

# **Price caps for agency staff: impact assessment**

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## Summary

NHS providers face a very significant financial challenge. On the one hand, they face upward cost pressures driven by rising demand and moves to improve clinical quality and safety, and on the other, an ongoing period of public spending constraint, from which the NHS has been relatively shielded, but which has always meant that funding has not always increased in line with cost pressures.

One key component of these cost pressures has been the rapid increase in spend on temporary agency staff, which reached £3.3 billion in 2014/15, and is on trend to grow by up to 30% in 2015/16. Such growth is unsustainable, and has contributed to a growing provider deficit, which reached £930 million in the first quarter of 2015/16.<sup>1</sup>

The Secretary of State for Health has asked the NHS regulatory bodies<sup>2</sup> to consider the feasibility of implementing caps on the prices paid by NHS providers for agency staff. This paper assesses the risks, potential costs and benefits of such a policy.

### Proposed policy approach

It is proposed that price caps be applied to agency and bank staff rates paid by NHS trusts and NHS foundation trusts for both clinical and non-clinical staff. The only exception to this would be for ambulance trusts, where further work would be needed to assess the feasibility of such caps.

The caps would initially be set at 100% (150% for junior doctors) on top of Agenda for Change (AfC) or equivalent permanent pay rates, before being reduced over several months to 55% above AfC or equivalent levels.

### Balance of risks, benefits and costs

The analysis of risks, benefits and costs associated with these proposals involves making complex trade-offs between risks that are difficult to assess because of uncertainties about the likely response of trusts and agency staff, in addition to other data limitations.

Our analysis suggests that the proposed price caps could deliver savings, in our central scenario, of around £200 million under a cap of 100% above AfC/permanent staff rates, and £370 million under a 55% cap. Further details are set out below. It is important to note that there is a significant margin of error around these estimates.

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<sup>1</sup> [www.gov.uk/government/publications/nhs-foundation-trusts-quarterly-performance-report-quarter-1-201516](http://www.gov.uk/government/publications/nhs-foundation-trusts-quarterly-performance-report-quarter-1-201516)

<sup>2</sup> Monitor, the NHS Trust Development Agency (TDA), NHS England and the Care Quality Commission (CQC)

Without the proposed mitigation, the policy would carry very high risks of creating staff shortages, which in turn would lead to increased risks to patient safety and to the quality and continuity of services, including increased waiting times.

These risks are likely to be mitigated to some extent by the proposals to introduce the price caps gradually over time, and to allow trusts to use 'break-glass' clauses, which would allow them to pay rates above the caps when justified on clinical safety grounds. In addition, commissioners – both clinical commissioning groups (CCGs) and NHS England for nationally commissioned services – have a vital role in ensuring the continuity and quality of services, and will have contingency plans to help manage any risks that emerge.

However, despite these mitigants, significant risks will remain. These risks are likely to be broadly greater for locum doctors than for other staff, and more problematic in specialties where there are shortages, in geographically isolated trusts, and in trusts with reputational difficulties.

These risks, however, need to be weighed against a counterfactual where larger financial deficits and ever greater reliance on agency staff have an increasingly negative impact on patient safety and access. Clinical leads across Monitor, the Trust Development Authority (TDA), the Care Quality Commission (CQC) and NHS England have advised that the balance of clinical risks supports taking action to tackle agency costs now and bring agency staff back into the regular workforce, including through the use of price caps, provided that:

- The price caps are introduced on a graduated basis (as is proposed).
- Trusts are able to use the 'break-glass' clauses in response to significant risks to the clinical safety of patient services.
- There is very close and careful monitoring of any emerging clinical risks following implementation.
- Action is taken rapidly in response to those risks crystallising, including if necessary adjusting the price caps.

### **Detailed assessment of financial savings**

We assess that, on an annual basis, total savings under the central scenario (which assumes 70% compliance with the caps) are likely to be as follows:

- Under a cap of 100% above AfC/permanent staff rates (150% for junior doctors; 55% for non-clinical staff): £110 million for nursing staff, £50 million for locum doctors, and £40 million for other agency staff, totalling around £200 million.

- Under a cap of 55% above AfC/permanent staff rates: £110 million for nursing staff, £210 million for locum doctors, and £40 million for other agency staff, totalling around £370 million.

These savings are not entirely additional to those arising from existing rules on trust spending on agency staff, announced on 1 September 2015. They have been calculated against data on agency spend for 2014/15. As early data suggests that spend has increased significantly so far in this financial year, the actual savings may be larger. However, significant caveats apply to the numbers, given the assumptions we have needed to make as a result of data limitations.

### **Compliance and financial risks**

We have assumed 70% compliance with the price caps in our central scenario to reflect the potential use of 'break-glass' clauses as well as the likelihood that some trusts may not be able to fully comply with the rules. Although some scenarios have higher compliance, there are other scenarios under which compliance could fall below this level. One example could arise where a trust using the 'break-glass' clause to ensure safe levels of staffing sparks a chain reaction, in which other trusts competing for the same staff also make use of the 'break-glass' clauses. These and other potential trust responses to the price caps, such as increased use of staff paid at AfC overtime rates and/or 'grade drift', could significantly reduce the potential savings, although there could be important clinical benefits from the increased use of permanent staff.

### **Equalities impact**

In line with the public sector equality duty, we have considered the potential impact of the proposed price caps. Our initial consideration is that any such impact is likely to be small and outweighed by the wider considerations outlined above. However, it will be important to monitor the equalities impact of the proposals following implementation, alongside clinical and financial measures, so that appropriate action can be taken if any significant adverse impact should arise.

## Introduction

1. The use and cost of agency staff by the NHS – both providers and commissioners – has become an area of increased focus over recent years, reflecting in particular trends to improve the quality and safety of NHS care against a backdrop of increased pressures on NHS finances.
2. As a result, the Secretary of State for Health has asked the NHS regulatory bodies to consider the feasibility of implementing caps on the prices paid by NHS providers for agency staff.
3. This paper:
  - starts by setting out the problem under consideration, including why spending on agency staff in the NHS has become problematical
  - explores the potential rationales for intervention
  - sets out the proposed national policy intervention of setting caps on the prices the NHS pays for agency staff and briefly explains the underlying theoretical and empirical evidence
  - evaluates the potential savings from the proposed price caps, based on available sample data, and applies scenarios around compliance rates of trusts and the potential responses of agency staff to the caps
  - explores the associated risks to service safety, quality and operational performance
  - sets out the likely range of costs and benefits from applying different levels of price caps.

## Problem under consideration

4. Spend on agency staff by NHS trusts and NHS foundation trusts is rising rapidly; there was an 80% increase between Q1 (April to June) 2011/12 and Q2 (July to September) 2013/14, reaching £3.3 billion over the 2014/15 financial year. This has been a key driver in the growth of provider deficits across the NHS, which reached £822 million in 2014/15 and £930 million in the first quarter of 2015/16. This represents a major challenge, particularly considering the £22 billion efficiency savings to be made in the NHS by 2020.<sup>3</sup>

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<sup>3</sup> [www.england.nhs.uk/ourwork/futurenhs/](http://www.england.nhs.uk/ourwork/futurenhs/)

