Monitor
Making the health sector work for patients

tda Trust Development Authority
Quality. Delivery. Sustainability.

Price caps for agency staff: summary of consultation responses

November 2015

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Contents

1. Introduction

Monitor and the NHS Trust Development Authority (TDA) recognise that, used appropriately, agency staff can be an important resource in allowing NHS providers to respond to unforeseen peaks in demand. However, it is clear that agency expenditure is costing the NHS increasingly significant sums of money. NHS provider spending on agency staff has been rising year on year and is a significant driver of the recent deterioration in NHS provider finances. Over-reliance on agency staff can also compound and embed quality problems.

Monitor and TDA have been engaging with the sector since the summer on the need to work together to manage agency staffing in the NHS, to ensure that NHS resources are used in a way that brings maximum benefit to patients.

When Monitor and TDA engaged with the sector in August on a proposed set of rules for agency expenditure, a large number of trusts signalled that moving as quickly as possible to cap the rates paid for agency workers would help them to reduce agency expenditure to a more affordable rate.

Taking this feedback and further engagement into account, on 15 October Monitor and TDA published a public consultation on proposed rules on price caps for agency staff and an associated impact assessment. The consultation ran from 15 October to 13 November 2015. We received 3,404 responses to the consultation, the majority from doctors. We received 108 responses from NHS trusts and NHS foundation trusts. Thank you to everyone who took the time to respond to the consultation.

This document:

- outlines the proposals we set out in the consultation
- summarises responses to the consultation
- describes our response and rationale for the approach we are adopting.

2. Consultation

The consultation proposed rules on price caps for agency staff and bank staff procured by trusts. The scope of the consultation was whether, when and how Monitor and TDA should implement the proposed rules.

The public consultation proposed:

- to implement caps on the total amount trusts can pay per hour for an agency worker
- that hourly caps would apply to all staff groups employed by NHS trusts and NHS foundation trusts: nursing, medical, all other clinical and other non-clinical staff

- that hourly caps would apply to all agency staff
- that hourly caps would also apply to bank staff
- to implement caps on a step-by-step basis so that by 1 April 2016 trusts would not be able to pay more than 55% above national pay rates for an agency worker or bank worker
- that the caps would not initially apply to staff employed by ambulance trusts
- that the price caps would include mechanisms to allow the rules to be overridden in the interests of patient safety.

The consultation asked 13 questions on the following areas of the proposals:

- concept of the proposed price caps
- design of the proposed price caps
- implementation of the proposed price caps
- impacts of the proposed price caps.

3. Summary of consultation responses and the approach we are adopting

Of the 3,404 responses to the consultation, a high level summary of responses is:

- 108 NHS trusts and foundation trusts (43% of NHS providers) responded, with over 90% in favour of the caps in principle
- 60% of respondents were doctors, of whom over 80% were opposed to the proposed price caps; nurses made up 11% of respondents, of whom over 80% were also opposed
- for all other respondent groups, a majority disagreed with the proposed price caps.

Table 1: Breakdown of responses to the consultation

	Number	% of respondents
Trusts and foundation trusts	108	3%
Doctors	2031	60%
Nurses	371	11%
Non-clinical	107	3%
Agencies	80	2%
Other	707	21%
Overall	3404	100%

During the consultation period we also engaged face to face with a range of stakeholders including framework managers, unions, and staff representative groups and national partners. We hosted a webinar and have held several engagement events with NHS trusts and foundation trusts.

3.1. Our approach

In deciding whether, when and how to implement price caps, Monitor and TDA have taken all responses to the consultation into consideration, as well as feedback from wider engagement throughout the consultation period.

Based on this, we have decided to implement price caps for agency workers, effective from 23 November 2015. The rules can be found here.

As outlined above, the recent increases in agency expenditure across the provider sector are placing a major strain on the NHS. We are implementing price caps as one of a number of national initiatives to address this. We recognise the challenges of implementing these caps, but consider that they are necessary measures to help support the overall sustainability of the NHS.

