Trust Board 1 October 2015

Delivery of the Revised 2015/16 Financial Plan

Executive Summary

Paper Q

Context

The Trust is planning for a deficit of £34.1m in 2015/16 following a request from the NTDA to improve the deficit by £2m.

In addition to the above, the Department of Health has issued guidance on the limits to nurse agency spend from Quarter 3 onwards.

Questions

1. How are plans developing to deliver a £34.1m deficit?
2. What are the implications of nurse agency guidance?
3. What has been submitted to the NTDA as a revised plan?

Conclusion

1. There is a need to reduce the current run rate by £2m per month to deliver the £34.1m deficit. Plans have been identified for much of this, with a remaining risk of £7.5m. A list of recovery actions has been developed, each with an executive lead.
2. From Quarter 3, the Trust is limited to a spend on nurse agency of 4% of total nursing and midwifery spend. This is a reduction of £0.4m per month in agency spend. In addition, the Trust will only be able to pay a maximum rate per hour and only use agencies from agreed frameworks.
3. A revised plan was submitted to the NTDA on 11th September 2015 detailing a revised trajectory in delivering £34.1m.

Input Sought

1. **Note** the level of risk and the need to find mitigating actions for any deterioration
2. **Note** the options being considered for improvement to the forecast and the work ongoing to finalise
3. **Note** the need to amend forecasts at CMG and Directorate level based on decisions taken on how to deliver £34.1m
4. **Note** the need to amend forecasts at CMG and Directorate level based on decisions taken on how to deliver £34.1m

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes /~~No /Not applicable~~]
Effective, integrated emergency care	[~~Yes /No~~ /Not applicable]
Consistently meeting national access standards	[~~Yes /No~~ /Not applicable]
Integrated care in partnership with others	[~~Yes /No~~ /Not applicable]
Enhanced delivery in research, innovation & ed'	[~~Yes /No~~ /Not applicable]
A caring, professional, engaged workforce	[~~Yes /No~~ /Not applicable]
Clinically sustainable services with excellent facilities	[~~Yes /No~~ /Not applicable]
Financially sustainable NHS organisation	[Yes /~~No /Not applicable~~]
Enabled by excellent IM&T	[~~Yes /No~~ /Not applicable]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[~~Yes~~ /No /~~Not applicable~~]
Board Assurance Framework	[Yes /~~No /Not applicable~~]

3. Related Patient and Public Involvement actions taken, or to be taken: Not applicable

4. Results of any Equality Impact Assessment, relating to this matter: Not applicable

5. Scheduled date for the next paper on this topic: 05/11/2015

6. Executive Summaries should not exceed 1 page. [My paper does ~~/ does not~~ comply]

7. Papers should not exceed 7 pages. [My paper ~~does /~~ does not comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **1ST OCTOBER 2015**

REPORT FROM: **PAUL TRAYNOR – CHIEF FINANCIAL OFFICER**

SUBJECT: **DELIVERY OF THE REVISED 2015/16 FINANCIAL PLAN**

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1. INTRODUCTION AND CONTEXT

1.1 At the end of Month 5, we have an I&E deficit of £25.4m compared to a plan of £20.1m, so are £5.3m adverse to plan. Full forecasts have been developed and revised by CMGs and Directorates since Month 2, with recovery plans being developed for all CMGs.

1.2 On 31st July 2015, the NTDA wrote formally to UHL asking us to develop a plan for a deficit of no larger than £34.1m, representing a £2m improvement on the current control total. Since this point, discussions have been ongoing on how this can be delivered via the Executive Team and with CMGs. A revised plan was submitted to the NTDA on 11th September 2015 with an I&E deficit of £34.1m.

1.3 In addition, limits have been set on the levels of nurse agency spend that Trusts can incur. For UHL, this ceiling is 4% of total nurse spend in Quarters 3 and 4 of this financial year, which is a reduction to agency of c£400k per month.

1.4 This paper details the current challenge within the forecast, the actions being taken, how the nurse agency ceiling guidance impacts on the Trust and the revised NTDA financial plan submission.

2. CURRENT POSITION

2.1 In order to deliver the initial planned deficit of £36.1m and the further stretch target of £2m, there is a need to dramatically reduce the current run rate. The average overspend YTD is £1m a month. In addition to this, the YTD overspend of £5.3m must be recovered and the stretch target of £2m delivered. In total, the run rate therefore needs to improve by c£2m per month for the remaining 7 months of the year in order to deliver a £34.1m deficit. Within the Month 5 forecast, £1m per month of this has been included within CMG and Corporate forecasts. The remaining challenge of £1m per month improvement is detailed below.

2.2 Significant work has been undertaken since Quarter 1 in all CMGs, with forecast recovery plans being developed. These recovery plans forecast delivery to plan in only 2 CMGs (RRCV and CSI). In addition to this, the financial position has been worse than forecast in Months 4 and 5 by £0.6m and £0.5m respectively. This in turn has led to a worsening of the year end forecast for some CMGs compared to the forecast presented at Quarter 1.

2.3 Forecasts currently presented by CMGs and Corporate Directorates do not go far enough or fast enough to deliver the revised plan of £34.1m.

2.4 Table 1 below details the forecast presented at Month 3 compared with that produced at Month 5 before any application of further financial recovery actions, and so quantifies the size of actions required to support delivery. At Month 5, CMG forecasts have worsened by £4.3m, Corporate forecasts by £0.4m and the central assumption of £1m theatre and independent sector improvement is unlikely to deliver. With the addition of the £2m stretch target, actions of £7.5m are required.

Table 1 – Comparison of Month 3 Forecast to Month 5 Forecast

		£000s		
Area	**CMG's**	**Month 3 forecast outturn variance to plan**	**Month 5 forecast outturn variance to plan**	**Better / (worse)**
CMGs	C.H.U.G.G.S	(838)	(1,545)	(707)
	Clinical Support & Imaging	1	3	2
	Emergency & Specialist Med	(1,138)	(2,935)	(1,797)
	I.T.A.P.S	(741)	(741)	0
	Musculo & Specialist Surgery	(2,969)	(3,732)	(763)
	Renal, Respiratory & Cardiac	0	3	3
	Womens & Childrens	1	(1,043)	(1,044)
Clinical CMGs		**(5,684)**	**(9,990)**	**(4,306)**
Corporate		**(124)**	**(124)**	**0**
Alliance		**486**	**463**	**(23)**
Research & Development		**0**	**0**	**0**
Central Division		**1,272**	**1,138**	**(134)**
Total before Central Recovery actions		**(4,050)**	**(8,513)**	**(4,463)**
	Theatre session reduction and IS reduction	1,050		(1,050)
	Non Pay improvement	1,000	1,000	0
	Inflation control	1,000	1,000	0
	Use of contingency	1,000	1,000	0
Trust forecast variance to £36.1m if no further action taken		**0**	**(5,513)**	**(5,513)**
Stretch target			(2,000)	(2,000)
Trust forecast variance to £34.1m if no further action taken			**(7,513)**	**(7,513)**

2.5 At Month 5, CMGs are reporting a £9.3m deficit to plan. Delivery of a £10m deficit at year end therefore involves a significant improvement in run rate of c£12m compared to straight line. These forecasts are already challenging and so actions to deliver further improvement will require significant corporate support and consideration of quality and performance issues.

