NHS Improvement

Submission to the NHS Pay Review Body and the Review Body on Doctors' and Dentists' Remuneration 2017

collaboration trust respect innovation courage compassion

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

About NHS Improvement

NHS Improvement is responsible for overseeing NHS foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. We offer the support these 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.

From 1 April 2016, NHS Improvement is the operational name for an organisation that brings together:

- Monitor
- NHS Trust Development Authority
- Patient Safety, including the National Reporting and Learning System
- Advancing Change Team
- Intensive Support Teams

We build on the best of what these organisations did, but with a change of emphasis. Our priority is to offer support to providers and local health systems to help them improve.

1. Introduction

1.1. Scope of this submission

This submission confines itself to areas of direct relevance to the responsibilities of NHS Improvement. It should therefore be read in conjunction with submissions from the Department of Health and the other national NHS arm's length bodies.

1.2. Strategic workforce challenges and NHS Improvement's response

There are significant staff shortages in some sectors (eg mental health), professions (nursing), specialties (eg emergency medicine) and geographies (eg rural and coastal areas), leading to a reliance on expensive agency and locum staff and high turnover of staff.

Current workforce spending is in excess of the level planned by providers, bringing into sharp relief the difficult balance to be struck between affordability and workforce supply and demand.

Tackling these problems requires co-ordinated action across a range of national bodies with responsibilities for different aspects of planning, training and education, supply, retention and productivity to:

- improve supply, for instance by developing new routes into nursing, through international recruitment, and by maximising existing supply through conversion of agency staff to substantive workforce
- improve retention of the current workforce
- improve leadership culture and staff engagement
- improve productivity of the existing workforce, including by developing new innovative workforce models,

We are working alongside national partners to help address workforce challenges, including working with Health Education England to further develop a national workforce strategy following publication of its recent engagement document.

We are also running significant work programmes to support trusts to improve retention, reduce reliance on agency staff, encourage more agency staff to become substantive employees, and drive more effective and efficient use of the existing NHS workforce. **This work remains critical given the significant and continuing pressures on the provider sector, which in turn place excessive pressures on the provider workforce.**

We welcome the end to pay restraint for NHS staff, which clearly has an important bearing on morale. However**, NHS providers cannot afford any extra pay increases unless the increases are fully funded by the government. Any unfunded pay awards will simply increase provider deficits.**

1.3. Public sector equality duty

NHS Improvement has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. We believe this submission will not have any adverse impact on these groups and that NHS Improvement has fulfilled its duty under the Act.

2. Provider finances

2.1. Introduction

Over the last few years, the NHS has maintained and improved patient care and delivered efficiencies during a time of increasing financial pressure caused by slowing growth in the NHS budget combined with rising demand.

Recent financial pressures resulted in NHS providers recording an aggregate financial deficit of £2,447 million in 2015/16. Through the combined efforts of the sector and the introduction of £1,800 million of sustainability, and transformation funding, this reduced to £791 million in 2016/17. However, significant financial pressures remain, with providers forecasting, at the end of September 2017, an aggregate financial deficit of £623 million for the 2017/18 financial year – despite delivering larger cost improvement plans than in previous years and levels of efficiency far greater than the wider economy.

The Autumn Budget in November 2017 delivered an extra £1.6 billion of NHS revenue funding and £354 million of public capital for next year. As noted in NHS England's recent board paper, real terms NHS revenue growth for 2018/19 will therefore be 1.9% (versus growth of 2.0% this year, and 3.1% in 2016/17). Factoring in England's growing and ageing patient population, age-weighted NHS revenue growth per person becomes 0.9% in 2018/19 and -0.4% in 2019/20.

This extra revenue is welcome and clearly improves the NHS' prospects for next year. However, it is less than the 2018/19 figure that NHS England originally requested at the time of the 2015 Spending Review**. As such, the outlook for provider finances in 2018/19 remains very challenging. Any pay awards above the current 1% pay cap without extra funding from government will simply increase the deficits in the NHS provider sector.**

2.2. Current NHS provider finances

At the end of September 2017 providers had achieved significant agency savings and maintained the high efficiency levels seen in previous years. However, this was in the context of a challenging financial plan for the sector, which required

unprecedented levels of provider efficiency. At the mid-point in the financial year, the latest results indicate that NHS providers continued to do more for less.

For the first six months of the year, the sector outperformed the wider economy by delivering an implied 2.0% efficiency improvement. This was supported by cost improvements of 2.9% − equivalent to £1,257 million of improvements in the first six months of the year. Taking into account inflation assumptions built into the national tariff of 2.4%, this performance indicates implied efficiency above 2016/17 levels. Despite this level of efficiency and cost improvement however, there was a shortfall of £169 million, against the ambitious level of cost improvements planned to date.

Responding to low levels of income growth, providers planned for pay growth of just 0.4% in aggregate, which is significantly below anticipated pay inflation of 2.1% and represents a planned real-terms reduction in the sector's pay bill. This is to be delivered mainly through a planned reduction in temporary staffing costs.

Looking ahead, the provider sector is forecasting a deficit of £623 million against a planned deficit of £496 million by the end of 2017/18. This figure is derived from aggregating ambitious provider plans and depends on assumptions around risk management including winter costs, agreed activity levels, beds being freed up and the delivery of significant extra efficiencies and cost improvements. Cost improvements are forecast to rise to 4.1% of expenditure by the end of the year.

2.3. NHS provider workforce costs in 2017/18

NHS trusts employ almost 1.1 million whole time equivalent (WTE) staff. The pay bill is the single biggest area of expenditure and NHS Improvement has made supporting providers with management of the pay bill and recruitment to fill key staff vacancies a key priority.