The purpose of these measures is not to prevent all agency usage: hospitals will always require ad hoc resource to meet variations in demand. Our intention is to make sure that staffing costs can be managed appropriately at a time of considerable financial and operational pressure across the whole NHS, as well as discourage over-reliance on agency staff.

Some aspects of the proposed rules have been adjusted in response to feedback on the price caps. The changes from the proposals in the consultation are:

- **The exclusion of bank from the caps**. This reflects feedback from some trusts, unions and representative bodies that this would help trusts to manage the impact of price caps on their workforce. However, it is expected that trusts will maintain their bank rates at appropriate levels. We will consider introducing price caps on bank workers if bank rates rise significantly.

- **Implement regular and detailed monitoring**. We are therefore introducing a weekly collection of quality, safety, workforce and compliance metrics. We have listened to trust feedback and have sought to balance the need for sufficiently detailed monitoring to mitigate risk with ensuring the reporting burden on trusts is kept manageable

- **Track equality impact.** We received feedback from the consultation on the importance of closely monitoring the impact on equality. We will track the impact on agency staff based on age, ethnicity, sex and disability to assess whether there is any disproportionate impact on these groups.

The following design principles are unchanged from the proposed rules set out in the consultation document:

- the hourly caps apply to all staff groups employed by NHS trusts and NHS foundation trusts: nursing, medical, all other clinical and other non-clinical staff
- the hourly caps apply to all agency staff
- implement caps on a step-by-step basis so that by 1 April 2016 trusts will not be able to pay more than 55% above national pay rates for an agency worker
- the caps will not initially apply to staff employed by ambulance trusts
- retain 'break glass clauses' to allow trusts to override the caps on patient safety grounds

The price cap rules are subject to monitoring from implementation, and rules may be subject to further review based on the results of this monitoring.

3.2. Thematic summary of consultation responses

This section sets out a summary of responses to the consultation by theme along with a description of and rationale for the approach we are adopting. See the annex for a summary of responses to each individual question and our response.

Support trusts to develop their workforce and reduce reliance on agency

The majority of trusts welcomed the introduction of price caps as a valuable tool to help them reduce reliance on agency staff and encourage a shift back to substantive and bank working, particularly in the longer term. In particular, they welcomed a consistent national approach.

Some trusts said they anticipated significant local savings from successful introduction of price caps and were pleased that it would lead to reduction in some of the rates charged for agency work.

This theme was also supported by some workers and agencies, despite the majority being opposed to the caps. Some considered that current agency rates were excessive and can lead to a sense of unfairness among substantive and bank staff on wards.

Impact on supply of staff

Many respondents, particularly doctors, indicated that those working agency shifts might decrease their hours or stop working agency shifts if the price caps were implemented. Respondents reported a risk that price caps could, as a result, lead to a significant staffing shortage in the NHS. Respondents suggested the greatest supply risk would likely be for hard-to-fill-shifts, such as less attractive geographies or specialties where there are national or regional shortages.

Respondents highlighted that the following issues could contribute to the risk to supply of staff:

- shifts might no longer be lucrative enough to attract workers
- by not including travel/accommodation/subsistence costs in the caps, it could mean agency work was no longer seen as financially attractive
- lower pay could attract lower quality staff
- NHS staff might leave England for more competitive remuneration elsewhere in the UK or overseas or in another sector

Trusts told us they want the tools to enable them to decrease continuous and heavy reliance on agency staff. They have told us they want to increase the proportion of their own staff working in their organisations. The price caps aim to support trusts when negotiating with agencies and encourage a move by staff back to permanent and bank working. This will enable trusts to manage their workforce in a more sustainable way and reduce their reliance on temporary staffing options.

However, Monitor and TDA are aware that there are risks as well as benefits to implementing price caps. We are taking measures to minimise these risks:

- We will implement the price caps on a step-by-step basis, giving the sector and the market time to adjust.
- We are excluding bank from the price caps, allowing trusts the flexibility to manage the impact of the price caps on their workforce.
- We will implement monitoring to oversee the impact of the price caps on patient safety, service performance, and the impact on agency, bank and substantive workforces – and we will highlight to trusts their primary responsibility for this.
- Monitor and TDA will review the impact on the sector and take a decision ahead of each ratchet whether it is safe to reduce the price caps further.

