NHS Improvement

Technical guidance: workforce planning 2019/20

January 2019

collaboration trust respect innovation courage compassion

About NHS Improvement and Health Education England

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Health Education England (HEE) invests £1.9 billion annually in education and training to support the development of the workforce and is responsible, on behalf of the system, for leading the development of workforce solutions. To invest optimally and develop effective solutions, the system requires robust intelligence on workforce supply and demand.

The workforce information that the NHS Improvement/HEE joint collection requires through the operational planning process provides detailed evidence on current workforce shortages. Further data will be sought through the strategic planning process. Together, this data will inform our plans to support you in the future. HEE will use the information in your organisation’s return to model supply versus demand. Aggregated data will be combined and made available through local workforce advisory boards to support discussions with sustainability and transformation partnerships and other regional stakeholders, and from there identify workforce risks and mitigations.

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1. 2019/20 Workforce planning technical guidance: what's new?

1. NHS Improvement and Health Education England (HEE) continue to work together to ensure that trust planning requirements identify the workforce planning requirements for delivering patient services. This is designed to ease the burden on trusts but also align short-term planning needs with longer-term resource requirements.

2. All providers are responsible for ensuring workforce plans meet future requirements while aligning with activity and financial needs to deliver care to patients. Each arm's length body will review providers' submissions in accordance with its role in the health system, while also collaborating on overall planning requirements for the NHS. This document details specific changes to the template, which we recommend you consider before completing the template and submission of workforce plans.

3. Information governance requirements on the collection of data from acute, specialist, mental health, community, and ambulance trusts relating to annual operational and strategic planning, intended data uses and further sharing are included in Appendix 1. **NHS Improvement requests that trusts advise us immediately in writing if they have any objections to NHS Improvement sharing current or historic data in accordance with the information provided below. Trusts should contact their NHS Improvement relationship lead if they have any objections.**

NHS Improvement operational plans: summary of changes from the 2018/19 template

4. A joint NHS Improvement and HEE operational plan, collecting workforce plans for one year (2019/20).

5. WTE (whole-time equivalent) tab changes include:

- NHS standard occupational codes against each of the roles
- information boxes (indicated with the symbol *i*), providing further guidance notes within the template
- breakdown of specific roles to include district nurses, health visitors, school nurses and clinical psychology (Health and Care Professions Council registered and assistants)
- the ambulance workforce, both qualified and support, has been broken down further this year to reflect the new occupational codes due to be released in the occupational code manual by NHS Digital in March 2019
- medical and dental specialty areas have been expanded to collect this data at a career/staff-grade and trainee-grade level.

6. The A&E tab, which is currently collected in the monthly workforce collection, has been included in the operational plan to collect at a plan level.

7. A transformational role tab has been included to collect plan data for roles that are currently part of national programmes across the arm's length bodies. Apprenticeships are also captured here as we are unable to identify them separately within the WTE tab, due to these roles not having specific occupational codes. The plan data collected on this tab will already be captured within the WTE tab, under the relevant staff group, and will not feed into any totals on other tabs as we are looking to capture this as a separate piece of analysis.

8. The hosted tab includes two additional lines capturing Macmillan nurses and Marie Curie nurses, as an 'of which' section under the registered nursing staff group.

9. Removal of additional bridge tabs and the development of a new bridge that is in line with the bridge tab contained in the finance operational plan.

10. New validations that include looking at the phasing of the planned workforce for 2019/20.

11. The KPI (key performance indicator) tab now captures sickness absence and turnover data as a rolling 12-month total and financial year-end targets set for mandatory training and appraisals.

12. The forecast demand tab has been removed as the WTE tab now collects the information required for both NHS Improvement and HEE. The strategic system plan due for collection over the summer will look to expand on the operational plans submitted for 2019/20.

Planning requirements 2019/20: overview and contacts

13. The operational workforce plan is designed to capture workforce information that forms part of the trust's integrated plans. This submission is intended to collect one-year operational workforce plans. For 2019/20 the workforce plan is profiled for each month, including 2018/19 forecast outturn values.