*Why has agency spend increased so rapidly in recent years?*

5. The increase in agency spend can be attributed to the confluence of a number of factors, which have affected both the volume and cost of agency staff.
6. Primarily, there is a fundamental mismatch between demand for clinical staff and supply. This is probably a function of a range of underlying factors, which might be resolved in the long run through a combination of increasing training places (noting the very long lead times for training doctors in particular), greater capital substitution for labour, more skills mix shift, and a wide range of other efficiency and productivity improvements in individual trusts.
7. In addition to continued activity growth across the NHS, the market for nursing staff in particular experienced a demand shock as a result of the Francis report and the resulting regulation on safer staffing.
8. Until recent years, trusts used agency staff primarily as a flexible resource to help them manage peaks and troughs in demand. They have also used agency staff as a way of managing posts that were difficult to fill: this can allow trusts to differentiate between the wages of permanent and temporary employees, allowing them to fill posts without having to raise wages across the board.<sup>4</sup>
9. Over the last three years, while trusts have managed to recruit some extra nurses, demand has continued to grow, resulting in supply pressures that had not been anticipated in NHS training forecasts. The power this created for agencies supplying temporary staff has allowed them to increase charges.
10. Historically, supply shortages have been filled by overseas recruitment, but the pace of demand post-Francis has outstripped the ability of trusts to secure staff from overseas.
11. Over the last five years, NHS wages for permanent staff have been subject to public sector wide pay restraint. As agency wages have not been subject to the same constraints, this has increased the attractiveness of agency working for staff.
12. In addition to these factors, there is evidence that many medical staff like the greater flexibility that agency working offers over not only permanent work but also the bank arrangements that trusts use as a source of additional staff. Examples of this kind of flexibility include:
  - the ability to fit work around caring responsibilities or outside interests, rather than having to work a set pattern of shifts

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<sup>4</sup> This phenomenon is not unique to the NHS, for example, it is described in detail in a paper on the US health system: Houseman, Kalleberg & Erickcek (2003) *The role of temporary agency employment in tight labour markets*. Upjohn Institute Working Paper No.01-73

- shorter shifts
  - the ability to work in a number of different parts of the NHS, increasing experience but also, for example, allowing A&E nurses to work their overtime in less pressured services
  - the ability to receive payment more quickly, eg weekly or even the day following a shift, rather than monthly.
13. In the longer term, increasing the supply of staff by increasing the numbers trained should counteract the increased market power of staff and agencies, but in the short term, they are able to extract significantly higher fees for temporary work. Where it is not possible to plan for staffing needs, a spot market has developed where these charges have, in some cases, reached exceptionally high levels, again contributing to the agency staff bill but also potentially demoralising permanent staff, who may feel less valued given relative pay rates.
14. Trust responses to the increases in agency costs have varied. Some have achieved success through better management of rotas and greater flexibility over shift patterns, overseas recruitment, back to work schemes, etc., but this has not been to the scale and extent necessary across all providers to tackle the rapid rise in costs. Others have changed the pay rates for overtime and bank work to make it more attractive. However, given the high likelihood that labour markets will operate differently across the country (eg urban vs. rural areas; recruitment difficulties faced by troubled providers), it is not clear that particular examples of good practice will always be readily transferable to other providers.

## **Rationale for intervention**

15. As additional clinical staff will take years to train, other actions are likely to be required in the short-to-medium term to achieve a sustained – and sustainable – reduction in agency costs. Such actions could take place:
- in individual trusts, eg by tackling some of the issues identified in paragraph 12
  - at local level, eg through collaboration between different NHS organisations
  - at national level through interventions by the regulators of trusts and foundation trusts, acting in their roles as guardians of the public purse or providing support to trusts to act individually or collectively
  - at national level by regulators and government.
16. Individual trusts will continue to have primary responsibility for reducing agency costs and delivering patient safety. Actions such as increased flexibility on



working arrangements for permanent and bank staff can help by providing alternative ways of filling vacancies. Similarly, there are opportunities for trusts and commissioners to work together, for example by commissioning and supporting nurse training places outside the national system overseen by Health Education England (HEE) – this is the approach taken, for example, by Lancashire Teaching Hospitals NHS Foundation Trust.<sup>5</sup> However, it will take time for this to bear fruit.

17. In the long run, increasing training places for both nursing and other clinical staff will help tackle the underlying mismatch between demand and supply. Similarly, it may be possible to tackle some of the demand issues by supporting and assessing trusts that are attempting to implement new models of working involving skills mix change and capital substitution for labour. However, these are unlikely to tackle the immediate challenge.
18. Monitor and TDA have already put in place measures to tackle the increase in expenditure on agency nursing staff by setting limits for each trust on the proportion of nursing staff spend that can be spent on agency staff; and by requiring that spend to be directed through an approved framework.<sup>6</sup> Monitor/TDA will also provide support to individual trusts, eg providing advice on best practice approaches to employment terms and conditions.
19. However, these policies only go part of the way to address the specifically short-run challenges. The key question, then, is whether further national interventions could deliver significant additional benefits, and whether these would outweigh any costs/risks. Based on the summary of the underlying challenge outlined earlier, this would depend on whether such interventions could successfully help tackle the market power of agency staff and agencies supplying the NHS, and therefore help tackle some of the resulting financial and clinical consequences of the excessive use of agency staff. They will also need to be weighed against a counterfactual which takes into account the risks, both clinical and financial, of taking no action to address the sector-wide deficit.

## Policy objective

20. The overall policy objective is to reduce reliance and excessive expenditure on agency staff, without compromising patient safety, in order to make best use for patients of constrained resources, as well as to ensure high quality staffing. This will also help to tackle the deficits currently being run by a large number of trusts.

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<sup>5</sup> [www.nursingtimes.net/nursing-practice/specialisms/educators/first-self-funded-nursing-course-launched-to-tackle-shortage-in-nw/5077980.article](http://www.nursingtimes.net/nursing-practice/specialisms/educators/first-self-funded-nursing-course-launched-to-tackle-shortage-in-nw/5077980.article)

<sup>6</sup> [www.gov.uk/government/news/new-rules-launched-to-reduce-agency-spend-in-the-nhs](http://www.gov.uk/government/news/new-rules-launched-to-reduce-agency-spend-in-the-nhs)

## Policy options

21. Monitor and TDA have previously considered and put in place rules on nursing agency expenditure. These include limiting the total expenditure on nursing agency staff and mandating the use of approved frameworks to secure agency nursing shifts.<sup>7</sup>
22. Going beyond this, the Secretary of State for Health has asked the NHS regulatory bodies to consider the feasibility of implementing caps on the prices paid by NHS providers for agency staff. We have considered this approach, including a number of design elements discussed below (level of cap, graduated approach, exemptions, 'break-glass' clauses), as well as an alternative of doing nothing.

### *The economics of price caps*

23. In well-functioning markets, the price mechanism enables supply and demand to adjust to reach the optimum outcome. In such instances, price caps risk distorting markets and leading to supply shortages. Where there are significant market failures, such as in the utilities sectors where firms can potentially wield strong market power, price caps in the form of RPI-X regulation<sup>8</sup> have been more successful.
24. The empirical evidence of price caps prompts caution in respect of their use. While in some utilities markets, price caps have limited the extraction of economic rents from consumers, this has been linked to clear market failure and they have retained the ability to raise prices if input prices rise substantially.<sup>9</sup> Where market failures are less obvious, for example the capping of housing rents in major conurbations, there have been adverse consequences for compliance, supply and quality.
25. These insights highlight a number of points. First, that there are significant economic risks to using price caps, such that economists will not, under most circumstances, advocate their use. Second, the experience of regulated utilities markets is that it is important to retain flexibility to adjust prices depending on behavioural responses and as economic circumstances change. Third, they highlight the need for strong policies to address supply risks and a careful, considered approach to enforcement of interventions.

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<sup>7</sup> [www.gov.uk/government/publications/nursing-agency-rules](http://www.gov.uk/government/publications/nursing-agency-rules)

<sup>8</sup> This requires firms to deliver cost efficiencies over an extended period of time.

<sup>9</sup> In contrast, in the Californian electricity market in the late 1990s, price caps were introduced that could not be adjusted to reflect the increased costs of generating electricity, leading to supply shortages.

