1. Executive Summary

This paper summarises Independent Clinical Services’ (ICS’s) response to the agency staff price cap proposals made by Monitor and the Trust Development Agency (TDA). ICS has serious concerns about the likely impact of these proposals. In summary:

- The proposed price caps will exacerbate staff shortages in the NHS. Agency staff anticipate reducing the number of shifts they work by half to three quarters if the proposed caps are implemented. On top of this, significant numbers of permanent NHS staff who top up their income through agency work anticipate leaving their NHS jobs.

- The lack of staff willing to work at capped prices will drive NHS trusts into using the ‘break glass’ provisions. Due to their last-minute nature, appointing staff under ‘break glass’ provisions will incur higher prices. Operating outside existing framework agreements, Trusts will not have assurance on quality of temporary staff and care quality risks for patients will increase.

- The cost to the NHS of administering the proposed price cap rules will be very high. Conservative assumptions, suggest administering these rules could cost Trusts in the region of £100 million a year.

- Alternatives to price caps will be more effective in reducing expenditure on agency staff, without risking patient care resulting from staff shortages and quality. Partnerships between staffing agencies and NHS Trusts are proven to deliver improved management of temporary staffing and major cost savings.

2. Monitor’s assessment of the impact of price caps lacks any evidential basis for predicting how agency staff will respond. Further, there is no assessment of how proposed caps will impact on staffing agencies, which play a vital role in matching temporary staff to vacancies.

3. A realistic assessment of the likely effect of the proposed caps is provided by an independent survey conducted by ZPB Associates of around 3,600 clinicians registered with ICS agencies, including 1,960 nurses, 978 allied health professionals (AHPs) and 675 doctors. Key points are:

- The Government should not expect planned price caps to cause agency staff to return to NHS employment. One reason is that nearly half of agency nurses and locum doctors (45% and 39% respectively) are already NHS employees. Agency work is being used by NHS employees to top up income.

- Over half of agency staff that are not NHS employees (63% of nurses, 65% of doctors, 55% of AHPs) work through an agency because of flexibility. Cutting pay will not encourage their return to the NHS; they will still need flexible working arrangements that NHS permanent positions have not been able to provide to look after children, care for relatives or pursue other interests.

- More than half of agency nurses (54%) and AHPs (53%), and around three quarters of locum doctors (74%), will work fewer shifts, pursue work outside England, or change career. If the proposed caps are implemented, very few agency staff (13% of nurses and 2% of doctors) anticipate working more shifts.

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1 For ease of reference, this submission refers to Monitor and the Trust Development Agency collectively in this paper as ‘Monitor’.
• The number of shifts that agency staff will work will decline by half to three quarters if agency staff are paid lower capped rates. Further, the NHS will also lose the contribution of permanent staff working additional shifts through agencies who, as a result of the caps, choose to pursue careers outside the NHS in England. This could increase the total number of shifts lost to the NHS as a result of these proposals by 40% for nurses and 80% for doctors.

• The effect of fewer shifts and placements, worked by agency staff will be particularly felt by Trusts in more remote locations. Around 28% of AHPs, and 41% of those locum doctors that primarily work through placements, lived away from home for their most recent placement. However, only half this amount (13% of AHPs and 20% of doctors) would be willing to take a placement that involved living away from home under the proposed price caps, given that travel and accommodation costs would no longer be covered.  

4. **Staffing agencies play a vital role in matching clinical staff with temporary vacancies, and providing a flexible workforce that NHS trusts can switch on and off as demand fluctuates.** Further, the quality standards that ICS, and other agencies, adhere to mean that trusts can rely on agencies to provide the high quality temporary clinical staff necessary to deliver a high standard of patient care.

• The Government has chosen not to recognise this and characterised the industry as ‘ripping off’ the NHS. Monitor’s impact assessment provides no supporting evidence; on the contrary, the large number of agencies serving the NHS, and small market shares, evidence a highly competitive market.

• Proposed price caps are not sufficient for ICS and other agencies to cover the costs necessary to deliver high quality services. For example, in line with framework contracts, agencies currently carry out more than 20 separate checks before a nurse is available for temporary work in the NHS. This quality assurance will simply be unaffordable and trusts will be left in a position where agency staff cannot be assured to the existing high standard resulting in increased risks for patients.

5. **In summary, if the proposed price caps are implemented, many clinicians will no longer be willing to work on a temporary basis, and agencies will no longer be able to serve the NHS with the same level of quality assurance. The result would be significant staff shortages, much less efficient matching of temporary staff with vacancies (exacerbating the effect of these shortages), and a much reduced degree of quality assurance in relation to those temporary staff supplied.**

6. In any event, ICS has considerable doubts about whether the proposed agency price caps can even be effectively implemented on a sustainable basis.

• **It is not clear that current framework agreements can be amended to incorporate the proposed price caps.** These agreements contain strict controls on how prices are set. They do not contain clauses that would enable NHS bodies to lower prices unilaterally in the manner Monitor’s proposal suggests. But, if price caps are implemented outside of these frameworks, future appointments of temporary staff will take place in the absence of existing quality assurance arrangements.

