providing corporate support to NHS Improvement, and ensures that relevant core services, plans and systems are in place to support the delivery of NHS Improvement's operating model and business plan. In addition, the directorate is responsible for some statutory functions concerning NHS trusts, in particular the appointment and development of NHS trust chairs and non-executives.

The directorate will focus on the management and development of corporate services including the full range of communications functions, HR and recruitment, organisational effectiveness, estates and accommodation. In addition, the directorate includes the Chair and Chief Executive's private office.

Whilst there is a separation of functions in the proposed structure, as they have different responsibilities, all the teams within the directorate will support each other. The directorate and the wider organisation should have a clear understanding of what each can expect the other to deliver.

Those functions that support trusts have been separated from those that support NHS Improvement, so that the necessary internal and external focus is maintained.

Proposed new structure 75.2 FTE

Transition proposals

HR and Organisational Effectiveness

It is proposed that the Organisational Transformation Team in Monitor and internal HR team in TDA become two teams - an HR team and an Organisational Effectiveness (OE) team, the latter including organisational development, workforce data and corporate services.

It is envisaged that the HR and Recruitment team will be filled largely by slotting in and a small number of posts by ringfencing. There is at least one role currently identified where there may not be any potential post holders within the organisation.

It is proposed that the OE team will be filled by a mixture of slotting in and ringfencing. It is anticipated that there may be a need for redeployment outside of the OE team where possible. There may be a new role with no potential post holder within the organisation.

Trust Resourcing

It is planned to separate the external HR governance function currently sitting in TDA HR from the new internal HR function to form the Trust Resourcing team. It is proposed the team will largely be filled by slotting in.

NHS Trust Non-Executive Director Appointments

The NED appointments team will remain largely unchanged for the present although it will no longer be aligned with the TDA corporate governance function that now sits in the Legal team in the Regulation Directorate. Discussions are underway with the Office of the Commissioner for Public Appointments that may change the statutory functions delivered by this team. As those discussions conclude, the role and structure of this team will be reviewed further and consulted upon if necessary.

Private Office

The Private Office remains largely unchanged and will be supported by secondments from Strategy and/or clinical fellows (Medical Directorate). The majority of roles are proposed to be filled by slotting in.

Communications

It is proposed that the Communications function will be a central function; but there will be communications roles also located in the Regional directorates.

The majority of roles within the central communications team will be filled by slotting in. Although there are fewer posts overall in the new structures, it is envisaged that based on pre-planned movements, and the filling of roles in the regional teams, no immediate headcount reductions will be required.

7. Proposed appointment processes

The Filling of Posts Guidance **Appendix A3** sets out the processes which the organisation is proposing to use to populate the new organisational structures.

Terms and conditions of employment

Following the slotting in and ringfencing process staff will be appointed on their current salary, unless the role is of a lower grade, whereby pay protection will apply in line with existing policies (see **Appendix A5** for supporting policies and links).

There are no proposed changes to terms and conditions of employment for individuals as part of these proposed changes to our structures, and staff will retain the terms and conditions of their current employing entity (Monitor or NHS TDA).

8. Supporting individuals at risk of redundancy

Given the nature of the proposed changes described above, it is anticipated that the majority of roles will be filled by existing staff by slotting in or ringfencing, and so **the number of potential redundancies will be minimised overall.**

There is a requirement to collectively consult if we are going to make 20 or more redundancies. It is not possible to determine the potential numbers of redundancies until the filling of posts processes are completed. Therefore, we are currently consulting collectively in the event that there may be 20 or more redundancies. This does not in itself mean that there is a requirement for the organisation to make redundancies at this level. We will provide further information to employee and trades union representatives on potential redundancy numbers when this information is known.

For those individuals who find themselves unassigned at the end of the filling of posts processes, it is proposed that NHS Improvement will offer the following support:

Individual consultation

Each individual at risk of redundancy will be supported in a two-week individual consultation period during which efforts will be made to find a suitable alternative role. If this does not prove successful then notice will be given, in line with the organisation's change management policy (**Appendix A5**). We will support individuals with search for suitable alternative employment during the two-week individual consultation period and if notice is given, during the notice period.

Internal support

The HR team will provide support with workshops on CV preparation, using online job search tools (eg LinkedIn), managing job searches, preparing for interviews, and, if appropriate, one-to-one career coaching.

The HR and Recruitment team will also track unfilled vacancies from the Filling of Posts processes, and support internal candidates in seeking suitable alternative employment across NHS Improvement and in the wider sector, using websites and job lists from other arm's length bodies, NHS Jobs, the civil service, and other regulators.

Outplacement

The use of outplacement services will be considered once the number of potential redundancies is known, so that the appropriate level of offering can be considered. We will discuss this further with trades union and employee representatives at that point.

