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

September 2016
About NHS Improvement

NHS Improvement is responsible for overseeing NHS foundation trusts, NHS trusts and independent providers. 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.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.
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1. Introduction

1.1. Our role

NHS Improvement supports NHS foundation trusts and NHS trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

Our business plan (NHS Improvement, 2016d) sets out what we will do in 2016/17 to support providers in improving quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability. Our main priorities are to:

- implement the *Five Year Forward View* (5YFV) (NHS, 2014) to drive improvements in health and care
- restore and maintain financial balance
- deliver core access and quality standards.

We will work alongside providers, building deep and lasting relationships, harnessing and spreading good practice, connecting people, and enabling sector-led improvement and innovation.

In what is undoubtedly a challenging time, we will stimulate an improvement movement in the provider sector, helping providers build improvement capability, so they are equipped and empowered to help themselves and, crucially, each other.

1.2. Scope of this submission

This submission confines itself to areas of direct relevance to the work of NHS Improvement. Accordingly, it should be read in conjunction with submissions from the Department of Health and the other NHS national arm’s length bodies.

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 upon these groups and that NHS Improvement has fulfilled its duty under the Act.
2. Provider finances

2.1. The provider task to 2020

Over the last few years, the NHS has achieved improvements in care and delivered efficiencies during a time of increasing financial pressure caused by slowing growth in the NHS budget combined with rising demand. This was the key impetus for the Five Year Forward View.

In response to the 5YFV, the government pledged an additional £8.4 billion of real-term investment in the NHS by 2020. The profile of this investment is uneven. It is heavily weighted to the earlier years of the spending period because this is the time for the NHS to invest in making lasting improvements in the quality and efficiency of care so that standards can be sustained as funding growth slows later in the period.

This is an opportunity – and an obligation – that the NHS cannot afford to miss. Quality must be maintained or improved, performance against access standards recovered, financial performance stabilised, and the transformation of local health and care services begun.

As we said in Implementing the Forward View (NHS Improvement, 2016a), this is an extremely stretching and ambitious task, and needs to be matched by a realistic view of how quickly improvement can be delivered.

As a national body, we recognise that individual providers find themselves facing similar challenges but are at different starting positions on their journey to 2020 and we need to tailor our support accordingly.

2.2. NHS provider finances and workforce

The NHS provider sector has been facing significant and sustained financial strain. The sector ended the financial year 2015/16 with a deficit of £2.45 billion. This was a £1.61 billion deterioration from 2014/15 and £0.46 billion worse than that planned (NHS Improvement, 2016e).

For the first three months of 2016/17, the sector reported a deficit of £461 million, £5 million ahead of plan. The majority of provider expenditure is workforce costs, covering 66.1% of total expenditure in 2015/16 and 65.5% for Q1 2016/17. Within this, agency and contract costs accounted for 4.9% of total expenditure in 2015/16, and for 4.0% in Q1 2016/17 (NHS Improvement, 2016g).
Table 1: NHS pay costs – plan versus actual, England*

<table>
<thead>
<tr>
<th></th>
<th>Year ended 2015/16</th>
<th>Q1 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td>Surplus/(Deficit) (£m)</td>
<td>(1,986)</td>
<td>(2,447)</td>
</tr>
<tr>
<td>Permanent and bank staff (£m)</td>
<td>(45,513)</td>
<td>(45,136)</td>
</tr>
<tr>
<td>Agency and contract staff (£m)</td>
<td>(2,240)</td>
<td>(3,635)</td>
</tr>
<tr>
<td>Total pay costs (£m)</td>
<td>(47,753)</td>
<td>(48,771)</td>
</tr>
<tr>
<td>Agency costs as % of total pay</td>
<td>4.7%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Agency costs as % of total expenditure</td>
<td>3.1%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Total pay as % of total expenditure</td>
<td>66.1%</td>
<td>65.5%</td>
</tr>
</tbody>
</table>

Source: NHS Improvement (2016e, 2016g)
*All surplus/(deficit) figures are sector-reported financial positions.

Although providers are reporting actual workforce costs below plan for the first three months of 2016/17, they continue to overspend against plan for agency and contract costs. Average actual monthly workforce costs were higher in Q1 2016/17 than in 2015/16, although this comparison does not adjust for seasonality.

