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Allied health professionals within integrated care systems

Guidance for system executives and senior leaders

June 2022

Equality and Health Inequalities Statement
Promoting equality and addressing health inequalities are at the heart of NHS England/NHS Improvement's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment, and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

Contents

Foreword

The coronavirus pandemic has presented extraordinary challenges for today's leaders. In the NHS, leaders have faced a highly uncertain and rapidly changing landscape.

Critical functions of leadership include maximising efficiency within a system and achieving organisational goals. During the pandemic this has never been truer.

Where strategic leadership has been in place for allied health professionals (AHPs), the AHP workforce has helped to bring local organisations together to redesign care and improve population health. Maximising use of their skills across the spectrum of health and care has also contributed to achieving the ambitions outlined in the NHS Long Term Plan and NHS People Plan.

It is crucial, as we transition to the proposed new statutory arrangements for ICSs, that the full range of clinical and care professional leaders, from a diversity of backgrounds, should be involved in decision-making throughout the ICS so they can share and contribute towards a collective ambition for the health and wellbeing of the population.

AHPs across the country are embracing the opportunities these new ICS structures create – developing AHP councils to bring together collective strategic leadership and support the ambitions and priorities of the ICS. AHP faculties – a commitment in the Interim People Plan – have also been created to focus on our people, specifically their supply, retention, careers, education, and training.

These governance structures, which support wider system architecture, must be recognised, and backed to ensure each system truly benefits from the transformational potential of the AHP workforce.

This document takes learning and evidence gained during the pandemic and provides guidance for system executives, chief AHPs and those responsible for planning, developing, and supporting the workforce. It provides an overview of the AHP system architecture required to ensure optimum AHP operational delivery, the AHP leadership of that architecture and a quality and improvement framework to

support AHP workforce transformation. This guidance is designed to complement the existing key guidance, produced for ICSs.

AHPs must continue to deliver the commitments in the NHS Long Term Plan, the NHS People Plan and The Allied Health Professions (AHPs) Strategy for England: AHPs Deliver 2022 to 2027. AHPs lead and support new ways of working, improve flow, keep care closer to home and improve the health and wellbeing of individuals and populations we serve. Effective workforce planning, deployment and transformation is essential if the system is to truly harness AHPs' full potential.

It is clinical and care professional leaders, working in partnership with others and with people in local communities, who make improvements happen. AHPs will help realise the ICS mission to improve population health, tackle unequal access to services, experience, and outcomes, and enhance productivity, effectiveness, and value for money. The evidence is clear that strong clinical and care professional leadership is associated with higher quality care and therefore ICSs must make this a priority from the outset.

I hope you find this document useful in describing the AHP architecture and leadership required to deliver high quality care for our people and populations.

Suzanne Rastrick
Chief Allied Health Professions Officer
NHS England and NHS Improvement

Summary and key recommendations

This document provides an overview of:

- the AHP system architecture required to ensure AHP operational delivery
- AHP leadership of this architecture
- An AHP quality framework to support AHP workforce transformation.

As the third largest clinical workforce, AHPs will play a key part in the transformation and delivery of services across ICSs. Integrating the AHP system architecture into the new and evolving ICS governance architecture will allow chief AHPs to be part of the leadership conversation, ensure the workforce is visible and engaged, and contribute widely to the improvement and transformation of health and care delivery.

Our key recommendations for this are:

Integrated Care Board (ICB) executives:

- Identify senior AHP leadership within the system, to harness the AHP workforce's potential for system redesign.
- share the AHP system architecture, within the document, with leaders across the system, so that there is clarity and understanding of the 'go to' place regarding AHPs
- support robust AHP systems governance to ensure there is AHP leadership at key discussion and decision-making tables, for example the System Quality Group (SQG) and the System People Board.

Regional, ICB, provider chief AHPs and other senior AHP leaders:

- all NHS provider organisations within the ICS have dedicated chief AHP leadership, contributing to, and part of the AHP system architecture
- establish AHP leadership resource, to support the planning and delivery of services across the footprint
- improve the scope, consistency, and availability of AHP data, to measure, evidence, improve and transform AHP care.

Leaders of workforce planning, development, deployment, and transformation:

- work with chief AHPs and the system architecture to ensure systems have the right workforce with the right skills in the right place to deliver high quality care, by 2024
- all AHPs to be deployed on an electronic system
- all AHPs to have an up-to-date job plan
- an evidence-based approach to capacity and demand planning
- the use of metrics and key performance indicators to monitor and challenge the workforce skill mix.

If you need support to take these recommendations, please contact the office of the chief allied health professions officer (CAHPO) at england.cahpo@nhs.net.