9. Consultation timeline

Key consultation milestones	Dates
All staff announcement – launch of formal collective consultation	16 May 2016
Commencement of formal consultation	16 May 2016
Collective consultation closes	14 June 2016
Appointment processes for restructure	Mid June to July
Individual consultation with colleagues not appointed, including search for suitable alternative roles	July
Continue to recruit for remaining gaps in organisational structures	July

10. Communication plan

Key communications	Dates
All staff announcement and publishing of consultation paper	16 May 2016
Directorate group meetings	16 May to 20 May
Wider Leadership Team – update briefing	19 May
Feedback on consultation paper: Executive Director reviews and responds to individuals/teams	21 May to 14 June
All staff briefing – update	24 May
Consultation updates/FAQs included in Inside Improvement (as needed)	23 May; 31 May; 6 June; 13 June
Close of consultation and next steps	16 June
Response to consultation paper feedback: summary paper of key feedback and how it has been considered.	20 June

Appendices Index

A1 Draft Operating Model Principles

A2 Proposed Directorate Structures

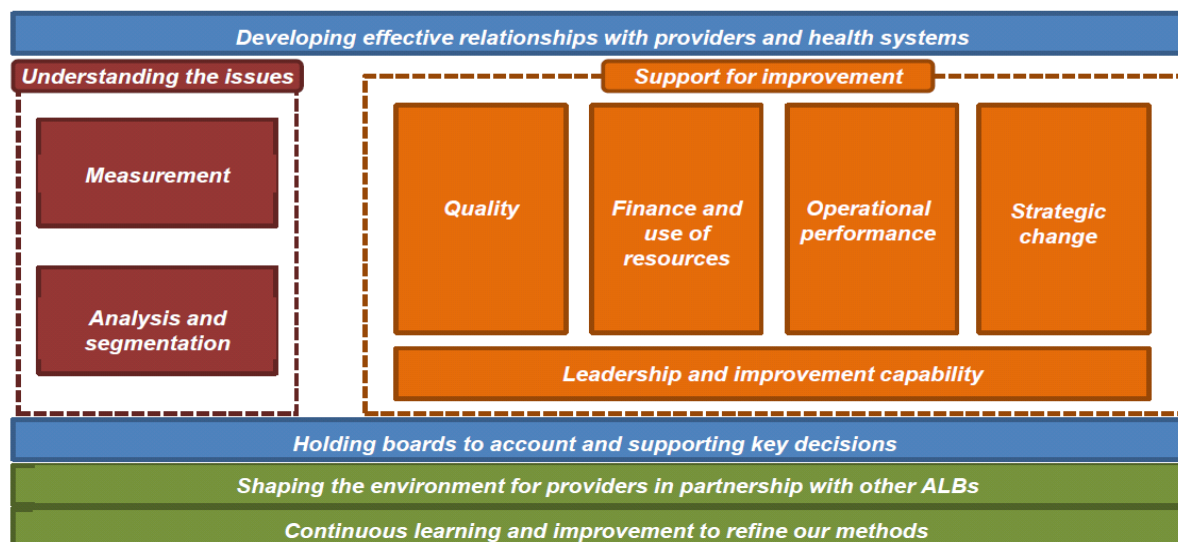
A3 Filling of Posts Guidance

A4 Support for colleagues

A5. Supporting policies and links

APPENDIX A1 – DRAFT OPERATING MODEL PRINCIPLES

This diagram includes the core components of our draft high level operating model, which is designed to help us deliver better healthcare, transformed care delivery and sustainable finances. The operating model is being developed alongside our organisational structure.



Among the features of the operating model:

Regional teams developing effective relationships with local health systems

Providers will be accountable to NHS Improvement and other partners, such as CQC, providing the basis for building an understanding of the issues

In addition to the universal support for improvement to all providers and systems, segmentation according to the new single oversight framework will inform targeted and directive support for improvement. Most support will be provided through regional teams with expertise and professional leadership from national teams. National teams will take the lead only on some of the most challenging issues – which is determined when a provider meets a clear set of conditions and is considered to be in the lowest segment in the framework

Where NHS Improvement has a duty to hold boards to account it will do so based on an understanding of effective relationships on the ground and with insight from the Analytical Hub

NHS Improvement will shape the environment at a macro level for providers and systems

In everything NHS Improvement does it will encourage providers and systems to become continuous learning organisations and will demonstrate these behaviours in its own ways of working

We will need effective cross-functional working across NHS Improvement with colleagues working in a spirit of collaboration.

APPENDIX A2 – [REDACTED]

[REDACTED]
[REDACTED]

APPENDIX 3 - FILLING OF POSTS GUIDANCE

Background and context

1. In order to support the integration activities to create NHS Improvement we need an approach that will allow us to fill posts in the new structure, as far as possible through slotting in or ring-fence competition (through competitive interview) of Monitor and TDA employees in a fair and equitable manner. We need to do this at pace, and in line with our change management policy principles.
2. Proposals were discussed during March with the Wider Leadership team, and also the TDA JCNC and Monitor Employee Forum on the proposals to support the approach to job matching and slotting in/ring fencing. The key feedback received and the subsequent revised approach to take into account the feedback received are below.

