

Agency rules

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

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1. Introduction

- 1.1. In 2015 trust spending on agency staff had increased to the extent that it was one of the most significant causes of deteriorating trust finances. NHS Improvement¹ introduced a set of rules in April 2016 to support trusts to reduce their agency expenditure and move towards a sustainable model of temporary staffing. In the intervening two years these measures have reduced agency expenditure by a third.
- 1.2. This document sets out all the rules for trusts on agency expenditure, which are collectively known as the 'agency rules'. It builds on and supersedes previous rules documents for trusts (including those published on 1 September 2015, 23 November 2015 and 23 March 2016). Trusts should refer to this document for details on how to comply with all the agency rules, including the requirements to:
 - comply with a ceiling for trust total agency expenditure
 - procure all agency staff at or below the price caps
 - use approved framework agreements to procure all agency staff.
- 1.3. The agency rules apply to all staff groups (ie those listed in section 3).
- 1.4. The agency rules are designed to:
 - significantly reduce agency spend
 - improve transparency on agency and bank spend
 - bring greater assurance on quality of agency supply
 - encourage agency staff to return to permanent and bank working.

¹ NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority (TDA), Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams. From 1 April 2016 all references to Monitor or TDA have in effect been replaced by 'NHS Improvement'. This document therefore uses NHS Improvement throughout.

2. Organisations in scope

2.1. The agency rules apply to:

- all NHS trusts
- NHS foundation trusts receiving interim support from the Department of Health and Social Care
- NHS foundation trusts in breach of their licence for financial reasons.

2.2. Throughout this document 'trusts' refers to 'all trusts in scope of the rules' unless otherwise specified.

2.3. There is a strong expectation that all other NHS foundation trusts will comply. Year-to-date performance against agency ceiling is an equally weighted metric in the 'use of resources' theme of the Single Oversight Framework.² Additionally, the proportion of temporary staff is measured quarterly in the 'quality of care' theme. Under the 'use of resources' theme we may also consider whether there is any evidence that suggests a provider is failing to operate effective systems and/or processes for financial management and control, and not operating economically, effectively and efficiently. Providers that are not adequately controlling their agency spend can be investigated under these broader value-for-money considerations.

2.4. Ambulance trusts and ambulance foundation trusts have been covered by the agency expenditure ceiling and framework rules since 1 April 2016 and by the price cap since 1 July 2016.

2.5. While these rules apply to trusts and foundation trusts, commissioners have an important role in monitoring performance. We encourage trusts to work with their commissioners to agree plans for services in the event of staffing issues and, where appropriate, to engage wider system partners in developing plans for sustainable temporary staffing across local systems.

² Outlined in: <https://improvement.nhs.uk/resources/single-oversight-framework/>

3. Staff groups in scope

- 3.1. The agency rules apply to all staff groups covered by national pay scales:
- medical staff (including dental staff where applicable)
 - nursing and midwifery staff
 - all other clinical staff
 - all non-clinical staff.
- 3.2. GPs are not covered by the agency rules, except where they would be employed substantively by a trust (that is, they are on the trust's payroll). Where this is the case, the appropriate equivalent medical price caps should apply.
- 3.3. Very senior managers are not covered by this set of agency rules. Separate [guidance](#) applies to very senior managers.³
- 3.4. Please see Annex 1 for definitions of terms.

³ https://improvement.nhs.uk/documents/429/interim_agency_VSM_approval_process.pdf