14. Submissions should be prepared in accordance with this guidance and aligned with the finance plan submission.

15. Table 1 summarises the sections to be included in the plan.

Table 1: Summary of sections in the operational workforce plan

Workforce planning tab	Summary	Contact point for queries/support
Cover	Contains trust name, contact details in the event of query and executive sign-off.	NHSI.workforce@nhs.net
Information	Provides information relating to the template's format and structure.	NHSI.workforce@nhs.net
0. Self Cert	Trusts sign off their plan submission. The board is satisfied that adequate governance measures are in place to ensure the accuracy of data entered in this planning template.	NHSI.workforce@nhs.net

Workforce planning tab	Summary	Contact point for queries/support
1. Summary	This tab is intended to provide a high level overview of the workforce plan and is dynamically linked to other areas of the template, so does not require trust data input.	NHSI.workforce@nhs.net
2. WTE	Substantive, bank and agency WTE forecasts by staff group and by professions.	NHSI.workforce@nhs.net
2a. WTE Chart	Provides high level analysis on the WTE key trends for substantive, bank and agency staff.	NHSI.workforce@nhs.net
3. Hosted	Hosted staff (where applicable) WTE forecasts by staff group and professions.	NHSI.workforce@nhs.net
8. KPI	Includes year-end targets for mandatory training and appraisals and 12-month rolling totals for sickness and turnover.	NHSI.workforce@nhs.net
10. A&E	Substantive, bank and agency WTE forecasts by staff group and profession for A&E.	NHSI.workforce@nhs.net
10a. A&E Chart	Provides high level analysis on the A&E workforce.	NHSI.workforce@nhs.net
11. Transformation	Substantive WTE forecasts for transformational roles and apprenticeships.	NHSI.workforce@nhs.net
12. WTE Bridge	Captures WTE movements across several categories that are in line with the finance bridge.	NHSI.workforce@nhs.net
12a. WTE Bridge Chart	Provides a graphic representation of the movements described in the WTE bridge.	NHSI.workforce@nhs.net
Validations	Summary of any errors highlighted, to be cleared before final submission.	NHSI.workforce@nhs.net

16. If you have difficulty clearing any validation errors or general queries about inputting data, please refer to Table 1 above for information on who to direct your query to.

17. For submission portal queries, ie obtaining access to the submission portal or resetting a password, please contact it.support@improvement.nhs.uk. You can also use this email contact if you have any new users who require access to the portal.

2. Cover section

1. This section will already carry trust identifying details including the organisation (org) code, which is the unique identifier for your trust. You are required to provide contact details of who has completed the template (this named individual will act as primary contact during the submission process). The contact details of the authoriser should be recorded as detailed in Section 4 of this guidance.

3. Information section

1. This section provides information on the template’s structure and format. In this section you will be able to identify:

   - editable cells – current year input, comparative year input, next planning year input
   - protected cells – including no input, pre-populated, calculated and information buttons
   - expected signs – specified as positive or negative
   - pre-submission checks – these include a series of validation checks which help identify where there may have been an input error or adverse data.

4. Self-certification (tab reference ‘0. SelfCert’)

1. The trust lead needs to complete this. This person is expected to be at trust executive director level, with lead responsibility for workforce planning.

2. By authorising the plan, the executive director confirms it is a true reflection of the organisation’s workforce plan and reconciles with both finance and activity plans in all relevant aspects.

5. Summary (tab reference ‘1.Summary’)

1. This section provides a high-level summary of the trust workforce plan and provides a quick reference overview for use by both the trust and NHS Improvement.

2. It specifically details the end-of-year position for the previous year (31/03/19) and the period ending the planning collection (31/03/20).

3. The narrative presented on the form reflects the corresponding cell to which narrative has been input in the respective area of the form.

4. This sheet does not require input with trust data as it is dynamically linked to other data inputs in the template

6. WTE staffing forecast section (tab reference ‘2. WTE’)

1. This section collects whole-time equivalent (WTE) forecast information by staff and professional groups for substantive, bank and agency staff numbers.

2. Substantive staff WTE should be based on WTEs from the electronic staff record (ESR), or similar workforce system, adjusted for:

   - secondments in and secondments out
   - recharges in and recharges out
   - staff provided or received through provider-to-provider contracts.