Figure 1: Average workforce cost per month, NHS, England* (£ million)

Source: NHS Improvement estimates, based on monthly sector reports * Not adjusted for seasonality
3. Workforce analysis

3.1. Evidence on clinical staff shortages

A recent NHS Improvement (2016b) analysis of clinical staff shortages is summarised below. Please note that the analysis was correct as at October 2015.

There has been a rapid rise in demand for hospital nurses since publication of the Francis report in February 2013 and the push for higher staffing levels that followed. For example, hospitals' demand for nurses caring for adult acute patients in 2014 was 189,000, around 7,000 more than hospitals had been forecasting just a year earlier and 24,000 more than was forecast two years before. Taken together, trusts' current forecasts anticipate further growth in the nursing workforce.

Rapid growth in the number of nurses employed over the last 2½ years resulted in an increase in the ratio of nurses to patients in hospitals. As Figure 2 shows, the recent increase has returned this ratio to where it stood at the end of 2011.

Figure 2: Trends in nurse-to-patient ratio, admissions and length of stay 2010 to 2015*

Source: NHS Improvement (2016b) * Substantive nurses only.
The supply of nurses has failed to keep up with this rapid growth in demand. Hospitals estimated they were 15,000 nurses\(^1\) short of what they need. A significant element of this supply shortfall can be ascribed to the decline in the number of nurses from outside the European Economic Area (EEA) joining the NHS each year. This figure has fallen by over 95% from its peak of more than 15,000 in the early 2000s.

Inevitably, this significant supply shortfall has driven up the cost of agency nurses. Agency charges for nurses increased by around 30% from 2012 to 2015.

The nurse shortfall would be even worse were it not for productivity improvements made by trusts over the last two years. In particular, reductions in average length of stay have offset a sharp increase in hospital admissions (see Figure 2 above). Without this improvement, there would likely be a need for around 5,000 extra nurses at a cost to the NHS of about £250 million at agency rates.\(^2\)

We are supporting local workforce initiatives and working with system partners to rebalance supply and demand at the national level. Our actions include:

- supporting providers on workforce planning and improving co-ordination at a national level
- building on the work of the Carter review to improve provider productivity
- reducing providers’ agency costs.

Steps we are taking on agency costs and provider productivity are outlined below.

3.2. Clinical workforce retention

The Committee of Public Accounts (2016) recently recommended that:

“NHS Improvement should review trends in clinical staff leaving the NHS and variations between trusts, and provide us with a plan by December 2016 on how it will support trusts to retain staff better.”

As part of our response to that recommendation, we are exploring the key drivers of nursing turnover and how staff retention can be improved. We have also begun a related project on medical workforce retention. We expect to complete our analysis by year-end.

\(^1\) Nurses trained to care for adults and working in both the acute and the community sectors.

\(^2\) Our calculation is based on NHS Professionals’ observed rate for a band 5 nurse in 2014/15.
4. Use of agency staff in the NHS

4.1. Background

Staff can be employed to work in NHS provider organisations in three main ways:

- as substantive staff, who are usually paid according to nationally determined pay bands (foundation trusts have the flexibility to vary these pay bands but in practice rarely take this option)

- as overtime/bank staff, who tend to be staff who also work substantively at the trust but choose to do extra hours usually at a rate that is slightly more than substantive rates

- as agency staff, who can be employed under a range of different models to provide flexible workforce cover.

In recent years the price for agency staff has increased beyond that for staff employed substantively by the NHS. This, together with an increase in the volume of agency staff used, has led to a significant increase in total agency spend: up by 80% from Q1 2011/12 to Q2 2013/14. By mid-2015 agency spend comprised a greater share of total staff spend than ever (see Figure 3).