4. Expenditure ceilings

- 4.1. NHS Improvement sets expenditure ceilings on the total amount individual trusts can spend on agency staff across all staff groups.
- 4.2. All trusts, including all foundation trusts, have a ceiling.
- 4.3. The annual expenditure ceilings are set in collaboration with NHS Improvement regional teams.
- 4.4. Each trust receives its annual ceiling as part of the annual planning round. Trusts with planned agency expenditure above their annual ceiling will need to revise their plans to ensure agency expenditure is at or below their ceiling.
- 4.5. There is a strong expectation that all trusts will comply with this rule, and revise their plans to ensure agency expenditure is at or below their ceiling where necessary.
- 4.6. The monthly profile of a trust's ceiling should match the monthly profile of its planned agency spend and be in line with wider trust activity and workforce plans. All trusts should therefore ensure that their planned monthly profile of agency expenditure is robust.
- 4.7. A trust's year-to-date performance against its agency ceiling will be monitored on a monthly basis through the trust's monthly data submissions to NHS Improvement. All trusts will be held to account against their planned expenditure in line with the 'use of resources' theme of the Single Oversight Framework.
- 4.8. Ceilings are maximum levels, and trusts should reduce agency expenditure below these levels as far as possible.
- 4.9. Only in exceptional circumstances will an adjustment to individual trust ceilings be considered. Trusts should speak to their regional team or email nhsi.agencyrules@nhs.net for further guidance.

- 4.10. When trusts merge, the ceiling for the new organisation is calculated by adding together the unspent ceiling across the two trusts; the spend trajectory for the remainder of the financial year is agreed with the new organisation. The process is the same for an acquisition.
- 4.11. NHS Improvement monitors agency spend and may subsequently adjust trajectories and ceilings as appropriate, or as new data becomes available.

5. Price caps

5.1. The price caps set by NHS Improvement apply to the total amount a trust can pay per hour for an agency worker. Trusts should not pay more than the price caps to secure an agency worker, except in exceptional patient safety circumstances, referred to as 'break glass' (see Section 8).

5.2. The price caps apply when:

- an agency fills a shift directly
- an agency finds a worker to fill a shift, but the trust pays the worker directly for that shift and pays the agency a finder's fee (all of this expenditure, including payment to the worker, fees and on-costs, should be classified as agency expenditure)
- an outsourced bank provider releases an unfilled bank shift to be filled by an agency worker (all expenditure, including payments to the worker, fees and on-costs paid to the agency providing the worker, and any additional hourly or introductory fees charged by the bank provider, should be classified as agency expenditure)
- workers are paid through their own limited/personal service company, including where workers are engaged via a third-party limited liability partnership, sole trader or an umbrella company.

5.3. The price caps do **not** apply to:

- substantive/permanent staff
- bank staff (both in-house banks and outsourced banks)
- overtime payments to substantive/bank staff (eg waiting list initiatives)
- staff employed by a trust on a fixed-term contract.

5.4. The price caps apply to all staff providing NHS services at the trust and to all specialties and departments, subject to paragraph 5.3.

5.5. The price caps also apply to agency workers who are contracted on a sessional or fee-for-service basis.

- 5.6. The price caps set are the maximum total hourly rate that trusts can pay for an agency worker. The price cap is designed to ensure that agency workers are paid in line with NHS substantive pay rates and comply with all regulations, including agency worker regulations.
- 5.7. Price caps for all staff are calculated at 55% above basic substantive pay rates. This takes into account holiday pay (annual leave and bank holidays), employer National Insurance contributions, a nominal employer pension contribution and a modest agency fee; see Annex 2 for further details on how the price caps are calculated and Annex 4 for further details on the seven pillars of the price caps.

Table 1: Price caps as a percentage above basic substantive hourly rates

Staff groups	Maximum charge from 1 Apr 2016 ⁴
Junior doctors	55% above basic rates
Other medical staff	
All other clinical staff	
Non-clinical staff	

- 5.8. The price caps include worker pay and all other elements of the payment, including all expenses such as travel and accommodation.⁵ Trusts cannot pay other additional sums to agency workers or to agencies.
- 5.9. The price caps represent the maximum that trusts can pay and should not be interpreted as standard or default rates.
- 5.10. Trusts that currently pay agency staff below the capped rates are expected not to exceed the rates they currently pay, except to comply with legal obligations.

⁴ The price caps (ie 55% above basic pay rates) have applied to ambulance trusts and ambulance foundation trusts from 1 July 2016.

⁵ The price caps do not include travel costs as part of the role where these would normally be paid to a substantive worker, eg for home visits.

