If the government wishes to be able to deliver a seven-day service by 2020, it is critical that funding is made available for the recruitment and training of doctors and nurses. However, despite the junior doctor’s rows dominating the headlines, the health and social care-staffing crisis goes beyond simply paying their existing staff higher wages. For a number of years now staffing agencies have been able to benefit from the dearth in NHS staff, with staffing agencies also making the headlines for charging “extortionate” rates and creating “crippling” agency bills for NHS trusts (figure 1).

In response, in June last year, Jeremy Hunt introduced guidance to NHS trusts in England to cap the amounts that could be paid to temporary staff working through staffing agencies, including junior doctors, other clinical staff and non-clinical staff. Caps for clinical staff were initially set at a 100% uplift from 23 November 2015, with the caps proposed to reduce further to a 75% uplift from 1 February 2016 and then a 55% uplift from 1 April 2016. In addition, the rules specify the mandatory use of approved frameworks for procurement of agency nursing staff. Under the new rules agencies have to compete on their commission, with the purpose of leading to a fairer deal for the NHS. Monitor predicts that the caps will generate £160 million per year in savings before the end of the year and £1 billion by the end of 2018.

Within the industry there is recognition that regulation is needed in order to curb NHS agency spend. However, Monitor’s approach is likely to leave the government sorely disappointed if their long-term objective is to solve the financial crisis by capping agency spend. With such a short timeline in place for NHS trusts to implement the caps following little to no consolation, and little evidence of blanket implementation to date, early signs indicate the guidelines might be a futile attempt by...
FIGURE 1: THE NHS AGENCY STAFFING MARKET

NHS spend on agency staff

- Agency spend is currently on track to hit £4 billion with NHS Improvement and NHS England expected to tighten controls on the use of temporary staffing agencies to drive down costs
- As expected, spend on nursing staff and medical locums makes up the highest proportion of agency spend
- Monitor predicts that the agency price caps, which have been in force since November 2015, will generate £160m per year savings before the end of the year and £1 billion by the end of 2018.

NHS spend by agency staffing group, 2014-15

Sources: Department of Health
the government to make vital cost savings, in turn further exacerbating the staffing crisis blighting the NHS (figure 2).

Without further investment in the NHS to allow trusts to provide safe staffing in a sustainable, long-term manner, trusts will instead be forced to essentially break the law in order to protect their patients. Howard Catton, head of policy at the Royal College of Nursing (RCN), has stated: “Ultimately, despite what Monitor say, more money and more investment is needed in the health service.” With little financial recognition in place within the NHS for experienced clinical staff to remain in post, there is no wonder that staffing agencies are such an attraction.

To date, evidence would suggest that with the NHS system at close to breaking point, and wards often badly staffed, certain staffing agencies have not been as badly impacted by the new guidelines as initially expected. As highlighted by Janet Davies, chief executive and general secretary of the RCN: “While capping agency charges may look like firm action from the government, it will not resolve the huge financial deficit trusts are facing because of spiraling patient demand and flat-lining budgets.” Loopholes have already been identified and Trusts have been forced to break the rules, breaching agency caps and going off framework in order to find recruitment firms that are able to fill staffing gaps, particularly where contracted rates are too low to procure sufficient quality of staff (figure 3).

The most prominent loophole that can be exploited by staffing agencies is the ‘break-glass’ clause, included within the Monitor guidance, which allows trusts to override the rules in the interests of patient safety. Where more critical staffing requirements are in play, such as nursing, trusts already appear to have reduced bargaining power against staffing agencies, with higher rates still being accepted in excess of the cap, as trusts are forced to pay the ‘going rate’ to secure sufficient resource. University Hospital of Leicester NHS Trust is one of 20 Trusts in the country who have been identified as breaking the rules more than an average of 100 times a week because of patient safety concerns.

Despite this, staffing agencies are certainly not getting complacent, particularly as from 1 April 2016; all staff groups must be procured through Monitor and Trust Development Authority-approved frameworks. Many of those that previously acted off framework have already seen the impact of the cap on their profitability. In addition, with the 55% above basic pay rate
cap now in force, and the added pressures of the national living wage, employer pension contributions, national insurance, holiday pay and an administrative fee, some staffing agencies will no longer be able to provide staff at the rate set out by Monitor. In those cases, agencies will likely walk away from the NHS and seek other sources of work, such as providing for the social care sector where there are also staff shortages blighting providers.

Response to date
Responses to the cap by both NHS trusts and staffing agencies have been mixed, with no evidence that there has been complete implementation of even the more ‘generous’ early caps by all the trusts across England. A number of trusts have either not yet reviewed their procurement frameworks, or have not been proactive in requesting uplifts in prices to reflect the implementation of the cap, let alone notify staffing agencies of the impact of future caps. Those trusts that took early action have shifted towards supplying through national government frameworks, of which there are three – the London Procurement Partnership (LPP), the Crown Commercial Service (CCS) and HealthTrust Europe (HTE) – with trusts that weren’t previously requesting framework rates now asking for them in line. In general, there has been a significant amount of disruption to the market as Trusts run re-procurement exercises, leaving a lot of staffing agencies on edge as to how much work they will receive from trusts in the future.