Introduction

This guide has been developed to ensure ICSs benefit from the effective planning, deployment, and transformation of the AHP workforce, ensuring the full breadth of their skills are optimised for the successful delivery of the NHS Long Term Plan and NHS People Plan. This guidance has been developed to complement the existing suite of documents for ICSs.

- Key documents for integrated care systems
- ICS implementation guidance on effective clinical and care professional leadership
- National Quality Board's (NQB) Shared Commitment to Quality
- NQB Guidance for System Quality Groups.

It will be useful for:

- ICB executives
- regional, ICB, provider chief AHPs and other senior AHP leaders
- leaders of workforce planning, development, deployment, and transformation.

It sets out three key areas of focus which, when in place, will support and enable the AHP workforce to work optimally in delivering the priorities and ambitions of the ICS:

1. AHP system architecture
2. Professional and system AHP leadership
3. Guidance for measuring, improving, and transforming the AHP contribution to wider care delivery.

This guide provides essential understanding of the AHP architecture (operating model) that will support systems to harness the opportunity AHPs offer in the delivery of system transformation. Factoring these into ICS plans will advance the development of a truly multi-professional workforce, accelerating the redesign of care and futureproofing it for the decade ahead.

The NHS Long Term Plan highlights both the importance of visible clinical leadership within organisations and ICSs, and of realising the transformative potential of the AHP workforce – as described in The Allied Health Professions (AHPs) Strategy for England: AHPs Deliver 2022 to 2027, the national AHP strategy.

Building strong integrated care systems everywhere: ICS implementation guidance on effective clinical and care professional leadership recognises that as we transition to the proposed new statutory arrangements for ICSs, the full range of clinical and care professional leaders, from a diversity of backgrounds, should be involved in decision-making throughout the ICS so they can share and contribute towards a collective ambition for the health and wellbeing of the population.

The pandemic has shown that effective strategic and professional leadership optimises the capacity and capability of the workforce. AHPs commonly work across organisational boundaries, delivering person-centred interventions in environments where they make the most difference to people's lives. Their autonomy and collective breadth of skills make them perfectly placed to transform pathways, reduce fragmentation, and bring care closer to home.

Collectively, AHPs form a significant proportion of the clinical workforce; yet leadership structures vary greatly from system to system. To ensure the power of AHPs is being harnessed optimally, systems should commit to appropriate leadership structures.

AHPs offer solutions to many of the challenges being faced by the NHS. Delivering 'triple integration' of primary and secondary care, physical and mental health services, and health with social care, will only be achieved by creating shared leadership across those settings.

AHPs have a key role in planning for this integrated future; they have many skills that can provide new solutions to old demand and capacity problems, and systems should consider the role of AHPs in pathway and service redesign.

AHPs are a key component of current Clinical Commissioning Group structures, offering clinical leadership and expertise. As new leadership arrangements develop and ICBs take on all the functions and duties of CCGs, it is vital that the AHP voice is, and continues to be present.

By committing to the architecture and leadership recommendations in this guide, systems will be ensuring that AHPs are integrated within all ICS governance and can therefore be confident that the full potential of their AHP workforce will be realised.