3. ACTIONS FOR DELIVERY OF £34.1M DEFICIT

3.1 A number of financial recovery actions, in addition to those already in place within CMGs and Directorates, are being put into place. Table 2 details these actions including the relevant executive lead

Table 2 – Recovery Plan Actions

Action	Exec Lead	Update
EXPENDITURE		
Recruitment control process	L Tibbert	Process circulated to the organisation, panel in place from 22nd September
Control of temporary nurse staffing costs, eso. Agency and introduction of bank incentives	J Smith	New guidance on nurse agency ceilings assessed and in line with Trust wide forecast on nursing spend Initiatives to enhance nurse bank working in place from 28th September
Assess scope for short term reduction in medical locum and agency spend (within workforce cross cutting workstream)	P Traynor	Analysis of premium pay and opportunities being undertaken by EY, including review of top earners
Review all agency / interim non-clinical posts	L Tibbert	Review of posts underway
Review pay forecasts esp. Corporate areas with a view to minimising	P Traynor	Review underway with Corporate Directors. To be embedded within control totals
Identify feasible reductions in spend on emergency care pathways	R Mitchell	Review ongoing with relevant CMGs
Review potential for MARS / redundancy scheme	L Tibbert	Being scoped
Identify opportunities to reduce spend on CQUIN / QS action plan	J Smith / A Furlong	Review undertaken and a safely manageable reduction identified
Negotiate reductions in cost of external contracts	P Traynor	Review underway through non pay workstream
INCOME		
Increase the amount of work that takes place during pre-exisiting sessions including OPD	R Mitchell	Review ongoing with relevant CMGs as part of recovery plans
Improve depth of coding where appropriate	R Mitchell	Additional coders in place (via agency) to reduce coding backlog. Specific examples identified where improvement can be undertaken.
Review emergency activity performance mechanism with CCGs as well as use of CCG reserves and contingency	P Traynor	To be negotiatied with CCGs
Seek reinvestment of UHL share of Alliance surplus	P Traynor	To be negotiatied with Alliance
Undertake payroll overpayment analysis	L Tibbert	Review underway

3.2 The possible financial consequences of these actions are being established with a view to incorporating into year end control totals for CMGs and Directorates. These actions, plus any further identified by CMGs and Directorates, have to be sufficient to deliver £34.1m deficit to mitigate against the need for more specific turnaround actions.

3.3 Control totals will be set for each CMG and Directorate in support of delivery of the planned deficit. This will involve all areas improving on their current forecasts. Work to identify control totals is ongoing to ensure that they are transparent and understood. The following is proposed as a basis for the setting of totals:

- The deterioration in CMG and Corporate forecasts since Quarter 1 will not be accepted
- The likely financial consequences of the actions in 3.1 will be split by area and will improve the control total for these areas
- Specific CMG and Directorate adjustments will be made based on local discussion and will incorporate views on how challenging initial forecasts were and scope for local improvement

4. NURSE AGENCY CEILING

4.1 Nationally, the Department of Health, Monitor and NTDA have implemented a number of measures designed to reduce nurse agency spend across the NHS. All NHS Trusts, FTs in receipt of financial support and FTs in breach of their licence for financial reasons will be required to operate within the following guidelines:

- Not spend more on qualified nurse agency than the set ceiling from October 2015. Ceilings are set individually for each Trust based on 2014/15 nursing agency spend as a proportion of total nursing spend. For UHL, spend cannot exceed 4% from October 2015, reducing to 3% from April 2016
- Non- framework agencies must not be used and a maximum hourly rate will be specified. Any breach of this will have to be reported on a shift by shift level to the Board and NTDA with full documentation of the reasons for operating off framework

Full guidance is included with this paper.

4.2 For the first 5 months of 2015/16, nurse agency spend in the Trust has been 6.1% of the total qualified nursing spend. Reduction to 4% represents a reduction in agency from an average of £0.8m per month to £0.4m per month. This reduction in agency spend is already included in forecasts for CMGs as part of their recovery plans and is reliant on continued recruitment to vacant posts to allow agency reduction.

4.3 In September 2015, a number of measures will be implemented to incentivise staff to work on the bank and so enable reductions in agency. These include weekly payroll, payment at the top of a Bank 5 for bank only staff and overtime for part-time staff. In addition to this, work is ongoing with individual ward sisters and matrons on rostering and booking processes as well as controls around agency usage. Prospective monitoring of agency shifts booked is in place to measure compliance with the ceiling.

4.4 The Trust was required to provide a trajectory on nurse agency spend reductions to the NTDA complaint with the ceiling on 14th September 2015 (included at Appendix 1). This trajectory is in line with the nursing forecast and included within figures in Table 1.

5. PLAN RE-SUBMISSION TO NTDA

5.1 The Trust was required to submit a revised plan to the NTDA on 11th September 2015 to deliver the stretch target of a £34.1m deficit. Delivery of the £2m improvement assumed a further £1m in income linked to discussions with commissioners on reserves and contingency as well as improvements to coding, and £0.7m of pay and £0.3m of non-pay improvements associated with central recovery actions.

5.2 It should be noted that the plan re-submission was made before Month 5 finances were reported, which was £0.5m worse than forecast. This £0.5m pressure is inbuilt to the £7.5m challenge detailed in Table 1.