### *The case for price caps in the agency market*

26. The main argument for applying price caps to the agency market is that price caps would constitute an urgent measure to try to reverse a trend of rapidly rising agency staff costs in the NHS, while longer-term measures, such as training more staff, take effect. While the shortages of clinical staff in some specialties was always likely to have led to increases in agency charges, there are instances now where these charges have climbed so high that, if left unchecked, other services – and therefore patients – may well be adversely affected.
27. In particular, where trusts need to find key staff or consider closing services because they may not be safe, demand is highly inelastic and therefore agencies and agency staff are able to charge high prices. This is contributing to deficits across the NHS which, without urgent action and given constrained budgets, could require the scaling back of services to bring NHS finances back into balance.
28. The costs, benefits and risks of setting price caps for agency staff depend on the precise way in which they are implemented, including:
  - The level(s) at which they are set: if set too low, they may encourage staff to exit the market and lead to shortages of staff; if set too high, they may ‘anchor’ prices upwards, perhaps even increasing costs rather than reducing them. Indeed, there is a general risk that price caps will, in fact, become the default prices in each market affected.
  - The elasticity of supply of agency staff: ie the precise trade-offs that agency staff will make between work at different levels of pay and other uses of their time.<sup>10</sup>
  - Whether there are any exemptions/arrangements for trusts to overrule the price caps, eg allowing them to pay more to avoid (temporary) service closures because of a lack of the necessary staff.
  - The level of trust compliance with the caps (which may be affected by all of the above).

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<sup>10</sup> The price elasticity of supply is the percentage change in supply in response to a price (wage) change, divided by the percentage change in price (wage). In this case, this would be the percentage change in the whole time equivalent (WTE) number of agency staff employed divided by the percentage change in pay before and after the introduction of price caps. For example, under an elasticity of 1, we would expect a 1% change in price to lead to a 1% change in supply.

## Policy proposal

29. The proposed approach to setting price caps is set out in the Price Caps Consultation Document, published by Monitor and TDA on 15 November 2015.
30. Under the proposed option, price caps would take effect from late November 2015. They would initially be set at around the average charge for agency shifts. Subject to monitoring, they would be reduced in two further stages so that by April 2016 capped agency rates will be equivalent to national NHS pay rates for substantive staff. From this date, trusts would not be able to pay more than 55% above the relevant national pay rates (AfC or doctor basic pay scales) for an agency worker from April 2016. The 55% uplift accounts for employment on-costs including employer pension contribution, employer national insurance, holiday pay to the worker and a modest administration fee.
31. This 'ratcheting down' approach is intended to partly mitigate risks through monitoring the consequences as the price cap is tightened and, if necessary, allowing adjustments to be made. 'Break glass' clauses are also proposed so that providers can override the caps in the interests of safety, where needed.
32. Agency expenditure is roughly evenly distributed among nurses, doctors and other clinical and non-clinical staff. Therefore, caps are proposed to apply to all staff groups. Available data suggests that some staff groups currently receive higher premiums through agency shifts than others. For example, the premiums for junior doctor shifts are significantly higher than admin and clerical work. Therefore the proposed initial price caps allow for a greater initial premium for junior doctors in particular and clinical staff in general. These are set out in the table below. Subject to monitoring, charges for all agency shifts would be capped at 55% above relevant national pay scales by April 2016.

**Table 1: Price caps, expressed as percentage uplift to current AfC/basic pay maximum rates**

	<b>Group 1: Junior doctors</b>	<b>Group 2: Other clinical staff</b>	<b>Group 3: Non-clinical staff</b>
	Foundation year 1 and 2 doctors, registrars	Consultants, other doctors, nurses (all bands), AHPs, healthcare scientists, other clinical staff	Administration and clerical, infrastructure, other non-clinical staff
23 November 2015	+ 150%	+ 100%	+ 55%
1 February 2016	+ 100%	+ 75%	+ 55%
1 April 2016	+ 55%	+ 55%	+ 55%

33. Caps on the rates a trust can pay for an agency worker are expected to lead to reductions in agency expenditure through two main routes: price and volume. First, some workers will continue to offer their services at lower prices so the average cost per shift worked would be expected to fall, both through reduced worker pay and reduced agency fees. This effect would bring a direct net financial saving to the NHS.
34. Second, reducing the price paid per hour is likely to lead to a reduction in the number of agency hours worked. Agency workers may withdraw labour from the NHS or choose to move to bank or substantive work. To the extent that there is a move to bank/substantive case (and where rates paid are equivalent between capped agency, bank and substantive), there will be reductions in agency spending but some offsetting increase in expenditure on bank/substantive spending. To the extent to which fewer people work in the NHS as a whole, this is covered in the 'risks and mitigation' section.

## Potential workforce and financial implications

35. Full details of the assumptions and methodology used in the following sections, including the rationale for the price elasticities chosen, can be found at Annex 1.
36. Given the assumptions that, in the absence of existing evidence, we have needed to make around critical factors such as supply elasticities, all numbers in this analysis will be subject to significant margins of error and must therefore be treated with a fair degree of caution.

## Nursing staff

### *Consequences for supply*

37. Table 2 illustrates the potential impact in terms of percentage reductions in agency hours worked under different assumptions of elasticity – essentially, the trade-offs nursing staff will make between agency work and other activities (including non-agency work and leisure) at different levels of agency pay.

**Table 2: Estimated reduction in nurse agency hours worked if 100% compliance, dependent on level of cap and assumed supply elasticity**

	Supply elasticity			
	1	1.5	2	3
Cap at 100% above AfC	15%	22%	29%	41%
Cap at 75% above AfC	15%	23%	30%	42%
Cap at 55% above AfC	16%	24%	32%	44%

38. To assess what this might mean in terms of whole time equivalent (WTE) nurse numbers, we can apply the percentage reductions to the figures trusts have

provided for agency nurse usage during 2014/15, which suggest that agency use was equivalent to roughly 15,000 nurse WTEs. Therefore, reductions in WTE nurse numbers would range from 2,000 to 6,000. This represents 1–3% of the total relevant nursing workforce of 224,000,<sup>11</sup> or between around 10% and 30% of the expected number of (about 20,000) newly qualified nurses entering the NHS each year. However, this may be a conservative estimate of the effect, given that agency costs have been rising in the first part of 2015/16.

39. It is important to note that some of this reduction in agency nursing would be likely to be offset by an increase in the supply of substantive staff and, other things being equal, the number of bank staff.
40. While the average effect may be small, the available evidence suggests it will be stronger in some areas than others. For example, it is likely to be concentrated in more skilled nurses (band 5 and above), where there has been more upwards pressure on agency wages.
41. In addition, some specialties or wards in some trusts are already operating with adequate staffing rather than optimal levels. Therefore a small reduction in WTE nursing staff is likely to have a negative impact on some wards or services. Certain specialties attract the highest uplift above AfC rates, including A&E, Intensive Care Units and Neonatal Intensive Care Units (NICU). These are often the most pressured and have the greatest countrywide shortage of staff.
42. Equally, reduced staffing will increase the challenge of maintaining operational performance levels.
43. There are some important potential mitigations against these risks – in particular, it is proposed that:
  - The caps are set at the median rate from 23 November 2015, with the level reduced to AfC levels (plus on-costs) by 1 April 2016. This will allow the impact of the caps to be tested via monitoring of a range of quality, safety and performance metrics, with scope to delay the ratcheting process if those measures raise any concerns.
  - Subject to reporting requirements, trusts can use ‘break-glass’ clauses in the rules to pay agency staff more than the caps, where this is clinically justified on the grounds of patient safety.

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<sup>11</sup> It is difficult to ascertain the precise level of the relevant workforce. This figure consists of: 177,000 acute, geriatric and elderly nurses; 16,380 paediatric nurses; 24,915 working in maternity services; and 5,199 working in neonatal nursing. Source: HSCIC, NHS electronic staffing record, [www.hscic.gov.uk/searchcatalogue?productid=18205](http://www.hscic.gov.uk/searchcatalogue?productid=18205)

44. These mitigations will obviously reduce the potential level of financial savings, but will ensure that trusts are able to overrule the restrictions on clinical safety grounds. This is vital to ensuring that clinical risks associated with the proposals are minimised.