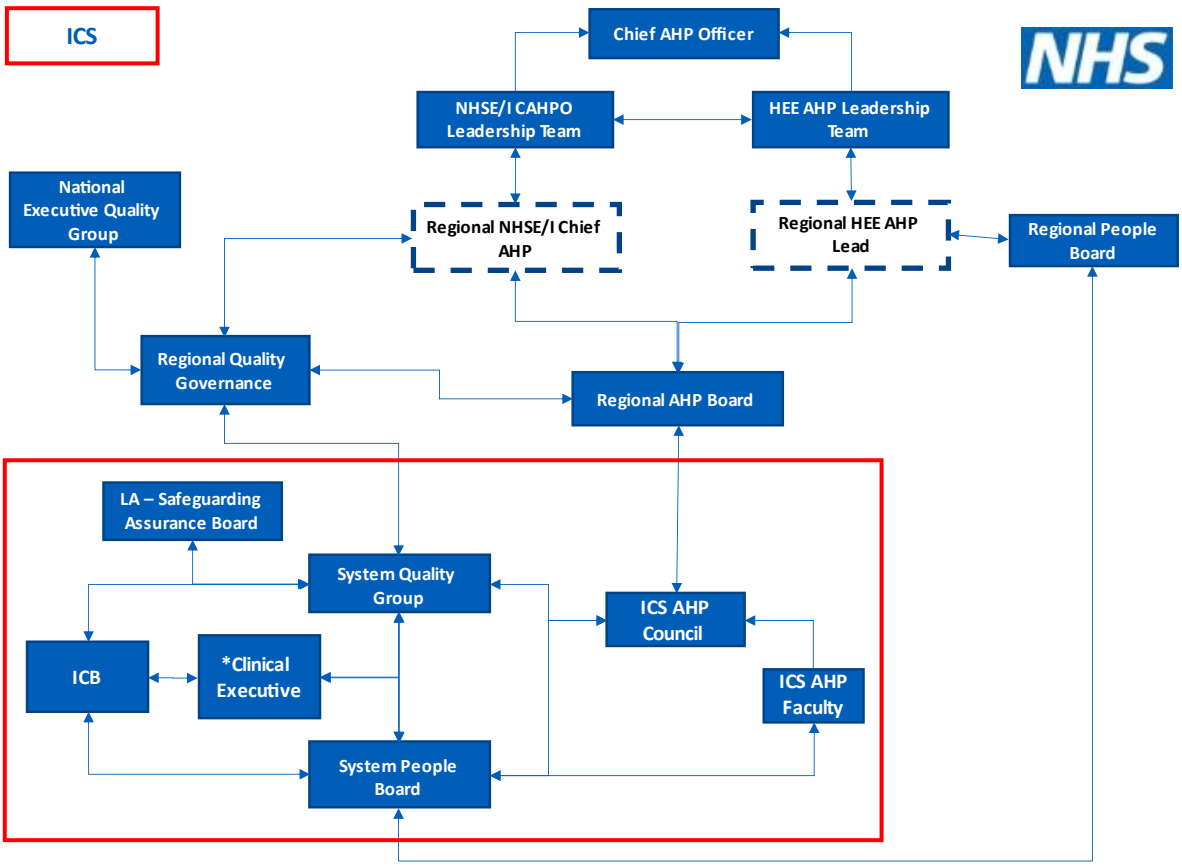
1. AHP system architecture

To ensure AHPs support the development and delivery of priorities within ICSs, the following structures have been developed to ensure AHPs are visible and present within the existing ICS governance, and therefore able to optimally contribute:

- Regional AHP Board (see Section 1.2)
- ICS AHP council (see Section 1.3)
- ICS AHP faculty (see Section 1.4).

Figure 1 shows how these structures fit into, and compliment, the existing system architecture. It is recognised that variation will occur between each system, including specific names and structures, but hope this highlights the key AHP architecture and how it can fit within existing and evolving system structures.

Figure 1: AHP system architecture



* May have another name, such as Clinical Senate, Clinical or Healthcare Leadership Group, for example

1.1 Common principles

To work in partnership with wider system structures, the above system architecture follows these common principles:

- It is integrated with wider quality and workforce leadership structures, and engages with all relevant stakeholders and regular strategic communications
- Agreed principles of subsidiarity are put in place for place, system, regional and national activities
- Clear governance and reporting processes are put in place, including agreed performance indicators and outcomes that contribute to wider system or regional objectives
- Clear plans are made to support local, regional and/or national priorities
- An operating model is built around the model for improvement, or equivalent improvement practices.

1.2 Regional AHP Board (formerly Council)

Regional AHP Boards bring together senior strategic AHP representatives from NHS England and Improvement, ICS AHP councils (see Section 1.3), higher education institutes, Health Education England (HEE), and Local Authorities to support local systems in providing more joined-up and sustainable care.

Regional AHP Boards, on behalf of and supporting regional teams, should oversee the quality, safety, transformational and operational performance of AHP services across all NHS organisations in their region. The Board should act together **regionally** where:

- there is a need for co-ordination and improvement support to deliver regional and national priorities
- there is a need to help foster capacity in local health systems
- decisions, co-ordination, and intervention are needed across a regional labour market.

The Regional AHP Board should be chaired by the NHS England and Improvement Regional Chief AHP, or co-chaired with Regional AHP lead - HEE.

To ensure reporting and co-ordination of regional AHP quality issues/priorities, the NHS England and NHS Improvement Regional Chief AHP sits on the wider regional quality governance structure in place within the region, responsible for assuring the quality of care across the region.

Similarly, the HEE Regional Head of AHPs is the designated representative on the Regional People Board, to ensure the wider AHP workforce, supply, education and training priorities and issues are reported and actioned accordingly.

1.3 ICS AHP councils

AHP ICS councils are already in place across systems and bring together chief AHPs from local providers across the system. They work collectively, as part of the wider system architecture, to support the quality, operational delivery, and financial priorities of the ICS.