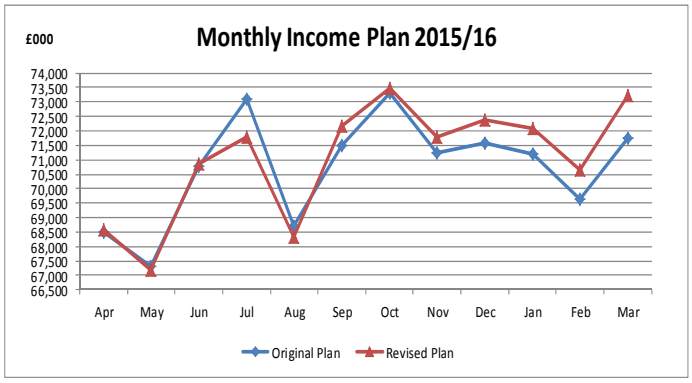
5.3 The revised plan can be seen in Table 3 with monthly phasing included at Appendix 2.

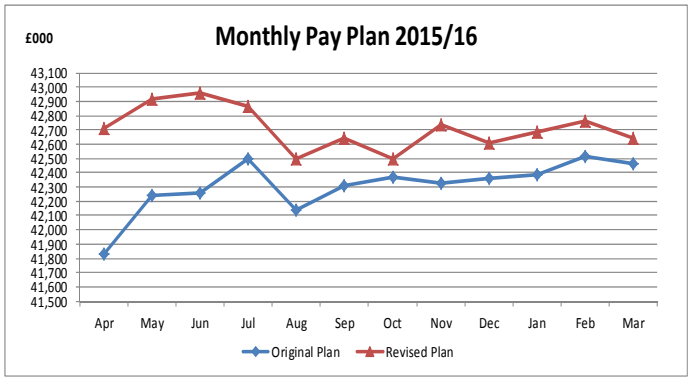
Table 3 - Revised Plan submitted to NTDA

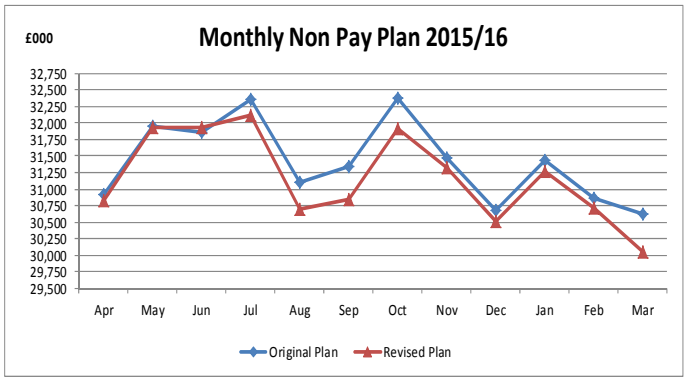
	April 2015 - March 2016 Current plan £ 000	April 2015 - March 2016 Revised Plan £ 000	Increase / (Decrease) from initial plan Plan £ 000
NHS Patient Care Income	726,328	729,219	2,891
Non NHS Patient Care	6,307	7,138	831
Teaching, R&D income	76,717	77,294	577
Other operating Income	37,921	38,858	937
Total Income	**847,273**	**852,509**	**5,236**
Pay Expenditure	**(507,030)**	**(512,533)**	**(5,503)**
Non Pay Expenditure	**(330,396)**	**(328,030)**	**2,366**
Total Operating Expenditure	**(837,426)**	**(840,563)**	**(3,137)**
EBITDA	**9,847**	**11,946**	**2,099**
Interest Receivable	77	85	8
Interest Payable	(1,938)	(1,938)	0
Depreciation & Amortisation	(33,219)	(33,219)	0
Surplus / (Deficit) Before Dividend and Disposal of Fixed Assets	**(25,233)**	**(23,126)**	**2,107**
Profit / (Loss) on Disposal of Fixed Assets	**0**	**(18)**	(18)
Dividend Payable on PDC	**(11,514)**	**(11,508)**	6
Net Surplus / (Deficit)	**(36,747)**	**(34,652)**	**2,095**
EBITDA MARGIN	**1.16%**	**1.40%**	
Less: Adjustments in respect of donated assets	**647**	**552**	(95)
RETAINED SURPLUS / (DEFICIT)	**(36,100)**	**(34,100)**	**2,000**

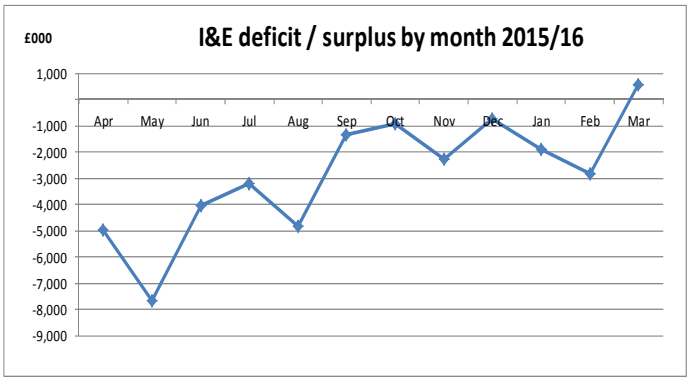
5.4 Chart 2 graphically demonstrates the trend for pay, non-pay and income as well as the revised planned deficit for each month this year. This last chart highlights the need for rapid and significant improvement to the run rate to ensure financial delivery.

Chart 2 – Income, Pay and Non-Pay Monthly Trend & Monthly I&E Deficit/Surplus









6. RISKS

6.1 There are a number of risks to the delivery of the revised deficit and compliance to the nurse agency ceiling:

- CMG and Directorate specific areas of risk total £7.5m as per Table 1, including the deterioration in the Month 5 position of £0.5m. Recovery actions need to be implemented and delivered to mitigate this risk. In addition, control totals will be finalised for each area. This is detailed in Section 2 of the paper
- It is assumed within this forecast that increased activity over winter can be managed within existing capacity and resource. Any increase in costs will need mitigating against. Increases in nurse agency costs will impact on compliance with the nurse agency ceiling
- The revised plan assumes full delivery of the CIP target of £43m. Year to date, CIP slippage is £1.5m and this needs to be recovered and the full target delivered
- Compliance with the nurse agency ceiling will be supported by recruitment. If recruitment plans are not as successful as forecast, there is a risk that agency spend cannot safely be reduced in line with the ceiling. This will also adversely impact on the delivery of the overall financial position
- Elements of the plan rely on improvement to income that are within the contract terms for payment. However, there is a risk that this is challenged as non-payable by CCGs or is not affordable within the overall health economy. In addition, no specific forecast or provision has been made for penalties to be charged via NHSE contract, for example 52 week breaches
- There are no remaining reserves. Any slippage in the forecast or new costs identified will need to be recovered or funded in a way not currently included in the forecast

7. CONCLUSION AND RECOMMENDATIONS

7.1 The Trust has been asked to improve the planned deficit by £2m to £34.1m and has re-submitted the plan to the NTDA as required by 14th September 2015.