Feedback Received

3. The key feedback themes from our meetings with the 2 forums were:
 - Feasibility of matching roles across the two employing entities, due to the differences in the existing evaluation systems, and concern about potential risk of equal pay issues
 - The impact on grade for individuals matched
 - Ability to cross reference job descriptions, given different evaluation systems they were written for
 - Clarity on job families and how unique or common roles would be identified
 - Volumes of matching required and timescale to achieve this in
 - Requests for amends to improve readability and understanding of the proposal

Solutions: Ensuring a fair process

- The two employing entities will continue from 1 April 2016, and so the two associated sets of terms and conditions will remain in place for existing staff after 1 April
- The two job evaluation and pay frameworks will be maintained and operated throughout the integration process and a distinction has been factored into the proposal (below) for evaluation of roles in the new structure.
- New hires will be employed on NHS Agenda for Change terms (unless it is an unique Monitor role which will be approved by the Remuneration Committee by exception)
- Current staff will fill roles through slotting in and ring fencing as far as possible in accordance with the current Change Management policy, and the offers made as a result of the integration process will be defined by the individual's current employer in terms of which pay framework and terms are confirmed.

A summary of some terminology used is attached at annex 3.

Filling of posts proposal:

There are four stages in the process, which are Stage 1 – Review of current roles, Stage 2 – Develop new role descriptions, Stage 3 - Filling of posts through slotting in/ringfencing, stage 4 – Filling of posts after slotting in/ringfencing which are explained below:

Stage 1 – Review of current roles

Review of current Monitor and TDA roles grouped by job family and job title (and if necessary look at JDs) by HR teams, with referral to Executive Directors/their nominees as necessary, to assess the following:

- a. Roles that are considered uniquely Monitor or TDA (and therefore do not need to be priority for evaluation);
- b. Roles that are common to both Monitor and TDA. Job descriptions for these roles will be made available as necessary to inform the new job descriptions for NHSI.

Stage 2 - Develop new role descriptions

1. Assess number of roles arising from new structures and classify as:
 - (a) Monitor roles that have been carried forward from the old world structure into the new organisation and are unique Monitor roles (retaining their Monitor grade), and are unchanged.
 - (b) TDA roles that have been carried forward from the old world structure into the new organisation and are unique TDA roles (retaining their existing AFC grade), and are unchanged.
 - (c) roles that are common across NHSI (including those current roles in Monitor and/or TDA that are updated with changes) and need matching/evaluating for BOTH an AFC grade, which is a national process used throughout the NHS, and evaluating under the Monitor JE approach for a Monitor grade, this is the system which has been used in the past to evaluate Monitor roles and which was developed by Mercer, a global reward and talent management consultancy, (VSM roles – ie over £100/120K will be evaluated independently through DH in accordance with current practice for ALB VSM roles).
2. Wider leadership team nominees (advocated by Executive Directors) to draft JDs for (c) as a priority, supported by HR Business Partners (HRBPs) acknowledging the confidentiality of the task. JDs need to be in NHSI JD template format (which should then provide enough information for VSM, Monitor and TDA AFC job grading systems).
3. Evaluate roles for (c) under the existing Monitor job evaluation system, (Mercer with HR/business validation session)
4. Evaluate any roles under (a) that were not previously fully evaluated under the Mercer process.
5. Arrange a combination of matching (fast track evaluation) panels, either internally or externally via other external NHS evaluators or other providers to match roles at (c) to AFC bands. Matching and evaluation panels will be made up of one management side and one staff side member.
6. Outcomes will be consistency checked by a panel made up of one trained management side representative and one trained staff side representative, in line with the NHS Job Evaluation guidance.

Stage 3 – filling of posts through slotting in/ringfencing

Process summary

Relevant senior staff, including Executive Directors, will meet with a senior HR facilitator to identify slotting in and ringfences in accordance with the change policy definitions and the table at annex 5. These staff will review the new JDs against current JDs also taking into account information from the senior staff regarding current roles so that information regarding current roles is as contemporaneous as possible. All staff will be given the opportunity to challenge a decision that they are included or not included in a particular ringfence or slotted into a particular role. An individual can only challenge a decision which personally affects them.

Detailed process (timeframes are indicative only at this stage)

Part 1 (Days 1 & 2) Identifying slotting in and ring fencing across direct reports to director roles and special categories of staff

The appointment of maternity leavers will be prioritised using slotting in and single ringfencing to roles. Appropriate consideration, taking into account the requirement for reasonable adjustments, will be given to those employees who have identified disabilities. There will also be a review of those on long term sick to ensure that they are dealt with appropriately throughout the process.

Slotting in/ringfencing will take place for the appointment of each Executive Director (ED)'s direct reports. Identification meetings will involve each ED meeting their HRBP and a senior member of the People Workstream (PW). As far as possible the same member of the PW will attend all senior slotting in/ringfencing meetings to ensure consistency of approach, challenge proposals where necessary and to highlight similar role(s) within another directorate of which the ED may not be aware. If scheduling does not allow this then a second member of the PW will be involved and they will debrief after the last meeting.

