Agency staff in the NHS

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Introduction

The quality of care and safety of patients in NHS hospitals depend on having an adequate number of skilled healthcare professionals. Growing shortages of qualified clinical and non-clinical staff have led to increasing reliance on agency staff to resolve staffing shortfalls and ensure safe staffing numbers. This has engendered a rapid growth in agency expenditure, and contributed to deficits in hospital budgets (King's Fund, 2015a).

To reverse the ongoing trend, Monitor and the NHS Trust Development Authority (now combined to form NHS Improvement) introduced a cap on the hourly rates paid to the agencies. Introduced in November 2015, a cap was initially set for nurses; since 1 April 2016 it has applied to all categories of staff (Monitor, 2015a). The main objective of the policy was to bring payments made to the agency staff closer to the salaries of NHS payroll staff and so reduce NHS expenditure.

As seen in the figure below, agency expenditure has rapidly increased in recent years, both in absolute terms and as a proportion of total staff expenditure. It totalled around £3.3bn in 2014/15 before the cap was in place, and £3.6bn in 2015/16, when the cap was partially in place (NHS Improvement, 2016).

The estimates by Monitor show that of the £3.3bn spent in 2014/15, around £0.7 billion (21%) was a premium paid for agency staff over the equivalent pay and other costs (NI contribution, pension) for staff on the NHS payroll (Monitor, 2015b). This premium payment corresponds to around 0.6 per cent of the total healthcare budget (NHS England, 2016) and is considered one of the largest areas of inefficiencies in the NHS (Lord Carter, 2015).

The role of the cap was to reduce agency profit and rebalance the incentive for people to accept permanent NHS contracts rather than taking agency work. For a critical evaluation of the new policy, we need first to gain an understanding of the root of hospitals' ever-growing reliance on the use of agency staff.

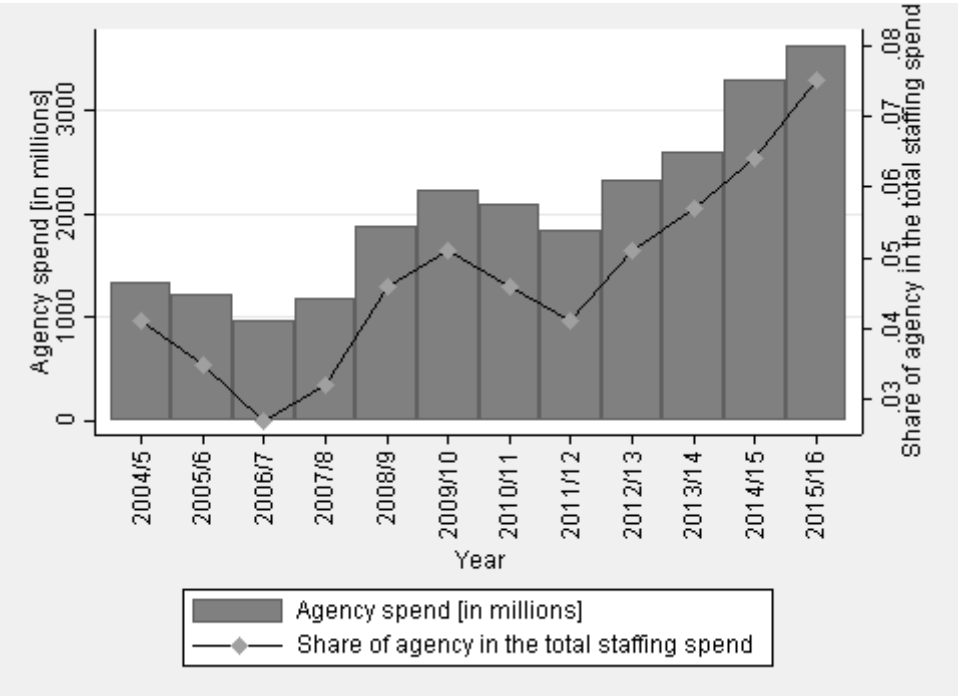

Figure 1: Agency spend over time

Factors driving demand for staff

Three principal factors have driven increased demand for staff. The first is that more patients are being treated. According to the recent report on NHS productivity, there was an increase of 8 per cent in the total NHS activity[1] between 2010/11 and 2013/14 (Bojke, 2016). The number of hospital admissions[2] grew by over 0.6 million in the same period, while the number of outpatient appointments increased by 7.8 million in just two years, from 2011/12 to 2013/14.[3] We can observe similar positive growth trends in other settings - for example, mental health, community care and specialised services - while A&E demand is at an all-time high (Vize, 2016). Growth in the population is partially responsible for the increase in hospital activity, although in recent years the number of admissions has grown at a higher rate than the population (King's Fund 2015b).

The second factor is that there has also been a shift in the case mix of patients: they are becoming older and their health conditions more severe. The average age for inpatients increased from 54.9 in 2010/11 to 56.3 in 2013/14 (Bojke, 2016) and care for people with long-term health conditions absorbs 70 per cent of the health service budget (NHS England, 2014). So changes in both the number of patients treated and in their case mix drive the need for more qualified staff.