• **Further, given clinicians’ lack of willingness to work at the reduced rates, ICS anticipates that NHS trusts will have to use the ‘break glass’ provision much more frequently than anticipated in Monitor’s impact assessment.** There is, however, no contractual framework for the appointment of temporary workers under the ‘break glass’ provisions. This means that prices can be expected to gravitate to at least current levels, and most likely higher prices, because a greater proportion of transactions will take place at the last minute, given the rules proposed by Monitor. These transactions will also take place outside the quality assurance arrangements that are embedded in the existing framework contracts.

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1 This can be expected to increase inequalities in access for the populations living in these areas, which should be taken into account in Monitor’s equalities impact assessment.
• Lasting damage to the supply of the workforce can be anticipated if significant numbers of clinicians working through agencies, including permanent NHS employees, decide to pursue career paths outside the NHS, as our survey data indicates is likely to be the case.

• Managers at NHS trusts will be put in an invidious position and will – prior to using the ‘break glass’ provisions – be forced to choose agencies that cannot possibly meet quality and safety standards for agency staff under the proposed price caps.

• For these reasons, ICS believes that the agency price cap proposals can be expected to lead to increased patient care risks, and increased staffing costs, for the NHS.

7. **In conclusion, there are major gaps and shortcomings in Monitor’s analysis of the impact of the planned agency price caps.** These gaps relate to both the direct effect of its proposals on agency staff, and the effect of its proposals on the ability of agencies to supply high quality temporary staff to NHS trusts.

8. **The four week period for consultation has been manifestly inadequate to permit a full response to be made.** Monitor has refused to agree to an extension despite accepting that no assessment of the impact on agencies was carried out appears to have proceeded on the assumption that it is irrelevant, and does not even need to be assessed.

• Without understanding the full impact of its proposals, it is simply not possible for Monitor to make a rational, informed decision regarding agency price caps, or to ensure that its proposals are proportionate and rationally connected to their aim, as the law requires.

9. **There are good reasons to expect that the outcome from the proposed price caps will be radically different to those anticipated by Monitor.** ICS expects the proposals, if implemented, to lead to increased patient care risks and increased staffing costs for the NHS. We fail to see how the implementation of such a proposal would be consistent with Monitor’s obligation to act in the best interests of patients.

• ICS’s views on the likely implementation path for the proposed agency price caps are informed by its knowledge and experience of the last time, in 2006, that the Government sought to reduce agency spending. While the NHS was able to reduce spending on agency nurses, the subsequent increase in waiting lists for elective surgery resulted in various waiting list ‘initiatives’, which increased demand for agency nurses once more, and overall spending and pay rates returned to previous levels.

10. **Despite serious concerns in relation to the proposed agency price caps, ICS agrees that action should be taken to address existing levels of expenditure on agency staffing.**

• ICS believes that this would be best achieved by channelling demand for temporary staff in the NHS through the existing framework contracts, where staff rates and agency fees have been set through transparent market processes, often involving bids from more than 100 suppliers, and clinical quality safeguards have been agreed.

11. **Additionally, ICS’s experience is that structured partnerships with NHS Trusts, can deliver improved management of staff banks, recruitment processes, workforce planning and internal controls and realise significant cost savings.** (These partnerships can take the form of outsourced management of NHS trust staff banks, or master vendor arrangements with ICS as a lead agency delivering supply chain management.)

12. **Given the alternatives available for reducing NHS expenditure on agency staff, ICS is concerned that the imposition of agency price caps is a completely disproportionate, as well as ineffective, solution.**

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3 Adapting such a disproportionate measure would be contrary to the obligations placed on Monitor under EU law by Article 56 of the Treaty on the Functioning of the European Union (TFEU), and Article 4 of Directive 2008/104/EC on Temporary Agency Work, which require that restrictions on the supply or use of temporary agency workers be justified – requiring that they are rationally connected to a legitimate objective and that the interference they caused is proportionate to the objective sought to be achieved. In the case of the Temporary Agency Work directive, the objective must relate to the protection of temporary agency workers, the requirements of health and safety at work or the need to ensure that the labour market functions properly and abuses are prevented. There is no sustainable basis for any allegation of market abuse.
2. **Overview of ICS**

13. ICS is a leading provider of health, life sciences and social care staffing and services to the UK health sector. It has more than 1,700 employees in 38 locations across the UK, more than 30,000 candidates across health, life sciences and social care, and fills approximately 500,000 agency shifts annually at NHS trusts.\(^4\)

14. ICS operates in four market segments: (i) provision of staff to the NHS and private sector for temporary and permanent jobs; (ii) managed staffing solutions and outsourced banks for NHS trusts; (iii) care and nursing support to people with complex conditions at home; and (iv) managed health services.