- 5.11. Price caps, excluding any relevant VAT, are set out on our [website](#). Price caps are based on standard NHS pay scales and may be revised in light of any changes to contracts for substantive workers.
- 5.12. There are different price caps for high cost supplement areas, in line with Agenda for Change (AfC).⁶ The full set of price caps can be found on our [website](#).
- 5.13. For medical and dental staff, rates are set for eight pay scales. Two different rates apply for 'core' hours and 'unsocial' hours. For the purposes of the agency price caps, core hours are defined as 7am to 7pm, Monday to Friday (excluding bank holidays). Unsocial hours are all other hours. On-call hours should be treated the same as core or unsocial hours, depending on when they fall. Neither high cost area supplements nor regional supplements are applicable to medical and dental staff.
- 5.14. The price caps will be reviewed in line with adjustments to national pay scales as appropriate.
- 5.15. Trusts need to be aware of their responsibilities under the Agency Workers Regulations 2010 and Working Time Regulations. This includes ensuring that after the first 12 weeks of their engagement (including workers who a trust has previously engaged in a similar role with a gap of less than six weeks between engagements), agency workers are entitled to treatment equal to an equivalent substantive employee, including pay and annual leave.
- 5.16. The price caps remain the same regardless of the length of time an agency worker spends on assignment.
- 5.17. Trusts will therefore need to consider whether long-term reliance on agency staff is appropriate and sustainable at or below the price caps.
- 5.18. Where trusts have entered into bookings or contracts at rates above the price caps, they should seek to renegotiate or conclude these arrangements as quickly as possible, taking into account any contractual requirements for

⁶ The London high cost area (HCA) is set out in the [NHS terms and conditions of service handbook \(Agenda for Change\)](#). Annex H outlines the areas covered by the high cost area payment zones and Annex I outlines the high cost area supplements for Inner London, Outer London and Fringe.

notice and/or exit fees. All shifts at rates above the price cap must be reported as overrides to the price cap.

- 5.19. Trusts found to be entering into block bookings to avoid the price caps may be investigated by NHS Improvement. Appropriate regulatory action may be taken in response to non-compliance with the agency rules.
- 5.20. NHS Improvement monitors the price caps in partnership with NHS England and the Care Quality Commission (CQC). The rules, including the level of the price caps, may be subject to change as a result of this monitoring.

6. Mandatory use of approved framework agreements

- 6.1. Trusts are required to procure all agency staff (nurses, doctors, other clinical and non-clinical staff) via framework agreements that have been approved by NHS Improvement. Overrides to this rule are permitted on exceptional patient safety grounds only.
- 6.2. A list of approved framework agreements can be found on our [website](#). NHS Improvement will continue to review framework applications as they are submitted. NHS Improvement will continue to communicate outcomes to framework operators and trusts, including any updates to the list of approved framework agreements.
- 6.3. Framework agreements that do not meet the conditions set out in the framework approvals guidance will have their approved status reconsidered by NHS Improvement and risk having that status removed. If approval is removed, NHS Improvement will notify trusts that they are no longer able to use that particular framework agreement and allow trusts a reasonable time period, at NHS Improvement's discretion, to adjust their arrangements to approved framework agreements.
- 6.4. All procurement from approved framework agreements must comply with the price caps and maximum wage rates. NHS Improvement has worked with framework operators to ensure that all approved framework agreements contractually embed the price caps.
- 6.5. It is the responsibility of framework operators, not trusts, to seek approval from NHS Improvement for their framework arrangements.
- 6.6. We have [published guidance](#)⁷ setting out how framework operators can apply for their framework agreements to be approved by NHS Improvement for use

⁷ https://improvement.nhs.uk/documents/18/Framework_Operator_Guidance_Feb2017.pdf

by trusts. Framework operators can apply using the application form on our [website](#). We will continue to review applications on an ongoing basis

- 6.7. Where contractual arrangements with agencies already exist, trusts are expected to renegotiate or terminate those arrangements where appropriate and so far as legally possible, taking into account any contractual requirements for notice and/or exit fees.