### *Compliance*

45. From discussions with the sector on the principles around capping agency staff rates, we have identified several types of trust/labour market positions which will affect compliance levels and the use of mitigations. These are as follows:
- The highest compliance levels are likely to be for trusts located in urban areas with good transport links, which provides them with access across a number of linked labour markets. Such trusts can be found in central London and in other major cities with good motorway links.
  - Some trusts in urban locations may struggle to compete for staff, particularly in specialties where, nationally, demand exceeds supply significantly, perhaps because neighbouring providers are more prestigious or are simply larger and therefore potentially able to offer more flexibility around shift timings. They also have to compete for staff with private-sector hospitals and care homes, and therefore the package of wages and working terms and conditions will be important in securing a sufficient supply of staff.
  - Trusts that are located in more rural locations are likely to have access to a smaller pool of labour; while outside options may be fewer than for clinicians based in cities, helping them to retain permanent staff, this also means that there are likely to be fewer temporary staff able to fill in for gaps in rotas.
46. The greatest difficulties are likely to be faced by challenged trusts, especially those formally in special measures and/or subject to CQC compliance/enforcement actions related to staffing. Experience suggests that, particularly as a result of adverse reputational issues affecting their ability to recruit substantive staff, such trusts often rely on agency staff to maintain continuity of services, and that those agency staff have usually required a significant premium to take on such roles.

### *Financial implications*

47. Table 3 illustrates the potential reduction in agency nursing costs (gross savings, compared to a “do-nothing” counterfactual) based on 100% compliance.
48. These potential reductions in agency costs do not equate to savings as there may be countervailing increases in substantive staffing/overtime (given that those will not be capped) to ensure adequate staffing levels. Alternatively, if the reduction in staffing is not offset through other routes, there could be reductions

in service quality (including waiting times and/or patient experience) or safety, for which the costs are difficult to monetise.

**Table 3: Estimated reduction in agency nursing costs if 100% compliance, and reductions in workforce in line with elasticity**

	Supply elasticity			
	1	1.5	2	3
Cap at 100% above AfC	£350m	£420m	£490m	£600m
Cap at 75% above AfC	£370m	£440m	£510m	£630m
Cap at 55% above AfC	£380m	£460m	£530m	£650m

49. Table 4 provides the best indication of the range of likely savings arising from applying the caps at different levels, as it assumes that current numbers of staff are maintained, whether working as agency staff or switching to bank arrangements or permanent employment. Under a scenario of 100% compliance, savings are in the region of £230 million per year with a 55% cap and £210 million per year with a 100% cap. A more realistic 'central scenario' of around 70% compliance would reflect the greater recruitment difficulties faced by some trusts. This is associated with lower savings, in the region of £110 million per year under either option.

50. These savings are not entirely additional to savings under the existing rules governing trust spending on agency staff that were announced in September 2015.

**Table 4: Reduction in agency nursing costs (£), assuming no change in workforce numbers<sup>12</sup>**

	Compliance rates					
	100%	90%	80%	70%	60%	50%
Cap at 100% above AfC	£210m	£190m	£150m	£110m	£60m	£30m
Cap at 75% above AfC	£220m	£200m	£160m	£110m	£70m	£30m
Cap at 55% above AfC	£230m	£200m	£160m	£110m	£70m	£30m

<sup>12</sup> For each assumed reduction in staffing, we calculate the saving given different compliance levels with the proposed caps. Here, we assume: a) evenly distributed 'non-compliance' with the capped rate for those staff who had wages higher than the cap. X% of all of those with rates higher than the cap remain on those rates and everyone else complies. b) Non-compliance is only an issue for those shifts which do not currently meet the caps. We therefore reduce the total savings from the 100% compliance rates by the percentage of non-compliance.



## Medical staff

### *Consequences for supply*

51. We have applied the same assumed levels of supply elasticity as for nurses (ie 1, 1.5, 2 and 3). However, greater weight needs to be given to the higher elasticity numbers, to reflect the likelihood that the elasticity for medical locums is higher than for agency nurses:
- agency fees are significantly higher for medical locums
  - clinicians and framework owners have told us that doctors tend to be more willing to travel longer distances to work as locums
  - while there is an international market for nurses, the international outside options for doctors tend to be even greater (including Wales and Ireland)
  - there are also significant domestic outside options, not only in the private health sector but in a range of fields related to medicine (eg management consultancies who work with health providers).
52. As a result, a supply elasticity of 3 may well be closer to a notional ‘central case’ than it would be for nursing and other staff.
53. The results of our analysis are set out in Tables 5, 6 and 7, below. As with the analysis for nursing staff, strong caveats apply to the estimates of savings, given the uncertainties around key assumptions. Again, Annex A sets out the detail of these assumptions.
54. Table 5 illustrates the potential impact in terms of percentage reductions in agency hours worked under different assumptions of elasticity. These suggest significant potential reductions in supply of junior doctor locums in particular. However, reductions in other medical locums are likely to be more modest, but still substantial.

**Table 5: Estimated reduction in medical locum agency hours worked, dependent on level of cap and assumed supply elasticity**

	Supply elasticity			
	1	1.5	2	3
Junior doctors (150% above); Other doctors (100% above)	11%	16%	22%	33%
Junior doctors (100% above); Other doctors (75% above)	28%	42%	55%	81%
Junior doctors (55% above); Other doctors (55% above)	44%	65%	87%	98%
	11%	16%	21%	31%
	4%	6%	8%	12%
	20%	29%	39%	57%

55. Medical locums accounted for around 9,000 WTE, out of a total workforce of 124,000 WTE, ie 8% of the total. For junior doctors, locum WTE rates are about half this, ie 4% of the total. Therefore, conservatively assuming a supply elasticity of 2, the proposed caps at 150% above permanent rates for junior doctors and 100% for other doctors could lead to a WTE reduction in the agency workforce of 400 junior doctors and 700 other doctors. The proposal to cap all locum agency rates at 55% above permanent rates would imply a WTE reduction of 1,600 junior doctors and 3,500 other doctors. Some of these staff would be expected to move to substantive/bank roles.

*Financial implications*

**Table 6: Estimated reduction in agency doctor costs (£m) if 100% compliance, and reductions in workforce in line with elasticity**

	Supply elasticity			
	1	1.5	2	3
Junior doctors (150% above); Other doctors (100% above)	£140m £50m	£170m £70m	£200m £80m	£260m £100m
Junior doctors (100% above); Other doctors (75% above)	£320m £120m	£380m £150m	£450m £170m	£570m £220m
Junior doctors (55% above); Other doctors (55% above)	£460m £200m	£540m £250m	£620m £290m	£660m £370m

NB: The higher savings under lower caps /higher elasticities result from shifts / posts going unfilled. Clearly, unless hospitals are over-staffed, these posts will need to be filled through other means or changes made to the service offered.

56. Table 7 provides the best indication of the range of likely savings arising from applying the caps at different levels, as it assumes that current numbers of locum doctors are maintained, whether working as agency staff or switching to bank arrangements or permanent employment. Assuming 100% compliance the higher caps imply a saving of around £100 million per year, while the lowest caps are associated with a saving of around £410 million per year. Under a 'central scenario' of 70% compliance, savings could range from £50 million to £210 million per year respectively. With the caps, this suggests that annual savings could range between £100 million and £410 million, depending on the level of the price caps applied, while savings would drop to between £20 million and £60 million if compliance were as low as 50%. Given the impact of supply elasticities illustrated in Tables 4 and 5, this lower level of compliance seems more likely than it does for nursing staff.

