



Improvement

Evidence from NHS Improvement on clinical staff shortages

A workforce analysis

February 2016



About NHS Improvement

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

NHS Improvement brings together Monitor, the NHS Trust Development Authority plus groups from three other organisations: from NHS England both the Patient Safety Team and the Advancing Change Team, from NHS Interim Management and Support two Intensive Support Teams, together with the National Reporting and Learning System. NHS Improvement is an operational name for the organisation which formally comes into being from 1 April 2016.

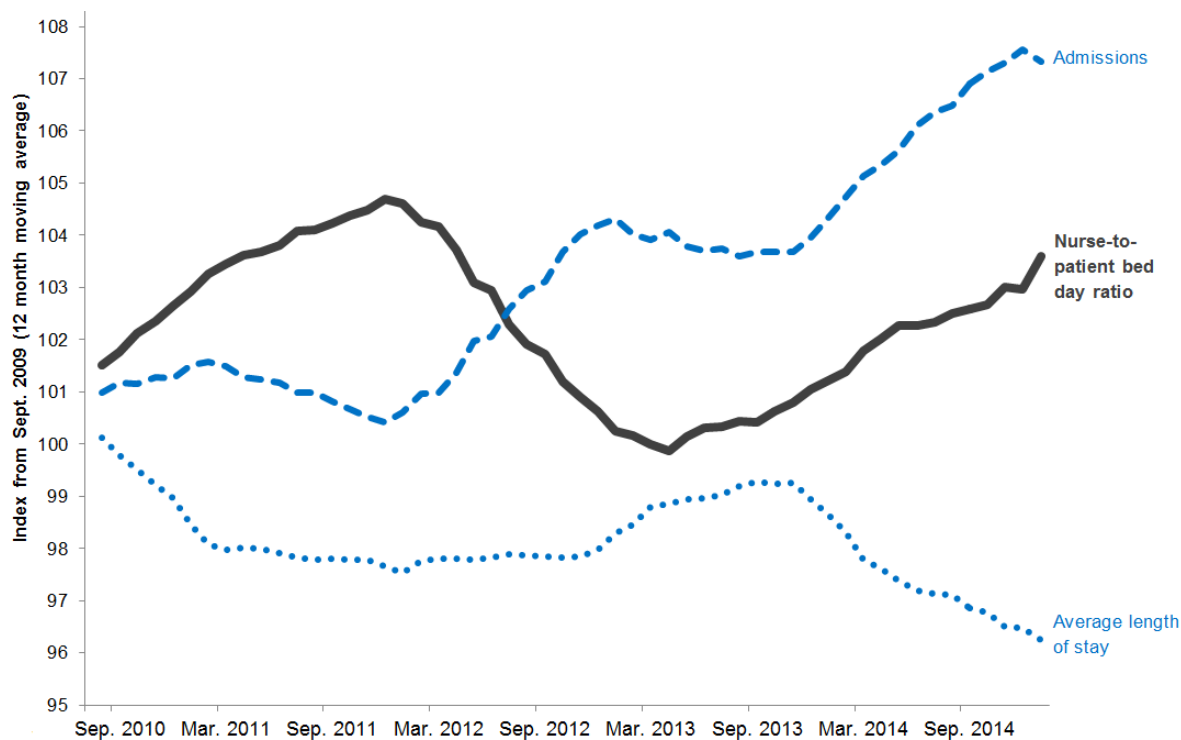
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Summary¹

1. There has been a rapid rise in demand for hospital nurses since publication of the Francis Report in February 2013 and the push for higher staffing levels that followed. For example, hospitals' demand for nurses caring for adult acute patients in 2014 was 189,000, around 7,000 more than hospitals had been forecasting just a year earlier and 24,000 more than was forecast two years before. Taken together, trusts' current forecasts anticipate further growth in the nursing workforce.
2. Rapid growth in the number of nurses employed over the last two-and-a-half years has resulted in an increase in the ratio of nurses to patients in hospitals. However, the recent increase has only returned this ratio to where it stood at the end of 2011 (see figure below).

Trends in nurse-to-patient ratio, admissions and length of stay 2010 to 2015²



3. The supply of nurses has failed to keep up with this rapid growth in demand. Hospitals estimate they are 15,000 nurses³ short of what they need. A significant element of this supply shortfall can be ascribed to the collapse in the number of nurses from outside the European Economic Area joining the NHS

¹ Analysis correct as at October 2015.

² Substantive nurses only.

³ Nurses trained to care for adults and working in both the acute and the community sectors.

each year. This figure has fallen by over 95% from its peak of more than 15,000 in the early 2000s.

4. Inevitably, this significant supply shortfall has driven up the cost of agency nurses. Agency charges for nurses increased by around 30% from 2012 to 2015.
5. Nevertheless, the nurse shortfall would be even worse were it not for productivity improvements made by trusts over the last two years. In particular, reductions in average length of stay have offset a sharp increase in hospital admissions (see figure above). Without this improvement, there would likely be a need for around 5,000 extra nurses at a cost to the NHS of about £250 million at agency rates.⁴
6. We are supporting local workforce initiatives and working with system partners to rebalance supply and demand at the national level. Our actions include:
 - supporting providers on workforce planning and improving co-ordination at a national level
 - building on the work of the Carter Review to improve provider productivity
 - reducing providers' agency costs.

⁴ Our calculation is based on NHS Professionals' observed rate for a band 5 nurse in 2014/15.

1. Background

The NHS as a whole directly employs over 640,000 people in the professionally qualified clinical workforce, including 110,000 doctors and over 315,000 nurses.⁵ Spending on total workforce represents an estimated 70% of a typical hospital's⁶ costs, with much of this spent on the clinical workforce.⁷ The right workforce is crucial to ensuring the quality of care that hospitals provide. It is also central to making the productivity and efficiency gains needed to meet their financial challenges, and transforming services through new care models.

Growing shortages of qualified clinical staff have led providers to make increasing use of agency and other temporary workers to fill vacancies. We have recently introduced new rules on agency workers to help providers address the impact of this trend on their costs.