7. Tax

7.1 In some circumstances, trusts may choose to engage workers directly and not via PAYE. In these instances, it is the responsibility of the trust to ensure compliance with current HMRC legislation including IR35. Please refer to the [latest guidance](#).⁸

⁸ <https://www.gov.uk/government/organisations/hm-revenue-customs>

8. Overriding the agency rules

- 8.1. The agency rules include a 'break glass' provision for trusts that need to override the price caps or framework rules on exceptional patient safety grounds only.
- 8.2. Overrides should be used within a robust escalation process sanctioned by the trust board. Trust boards have primary responsibility for monitoring the local impact of the agency rules and ensuring patient safety.
- 8.3. All trusts, including foundation trusts that are not in breach of their licence conditions, are expected to report weekly to NHS Improvement the number of shifts and all off-framework shifts which override the rules, and to complete a short qualitative survey. The weekly monitoring return should be signed off by a voting board member, eg chief executive, finance director, medical director, nursing director, human resources director. Further detail on trust reporting requirements is set out in Annex 3.
- 8.4. Overrides to the price caps rule are where a trust procures an agency worker at a rate that exceeds the price caps.
- 8.5. Overrides to the framework rule are where a trust procures an agency worker via any mechanism other than an approved framework agreement or arrangement, for example:
 - via an agency that is not on or formally subcontracting to an agency that is on an approved framework
 - via an agency that is on an approved framework agreement but a worker is not procured in line with the framework terms and conditions.
- 8.6. Where trusts override the agency rules they should indicate in their weekly returns the main mechanism for overriding the rules and whether this is off-framework or which framework was used.
- 8.7. Where trusts have needed to override the agency rules, they should report the following information on the overrides at shift level in their weekly returns:

- staff group (medical, nursing, other)
- type of rule (eg price cap, framework or both)
- number of shifts where a rule(s) has been overridden.
- total number of agency shifts worked.

8.8. NHS Improvement expects trusts to have in place the necessary governance to scrutinise and challenge use of agency staff, in particular where it does not comply with the agency rules. We therefore require trusts to ensure that:

- All agency shifts at £100 an hour or more and above price cap must be signed off by the chief executive and reported to NHS Improvement via weekly reporting prior to the shift. This is reduced from the current requirement to sign off and report shifts over £120 an hour.
- Where an agency shift has an hourly rate agreed below £100 but is 50% above the published price cap rate, the shift must be signed off by an executive director and reported to NHS Improvement via weekly reporting.
- All bank shifts over £100 an hour must be signed off by the chief executive and reported to NHS Improvement via weekly reporting. This is reduced from the current requirement to report shifts over £120 an hour.
- All agency shifts above the price cap where the worker has not been supplied by an agency on an approved framework must be signed off by the chief executive prior to the shift, and reported to NHS Improvement via weekly reporting.

9. Governance

9.1. We expect all trust boards, including the boards of all foundation trusts, to ensure that they are following robust and effective processes for managing the implementation of the agency rules. We expect:

- accurate and timely reporting to NHS Improvement:
 - data submitted weekly by Wednesday noon
 - submissions signed off by a voting board member
- board accountability:
 - one accountable officer in place for agency expenditure and compliance with the agency rules
 - chief executive sign off for all shifts as required (see Section 8)
- escalation process for sourcing agency staff which ensures:
 - appropriate review of agency use taking into account safety, quality and finances
 - appropriate use of the override mechanism
 - appropriate use of escalation rates within framework agreements prior to engaging workers through high-cost, off-framework suppliers
- regular internal review panels for monitoring trust overrides and reviewing agency rules monitoring data
- regular board review of agency expenditure and overrides to ensure compliance with agency ceiling.

9.2. NHS Improvement will scrutinise any overrides. Inappropriate use and failure to make rapid improvements to workforce management may lead to regulatory action as appropriate. This could include trusts boards being required to develop a clear workforce strategy on how the overrides will be avoided in the future.⁹

⁹ NHS Improvement, CQC and the Chief Nursing Officer for England emphasise the importance of trusts and commissioners fulfilling their responsibilities for safe staffing, as set out in the joint letter of 13 October 2015 from Sir Mike Richards, Dr Mike Durkin, Jane Cummings, Sir Andrew Dillon and Ed Smith and also detailed in the National Quality Board (NQB) guidance (including the 10 expectations published in November 2013). <http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf>

10. Support

10.1. Trusts are encouraged to work closely with commissioners to:

- agree plans for continuing or suspending services in the event of staffing issues
- understand potential patient safety concerns and their impact on delivery of trust/clinical commissioning group contracts.