15. ICS-owned agencies include Pulse, Thornbury, Maxxima, Asclepius and Hobson Prior. Temporary and permanent staff supplied cover all major health and social care disciplines. ICS also owns Bank Partners, the leading independent provider of bank management services to the NHS which has a strong reputation for reducing overall agency spend whilst providing high quality staff.

3. **Overview of agency staffing**

3.1 **NHS Trusts’ use of agency staff**

16. Agency staff are used by NHS trusts to fill workforce vacancies that come about through temporary absence (e.g. illness, holidays etc) or where a permanent appointment has not yet been made. Agency staff are generally called on when a trust has not been able to cover the vacancy through the overtime or its staff bank.\(^5\) Agency workers fill either individual shifts or longer-term vacancies, which may be of several weeks or months duration. Agency staff are also used as a way of flexing workforce up or down in response to fluctuations in demand (e.g. in A&E) as a more efficient way of managing demand fluctuations than maintaining a permanent workforce that is sized for peak demand.

17. Staff banks include both permanent employees looking to work additional shifts, and non-employees that have registered with the trust’s bank for temporary work. An NHS trust may manage its own bank, or appoint a third party to take on this role. Outsourced staff bank managers will generally be responsible for filling all temporary vacancies at an NHS trust using both bank staff and staff sourced from agencies.\(^6\)

3.2 **Framework and non-framework purchasing of staffing agency services**

18. Agency staff are usually retained by an NHS trust under the terms of a framework agreement, which sets out conditions (e.g. pricing) under which a staffing agency will supply staff. Alternatively, where an NHS trust (i) has found that it is not possible to locate a suitable worker via a framework agency; or (ii) the last-minute or specialist nature of the request means that a framework agency will not be able to supply candidates, the trust may reach an agreement with an agency for the supply of staff outside of the terms of a framework agreement.\(^7\) Where a trust purchases outside a framework agreement, the terms under which temporary staff will be supplied are agreed at the time a booking is made.\(^8\)

19. The number of agency staffing frameworks has increased significantly in recent years. In the past, there was a single national framework operated by the former NHS Purchasing and Supplies Agency (PASA). Now, however, there are many different framework agreements operated by the Crown Commercial Service.

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\(^4\) This compares with around 844,000 shifts for doctors and nurses that were filled by NHSP in the one year period reviewed by Monitor (see Annex 2 of Price caps for agency staff: impact assessment).

\(^5\) Overtime policies vary between Trusts, with some Trusts directing all overtime through their staff bank, while others make greater use of paid and unpaid overtime outside of their staff bank.

\(^6\) NHSP is the largest outsourced manager of NHS trust staff banks, and works with around 60 NHS trusts. Bank Partners is the second largest outsourced manager of NHS trust staff banks, and works with seven NHS trusts.

\(^7\) Agency workers that are willing to get called out at short notice demand higher payments, and agencies serving this part of the market incur higher costs in locating and making staff available. Prices agreed under framework agreements are not generally sufficient to cover these costs.

\(^8\) In some cases, an NHS trust may directly contract with temporary staff outside the services of a staffing agency.
(CCS), Health Trust Europe (HTE) and the London Procurement Partnership (LPP). There are also other regional frameworks operated by purchasing hubs and other NHS procurement bodies.

20. The proliferation of frameworks has imposed additional costs on agencies due to the need to go through lengthy and complex bidding arrangements and the need to comply with the different requirements in relation to staff checks and so on. This, in turn, increases costs for NHS trusts as these costs need to be reflected in the prices charged by agencies.\(^9\)

21. Quality assurance of temporary clinical staff supplied by agencies is provided for through these frameworks. The assurance process encompasses numerous checks that an agency must carry out when registering a clinician for placement through their agency (and periodically re-check thereafter).

22. While expensive to operate, this process ensures that NHS trusts can have confidence in the staff sourced through staffing agencies that operate under framework.\(^10\) However this is more expensive than it needs to be as a result of the different assurance processes that apply and the costs of ensuring compliance with multiple different processes.

23. It is not clear that these framework agreements can be altered to accommodate Monitor’s price cap proposals as they contain strict controls on how prices are to be set, and do not contain clauses that would enable NHS bodies to lower prices unilaterally in the manner Monitor’s proposal suggests. It is doubtful whether the implementation timetable set out in the consultation is achievable. Further, the cost of the quality assurance processes that are embedded in these frameworks will simply not be affordable under the proposed price caps.

3.3 Staffing agencies serving the NHS

24. Agencies play a vital role in supplying clinical staff to fill temporary vacancies, providing a flexible workforce that NHS trusts can switch on and off as demand fluctuates. The quality standards that ICS, and other agencies, adhere to mean NHS trusts can rely on agencies to provide the high quality temporary staff necessary to deliver a high standard of patient care. It is disappointing that the Government has chosen not to recognise this role, but has instead sought to characterise the industry as ‘ripping off’ the NHS.