**Figure 3: Trends in NHS agency spend as percentage of total staff spend, England**

<table>
<thead>
<tr>
<th>Month</th>
<th>Agency spend as % of total staff spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-11</td>
<td>4.1%</td>
</tr>
<tr>
<td>Apr-12</td>
<td>5.1%</td>
</tr>
<tr>
<td>Oct-12</td>
<td>5.7%</td>
</tr>
<tr>
<td>Apr-13</td>
<td>5.7%</td>
</tr>
<tr>
<td>Oct-13</td>
<td>6.9%</td>
</tr>
<tr>
<td>Apr-14</td>
<td>7.2%</td>
</tr>
<tr>
<td>Oct-14</td>
<td>8.2%</td>
</tr>
<tr>
<td>Apr-15</td>
<td>7.2%</td>
</tr>
<tr>
<td>Oct-15</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

Source: Analysis of monthly NHS provider returns

Trusts spent £3.3 billion on agency staff in 2014/15 and had been on course for around £3.9 billion in 2015/16 before the controls were introduced (the 2015/16 outturn was £3.6 billion). This has been a key driver in growing provider deficits.
A number of factors led to this increase in both the volume and price of agency staff.

There was a fundamental mismatch between demand for doctors and nurses and supply during this period. With activity growth outstripping demographic change across the NHS and trusts increasing staffing to respond to the Francis report, there was significant and unplanned growth in demand for doctors and nurses. The supply problem was exacerbated by both a collapse in nurse migration from outside the EEA from around 15,000 in the early 2000s to less than 1,000 in 2015 and the legacy of past reductions in the number of funded nurse training places.

The supply for doctors and nurses tends to be largely fixed in the short run, with long lead times for medical training in particular. While trusts managed to increase overseas recruitment, this was not enough to match the increase in demand.

Wages for permanent staff were subject to public sector-wide pay restraint over this period. Around 50% of agency nurses and locum doctors are full-time NHS employees ‘reselling’ part of their time to their employers. With these combined factors, it is unsurprising that this led to higher average and marginal prices and volumes in the agency market, which served as the ‘overflow’ market for the NHS workforce.

4.2. The agency spend rules

NHS Improvement engaged with trusts in August 2015 on proposed rules to support the short-term reduction of agency spend across the sector. Trusts were highly supportive of action to move as quickly as possible to cap rates paid for agency workers to help them procure agency staff at more affordable rates.

Following this feedback, we introduced the agency rules in November 2015 (see NHS Improvement, 2016c). The rules intend to encourage staff to return to permanent and bank working, increase managerial focus on agency spend, bring greater assurance on quality of agency supply and reduce agency spend.

The rules apply to all staff groups employed by NHS trusts and NHS foundation trusts: nursing, medical, all other clinical and other non-clinical staff. They apply to agency workers only; not substantive or bank workers, and do not apply to very senior managers.
Briefly, the rules comprise:

- **Expenditure ceilings** on the amount individual trusts are able to spend on agency staff in the financial year. These initially applied to nursing only but have been extended to all staff groups. Trust spend against these ceilings will be monitored as part of the new Single Oversight Framework (NHS Improvement, 2016f) and will provide a formal lever for intervention when needed.

- **Price caps** on the overall unit charge that trusts can pay for agency staff. When introduced in November 2015, the price caps were set so that clinical agency staff could be paid a premium compared with substantive staff pay. Price caps have now ratcheted down to be 55% above substantive pay, with the cap broadly covering employer on-costs, holiday pay, employer national insurance and a modest agency fee. The agency price caps, expressed as a percentage uplift to current Agenda For Change basic pay maxima, are shown in Table 2.

<table>
<thead>
<tr>
<th></th>
<th>Group 1: junior doctors</th>
<th>Group 2: other clinical staff</th>
<th>Group 3: non-clinical staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>23 November 2015</td>
<td>+ 150%</td>
<td>+ 100%</td>
<td>+ 55%</td>
</tr>
<tr>
<td>1 February 2016</td>
<td>+ 100%</td>
<td>+ 75%</td>
<td>+ 55%</td>
</tr>
<tr>
<td>1 April 2016</td>
<td>+ 55%</td>
<td>+ 55%</td>
<td>+ 55%</td>
</tr>
</tbody>
</table>

- **Wage caps**, introduced in July 2016, that require trusts to seek confirmation from agencies that workers are not paid more on an hourly basis than maximum wage rates. These maximum wage rates are set in line with substantive pay.

- **Mandatory use of approved framework agreements**, introduced in April 2016. We have been working with framework operators to ensure that all approved framework agreements contractually embed the price caps and maximum wage rates. We expect to achieve this by the end of October 2016.