7.2 There is risk of £7.8m within the forecast based on forecasts at Month 5. A number of central recovery actions have been developed and control totals will be established by early October 2015.

7.3 The Trust Board is asked to:

- **Note** the level of risk and the need to find mitigating actions for any deterioration
- **Note** the options being considered for improvement to the forecast and the work ongoing to finalise
- **Note** the need to amend forecasts at CMG and Directorate level based on decisions taken on how to deliver £34.1m

Paul Traynor
Chief Financial Officer

1st October 2015

APPENDIX 1 – NURSE SPEND COMPLIANT WITH NURSE AGENCY CEILING

Nursing Employee Benefits	Sign	Monthly actual values					Plan	Monthly revised plan values						Cumulative revised position		
		Month ending 30-Apr-15	Month ending 31-May-15	Month ending 30-Jun-15	Month ending 31-Jul-15	Month ending 31-Aug-15	Month ending 30-Sep-15	Month Ending 31-Oct-15	Month Ending 30-Nov-15	Month Ending 31-Dec-15	Month Ending 31-Jan-16	Month Ending 29-Feb-16	Month Ending 31-Mar-16	Revised Position Year Ending 31-Mar-16	Revised Plan Six Months Ending 31-Mar-16	Organisation Ceiling Six Months Ending 31-Mar-16
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	%
Nursing - Total Agency costs (excluding outsourced bank)	+	943	742	816	692	855	607	533	539	481	466	466	461	7,601	2,946	
Nursing - Total Gross Employee Benefits (including agency)	+	13,417	13,354	13,405	13,017	13,399	13,273	13,279	13,369	13,301	13,374	13,445	13,365	159,997	80,133	
Nursing agency costs as % of total nursing costs		7.03%	5.55%	6.09%	5.32%	6.38%	4.58%	4.01%	4.03%	3.62%	3.48%	3.47%	3.45%	4.75%	3.68%	4%

APPENDIX 2 – PHASING OF REVISED RECOVERY PLAN

	£000s Apr	£000s May	£000s Jun	£000s Jul	£000s Aug	£000s Sep	£000s Oct	£000s Nov	£000s Dec	£000s Jan	£000s Feb	£000s Mar	£000s 2015/16 Full Year
Income	68,571	67,187	70,861	71,778	68,346	72,152	73,467	71,796	72,381	72,074	70,657	73,238	**852,509**
Pay	(42,712)	(42,918)	(42,959)	(42,862)	(42,494)	(42,647)	(42,496)	(42,739)	(42,606)	(42,686)	(42,767)	(42,647)	**(512,533)**
Non Pay	(30,830)	(31,938)	(31,927)	(32,114)	(30,691)	(30,845)	(31,916)	(31,321)	(30,497)	(31,258)	(30,701)	(30,037)	**(374,076)**
Total	**(4,971)**	**(7,669)**	**(4,025)**	**(3,199)**	**(4,839)**	**(1,340)**	**(945)**	**(2,264)**	**(722)**	**(1,870)**	**(2,811)**	**554**	**(34,100)**

Monitor
Making the health sector work for patients

tda Trust Development Authority
Quality. Delivery. Sustainability.

1 September 2015

John Adler
Chief Executive
University Hospitals of Leicester NHS Trust
Headquarters
Level 3, Balmoral Building
Leicester Royal Infirmary
Infirmary Square
Leicester
LE1 5WW

Dear John

Monitor and the NHS Trust Development Authority (TDA) are today jointly launching a set of rules for nursing agency spending. This letter sets out the spending ceilings for your trust, which take effect from 1 October.

Monitor and TDA recognise that, used appropriately, agencies can play an important role in meeting unforeseen peaks in demand and ensuring patient safety. However, we also know that in 2014/15, NHS providers spent £3.3 billion on temporary staff and the rapid rise in agency spend in the NHS is associated with financial and quality issues.

These rules for nursing agency spend are part of a national programme to help NHS foundation trusts and NHS trusts meet the complex workforce challenges facing the sector. They apply to nursing agency spend only, with rules on spending on other agency staff to follow shortly. We would like to thank everyone who has contributed to the shaping of these rules, including those who submitted written responses in August.

The new rules, set out in the accompanying *Nursing Agency Rules* document, are:

- **an annual ceiling for total nursing agency spending for each trust**
- **mandatory use of approved frameworks for procuring agency staff.**

We plan to implement **price caps** later in 2015 and further detail on these will follow.

These rules will apply to all NHS trusts, NHS foundation trusts receiving interim support from the Department of Health and NHS foundation trusts in breach of their licence for financial reasons. All other NHS foundation trusts are strongly encouraged to comply and Monitor will take into account inefficient or uneconomic spending practices when considering the need for regulatory action concerning any potential breaches of governance licence conditions. The ceiling for nursing agency spending does not currently apply to ambulance trusts.

Ceiling for nursing agency spending

For each trust, we have set an annual limit for agency nursing expenditure as a percentage of total nursing staff spend. For the purpose of this ceiling rule, nursing is defined as registered general and specialist nursing staff, midwives and health visitors.

These are the ceilings for your trust:

Trust name	Q3/4 2015/16	2016/17	2017/18	2018/19
University Hospitals of Leicester NHS Trust	4%	3%	3%	3%

This rule takes effect from 1 October 2015 and we ask you to submit by 14 September 2015 a profile for your planned monthly spending across Q3 and Q4 2015/16.

Following implementation, Monitor and TDA will monitor agency spending and may subsequently adjust ceilings and trajectories based on the progress of the sector or individual trusts, or as new data becomes available.

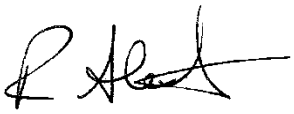
Mandatory use of approved frameworks

From 19 October 2015, all procurement of nursing agency staff must be through approved frameworks (unless otherwise authorised by Monitor and TDA). Framework owners are being asked to submit their frameworks for approval by 14 September 2015. Monitor and TDA will then publish a list of approved frameworks that you can use.

Together these rules aim to increase trusts' bargaining power when contracting with agencies and to encourage a move among nurses back to permanent and bank working. Their success should enable trusts to manage their workforce in a more sustainable way, reduce reliance on temporary staffing, raise quality and improve the working environment for staff.

We thank you for your support in developing and complying with these rules.