Their purpose is to ensure a strategic, system wide approach to service priorities by:

- identifying service and operational delivery risks and issues across the 14 professions
- undertaking strategic planning and activities that span multiple services and providers across the system
- supporting and implementing relevant system strategy
- supporting access to timely professional expertise and advice
- taking responsibility for providing clinical advice and leadership to PCNs and associated ambitions of the GP contract agreement.

AHP focused activities should be co-ordinated at **system level** where:

- strong local partnerships are required across health and care providers
- decisions need to be made across a local labour market
- there are benefits of scale from joined-up solutions to shared challenges
- there is a need for co-ordination and improvement support to deliver system priorities.

1.4 ICS AHP faculties

AHP faculties are newly established following a commitment in the Interim People Plan and have been developed with support from HEE. They act as an operational workforce sub-group of the ICS AHP council and as a delivery arm for HEE mandate and priorities. AHP faculties should provide regular updates to the ICS AHP council, with formal reporting in place for all funded programmes of work.

An AHP faculty is a group of health, social care, private, independent, voluntary organisations, and education providers. Their purpose is to work together across a system to address AHP ICS and regional workforce supply and transformation priorities driven by the National AHP workforce improvement framework (see Section 3.3).

AHP faculties provide a cost-effective means of co-ordinating AHP workforce supply, training, and education at scale. Further information and evaluation is available from HEE.

Work of the Faculty should report into the ICS Workforce Hub and ICS People Board, as well as the Regional AHP Board. This is important for AHP workforce supply due to the location of pre-registration education programmes. Regional placement circuits for most professions and many systems depend on graduate supply from other areas of the region/country.

2. Professional and system AHP leadership

2.1 AHP leadership

Like all clinical professionals, AHPs will be most effective in delivering and improving healthcare if there is sufficient strategic, professional, clinical, and operational leadership across the system architecture to maximise their contribution to high quality, efficient and effective services.

ICS implementation guidance on effective clinical and care professional leadership supports and recognises the importance of distributed clinical and care professional leadership across ICSs, to ensure the successful integration and delivery of safe and effective care.

It is not possible to set out a single model of AHP leadership. However, evidence indicates that senior AHP leadership, chief AHPs, have quantifiable quality benefits for regional teams, ICSs and provider organisations that have established senior AHP leadership roles.

In 2018, NHS Improvement's Leadership of allied health professionals in trusts in England: what exists and what matters? recommended that provider organisations should appoint a senior AHP with strategic focus. Further to this, we recommend that ICS NHS Bodies should also appoint a senior AHP leader across the system to:

- strengthen leadership arrangements
- harness the AHP workforce's potential for system redesign[1]
- implement new care pathways to improve quality and efficiency
- build workforce capacity and capability to realise leadership benefits
- analysis of the AHP workforce diversity and development of sustainable interventions to ensure the workforce is reflective of the populations and people it serves

As detailed below, there are already examples of systems appointing a Chief AHP to lead the AHP workforce across their system, however we recognise that there may be different ways/options of securing AHP leadership at system level, given the

[1] https://www.england.nhs.uk/ahp/implementing-ahp-action/

different size, scale and configuration of the systems. We recommend that ICS leaders work together across their system to ensure the AHP leadership is adequate and has the full authority to harness the transformational ability of the workforce.

2.2 Benefits of AHP leadership

Where provider chief AHP leadership is in place, the following benefits have been recognised:

- the AHP workforce has greater visibility
- the workforce is more engaged with the improvement and transformation agenda
- the workforce makes a greater contribution to the strategic priorities and objectives as set out by the trust
- the trust is involved in ICS AHP workforce and quality discussions, via the AHP system architecture discussed earlier in this document
- there are greater linkages with regional programmes of work, including quality, operational and education/training.

Where ICS chief AHP leadership is in place, the following benefits have been recognised:

- greater voice and visibility of the AHP workforce and their contribution to system wide challenges and opportunities
- contribution to the regional AHP boards and support/delivery of the regional strategy and quality initiatives
- faster growth and adoption of new ways of working
- joined-up approaches to clinical pathway design and development
- greater overview and insight as to the quality, financial and operational performance of AHP services.