10.2. Trusts are also encouraged to work closely with framework operators who can support trusts to comply with the agency rules.

10.3. NHS Improvement will support trusts as much as possible in complying with the agency rules. Where trusts are struggling to comply, we will seek to work with them to identify key issues, develop and prioritise actions, and implement solutions. We have developed a series of toolkits to help NHS providers move to best practice and reduce their use of agency staff; these are available on our [website](#). We strongly encourage all trusts to use the diagnostic tool and to develop robust action plans to better manage agency spend and compliance with the agency rules.

10.4. NHS Improvement's Agency Intelligence Team helps trusts to use the diagnostic tool and provides improvement support where needed. Please see our [website](#) for more information, support tools and [webinars](#)¹⁰ on issues such as rota management, developing a bank and explaining the agency rules.

¹⁰ www.workcast.com/?cpak=9747167076605020&pak=9835807670444027

11. Enforcement

- 11.1. Inappropriate overriding the rules, or any deliberate action to circumvent the rules, will have a bearing on NHS Improvement’s regulatory judgements, on the basis that a trust may not be achieving value for money, which may indicate wider governance concerns.
- 11.2. NHS Improvement will consider compliance in accordance with the provider licence and Single Oversight Framework. NHS Improvement may investigate trusts if there is sufficient evidence to suggest inefficient and/or uneconomical spending at a trust, for instance agency and management consultant spend, which indicates wider governance concerns.
- 11.3. Before considering any action, we will seek to understand the degree to which a trust is aware of the issue and has a credible plan to address it. We expect providers to take the lead in developing and implementing workforce solutions.
- 11.4. While trust boards are ultimately accountable for compliance with the rules, we will seek to support trusts in implementing them and addressing issues. The plan in Table 2 sets out how we intend to approach non-compliance.

Table 2: NHS Improvement’s response to non-compliance

1. Test trust’s understanding of the issue and the ability to address it	
Trust explains to NHS Improvement the reasons behind its level of override(s)	Trust provides: <ul style="list-style-type: none"> • a clear explanation of the causes of the override(s) • evidence of appropriate and effective governance and workforce management processes, eg activity plans and links between staffing and financial plans • evidence of best practice in considering other options before the trust overrode the controls
Trust develops an evidence-based plan to return to compliance	Plans must be signed off by the trust’s nursing director/ medical director/human resources director/director of finance as appropriate, endorsed by the executive team and approved by the board The plan should reference processes that both control costs and preserve patient safety

Trust delivers this plan	NHS Improvement will request information on whether the trust is meeting the plan via the reporting cycle or more frequently
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Where trusts have deep-seated or complex staffing issues driving their agency spend, the regional workforce teams may carry out diagnostic work with the trust to better inform its recovery plans.

2. If necessary, provide best practice support to develop a solution

Trust seeks support via relevant best practice teams	<p>If the trust is unable to deliver the plan, or considers that it needs external support immediately, then the trust should work with experts to go through any or all of step 1 above. Experts may include NHS Improvement's Agency Intelligence Team and/or the Workforce Efficiency Team</p> <p>A follow-up plan should be agreed with the central bodies, referencing the gap between actions to date and best practice, and how this will be closed</p>
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3. Escalation if rules are still being overridden

Present case to NHS Improvement	<p>If the trust is still unable to meet the price caps despite following steps 1 and 2 above, then the board may be requested to explain to NHS Improvement why this is so. We will use this interaction to identify the degree to which the board understands the problem and has engaged with it</p>
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11.5. NHS Improvement considers that all elements of the approach above – developing and implementing plans, leveraging regional and central support, identifying necessary exceptions – can be achieved via routine engagement with trusts. If, however, we consider that trusts are not doing all they can to meet all the agency rules in a timely manner, then we may consider regulatory action to formally direct trusts to apply the steps described above.

