RCPCH response to price caps for agency staff consultation- Monitor and Trust Development Agency

November 2015

Do you support the introduction of price caps? Please give reasons for your answer.

The College is acutely aware of the existing problems regarding high expenditure on agency staff within the NHS. Some of our members report trusts doubling their expenditure on locums over the past 12 months, which is clearly unaffordable and an inefficient use of NHS resources.

As a driver to reduce overall NHS expenditure, improve efficiency and human resources practice, the introduction of price caps is good in principle, but it has to be done safely, appropriately and sustainably. There are no details in the consultation document on how any savings realised will be used.

The RCPCH believe that investment must be made in safe and sustainable workforce planning, by training and employing enough nurses and doctors to reduce demand for agency staff. The introduction of the new policy needs to ensure compliance with the European Working Time Regulations which RCPCH strongly support and is embedded in our standards.

Capping cannot be done in isolation from ensuring adequate buffering capacity on rotas, by for example increasing the non-training establishment to cover expected gaps due to maternity leave and out of programme activity - a major issue in paediatrics.

The College has reported a 19.5% vacancy rate on middle grade (tier 2) medical rotas. There is a danger that these regulations could cause a decline in the number of locum doctors and agency nurses being employed, exacerbating current staffing shortages. No mitigation or contingency has been proposed to deal with this situation.

There is also a danger that trusts with greater independence (foundation trusts) and more ability to pay will be able to solve workforce issues more effectively and others will suffer.

We also have concerns that more remote hospitals and services will have greater difficulty attracting locum cover unless there is provision to cover travel and accommodation. If posts are not filled and staff are already working long hours, or carrying out highly intense work, there do not appear to be additional safeguards to protect them from being pressurised to do more hours.

It is not clear how this proposal will work in respect of non-NHS providers. Many paediatric community services are now outsourced to social enterprises or private organisations.

Do you agree with the proposed design of the price caps? Please give reasons for your answer.

The RCPCH has the following concerns about the design of the price caps:

- Although they are graduated over a period of time, the timescales are very tight - especially the November timelines for some staff.

- The significant gaps in paediatric rotas may mean that trusts have no choice but to use the override mechanisms to ensure that patient safety is not compromised.

- Systems should be developed to encourage permanent staff to do additional shifts, rather than agency staff, but within the EWTD.

- In the consultant document working time is divided into core hours and unsocial hours without any definitions. This of course is one of the main points of contention with junior doctors and until this is resolved it is difficult to assess whether the uplifts are appropriate.

- Agency/bank/locum work is paid per hour, which is appropriate for single or flow numbers of shifts. However caps on hourly rate or total agency spend should take into account the number of shifts. A locum doctor through an agency may charge £80 per hour for a shift or a short notice weekend locum, but if the same locum is covering 15 shifts for a month within the same service, then a lower rate may be appropriate.

Do you agree with including bank staff in the price caps? Please give reasons for your answer.

Bank doctors are rarely used for paediatric care, but there should be a principle of equity of pay if there is a long term contract. More should be done to encourage doctors away from agencies into banks.

There needs to be clarity whether you are referring to bank shifts or permanent staff with an additional bank contract. A lot of hospitals have caps in place which limit their permanent staff from being paid above a particular level; however organisations will pay considerably more to an agency for staff that may not understand the local system and patients as well as permanent staff.

Caps should be based on the shift i.e. bank or agency irrespective of whether the staff member has a permanent contract or not (with some obvious safeguards to prevent misuse) It would be useful to do a national piece of work looking at need for external agency staff if in house staff were paid 55% above base rate.

Do you agree with the objective to bring agency workers' pay in line with substantive workers' pay by 1 April 2016? Do you think the 55% uplift is appropriate? Please give reasons for your answers.

It is difficult to comment in the context of ongoing discussions over junior doctor contracts where the outcome has not been resolved and without resolution over whether hours for juniors and consultants are protected as they are now - especially as even now EWTD is often exceeded.

It is not clear whether there is an evidence base for the 55% uplift figure. Is this figure based on the desired savings or on market forces?
Often shifts are covered at short notice to cover sickness, causing inconvenience to the person covering the shift. The duration of the cover period should be a factor in the uplift calculation.

On balance we feel that April 2016 is too tight a timeline for this. At the same time as considering agency uplifts for medical and nursing staff, there needs to be simultaneous consideration of the premium on salaries paid to interim very senior management roles, for example CEOs, COOs or 'Turnaround' Directors.

The College's position on the junior doctor's contract can be found here:
http://www.rcpch.ac.uk/news/junior-doctors-contract-statement-rcpch-president

Do you agree that in trusts where staff are eligible for high cost area supplements, these uplifts should be added on top of the capped rates? Please give reasons for your answer.

We believe it would be appropriate, but there should also be consideration of supplements in areas where vacancy rates are high to incentivise work in these locations.

The uplifts are largely for cost of living, accommodation and transport etc. If someone is already living in the area then extra uplift may not be necessary for the agency or bank shifts, however parking or transport costs may need to be considered.

Duration of agency/bank work also needs to be considered especially if doctors are away from their home base in a more expensive area.

Is the proposed design of the price caps likely to change agency and/or bank workers' behaviour? Please give reasons for your answer.

There may be a struggle between the system and the agencies and bank shift workers to test who relents first and there needs to be a plan and contingency for this, i.e. there may be a reduction in availability in order to achieve higher rates which will then need to be paid in the interests of patient safety

The majority of paediatric junior doctor shifts are filled by trainees who either fill internally to cover the service or for less often in a planned way for a little extra money from time to time.