This report sets out our analysis of the causes and extent of current clinical staff shortages in acute hospitals, focusing on adult nurses⁸ and consultants.⁹ Its aims are to provide evidence informing decisions about the sector at a national level,¹⁰ and to highlight some of the materials we are developing to support providers. Further, the report sets out the actions we will take at a national level with our system partners to support providers facing workforce shortages.

2. What has happened to the nursing workforce?

2.1. Nursing demand has risen rapidly and is outstripping supply

Since the end of 2012, there has been a large increase in demand for hospital nurses across the NHS. In 2014, providers reported to Health Education England (HEE)¹¹ that they needed 189,000 adult nurses¹² (acute) in total, yet two years earlier they predicted they would need only 165,000; in 2013, this had risen to over 180,000 (see Figure 2).

⁵ Health and Social Care Information Centre *NHS workforce statistics – June 2015, provisional statistics*.

⁶ www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/the-nhs-productivity-challenge-kingsfund-may14.pdf

⁷ According to NHS Employers, 50.6% of NHS employees are professionally qualified clinical staff – www.nhsemployers.org/news/2015/07/the-nhs-workforce-in-numbers

⁸ 'Adult nurses' in our analysis refers collectively to all nurses caring for adult acute, elderly and adult general patients.

⁹ Other areas and specialties, such as general practice, may also be experiencing shortages but are outside the scope of this study.

¹⁰ Analysis correct as at October 2015.

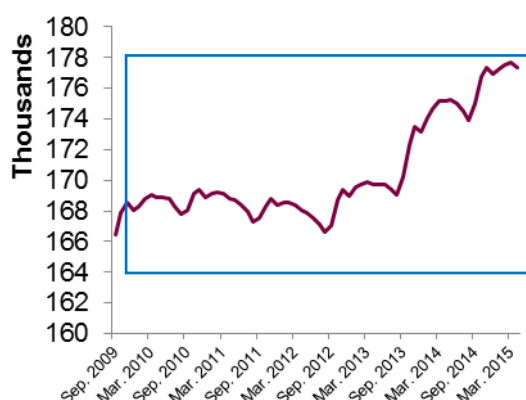
¹¹ HEE asks providers for their forecast workforce demand each year.

¹² HEE defines adult nurses differently from us as it bases its definition on training branches. Where we cite HEE adult nursing data, we indicate whether the data are for nurses working in the adult acute and/or community sector.

This rise in demand is reflected in the increasing numbers of nurses employed. Between October 2012 and April 2015 the number of adult nurses employed grew by 10,000 full-time equivalents (FTEs) or 6.4% (see Figure 1).

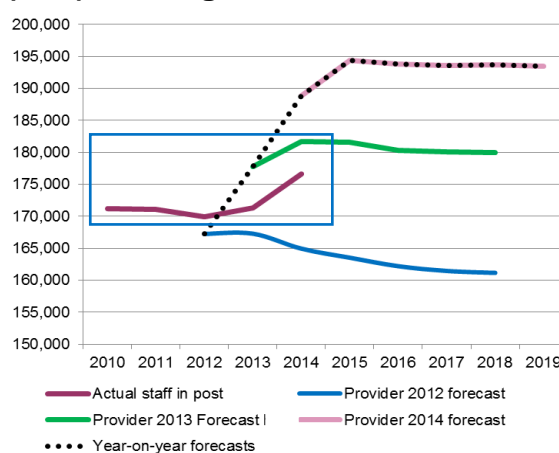
However, demand still exceeds supply. HEE’s data indicate that providers had 15,489 FTE vacancies for adult nurses (both those working in the acute and the community sector) in April 2014, equivalent to a 6.5% vacancy rate.¹³ At that time, trusts also indicated to HEE that they expected to need a further 6,389 nurses in 2014/15.¹⁴

Figure 1: Qualified adult nurses employed in the NHS



Source: HSCIC

Figure 2: Numbers employed and forecast demand for adult nurses (FTE) working in the acute sector



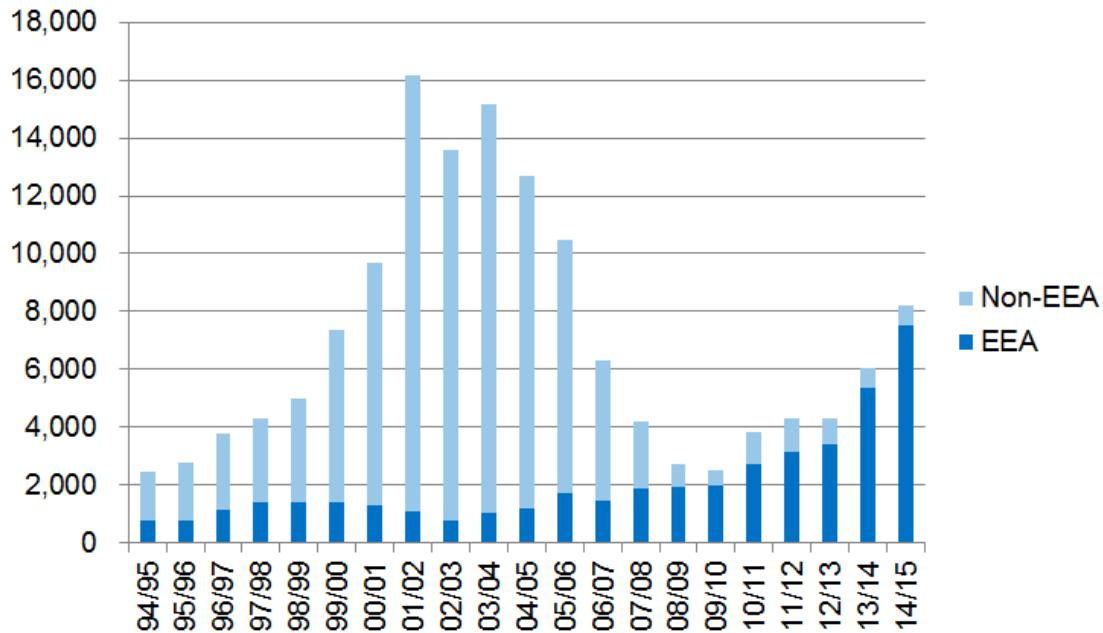
Source: HEE

One factor contributing to continuing high vacancy levels is the drop in recruitment of nurses from outside the European Economic Area (EEA). International recruitment has historically helped fill gaps between predicted and actual demand for nurses, and since 2009 the number of nurses coming to the UK from the EEA has increased. However, the number of nurses who join the UK nursing register from outside the EEA has declined substantially. As shown in Figure 3, in the early 2000s, 12,000 to 15,000 non-EEA nurses joined the UK nursing register each year. From 2008/09 to 2014/15 this number fell to around 1,000 nurses a year, and in 2014/15 only 665 non-EEA nurses were registered.