Using the guidance in the table at annex 5, the ED and HRBP will look at all the roles in their new directorate structure and, referring to their staff list, new JDs and current JDs (and using the knowledge of those in the room about current job descriptions) and any other relevant information, will identify proposed slot ins, ringfences, single ringfences and unassigned individuals. The decisions on each role will be recorded by a note taker and then they will be crosschecked against the staff list to ensure everyone has been assigned to a category as identified above. The process may lead to individuals being ringfenced for more than one role.

Once all the meetings have taken place a review will be held with the PW member and HRBPs, involving EDs if necessary, to resolve any issues and further identify potential roles for unassigned individuals.

Part 2 (Days 6 & 7) Identifying slotting in and ring fencing across all other roles

Each directorate will hold an identification meeting to be attended by the ED, their current direct report(s) with people management responsibilities, any other relevant senior staff with knowledge of the current roles (but not affected by the decisions to be made), their HRBP and a note taker. Using the guidance in the table in annex 5, they will look at all the roles in their new directorate structure and, new JDs and current JDs (and using the knowledge of those in the room about current job descriptions) and any other relevant information, will identify proposed slotting in, ring fences, single ringfences which will be cross checked against the staff list to ensure everyone has been assigned to a group and unassigned individuals. The decisions on each role and individual

will be recorded by the note taker. The process may lead to individuals being ringfenced for more than one role.

Where a ringfence is identified, staff will be offered a competitive selection process for the available roles.

Part 3 (Day 8) Review process

A moderation meeting, attended by the HRBPs, Head of HR, People workstream lead (and relevant staff from part 1/2 meetings) will take place to review the decisions made, specifically to:

- Review all unassigned individuals against unfilled roles
- Check that any ring fences that span more than one directorate appear viable
- Review decisions on single ringfences where any queries
- Conduct an impact assessment

By the end of the meeting there will be a confirmed route for all individuals in NHSI.

Part 4 (Days 9 - 14) Communication process

Note: If individuals are on annual leave through this process, they will be expected and advised to inform their line manager if they are contactable or not and therefore able to respond to the notifications which will follow. Wherever possible ringfence interviews will be postponed to accommodate holiday however in certain circumstances individuals may be asked to attend interview via skype or a phone call.

All individuals below the level of ED will receive a letter confirming their situation, ie that:

- They are slotted in to a specific role and that a conversation about the scope of the role with their new line manager will follow; or
- They are in a ringfence for one or more specific roles. In this instance they will be informed that there will be an interview process and further details will follow; or
- They are a single ringfence to a role, as defined in table below at appendix 3 (or see definitions at appendix 1). In this instance the individual will be interviewed by the line manager to assess suitability for the post; or
- They are unassigned, and therefore at risk of redundancy.

All the above communications will state that the decision is provisional and will not be confirmed until the close of the employee challenge process and the letter will set out this process. If an individual wants to challenge the decision they must send an email to the Role Challenge mailbox by 5pm on day 13 and their challenge can be on any of the following grounds:

- They have not been slotted in to a particular role
- They have been slotted in to a role which they believe varies by more than 30% to their current role
- They have been incorrectly ringfenced, based on more than a 50% variance to current role
- They have not been included in a particular ringfence where they believe their role has a similarity of more than 50%
- They have been identified as a single ringfence to a role which they believe varies by more than 50% to their current role

- They have not been identified as a single ringfence to a role which they believe varies by less than 50% to their current role
- They are unassigned and they should be assigned to a particular role or a ringfenced group

On day 14 it will be possible to identify and confirm those who are being slotted into roles and those who are in uncontested ring fences. These individuals will receive confirmation of their status and where appropriate will be invited to attend an interview(s). Any unassigned employees who have not challenged the decision will be notified that they are at risk.

On day 14 individuals who are in a slot in or ringfenced position that is subject to challenge from another member of staff will be informed that there is a challenge (no further details will be provided) and that they will be notified of the outcome of the challenge by day 28.

Interviews for non-contested ringfenced roles will start on day 18. The selection process will include as a minimum submission of a summary CV/application form and an interview. The Interviewing panel will include as a minimum, the line manager or a relevant more senior team manager and another manager from a different team or a representative from HR. Support will be offered to staff for CV/application form writing and interview preparation. Once this process has been completed, any employees who have not been successful will be notified that they are at risk.

Part 5 (Days 15 – 27) Managing challenges to slotting in/ringfencing decisions

On day 15 individuals who registered a challenge will have a short meeting with a HRBP or member of the PW to establish the nature of their challenge. If, following this meeting, they decide to proceed with their challenge they will be given copies of relevant JDs, notes of the discussion around the decision and will be given a date for their challenge meeting. They will also receive a challenge template to complete and return by day 20 which should be no longer than 2 sides of A4. Should they wish, they can be supported by their employee rep or Forum member in completing the template.