2.3 How can you strengthen your AHP ICS leadership?

Contact system executives who have already established AHP leadership roles across their ICS. Examples of these systems include:

- Lancashire and South Cumbria
- One Gloucestershire

- Dorset
- Hampshire and Isle of Wight
- Sussex Health & Care Partnership
- Buckinghamshire, Oxfordshire & Berkshire West
- Surrey Heartlands
- South Yorkshire & Bassetlaw.
- Buckinghamshire, Oxfordshire, and Berkshire West
- Frimley Health and Care

2.4 How can you strengthen your ICS AHP Council and regional AHP board?

AHP leadership is central to the performance of the regional AHP board and ICS AHP Council, and the contribution they can make to the quality, operational and financial challenges being faced across the ICS and region. Consider the following key factors in ensuring the regional AHP board and ICS AHP council are well equipped to contribute:

- Chief AHP leadership in all provider trusts within the region
- Mature ICS AHP councils, linked with the existing ICS governance
- A designated chair for each of the ICS AHP councils within the region, who is committed to supporting and representing the regional AHP board and has the support of their organisation to do this
- To date, AHPs have been invited as routine members of the SQG in line with the NQB Guidance on SQG., which would normally be a member of the ICS AHP Council
- The regional AHP board is linked with, and has support from, the regional NHS England and Improvement team and the regional HEE team, as well as the Regional Quality Governance and Workforce structures.

2.5 Resources to support AHP leadership

Below are several evidence-based publications produced on AHP leadership, that may clarify the impact of the right leadership in the right place and provide frameworks to support that leadership.

- Leadership of allied health professionals in trusts in England: what exists and what matters? (2018)
- Investing in chief allied health professionals: insights from trust executives (2019)

The chief AHPs handbook is a guide for aspirant and incumbent chief AHPs, and a guide for NHS trusts and ICSs looking to improve their AHP leadership capacity and capability, whilst wanting to understand more about the day-to-day work of a chief AHP and the context in which they can optimally operate and deliver.

- Chief allied health professionals' handbook: A guide for chief allied health professionals, aspiring chief allied health professionals and trust boards (2022)

Both these documents recommend appointing a chief AHP with professional and strategic oversight of the AHP workforce.

- Clinical Leadership – a framework for action (2019)

This policy document was created as part of a series of interventions following publication of Barriers and enablers for clinicians moving into senior leadership roles. It was commissioned by the Department of Health and Social Care at the instruction of the then Secretary of State for Health, the Rt Hon Jeremy Hunt, MP.
It examines the experiences of clinicians who have made the journey into senior leadership roles, and the common themes that occur across their leadership journeys.

- Developing allied health professional leaders: a guide for trust boards and clinicians (2019)

To achieve the sustained cultural shift identified and necessary to achieve multi-professional systems-based, cross-sector leadership health and care, AHP leadership is a necessary and crucial part of health and wider care service delivery. This guidance highlights key themes of the journey from clinician to senior strategic leader within the NHS, built from research with senior leaders and executive leaders.

- ICS implementation guidance on effective clinical and care professional leadership

This guidance supports the development of distributed clinical and care professional leadership across integrated care systems (ICSs). It describes ‘what good looks like’ in this regard, based on an extensive engagement exercise involving over 2,000 clinical and care professional leaders from across the country, led by a multi-professional steering group.

3. Measuring, improving, and transforming the AHP workforce

Using data to demonstrate that care is safe, effective, and sustainable is essential. It will ensure services have the right number of staff in the right place, and that those staff have the right skills and are collaborating to deliver high quality person-centred care.

The impact of the pandemic on the NHS workforce has brought into sharp focus the importance of accurate workforce deployment systems as a key enabler of flexible, agile deployment. It has also highlighted the importance of maintaining and responding to service level capacity and demand data to measure, improve and transform care.

The NHS Long Term Plan articulates a commitment to moving decisively to a model where teams of professionals from different disciplines work together to provide more joined-up care, and to achieve this it is crucial that AHPs have rigour in developing and managing staffing establishments that meet patient need. This can be achieved by:

- Measuring and benchmarking productivity:
  - AHPs are deployed using an electronic roster to facilitate multi-professional capacity and demand planning, and flexible operational deployment. Roster systems should reconcile with staff details on the electronic staff record (ESR, see Section 3.4).
  - Clinical capacity is consistently measured using NHS Improvement job planning guidance and reported as DCC/FTE (see Section 3.4).
  - Trusts use clinical hours to contacts (CHtC) to measure productivity of their AHP services and compare themselves to benchmarks for each speciality or pathway.

- Optimising the AHP workforce:
  - Trusts can set AHP establishments for each specialty using available evidence base that enables AHPs to work to the top end of their competencies and fully utilise their unique skills.
  - AHPs can classify the priority, complexity, and dependency of their patients in a way that informs planned and actual staffing requirements.

  - Trusts harness technology to roster (see Section 3.4) capacity to demand and drive improvements in clinical capacity, clinical productivity, and staff experience.

- Identifying unwarranted variation (benchmarking) and/or areas for improvement and addressing these:
  - A suite of metrics is available to identify unwarranted variation in productivity, quality, and efficiency. The Model Hospital (model health system) supports this and the AHP Quality Dashboard scorecard (see Section 3.1).
  - Trusts are supported to use the Model Hospital (model health system) to identify opportunities for workforce transformation.
  - Benchmarks of good practice are identified for each specialty and best practice guidance and case studies are shared.