25. A large number of agencies supply the NHS with temporary clinical staff. Evidence of this is the number of agencies admitted to the different framework contracts. Purchasing through frameworks can take the form of mini-competitions, or other rankings of providers to allow NHS Trusts to source agency staff from those agencies offering the most competitive terms.

26. The large number of agencies and the low market share of each is not consistent with a view that agencies possess market power. It is erroneous to conclude that the price of agency staff is being driven by agencies exercising market power. Monitor’s consultation documents, however, conflate: (a) the fact that there is a currently a shortage of supply to meet the demand for clinical staff – driving up prices in accordance with normal market dynamics, with (b) its unsupported suggestion that high prices result from the exercise of market power by agencies.

27. Monitor’s impact assessment provides no evidence in support of the view that agencies possess market power. On the contrary, the large number of agencies serving the NHS, and their small market shares, are evidence of a highly competitive market. Still less is there any evidence of abuse of market power.

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\(^9\) Charging arrangements by framework owners can also result in greater costs for the NHS where payments need to be made to multiple framework owners for their use. These costs are ultimately borne by the NHS.

\(^10\) Thornbury Nursing, owned by ICS, specialises in the provision of urgent and last-minute nursing staff, and as a consequence, can only operate sustainably by working outside of existing framework agreements. However, Thornbury chooses to apply stringent quality checks to the staff that it supplies, and for this reason it is often the staffing agency of choice for NHS Trusts that must fill a last-minute vacancy who know that they can have confidence in the quality of staff that Thornbury will supply. Evidence of Thornbury’s quality is independently verified by Neuven Audit Solutions, an independent auditor of staffing agencies compliance with framework quality standards. Thornbury’s most recent audit showed that it had achieved 100% compliance with relevant quality standards.
3.4 Agency staff: key characteristics

28. Data is drawn, primarily, from an independent survey of 3,613 agency staff registered with ICS (including 1,960 nurses, 978 AHPs & 675 doctors) carried out by ZPB Associates in October 2015 (2015 survey). It also draws on a survey of agency staff registered with ICS in 2014 (2014 survey).

Agency staff: permanent employment, multiple agencies and NHS staff banks

29. Agency work is being used by significant numbers of NHS employees to top up income. Nearly half of agency nurses and doctors (45% and 39% respectively) are permanent NHS employees. Approximately 29% of agency nurses have full-time NHS positions, a further 17% have part-time positions. Similarly, 33% of locum doctors have full-time NHS positions, and a further 6% have part-time positions.

30. Monitor stated that one of its goals is to encourage agency staff to return to permanent NHS employment.\(^\text{11}\) However, many agency staff are NHS employees already. ICS is concerned that proposals are based on the false premise that agency staff mainly work through agencies.

Figure 1: Agency staff with permanent positions in the NHS

31. The prevalence of permanent NHS employees among agency staff means that any impact assessment needs to take account of the supply of temporary labour by agency staff, but also permanent labour. That is, cutting agency pay will reduce household income for permanent NHS employees that are also agency staff, and may result in choices being made that affect both their temporary and permanent employment.

32. There is no sign of this effect having been considered in Monitor’s impact assessment, which is consistent with our observation that proposals appear to be based on the false premise that agency staff mainly work through agencies and are not NHS employees.

\(^{11}\) See Price caps for agency staff: proposed rules and consultation, paragraph 1.10.
Most agency staff are registered with more than one agency (including 71% of doctors, 68% of AHPs and 49% of nurses). Substantial numbers of agency staff report registering with a new staffing agency for higher pay (36% of doctors, 37% of nurses and 87% of AHPs).

This result is consistent with agencies lacking market power. Agency staff can choose between those agencies which they are already registered with, or can move to new agencies relatively easily. That is, there is little capacity for agencies to achieve higher prices from customers, without passing these higher prices onto agency staff.

Only a small proportion of agency staff are registered with NHS banks (35% of nurses and 28% of doctors). Less than 20% of agency nurses and doctors are registered with NHS Professionals (according to the 2014 survey). The small proportion of agency staff that are registered with ICS and NHSP poses questions about the representativeness of the data which Monitor has sourced from NHSP for its impact assessment.
Agency staffs’ reasons for working through a staffing agency

36. Agency staff with permanent positions as NHS employees mostly work through an agency due to the higher rates of pay compared with shifts through a bank (64% of nurses and 50% of doctors). Around 20-30% of nurses and doctors with permanent positions, however, report that their motivation for agency work is a desire to work their extra shifts at a different location or gain experience in different areas.

Figure 5: What is the main reason you work through a staffing agency?

Figure 6: What is the main reason you work through a staffing agency?

37. Agency staff without permanent positions at NHS trusts cite the flexibility of agency work as a key driver for their decision to work through an agency. This includes around two thirds of nurses (63%) and doctors (65%) and half of AHPs (55%). For nurses, a significant proportion of this need for flexibility is driven by childcare requirements. Around 20% of nurses say that flexibility for childcare is their main reason for working through an agency.