The third, more recent factor, that contributes to increasing staff demand is the change in recommended staffing levels, following the publication of the Francis Report in February 2013 (Quality Commission, 2013).

This Francis report was commissioned to examine the causes of the serious failings in care at mid-Staffordshire NHS Foundation Trust between 2005 and 2009. The Report gives 290 recommendations, with major implications for all levels of the health service across England. One recommendation was to create tools to establish the safe staffing needs for each service. The National Institute for Health and Care Excellence (NICE) then started to develop safe staffing guidelines for hospital wards. While the NICE guidance did not specify a staff-to-patient ratio, it implied an increased risk of harm for patients if a nurse regularly had to care for more than eight patients on a ward during a shift (Monitor, 2015a). Development of the staffing guidelines was subsequently stopped, possibly to help tackle the trusts' growing financial problems (Siddique, 2015).

Changes in the workforce

The number of employees working for the NHS has not increased at the pace required to meet the demands driven by the factors identified above. According to the NHS Digital (2016), the total number of NHS staff increased only by 3,660 FTE (0.36%) from 2010/11 to 2015/16. In fact, there were noticeable drops in 2011/12 and 2012/13 due to cuts to the NHS budget and the pressure to reduce the staffing costs (Buchan & Seccombe, 2012).

The increase in the number of clinical staff is somewhat larger (17,805 FTE or 3.32%), with the highest growth in the number of doctors (7,791 or 8.09%). Somewhat surprisingly, the rise in the number of nurses was very modest, with only 2,275 nurses (FTE) more in 2015/16 than in 2010/11, representing a growth of only 0.81 per cent.

Bojke (2016) identifies that the labour index, calculated as a wage-weighted growth index, increased by 12 per cent from 2004/5 to 2013/14, while at the same time, NHS output rose by 42 per cent (see Figure 3). Looking only at 2010/11 to 2013/14, the growth in outputs was 7.5 per cent, while the labour growth was negative, at -1.5 per cent. With such a significant discrepancy between the expansion of NHS activities on one hand, and only a modest increase in labour inputs on the other hand, it is therefore not surprising to observe a big expansion in the use of agency services to meet the difference.

[1] Measured as cost-weighted output.
[2] Admission is counted as a continuous inpatient stay.
[3] Data from 2010/11 is not included as it comes from a different data source and therefore it is not comparable to the later series.

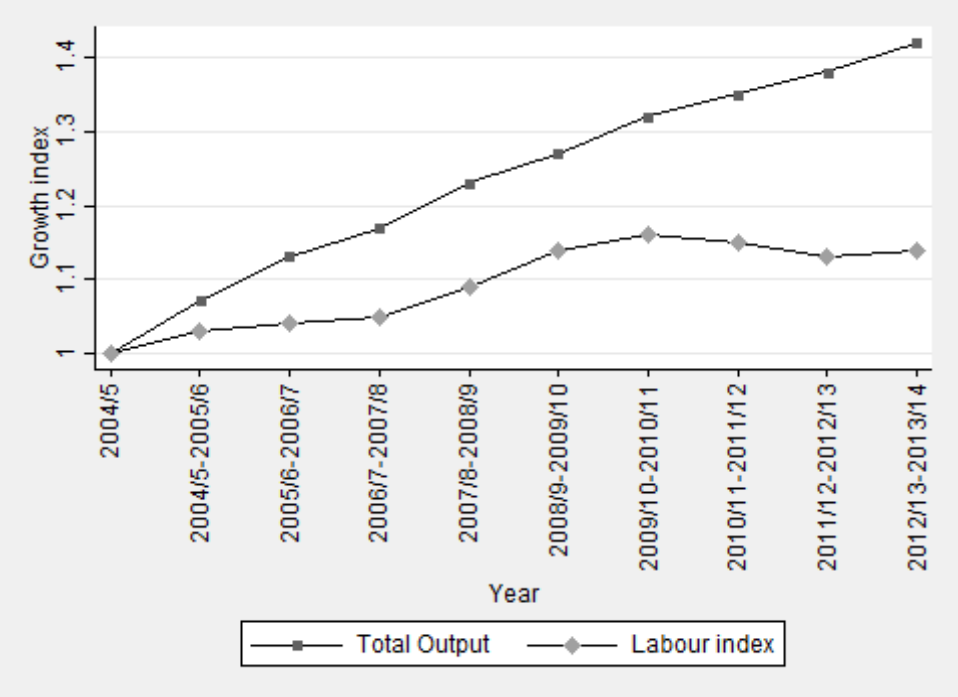

Figure 2: Comparison between labour index and output growth index

Impact of the agency cap

The agency cap has only recently been introduced so it is hard to assess its impact. However, as Figure 1 suggests, agency expenditure by the NHS did not fall in the immediate aftermath of the cap's introduction. In fact, agency spend increased by almost 10 per cent in the year that the policy was introduced.

While some initial figures indicate the new policy made some savings (BBC, 2016), other statistics show that the hospitals are still paying more than the rate set in November 2015. Since the introduction of the caps, most trusts have used the 'break glass' clauses to exceed the cap payment for agency staff. Although these clauses should only be used in exceptional cases when patient safety is at risk, Monitor (2016) found more than 50,000 cases exceeding the cap every week.