Total pay costs for the first two quarters of the year were £256 million worse than plan. This was driven by adverse variances of £217 million (3.4%) on medical staff and £66 million (0.7%) on nursing staff. The bulk of the overspending took place in the acute and mental health sectors with respective overspends of £245 million and £38 million at Quarter 2. In contrast to previous years, the year to date overspend was reflected in the use of bank staff, which was £407 million above plan at Quarter 2. This reflects the increasing use of bank staff by trusts to manage workload in the

face of increased demands, high levels of vacancies, sickness/absence and staff turnover.

Figure 1: NHS pay costs

6 months ended 30September 2017	**Year to date Month 6 2017/18**			
	Plan	Actual	Variance	
	£m	£m	£m	%
Medical staff	6,295	6,512	(217)	(3.4%)
Nursing staff	10,075	10,141	(66)	(0.7%)
Other staff	9,208	9,181	27	0.3%
Total employee expenses	**25,578**	**25,834**	**(256)**	**(1.00%)**
Of which:				
- bank	1,020	1,427	(407)	(39.9%)
- agency ceiling performance	1,272	1,194	78	6.1%
6 months ended 30 September 2017	**Forecast outturn 2017/18**			
	Plan	Forecast	Variance	
	£m	£m	£ m	%
Medical staff	12,506	12,770	(264)	(2.1%)
Nursing staff	20,026	20,144	(118)	(0.6%)
Other staff	18,286	18,333	(47)	(0.3%)
Total employee expenses	**50,818**	**51,247**	**(429)**	**(0.84%)**
Of which:				
- bank	1,998	2,631	(633)	(31.7%)
- agency ceiling performance	2,500	2,251	249	10.0%

3. Workforce analysis

3.1. Introduction

Its workforce is the NHS's greatest asset. Securing a workforce with the appropriate skills and deploying these appropriately is critical to effective healthcare delivery. Achieving correct staffing levels across all professional groups and for all services is crucial for realising optimal outcomes for patients and for maximising productivity. The workforce is also the NHS's most significant area of expenditure, accounting for 64% of spend in the NHS provider sector. It is therefore vital that current and future workforce requirements are sustainable within the overall NHS financial budget.

There are significant staff shortages in some sectors (eg mental health), professions (nursing), specialties (eg emergency medicine) and geographies (eg rural and coastal areas), leading to a reliance on expensive agency and locum staff and high degrees of churn.

Current workforce spending is in excess of the levels planned by providers; bringing into sharp relief the difficult balance to be struck between affordability, and workforce supply and demand.

Tackling these problems requires co-ordinated action across a range of bodies to:

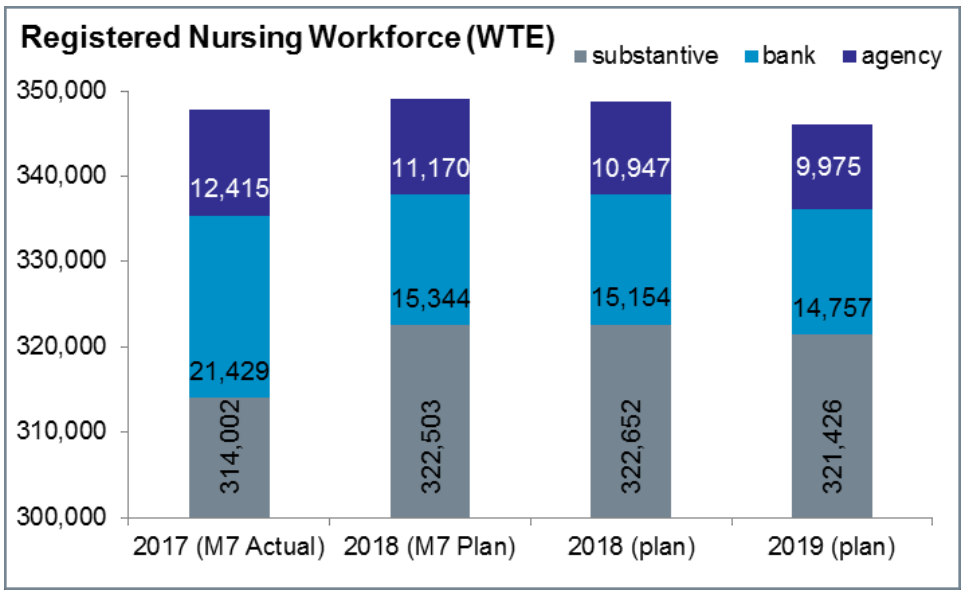
- improve supply, for instance through developing new routes into nursing, through international recruitment, and by maximising existing supply through conversion of agency to substantive workforce
- improve retention of the current workforce
- improve leadership culture and staff engagement
- improve productivity of the existing workforce, including by developing new innovative workforce models.

The following section sets out our analysis of the nursing, medical and agency workforce.