The agency rules contain an important ‘break glass’ provision for trusts that need to override the rules, allowed only for exceptional patient safety grounds. Trusts may procure an agency worker above the price cap, above maximum wage rates or off
framework where it is needed to maintain patient safety. Trusts are expected to have a robust escalation process, sanctioned by the trust board, for approving these overrides and they are required to submit weekly data to NHS Improvement on the number of overrides used by staff group.

4.3. Impact of the rules

*Agency spend has fallen since the rules were introduced*

The continued upward trend in agency spend shown in Figure 3 has reversed since the introduction of these rules. Compared to a counterfactual of yearly increases in spend expected from a ‘do nothing’ approach, trusts have together reduced agency expenditure by over £500 million, as shown by Figure 4. In absolute terms, recent expenditure is around 20% below 2015 levels.

**Figure 4: Actual compared to trend monthly agency spend (£ million)**

NHS Improvement asks trusts to report safety issues and service closures that they consider to be directly due to the controls. There has not been a spike in these metrics.

*Most trusts report that the price caps are helpful in bringing net savings*

Regular surveys of trusts have shown that trusts remain supportive of the rules. Trusts say that on the whole the rules help them in negotiating with agencies and staff, supporting them to bring down prices to deliver net financial savings.
**Prices have fallen sharply but average rates remain above the cap, especially for doctors**

Sample data show that since the introduction of the agency rules, average rates have fallen significantly. For nurses (on a like-for-like basis) they have declined by around 18%, while prices for doctors have fallen by around 13%. This is likely to be a result of the price caps having encouraged trusts to negotiate more strongly with agencies, and the greater management focus on tackling agency spending in the NHS.

Average rates paid are nonetheless significantly above the agency caps for doctors and slightly above the caps for nurses. Sample data show that trusts currently pay around 70% above substantive rates for nursing agency staff and 125% above substantive rates for medical agency staff. Employer on-costs, holiday pay, employer national insurance and agency fees usually cost around 55%. Therefore agency nurse wages are on average around 15 percentage points above substantive rates, while medical agency wages are still 70 percentage points above, although there is huge variation across specialties and grades.\(^3\)

This suggests that the mismatch between supply and demand for nurses and doctors remains, and is particularly pronounced for doctors. This is an issue that cannot be resolved solely through the agency rules.

The volume of agency use does not appear to have reduced significantly at national level. We do not collect data on agency volumes, but can infer this based on

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\(^3\) Agency nurses: 70 – 55 = 15 ppts above substantive pay; medical locums: 125 – 55 = 70 ppts. Both estimates are approximate.
spending data and the sample price data. While some trusts have made significant progress in reducing agency volumes, others have had to increase volumes to deal with staffing shortages.

**Figure 6: Average prices paid for agency staff as percentage of substantive pay rates**

![Graph showing average prices paid for agency staff as percentage of substantive pay rates.](Image)

Source: Monthly NHS provider returns; NHS Professionals (nursing index); Liaison (medical index)

*Analysis from sample data of around 60 trusts. May not be representative.

**Trust overrides are more frequent for doctors than nurses**

Average agency rates remain above cap because trusts are still frequently overriding the price cap rules (ie exceeding the price caps where considered necessary to protect patient safety). Currently, trust-reported data show that in the first week of September 2016, 26% of all shifts (around 49% of medical shifts and 29% of nursing, midwifery and health visiting shifts) were paid for at above the price cap. (As this is a new dataset, there are likely to be some inaccuracies in relation to both the level and trend of overrides.)

Nursing and other overrides appear to have increased each time NHS Improvement ratcheted down the price cap (see Table 2), and then slowly returned to previous levels as the new prices were embedded. Medical overrides, however, rose significantly in April 2016 and have only gradually declined since (see Figure 7). This reflects an improvement in the quality of medical override data, but also highlights the more complex task that trusts have reducing medical agency spend in face of a highly heterogeneous and mobile doctor workforce facing supply shortages in some grades, specialties and regions (see below).
**Figure 7: Average number of overrides per trust**

Source: Analysis of monthly NHS provider returns

*Trusts are more likely to comply with the price caps for doctors working unsociable hours than core hours*

Sample data on medical locum prices indicate that average prices paid for doctors working core and unsocial hours are roughly the same. As the price cap is substantially higher for doctors working unsocial hours, this leads to fewer overrides for unsocial than core medical shifts.