**Table 7: Reduction in agency doctor costs (£), assuming no change in workforce numbers**

	Compliance rates					
	100%	90%	80%	70%	60%	50%
Junior doctors (150% above);	£70m	£70m	£50m	£40m	£20m	£10m
Other doctors (100% above):	£30m	£30m	£20m	£10m	£10m	£0m
<b>Total</b>	<b>£100m</b>	<b>£90m</b>	<b>£80m</b>	<b>£50m</b>	<b>£30m</b>	<b>£20m</b>
Junior doctors (100% above);	£190m	£170m	£140m	£90m	£60m	£30m
Other doctors (75% above):	£70m	£60m	£50m	£30m	£20m	£10m
<b>Total</b>	<b>£260m</b>	<b>£230m</b>	<b>£180m</b>	<b>£130m</b>	<b>£80m</b>	<b>£40m</b>
Junior doctors (55% above);	£290m	£270m	£210m	£150m	£90m	£40m
Other doctors (55% above):	£120m	£110m	£80m	£60m	£40m	£20m
<b>Total</b>	<b>£410m</b>	<b>£370m</b>	<b>£300m</b>	<b>£210m</b>	<b>£120m</b>	<b>£60m</b>

Figures may not sum to total due to rounding.

### Other clinical and non-clinical staff

57. Other agency staff employed by trusts include:

- allied health professionals, such as pharmacists, radiographers and dieticians
- administrative and clerical staff, which includes anyone from receptionists to clinical coders, as well as middle and senior managers.

58. The diversity of this category makes it more difficult to apply single assumptions, such as the level of supply elasticity: pharmacists, for example, have significant outside options in community pharmacy and experienced NHS managers are often sought out by consultancy firms, while clerical and administrative staff have skills that should be transferable to other sectors, but may be better paid in the NHS (at least, outside London and the south east).

59. In the absence of better comparators (particularly given the limited timescale we have had to carry out this analysis), we have chosen to apply a similar approach to that taken for assessing the impact on agency nurses, but noting that its likely limitations mean an even greater margin of error.

#### *Consequences for supply*

60. We have applied the same assumed levels of supply elasticity as for nurses and locum doctors, i.e. 1, 1.5, 2 and 3, to provide a reasonable range that might cover each of the staff types in the 'other staff' category.

61. Table 8 illustrates the potential impact in terms of percentage reductions in agency hours worked under different assumptions of elasticity. The impact is relatively small for all categories of staff at a cap of 100% above AfC, but rises for Allied Health Professionals (AHPs) at a price cap of 55% over AfC. The limitations of our understanding here mean that particular emphasis would need to be placed on the data collection showing the emerging impact, prior to

reducing the cap from 100% to 55% above AfC rates. It has not been possible to find and assess relevant data on the numbers of staff likely to be affected by the cap.

**Table 8: Estimated reduction in agency hours worked**

		Supply elasticity			
		1	1.5	2	3
Cap at 100% above AfC	AHP	2%	3%	4%	6%
	Admin & clerical	1%	2%	2%	3%
	Other	3%	5%	6%	8%
Cap at 75% above AfC	AHP	5%	8%	11%	16%
	Admin & clerical	2%	3%	4%	5%
	Other	7%	11%	14%	19%
Cap at 55% above AfC	AHP	14%	21%	28%	42%
	Admin & clerical	3%	4%	6%	7%
	Other	13%	20%	26%	37%

*Financial implications*

**Table 9: Estimated reduction in agency costs if 100% compliance, and reductions in workforce in line with elasticity**

		Supply elasticity			
		1	1.5	2	3
Cap at 100% above AfC	AHP	£0m	£10m	£10m	£10m
	Admin & clerical	£20m	£30m	£30m	£40m
	Other	£20m	£30m	£30m	£40m
Cap at 75% above AfC	AHP	£10m	£10m	£20m	£20m
	Admin & clerical	£30m	£40m	£50m	£50m
	Other	£40m	£50m	£60m	£70m
Cap at 55% above AfC	AHP	£30m	£30m	£40m	£50m
	Admin & clerical	£50m	£60m	£60m	£70m
	Other	£70m	£80m	£90m	£110m

NB: The higher savings under lower caps/higher elasticities result from shifts/posts going unfilled. Clearly, unless hospitals are over-staffed, these posts will need to be filled through other means or changes made to the service offered.

62. Table 10 provides the best indication of the range of likely savings arising from applying the caps at different levels, as it assumes that current numbers of 'other' temporary staff are maintained, whether working as agency staff or switching to bank arrangements or permanent employment. Assuming 100% compliance with the caps, this suggests that annual savings could range between £30 million and £90 million, depending on the level of the price caps

applied. A 'central scenario' of around 70% compliance would point to savings of between £20 million and £40 million.

**Table 10: Reduction in agency costs, assuming no change in workforce numbers**

		Compliance rates					
		100%	90%	80%	70%	60%	50%
Cap at 100% above AfC	AHP	£0m	£0m	£0m	£0m	£0m	£0m
	Admin & clerical	£20m	£10m	£10m	£10m	£0m	£0m
	Other	£20m	£10m	£10m	£10m	£0m	£0m
	<b>Total</b>	<b>£30m</b>	<b>£30m</b>	<b>£20m</b>	<b>£20m</b>	<b>£10m</b>	<b>£10m</b>
Cap at 75% above AfC	AHP	£10m	£10m	£0m	£0m	£0m	£0m
	Admin & clerical	£20m	£20m	£20m	£10m	£10m	£0m
	Other	£30m	£20m	£20m	£10m	£10m	£0m
	<b>Total</b>	<b>£50m</b>	<b>£50m</b>	<b>£40m</b>	<b>£30m</b>	<b>£20m</b>	<b>£10m</b>
Cap at 55% above AfC	AHP	£10m	£10m	£10m	£10m	£0m	£0m
	Admin & clerical	£30m	£30m	£20m	£10m	£10m	£0m
	Other	£40m	£40m	£30m	£20m	£10m	£10m
	<b>Total</b>	<b>£90m</b>	<b>£80m</b>	<b>£60m</b>	<b>£40m</b>	<b>£30m</b>	<b>£10m</b>

Figures may not sum to total due to rounding.

## Overall potential savings

63. Table 11 sets out the range of potential overall savings. The total savings presented are net savings to the NHS, taking account of potential increases in expenditure on bank and substantive staff.

**Table 11: Annual savings from price caps**

		Compliance rates					
		100%	90%	80%	70%	60%	50%
First ratchet	Medical staff	£210m	£190m	£150m	£110m	£60m	£30m
	Nursing staff	£100m	£90m	£80m	£50m	£30m	£20m
	Other staff	£70m	£70m	£50m	£40m	£20m	£10m
	<b>Total</b>	<b>£390m</b>	<b>£350m</b>	<b>£280m</b>	<b>£200m</b>	<b>£120m</b>	<b>£60m</b>
Second ratchet	Medical staff	£220m	£200m	£160m	£110m	£70m	£30m
	Nursing staff	£260m	£230m	£180m	£130m	£80m	£40m
	Other staff	£80m	£70m	£60m	£40m	£20m	£10m
	<b>Total</b>	<b>£550m</b>	<b>£500m</b>	<b>£400m</b>	<b>£280m</b>	<b>£170m</b>	<b>£80m</b>
Third ratchet	Medical staff	£230m	£200m	£160m	£110m	£70m	£30m
	Nursing staff	£410m	£370m	£300m	£210m	£120m	£60m
	Other staff	£90m	£80m	£60m	£40m	£30m	£10m
	<b>Total</b>	<b>£730m</b>	<b>£650m</b>	<b>£520m</b>	<b>£370m</b>	<b>£220m</b>	<b>£110m</b>

**Notes:**

- First ratchet: 150% above basic for junior doctors, 100% for all other clinical staff, 55% for all non-clinical staff
- Second ratchet: 100% above basic for junior doctors, 75% for all other clinical staff, 55% for all non-clinical staff
- Third ratchet: 55% above for all staff
- Figures may not sum to total due to rounding.

64. On an annual basis, total net savings under the central scenarios are likely to be as follows:

- Under a cap of 100% above AfC/permanent staff rates (150% for junior doctors; 55% for non-clinical staff): £110 million for nursing staff, £50 million for locum doctors, and £400 million for 'other' agency staff, totalling around £200 million.
- Under a cap of 55% above AfC/permanent staff rates: £110 million for nursing staff, £210 million for locum doctors, and £40 million for 'other' agency staff, totalling around £370 million.