Yours sincerely,



David Bennett
Chief Executive, Monitor

Robert Alexander
Chief Executive, TDA

Copied to:
Paul Traynor, Director of Finance and Business Services
Julie Smith, Director of Nursing

Monitor
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Nursing agency rules

 IRG 27/15

Contents

1. Introduction

1. Monitor and the NHS Trust Development Authority (TDA) recognise that agencies can perform an important role by helping align the supply of staff with where they are most in demand. This applies as much to nurses, midwives, health visitors and support staff (who are covered by these rules - see paragraphs 16-17 for the specific scope of each rule) – as to doctors.

2. However, trust spending on agencies has increased to the extent that it is one of the most significant causes of deteriorating trust finances and evidence suggests it can be linked to quality concerns. Temporary staff are more expensive than both bank and permanent staff. In 2014/15, NHS providers spent £3.3 billion on temporary staff. Agency nurses can be less familiar with a trust's layout and procedures, and trusts with high temporary staff usage tend to have poorer patient experience ratings.[1]

3. We recognise that managing agency staff is just one element of a trust's wider workforce management strategy. We also recognise that trusts face increasing workforce cost pressures because shortages in certain staff groups have significantly increased agencies' bargaining power. These shortages have been compounded by:

    - demand for NHS nurses rising in response to the sector's heightened emphasis on service quality and safety
    - the movement towards seven-day access for patients to hospital and GP services increasing demand for nurses
    - the rate of nurses leaving the profession rising by 29% over the past two years
    - limits to the supply of nurses from UK training and other sources.

4. Against this backdrop, agencies have been able to develop a more attractive offer to nurses than trusts' banks, including more flexible hours, higher pay and near certainty of full-time agency work if desired. We understand that for these reasons, some trusts' banks are struggling to compete with agencies for temporary staff.

5. Further, the market for temporary staff is highly fragmented. Trusts tend to procure individually rather than as buying groups and often find themselves in direct competition with each other for a limited supply of labour. Even where frameworks for procuring agency staff are in place, many trusts go 'off-

[1] Healthcare Commission (2005)

framework', often because they find they have to pay higher rates than those negotiated through the frameworks to secure the staff they need.

6. These rules are intended to increase trusts' bargaining power when they procure from agencies and encourage nurses to return to permanent and bank working. Their success should enable trusts to manage their workforce in a more sustainable way, reduce reliance on temporary staffing, raise quality and improve the working environment for their staff.

7. The rules launched in this document are:

   - an annual ceiling for total nursing agency spending for each trust, and
   - mandatory use of approved frameworks for procuring agency staff.

8. We also plan to implement price caps later in 2015 and further details on these will follow. These rules apply to nursing agency spend only, with rules on spending on other agency staff to follow shortly.

9. The rules include mechanisms for local managers and clinical leaders to override them under exceptional circumstances in the interests of patient safety.

10. These rules are part of a national programme of work to help trusts meet the complex workforce challenges facing the healthcare sector. More information on this work can be found in Annex B 'Wider programme on effective staffing'.

2. Trust guidance

2.1. Scope

11. The agency rules apply to:

    - all NHS trusts
    - NHS foundation trusts receiving interim support from the Department of Health (DH)
    - NHS foundation trusts in breach of their licence for financial reasons

12. All other NHS foundation trusts are strongly encouraged to comply. The new value for money risk assessment trigger[2] means that Monitor will be explicitly taking into account trusts' inefficient or uneconomic spending practices, including in relation to agency spending, as a measure of governance. In

[2] Outlined in: www.gov.uk/government/uploads/system/uploads/attachment_data/file/451387/Risk_Assessment_Framework_updated_August_2015_final.pdf

assessing value for money, Monitor is likely to look at the extent to which trusts have followed good practice.

13. Commissioners also have an important role in monitoring performance. Where problems with staff capacity and capability pose a threat to quality, commissioners should use commissioning and contractual levers to bring about improvements. This includes considering financial support to enable trusts to deliver contract activity safely and to the required quality.

14. We will continue to refine and update these rules, as appropriate, including taking account of the sector's progress in managing agency spending.

2.2. Definitions

15. The following definitions form the basis of these rules. Any attempt to circumvent the definitions may be considered as overriding the rules.

Nursing

16. For the ceiling rule, nursing is defined as all registered nursing, midwifery and health visiting staff as defined by matrix N and P of the Occupation Code Manual v.13.1. It does not include healthcare assistants and other support staff, as defined by matrix H of the Occupation Code Manual v.13.1.[3]

17. For mandating the use of approved frameworks, nursing is defined as including all groups listed in paragraph 16 (ie including healthcare assistants and other support staff).

Agency staff

18. Agency staff are defined as those who work for the NHS but are not on the payroll of an NHS organisation.

Framework

19. A framework agreement is an agreement with providers that sets out terms and conditions under which agreements for specific purchases can be made throughout the term of the agreement. In most cases a framework agreement will not itself commit either party to purchase or supply, but the procurement to establish a framework agreement is subject to the EU procurement rules.

20. It must be procured in accordance with the EU public contracts directives as implemented in UK law by the Public Contracts Regulations 2006 or the Public Contracts Regulations 2015.

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[3] See www.hscic.gov.uk/media/13060/NHS-Occupation-Code-Manual/pdf/NHS_Occupation_Code_Manual_Version_13.1.pdf

2.3. How we can help

21. NHS Trusts and NHS Foundation Trusts should contact agencyrules@monitor.gov.uk if they have queries or concerns.

3. Annual ceiling for total agency spending

3.1. Summary

22. Monitor and TDA are setting ceilings on the amount individual trusts can spend on nursing agency staff. On 1 September 2015 trusts will be sent their annual ceilings that are their maximum rates for October 2015 to March 2016, and for 2016/17, 2017/18 and 2018/19.

23. Trusts will be monitored monthly and held to account on a quarterly basis for meeting their ceiling in that year.

3.2. Rationale

24. These rules are intended to primarily encourage trusts to change the balance of their spending on different types of staff (ie from agency to non-agency), rather than the balance of their spending on staff and other resources (eg between staff and drugs or clinical supplies).

25. The rules should retain trusts' flexibility to change their spending on staff in different ways – for example, they can reduce the wages they pay to agency staff or change the mix or volume of staff they employ overall, spending less on agency staff, say, and more on other, less expensive sources.

26. Trusts already at or below their ceiling, but who are managing their workforce strategy and agency spending effectively, will not be unfairly disadvantaged.

3.3. How the annual ceiling works

27. The annual ceilings are for nursing agency spend as a percentage of total nursing staff spend.

28. The ceilings set depend on trusts' 2014/15 nursing agency spend percentage of their total nursing staff spend. The profile for trusts' ceilings is described in Table 1 below.