3.2. Nursing workforce

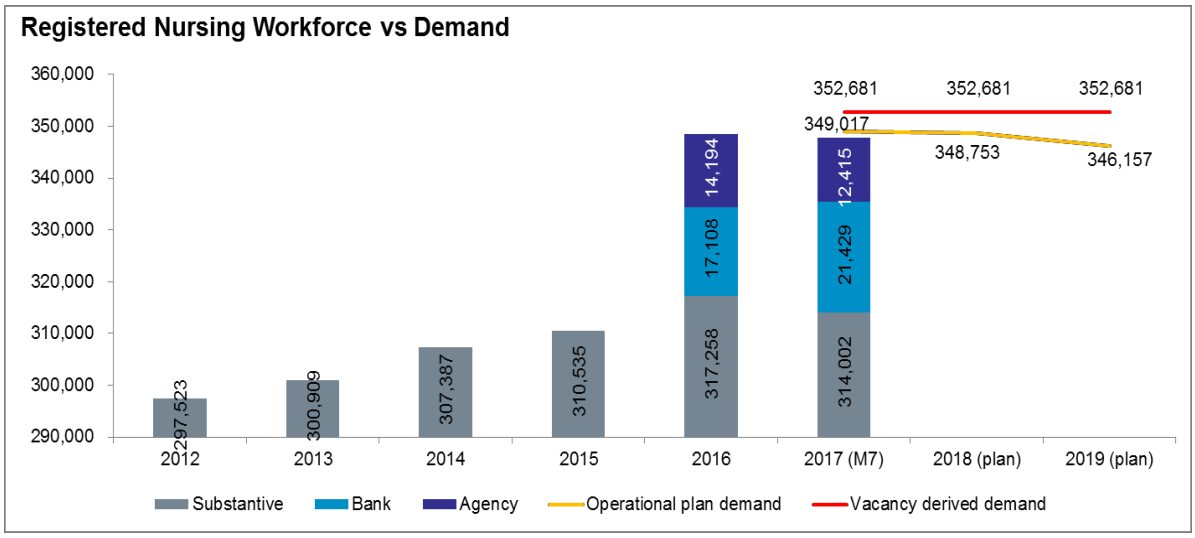
Figure 2 below shows the current registered nursing workforce position across the NHS provider sector. The data suggests that although there is excessive use of bank staff, this appears to be in response to a significant substantive staffing shortfall. However, even with this increase in bank, and to a lesser extent agency, the combined total (substantive, bank and agency) still remains under plan by over 1,000 WTE.

Figure 2: Current registered nursing workforce position across the NHS provider sector



The current (Month 7) use of temporary staffing equates to nearly 34,000 WTE. This, combined with the additional gap to overall operational demand equates to a substantive staffing workforce gap (vacancy) of over 35,000 WTE.

Figure 3: Registered nursing workforce vs demand

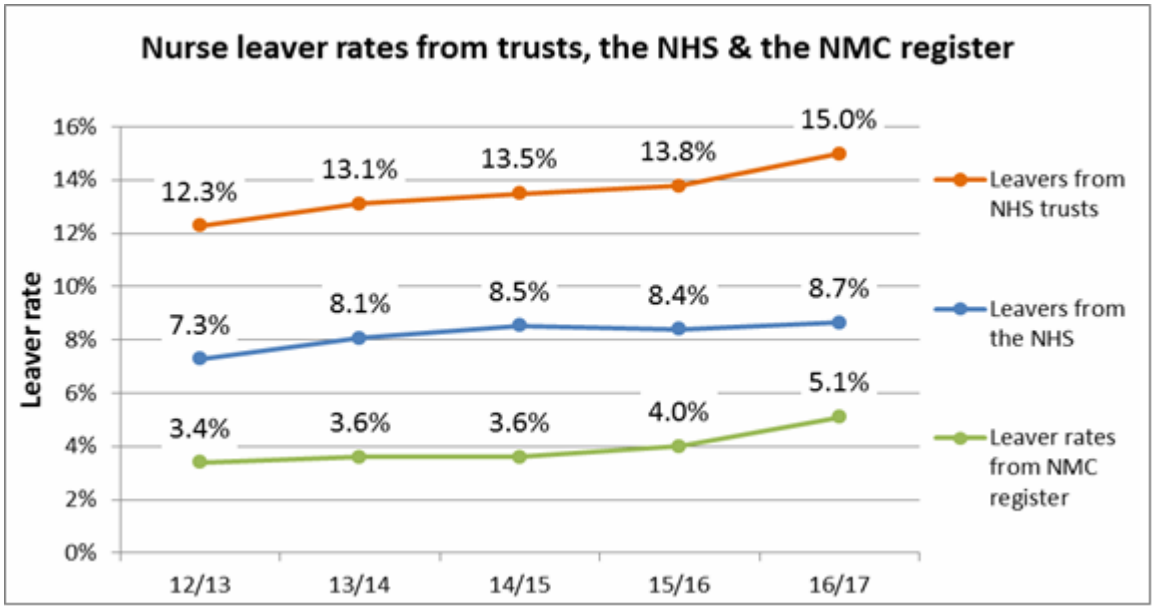


To get a better understanding of the true demand gap, we calculated the above 'vacancy derived demand' based on nursing vacancy rates submitted to us via the monthly workforce return. This further increases the current demand gap: we calculate it to be between 35,000 and39,000 as at Month 7, which equates to around an 11% vacancy rate.

Data from the Electronic Staff Record (ESR) indicates that that the percentage of nurses leaving the NHS has gradually gone up from 7.3% in 2012/13 to 8.7% in 2016/17. This is an increase of 1.4 percentage points over the last 5 years. The rate at which registered nurses are leaving trusts (including to move to other trusts) has increased from 12.3% to 15.0%, suggesting that insufficient growth, more retirements and increased demand for staff may mean that trusts are working harder to compete with each other for the same nursing supply.

This costs the NHS significant amounts of money collectively, and in individual organisations, as well as potentially affecting the quality and availability of services as staff move between trusts.