We expect trusts to use the price caps to bring a significant reduction in agency spend but we expect trusts to be sensible and use the override mechanism appropriately if there are exceptional patient safety grounds.

Timing

The phased approach to implementing price caps was viewed favourably. However, the majority of respondents viewed the timescale as too fast. They indicated that the timescale could heighten the risk of a supply issue with staff and therefore heighten risk to patient care. Responses also suggested that the timeline might result in high

levels of non-compliance at the outset. Some respondents noted that implementation close to the winter period may increase risk to patient care.

We recognise that the timeline for implementation is stretching, requiring a significant reduction in current rates paid within six months. We have been engaging with the sector on the design of agency rules since August 2015 and we have been continually pressed by a large number of providers to take urgent national measures to cap the rates paid for agency staff to encourage workers back into substantive and bank roles as soon as possible.

The price caps will be subject to monitoring from the date of implementation. The rules may be subject to further review based on the results of the monitoring.

Level of the price caps

The response of trusts on the level of the price caps was mixed. Some trusts told us the caps were too high, some considered them appropriate and others told us the caps were too low. The majority of other respondents suggested the caps were too low. Of trusts that responded, 43% agreed with the 55% cap.

Many trusts have told us that rates currently paid for agency staff are unaffordable and unsustainable, and that they would like to see agency workers paid more in line with substantive workers. By 1 April 2016 it is planned that trusts will not be able to pay more than 55% above national pay rates for an agency worker, and that this will mean that an agency worker should not be rewarded more than an equivalent substantive NHS worker. However, we will continue to monitor the implementation of the price caps with a view to reducing the caps further if supported by evidence from ongoing monitoring.

The impact of the price caps will be monitored through our monitoring and reporting processes and a decision taken at each proposed stage whether it is safe to ratchet down the price caps along the trajectory set out in the rules. This includes any decision to reduce the price caps below the 55% uplift, planned for 1 April 2016.

We are aware that in some cases the price caps will be lower than rates in existing framework agreement rates. This will particularly be the case by 1 April 2016. We have been working with framework managers and are encouraged by their willingness to enable trusts to become compliant with the price cap rules. Please see the Section 7 of the rules for further guidance on how the price caps interact with frameworks.

Care quality and patient safety

A large number of respondents suggested that there was a high risk of price caps having an adverse impact on patient safety and care, as a result of a reduced ability to staff services.

We recognise these risks. However, the financial impact of doing nothing, and the increased reliance on agency staff, could present a similar or even greater risk to patient safety and access. The initial price caps would be around the median of rates currently paid and this is intended to allow time for the sector to adjust to the new rules. Trusts have asked for price caps to help them get a grip on agency expenditure and it is trusts' responsibility to manage their workforce safely. Trusts have primary responsibility for patient safety locally and the 'break glass' clauses are intended to allow trusts to override the price caps if there are exceptional patient safety grounds.

Monitor and TDA will work alongside the sector to monitor the impact of the price caps, which, by ratcheting down, will be implemented on a step by step basis.

Wider causes of workforce issues

Some respondents were concerned that the policy would not address underlying supply issues for substantive staff in the NHS.

Monitor and NHS TDA intend the price caps and other agency rules to be a positive helpful response to some of the staffing challenges. The proposed price caps are intended to work alongside the workforce programmes overseen by the Chief Nursing Officer (CNO) and Health Education England (HEE) to increase retention, training and recruitment of NHS staff.

Monitor and NHS TDA will also continue to work with trusts to better understand their approach to managing agency staffing, to benchmark trusts against best practice and support them to improve workforce management, including workforce planning, rota management and retention of substantive staff. Please contact agencyprojectsupport@monitor.gov.uk or TDA.workforce@nhs.net for more information on support available.

Thank you to everyone who took the time to respond to the consultation.

Annex: Responses by question

1) Support for the introduction of price caps

The majority of trusts (92%) supported the introduction of the caps in principle, indicating they would be important tools to limit agency expenditure.