65. However, significant caveats apply to the numbers, given the assumptions we have needed to make as a result of data limitations. More widely, there is a very broad range of potential economic consequences, which means that savings could turn out above or below our estimated central case.

## Risks and mitigation

66. There are two broad risks to introducing price caps:

- Price caps may reduce the supply of agency shifts, leading to staff shortages. This could lead to risks to patient safety and clinical quality, and to performance and patient access. This may be experienced more acutely in particular trusts or in particular specialties.
- Lower compliance may reduce the potential financial savings from price caps. Trusts may increase bank rates to attract staff and reduce any potential shortages.

67. These risks will be greater where caps are significantly lower than the existing rates paid. The available evidence, described above, suggests this is more likely to be the case in staff groups and specialties where there are particular shortages, eg junior doctors, A&E nurses, ICU/NICU nurses, AHPs. It is also more likely to be the case in trusts that face particular reputational issues or have a relatively small labour market (eg in rural areas), and therefore pay high agency rates to attract staff.

68. The proposed inclusion of bank staff within the price cap seeks to mitigate the risk that trusts increase bank rates and negate any financial savings. Bank rates are currently relatively low, compared to agency rates. Therefore, this risks anchoring rates upwards if they are set high. If rates are set low, it reduces trusts flexibility to respond to any reduced supply in agency shifts. However, price caps on bank staff may be necessary to ensure that the problem of high agency rates is not simply transferred to the bank market. We therefore propose to monitor closely the impact on bank shifts as well as agency.
69. There is a further risk that costs may increase overall, if trusts respond to price caps by significantly increasing the wage rates of all staff, including substantive staff, potentially through increased use of overtime. This will also be monitored.
70. To mitigate risks to patient safety, we propose that price caps will initially be set at rates around the median charged. This is around 150% above basic for junior doctors, 100% above AfC/basic for all other clinical staff (including other doctors and all nursing staff), and 55% above AfC for all non-clinical staff. This includes all allowances for on-costs. This would be reduced in two stages, so that by April 2016, the cap on all staff is at basic/AfC plus 55%. This will be subject to stringent monitoring, to ensure there are no adverse effects for particular trusts or specialties.
71. In addition, to mitigate risks to patient safety, it is proposed to use 'break glass' clauses, whereby trusts are able to override the price caps in exceptional circumstances and where there are risks to patient safety and clinical quality. All overrides will be reported and monitored.
72. By their nature, 'break glass' clauses can only be used on an exceptional basis. Therefore, they are unlikely to significantly mitigate the second risk, that waiting times increase. This risk therefore remains under the proposed option.

## Conclusion

73. The analysis of risks, benefits and costs associated with these proposals involves making complex trade-offs between risks that are difficult to assess because of uncertainties about the likely response of trusts and agency staff, in addition to other data limitations.
74. The above analysis suggests that national level price caps may play a role in reducing the reliance and expenditure on agency and locum staff. They come with significant risks to patient safety and performance, which need to be managed, and risks that savings will be limited. The preferred option of introducing initially higher price caps and then reducing these by April 2016, alongside 'break glass' clauses, mitigates some of these risks. In addition, commissioners – both CCGs and NHS England for nationally-commissioned services – have a vital role to play in ensuring the continuity and quality of

services, and in having contingency plans in place to help manage any risks that emerge.

75. However, despite these mitigants, some risks will remain. These risks are likely to be broadly greater for locum doctors than for other staff, and more problematic for specialties for which there is a shortage of staff, in geographically isolated trusts, and in trusts with reputational difficulties.
76. These risks, however, need to be weighed against a counterfactual where larger financial deficits and ever greater reliance on agency staff have an increasingly negative impact on patient safety and access. Clinical leads across Monitor, TDA, CQC and NHS England have advised that the balance of clinical risks supports taking action to tackle agency costs now and bring agency staff back into the regular workforce, including through the use of price caps, provided that:
- the price caps are introduced on a graduated basis (as is proposed)
  - trusts are able to use the 'break-glass' clauses in response to significant risks to the clinical safety of patient services
  - there is very close and careful monitoring of any emerging clinical risks following implementation
  - action is taken rapidly in response to those risks crystallising, including if necessary adjusting the price caps.

## **Equalities impact**

77. The public sector equality duty requires, among other things, analysis and consideration of the impact of policies on equality as part of decision-making, in relation to the following protected characteristics:
- age
  - disability
  - gender reassignment
  - marriage and civil partnership
  - race (including ethnic or national origins, colour or nationality)
  - religion or belief (including lack of belief)
  - sex
  - sexual orientation.



78. In line with these requirements, Monitor has made an initial assessment of the impacts on the protected characteristics of introducing price caps. Monitor looked, in particular, for impacts that disproportionately affect patient groups with the protected characteristics, ie any positive or negative impact that was materially different from the impact on those who do not share the characteristic in question.
79. Our initial consideration is that any such impact is likely to be both small and outweighed by the wider considerations outlined above. However, it will be important to monitor the equalities impact of the proposals following implementation, alongside clinical and financial measures, so that appropriate action can be taken if any significant adverse impact should arise.
80. As part of the consultation process on the proposed arrangements and this impact assessment, we are seeking respondents' views on potential impacts on the protected characteristics, and will include these in our consideration of next steps and any monitoring process.

## **Annex 1: Methodology for calculating cost savings and agency hours worked**

1. Using a sample of actual shift level data for approximately one million agency staff in 2014 and 2015 from NHS Professionals, we have estimated the impact of the proposed agency caps on staffing levels and costs to the sector. The method and assumptions are set out below.
2. We have assumed that the number of hours agency staff are willing to work is dependent on what they are paid, and therefore reducing the rate of pay for agency work will lead to a reduction in the number of hours they are willing to work.
3. Using individual staff shift information, we have built a bottom-up estimate of the whole-system saving and changes in staffing level which result from the proposed caps.
4. First, given the number of hours worked per shift for a given pay rate, we have estimated the change in hours staff are likely to work given the reduction.
5. Using proposed caps for agency work, the type of shift (weekday, weeknight, Saturday and Sunday/Bank Holiday) and the grade, we have calculated the change in wage rate needed to meet the cap for each shift. For each shift that has been paid at a rate lower than the cap, we assume the rate is not affected by the cap and therefore there is no change in the wage rate.
6. With this change in pay, we have estimated the resulting change in the number of hours we would expect a nurse to work given different assumptions on how the number of hours worked changes with pay. We have assumed that staff members will react with the same percentage change in hours worked for a percentage change in wage irrespective of their grade, shift type or rate of pay.
7. For example, if we assume that a percentage change in the wage rate translates to an equal change in the numbers of hours worked (an elasticity of one), an agency worker currently being paid double the proposed cap would receive a 50% reduction in their wage. With the cap imposed, we assume the worker will be willing to work 50% fewer hours per shift or 50% of the number of shifts they would have done under their previous rate.
8. We then calculate the total change in staffing hours resulting from the caps and (direct) financial savings for the sample. We sum the difference in the number of hours of work supplied before and after the proposed caps at a shift level to give the overall change in staff given the caps. For each shift, we calculate the difference between the cost of the number of hours of labour supplied prior to implementing the caps and the cost of nursing hours supplied at the wage rate

for each shift following the introduction of the proposed caps. We sum these to give the overall savings.

9. Finally, we scale the impact to be representative of the nursing agency market in England. Using foundation trust and trust accounting data to give the total value for nursing agency spend for nursing Grade 5 and above we calculate the percentage of total agency shifts our sample represents. We assume that the sample of agency shifts is representative of all agency shifts across England for a year in terms of staff grade, shift types, pay rates, etc. Given the percentage of shifts represented in the sample, we scale up financial savings and staffing hours to give representative yearly figures for all NHS trusts in England. For each assumed reduction in staffing, we calculate the saving given different compliance levels with the proposed caps.
10. Finally, we assume an evenly distributed 'non-compliance' with the capped rate for those staff who had wages higher than the cap. x% of all of those with rates higher than the cap remain on those rates and everyone else complies. Non-compliance is only an issue for those shifts which do not currently meet the caps. We therefore reduce the total savings from the 100% compliance rates by the percentage of non-compliance.