Figure 4: Rates of nurses leaving trusts, the NHS and the Nursing and Midwifery Council



Source: NHS Improvement analysis of NMC Register and ESR data

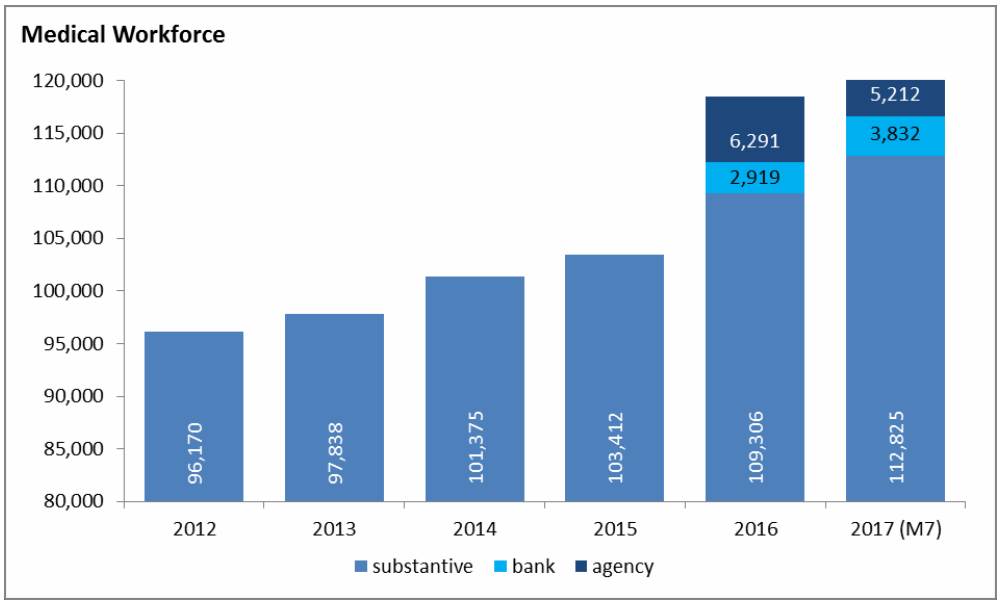
Numbers of nurses leaving the Nursing and Midwifery Council (NMC) register also indicate a general increase in rates over time, though the rate of increase of leavers from the register has increased in the last couple of years.

3.3. Medical workforce

As outlined in the draft Health and Care workforce strategy for England to 2027, ensuring we have sufficient supply of doctors across all grades and specialties is the key to ensuring the NHS delivers excellent patient care.

The medical profession has seen the largest and most consistent growth of any healthcare profession but this masks variations in geography and specialty. In some areas and in some specialties employers are finding it challenging to maintain cover, which is leading to a reliance on locum agency workforce.

Figure 5: Medical workforce growth 2012 to 2017 (Month 7)



Since 2012, the total substantive medical workforce has increased year on year, with a total growth of 16,655 WTE (17.3%) across the provider sector.

In 2017/18 the substantive workforce has increased by 3,361 WTE (3.1%) since the start of this financial year. The bank WTE workforce has increased by 826 WTE (27.5%) and the medical agency WTE increased 221 WTE (4.4%) over the same period.

Early indication from provider monthly workforce submissions to NHS Improvement suggests a current medical vacancy rate of between 10.5% and 11.5%, which would equate to a gap of approximately 11,000 to12,500 WTE. A large proportion (9,000 WTE) of this gap is currently filled by a combination of locum, bank and agency doctors.

These numbers are currently derived from a management information collection that we are currently working with NHS trusts to validate.

3.4. Use of agency staff in the NHS

We have established agency ceilings for all trusts. This work began in 2015/16 for nursing staff and has now been expanded to all staff groups.

Agency costs have continued to decrease significantly following these initiatives and action by providers over the last two years.

At Quarter 2, the positive variance had risen to £78 million from the £9 million reported at Quarter 1. This represents a 6.1% underspend against the planned ceiling (1.5% at Quarter 1). In overall terms, this is £320 million or 21% lower than the same year to date period in 2016/17.

In aggregate, agency spend as a percentage of the total NHS provider pay bill has fallen from 5.0% included in plans to 4.6% at Quarter 2 and providers anticipate a further fall to 4.4% by the financial year end. Overall, providers are forecasting to underspend by £249 million this year. Based on the reported figures to date, this will be a challenging forecast that will require continued month-on-month reductions for the rest of the year. Given known pressures on this position, a more likely risk-adjusted forecast outturn would be closer to the ceiling of £2.5 billion, although the sector is on track to deliver the agency expenditure for the year within this ceiling.