29. As stated in paragraph 16, for the purpose of the ceiling rule, nursing is defined as all registered nursing, midwifery and health visiting staff, but excluding healthcare assistants and other support staff registered nurses.

Table 1: Ceiling trajectories for trusts

2014/15 nursing agency spend rate	Banding	Q3 & Q4 2015/16 ceiling	2016/17 ceiling	2017/18 ceiling	2018/19 ceiling
Under 3%	A	3%	3%	3%	3%
3% to 4%	B	3%	3%	3%	3%
4% to 5%	C	4%	3%	3%	3%
5% to 6%	D	5%	4%	3%	3%
6% to 8%	E	6%	5%	4%	3%
8% to 10%	F	8%	6%	4%	3%
10% to 12%	G	10%	8%	6%	4%
Over 12%	H	12%	10%	8%	6%

30. Following implementation of the ceiling, Monitor and TDA will monitor agency spending and may subsequently adjust trajectories and ceilings based on the progress of the sector or individual trusts, or as new data becomes available.[4]

3.4. What trusts are required to do

31. Each trust will receive its annual ceilings for October 2015 to March 2016, and for 2016/17 to 2018/19 on 1 September 2015. Once a trust has received this information it should provide a monthly profile of the planned nursing agency spend that enables it to achieve its ceiling for October 2015 to March 2016. A template will be provided and should be completed and submitted to Monitor/TDA by 14 September 2015.

32. Trusts can submit plans as soon as they are ready and the Monitor/TDA team will aim to assess plans submitted early as quickly as possible.

33. If a trust seeks an adjustment change to their ceiling, they can do this by completing an application form, along with a monthly profile, and submitting to the Monitor/TDA team by 14 September 2015. Trusts are expected only to apply for an adjustment in exceptional circumstances. See Section 6 for more detail.

3.5. Monitoring

34. A trust's performance against its annual ceilings will be monitored on its monthly returns and trusts will be held to account on a quarterly basis. The relevant data

[4] Our engagement process has indicated that some trusts include bank staff through NHS Providers in their agency financial information. We expect trusts to be fully transparent about this and we expect trusts when submitting their planned profiles to indicate whether their banding should be revised and to submit an appropriate profile in light of this definition of agency workers.

is already collected and so no further reporting to Monitor/TDA is envisaged for the ceiling rule.

35. For these rules to be effective, all trusts must keep to them. Patient and staff safety must be prioritised but we expect overriding the rules to be rare. Monitor and TDA will take appropriate and proportionate action in cases of non-compliance. Compliance is discussed in detail in Section 6.

4. Frameworks

4.1. Summary

36. From 19 October 2015, trusts subject to this agency spending rule will have to secure nursing agency staff via framework agreements that have been approved by Monitor and TDA.

37. See paragraphs 16-17 for the definition of nursing.

4.2. Rationale

This rule is designed to bring:

- greater transparency on nursing agency spend
- greater assurance on quality of nursing agency supply
- control on cost of nursing agency spend.

4.3. Mandatory use of approved frameworks

38. Trusts subject to this agency spending rule will have to secure nursing agency staff via approved framework agreements from 19 October 2015.

39. Trusts must adhere to the rates published in the framework agreements for their chosen supplier, eg if the maximum rate for a nurse from an agency on an approved framework is £X, then a trust must not pay higher than this rate.

40. If a trust uses an agency through a non-approved framework or off-framework, or exceeds the maximum rate for a particular agency within the framework, unless this has been pre-approved by Monitor and TDA (see paragraphs 43-47), it will be considered as overriding these rules. A trust will have to report each instance in its monthly returns – See section 6.

4.4. Framework approvals process

41. It is the responsibility of all framework owners to seek approved framework status from Monitor and TDA by 14 September 2015, via the application form on the website, at https://www.gov.uk/government/publications/nursing-agency-rules. They will be assessed in accordance with the criteria set out in Table 2

below. Monitor and TDA will publish a list of approved frameworks on 17 September 2015. Trusts will then have until 19 October 2015 to ensure all nursing agency staff are booked through approved frameworks.[5]

Table 2: Assessment criteria for frameworks

Criteria	What we will look for
Legal status of framework	• Procured in accordance with the EU public contracts directives as implemented in UK law by the Public Contracts Regulations 2006 or the Public Contracts Regulations 2015
Value for money	• Transparent and maximum pay rates, set in context of Agenda for Change pay, existing framework rates and market conditions • Transparent pricing mechanism – no hidden charges or membership fees. • Transparent and capped agency fee
Quality and cost improvement	• Evidence of a clear and successful strategy to improve the quality of services for patients and reduce NHS spend on agency staff • Access to a wide list of suppliers • Suppliers under the framework are subject to regular formal audit to ensure they maintain NHS employers' quality and code of practice standards and comply with all national guidelines • Regular assurance programme with results communicated transparently • Capacity to supply high quality fully vetted temporary staff, including review of the number of compliant temporary staff • Robust performance management and monitoring of suppliers
Customer support	• Support and expertise offered to customers to help them implement the framework • Detailed management information available to customers • Evidence of ability to address customer concerns in a timely manner • Evidence of steps taken to understand and manage trusts' 'off-framework' spend • Evidence of steps taken to help NHS providers manage their demand for temporary staff more sustainably

[5]These proposals should not override advance bookings with agency nursing staff that are currently in place. However, trusts must seek prior approval from Monitor/TDA or justify overrides of the rules in their monthly returns. Trusts should not make advance bookings after 1 September 2015 which do not represent value for money or meet quality standards compared to the frameworks rates.

42. Frameworks that Monitor and TDA consider to meet all the criteria above will be awarded full approval. Frameworks that do not meet all the above criteria may be awarded conditional approval. To be awarded conditional approval, framework owners will need to propose a realistic and timely plan to ensure, among other things:

    - the framework fulfils the approval criteria, including around the price capping element, and
    - the framework provides adequate monitoring and policing of escalation.

4.5. Approval for use of off-framework arrangements

43. It is expected trusts will take the necessary steps to procure all of their nursing agency staff through approved frameworks. However in some instances, trusts may have existing arrangements with an agency supplier in place where they receive superior quality and better value for money than is available on approved framework agreements.

44. For trusts to use this arrangement without having to report an override of the controls to Monitor/TDA on a shift by shift basis, trusts will be required to seek prior approval from Monitor/TDA to use that agency. Trusts will need to apply for approval by 1 October 2015. We encourage earlier submissions to allow Monitor and TDA to make decisions sooner and to facilitate your planning.