#### *Rationale for the chosen labour market elasticities*

11. The demand for clinical staff is largely inelastic and exogenous, at least in the short term, because it is related to regulatory requirements around quality and safety, set by external bodies such as the CQC and National Institute for Health and Care Excellence (NICE). Over time, of course, trusts can flex this through capital substitution for labour, skills mix changes and other productivity gains, but these considerations will not apply in the relatively short timeframes which we consider in this paper.
12. In practice, this means that we would expect trusts to prioritise clinical safety over financial concerns where the two clash – to be clear, good financial performance and good performance on clinical safety and quality tend in general to be aligned; but there are likely to be cases in the very short run where they are not, eg when it is necessary to replace a key member of staff who has called in sick shortly before a shift is about to commence.
13. Conversely, the supply of clinical staff is likely to be elastic – and much more so for agency than for permanent staff. In layperson's terms, this means that, particularly for agency workers, the supply of clinical staff is likely to respond significantly to changes in pay (and potentially working conditions).

#### *Elasticity of supply for agency nursing staff*

14. The literature on the elasticity of supply of clinical staff is quite limited, with many studies being based on experience in the United States and dating back

to the 1960s and 1970s, when the labour market for nurses was quite different.<sup>13</sup> The closest example to the markets under discussion is a recent study by the Institute for Fiscal Studies (IFS) into the short run elasticity of supply of NHS nurses in permanent employment. This found a relatively low elasticity of supply in geographical areas where there are not many alternative sources of employment for nurses ('outside options'), but a much higher elasticity where outside options were more attractive, as in London. However:

- the study was based on small samples, especially outside London
  - the study did not measure elasticities for absolute wages, but rather for relative wages (ie relative to outside options) and
  - the estimates are likely to be underestimates because they group local markets with higher elasticities together into a single market, which will naturally have lower elasticities.
15. These limitations are exacerbated by the significant expected differences in elasticities between permanent and temporary staff. Supply of agency staff, by definition, will be more elastic than that for permanent staff because it is a secondary market. Moreover, the study's findings conflict significantly with the experiences of both employing trusts and the agency frameworks with which we have discussed the proposed approach to price caps. In particular:
- They have told us that central London trusts often have fewer difficulties in finding agency staff than trusts elsewhere. This may reflect the relatively larger pool of potential staff in London, given that many hospitals and other health and care facilities (eg care homes) are located within relatively close reach of each other, with good public transport links. It may also reflect the relative prestige of many London teaching hospitals, which may be a factor in attracting staff, even on a temporary basis.
16. This view of the London agency market is supported by the data on agency wages provided to us by the main agency frameworks, which suggest that agency nurses in London are paid no more than agency nurses in other parts of the country, despite higher AfC pay rates and higher costs of living.
- They have also suggested that agency nursing markets elsewhere in the country often reflect similar economies of density: in general, trusts in urban locations with good transport links (perhaps to several major population centres along a small stretch of motorway) tend to find recruitment of

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<sup>13</sup> See, eg Shields (2004) *Addressing Nurse Shortages: What Can Policy Makers Learn from the Econometric Evidence on Nurse Labour Supply?*

temporary, including agency, staff more straightforward than those in less connected geographies.

- At its extreme, those trusts in the most isolated geographies often struggle the most to recruit agency staff, who would have to travel significant distances to work in those locations and tend to be reluctant to do so (this is in contrast perhaps to locum doctors, who tend to be offered significantly higher pay rates, which are more likely to outweigh the costs of significant travel). This perhaps works in contrast to permanent staff, who, as the IFS work suggests, may have fewer outside options and so are less likely to leave geographically isolated trusts.
  - Those trusts with 'troubled' reputations (eg because of well-publicised clinical or financial problems) struggle even more to fill both permanent and temporary vacancies. One of the reasons that the agency bill has risen so much in recent years is that such trusts have needed to pay very high wages, relative to permanent staff, in order to successfully compete for agency staff.
17. Moreover, agencies have told us that many NHS agency workers choose that form of work because it offers more flexibility than permanent or even 'bank' NHS work, e.g. around shift patterns, more flexible hours, and even receiving pay immediately or weekly rather than monthly. The former helps staff fit their work around caring responsibilities and/or other non-work commitments. Some staff also choose to work overtime via agency because it allows them to work in less pressured/stressful parts of the hospital or enables them to develop new skills, eg ITU or A&E nurses want to work overtime in other areas of a hospital.
18. It is therefore difficult to rely on the IFS study for estimates of supply elasticities for the purposes of this impact assessment.
19. We have therefore modelled a range of possible impacts on agency nursing supply and cost savings based on four estimates of the supply elasticity, set at 1.0, 1.5, 2 and 3. This is a major simplification – and therefore limitation – of our estimates – while the supply elasticity is very unlikely to be less than 1, it is possible that it could be higher than 3 in some geographical or specialty markets.

#### *Elasticities for locum doctors*

20. We have applied the same assumed levels of supply elasticity as for nurses (ie 1, 1.5, 2 and 3). However, greater weight needs to be given to the higher elasticity numbers, to reflect the likelihood that the elasticity for medical locums is higher than that for agency nurses:
- agency fees are significantly higher for medical locums

- clinicians and framework owners have told us that doctors tend to be more willing to travel longer distances to work as locums
- while there is an international market for nurses, the international outside options for doctors tend to be even greater
- there are also significant domestic outside options, not only in the private health sector but in a range of fields related to medicine (eg management consultancies who work with health providers).

21. As a result, a supply elasticity of 3 may well be closer to a notional 'central case' than it would be for nursing and other staff.

*Elasticities for 'other' agency staff*

22. The 'other' agency staff category includes a wide range of occupations, from allied health professionals (AHPs), such as pharmacists, dieticians and radiographers, to clerical support workers and middle and senior management. It is therefore very difficult to apply a single supply elasticity to this group; time limitations in preparing this impact assessment mean that we have not been able to assess individual elasticities for each professional group.

23. As a result, we have used the same range of elasticities as for nursing and medical locum staff, ie 1, 1.5, 2 and 3, in order to provide a range of possible staffing impacts that could result from the application of price caps. Given the simplification this represents, however, we have advised that the resulting estimates should be used only indicatively, with more weighting put on any intelligence that can be gleaned from framework owners, together with the information from early monitoring following implementation of the policy.

## **Annex 2: Source data**

### **Nursing**

The source data is a sample of wage rates paid for agency shifts over a one-year period. The data consisted of over 800,000 individual agency shifts, giving the number of hours worked, type of shift and qualification of the staff on that shift, along with their pay.

The Monitor Data analytics team has collapsed the dataset to amalgamate shifts into groups with the same qualification, hours and wage rate

The scaling factor applied to the dataset is based on known agency spend for England at band 5 and above, which was £988 million in 2014/15. Agency spend in this dataset for band 5 and above is £111 million (11% of the total agency spend); we therefore assume a scaling factor of 8.9 to the England totals.

### **Doctors**

The source data are a sample of wage rates paid for agency shifts over a one-year period. The data consisted of over 44,000 individual agency shifts, giving the number of hours worked, type of shift and qualification of the staff on that shift, along with their pay.

The Monitor Data analytics team has collapsed the dataset to amalgamate shifts into groups with the same qualification, hours and wage rate

The scaling factor applied to the dataset is based on known agency spend for doctors in England, which was £1,199 million in 2014/15. Agency spend in this dataset was £24.5 million (2.04% of the total agency spend); we therefore assume a scaling factor of 49 to the England totals.