38. Price caps are unlikely to result in these agency staff returning to permanent NHS employment (as per Monitor’s stated objective for agency staff price caps). This is because these staff will still require the flexibility that permanent jobs in the NHS have not been able to provide.
Figure 7: What is the main reason you work through a staffing agency?

Nurses without a permanent position at an NHS Trust

Figure 8: What is the main reason you work through a staffing agency?

Doctors without a permanent NHS position

Figure 9: What is the main reason you work through a staffing agency?

Allied Health Professionals
39. When working through an agency, the location of a placement is – according to agency staff – the most important factor in choosing between placement options. This is followed by pay, knowledge of the place of employment and length of placement. The importance that agency staff put on the location of a placement is consistent with the findings in Section 4 regarding the willingness of agency staff to take placements in more distant locations under the proposed price caps.

Figure 10: If presented with more than one placement option, how do you decide which placement to fill?

Citizenship of other countries

40. Citizenship of other countries is widespread among agency staff. Around half of locum doctors (48%) and a third of the AHPs (31%) are citizens of a country other than (or in addition to) the UK.

41. Nearly 20% of locum doctors that are citizens of another country have citizenship in a EU country. Around a third of AHPs that are citizens of another country are from Australia and New Zealand. These figures are consistent with the number of agency staff saying they would work outside England if agency caps are implemented (see Section 4).
3.5 Current and proposed pay rates for agency staff

42. Under proposed caps, most agency staff face significant reductions in their hourly rate of pay. The size of agency staff pay reductions, and how this varies across staff groups, is important to understanding how agency staff are likely to respond to the proposed caps.\(^\text{12}\)

43. ICS estimates that its agency staff working through frameworks would have their hourly rate of pay reduced by up to 50% where the 55% maximum uplift is introduced.\(^\text{13}\) Critical care nurses face a significantly greater pay reduction than general nurses due to the higher rates of pay that currently prevail for these nurses given their greater scarcity.

44. Monitor’s price cap proposals state that the “55% uplift has been calculated to approximate to the non-pay benefits and costs of substantive staff, including employer pension contribution and national insurance, administration fee etc”.\(^\text{14}\)

45. Details of Monitor’s calculations are not set out. Nevertheless, ICS’s calculations show that the total remuneration for agency staff, if receiving the same non-pay benefits as substantive NHS staff, would – for some workers – be greater than they currently receive under existing framework agreements (where, for example, agency staff do not receive the same generous pension entitlements as permanent NHS staff). That is, the incentive for some NHS staff to become agency workers could actually increase under the price cap proposals if agency workers receive the same non-pay benefits as permanent NHS employees.

46. At the same time, if agency staff received the same benefits as permanent NHS employees under the price cap then the margin available for the staffing agency would be squeezed to the point where ICS would not be able to cover its operating costs. That is, the proposed 55% uplift is not sufficient to pay agency staff at the same rate as NHS staff, including associated non-pay benefits such as pension, sick and holiday pay, and cover ICS’s costs. ICS’s operating costs – as well as including the cost of matching agency staff to vacancies – also include the significant quality assurance processes embedded in framework contracts that allow NHS Trusts to have confidence in the quality of agency staff that ICS supplies.

47. Further, the proposed 55% uplift does not appear to make any allowance for the additional costs incurred by agency staff compared with permanent NHS employees, such as uniforms, professional registration fees, professional indemnity insurance, and the cost of travel and accommodation (where this is required for longer term placements). It also does not make any allowance for the risk that agency staff bear in terms of lost income due to work not being available or shifts being cancelled.

48. In summary, the cap is too low to pay agency staff the equivalent of a permanent NHS employee, including non-pay benefits, and cover the costs of operating a staffing agency.

4. Impact of proposed price caps on the supply of agency staff

49. This section assesses the impact of the proposed agency staff price caps on the availability (and cost) of staff for the NHS.

4.1 Response of agency staff if paid at proposed price cap levels

50. Agency staff were asked what action they would take if paid at the proposed price cap levels. Care was taken to put this question to respondents without biasing the results,\(^\text{15}\) and respondents were able to choose between several options as well as being able to specify other alternatives.\(^\text{16}\)

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\(^\text{12}\) We note that Monitor’s consultation documents do not contain any estimates of the size of the likely reductions in agency staff pay.
\(^\text{13}\) This assumes that none of the 55% maximum uplift is converted into agency staff remuneration.
\(^\text{14}\) See Price caps for agency staff: proposed rules and consultation, footnote 5 to para 5.1.
51. The survey shows that a substantial loss in the supply of clinicians to the NHS can be anticipated if agency staff are paid at the proposed price cap levels.

- Around 54% of nurses said they would change career, seek work outside England, or reduce agency shifts without increasing hours in permanent employment or bank shifts. This compares to the 13% of nurses that said they would increase the number of agency shifts that they work (to compensate for the loss of income). The number of nurses that anticipate shifting from agency employment to permanent positions or increased hours in permanent employment was less than 10%.