Trusts have said this is because many unsocial shifts are actually also on-call and in many cases off-site on-call, thereby commanding significantly lower rates.

*Most challenged grades and specialties*

We have identified some specific challenged grades, specialties and regions through conversation with trusts and sample data. These include:

- significantly fewer challenges at lower pay grades: wages for band 2 and 3 agency nurses appear to be similar to that of substantive
- band 5 core nursing shifts now below or near agency cap rates but trusts still struggling with critical nursing shifts
- greater reduction in agency rates at the consultant level than at staff grade and junior doctor level according to sample data (although overrides are high at all medical grades).
- bigger challenges in some medical specialties than others, in line with supply shortages: sample data show consultant locum costs are highest in the following specialties:
- radiology
- diabetes and endocrinology
- psychiatry
- gastroenterology
- dermatology
- paediatrics

- struggling to find locums to fill posts at all grades in emergency medicine and general medicine
- overrides for admin and estates staff are only an issue in London: probably a result of greater pay differential between these roles and average wages across the region
- outer London trusts tending to have the biggest challenges in bringing down spend, most likely as a result of the impact of the London weighting on wages.

4.4. Challenges and next steps

We are now supporting trusts to reduce agency spend further through:

- strengthening board accountability for agency spend by embedding spend against ceiling in the Single Oversight Framework (NHS Improvement, 2016f)
- supporting trusts to bring down volumes through improving their workforce use, looking at rostering, harmonising leave booking and other HR processes, setting up and running effective staff banks and improving recruitment
- supporting trust collaboration across sustainability and transformation plan (STP) footprints
- providing guidance to support trusts on reducing medical locum spend, the areas where trusts tend to face the greatest challenges.
5. Workforce improvement

5.1. Context

Securing a workforce with the appropriate skills and deploying them effectively is central to delivery of healthcare across the NHS provider sector and intrinsically linked to better outcomes for both patients and productivity.

Current workforce levels across the NHS provider sector account for around 65% of total expenditure.

NHS provider organisations face significant workforce challenges. There are well-publicised supply shortages in some areas that have contributed to over-reliance on agency staff with implications for affordability and quality of patient care.

The further challenge is to ensure that workforce plans are consistent with the objectives set out in the Five Year Forward View for simultaneous improvements in quality, health outcomes and effective use of resources. This will require significant consideration of:

- STP-wide workforce opportunities, flexible working models and the employee relation impact of proposed models
- improved use of the current workforce by reducing variation in workforce productivity
- helping providers ensure that workforce planning decisions keep better pace with service planning and support continued delivery of patient-centred care.

5.2. Response

NHS Improvement is working with the Department of Health, Health Education England (HEE), NHS Employers, NHS England and other bodies to help identify ways of improving the overall system of workforce planning and ensure it reflects the needs of NHS providers. In the meantime, our key focus in NHS Improvement is to help providers make safe and sustainable staffing decisions, reduce variations in workforce productivity and implement new care models.

We have developed a programme to support NHS providers to respond to national workforce challenges under four themes: productivity and transformation; recruitment and retention; safer staffing; and culture and engagement. Each of these themes is expanded on in the following sections.

5.3. Productivity and transformation

We will support providers to better manage their demand for agency staff through price caps and ceilings on agency expenditure (as outlined in section 4 above). We
are also facilitate providers to implement the recommendations of the Carter review of operational productivity (as outlined in section 6 below).

We will also seek assurance from trusts’ operational plans and from wider sustainability and transformation plans (STPs) that providers and local health economies have workforce plans that support their activity, financial and quality improvement objectives, providing additional support where necessary.

We are working directly with three STP footprints on productivity and transformation, including working with HEE, NHS Employers and NHS England to identify and remove any system-level barriers, and engaging with local workforce advisory boards to provide practical support in areas such as retention, recruitment and staff mobility.

We are also working with HEE to support NHS 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.

This programme will also support the development of advanced practice roles for nurses and learning opportunities for other staff groups to support the medical workforce, extending the skills of registered healthcare professionals such as nurses, pharmacists, physiotherapists and paramedics.