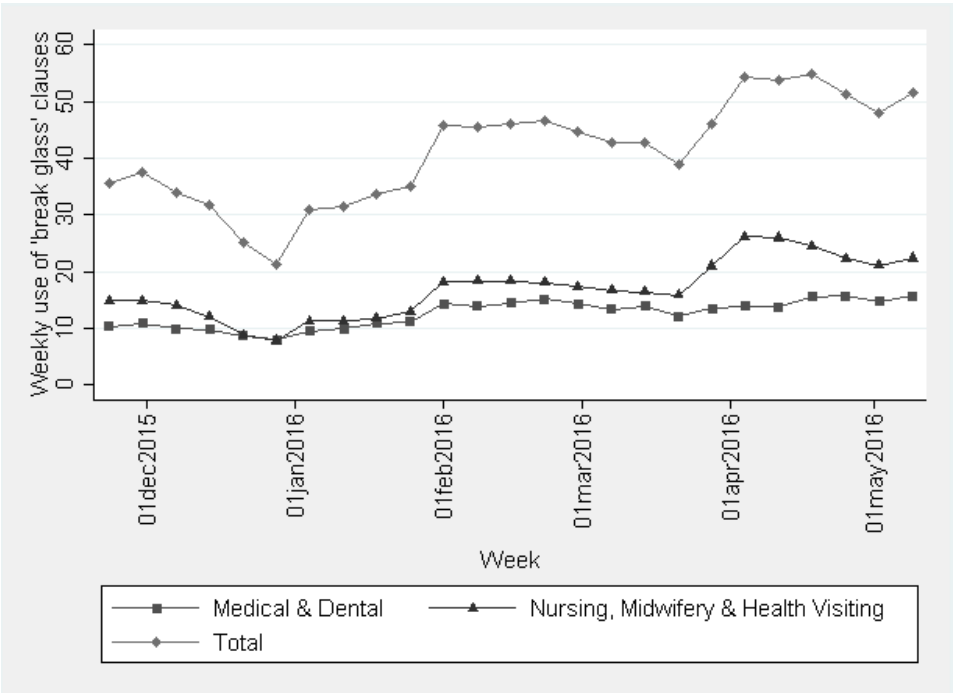

Figure 3: Weekly use of 'break glass' clause

At the same time, NHS trusts report very little effect on their vacancy rates. According to one survey conducted in May 2016, 65 per cent of trusts said they observed no change in the number of unfilled vacancies, with 28 per cent trusts observing an increase in the number of vacant posts (Monitor, 2016).

It seems unlikely that the cap will have a measurable effect on filling the staffing gap in the NHS, which is growing. In February 2016 there were almost 24,000 unfilled nursing vacancies in the NHS in England, Wales and Northern Ireland, representing nearly 9 per cent of all staff, much higher than the 2.7 per cent vacancy rate across other sectors (BBC, 2016). On the other hand, evidence shows that recruitment agencies now struggle to attract workers for NHS temporary positions (Lintern, 2016). This may worsen the staff situation in the NHS as, with inadequate numbers of permanent staff, there will not be enough temporary staff to fill the gaps.

Potential solutions

Instead of focusing on the agency staff costs, policy makers should pay more attention to having a proper workforce plan for the NHS (Public Accounts, 2016). Improving working conditions for NHS staff should be a priority as this has a direct impact on staff retention and might increase the uptake of payroll NHS posts by current agency staff.

- According to the annual NHS staff survey (Picker Institute, 2015), only 37 per cent of the NHS workforce is satisfied with their level of pay. However, 50 per cent were dissatisfied with the flexible working opportunities provided by their organisation, which might be one of the reasons some staff decide to work through an agency. While only 32 per cent of staff reported working paid overtime, this figure increases to 60 per cent when that overtime is unpaid.
- The majority of employees (70%) think that there are not enough staff at their organisation for them to do their job properly, and that this affects the ability of staff to meet demands of their work: only 43 per cent agreed that they were able to manage these requirements, while nearly one in three (31%) disagreed.
- Despite these complaints, NHS staff tend to like their job. Around 58 per cent of them look forward to going to work, with 74 per cent of staff feeling enthusiastic about their job. Seventy-eight per cent of staff also felt that time passed quickly while they were at work. This is an important message to take forward: NHS is a good place to work, despite its shortcomings.
- While improving NHS job satisfaction will undoubtedly help with recruitment of new staff, another important focus should be to increase the pool of potential candidates. England currently does not educate a sufficient number of clinical staff to meet its current or future needs (National Audit Office, 2016).

Conclusion

Agency staff provide a valuable contribution to the NHS. It is impossible to run a health system subject to demands that fluctuate unpredictably from day to day and hour to hour without being able to draw from a pool of temporary staff at short notice. To say that expenditure on agency staff is the sole cause of NHS financial problems is simplistic and partial. The longer term requires better workforce planning, so that vacant NHS posts can be filled by training a sufficient number of potential staff and reinforcing the message that the NHS is an exciting and rewarding workplace.

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