3. In each case the forecast outturn should be the 2018/19 (as at 31 March 2019) WTE staff-in-post position.

4. The monthly 2019/20 forecast WTE should be aligned with the 2019/20 pay spend plan position submitted in the finance plan submission.

5. The all-staff total in line 11 of the template represents the total planned total workforce. The substantive staff section should represent planned substantive staffing levels, while any staffing gaps between the substantive position and total planned workforce should be captured in bank and agency figures to indicate how the shortfall is planned to be filled.

6. ‘Of which’ categories – all roles need to be included within the main staff group heading and then separated out beneath as an ‘of which’ category. For example, ‘Maternity services’ – all qualified roles working in a maternity service should be included in this line, including registered midwives and neonatal nurses. Then beneath this, the WTE needs to be captured as an ‘of which’ for registered midwives and neonatal nurses. The formula has been set up to ensure the WTE captured for the individual roles is not included in the overall maternity services line. For example, a trust might record a WTE in the

forecast outturn column of 100 WTEs for its maternity services, of which 30 WTEs are registered midwives and 10 WTEs are neonatal nurses.

7. For each heading, the trust is required to provide the planned monthly profile of WTEs for the 2019/20 financial year.

8. The difference in WTE changes will trigger a section for mandatory commentary, and the trust is required to give a narrative description to explain the WTE change.

9. Where a monthly profile includes multiple changes, the trust should describe each change.

10. Where commentary remains optional, the trust can still add narrative to explain a change. This narrative will also complement the summary tab as detailed in Section 5.

11. Occupational codes are mapped against each of the roles and have been included as a guide for trusts.

12. 2a. WTE Chart provides high level analysis on the monthly WTE key trends for 2019/20 for substantive, bank and agency staff.

7. Hosted staff (tab reference ‘3. Hosted’)

1. Several trusts will host staff via their electronic staff record (ESR) system for payroll purposes; the template includes a section which enables the recording of WTE staffing levels for hosted staff.

2. Examples of this can include:

    - a trust that hosts doctors in training for the local area while the junior doctors undergo rotation with several providers as part of their training; this section offers an opportunity to highlight this element of the workforce to ensure trusts providing this service are easily identifiable when cross-checking against productivity metrics

    - pathology services across a large geographical network: for example, West Midlands as a region may have 1,000 WTE staff recorded on its ESR system for payroll purposes, but the 1,000 WTEs work in different trusts across the West Midlands providing pathology services; these staff would be recorded under the hosted tab as they are not contributing to service delivery within the trust but need to be captured as a workforce and balanced in the finance submission.

3. In each case the 2018/19 forecast outturn should be the 2018/19 (as at 31 March 2019) baseline WTE.

4. For each heading, the trust is required to provide the planned monthly profile of WTEs for the 2019/20 financial year.

5. Where such staff provide services to the hosting trust, these should be reflected in the rest of the template consistent with previous workforce planning submissions. This section is intended to give trusts the opportunity to reflect the staffing levels recorded on the trust’s ESR system for hosting purposes.

8. A&E (tab reference ‘10. A&E’)

1. This section has been included to capture staff working specifically within A&E departments and should be treated as an ‘of which’ section of the WTE tab.

2. Include staff who specifically work across type 1, type 2, type 3 A&E departments and children’s A&E if applicable.

3. 10a. A&E Chart provides high level analysis on the A&E workforce, including the substantive, bank and agency workforce, broken down by staff group.

9. Transformation (tab reference ‘11. Transformation’)

1. Under the transformation tab we are collecting the transformational roles in your trust, as defined below, and the apprenticeships at a staff group level. These roles will be included within the relevant staff groups in the WTE tab and should be treated as an ‘of which’ section of the WTE tab.

2. **Advanced clinical practitioner:** advanced clinical practitioners come from a range of professional backgrounds such as nursing, pharmacy, paramedics and occupational therapy. They are healthcare professionals educated to Masters level and have developed the skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients.

3. **Physician associate:** physician associates support doctors in diagnosing and managing patients and work across a range of areas, including primary care.

4. **Nursing associate:** nursing associates are new members of the nursing team who will provide care and support for patients and service users. This role is being used and regulated in England and is intended to address a skills gap between healthcare assistants and registered nurses.

5. **Apprenticeships:** please include under the relevant staff group the apprenticeships in your trust.