Annex 1: Definitions

Term	Definition
Price caps	Price caps are the maximum total amount of money, exclusive of VAT, that a trust can pay per hour for an agency worker. These include all related costs (eg employer pension contribution, employer National Insurance, holiday pay for the worker, administration fee/agency charge). These can be found on NHS Improvement's website .
Ceilings	Ceilings refer to the total amount a trust can spend on agency staff (as defined by the agency rules) in that financial year, excluding capitalised expenditure.
Framework agreements	All framework agreements must be procured in accordance with the EU public contracts directives as implemented by the Public Contracts Regulations 2006 or the Public Contracts Regulations 2015. The Regulations define a framework agreement as: "an agreement or other arrangement between one or more contracting authorities and one or more economic operators which establishes the terms (in particular the terms as to price and, where appropriate, quantity) under which the economic operator will enter into one or more contracts with a contracting authority in the period during which the framework agreement applies."
Medical staff	Medical staff are defined as all practising doctors who are registered with the General Medical Council, who are employed in that capacity. GPs are included when they are employed substantively by trusts, ie on a trust's payroll.
Other clinical staff	Other clinical staff are defined as those registered clinical staff who are not already included as part of 'medical staff', eg nurses, allied health professionals, etc.
Non-clinical staff	Non-clinical staff include but are not limited to estate and maintenance staff, and administration and clerical staff. Non-clinical positions also include managers.
Agency staff and agency expenditure	Agency staff are defined as those who work for the NHS but who, for the purposes of the transaction, are not on the payroll of an NHS organisation offering employment. Procurement should be classified as agency expenditure where:

	<ul style="list-style-type: none"> • an in-house bank is unable to fill a shift directly and sources the shift from a third-party agency • an outsourced bank (including but not limited to NHS Professionals) is unable to fill a shift directly and sources the shift from a third-party agency • an agency fills a shift directly • an agency finds a worker to fill a shift, but the trust pays the worker directly for that shift and pays the agency a finder's fee (all this expenditure including payment to the worker and on-costs should be classified as agency expenditure). <p>Where trusts employ a method of direct engagement (or 'finder's fee') for individual shifts or periods of employment, all costs associated with this supply (including the pay to the worker and on-costs through the NHS provider) should be classified as agency spend.</p>
<p>Bank expenditure (not in scope of agency price caps or trust agency expenditure ceilings)</p>	<p>Expenditure on shifts through both in-house and outsourced banks should be classified as bank and not under the scope of the price caps rules. This includes outsourced banks that are provided by organisations including, but not limited to, NHS Professionals. However, where these organisations are used to source shifts from a third-party agency, expenditure on those shifts should continue to be classified as agency expenditure, and all fees relating to the agency worker are included within the price caps. For the avoidance of doubt, agency shifts supplied through neutral or master vendor arrangements should continue to be classed as agency spend.</p> <p>Procurement should be classified as bank where: an in-house bank provides a shift directly an outsourced bank (including but not limited to NHS Professionals) provides a shift directly.</p>
<p>Agenda for Change (AfC)</p>	<p>AfC allocates posts to set pay bands (1 to 9) based on the principle of equal pay for equal value and harmonising uplifts for unsociable and geographical regions. All staff working for providers are subject to AfC except doctors, dentists and very senior managers.</p>
<p>Medical and dental pay scales</p>	<p>This Pay and Conditions circular informs employers of the pay arrangements for staff covered by the national medical and dental terms and conditions of service.</p>

Very senior managers (VSMs)	<p>VSMs are defined as those who are not subject to AfC; they are above band 9. They are currently paid at the discretion of the provider they work for. They are not in scope of this set of agency rules. There is published guidance for NHS employers on VSM pay; NHS Improvement published guidance for the use of off-payroll interims on 20 December 2016,¹¹ and introduced a system for seeking approval for interim VSMs on 31 October 2016.¹² VSMs are usually chief executives, executive directors or other senior directors.</p>
High cost areas	<p>The London high cost area (HCA) is set out in the NHS terms and conditions of service handbook¹³ (Agenda for Change). Annex H outlines the areas covered by the HCA payment zones and Annex I the HCA supplements for Inner London, Outer London and Fringe.</p>