5.4. Recruitment and retention

Supporting trusts to retain existing clinical staff is fundamental in ensuring safe, effective and efficient staffing levels. To support this, we are working to better understand nurse turnover and retention, inform trusts’ strategies to build nursing workforce capacity and reduce agency spend. The main output will be a report outlining key findings and summary of good practice for workforce and nurse directors. This will complement a wider improvement programme focusing on clinical workforce retention, which will disseminate best practice in a cohort of trusts.

We have also set up a programme to offer opportunities for current nurse leaders approaching retirement to continue practising as a nurse leader and avoid losing senior skills and knowledge to the system.
5.5. Safe and sustainable staffing

In recent years, some trusts have increased staff to address safety concerns but without looking sufficiently at sustainability and productivity. We now need a holistic approach to ensure that staffing decisions support patient safety, sustainability and productivity together. We are working with partners to deliver a multiprofessional approach to safer staffing. This includes the recent publication of the refreshed National Quality Board resources (NQB, 2016), covering:

- guidance on measurement and improvement
- care hours per patient day (CHPPD) and reporting staff deployment
- updated NQB expectations for making safe staffing decisions.

Following this publication, we are co-ordinating a programme on behalf of the Chief Nursing Officer to produce improvement resources for safe staffing in seven care-specific settings.
6. Operational productivity

6.1. The Carter review

The NHS is rated as one of the most efficient healthcare systems in the world, and every trust Lord Carter worked closely with in his review demonstrated some area where they are performing well. However, 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), but there is more than 20% variation between the most expensive (£3,850) and least expensive (£3,150) trust, as illustrated by Figure 8.

Lord Carter’s final report (2016) estimated that if all trusts could perform at least as well as the current average performers in all areas, the NHS in England could achieve total efficiency gains of at least £5 billion each year by 2020/21.

Figure 8: An indicative breakdown of total cost per WAU for two NHS trusts

Source: Lord Carter (2016)

The report set out 15 recommendations to help reduce variation across the biggest areas of spend in hospitals: clinical staff, pharmacy, procurement and estates and facilities. By eliminating unwarranted variation in hospitals – from staffing to services – we can make these efficiency improvements. Our Operational Productivity Directorate is taking forward the implementation of these recommendations.

4 WAU measures the total units of activity in a trust where one unit, or WAU, represents a quantity of clinical activity equivalent to the cost of the average elective inpatient stay (£3,500).
We have also developed a complementary product, *Options to improve operational efficiency*, for NHS Improvement regional teams to use in supporting providers through the planning process. This identifies actions trusts can take (across all settings), to meet the efficiency ask in the 2015 Spending Review and release the Carter productivity improvements. All actions are based on actual trust experience and described in evidence packs that also contain case studies, how to quantify impact and other useful information.

**6.2. 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 (Figure 9)
- the most expensive trusts spend around 1.3 times more on clinical staff per WAU than the least expensive trusts (Figure 10).

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

![Diagram showing spending split](source: Lord Carter (2016))

A range of resources and measures will help to optimise the use of the NHS clinical workforce and reduce unwarranted cost variation, including:

- **Improving people policies and practices**: The Carter review demonstrated the gains available to trusts where people policies and practices are improved, for example in the potential savings from reduced sickness absence rates, which vary between trusts from 2.7% to 5.8%.

- **CHPPD**: This metric can be used to describe both the staff required and staff available in relation to the number of patients. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and...
dividing the total by every 24 hours of in-patient admissions (or approximating 24 patient hours by counts of patients at midnight). It can be broken down by grade – initially registered nurses and healthcare support staff, but ultimately bands/grades within these groups and all other staff groups contributing to ward-based care, possibly including allied health professionals.

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

![Figure 10: A distribution of clinical staff cost per WAU across trusts](image)

Source: Lord Carter (2016)

- **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**: While 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.

- **Model Hospital portal**: The portal will support NHS providers to understand workforce productivity metrics at strategic, tactical and operational levels.
Figure 11: Required versus actual nursing hours per patient day for one ward in a trust

Source: Lord Carter (2016)
References


National Quality Board (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe sustainable and productive staffing, July 2016. Available online at: www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf


NHS Improvement (2016g) Performance of the NHS provider sector: 3 months ended 30 June 2016.
NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

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