- The majority of doctors (53%) stated that they would work outside England and a further 21% of doctors said they were likely to change career or reduce agency work without increasing bank shifts or permanent hours. Only 7% said they would keep working the same hours as currently, and 2% said they would increase the number of agency shifts. The number of doctors anticipate shifting from agency employment to permanent positions or increased hours in permanent employment was around 6%.

- A much higher proportion of AHPs (around 23%) compared with nurses or doctors said that they would try to switch from agency to permanent employment. However, more than 50% anticipate actions, such as working outside of England, establishing private practices, retiring, or otherwise reducing time worked in the NHS.

**Figure 12: Response to being paid at proposed price cap levels - Nurses**

For example, the agency price cap scenario put to respondents was described neutrally, and the order of the options put to respondents was rotated across the sample. The survey was also administered by a third party, respondents were encouraged to answer questions openly and honestly, and assurances were provided that no respondent identifiable data would be shared with ICS.

Different options were provided to those doctors and nurses with permanent NHS positions compared with respondents that only work through an agency. For the purposes of this submission, the responses of all doctors and all nurses were aggregated.

The effect on doctors also needs to be considered in the light of the current junior doctors dispute, which is also likely to impact on junior doctors’ willingness to continue working for the NHS in England.
Based on these responses, we estimate that if agency staff are paid at the proposed price cap levels:

- the number of shifts worked by agency nurses will decline by around half; and
- the number of shifts worked by locum doctors will decline by nearly three quarters.

On top of this, the NHS will lose nurses and doctors that have permanent positions in the NHS, and choose to no longer work for the NHS as a result of reduced pay for their agency work. Based on the survey data, this could increase the number of shifts lost to the NHS by 40% for nurses and 80% for doctors. This is a major impact that appears not to have been considered at all in Monitor’s impact assessment.

If agency staff are paid at the proposed price cap levels, this will also impact on willingness to travel to more distant NHS trusts for temporary work. This is because the proposed agency staff price cap will no longer allow the cost of travel or accommodation to be paid by NHS trusts.

Around 28% of AHPs, and 41% of those locum doctors that primarily work through placements, lived away from home for their most recent placement. However, only half this amount (13% of AHPs and 20% of doctors) would be willing to take a placement that involve living away from home under the proposed price caps. This means that Trusts in more remote locations will be particularly affected by staff shortages to
which the proposed price caps are likely to give rise, increasing inequalities in access to services (which needs to be taken into account in Monitor’s equalities impact assessment).

56. In summary, the NHS is likely to suffer a significant decline in the supply of clinical labour if agency staff are paid at the proposed levels.

- The number of shifts that agency staff are willing to work is likely to decline by half to three quarters.
- The NHS will lose the contribution of those permanent staff that also work through agencies who choose to pursue careers outside the NHS in England. This could increase the total number of shifts lost to the NHS by 40% for agency nurses to 80% for locum doctors on top of the loss in agency shifts.
- Further, the number of agency staff willing to take placements that involve living away from home is likely to halve under the proposed price caps.

57. This conclusion, assumes that agency staff are paid at proposed price cap levels. But, the ‘break glass’ provisions in the proposed rules allow NHS trusts to pay agency staff at higher rates where patient safety is of concern. Given clinicians’ lack of willingness to work at the reduced rates on offer, ICS anticipates that NHS trusts will have to use the ‘break glass’ provision much more frequently than anticipated in Monitor’s impact assessment.

58. There is, however, no contractual framework for the appointment of temporary workers under the ‘break glass’ provisions. This means that prices can be expected to gravitate to at least current levels, and most likely higher prices, because a greater proportion of transactions will take place at the last minute, given the rules proposed by Monitor, which require exhaustive process before the ‘break glass’ option should be exercised.

59. If enough transactions end up going through the ‘break glass’ provisions, temporary staffing costs for the NHS will increase under the proposed price cap rather than decrease. Moreover, these transactions will take place outside existing quality assurance arrangements.

60. ICS’s views on the likely implementation path for the proposed agency price caps are informed by its knowledge and experience of the last time, in 2006, that the Government sought to reduce spending on agency staff by the NHS.

- In 2006, many NHS trusts were in financial deficit, and as part of the response, the Government sought to reduce spending on agency nurses. Rates of pay and the number of agency nurses employed by NHS trusts were significantly reduced.
- At this time, the supply of nurses was less constrained. More UK trained nurses were available and immigration and regulatory arrangements made it easier for overseas nurses to practice in the UK. Further, NHS trusts were under less pressure to maintain nursing numbers, compared with the current post-Francis environment.
- While the NHS was able to reduce spending on agency nurses, the subsequent increase in waiting lists for elective surgery resulted in various waiting list ‘initiatives’, which in turn increased demand for agency nurses once more, and overall spending and pay rates returned to the levels observed prior to this initiative.