10. Bridge (tab reference ‘12. WTE Bridge’)

1. The WTE Bridge tab has been redesigned this year. This is to simplify the approach while creating a strong link between the reasons for WTE changes described in the workforce operating plan bridge and the reasons for pay cost changes described in the finance operating plan employee expenses bridge.

2. The workforce and finance plan bridges are brought together for the first time this year in the triangulation tool, with a pilot workforce and finance bridge comparison. You are encouraged to review this comparison once both returns are complete to understand whether the planning assumptions described in the two forms appear consistent. The triangulation comparison also includes the opportunity to provide voluntary commentary. By completing this commentary, especially where the bridges do not appear to align, you will help NHS Improvement develop this bridge approach in future years.

3. The workforce bridge starts with the M12 forecast outturn year WTE data. It enables you to describe your planning assumptions by comparing this to the M12 plan year WTE data and asking you to categorise the difference using the categories available. These categories map directly to those available in the employee expenses bridge in the finance operating plan.

4. Commentary boxes are available throughout the WTE bridge. You must use these wherever a value is input to explain the reason for the WTE change. An overall commentary is also required for each category for which you input values in the bridge. A validation failure will be triggered for any input cells where you include a value, as well as any overall category, until you provide a commentary. NHS Improvement uses these commentaries when assessing the basis of the workforce plan.

5. Commentary relating to the overall columns is always shown on the face of the bridge in row 27. Commentaries relating to specific cells in each column can be hidden/expanded as required using the ‘group’ buttons at the top of the workbook.

6. The categories included in the WTE bridge, as well as how they map to the finance employee expenses bridge (where appropriate), are described below:

- **FOT Year M12 (Column F):** this data is linked directly from the 2. WTE tab and is prepopulated in the bridge. This forms the start point of the bridge analysis.

- **Remove NR staffing impact on M12 of FOT year (Column G):** this column allows you to remove non-recurrent staffing numbers present in the M12 FOT WTE data that would not be present in the M12 plan year data. Please bear in mind this is an adjustment from M12 of the FOT year to M12 of the plan year, rather than the start of the plan year.

  A typical example of an appropriate non-recurrent adjustment would be staff who were present on fixed-term contracts in M12 of the FOT year who would not be present in M12 of the plan year. This would be reflected as a negative WTE movement against the relevant staff categories. Another adjustment you may wish to make might be to recognise a change during the plan year to the approach to staffing: for example, a move from agency or bank staffing to substantive. In this example, you might include a negative adjustment against the agency and/or bank staffing categories and a positive value against the substantive staffing categories concerned.

- **FOT Year WTE Recurrent (Column J):** this is a calculated column which reflects recurrent WTEs rolled over into the plan year, having adjusted the FOT year M12 data for non-recurrent impacts.

- **Underlying demand/volume changes 1, 2 and 3 (Columns L, O, R):** these columns map directly to the finance 22. Employee expenses bridge subcodes BRG2230, BRG2240 and BRG2250, and both should be prepared on the same basis. In these columns, enter WTE changes to support activity change arising from demographic (eg growth in population, change in age profile) and non-demographic changes (eg disease prevalence, diagnosis and treatment rate).

- **Redundancy and restructuring (Column U):** this column corresponds to the finance 22. Employee expenses bridge subcode BRG2300, and both should be prepared on the same basis.

- **Identified Efficiency (Column X):** this column corresponds to the finance 22. Employee expenses bridge subcode BRG2461 and both should be prepared on a consistent basis. WTE changes described in this column are likely to be based on robust plans, unlike the 'unidentified efficiency' category below.

- **Unidentified efficiency (Column AA):** this column corresponds to the finance 22. Employee expenses bridge subcode BRG2462 and both should be prepared on a consistent basis. WTE changes described in this column are likely to be based on a planning assumption rather than specific detailed plans.

- **Service changes, transfers or developments 1, 2 and 3 (Columns AD, AG, AJ):** these columns correspond to the finance 22. Employee expenses bridge subcodes BRG2470, BRG2480 and BRG2490, and both should be prepared on the same basis. These columns enable you to reflect service changes that commissioners start on or after 1 April each planning year. Also include any service transfers or tenders in that period.