The majority of doctors (88%), nurses (88%), other clinical staff (82%), non-clinical staff (55%) and agencies (65%) disagreed with the introduction of price caps. A representative body of agencies also disagreed with the introduction of price caps. The points most frequently cited across these groups were:

- Price caps could lead to a reduction in the supply of staff, particularly medical staff. Workers may take on fewer shifts, pursue work outside England or change career. Responses from trusts were mixed in terms of whether workers would continue to take extra shifts at the reduced rates. One agency surveyed their workers who reported a planned decrease in shifts by 50% to 75%. Some respondents were concerned that the price caps could discourage foreign workers to move to the UK to work.
- The proposals set out a challenging timetable, given winter pressures and the difficulty in making changes to workforce arrangements in a relatively short timeframe.
- Price caps could negatively impact quality of care due to shortages of staff.
- The caps do not wholly address underlying supply issues in the NHS.
- Capping agency workers' pay may be unfair, given market forces and that agency workers may take on a level of risk when providing temporary workforce supply.

We are aware of the risk of a reduction in the supply of staff, and that this risk might be greater for certain staffing groups than others. However, the financial impact of doing nothing, and the increased reliance on agency staff, could present a similar or even greater risk to patient safety and access.

Trusts have told us they want the levers to change their continuous and heavy reliance on agency staff. They have told us they want the tools to rebalance the attractiveness of agency relative to bank working, and that they want to increase the proportion of their own staff working in their organisations. We are implementing price caps to support them to achieve these objectives.

The price caps will be 'ratcheted down' to allow time for the sector to adjust to the new arrangements. Price caps will be accompanied by a national monitoring approach to oversee implementation and monitor the impacts of the price caps.

Monitor and TDA will monitor trusts' compliance with the price caps and we will seek to work with trusts and offer support, where possible.

The price caps are designed to complement other national initiatives to ensure that the NHS has access to the workforce it needs, such as national strategies to increase the supply NHS staff.

2) Proposed design of the price caps

A majority of responding doctors (95%), nurses (91%), other clinical staff (87%), non-clinical staff (75%) and agencies (91%) disagreed with the proposed design of the price caps. Members of all groups cited the issues noted in the thematic summary in Section 3.2.

Some individuals, agencies, unions and a framework manager have also suggested that the caps should be set on worker pay or agency fee (with the majority suggesting a cap on agency fee), not on total staff cost.

53% of trusts agreed with the proposed design of the caps.

The intention of agency price caps is to reduce the reliance on, and total cost to providers of, agency staff. In some instances, high costs are due to high agency fees, while in others they are due to high worker pay. Therefore, the caps will be set on the overall charge that a trust can pay.

In addition, some respondents were concerned that the price caps would not be compliant with the Agency Workers Regulation (AWR) guidelines, which give temporary agency workers the same basic rights, after 12 weeks in the same assignment, as those on permanent contracts of employment in a comparable role.

The proposed caps will in most cases exceed the remuneration to which qualifying staff are entitled under AWR. Nevertheless, trusts will need to be aware of their responsibilities under AWR, and consider whether long-term reliance on agency staff is appropriate and sustainable within the price caps.

3) Inclusion of bank staff in the price caps

The majority of doctors (83%), nurses (77%), other clinical staff (68%) and non-clinical staff (42%) disagreed with including bank staff in the price caps. Agencies were broadly split between including and not including bank staff. Framework managers agreed that bank staff should be included.

The majority of trusts (65%) who responded to the consultation agree with inclusion of bank staff in the price caps. However, wider engagement with trusts, unions and other representative bodies during the consultation period showed less support. We heard strong concerns that inclusion of bank in the price caps could reduce incentive for agency staff to move from agency to bank and could heighten the risk of workers withdrawing from the market.

Bank will not be included in the caps to give trusts flexibility to manage the impact of price caps on their workforce and encourage a shift from agency to bank working. However, it is expected that trusts will maintain their bank rates at appropriate levels. We will consider introducing price caps on bank workers if bank rates rise significantly

4) Bringing agency workers' pay in line with substantive workers' pay

The majority of trusts (53%) agreed with the objective to bring agency workers' pay in line with substantive workers' pay by 1 April 2016. However, they noted the issues regarding timing, speed of implementation and patient care identified earlier in this document.