¹³ HEE *Workforce plan for England 2015/16* – note that the vacancy figure is as at 1 April 2014.

¹⁴ Overall requirements are predicted to increase by 5,642 FTE in 2019. Increases in 2014/15 are predicted to be followed by reductions between 2015 and 2019. HEE *Workforce plan for England 2015/16*.

Figure 3: New registrations on the Nursing and Midwifery Council register according to EEA and non-EEA origin



Source: RCN (2015) *International recruitment 2015*

More generally, the supply of UK-trained nursing staff is slow to respond to demand changes. In the NHS, as in many other health systems,¹⁵ the future supply of nurses is planned centrally. Training a nurse takes more than three years. So when demand rises considerably and rapidly, the supply of trained nurses available to fill hospitals' substantive (ie permanent) nursing posts cannot easily respond at the same pace. The increase in demand has also come at a time when fewer nurses are qualifying – between 2010/11 and 2012/13 the number of nursing training places fell by 12.7% from 20,092 to 17,546.¹⁶

Return-to-practice schemes are another means of expanding supply. The centrally funded return-to-practice initiative between February 1999 and March 2004 resulted in 18,500 former nurses and midwives returning to work in the NHS.¹⁷ However, recent schemes have not had the same level of success – around 1,300 nurses signed up to HEE's most recent scheme.

¹⁵ See, for example, King's Fund (2009) *NHS workforce planning: limitations and possibilities*.

¹⁶ www.kingsfund.org.uk/time-to-think-differently/trends/professional-attitudes-and-workforce/non-medical-and-nursing-workforce

¹⁷ hee.nhs.uk/wp-content/uploads/sites/321/2014/05/HEE-Return-to-practice.pdf

The increase in demand for nurses appears to be continuing. In July 2015, 75% of NHS trust finance directors indicated they planned to increase their permanent nursing staff in the next six months.¹⁸

2.2. Nurse demand has risen partly because of increasing activity, but also as a result of safe staffing

Three main factors may drive changes in hospitals' demand for nurses. The first is expected levels of activity: the more patients that hospitals expect to admit, the more nurses they will need. The second is those patients' levels of sickness (or acuity): a high proportion of seriously sick patients will need more nursing hours. Lastly, sector reports and new policies concerning staffing levels can change demand for nurses.

The Mid Staffordshire NHS Foundation Trust Public Inquiry's findings (the Francis Report) were published in 2013. The report was commissioned after serious failings at the trust. One recommendation was to create tools to establish the safe staffing needs of each service. The National Institute for Health and Care Excellence (NICE) then developed safe staffing guidelines for hospital wards.¹⁹ Although the NICE guidance does not specify a staff-to-patient ratio, it suggests that patients are at increased risk of harm if a nurse regularly has to care for more than eight patients on a ward during the day.²⁰ In addition, in 2013 the National Quality Board (NQB) published guidance setting out expectations of hospitals' nursing staff capacity and capability. The Care Quality Commission's (CQC's) inspections also assess whether staffing is safe. We refer to the Francis Report, NQB guidance, NICE guidelines and their use alongside the CQC inspection regime collectively as 'safe staffing'.

We have tested whether safe staffing has been a cause of the recent increase in demand for nursing staff. It is difficult to disentangle its effects on nurse demand from the other two causes – activity and levels of sickness.²¹ However, the step change in demand in the period after publication of the Francis Report in early 2013 indicates that safe staffing has had a strong impact on acute hospitals' demand for nursing staff, specifically:

¹⁸ Response to the question: 'Is your organisation planning to increase the number of permanent nursing staff in the next six months?' *King's Fund Quarterly Monitoring Report* July 2015 – <http://qmr.kingsfund.org.uk/2015/16/>

¹⁹ Safe staffing timeline, key milestones:

- Francis Report, February 2013
- National Quality Board Guidance 2013 – www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf
- guidance on publishing staffing data monthly from April 2014 – www.england.nhs.uk/2014/04/01/hard-truths/
- NICE safe staffing guidelines, July 2014 – www.nice.org.uk/guidance/sg1/chapter/1-recommendations

²⁰ www.nice.org.uk/guidance/sg1/chapter/1-recommendations (July 2014).

²¹ In addition, here we have not controlled for any other aspects of quality.

- As highlighted above (Figure 1), there was a sudden upturn in employment of adult nurses from early 2013. It increased by 4.6% from January 2013 to January 2015.
- Providers revised upwards their forecasts for the number of adult nurses they would need to meet 2014 demand (Figure 2).
- The ‘nurse-to-patient bed day ratio’ (a measure we have developed to show the intensity of nursing care – see Box 1) shows an increase from January 2013 to January 2015, driven by providers employing greater numbers of nurses. The increase was about 4% when the ratio includes only substantive nurses and an estimated 6% when agency nurses are included.

The increase in the nurse-to-patient bed day ratio after the Francis Report followed a period when the ratio had been falling (see Box 1). More recent increases have returned the ratio to its December 2011 level. This has coincided with rising numbers of admissions, making it harder to maintain the ratio than it was in 2011.

Box 1: Nurse-to-patient bed day ratio

To assess the impact of safe staffing on demand for nursing staff, we have developed a new measure of the intensity of nursing care – the ‘nurse-to-patient bed day ratio’.²² This ratio increases when there are more nurses for each patient in hospital at any particular time.²³ The number of ‘patient bed days’ is the number of admissions multiplied by their length of stay, so we express the ratio as:

$$\frac{\text{FTE nurses}}{\text{Admissions} \times \text{average length of stay}}$$

Changes in each of its three elements affect the ratio: it will rise if either the number of nurses increases or admissions fall or length of stay falls.