There needs to be more clarity and consistency with regard to the override mechanism and pathways and a way to measure decrease in access or availability that may be driven by agencies and bank workers.

We need to quantify if permanent employees were paid similar amounts for a bank shift the need for agency staff decreases. Permanent agency staff may change their behaviour and be forced back into the NHS which is no bad thing.

Agency workers may also seek to work centrally (as opposed to remote units) as there will be more expense involved if long way to go to locum post and have to live away from home base.

What challenges and risks do you anticipate trusts facing in delivering the price caps (both at the individual level and the system level)?

In paediatrics there are significant rota gaps and vacancies as reported in our recent survey, available at: www.rcpch.ac.uk/rotas

Trusts and clinical managers have considerable challenges to face in terms of safely staffing paediatric services.

There is a risk that a price cap alongside override mechanisms will mean that agencies can reduce availability to increase risk or the perception of risk. Further, we do not want to have a situation where junior doctors are coerced into covering these shifts at reduced bank rates on top of potential pay cuts. This will lower morale and impact retention and recruitment.

Risks can be mitigated by using permanent staff better to fill bank shifts with appropriate incentivisation in cash and kind. However there is a potential for burnout and patient safety issues if staff feel more pressured to cover gaps.

If trusts do not work with each other and develop a common approach, there is a risk that agencies will be able to set de facto rates/procedures at the level of the trusts in the weakest negotiating position.
There are also particular workforce concerns in remote and rural units which need support.

Are there any support measures at a national level that would help with compliance with the price caps and with reducing agency spend?

The RCPCH proposes the following solutions to address agency spend:

- Reduce demand by increasing spending on the numbers of nurses and doctors in training following a managed and sustainable plan.
- Reconfiguration with less acute inpatient hospital care and more planned and urgent care provided out of the hospital setting (in line with Facing the Future standards, www.rcpch.ac.uk/facingthefuture).
- Further development of managed clinical networks (e.g. Neonatal Operational Delivery Networks) or other models of trusts working together across a geographical area.
- Alternative staffing models, for example increased training and regulation of Physician Associates.
- Improve actual establishment and fill vacancies by creating more long term posts.
- Offer similar rates to permanent staff for bank shifts with some safeguards in place to minimise misuse.
- Implement price capping more widely for all areas of NHS procurement (for example drugs, medical equipment, building/cleaning services, very senior management spend) to achieve efficiency savings.

How should the impacts of these proposals on workforce, quality, access and performance be monitored by trusts and at a national level? What metrics need to be monitored?

We believe that the following metrics should be routinely monitored:

- Locum spend, particularly on middle grades
- Time taken to fill a known gap
- Reliability of promised gap fill
- Impact on outcomes (RCPCH is developing a set of outcome measures for use in acute general paediatric services)
- Impact on compliance with service standards
- Permanent staff excess hours to fill gaps
- Staff health
- Patient mortality in relation to vacancy level
- Proportion of shifts at each tier covered by agency/bank/in-house bank per week or month
- Proportion of vacancies at each tier per quarter
- Number of unfilled gaps per month
- Impact of unfilled gaps or gaps filled at last minute on quality and safety, as indicated by:
    - adverse incidents,
    - staff experience,
    - service closures

There also needs to be sharing nationally of how much spend there is nationally on hourly or short term locum rate paid shifts for doctors, nurses and AHPs to improve awareness of gravity and extent of problem. Also this needs to be supplemented by

sharing of spend on interim very senior managers (VSMs) nationally who are paid on an hourly or locum type rate.

Should similar caps apply to ambulance trusts? What would be an effective approach? Please give reasons for your answer.

The RCPCH believe that the same approach should be applied to ambulance trusts as to other trusts; however a full risk assessment must be carried out to consider the effect on patient safety.

Are you aware of any equality issues or of any particular group for whom the proposals could have a detrimental or differential impact?

In paediatrics, we know that non-UK graduates are disproportionally represented among locum consultants. Professionals who do not have a permanent job and earn through locum work only may be adversely affected financially.

This needs to be compensated by incentivising longer duration of contracts to improve their own training and practice as well as improve continuity and quality of care.

Most trusts negotiate different rate with different group of clinicians. Compared to anaesthetic and surgical specialties, we believe paediatrics fares worse in these negotiations and this could continue in the context of an override mechanism. The proportion of women working in paediatrics is far higher than in surgical specialties. Therefore there is a potential for female consultants to be proportionally more adversely affected than the male consultant body.

Please provide any further comments on these proposals:

The issue of high locum cost is a direct result of the lack of training doctors and nurses to provide safe cover on rotas. Dealing with the consequences and not the cause will produce pressures elsewhere in the system. All solutions should be focussed on addressing this route cause.

Price capping should be considered more widely for other areas of NHS procurement (for example drugs, medical equipment, building/cleaning services, very senior management spend, management consultancy) to achieve efficiency savings.

There is a clear conflict between the need to reduce the NHS overspend by control on agency staff and the failings in safety observed by the CQC in its *State of Care* report due to an insufficient number and mix of staff.

There needs to be prioritisation in the system to look at how service reconfiguration and developing new care models can reduce demand while meeting patient need, e.g. Physician Associates and their position in the regulatory framework.

If reduced payments for agency staff result in a reduced supply, there is a greater risk of unplanned closures and cuts to services.

The price caps in isolation could be a high risk step. In summary, the following factors need to be considered:

- Rules should apply to all NHS employers within sensible timeframes
- The metrics listed above need to be closely monitored
- Good practice should be incentivised
- Recruitment and retention of permanent staff should be incentivised
- Further clarity on override mechanisms
- Parity with permanent staff on bank contracts
- Further clarity and evidence base is required for the 55% uplift figure