The majority of responding doctors (90%), nurses (92%), other clinical staff (90%), agencies (88%) and non clinical staff (71%) disagreed. A large number of respondents from these groups highlighted the disparity between agency and substantive worker benefits. Many respondents said that agency workers should receive a risk premium to reflect the nature of temporary working. Many also reported that substantive workers receive a wider package of benefits that agency workers do not receive which should be accounted for in their pay.

Some respondents considered that current agency rates were excessive and can lead to a sense of unfairness among substantive and bank staff on wards.

Rates available via agencies can discourage workers to take shifts through an NHS employer. The policy aims to encourage a shift from agency working back into bank and substantive roles. In line with this, Monitor and TDA will proceed with the proposals set out in the consultation. Bank rates will not however be capped to allow trusts flexibility to respond to the impact of price caps. The planned reductions in price caps will be subject to monitoring and evaluation, including the workforce impact.

5) Final price cap set at a 55% uplift over basic pay rates

Many doctors, nurses, other clinical staff, agencies and non clinical staff considered the uplift too low, suggesting it could discourage staff from doing agency work, particularly junior doctors and consultants. Some respondents said that a 55% uplift would not fully take into account employer on-costs, which could in some cases leave agency workers worse off than substantive staff.

Others noted concern for the survival of the agency market. This aligns with feedback from a representative body of agencies. There was also a request from multiple parties for more clarity as to the makeup of the uplift.

The majority of trusts agreed with the 55% uplift.

The price caps have been calculated to encourage a switch back to substantive and bank roles from agency working. Please see Annex 2 of the rules for a further explanation of how the rates are derived.

We are aware of the risks of disruption to supply of agency staff. However unless the price caps send strong incentives to move from agency to bank working, they will not realise the maximum potential benefits.

Given the pressing need to start realising savings in 2015/16, Monitor/TDA will not be adjusting the uplift at this point.

The effect on the agency market will be monitored alongside the effects on the workforce, and price caps will only be reduced subject to this monitoring and evaluation. In addition, given the responses from providers, staff and staff representative bodies, we will not be applying the price caps to bank rates.

6) High Cost Area Supplements

A majority of doctors (53%), nurses (56%), other clinical staff (57%), agencies (78%), trusts (64%) and non clinical staff (70%) agreed that the High Cost Area Supplements, where relevant, should be reflected in the caps. They are a core part of this national pay scale. However, clinical respondents also cited broader issues of impact on supply, the timing of their introduction and patient care points raised in the summary above.

Taking this into account, the price caps reflect that High Cost Area Supplements should be applied where appropriate, ie where a trust is eligible for a High Cost Area Supplement, they can be applied on top of the caps.

However a number of respondents raised concern that areas of the country other than London face workforce recruitment and retention challenges. Monitor and TDA will monitor implementation of the price caps nationally and locally. Certain trusts may need to use the override mechanism on patient safety grounds at least initially. Monitor and TDA will scrutinise use of overrides and while excessive use and failure to make improvements in workforce management may lead to regulatory action, equally where trusts are struggling to comply with the price caps we encourage them to contact us and we will seek to help ensure trusts are doing all they can to apply best practice.

7) Change to agency and/or bank workers' behaviour

A majority of doctors (91%), nurses (78%), other clinical staff (88%), agencies (75%), trusts (71%) and non clinical staff (81%) considered that agency workers' behaviour would change as a result of these caps.

These changes may vary across the NHS and may lead to staff supply shortages, at least in the short term. Respondents mentioned that it may take time for the sector

workforce to reach ‘steady state’ following introduction of the caps, as individuals and trusts adjust to the new arrangements. Other respondents identified the risk of a ‘stand-off’ between providers and agency staff/agencies during any immediate post-introductory phase, risking staff reductions and implications for patient care.

We recognise the concerns expressed regarding workforce supply as a result of these changes, and note that any changes to the composition of workforce are unlikely to take place overnight.