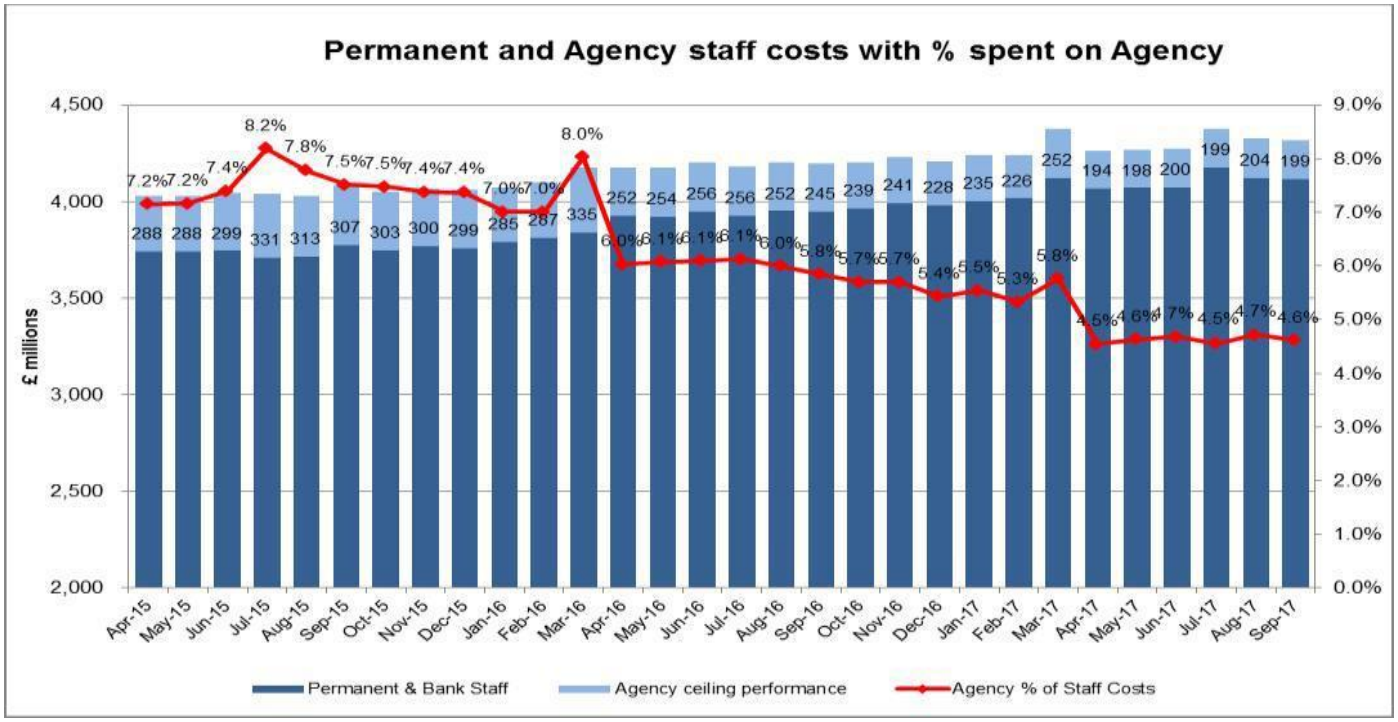
Figure 6: Agency ceiling performance to Month 6 2017/18

Agency ceiling performance	Year to date Month 6 2017/18			
6 months ended 30 September 2017	Plan	Actual	Variance	
	£m	£m	£m	%
Agency ceiling performance	1,272	1,194	78	6.1%
Agency costs as a % of total pay costs	5.0%	4.6%		
Agency ceiling performance	Provider Forecast outturn 2017/18			
6 months ended 30 September 2017	Plan	Forecast	Variance	
	£m	£m	£m	%
Agency ceiling performance	2,500	2,251	249	10.0%
Agency costs as a % of total pay costs	4.9%	4.4%		
Agency breakdown				
6 months ended 30 September 2017	Year to Date			
	Sep-16	Sep-17	Movement	
	£m	£m	£m	%
Medical staff	531	471	60	11.3%
Nursing staff	593	457	136	22.9%
Other staff	390	266	124	31.8%
Total	1,514	1,194	320	21.1%

Agency costs have decreased considerably in all staff categories when compared to the levels last year. The largest fall is in ‘other staff’ which has fallen by 31.8%, driven by a significant fall in the administrative and estates staff group amounting to 44.7%. There have also been significant reductions in nursing staff and medical and dental staff, which fell by 22.9% and 11.3% respectively.

By controlling the level of agency spending, the rules introduced over the last two years have facilitated a greater degree of workforce planning and improved the value for money in this area of significant spend.

Figure 7: Permanent and agency staff costs with % spent on agency



4. Workforce improvement

4.1. Introduction

Securing a workforce with the appropriate skills and deploying it effectively is central to delivery of healthcare across the NHS provider sector, and intrinsically linked to better outcomes for both patients and improved productivity. It is also imperative to maximise the contribution of the current workforce given that it accounts for around 65% of total expenditure of the NHS provider sector.

NHS providers face significant workforce challenges. Well-publicised supply shortages in some areas have contributed to over-reliance on agency staff with implications for affordability and quality of patient care.

We are working with the Department of Health (now the Department of Health and Social Care), Health Education England, NHS Employers, NHS England and other bodies to improve workforce planning and ensure it reflects the needs of NHS providers. We are also supporting providers to respond to workforce challenges by focusing on the following themes:

- recruitment and retention
- safer staffing
- culture and engagement
- productivity and transformation.

Each of these themes is expanded in the following sections.

4.1. Recruitment and retention

To help the system better manage retention, which is vital to maintaining and growing the overall workforce, we analysed the current situation in providers and developed a work programme to support improvements in retention which was launched in July 2017. As the drivers of staff attrition in mental health providers are distinct, we developed a bespoke programme of support for them. We are now directly supporting 53 mental health trusts and over 60 acute and community providers through specific interventions:

- A series of retention masterclasses aimed at directors of nursing and human resource (HR) directors with high profile speakers outlining how they have implemented successful interventions. These draw on best practice case studies focusing on evidence-based interventions such as staff offer, continuing professional development, careers advice and planning, retirement and organisational culture. To date we have run four events have been run to date, with over 500 delegates from 200 trusts.
- Rollout in early 2018 of a national retention improvement programme with NHS Employers, which will cover all staff groups and build on the existing NHS Employers' programme currently working with 92 trusts. All remaining trusts will be expected to complete the programme to help ensure the programme maximises the return on investment by increasing retention rates.
- An NHS Improvement retention direct support programme on nursing which provides targeted, clinically-led support to trusts in the top quartile of nursing leaver rates. It began with the top 20 trusts in July 2017, followed by a further cohort of trusts in October, and a final cohort in January 2018.
- A bespoke programme of support for mental health trusts, building on the retention direct support programme, but covering nursing and medical staff Providers with above average leaver rates will receive targeted support and will be required to achieve larger, proportional WTE savings. All mental health trusts are required to produce detailed improvement plans on how they will address their high leaver rates and improve retention over the next 12 months, as the mental health sector is working to achieve 6,000 WTE savings by 2020.
- A guide for all trusts (published December 2017) on improving retention rates, describing innovative approaches to improving retention.