### **Other staff**

The source data are a sample of wage rates paid for agency shifts over a one-year period. The data consisted of individual agency shifts, giving the number of hours worked, type of shift and qualification of the staff on that shift along with their pay.

The Monitor Data analytics team has collapsed the dataset to amalgamate shifts into groups with the same qualification, hours and wage rate

The scaling factor applied to the dataset is based on known agency spend for 'other' staff of £674 million in 2014/15. Agency spend in this dataset for band 5 and above was £84million (12% of the total agency spend); we therefore assume a scaling factor of 8 to the England total.

## Annex 3: Monitor's statutory duties

Under Section 69(5) of the 2012 Act, Monitor's impact assessment must include an explanation of how the discharge of Monitor's duties under Sections 62 and 66 would be secured by implementation of Monitor's proposals. This annex sets out each of the duties with an explanation of:

- how the implementation of the proposals would secure the discharge of that duty and
- where appropriate, how Monitor has complied with the duty in developing and making these proposals.

Monitor's general statutory duties are set out in sections 62 and 66 of the 2012 Act; the following subsections address each provision in turn.

### Section 62 of the 2012 Act

#### **Section 62(1): protect and promote the interests of patients**

This duty requires Monitor to promote "provision of health care services which – a. is economic, efficient and effective, and b. maintains or improves the quality of the services."

Consideration of the interests of patients is fundamental to the proposals to set price caps for agency staff working in the NHS. These proposals are part of a range of actions being taken by national bodies to support providers and commissioners to deliver savings, against a backdrop of a provider deficit in the first quarter of 2015/16 of £930 million. Without intervention, larger financial deficits and ever greater reliance on agency staff may have an increasingly negative impact on patient safety and access. Moreover, by encouraging NHS staff to switch from agency to permanent and / or bank staffing arrangements as a result of these proposals, the proportion of permanent staff in the NHS would be increased – this has been linked to the provision of higher quality services.

#### **Section 62(1)(a): economic, efficient and effective provision of healthcare services**

The proposals for agency price caps are directly aimed at promoting the provision of economic, efficient and effective care: by reducing the cost of employing agency staff, total staff costs would be reduced, representing a significant efficiency gain.

#### **Section 62(1)(b): maintaining or improving quality of healthcare services**

The proposed price caps have been developed with, and are supported by, clinical leaders in Monitor, TDA, Care Quality Commission (CQC) and NHS England. The consultation is a further key part of the process of obtaining assurance on the risks and mitigants of the proposals. In moving to implementation of the policy, we will



ensure that providers understand that the safety and quality of services remains the highest priority, with 'break glass' clauses available to allow them to pay above-cap rates where clinical safety is threatened.

### **Section 62(2): have regard to likely future demand for healthcare services**

The judgement that the balance of benefits and risks supports the introduction of price caps is based in large part on the concern that the future provision of NHS services would be at risk if the current sector deficit is not addressed rapidly. Therefore, the policy has specific regard to future demand for healthcare services.

### **Section 62(3): competition and co-operation**

Over the last three years, while Trusts have managed to recruit some additional nurses, demand has continued to grow, resulting in supply pressures that had not been anticipated in NHS training forecasts. The power this created for agencies supplying temporary staff has allowed them to increase charges. These proposals directly aim to address this balance.

### **Section 62(7): patient & public involvement**

As part of the consultation process, patient representatives are being invited to offer feedback.

### **Section 62(4), (5) and (6): integration and co-operation**

These proposals do not have any significant effect on integration and co-operation.

### **Section 62(8): clinical and public health advice**

*(8) Monitor must obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in-*

*a. the prevention, diagnosis or treatment of illness (within the meaning of the National Health Service Act 2006), and*

*b. the protection or improvement of public health.*

In developing the proposals, the clinical team at Monitor and TDA have worked closely with colleagues at CQC and NHS England and other experts. In particular:

- The proposals have been approved by the combined clinical team across the ALBs.
- Monitor's Clinical Advisory Forum (CAF) has also been consulted as the proposals for price caps have been developed. This panel is comprised of Nurse and Clinical Directors from a range of NHS providers. As well as formal discussion, there has been ongoing consultation with individual Medical and Nurse Directors to provide assurance on the detail of policy-making.

The views of a number of bodies with relevant professional expertise were also sought as part of stakeholder engagement.

### **Section 62(9): Secretary of State's duty to promote a comprehensive health service**

The proposals in the consultation notice are consistent with the discharge by the Secretary of State of his duty to continue the promotion of a comprehensive health service, in particular, the proposals:

- cover the whole range of NHS services, providers and settings, including acute and community services, and both nationally and locally determined prices. The only exceptions are areas where the legislation specifically provides an exception (e.g. public health services) and ambulance services, for which we are consulting on whether it might be possible to extend the arrangements in due course.
- cover mental health services as well as physical health services.

### **Section 62(10): non-discrimination between providers**

The proposals apply only to public providers of NHS healthcare services, as Monitor and the TDA do not have powers to cap the prices paid for staff by non-public sector organisations. However, we do not anticipate this creating an unfair advantage for one set of providers over another: providers will continue to be paid the same tariffs for the same types of NHS work, and it is for individual providers to determine how best to deliver high quality services within those tariff prices – as prudential regulators of NHS Trusts and Foundation Trusts, the TDA and Monitor are supporting those organisations to do this through the use of price caps for agency staff.

The proposed rules on price caps would apply to:

- all NHS trusts
- NHS foundation trusts receiving interim support from the Department of Health (DH)
- NHS foundation trusts in breach of their licence for financial reasons

All other trusts would be very strongly encouraged to comply with price caps. The new value for money risk assessment trigger means that Monitor will be explicitly taking into account trusts' inefficient or uneconomic spending practices, including in relation to agency spending, when assessing governance. In assessing value for money, Monitor is likely to look at the extent to which trusts have followed good practice.

All trusts (even foundation trusts not in breach of their licence conditions including foundation trusts in receipt of interim support from DH) would be required to report on shift-level detail when they exceed the price caps and the reason for doing so in their reporting returns.

### **Section 66 of the 2012 Act**

Section 66 requires that Monitor must have regard to various matters listed in that section, when exercising its functions. The first matter listed is safety, and section 66 makes it clear that when having regard to the other matters listed below, Monitor should do so only so far as is consistent with maintaining the safety of patients.

#### **Section 66(1): safety of people who use healthcare services**

The impact assessment has examined the proposals' impact on patients. Without mitigation, there is a risk that the policy may have a negative effect on patient safety. However, this is intended to be mitigated by a range of actions, including gradually reducing the level of price caps and incorporating break glass clauses.

Monitor, TDA, NHS England and CQC would monitor data on the impact of the price caps on workforce, service performance and service quality to ensure any safety concerns are appropriately managed.

#### **Section 66(2)(a): continuous improvement in quality**

The proposals aim to reduce expenditure on costly agency staff, while preventing costs from rising significantly in other areas. Without intervention, larger financial deficits and ever greater reliance on agency staff may have an increasingly negative impact on patient safety and access. Clinical leads across Monitor, the TDA, CQC and NHS England have advised that the balance of clinical risks supports taking action to tackle agency costs now, including through the use of price caps. In addition, reduced reliance on agency staffing is associated with improved quality of services.

#### **Section 66(2)(b), (c) and (d): duties of commissioners – ensuring fair access and best use of resources**

The proposals recognise that commissioners have limited budgets, while also having a duty to secure services for their local population. They aim to reduce expenditure on costly agency staff, while preventing costs from rising significantly in other areas.

#### **Section 66(2)(e): desirability of co-operation to improve quality of services**

Reduced reliance on agency staffing is associated with improved quality of services. The proposals are not considered to affect the desirability of co-operation.

**Section 66(2)(f) and (g): research and training**

The proposals do not include any specific changes to research, education and training.

**Section 66(2)(h): Secretary of State's guidance to Monitor on a document under section 13E of the NHS Act 2006 (quality outcomes framework)**

The Secretary of State has not published any guidance under this provision.