Ensuring services can consistently and efficiently deliver high quality care relies on accurate strategic and operational workforce planning. This is complex for AHPs, who can work peripatetically across pathways and across organisation boundaries, and who prioritise interventions on clinical risk rather than diagnosis. These deployment practices are often not supported by traditional place-based staffing establishment tools.

This section outlines what current evidence and tools are available to provide assurance for effective operational workforce planning of AHPs. It offers suggestions for the consistent collection of quality metrics as a starting point to support quality monitoring when improving and transforming services.

3.1 The AHP Quality Dashboard

The availability of routine, national level data to evidence the impact on quality and productivity of the AHP workforce is very limited. Many services collect a variety of workload and output data, but these are often provider specific, variously defined, and infrequently standardised.

Improving the scope, consistency, and availability of routine AHP data is increasingly important for systems to evidence the impact of the multi professional workforce on the strategic objectives of the NHS.

Figure 2 provides a governance framework for AHP services to monitor the consequences and impact of different workforce models on care delivery. The scorecard has four domains that each reflect a perspective of the strategic NHS objectives. There is a strong relationship between each of the four domains, as the framework illustrates. The scorecard should be used alongside the ICS Quality Toolkit - a library of consistent metrics to measure quality.

Figure 2: AHP Quality Dashboard – a framework for evidencing and improving the safe, effective, and efficient use of AHP resources