This measure reflects the volume of patients in hospital at any one time and so aims to capture the amount of nursing care they receive. However, it doesn’t completely capture the time patients spend (or need) with nurses because:

- As well as capturing nurses’ contact time²⁴ with patients, it also captures nurses’ time spent on activities that are not classified as direct patient care. We are not aware of evidence that the time nurses spend on either type of

²² Estimated using inpatient admissions and length of stay data from the Hospital Episode Statistics, the number of substantive adult, general and elderly nurses from the electronic staffing record, and an estimate of agency nurse use from our agency survey 2014/15.

²³ This could be more fully referred to as ‘acute, general and elderly nurse FTE per bed days within a calendar month in acute settings’.

²⁴ An example of how nursing activity can be defined can be found in Appendix A of NHS England’s *Guide to care contact time* – www.england.nhs.uk/wp-content/uploads/2014/11/safer-staffing-guide-care-contact-time.pdf

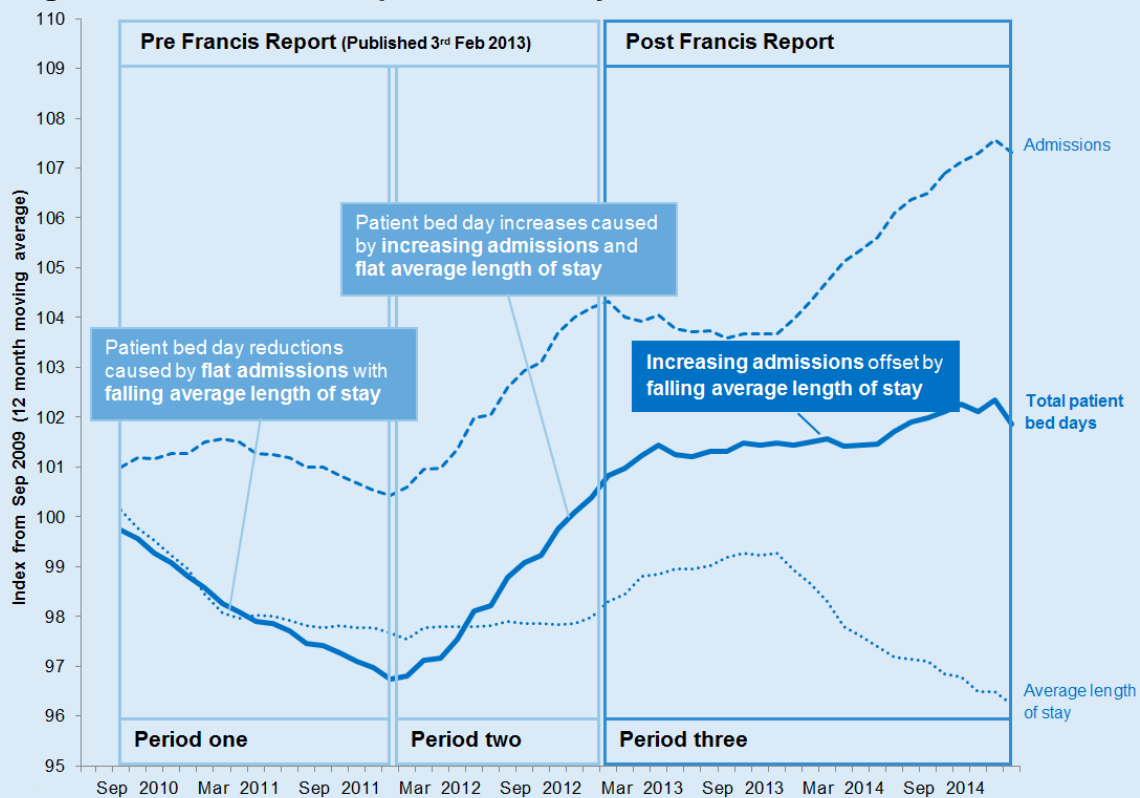
work has changed significantly over the period, although we might expect providers to have responded to safe staffing by increasing care contact time per patient for each nurse in the ways described by NHS England.²⁵

- It does not capture differences in different patients' needs for nurse time. For example, a higher prevalence of patients with dementia in a hospital would lead to a higher overall patient need for contact time.

Changes in components of the ratio

- FTE nurses. We described the upward trend in nurse numbers above.
- Patient bed days (ie admissions × average length of stay). As Figure 4 shows, changes in the bed days' component can be split into three periods. In period one, it fell as length of stay reduced faster than admissions grew. In period two, it started to rise, as admissions also rose and length of stay reductions stalled. In period three, it remained constant, as increases in admissions and reductions in length of stay cancelled each other out.

Figure 4: Breakdown of patient bed days, 2010 to 2015



Source: Estimated using inpatient admissions and length of stay data from the Hospital Episode Statistics, the number of substantive adult, general and elderly nurses from the electronic staffing record. Twelve-month moving averages used to account for seasonal fluctuations.