- **Other 1, 2, 3, 4, 5 (Columns AM, AP, AS, AV, AY):** these categories are specific to the workforce bridge only and allow you to capture reasons for WTE change that are not reflected in the other categories. Please include a full commentary explaining why they are required instead of the existing categories. NHS Improvement will review the use of these categories and use this when developing both the workforce and finance bridges in future years.

- **Total WTE at M12 Plan year (Column BB):** this is a calculated column which reflects the adjustments throughout the bridge on the start point of M12 FOT year. This calculated field is compared to the WTE tab data shown in column BD, and if the value is different a validation failure will be triggered. This validation ensures you have fully described the WTE movements between M12 FOT year and M12 plan year in the bridge.

- **Plan M12 WTE from 2. WTE tab (column BD):** this data is drawn direct from the 2. WTE tab and is used to check that the values described in the bridge fully explain the movement from M12 FOT year to M12 plan year.

- **Movement check (Column BF):** this is a calculated column which shows the difference between the calculated M12 WTE count described in the bridge and that shown in the 2. WTE tab. The values in this column will be nil for every line where the bridge correctly shows the full movement. Any values that are not nil will trigger a validation failure.

- **Commentary checks (Column BI onwards):** these checks include the details of all the validation checks to ensure that a commentary is included wherever a value has been input into the bridge. The checks can be expanded/hidden as required to enable you to see exactly which cells are triggering a validation failure.

7. The 12a. WTE Bridge Chart tab provides a graphic representation of the movements described in the WTE bridge table by category. It shows the bridging items moving from the M12 FOT year WTE, to M12 FOT year recurrent WTE and to M12 plan year WTE. It is provided as an opportunity to review the key drivers for movement in WTE between the FOT and plan years.

11. Workforce KPIs (tab reference ‘8. KPI’)

1. The trust must enter the baseline end-of-year forecast outturn for 2018/19 as a percentage rate, followed by a monthly 12-month rolling total for sickness and turnover and end-of-year target percentage for mandatory training and appraisal rates. It is assumed that the trust’s year-end position is the trust board’s approved target for each key performance indicator (KPI).

2. We recommend that in developing these forecasts no exemptions are applied to the information, including removal of staff on maternity leave, new starters and long-term sick. Providers should seek to understand trends and patterns in workforce KPIs and map these accordingly against planned levels of sickness absence, turnover and appraisal completion – ie seasonal fluctuations, attainment of pensionable age and impact on potential retirements. We envisage that planning in this way will enable the trust to plan resource to meet demand requirements, recognising increased workforce levels and mitigating reliance on agency staff by using bank staff.

3. We recommend that trusts do not set targets based on 1/12ths. Targets should be complemented by planned intervention and support to address levels of sickness absence, turnover and improved appraisal rates.

4. Variables such as workforce stability and sickness absence will be considered when reviewing the information. Where staff are seconded to another organisation, the trust should plan for the role if it has had to back-fill it or is recruiting to it, especially if the secondment is for more than a year.

5. Spaces for commentary have been provided for the trust to explain any exceptions or changes.

6. **12-month rolling staff turnover:** turnover is calculated as a rolling 12-month sum of the WTE of all leavers from a trust (ie the sum of the WTE of all leavers from a trust between March 2017 to March 2018). This 12-month rolling WTE sum is then divided by the rolling 12-month sum of the WTE of

staff in post at a trust (ie the sum of the WTE of all staff at a trust between March 2017 and March 2018). The data includes substantive staff who leave the NHS and those individuals moving on to employment at another NHS organisation: ie it includes movement between trusts. This will not include inter-organisational transfers (TUPE). Fixed-term contracts are also included in the data. As an example, if the total WTE of all leavers during a 12-month period (March 2017 to March 2018) was 10, and the total WTE of all staff in post between the same period was 100, the turnover rate calculated for March 2018 would be 10%.

7. **Total sickness absence:** calculated by dividing the number of working days lost during the 12-month period with the total number of working days available during the 12-month period. For example, there may have been 50 days lost out of a possible 300 working days between March 2018 and March 2019, which equates to 16.67% for March 2019.