Each challenge will be reviewed by at least 2 other more senior staff, someone with an understanding of the role and an HR Business Partner or people workstream team member, the challenger will not attend the meeting. The information contained in the template should be sufficient for the reviewers to reach a decision, however in exceptional circumstances the reviewers may request further information from the challenger or to meet with them. The challenge reviews will be held on days 22 - 27 and the outcomes, including the reason(s) for the decision, will be communicated to challengers as soon as possible afterwards. There is no right to appeal at this stage.

From day 28, contested slot ins can be confirmed and contested ringfence interviews will take place. Unallocated employees will be notified that they are at risk. Once this phase of ringfence interviews is complete employees who have not been successful will be notified that they are at risk.

Terms and conditions for those identified for roles in NHS Improvement

Following the slotting in/ring fencing process Monitor employees will be appointed on their current salary unless the role is of a lower grade whereby pay protection applies. It is anticipated that there should be no 'promotions' as a result of the slotting in/ringfencing process, unless there are

exceptional circumstances. Likewise TDA employees will be appointed on their current salary unless the role is of a lower grade whereby pay protection applies.

Stage 4 – filling of posts after slotting in/ring-fencing

Any employees put at risk of redundancy are required to look for suitable alternative employment (SAE) and will be given the opportunity to apply for any roles in the new structure which remain unfilled at the close of stage 3 for which they have the relevant skills, knowledge and experience. At risk employees will be given support in identifying suitable alternative employment, in line with the change management policy, both within NHSI and in other relevant external bodies. Where it is deemed unlikely that there will be any suitable internal candidates, posts can be advertised internally and externally at the same time. Any roles unfilled after stage 4 will be subject to normal external recruitment processes.

ANNEXES

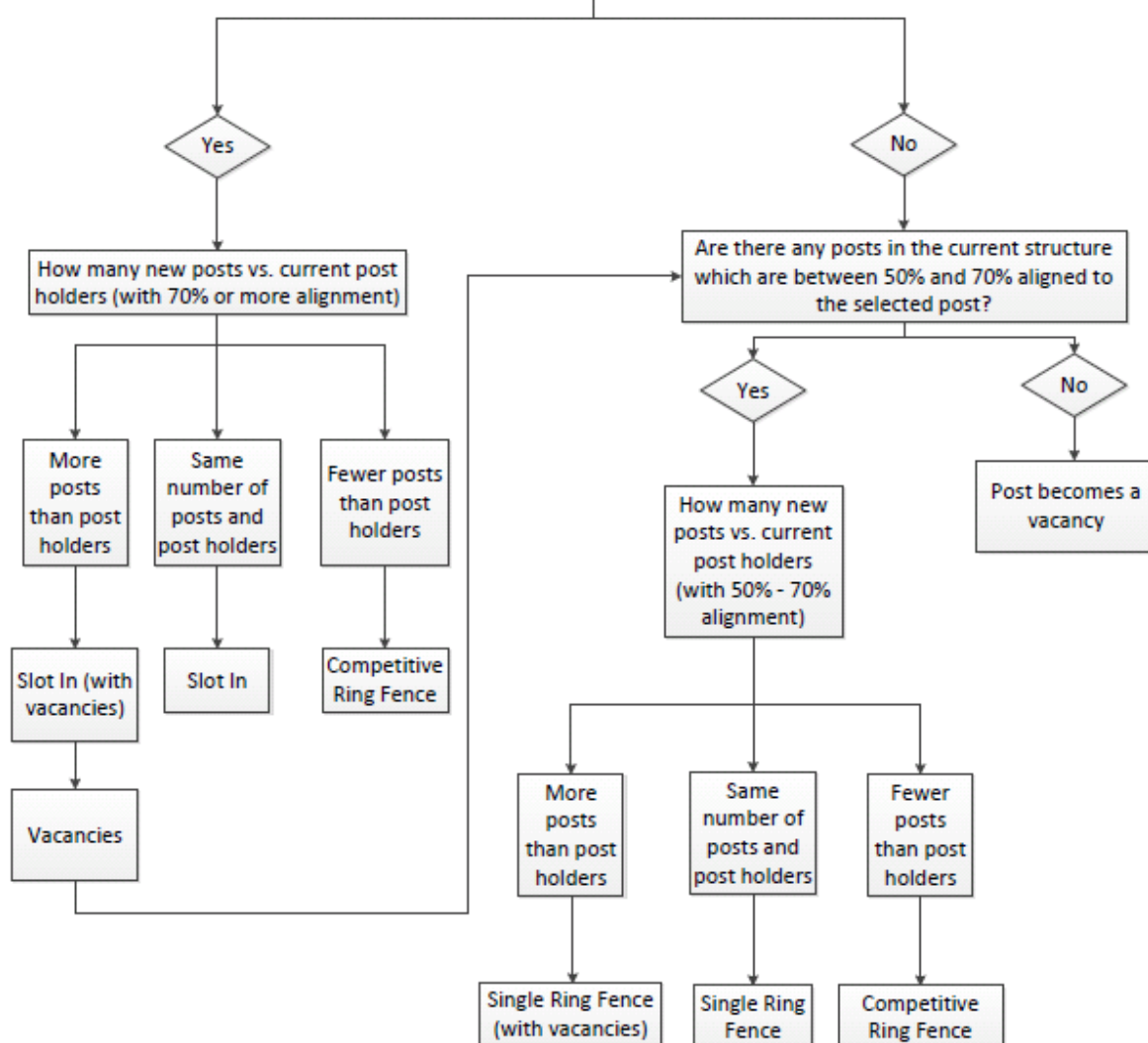
1. Flow chart to show stage 3 parts 1, 2 & 3 in the filling of posts guidance
2. Flow chart to show stage 4 onwards in the filling of posts guidance
3. Definitions
4. Consistency checking protocol
5. Table to show criteria for identification meetings at parts 1&2