¹¹ <https://improvement.nhs.uk/resources/very-senior-manager-vsm-staff-guidance-payroll-interims/>

¹² Interim agency very senior manager approval process and form can be found on our website at: <https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/>

¹³ The handbook can be found at <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

Annex 2: How the price caps are calculated

This annex illustrates the methodology behind the calculation of the price caps. Price caps are calculated based on a percentage uplift on substantive salaries.

Baseline calculation

The baseline is calculated from the substantive annual pay for each band or grade and converted to an hourly equivalent figure. This assumes a 52.18-week year for all staff. It also assumes a 37.5-hour week for Agenda for Change (AfC) staff and a 40-hour week for medical staff.

Core hours for junior doctors receive the Band 1C uplift (20%) and unsocial hours receive an uplift at the mid points of bands 1B and 1A (45%). Unsocial hours for other medical staff receive an uplift of 33.3%.

Price caps for AfC staff take into account existing AfC rules on unsocial hours for substantive staff.

Price caps for AfC staff also take into account existing AfC high cost area (HCA) supplements, at 5% for Fringe, 15% for Outer London and 20% for Inner London. These are subject to the annual minimum and maximum payments, converted to hourly rates.

Uplift calculation for cap on total charge

Price caps for all staff from 1 April 2016 are calculated at 55% above this hourly rate.

Annex 3: Trust reporting requirements

Data submission requirements	Frequency	Reporting mechanism
Agency expenditure, by staff group	Monthly	Monthly finance returns
Number of agency shifts, by staff group, breaking any combination of the agency rules	Weekly	Agency return
Report all safety issues, service closures or patient experience issues that are attributable to the agency rules	Weekly	Agency return
Details of all shifts worked by staff from off-framework agencies at rates above the price cap, with confirmation of chief executive sign-off	Weekly	Agency return
Details of all shifts worked by staff that are charging the trust £100 per hour or more, including agency fees but not including VAT, with confirmation of chief executive sign-off	Weekly or monthly ¹⁴	Agency return
Agency shifts worked at an hourly rate below £100 but 50% above the price cap rate, with confirmation of executive director sign-off	Weekly or monthly	Agency return
Details of the 10 highest paid agency workers, by hourly rate (including agency fee but not including VAT) working at the trust during the reporting week	Weekly or monthly	Agency return
Details of the 10 longest serving agency workers working at the trust during the reporting week	Weekly or monthly	Agency return
Details of bank shifts, by staff group	Weekly	Agency return
Details of bank shifts worked by staff at rates of pay over £100 per hour, with confirmation of chief executive sign off	Weekly	Agency return

¹⁴ Trusts that are within 25% of their ceiling (YTD) may report certain sections of the weekly data collection as a four weekly aggregate submission. All trusts must still submit the core information of the data collection weekly.

Annex 4: Seven pillars of the price cap



Component	Definition
Holiday pay allowance	All agency workers are entitled to the same holiday benefits as substantive NHS staff after 12 weeks.
Pay to worker	The pay to the worker element of the price cap is equal to the maximum a substantive worker can earn at that grade/band as an hourly rate.
Agency fee	Agencies charge a fee to supply workers. This is the only fee the agency should charge and should not increase when the trust 'breaks glass'.
Framework fee	The approved frameworks charge an hourly fee for each worker. This must be paid by the agency directly to the framework.
Other fees	Any other fees related to procurement of agency workers. This includes the apprenticeship levy and direct engagement fees.
Employer's pension contribution	As per all employees, agency workers are entitled to a workplace pension. The employer's contribution is set at maximum 3% of the worker's pay and holiday pay allowance.
Employer's NI contribution	The price cap includes a 13.8% employer's National Insurance contribution.

The definitions above are subject to any changes to employment legislation or NHS contracts.

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