8. **Staff appraisal:** financial year-end target set for the completion of appraisals in the trust. For example, a trust may set a target of 85% completion of appraisals by 31 March 2019 and 88% by 31 March 2020.

9. **Mandatory training completion rates:** financial year-end target set for the completion of mandatory training in the trust. For example, a trust may set a target of 90% completion of mandatory training by 31 March 2019 and 92% by 31 March 2020.

12. Validation section

1. The template contains several validation checks on the internal consistency of information. All validations should be passed before submission. Please email NHSI.workforce@nhs.net if you are unable to clear a validation before submission day. All validations will be described in the validation section and there are hyperlinks to each cell to reconcile and assist with the error clearance process. Please adhere to these guidelines to help minimise error:

   - Avoid dragging and dropping as this can corrupt formulas; please use ‘copy’ and ‘paste special values’ for data extracted from other sources.
   - The correct signage and currency must be used – eg WTE numbers; figures should be rounded to two decimal places.
   - Ensure when submitting that data is not password-protected or linked to other workbooks. A macro is provided on the cover sheet which will break links to external data sources.
   - Where no values are required, cells should be left blank or a zero value inserted; please do not write in ‘NIL’ or ‘N/A’.
   - Check the validation section summary to ensure all errors are cleared before submission.
   - Ensure the header section has been completed with executive sign-off.
   - An additional macro to expand grouped items within the 12. WTE Bridge tab is provided in the cover tab. Additional guidance on this will be sent out separately.

13. Triangulation data

1. A ‘Triangulation Data’ tab has been included in each planning template this year. It presents all data points used in the triangulation template. No input is required in this tab as the values in Column J are calculated automatically. The ‘Triangulation Data’ tab is for reference purposes only; no additional work is required. Column E shows the main code, and Column F shows the subcode for each data point, Column J calculates the relevant value. For each group of data points there is a link in Column L which takes the user through to the input cells being used to drive the data collected for triangulation.

14. Definitions

1. **Vacancy**

   The variance between the reported whole-time equivalent (WTE) substantive staff in post and planned workforce levels. A vacancy is a post that is unfilled by permanent or fixed-term staff. Agency or temporary staff may fill some vacant posts. Total vacancy rates are a calculation of the total number of WTE vacancies with the total funded or budgeted establishment.

2. **Forecast outturn**

   The predicted year-end staffing position, ie at 31/03/2019.

3. **Planned data**

   The number of staff or the planned position (in the case of KPI data) the trust forecasts to be in post during the respective month of the plan. The plan should be phased appropriately over the year to represent forecast staff movements, ie periods of recruitment.

4. **Hosted staff**

   Staff who are on the electronic staff record (ESR) at an organisation but do not directly deliver services for the organisation. For example, junior doctors maybe on ESR at Trust A but deliver care at Trust B.

15. Appendix 1

This is important information about changes to the collection and sharing of data from acute, specialist, mental health, ambulance and community trusts, relating to annual operational and strategic planning.

Please make your submission using the data collection template provided. If you have any concerns about the proposed sharing of current or historic annual operational and strategic planning data (as outlined below in this information governance data collection and data-sharing notice), please contact your NHS Improvement relationship lead.

Before you submit your trust's data, note that we ask you to validate it. Please ensure you check the data quality, including – but not limited to – accuracy and completeness. We will analyse the data and feed back on quality and accuracy issues where appropriate as part of the planning process.

1. Why are the NHS Trust Development Authority and Monitor (collectively referred to as NHS Improvement) collecting the data?

The purpose of collecting this data is to oversee and support trusts in the planning round, to develop safe and sustainable plans, support financial, activity, workforce and quality planning, assess and assure plans and provide feedback to trusts.

NHS Improvement will use the data to discharge our statutory duties, which include requirements to protect and promote the interests of people who use healthcare services by promoting provision of healthcare services which are, inter alia, economic, efficient and effective. This is in accordance with the NHS Trust Development Authority's (TDA) duty to:

- assist and support providers of NHS services to ensure continuous improvement in the quality and financial sustainability of the NHS services they provide in pursuance of its improvement functions under Direction 2 of National Health Service Trust Development Authority Directions and Revocations

and in accordance with Monitor's duty to:

- support providers of services for the purposes of the NHS, in exercise of its functions under Chapter 3 of Part 3 of, and paragraph 15 of Schedule 8 to, the Health and Social Care Act 2012 (licensing and general power) and having regard to its general duties in sections 62 and 66 of that Act.