FLOW CHART TO SHOW STAGE 3, PARTS 1, 2 & 3 IN THE FILLING OF POSTS GUIDANCE

Once the organisation structures are confirmed, the Executive Director/Senior Manager will go through the following process to determine if/how current posts fit in to the new structure.

Executive Director/Senior Manager selects a post in the new structure to review.

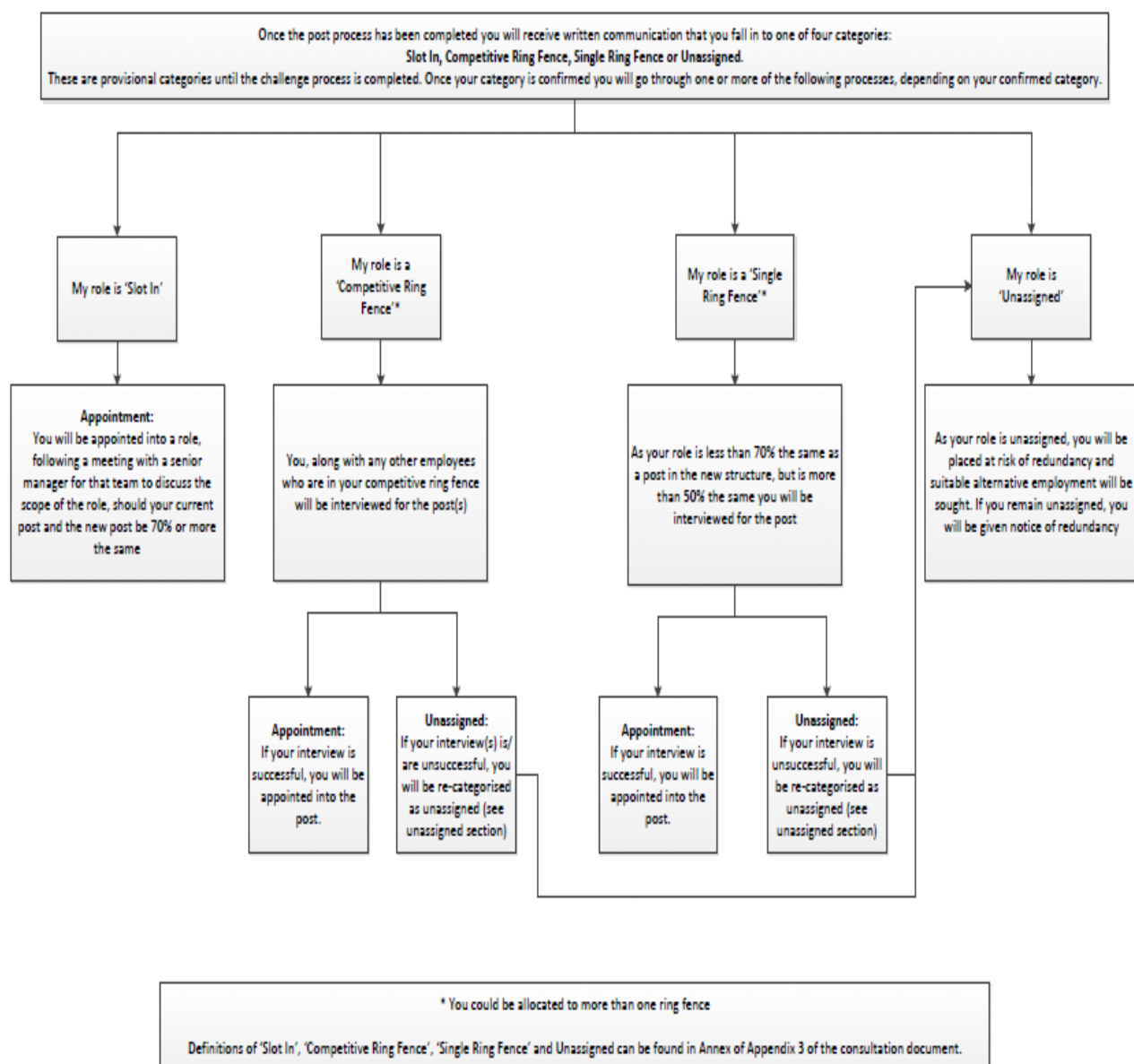
Are there any posts in the current structure which are 70% or more aligned to the selected new post?