61. In summary, the NHS was able to temporarily reduce pay rates and spending on agency nurses, but only at the cost of reducing activity and allowing waiting lists to increase. Given the pressure to maintain nursing

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18 A significant factor constraining the supply of nurses from countries such as Australia and New Zealand is the regulatory hurdles that these nurses face in practicing in the UK. This includes written and practical tests (including English language tests), the significant cost of obtaining the necessary permissions (around £1,700). While there have been some improvements to this system recently, the time required to go through this process is still lengthy, and ICS had no nurses from Australia or New Zealand obtaining their registration through its Pulse agency between February 2013 and May 2015.
numbers and the constrained supply of nurses, it is less clear that NHS will be able to achieve even a
temporary reduction in pay rates and spending on agency nurses under the proposed agency price caps.

4.2 Impact of proposed price caps on staffing agencies

62. Staffing agencies, as set out in Section 3, play a vital role in supplying clinical staff to fill temporary
vacancies, and providing a flexible workforce that NHS trusts can switch on and off as demand fluctuates.
The quality standards that ICS, and other agencies, adhere to mean that NHS trusts can rely on staffing
agencies to provide the high quality temporary clinical staff necessary to deliver a high standard of patient
care.

63. Without agencies, the market for temporary labour for the NHS would be considerably less efficient, with
shifts remaining unfilled as Trusts are unable to locate the necessary, qualified staff. This would exacerbate
the effect of any shortages that are induced by attempts to reduce the amount paid to agency staff.

Analysis of the impact of price caps on staffing agencies

64. The price cap proposed by Monitor is intended to include all charges in addition to worker pay, including
the payment of agency fees. As set out in Section 3, staffing agencies incur considerable costs in ensuring
compliance with the quality assurance processes that are laid down in the various framework agreements.

65. It is necessary for the agency fee that is chargeable under the proposed price cap to be sufficient to cover
the reasonable costs necessary to comply with these regulatory arrangements. If this is not the case, then
staffing agencies will no longer be able to operate sustainably while complying with these requirements.

66. ICS has considered the impact of the proposed agency price caps on its margins under three scenarios.

- First, agency staff are paid at Agenda for Change (AfC) rates and receive the same non-pay benefits as
substantive NHS staff. The remainder is then available for the agency margin.

- Second, agency staff are paid at Agenda for Change (AfC) rates, and the 55% uplift is used to cover
national insurance, pension contributions, sick pay and so on at existing rates for agency staff. The
remainder is then available for the agency margin.

- Third, agency staff remuneration is maintained at existing levels, including pay, pension contributions
and sick pay. The remainder, once national insurance and other costs are deducted, is then available
for the agency margin.

67. The difference between the second and third scenario is that under the second scenario, the full effect of
the agency staff price cap is passed on to agency staff. However, under the second scenario, bargaining
between agency staff and staffing agencies results in agency staff mitigating the effect of the agency price
cap, and the cost of the price cap is borne by staffing agencies.

68. None of these scenarios is affordable from a staffing agency perspective. Staffing agencies would incur
considerable losses on the placement of most staff, and where some positive margin, in theory, remained
for some staff placements, staffing agencies would be unable to cover their fixed costs, let alone cover their
cost of capital.

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19 “The cap would apply to the total charge and therefore would include: worker pay; holiday pay; employer national insurance; employer
pension contribution; administration fee / agency charge; and any other fixed or variable fees or payments (e.g. travel, accommodation,
finder’s fee, bonuses). ... other sums could not be paid in lieu to agency workers or to agencies” (paragraph 4.2, Price caps for agency staff:
proposed rules and consultation); and “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” (paragraph 30, Price caps for agency staff: impact assessment).
69. The only way that agencies will be able to continue to operate under the proposed price caps is to provide services under the ‘break glass’ provisions, where prices are not regulated, and there is no quality assurance process in relation to the provision of agency staff as agencies would be operating outside existing framework contracts.

70. ICS does not believe that this is a desirable outcome from the perspective of staffing agencies that serve the NHS. Further, it does not see how such an outcome, which would severely constrain agencies’ ability to supply the staff necessary to fill temporary vacancies in the NHS could rationally be thought to be in the interests of patients or healthcare providers.

Monitor’s obligations to assess the impact on staffing agencies’ ability to supply temporary labour to the NHS

71. Monitor has not carried out any analysis of the likely effect of its proposals on staffing agencies, and has stated that it is not obliged to carry out any such analysis under the provisions of s.69 of the Health & Social Care Act.20

72. We do not agree that this is the correct interpretation of Monitor’s legal obligations, and as set out above, it also ignores a factor that is key to assessing whether the proposed price caps will achieve their intended objective.

73. Monitor has obligations to consider: (a) how its proposals will affect staffing agencies directly; and (b) how its proposals will affect the provision of healthcare staff to the NHS by virtue of their impact on staffing agencies ability to supply these staff.