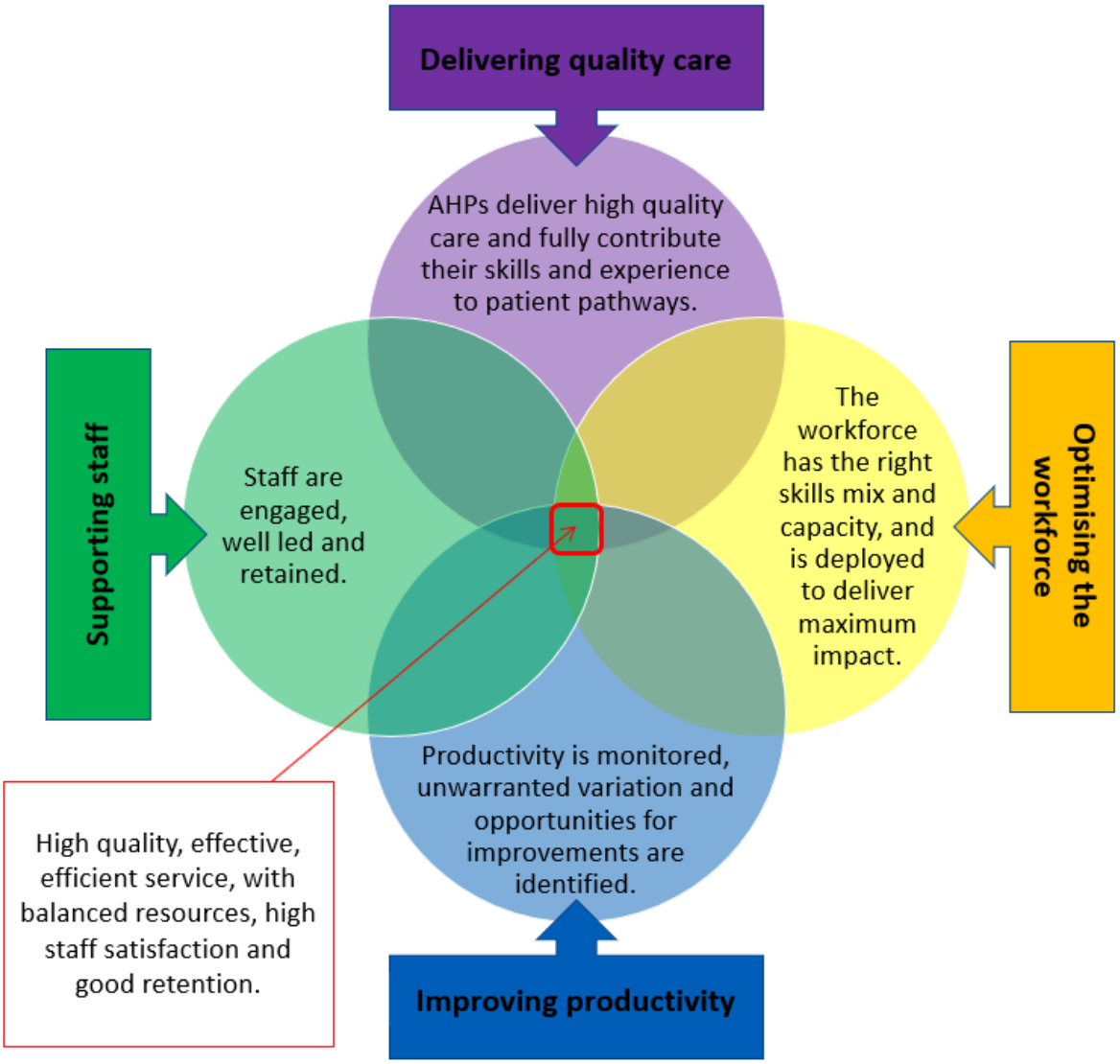


Figure 3 gives examples that could be used to measure the use of AHP resources, both at provider, ICS, and regional levels of the system architecture. The list is not mandated, nor exhaustive, but can be shaped and adapted through the development of indices that suit regional, ICS or trust reporting.

Figure 3: Example metrics and indices that could be used across the four domains of the AHP Quality Dashboard

3.2 Strategic workforce planning and deployment

Systems need to be agile in their approach to workforce deployment, as they manage challenges such as changing demography, future pandemics, seasonal

fluctuations in demand, new technologies and changing patients' needs and expectations.

All providers should ensure their AHPs are deployed using electronic workforce deployment systems that are fit for purpose and that enable transparency of AHPs skills and competencies, so that competency-based deployment opportunities are maximised.

> ".... more of the same will not be enough to deliver the promise of the NHS Long Term Plan. We need different people in different professions working in different ways. We also need to address the cultural changes that are necessary to build a workforce that befits a world-class 21st century healthcare system." (June 2019, 'Interim people plan' NHS Improvement)

NHS Improvement's Developing workforce safeguards document contains recommendations to support provider organisations in making informed, safe, effective, and sustainable workforce decisions, and identifies examples of best practice in the NHS. It was developed with sector leaders and frontline staff and builds on the National Quality Board's (NQB) guidance.

Trusts are required to comply with the 'triangulated approach' to deciding staffing requirements described in NQB's guidance. This combines evidence-based tools (where they exist), professional judgement and outcomes.

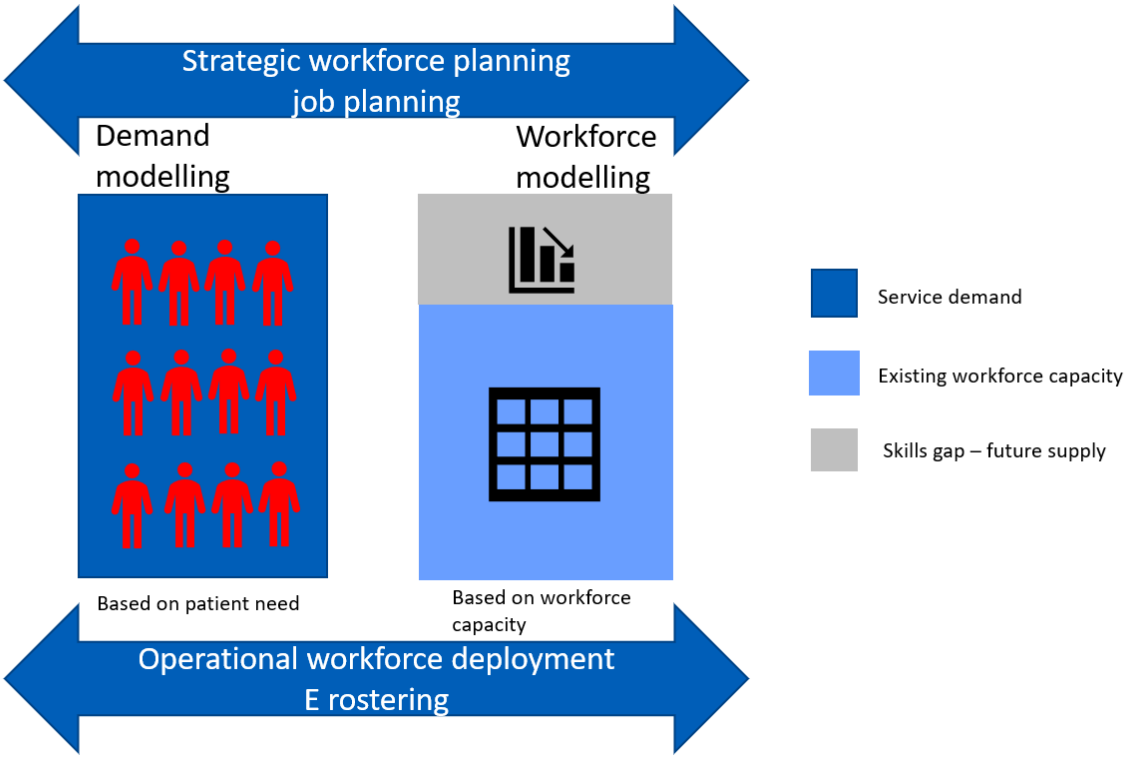
AHPs are usually deployed centrally, working peripatetically, to allow flexibility in care delivery. Referrals to AHP services are needs based and dependent on the outcome of individual assessment. This allows for efficient and effective deployment and redeployment of the workforce.