This process is repeated for each new post, until all posts have been identified as far as possible as Slot In, Competitive Ring Fence, Single Ring Fence or Vacancy.

Definitions of 'Slot In', 'Competitive Ring Fence' and 'Single Ring Fence' can be found in Annex 3 of Appendix 3 of the consultation document.

FLOW CHART TO SHOW STAGE 4 ONWARDS IN THE FILLING OF POSTS GUIDANCE



DEFINITIONS

Matching – national NHS process that fast tracks job evaluation by comparing new role descriptions against a number of national profiles, if there is a match as defined in the AFC job evaluation handbook between a new role and a national profile then the band of the role is determined as that of the national profile to which it matches.

The following definitions are taken from the Change Management policy

Slotting in - Slotting in means the process by which staff are confirmed into a post in a new staffing or management structure which is similar to their current post and where that individual is the only contender for that post (or there are fewer contenders than number of roles). Slotting in may occur where a post is in the same band as the individual's current post (or possibly a lower grade, in which case pay protection might apply) and where it remains substantially the same (usually defined as more than 70% the same) with regard to job content, responsibility, grade, status and requirements for skills, knowledge and experience.

(Competitive) Ringfencing - ring-fencing means the process by which staff are considered for a post in a new staffing or management structure which is more than 50% [this percentage is not stated in the policy] similar to their current post and/or where there is more than one contender for that post. Depending on the circumstances of the organisational change, the ring-fencing definition may be set out in more detail during the organisational change process.

Single ringfences – role is 50-70% the same as the previous role with the same number of posts as eligible staff and can be offered to those staff subject to a brief interview with the line manager.

Unassigned – staff for whom there was no role to slot into, who were not eligible for any ring fence, did not qualify for a single ring fence or were unsuccessful in a ring fence interview and who subsequently have no role offer at the end of stage 3.

Consistency Checking Protocol

Step 1 - After an evaluation:

The evaluation panel will check the overall score and number of variations before providing back to the HR team a completed scoring sheet for each post. HR will log these outcomes and then send a batch of job descriptions and scoring sheets to the consistency checking panel for their consideration. The consistency checking panel will consist of one staff side and one management side checker who will go through Step 2 below.

Step 2 - Post-matching or evaluation:

Consistency checking is largely a matter of taking an overview of a batch of results and applying common sense, but there are some useful questions to ask, for example:

1. Do manager and supervisor jobs match or evaluate higher than the jobs they manage or supervise on those factors where this is to be expected eg responsibility for policy and service development, responsibility for human resources, freedom to act? If not, is there a good reason for this?
2. Do specialist jobs match or evaluate higher than the relevant practitioner jobs on those factors where this is to be expected eg knowledge, analytical and judgemental skills, responsibility for human resources (if teaching others in the specialism is relevant)? If not, is there a good reason for this?
3. Do practical manual jobs match or evaluate higher than managerial or other jobs where hands-on activity is limited on those factors where this is to be expected eg physical skills, physical effort, working conditions? If not, is there a good reason for this?

Such checks are inevitably made in the first instance based on job titles. If these checks throw up apparent anomalies, then the next level of checking is on the matching or evaluation documentation. If the inconsistency is not explained by the second level checks, then it may be necessary to raise questions with jobholders, line managers or trade union representatives.

Once the consistency checks are complete, the panel will feed back the outcome to HR for logging and audit trail.

ANNEX 5 TABLE TO SHOW CRITERIA FOR IDENTIFICATION MEETINGS (PARTS 1&2 OF PROCESS)

Identification meeting – part 1 & 2 conclusions	Role	Decision criteria – some or all should apply	Outcome
1. Proposed job exactly the same	Compare purpose, accountabilities, dimensions and reporting structure	<ul style="list-style-type: none"> • Purpose the same • Accountabilities, duties the same • Dimensions/scope the same • Structures/reporting lines/span of control the same (even if change of line manager) • Person spec unchanged • Other conditions of service (eg grading) 	<ul style="list-style-type: none"> • If same number or more roles than eligible staff, slot in identified • If more roles than eligible staff, ring fence identified
2. Proposed job is substantially the same (more than 70% the same)	Compare the nature and number of accountabilities that have changed, the job's position in the structure (even if reporting lines/level has changed) and the degree to which different or greater scope has been added	<ul style="list-style-type: none"> • Purpose same/broadly the same • <i>No more than c3 out of 10 accountabilities changed</i> • Dimensions of the same order of scale • Job at same level of complexity even if reporting level has changed • Same band or one lower 	<ul style="list-style-type: none"> • If same number or more roles than eligible staff, slot in identified • If fewer roles than eligible staff, ring fence identified
3. Proposed job is different (different from current role by between 30% -50%)	As Above	<ul style="list-style-type: none"> • Purpose may be similar but different • 3-5 accountabilities out of 10 will be new or different • Dimensions may or may not be of same scale but may be different (eg from no line management to line management) • Reporting level may or may not be affected • Location of the role is significantly different (or other conditions of service changed) • Person specification for the role has changed by 30 – 50% 	<ul style="list-style-type: none"> • If same number or more roles than eligible staff, single ring fence identified subject to interview with relevant senior manager • If fewer roles than eligible staff, ring fence identified