45. The trust must be able to demonstrate the agency can provide high quality staff, and meet the prices agreed in the contract and the terms and conditions of the contract around escalation/increased prices. Any change to these terms must be approved by Monitor/TDA.

46. An application will be assessed against the criteria set out in Table 3 below.

47. Trusts will be informed of our decision to approve or not to approve by 15 October 2015, but we will aim to make decisions sooner for earlier applications. Trusts will have until 19 October 2015 to take the necessary steps to get all of their nursing agency procurement on approved frameworks or approved off-framework agencies.

48. Any instances of non-approved framework/agency supplier usage from 19 October 2015 will constitute an override and must be explained in the monthly returns.

Table 3: Assessment criteria for applications

Criteria	What we will look for
Legal status of contract	• Where applicable, procured in accordance with the EU public contracts directives as implemented in UK law by the Public Contracts Regulations 2006 or the Public Contracts Regulations 2015.
Value for money	• Transparent and maximum pay rates, fixed per hour and lower than available on existing framework agreements • Transparent and capped agency fee, which is lower than available on existing framework agreements
Quality	• Trusts will need to provide evidence to Monitor/TDA that they are taking the necessary steps to assure themselves that the supplier they are entering into an arrangement with is able to provide high quality staff members; and that the supplier maintains NHS employers' quality and code of practice standards and is complaint with all national guidelines • Trusts will need to evidence to Monitor/TDA that they take a robust approach to performance management and monitoring of suppliers
Other	• No fixed volume requirement

4.6. Monitoring

49. Trust performance against the use of approved frameworks will be reported through their monthly returns. Where Trusts are not compliant, they will be required to submit shift-level detail and explanations for the reason behind this. See Section 6 for more detail.

50. For these rules to be effective, all trusts must keep to them. Patient and staff safety must be prioritised but we expect overriding the rules to be rare. Monitor and TDA will take appropriate and proportionate action in cases of non-compliance. Compliance is discussed in detail in Section 6.

5. Price caps

51. We recognise that price caps on the rate paid to agency workers per hour are useful tools to enable trusts to reduce expenditure on nursing agency staff. However, it is complex to set reasonable caps across different nursing roles and all the regions of England. We want to ensure we set caps low enough to generate savings, while not so low as to discourage staff from working agency shifts where needed. We are therefore undertaking further work with Directors of Nursing and Finance Directors to get this balance right, and plan to implement price caps later in 2015.

6. Compliance

6.1. Overseeing providers' delivery of agency controls

52. For these rules to be effective, all trusts must keep to them. Patient and staff safety must be prioritised but we expect overriding the rules to be rare.

53. Monitor and TDA will support trusts as much as possible in meeting the planned agency controls. Where trusts are struggling to comply with the controls, we will seek to work with them to identify the causes of the issue while gaining assurance that trusts are doing all they can to apply best practice to the task. We plan to maintain teams of workforce and staffing experts to ensure that trusts have access to best practice in meeting the challenges of these controls.

54. Monitor, TDA and the Chief Nursing Officer for England emphasise the importance of trusts and commissioners fulfilling their responsibilities for safe staffing as described in the NICE and National Quality Board (NQB) guidance (including the 10 expectations published in November 2013).[6, 7]

6.2. Exceptional circumstances and overriding the rules

55. The rules will not be adjusted to accommodate inadequate staff rostering or poor planning of overall workforce requirements.

56. There may be some exceptional local circumstances where the rule on the agency ceiling might be suspended or flexed.

57. If a trust wishes to apply for an adjustment to its ceiling, it can do this by submitting the application form by 14 September 2015. This is available via the website, at https://www.gov.uk/government/publications/nursing-agency-rules. Trusts should also submit their proposed monthly nursing agency spend plan for Q3 and Q4 2015/16 by this date; this should match their proposed adjusted ceiling. Monitor and TDA can then provide support, where appropriate, to help the trust manage its agency spend back to a compliant level.

58. If the adjustment is not approved, trusts will need to submit a revised monthly plan for Q3 and Q4 2015/16.

59. Trusts are only expected to apply for an adjustment in exceptional circumstances.

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[6] www.nice.org.uk/guidance/published?type=guidelines
[7] www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

60. If the trust has to override the framework rule they must report the following information on a shift-level basis in their monthly returns:

    - date
    - type of nurse (band, job type)
    - shift type
    - reason for overriding the controls
    - price paid (hourly wage and agency fee)
    - name of agency
    - name of framework
    - director level approval.

61. Trust boards should ensure that they are following robust and effective systems, and that the exceptional circumstance could not have been avoided through effective contingency planning.

62. If a trust consistently urgently overrides the rules they may be investigated by Monitor and TDA.

6.3. Agency spend, value for money considerations and our oversight frameworks

63. Under the new risk assessment framework, Monitor may investigate NHS foundation trusts if there is sufficient evidence to suggest “inefficient and/or uneconomical spending at a trust ... for instance regarding agency and management consultant spend”.

64. TDA will also investigate trusts that are not managing their agency spend effectively.

6.4. Consequences of non-compliance with the rules

65. Inappropriate overriding the rules, or any deliberate action to circumvent the rules, will have a bearing on our regulatory judgements, on the basis that a trust may not be achieving value for money, which may indicate wider governance concerns.

66. For foundation trusts, Monitor will consider compliance in the usual way in accordance with its Enforcement Guidance and the TDA will continue the interface with NHS trusts through application of the accountability framework. Before considering any action, we will always seek to understand the degree to which a trust is aware of the issue and has a credible plan to address it.

67. While Monitor and TDA have formal powers to intervene at providers, the nature of agency spend is such that providers should always be in the lead in developing and implementing solutions in this area.

68. The following graduated plan sets out how we intend to approach non-compliance in a way that supports trusts in articulating the issues and developing solutions.