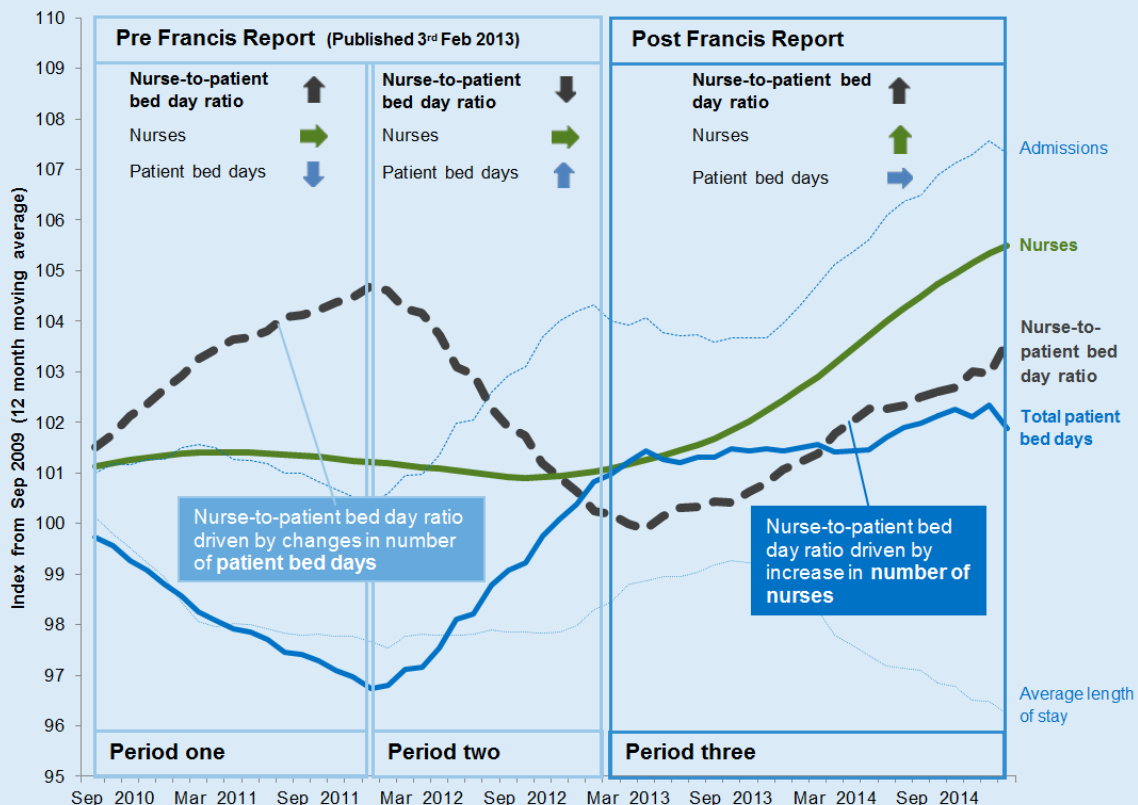
²⁵ NHS England *Safer staffing: a guide to care contact time* – www.england.nhs.uk/wp-content/uploads/2014/11/safer-staffing-guide-care-contact-time.pdf

The impact of changes on the ratio

Figure 5 below shows how changes in the ratio's components contributed to fluctuations in the ratio itself between 2010 and April 2015. The number of nurses is shown in green and the number of patient bed days in blue. Before publication of the Francis Report in February 2013, changes in the ratio were mainly driven by changes in patient bed days as adult nursing numbers remained broadly flat over the period (although overall nursing²⁶ numbers were falling slightly at this time).

However, from February 2013 onwards (period three), when we might expect to start seeing an impact from safe staffing, increases in nursing numbers drove the increase in the ratio. The number of patient bed days stayed broadly constant, but the nurse-to-patient bed day ratio increased by 4% because trusts were employing more substantive nurses. This is consistent with trusts implementing safe staffing in the wake of the Francis Report by increasing their nursing levels, bringing the nurse-to-patient bed day ratio back up to the levels of September 2011.

Figure 5: Nurse-to-patient bed day ratio, 2010 to 2015 (substantive nurses only)



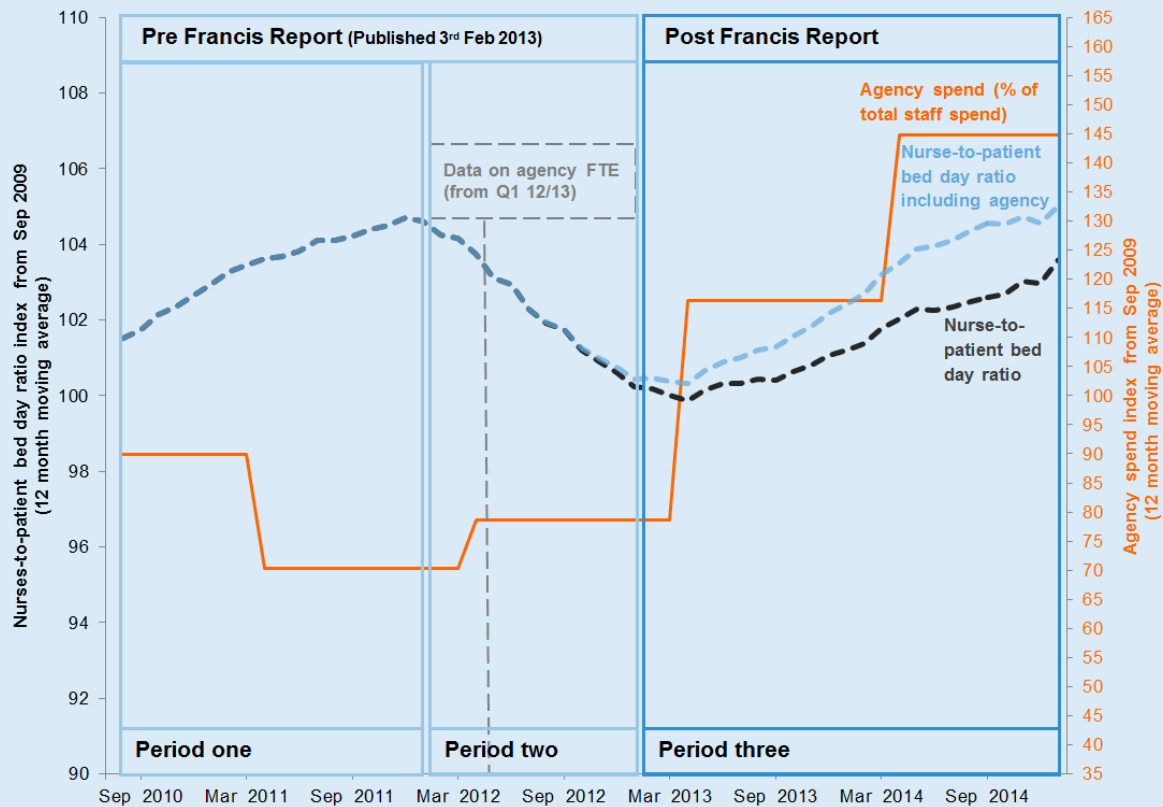
Source: Estimated using inpatient admissions and length of stay data from the Hospital Episode Statistics, the number of substantive adult, general and elderly nurses from the electronic staffing record. Twelve-month moving averages used to account for seasonal fluctuations.