4. Proposed job is more than 50% different	As Above	<ul style="list-style-type: none"> • Purpose will be new or significantly different • More than 5 out of 10 responsibilities will be new or different • Reporting level will be different • Location of the role is significantly different (or other conditions of service changed) • Person specification for the role has changed by more than 50% 	<ul style="list-style-type: none"> • unassigned role
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APPENDIX A4 [REDACTED]

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Bar 4	Bar 5	Bar 6
Bar 7	Bar 8	Bar 9
Bar 10	Bar 11	Bar 12
Bar 13	Bar 14	Bar 15
Bar 16	Bar 17	Bar 18
Bar 19	Bar 20	Bar 21
Bar 22	Bar 23	Bar 24
Bar 25	Bar 26	Bar 27
Bar 28	Bar 29	Bar 30
Bar 31	Bar 32	Bar 33
Bar 34	Bar 35	Bar 36
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Bar 130	Bar 131	Bar 132
Bar 133	Bar 134	Bar 135
Bar 136	Bar 137	Bar 138
Bar 139	Bar 140	Bar 141
Bar 142	Bar 143	Bar 144
Bar 145	Bar 146	Bar 147
Bar 148	Bar 149	Bar 150
Bar 151	Bar 152	Bar 153
Bar 154	Bar 155	Bar 156
Bar 157	Bar 158	Bar 159
Bar 160	Bar 161	Bar 162
Bar 163	Bar 164	Bar 165
Bar 166	Bar 167	Bar 168
Bar 169	Bar 170	Bar 171
Bar 172	Bar 173	Bar 174
Bar 175	Bar 176	Bar 177
Bar 178	Bar 179	Bar 180
Bar 181	Bar 182	Bar 183
Bar 184	Bar 185	Bar 186
Bar 187	Bar 188	Bar 189
Bar 190	Bar 191	Bar 192
Bar 193	Bar 194	Bar 195
Bar 196	Bar 197	Bar 198
Bar 199	Bar 200	Bar 201
Bar 202	Bar 203	Bar 204
Bar 205	Bar 206	Bar 207
Bar 208	Bar 209	Bar 210
Bar 211	Bar 212	Bar 213
Bar 214	Bar 215	Bar 216
Bar 217	Bar 218	Bar 219
Bar 220	Bar 221	Bar 222
Bar 223	Bar 224	Bar 225
Bar 226	Bar 227	Bar 228
Bar 229	Bar 230	Bar 231
Bar 232	Bar 233	Bar 234
Bar 235	Bar 236	Bar 237
Bar 238	Bar 239	Bar 240
Bar 241	Bar 242	Bar 243
Bar 244	Bar 245	Bar 246
Bar 247	Bar 248	Bar 249
Bar 250	Bar 251	Bar 252
Bar 253	Bar 254	Bar 255
Bar 256	Bar 257	Bar 258
Bar 259	Bar 260	Bar 261
Bar 262	Bar 263	Bar 264
Bar 265	Bar 266	Bar 267
Bar 268	Bar 269	Bar 270
Bar 271	Bar 272	Bar 273
Bar 274	Bar 275	Bar 276
Bar 277	Bar 278	Bar 279
Bar 280	Bar 281	Bar 282
Bar 283	Bar 284	Bar 285
Bar 286	Bar 287	Bar 288
Bar 289	Bar 290	Bar 291
Bar 292	Bar 293	Bar 294
Bar 295	Bar 296	Bar 297
Bar 298	Bar 299	Bar 300
Bar 301	Bar 302	Bar 303
Bar 304	Bar 305	Bar 306
Bar 307	Bar 308	Bar 309
Bar 310	Bar 311	Bar 312
Bar 313</		

Category	2019	2020	2021
1. Revenue	100%	100%	100%
2. Operating Expenses	100%	100%	100%
3. Operating Income	100%	100%	100%
4. Non-Operating Income	100%	100%	100%
5. Income Before Taxes	100%	100%	100%
6. Income Tax Expense	100%	100%	100%
7. Net Income	100%	100%	100%

APPENDIX A5 Supporting policies and links

Change management policy

<https://intranet.improvement.nhs.uk/NHSIUseful/Documents/Policies/NHSI%20Change%20management%20policy%20and%20Procedures%20final%20published%20pdf.pdf>

Government websites Agenda for Change and Civil Service Compensation scheme

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/60888/Civil_20Service_20Compensation_20Scheme.pdf

<http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook/nhs-redundancy-arrangements>

Pay Protection Policy

For colleagues employed on Monitor Terms

<https://connect2.monitor-nhsft.gov.uk/workingatmonitor/Pages/All-Policies.aspx>

For colleagues employed on TDA terms.

<http://ntdastaff.ntda.nhs.uk/wp-content/uploads/2014/04/Pay-Protection-Policy.pdf>H