5.2. Safe and sustainable staffing

We have been leading the national programme to develop safe staffing improvement resources for specific NHS care settings, including acute inpatients and children's services. Using evidence-based tools to determine staffing ensures that staffing levels are flexible and adapt to the needs of the patients.

Our approach to safe staffing is based around the use of evidence-based tools, professional judgement and quality monitoring to ensure that staffing levels do not

give rise to any patient safety or quality concerns. It also builds on previous NICE guidance on safe staffing for adult in- patient wards in acute hospitals and for nursing staff in maternity settings.

We have initiated a range of support offers to providers, including the refresh of the overarching NQB safe staffing guidance in July 2016. Aligned to Leading change: Adding Value – commitment 9, this safe staffing improvement resource provides an updated set of expectations for care staffing, to help NHS provider boards to work with commissioning colleagues to make local decisions that will support the delivery of high quality care for patients and communities within the available staffing resource. This improvement resource:

- sets out the key principles and tools provider boards should use to measure and improve their use of staffing resources to ensure safe, sustainable and productive service, including introducing the care hours per patient day (CHPPD) metric
- identifies three updated National Quality Board (NQB) expectations that form a 'triangulated' approach ('right staff, right skills, right place and time') to staffing decisions
- offers guidance for local providers and others to use other measures of quality, alongside CHPPD, to understand how staff capacity may affect the quality of care.

Eight sector-specific improvement resources have been developed by system leaders supported by academic teams. They are currently being released for publication following engagement.

During the engagement process for the improvement resources, we have been discussing with the provider sector the delivery plan and operationalisation of NQB guidance. The feedback has highlighted the requirement for some detailed implementation tools and workforce safeguards to ensure quality outcomes for patients. This work will be drawn together in a final set of tools for the sector in Quarter 1 of 2018/19. It will focus on four main areas: board oversight and governance of workforce risks, support approaches and strategic design, delivering workforce solutions safely and operational and quality outcomes.

4.3. Culture and engagement

Improving culture and leadership in NHS providers supports retention, recruitment and workforce effectiveness: improved morale has a direct impact on the quality of care. Through contributing to the creation of the National Leadership Development and Improvement Strategy, NHS Improvement has set the direction for capacity and capability-building, including leadership development and talent management for the NHS in England. This support is being provided through a culture programme to help NHS providers develop cultures that enable and sustain continuous improvement and compassionate care. The programme provides practical support to help trusts to diagnose their cultural issues, and develop collective leadership strategies to address them and implement any necessary change.

4.4. Transformation and productivity

We are working with Health Education England to support the broader transformation of the NHS workforce, through supporting providers in developing new roles. This includes recognising the value of non-registered care staff in bands 2 to 4, apprentices and nurse associate roles through sharing best practice and, where appropriate, facilitating buddy arrangements between trusts.

Employers themselves have developed new roles responding to local workforce needs. For example, advanced clinical practitioners (ACP) and specialist clinical practice give existing nurses or allied health professionals the opportunity to further develop their skills and provide more expert service to patients. Health Education England recognises the benefits from the ACP role and is working with us to systematically and safely support expansion of the role to deliver benefits in high priority areas such as A&E, cancer care and elective services.

To support greater use of the ACP role in the NHS, with Health Education England we launched a national framework for advanced clinical practice on 16 November 2017 which sets out for the first time in England an agreed definition for advanced clinical practice for health and care professions.

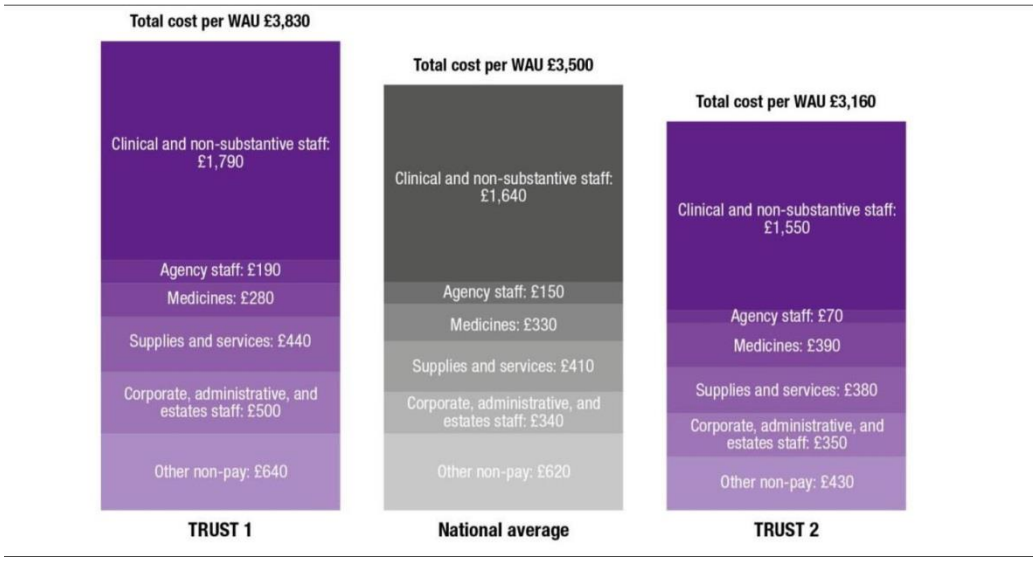
The national framework provides employers with advice on planning and implementing advanced clinical practice. It has been designed to provide a common framework and curriculum for advanced clinical practice to support individuals,

employers, commissioners, planners and educators in transforming their services to improve patient experience and outcomes. The agreed national education and competency arrangements provide an ideal platform to increase the use of this innovative NHS workforce solution.