²⁶ Qualified nursing, midwifery and health visiting staff.

Including changes in agency nurse use

Including only numbers of substantive nurses in the nurse-to-patient bed day ratio is likely to underestimate actual changes in the ratio. We know that demand for agency nurses increased rapidly over period three. Figure 6 shows that overall agency spend fell in periods one and two but rose significantly following the Francis Report. Including an estimate of the increase in employment of agency nurses from Q1 2012/13²⁷ in the ratio shows it may have grown by around 6% over this two-year period.

Figure 6: Nurse-to-patient bed day ratio (including agency) and agency spend, 2009 to 2015



Source: Estimated using inpatient admissions and length of stay data from the Hospital Episode Statistics, the number of substantive adult nurses from the electronic staffing record, and annual agency spend percentages taken from Financial Information Management Systems (FIMS) (NHS trusts) and foundation trust consolidation (FTC) accounts data (foundation trusts). Twelve-month moving averages used to account for seasonal fluctuations.

²⁷ Agency nurses estimated from our agency survey 2014/15 for a sample of acute foundation trusts. Earliest data available are for Q1 2012/13. We assume that trends have been similar for foundation trusts and NHS trusts.

2.3. Providers have responded to the supply shortage in large measure by hiring agency workers, driving up agency costs

To meet their rising demand for nurses, providers have turned increasingly to agency staff. This has raised NHS providers' costs as they have spent more on all agency staff. In 2014/15 these accounted for 7% of the total staff bill for NHS providers, up from 3.4% in 2011/12.²⁸ In total in 2014/15, NHS providers spent £3.3 billion on temporary staff. Of this, we estimate that around £0.7 billion is the premium paid for agency staff over the equivalent substantive pay and on-costs that providers would incur.²⁹

Demand for agency nurses has been a major cause of the overall growth in temporary staff spend: spend on nursing agency staff for a sample of foundation trusts grew by 150% between Q1 2011/12 and Q2 2014/15,³⁰ and nurses now account for 31% of total spending on clinical agency staff by all NHS foundation trusts.³¹ There is some evidence that with rising demand the average total rate charged for a nursing agency shift also increased, by around 10% each year from 2012 to 2015.³²

2.4. Improvements in providers' productivity have moderated the additional demand for nurses and the increase in agency spend

The impact on providers' costs of the recent imbalance between supply and demand for nursing staff would have been worse had providers not at the same time improved their productivity.

For hospitals, reducing average length of stay has historically been an important means of improving productivity: the less time patients spend in a hospital bed on average, the more patients hospitals can treat with the same number of beds and staff, avoiding the need to open new beds as patient numbers rise.

From January 2013 to January 2015, the average length of stay across English hospitals fell by 2.6%. Over the same period safe staffing increased the number of nurses required for any given number of beds. Without this reduction in length of stay, providers would have had to increase the number of adult nurses by around a further 5,000 – equivalent to an extra nurse for every hospital ward in England. In

²⁸ Source: FIMS and FTC data.

²⁹ Based on our (2015) *Price caps for agency staff: impact assessment*, p22 Table 11 – www.gov.uk/government/uploads/system/uploads/attachment_data/file/468469/Impact_assessment_-_agency_rules.pdf. Note this is based on trusts employing all staff at the maximum rates of Agenda for Change bands or the equivalent pay scale for doctors. On-costs of 55% allow for employer National Insurance, holiday pay and employer pension contributions. They also include an allowance for a modest administration fee, which may be reduced if administered through the trust.

³⁰ Our agency return – sample of foundation trusts.

³¹ APR data.

³² NHS Professionals' data. Note that shift length has also changed over this period, as has the mix of basic/unsocial hours.

money terms, the reduction in average length of stay meant the NHS avoided spending up to £250 million on nurses annually (assuming these extra nurses would have been employed through agencies).³³

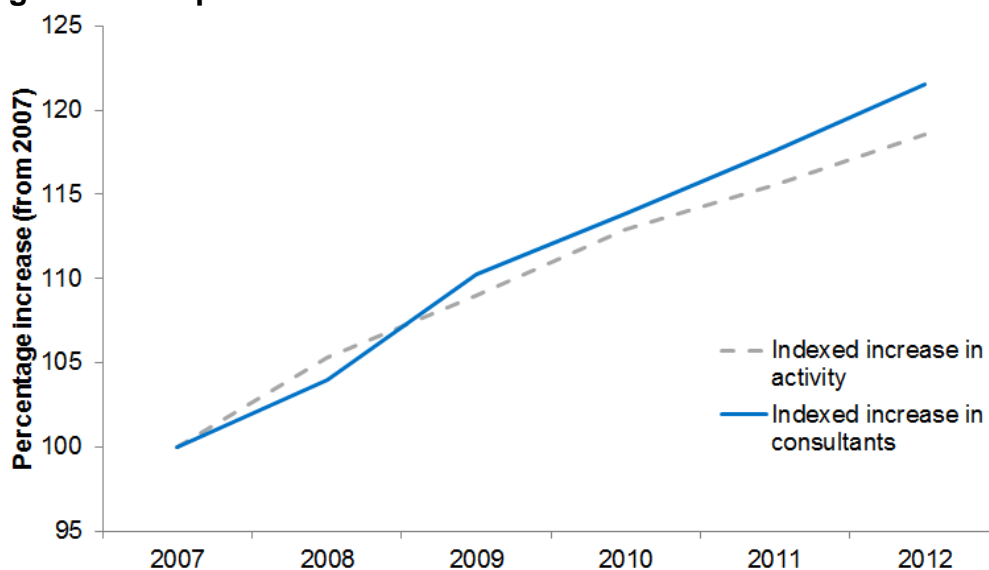
3. What has happened to the consultant workforce?