In the absence of nationally published, evidence-based staffing tools, the following simple framework (Figure 4) – which requires local assessment of patients' needs, acuity, dependency and risks, and local assessment of staffing establishment (capacity and capability) – supports the understanding of the interdependencies between demand and supply modelling and the use of workforce deployment systems.

The NHS Long Term Plan contains the commitment that by 2021, "[NHS England and NHS Improvement] will support NHS trusts and foundation trusts to deploy electronic rosters or e-job plans." By utilising e-rostering and e-job planning software,

trusts can make sure the right staff with the right skills are in the right place at the right time.

Figure 4: Interdependencies between demand and supply modelling and the use of workforce deployment systems



3.3 AHP workforce improvement framework

The breadth of AHPs' skills and their reach across people's lives and organisations makes them ideally placed to lead and support change and improvement. In 2016, NHS England published the first national AHP strategy AHPs into Action, focusing on the role of AHPs in transforming health, care, and wellbeing. It described a clear view of the potential of AHPs with over 50 examples of innovative AHP practice, and a framework to help develop local delivery plans.

The advances this workforce has made, following this publication in response to the NHS Five Year Forward View, is beginning to bear fruit. It is providing practical experience of successful implementation of most of the commitments already set out in the NHS Long Term Plan.

> “We need to unleash the energy insight and brilliance of the Allied Health Professions Workforce if we are to achieve integrated care” (Simon Stevens, 2017)

However, there is still work to do. In line with The NHS Long Term Plan, the CAHPO has followed through on the commitment to further develop the national AHP strategy with the publication of The Allied Health Professions (AHPs) Strategy for England: AHPs Deliver 2022 to 2027.

The National AHPs Workforce Improvement Framework sets out the necessary actions required to ensure there is an effective supply of AHPs, robust deployment and development, while placing a focus on the retention of the workforce, across professions and geography. So that systems have the right workforce with the right skills in the right place to deliver high quality care by 2024, the framework focuses on six ambitions across three key areas:

Future supply

1. **Stimulate demand:** Make AHPs a career of choice to stimulate and incentivise applications; this will address the decrease in applications and acceptances for AHP undergraduate course places.
2. **Increase capacity:** Applications and acceptances in AHP courses to further support the delivery of the LTP.

Bridging the gap between education and employment

3. **Support and pathways:** Support different entry routes into AHP roles and explore potential alternative routes.

Enabling the workforce to deliver and grow

4. **Effective deployment:** Effectively deploy AHPs in a way that recognises the needs of the system, the population and supporting staff.
5. **Support development:** Support AHPs to develop throughout their career, advanced practice, and new roles, including medicines management, digital, technology and informatics and leadership and improvement capacity and capability.
6. **Retention:** Provide support to the AHP workforce to retain AHPs – making the NHS the best place to work.

There is not one single action that will meet the workforce needs of the system. There needs to be a joint focus on increasing supply of new registrants, retaining our existing staff, and supporting them to develop and grow to meet the demands of the population.

3.4 Resources to support AHP workforce planning and deployment

The following resources are key guidance to delivering effective planning and deployment of the AHP workforce:

- **NHS ESR:** Working with ESR experts and also AHP leads who are starting their journey in addressing ESR, this guide will help AHP services ensure their workforce data in ESR is accurate and consistent.

- **Job planning the clinical workforce – AHPs:** This guide provides advice for trusts to ensure that their approach to job planning for AHPs is consistent with best practice. Job planning is an important way to link best use of resources with quality outcomes for patients and is a useful element in service redesign. By documenting professional activity in job plans, you can better understand your workforce capacity and match it to patients' needs.

- **E-job planning the clinical workforce: levels of attainment and meaningful use standards:** The NHS Long Term Plan committed that "by 2021; NHS Improvement will support NHS trusts and foundation trusts to deploy electronic rosters or e-job plans".

  This document provides detailed guidance for NHS provider organisations on implementing these systems and their governance, so that they can meet the highest level of attainment in e-rostering.