Operational productivity

Although the NHS is rated as one of the most efficient healthcare systems in the world, on average across trusts, there are still unwarranted variations. For example, the average cost of an inpatient treatment is £3,500 per weighted activity unit (WAU),[1] but there is more than 20% variation between the most expensive (£3,850) and least expensive (£3,150) trust, as illustrated by the diagram below.

Figure 8: An indicative breakdown of total cost per weighted activity unit for two NHS trusts



Source: Carter review (2016)

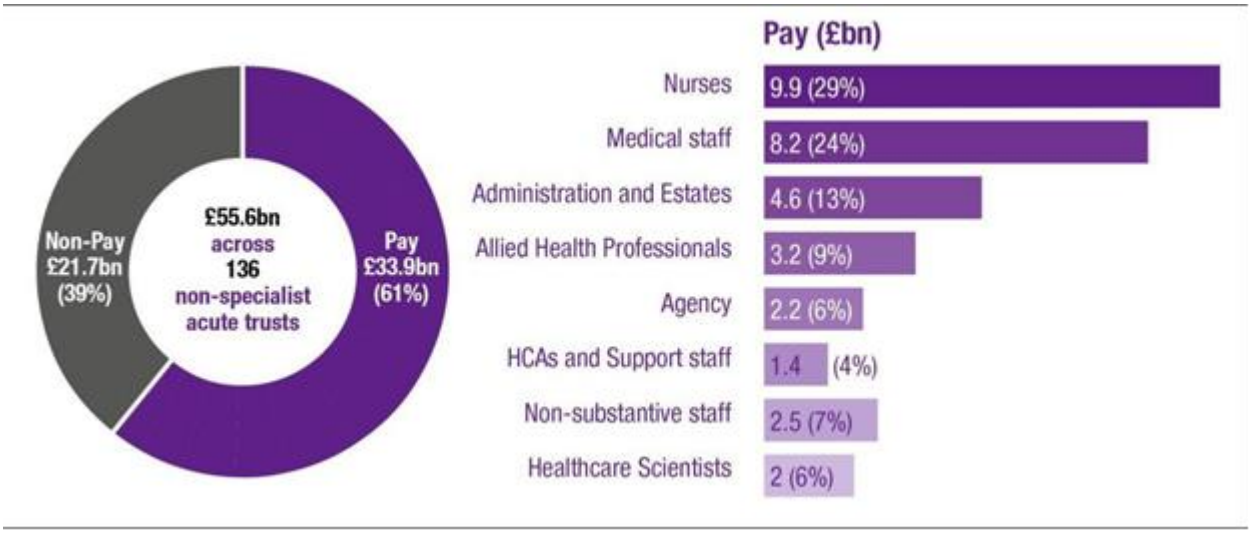
The Carter review in 2016 set out 15 recommendations to help reduce variation across the biggest areas of spend in hospitals: clinical staff, pharmacy, procurement, and estates and facilities. A significant focus of our work on improving operational productivity is therefore the clinical workforce.

[1] The weighted activity unit is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.

Improving clinical workforce productivity

The Carter review estimated that around £2 billion each year of efficiency gains could be achieved by reducing unwarranted variation in clinical workforce productivity across trusts. The analysis underpinning these conclusions found that £33.9 billion of £55 billion total spend in acute non-specialist trusts is on clinical resource (see below).

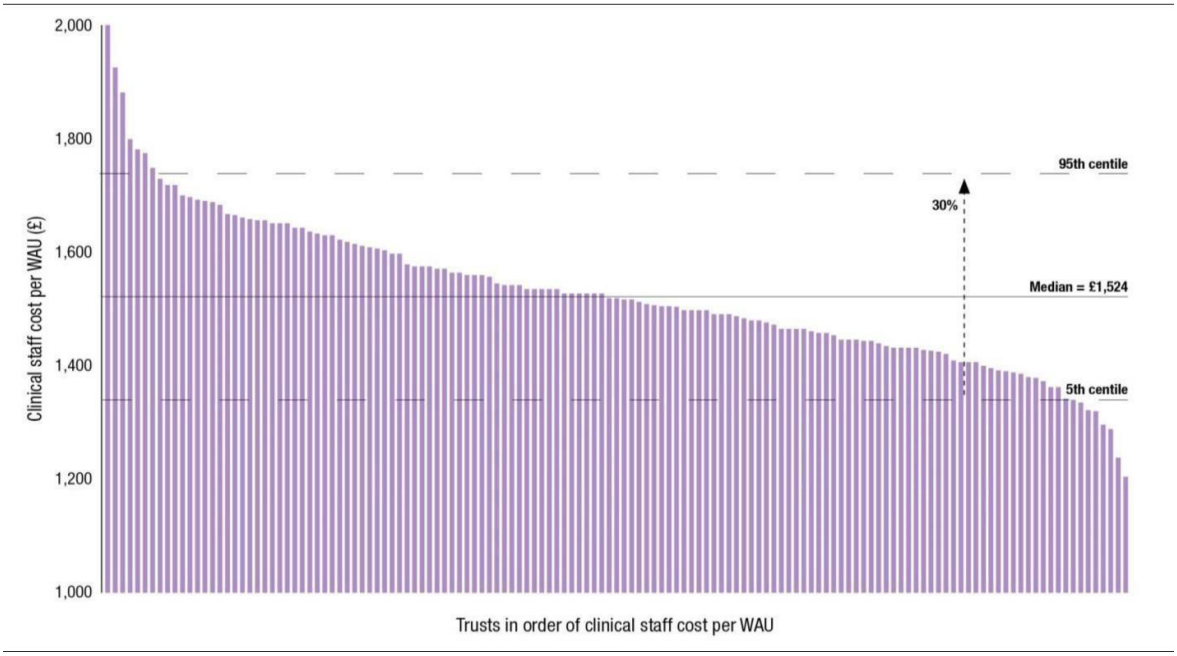
Figure 9: Spending split for the 136 non-specialist acute trusts, with pay breakdown