74. There are at least four provisions of Sections 62 and 66 of the Health & Social Care Act that are relevant.

75. Monitor, as a public sector body, should also be acting consistently with the requirements for better regulation, as set out in the Better Regulation Framework Manual, given that the proposed agency price caps represent such a significant regulatory measure.21 Monitor, however, has openly stated that it has not considered the impact of the proposed agency staff price caps on staffing agencies. This is clearly inconsistent with the obligation to make a robust and compelling case for agency staff price caps given the costs that will be imposed on staffing agencies.

76. The result is that Monitor’s proposals for agency staff price caps are incompatible with EU law.

20 This requires that an impact assessment by Monitor 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.

77. It is simply incorrect to suggest, as Monitor has, that it has no obligation to assess the impact of the proposed agency staff price caps on staffing agencies, and their ability to continue supplying high quality, temporary staff to the NHS.

5. Administrative costs for NHS Trusts of proposed price cap rules

- Monitor’s proposals represent the imposition of a significant new administrative burden on NHS trusts stating that: “All trusts (even foundation trusts not in breach of their license conditions) would be required to report at shift level detail any payments in excess of the price caps and explain why these were necessary in their reporting returns.

- “Overrides reported at shift level in monitoring returns would need to be signed off by a relevant board member, (e.g. finance/medical/nursing/HR director).”

78. For example, at one major Trust that ICS works with, there were approximately 208,000 agency shifts in the past 12 months. Assuming that just 30% of these shifts involve the use of the ‘break glass’ provisions (which is consistent with Monitor’s analysis), then a total of 62,000 agency shifts would require the reporting process set out above. Assuming that each report takes 10 minutes for the shift manager to fill out, and that a further 10 minutes is required for the more senior sign off process within the Trust, then the total cost of each sign off may be in the region of £19.50. This would result in a total cost of around £1.2 million for this Trust alone.

79. The example of the Trust set out above is for one of the larger NHS trusts, however even taking a conservative approach, total administrative costs for the NHS of these rules could be in the order of £100 million. As a result, it seems quite possible that the administrative costs will outweigh any of the potential cost savings achievable from this proposal.

6. Alternative approaches to controlling NHS expenditure on temporary staff

80. Monitor’s proposals for agency staff price caps are not based on an evaluation of a range of alternative measures, which supports a conclusion that agency staff price caps are the best way to achieve the overall objective of reducing NHS expenditure on temporary staff.

81. Monitor is aware of Trusts that have achieved success in managing the cost of temporary staff. It provides no analysis of why these examples would, or would not, be transferable to other providers. Rather, it is selecting an option (i.e. agency staff price caps) where there is no experience of it working in practice, compared to other options where success has clearly been achieved.

82. ICS believes that agency costs could be reduced through several measures, including:

- streamlining framework purchasing arrangements such that administrative costs for NHS trusts and agencies are minimised;
- making it easier for overseas nurses from countries such as Australia and New Zealand to practice in the UK by reviewing regulatory barriers to them working in the UK;
- increasing the flexibility of working arrangements offered by NHS trusts so that nurses and other clinicians are not forced to leave permanent NHS employment to achieve the working arrangements that allow them to look after their children or other family members;
- better management of NHS Trust staff banks; and
- managed service agency solutions.

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22 This is based on 10 minutes of a Band 7 manager filling out the required information at £24.04 per hour (including pay and on-costs) and 10 minutes of an Executive Director at £93.10 per hour (based on a £120,000 per annum salary and associated on-costs).
6.1 Improved management of NHS staff banks

ICS has found, through its Bank Partners business, that better management of NHS staff banks can deliver substantial savings to NHS trusts through understanding demand patterns, deploying technology, increasing bank fill rates and improving and controlling agency supply. There are five key areas where action can minimise agency spend:

- **Workforce vacancies**: Bank Partners’ experience is that over half of temporary staff requests cover outstanding vacancies for full time positions. For each client Bank Partners invests in recruiters, reducing the time to hire of qualified workers to around 28 days.

- **Investment in an effective staff bank**: Bank Partners provides a high touch service that operates 24/7 with on-site bank teams working closely at ward level, assisted by data from systems and management information to deliver the right flexible staffing strategies.

- **Optimising systems and processes**: Bank Partners integrates e-rostering systems with existing bank management software allowing end to end visibility of both the request and fulfilment and ensures each worker has remote access to view and book shifts which is both easier and more efficient.

- **Improving agency management**: Bank Partners generates cost efficiencies and improvements for NHS trusts through agency reduction and improved bank fill rates. By planning ahead, Bank Partners maximises fill rates and reduces the number of shifts issued to agencies, therefore reducing spend.

- **Strategic use of flexible staff**: Bank Partners work at ward, department and directorate level to identify vacancy requirements in advance and agree the most cost effective solution to fill them. Flexible staffing can be more strategically planned when a trust assigns a Head of Temporary Staffing to interface with the bank.

At NHS Trusts that ICS has worked with, through Bank Partners, bank fill rates have grown by around 80%, and this has translated into cost avoidance of more than £1 million per month across the seven clients that ICS works with.