Table 4: Response to non-compliance

1. Test trust's understanding of the issue and the ability to address it	
Trust explains to Monitor/TDA the reasons behind the override	Provide: • a clear understanding of the causes of the override • 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 director of nursing and the director of finance, endorsed by the executive team and approved by the board Until the plan for returning to compliance is submitted and accepted as reasonable by the relevant oversight body, the trust may not have access to increased central financing. The plan should reference processes that both control costs and preserve patient safety
Trust delivers this plan	Monitor and TDA will request information on whether the trust is meeting the plan via either the monthly reporting cycle or more frequently
2. If necessary, provide best practice support to develop a solution	
Trust seeks support via relevant best practice teams	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 the Monitor and TDA's Agency Rules Team and/or the Agency Intensive Support Team, for example 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
3. Escalation with Monitor/TDA if controls are still being overridden	
Present case to Monitor/TDA	If the trust is still unable to meet the controls despite steps 1 and 2 above, then the board may be requested to explain to Monitor/TDA why this is the case. We will use this interaction to identify the degree to which the board understands the problem and has engaged with it

69. Using the steps above to test the trust's ability and the applicability of best practice (and the challenges to it in specific cases) we can identify where there may be 'hard' constraints in implementing these controls. We will only accept these where there is clear evidence that the right actions have been considered and effectively implemented.

6.5. Use of our formal powers

70. Monitor and TDA consider that all elements in the approach above – developing and implementing plans, leveraging central support, identifying necessary exceptions – can be achieved via routine engagement with providers. If, however, we consider that trusts are not doing all they can to carry out these steps to meet the agency controls in a timely manner, then we may need to resort to the use of formal powers to apply the steps described above.

71. As new information becomes available on the feasibility of the trajectories, Monitor and TDA may revisit these ceilings.

Annex A: General expectations on trusts and their boards

Trusts subject to these rules are expected to have formal governance procedures, with the appropriate clinical and financial input, to authorise spending on agency staff, taking into account any impact of the rules on care quality. We expect this to be consistent with the NICE and NQB guidance (including 10 expectations published in November 2013).[8] Specifically, trust boards should take full responsibility for nursing staffing capacity and capability. This includes managing spend effectively and ensuring the spending rules outlined in this document are kept to.

Trusts have an important role working with commissioners to monitor performance. Where problems with staff capacity and capability pose a threat to quality, they must use commissioning and contractual levers to bring about improvements.

Monitor and TDA will expect trust boards to give assurance and evidence to the oversight bodies on request that the following best practice is undertaken in the short term:

- assessing patient acuity and dependency to see how far the existing nursing skill mix could be flexed to meet patients' needs cost-effectively
- considering not filling shifts when there is a short-term staff shortage and it is safe to do so
- depending on the level of patient risk, engaging on a temporary and fixed basis professionally qualified staff such as allied health professionals, pharmacists, clinical psychologists and paramedics to supplement the nursing workforce
- allocating support staff such as ward clerks, pharmacy technicians, house keepers, health records staff, etc, to help maximise nurse-patient contact time and improve the level of services for patients
- flexibly deploying existing nursing staff to undertake work beyond their usual area (provided they are competent to do so)
- redeploying suitably qualified and experienced nursing staff from non-frontline duties
- assessing nursing staff availability on all frameworks that have been approved.

In the longer term, trusts should explore options for flexible working, such as term-time contracts and on-call systems (particularly in specialist areas such as critical

[8] NICE guidance: www.nice.org.uk/guidance/published?type=guidelines and NQB guidance: http://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

care), promote flexible retirement options and explore options for retaining newly trained staff.

Annex B: Wider programme on effective staffing

The agency rules proposed in this document accompany other measures to help trusts manage their workforce strategy and temporary workforce spend. These include the cross-agency Workforce Board chaired by the Chief Nursing Officer for England, which focuses activities to support workforce capacity and capability.

Increasing supply of permanent staff

Monitor and TDA recognise the need to increase the supply of permanent nursing staff if the sector is to manage temporary workforce spend better in future. The Health Education England (HEE)'s Workforce plan for England 2015/16[9] describes how supply is forecast to grow by 23,000 full-time equivalents by 2019, thanks to the proposed education commission levels across the four branches of nursing and HEE's 'return to practice' campaign. Monitor and TDA welcome this announcement.

DH and the Chief Nursing Officer for England also have workforce programmes for increasing the supply of nurses in the short to medium term. They are considering how to improve retention and facilitate international recruitment. Monitor and TDA are working closely with our national partners on these programmes.

Alignment with safer staffing

We understand that it can be burdensome for trusts to review and interpret all the documents concerning the development, maintenance and reporting of safe staffing levels. We are working with the Chief Nursing Officer for England and NICE to clarify guidance on safer staffing. On 4 August 2015 Jane Cummings (Chief Nursing Officer for England) and Dr Mike Durkin (Director of Patient Safety for NHS Improvement) wrote a letter to inform the sector we will soon collect all the guidance in one place.

The work is to ensure that staffing requirements and assessments of compliance take an appropriate risk-based approach, i.e. they take into account patient acuity and dependency, outcome measures and professional judgement in calculating safe staffing levels rather than relying on simple staff-to-patient ratios.

Monitor, TDA and the Chief Nursing Officer for England emphasise the importance of trusts and commissioners fulfilling their responsibilities for safe staffing as described in the NICE and NQB guidance (including the 10 expectations published in November 2013).[10, 11]

The agency rules will not compromise patient safety but do ask if more could be done to introduce better control of temporary staffing.

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[9] hee.nhs.uk/2015/02/05/workforce-plan-for-england-201516/
[10] www.nice.org.uk/guidance/published?type=guidelines
[11] www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

Help with workforce management from the Agency Intensive Support Team

We know that many trusts already do a great deal to manage their workforce and reduce their demand for agency staff. However, there are significant variations in the way trusts manage their workforce. Monitor and TDA have set up a support team to help trusts achieve best practice. The team will work with trusts to understand their approach to managing agency staffing, benchmark trusts against best practice and help them improve workforce management including retention of substantive staff. The Agency Intensive Support Team (AIST) programme also aims to help trusts develop effective data collection procedures to support workforce management.

For further information on AIST please contact agencyprojectsupport@monitor.gov.uk and tda.workforce@nhs.net.

Annex C: Key dates and links to templates

By 14 September 2015	Trusts submit monthly ceiling profile to Monitor/TDA Trusts may apply to Monitor/TDA for adjustment to ceiling (by exception) Framework owners submit frameworks for approval to Monitor/TDA
By 17 September 2015	Monitor/TDA publish list of approved frameworks
By 1 October 2015	Trusts may apply for approval of arrangements that fall outside approved frameworks (by exception)
1 October 2015	**Ceilings take effect**
By 15 October 2015	Monitor/TDA issue decisions on arrangements that fall outside approved frameworks
19 October 2015	**Framework rule takes effect: trusts must have all nursing agency procurement on approved frameworks and arrangements**

Please wee the website to access the application forms:
https://www.gov.uk/government/publications/nursing-agency-rules