We are excluding bank from these caps. Our intention in doing this is, in recognition of the challenges above and elsewhere, to offer providers a degree of flexibility in achieving a reduction in their agency usage. Banks are often able to be more flexible in their employment models than substantive contracts. We encourage trusts to think innovatively about implementing flexible substantive and bank employment models in order to attract employees back into full-time roles.

8) Challenges and risks to delivering the price caps (both at the individual level and the system level)

Respondents highlighted a range of risks that are associated with the introduction of price caps on agency and bank workers. Respondents referenced risks highlighted in their responses to earlier questions. Frequently cited risks included:

- impact on supply of staff
- timing and speed of implementation
- ambition of the price caps
- care quality and patient safety
- wider causes of workforce issues.

Monitor and TDA recognise that introducing price caps carries a range of risks, as outlined in the consultation impact assessment and raised by respondents to the consultation.

Monitor and TDA’s approach to gradually reducing the price caps, subject to monitoring and evaluation, combined with the ‘break glass’ clause to ensure patient safety, will mitigate some of these risks.

These risks also need to be weighed against a counterfactual where larger financial deficits and ever greater reliance on agency staff risk an increasingly negative impact on patient safety and access. On balance, Monitor and TDA recognise a need to take action now to reduce reliance on agency staff.

9) Support measures at a national level to help with compliance with the price caps and with reducing agency spend

Respondents generally agreed that a national support function would help them to use price caps to reduce agency spend as effectively as possible. These include supporting providers in filling positions and managing workforce effectively.

Monitor and TDA recognise the importance of providing trusts with appropriate support and tools to manage their agency spend. We have designed a joint programme of workforce support, to support trusts to operate within the price caps. This will include on-the-ground support, collection and publication of best practice, seminars, and analytical and investigative capacity.

10) Monitoring impacts of the proposals on workforce, quality, access and performance

Most respondents indicated that regular and detailed monitoring should be conducted at both local and national level, including effects on patient safety and clinical quality. Many felt that compliance and reasons for non-compliance should also be monitored, and a governance structure should be reviewing the results of the monitoring.

Monitor and TDA agree that the impact of this policy on the NHS needs to be monitored centrally. We have designed, developed and introduced a process to do this. This will combine a new data collection on compliance with existing data on patient safety, clinical quality, operational performance and workforce. While new data collections will minimise the burden on trusts, this will be combined with a range of wider qualitative and quantitative intelligence.

Monitor and TDA emphasise that trust boards hold primary responsibility for ensuring patient safety locally.

11) Ambulance trusts

The majority of doctors (70%), nurses (59%), other clinical staff (53%), agencies (38%) and non clinical staff (43%) said that a similar cap should not apply to ambulance trusts. This is mainly due to the considerations surrounding impact on staff supply and patient care, as well as timing of implementation, outlined in the summary above. Most trusts (61%) said that a similar cap should apply for ambulance trusts, arguing for parity of treatment. 43% of agencies were undecided.

Monitor and TDA note the concerns raised by respondents and will therefore not apply price caps to ambulance trusts at this time. Monitor and TDA will work with this group over the coming months to develop rules for this sector.

12) Equality issues or issues of either a detrimental or differential impact on any particular group

Some respondents were of the view that the agency caps could have a negative effect on particular parts of the NHS workforce. These included:

1. those who depend on agency work to supplement existing pay, such as clinicians in research or academic roles
2. staff on maternity leave
3. those who require flexibility in their working life, such as:
    - parents with young children, in particular single parents
    - anyone with a disability or long term health problems limiting them from working substantive hours
    - students
    - carers
    - older agency workers
4. ethnic minorities, who may be overrepresented in agency or locum staff.
5. doctors from overseas, who are ineligible to enter into training programmes until they have a certain amount of experience in UK hospitals, which they gain from locum work.
6. junior doctors, due to the perceived harshness of the proposed caps.