3.1. The number of consultants has increased faster than activity

The size and composition of the consultant workforce at any time is largely the result of plans made 10 to 20 years ago³⁴ because of the time it takes to train entry-level doctors and for some of those doctors to reach consultant level. The difficulties of planning the consultant workforce so far ahead are compounded by new technologies, changing demographic needs, and innovations in care models, all of which can lead to large changes in demand for consultants, especially in particular specialties.

The supply of and demand for consultants have both continually increased since the late 1990s. In recent years, the number of consultants has increased faster than activity. While consultant activity rose by 18%³⁵ between 2007 and 2012, the number of consultants employed grew by 22% (see Figure 7). In other words, increasing activity drove only part of the increase in demand for consultants over this timespan, as was the case with demand for nurses over the past two years.

Figure 7: Comparison of increases in consultant numbers and activity



Source: Electronic Staffing Record; Centre for Health Economics, York 2007 to 2012.

³³ Our calculation is based on NHS Professionals' observed rate for a band 5 nurse in 2014/15.

³⁴ King's Fund (2013) *NHS and social care workforce: meeting our needs now and in the future?* – www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/perspectives-nhs-social-care-workforce-jul13.pdf

³⁵ Casemix-adjusted and cost-weighted output from York Centre for Health Economics – Research Paper 87: output growth, Table 11; Research Paper 94: output growth, Table 14.

3.2. Demand is outstripping supply in some key specialties

Despite expansion in the consultant workforce more than keeping pace with activity, shortages are apparent in some individual specialties. We found some specialties indicating significant shortages of doctors, in particular of consultants. Difficulties in recruiting consultants and increasing spending on temporary locums are reported in the mainstream specialties of emergency medicine, acute general medicine, diagnostic services and psychiatry (see Table 1). Other areas of NHS care, notably GP services, are also reported to be experiencing shortages of doctors,³⁶ but these are outside the scope of this report.

Several factors could be causing shortages in these specialties. For instance, demand may fluctuate because of changing demographics or changes in how services are delivered. Some specialties may also be less attractive to newly qualified doctors.

Table 1: Indicators of shortage of doctors by specialty

Specialty	Indicator(s) of shortage
Emergency medicine	<ul style="list-style-type: none"> All grades (consultant to non-training) are included on the Home Office shortage occupation list³⁷ 73% of providers' total spend on locum staff is concentrated in general medicine and emergency departments³⁸
Acute general medicine	<ul style="list-style-type: none"> A report by Liaison found that general medicine represents 50% of spend on agency doctors³⁷ Providers have told us that it can be particularly difficult to recruit to general medicine, with the attractiveness of sub-specialisation appearing to have resulted in significant shortages for generalist posts
Diagnostic services	<ul style="list-style-type: none"> Consultant clinical radiologists are included on the shortage occupation list³⁹ The Carter review of pathology (2008) identified significant reconfiguration needed because of 'constraints imposed by the supply of a skilled workforce'
Psychiatry	<ul style="list-style-type: none"> Both consultant (old age psychiatry) and core trainees in psychiatry are included on the Home Office shortage occupation list³⁸ 32.1% increase in numbers of full-time consultant locum posts from 2011 to 2013; 93.9% increase in number of vacant and unfilled posts from 2011 to 2013 (to 97.7 posts in total)⁴⁰

³⁶ See, for example, Centre for Workforce Intelligence (2014) *In-depth review of the general practitioner workforce* - www.cfwl.org.uk/publications/in-depth-review-of-the-gp-workforce/attachment.pdf

³⁷ www.gov.uk/government/uploads/system/uploads/attachment_data/file/423800/shortage_occupation_list_april_2015.pdf

³⁸ Liaison (2015) *Taking the Temperature: A review of NHS agency staff spending in 2014/15* – www.liaisonfs.com/ttt

³⁹ www.gov.uk/government/uploads/system/uploads/attachment_data/file/423800/shortage_occupation_list_april_2015.pdf

⁴⁰ Royal College of Psychiatrists census 2013 – www.rcpsych.ac.uk/pdf/RCPsych_Census_2013_FINAL.pdf

The attractiveness of a specialty to newly qualified doctors is a complex issue. It depends on their individual position on a range of motivators, including the intrinsic attractiveness of the work, work–life balance, and potential NHS and non-NHS earnings. But clearly some specialties currently appear less attractive to most newly qualified doctors. For example, the Keogh review found that too few doctors choose to specialise in emergency medicine because of the nature of the work and the working conditions.⁴¹

Current shortages of consultants and other doctors in some specialities may in part reflect a desire to improve quality by increasing consultant-delivered care faster than supply can respond.⁴² Several Royal Colleges have issued guidelines in this area. For example, the Royal College of Physicians recommended in 2012 that acute medical units, which provide the critical first stage in hospital admissions, have consultants on the unit for at least 12 hours a day, seven days a week. Similarly, guidance from the Royal College of Emergency Medicine (RCEM) recommended that a senior emergency department doctor should be available to take decisions in emergency departments 24 hours a day, seven days a week.⁴³ The resulting upward pressure on demand is illustrated by RCEM estimates that meeting its recommended standards⁴⁴ in emergency departments would require an increase in the number of consultants from 852 FTE (the 2010 total) to 2,222.

4. NHS Improvement's plan to help providers respond to workforce shortages

Imbalances remain between supply and demand for both hospital nurses and consultants in some specialties, as shown by shortages in these areas of the workforce and continuing agency cost pressures. Our research suggests that providers are responding with a number of actions to help bring local workforce supply and demand back into balance. This section details what we are doing to support these local initiatives, and the actions we and our system partners are taking at a national level to rebalance workforce supply and demand.