The supporting legislation for the TDA to collect this data is:

- Direction 2 of National Health Service Trust Development Authority Directions and Revocations and the Revocation of the Imperial College Healthcare NHS Trust Directions 2016.

The supporting legislation for Monitor to collect this data is:

- Chapter 3 of Part 3 of, and paragraph 15 of Schedule 8 to, the Health and Social Care Act 2012 (licensing and general power) and having regard to its general duties in sections 62 and 66 of that Act.

The data collected will enable NHS Improvement to assist and support providers of NHS services to ensure continuous improvement in the quality and financial sustainability of the NHS services they provide.

The guidance and data collection templates provided set out the data required for the above purposes. NHS Improvement will request collection of this data from your organisation directly and instructions regarding this will be provided in the national planning and technical guidance and in the templates and other relevant communications.

This request relates to an annual operational and strategic **planning** data collection by you, and we request this data submission to be sent to us in accordance with the planning timetable as outlined in the national guidance.

2. Type and level of data being collected?

Patient-level data (including NHS number) is **not** required for this data collection exercise. What we are requesting is set out in the national planning and technical guidance documents, which include finance, activity, performance and planning

data. Any fields that could enable a patient or staff member to be identified must be excluded.

3. Who will access the data and how will it be further shared in the context of the joint working between NHS Improvement and NHS England?

The data submitted by you will be primarily accessed by NHS Improvement national and regional teams on a 'need to know' basis and in line with role-based access controls for the purpose described in this document.

NHS Improvement may also share the data internally to support our wider delivery of all Monitor and TDA statutory responsibilities.

Where we are, or intend in the near future, to work more closely with NHS England we will share this data with NHS England for the purpose for which we are collecting the data and for fulfilling both NHS Improvement and NHS England functions.

NHS England will use this data to discharge its statutory functions, duties and powers reserved to the board to 'ensure compliance with the concurrent duty, held with the Secretary of State for Health, to continue the promotion in England of a comprehensive health service'.

NHS England's supporting statutory duties are set out in the NHS Act 2006 s13E and Health and Social Care Act 2012 s23 and require NHS England to secure continuous improvement in the quality of health and public health services provided to individuals.

4. Sharing the data with other partner organisations and arm's length bodies

This data will be shared with other partner organisations and arm's length bodies (ALBs) to facilitate joint working arrangements and support individual providers (where necessary). Sharing with a third party will always be done securely and in accordance with the guidance in this document. The organisation that data will be shared with is Health Education England (HEE) to support NHS Improvement and NHS England as part of a jointly agreed collection to enable both to fulfil their statutory functions in support of the system as follows:

- at both national and regional level to understand and comment on plans individually and in aggregate
- some aggregate analysis will also be deployed in the development of workforce and service-level programmes
- for HEE to inform its education commissioning requirements
- at ICS/STP level the data will be deployed by NHS Improvement and HEE locally in joint endeavours determined by local factors and relationships. It is understood that individual trust-level data is not to be shared with any other trusts unless the organisations that comprise an individual ICS/STP agree to this.

If we intend to share further with other organisations, we will contact you and seek your views about this.

5. Where will the data be stored and for how long?

Data collected and processed will be stored securely at all times within the NHS Improvement internal secure servers. Data made available to other partner organisations or ALBs will be required to be held securely in line with the security and confidentiality requirements, including those in any data-sharing agreements.

All data will be regularly backed up and will be securely held until no longer required for audit purposes.

6. What analysis will be done on the data and how will the results be used?

NHS Improvement staff, in partnership with NHS England and HEE, will analyse the plan submissions to assess and provide feedback to trusts. Part of the analysis may involve cross-checking your submitted data with other data or information held by NHS Improvement, NHS England or HEE to provide more in-depth understanding of planning positions across commissioner/provider or ICS/STP level.

7. Sharing historical planning round data already collected from trusts.

To support joint working arrangements between NHS Improvement and NHS England, in liaison with HEE, it is necessary to also share historic data already collected for planning with NHS England for the purposes set out above.

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