Overall it is important to keep in mind that the purpose of the new price caps is not to prevent all agency use. A key intention of the price caps is to encourage a shift from agency working to substantive and bank roles, which will not be capped. Workers will continue to be able to undertake agency working, as long as the hourly rate paid is within the proposed cap.

Accordingly, although the potential detrimental impact on particular groups, including those with specific protected characteristics (as set out in equalities legislation) is acknowledged, we believe that these considerations are outweighed by the wider consideration of the need to take action to ensure the overall sustainability of the NHS for patients. The cost of agency staff to the NHS has increased substantially over the past three years and action must be taken to tackle costs and bring agency staff back into the regular workforce. Bringing costs under control and reducing reliance on agency staff is in the wider interests of patients and service users.

Monitor and TDA also plan to review the impact of the introduction of the price caps on groups with relevant protected characteristics (age, sex, disability and ethnicity)

as part of their regular monitoring and will keep this in mind when evaluating the policy.

13) Further comments

A large number of responses were consistent in the comments raised. However there were small numbers of respondents who made further comments.

Other options

Some agencies suggested that there has been no exploration of alternative options to agency caps as a way of resolving the issue of over-expenditure on agency staff within the NHS.

Monitor and TDA have engaged with the sector on a number of agency rules. We implemented frameworks and ceilings initially on 1 September 2015, and there was still support for further rules to reduce the unit cost of agency staff.

These rules are also part of a wider programme of measures, across DH, Health Education England and NHS England to help trusts manage their workforce strategy and temporary workforce spend.

Monitor and TDA recognise the importance of providing trusts with appropriate support and tools to manage their agency spend. We have designed a joint programme of workforce support which will include support on demand management.

Market effects

A small number of respondents had concerns regarding the market effects of these price caps. They stated that current agency rates are determined by existing demand and supply, so should not be subject to capping.

Monitor and TDA are taking action to reduce reliance on agency staff. The agency cap is a limit on what individual providers can spend on agency resource rather than a restriction on agency charges.

Impact on agencies

A number of respondents indicated that, in addition to providers, Monitor should consider the impact on agency firms that will be affected by caps on the hourly rates they can charge NHS providers. These organisations were not included in the impact assessment published in October 2015.

Some agencies were concerned that the rates proposed for 1 April 2016 would squeeze agencies' profit margins and might encourage some to leave the NHS market. Agencies argued that the NHS market will be less efficient without them.

We have set a cap on the total charge that trusts can pay for an agency worker. Agency fee margins are not specifically capped and there therefore remains scope for agencies to determine their optimal way of operating.

Costs of price caps

Some responses suggested that administration costs to trusts of monitoring the impact of price caps could be costly, potentially negating some of the savings made on agency costs.

Monitor and TDA have designed the monitoring process to be as light touch as possible, while recognising the need for sufficient information to be available nationally and to trusts' boards. Responsibility for monitoring the impact of price caps, including any potential effects on patient safety, lies primarily with trusts' Boards. Monitor and TDA will monitor the impact of price caps at a national level and confirm if it is appropriate to reduce the price caps in line with the rates set out in the rules.

Additionally, some respondents including agencies raised concern that the costs of agency staff could increase as a result of the policy. Price caps could be misinterpreted by workers or agencies as expected rates. They also suggested a potential decrease in supply could lead to trusts going off framework, leading to rising costs. Some said that trusts may be reticent to utilise the 'break glass' clause until late, resulting in increased prices.

The price caps represent the maximum that trusts can pay and should not be interpreted as standard or default rates. Trusts will want to, and should, continue to secure the majority of agency staff at rates below the price caps. Trusts that currently pay agency staff below the capped rates are expected not to exceed the rates they currently pay.

The rules include a 'break glass' provision for trusts that need to override the caps on exceptional safety grounds. However trusts should not use the 'break glass' clause as a substitute for effective workforce planning. The 'break glass' should be used only after all possible alternative strategies have been explored, within a robust escalation process sanctioned by the trust board and only used for patient safety reasons. Any payments in excess of the price caps will be scrutinised by Monitor and TDA, and excessive use and failure to make rapid improvements to workforce management may lead to regulatory action as appropriate.

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Making the health sector work for patients

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