⁴¹ NHS England (2013) *Transforming urgent and emergency care services in England, Urgent and Emergency Care Review End of Phase 1 Report Appendix 1* – Revised evidence base from the Urgent and Emergency Care Review – www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.Appendix%201.EvBase.FV.pdf

⁴² The Academy of Royal Medical Colleges in 2012 set out evidence for the benefits of consultant-delivered care across the health service – www.aomrc.org.uk/general-news/benefits-of-consultant-delivered-care.html

⁴³ College of Emergency Medicine: *The way ahead 2008-2012* – www.marathe.org/media/the-way-ahead-2008-2012.pdf

⁴⁴ Based on recommended minimum number of whole-time equivalent (WTE) consultants per emergency department to achieve 16/7 'shopfloor presence' and additional numbers of WTE consultants per major trauma centre needed to expand from 16/7 presence to 24/7 – www.rcem.ac.uk/Shop-Floor/Service%20Design%20&%20Delivery/The%20Emergency%20Medicine%20Workforce/Expanding%20the%20Consultant%20Workforce

4.1. Supporting local action by providers

We have found providers doing a variety of things to manage supply, including attracting more new entrants into their workforces, reducing exit and employing the existing workforce for more hours (increasing participation). Providers are also reducing growth in their demand for staff through initiatives to increase productivity or alter the range of work that people in particular roles can take on (role substitution). However, several providers highlighted to us that workforce demand and supply management plans capable of delivering longer-term, sustainable solutions are complex to develop and that they often lack the ‘head space’ these plans require.

We recognise that having the time and tools to develop good workforce plans and processes is critical to providers’ management of workforce pressures. To support providers’ workforce planning further, we intend to feed insights from the analysis behind this document into our work to support providers. This work may include:

- developing measures of good practice in workforce planning. These measures will support trust boards’ in their oversight and challenge role
- publishing case studies highlighting good practice and lessons learned in workforce development and culture
- giving NHS providers better access to available improvement planning tools and guidance, including workforce planning tools. We have identified several such tools, including those available from NHS Employers⁴⁵ and those in the strategy development toolkit⁴⁶ developed by us in 2014.

We are committed to helping providers improve their productivity, which will help curb the rate of increase in their demand for nurses and doctors in areas of shortage. To support this, we have made the Reference Cost Benchmarking Tool available to NHS trusts and foundation trusts. This allows providers to compare their costs with those of similar NHS providers and identify any areas of outlying cost that they need to work on. In October 2015, we published a report on opportunities to improve productivity in elective care, which was co-developed with hospital clinicians, directors and operational managers from eight NHS providers and with the Royal College of Ophthalmologists and the British Orthopaedic Association.⁴⁷

⁴⁵ See, for example, those provided by NHS Employers – www.nhsemployers.org/case-studies-and-resources

⁴⁶ www.gov.uk/government/uploads/system/uploads/attachment_data/file/365275/Strategy_development_toolkit_Strategic_workforce_planning_tool_20102014.pdf

⁴⁷ www.monitor.gov.uk/guidance/improving-productivity-in-elective-care

The Carter Review⁴⁸ is helping providers to benchmark their performance against that of peers in specific areas, and then examine in detail areas for improvement, including workforce productivity.

4.2. National actions to support local responses

We recognise that local providers' actions cannot solve all the workforce issues they face. We and our system partners are therefore working on several actions at a national level. These aim to support providers by increasing the national workforce supply, helping to moderate demand for staff in short supply, and improving the operation of the agency market.

Increasing workforce supply

- **Training liberalisation:** The government announced in the Spending Review plans to introduce new funding arrangements for nursing, midwifery and allied health students. These will replace grants and bursaries with standard student loans, to increase the supply of nurses and achieve a better balance between supply and demand in future.
- **International recruitment:** We submitted evidence to the Migration Advisory Committee (MAC) in September 2015 supporting the case for exempting nursing from restrictions on international recruitment, as well as wider evidence of nurse shortages across the NHS. In October 2015, those restrictions were relaxed: nurses were added to the Tier 2 shortage occupation list on an interim basis, with MAC due to publish a fuller review this month (February 2016).
- **Co-ordination of workforce plans and forecasts:** Providers have told us that workforce forecasts might understate true demand as they are often driven by financial controls. To address this, we have worked closely with partners, including NHS England and HEE, to improve the 2015/16 planning process with, for example, greater coherence between workforce plans and submissions.

Moderating workforce demand

- **Better assessment of the impact of policies on workforce:** To make sure providers can respond quickly and cost efficiently to new policies and standards, the impact of these on workforce and provider costs should be accurately assessed before their introduction. In light of this, we will be taking account of labour market implications as we assess new staffing guidelines.

⁴⁸ See, for example, *Review of operational productivity in NHS providers – interim report* (June 2015) – www.gov.uk/government/uploads/system/uploads/attachment_data/file/434202/carter-interim-report.pdf

- **Ensuring the best use of the workforce:** The Carter Review has found that many parts of the NHS use their workforce efficiently, but practice across the sector is highly variable. Building on this work, together with the Department of Health we are developing measures of ‘unit labour costs’. These will help providers identify in-year how well they are utilising their workforce to provide healthcare, so they can understand what drives their overall workforce efficiency and make comparisons with their peers.

Improving the operation of the agency market

- **Agency price controls:** We are taking action to reduce providers’ agency costs,⁴⁹ including capping agency spend and rates, and mandating use of approved frameworks.⁵⁰ Our Agency Intensive Support Team is helping some providers to improve their use of agency staff.
- **Further research on the agency market:** We will continue our work to understand and monitor the impact of our policies on agency caps, and shed light on the agency market and the impact of current agency practices on providers.

We recognise that workforce challenges cannot be resolved overnight because it takes time to train new nurses and doctors. However, providers can continue to make improvements at a local level. Our role is to support local providers in this complicated area and to help resolve some of the difficulties they face at the national level.

⁴⁹ www.gov.uk/guidance/rules-for-all-agency-staff-working-in-the-nhs

⁵⁰ A framework agreement is an agreement with providers that sets out terms and conditions under which agreements for specific purchases (eg to hire an agency worker) can be made throughout the term of the agreement.



Improvement

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From 1 April 2016 NHS Improvement will be the operational name for the organisation that brings together Monitor, the NHS Trust Development Authority plus groups from three other organisations: from NHS England both the Patient Safety Team and the Advancing Change Team, from NHS Interim Management and Support two Intensive Support Teams, together with the National Reporting and Learning System.

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