Source: Carter review (2016)

In addition, the most expensive trusts spend around 1.3 times more on clinical staff per WAU than the least expensive trusts (below).

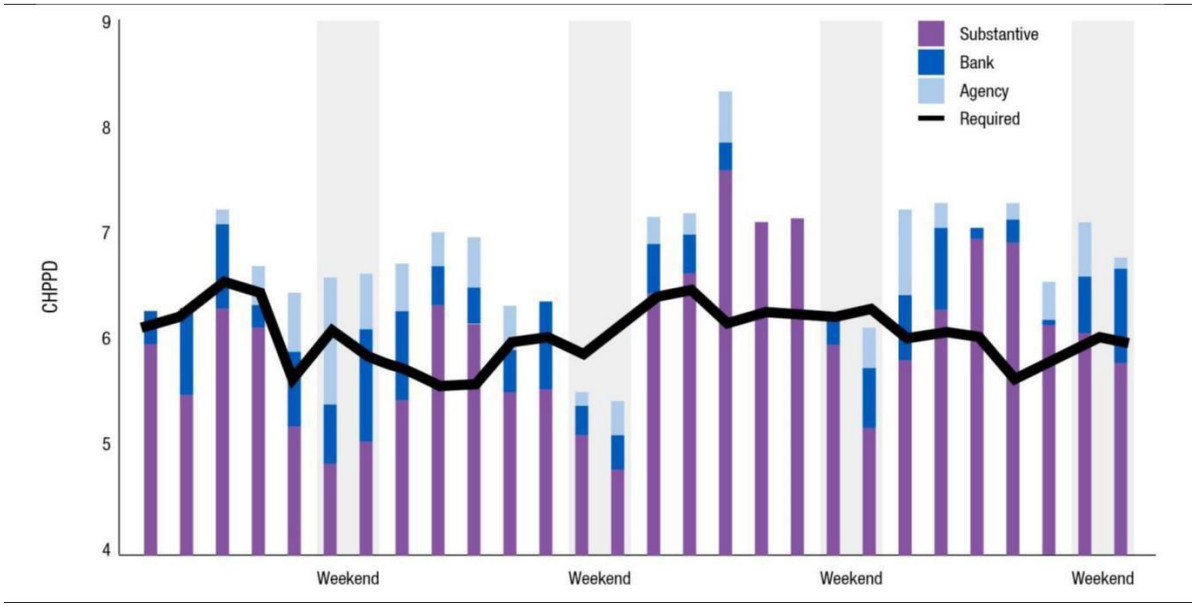
Figure 10: A distribution of clinical staff cost per WAU across trusts



Source: Carter Review (2016)

- Model Hospital portal: The portal will support NHS providers to understand workforce productivity metrics at strategic, tactical and operational levels.
- Electronic staff records: Analysis of Electronic Staff Record (ESR) data was important to the Carter review and is used in the Model Hospital portal to allow trusts to compare their workforce productivity with peers. It is important that the quality of this data improves to enable this work.
- E-rostering: Although most hospitals use e-rostering, the Carter Review found that few trusts were benefiting fully from it. A firmer grip of e-rostering will reduce dependency on bank and agency staff and improve predictability and consistency of deployment for staff even where recruitment is still a challenge. Figure 11 uses an example from one ward in one trust to highlight that on many days across the month, there were not enough substantive staff rostered on duty while on others there are more than required.
- Medical job planning: Ensuring that each consultant has an up-to-date, accurate job plan which clearly sets out the sessions allocated to clinical procedures, patient/carer facing time and quality improvement.

Figure 11: Required versus actual nursing hours per patient day for one ward in a trust



Source: Carter Review (2016)

5. Conclusion

We are working alongside national partners to address workforce challenges, including working with Health Education England to further develop a national workforce strategy following the publication of its recent engagement document.

We are also carrying out significant programmes of work to support trusts to improve retention, reduce reliance on agency staff, encourage more agency staff to become substantive employees, and to drive more effective and efficient use of the existing NHS workforce. This work remains critical given the significant and continuing pressures on the provider sector, which in turn place undue pressures on the provider workforce.

We welcome the end to pay restraint for NHS staff, which clearly has an important bearing on morale. However, NHS providers cannot afford any additional pay increases unless they are fully funded by the government. Any unfunded pay awards will simply increase the deficits of providers.

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