As touched on above, for some staffing agencies, the cap and framework requirements have put them at an immediate disadvantage, as framework charge rates are below those that were previously available by going off-framework. However, it has been noted that some nursing frameworks have maximum charge rates that are higher than others, such as the CCS multi-disciplinary framework rates for nursing, resulting in staffing agencies suffering a minimal decrease in charge rates. Geography has also played a part, with one agency indicating that is has largely managed to reduce it’s rates to below the cap for nursing in London, as a result of the London weighting on pay, however, outside of London, it has been more difficult to get rates above the capped rate, particularly for more highly specialist nurse staff. In general, however, off-framework providers have suffered the worst, with those refusing to accept the capped rates being hardest hit.

Despite this, other staffing agencies have been able to take advantage of the current

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**FIGURE 3: KEY DRIVERS FOR THE USE OF STAFFING AGENCIES**

<table>
<thead>
<tr>
<th>Shortage of resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>• There is a national shortage of care staff across the UK</td>
</tr>
<tr>
<td>• The NHS itself has a significant staffing shortage, particularly when it comes to clinical staff</td>
</tr>
<tr>
<td>• Social care providers also regularly cite difficulties in the recruitment and retention of nursing staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rising demand for care staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Rising population</td>
</tr>
<tr>
<td>• Political pressure regarding NHS performance requires a certain volume of care staff to be maintained in order to ensure patient safety</td>
</tr>
<tr>
<td>• Move towards 24/7 NHS will only increase demand further</td>
</tr>
</tbody>
</table>

**Resulting reliance of staffing agencies may allow agencies to breach the spending cap**

- Supply side shortages will not be resolved for a very long time
- As a result, the NHS may find themselves in a position where they have to pay the ‘going rate’ to ensure that they can provide sufficient resource that is of a high enough quality to ensure patient safety
- NHS trusts will be reluctant to use less agency if it will result in unsafe practice
- As demand rises, with a deficit of permanent staff, temporary workers will continue to be required to plug staffing gaps.

Sources: Connell Consulting analysis
situation, adopting a high volume-low margin approach. With smaller agencies dropping out of the market, those larger agencies have been able to swoop in and pick up framework contracts that were previously held by other providers. In doing so, the impact of the Monitor guidelines have been offset by the increase in business, reducing revenue by far less than previously anticipated. It is thought that continued shortage of resource and a potential move towards a 24/7 NHS will only increase demand further, enabling those staffing agencies with a strong foot in the door to generate an even greater volume of business.

Enforcement of the guidance
Another immediate flaw lies with how the guidelines will be enforced by Monitor. Whilst the guidelines state “investigations may be made of NHS trusts if there is sufficient evidence to suggest inefficient and/or uneconomical spending at a Trust, regarding agency spend”, with 245 trusts in the NHS England, it is hard to see how Monitor’s team will be able to assess the extent to which the caps have been implemented by trusts and escalate with those individual trusts in breach accordingly.

Under the Monitor guidelines it is the trusts’ responsibility to report all instances of procurement over capped rates, however, despite NHS providers submitting weekly data returns to Monitor and the Trust Development Authority, no official figures have yet been published. With no data showing the number of agency staff working in the NHS, nor the number of agencies who supply staff to the NHS available at present, it leaves us all rather in the dark as to the early impact of the measures on agency usage. It also calls into question whether NHS trusts and Monitor have the administrative resource and systems in place to be able to analyse and enforce the measures effectively.

Future impact
With the 55% uplift having only recently been implemented, time will tell as to the extent of enforcement and potential savings, which can be made. Lord Carter of the NHS, in an attempt to crack down on the implementation of tough new financial pressures is hoping that trusts might be swayed into changing their practice in light of the announcement that compliance with the guidelines is a condition of access to the Sustainability & Transformation Fund. However, whether this is a realistic incentive in light of the underlying issue of a nationwide shortage of care staff may be questioned by trusts up and down the country. Howard Catton’s comments, suggest not, noting that “leaving the health service in this perpetual loop of short term decisions, each one of which costs unnecessary money, makes it all the harder to get long term workforce planning right and leaves the health service even more stretched”.

In an ideal world, and given time, the trusts may be able to adapt their practice and procurement frameworks to effectively operate in line with the measures, enabling lower pay for agency staff. However, if the situation continues as it is currently, this could seriously harm the credibility of the measures with questions over whether the latest tightening of rates to an uplift of 55% will ever be consistently achieved across all trusts. ■
The Role of Housing in Good Health

Quality housing is vital to sustaining good mental and physical health...

was struck on joining Trowers & Hamlin's lately, where I will work closely with the housing and public sector teams, just how important the development of good housing is to the delivery of good health.

Academic studies have shown the link between housing and good mental and physical health. I attended a presentation by Thurrock District Council last autumn on how limited investment in appointing a sole member of staff to survey housing in the private rented sector and make suggestions for improving the physical state of an individual’s home, e.g. to avoid falls, had a huge impact on admissions to hospital and therefore the cost to the local NHS. In a microcosm, this is an example of how step by step differences can be made that ultimately will lead to better public health, individual outcomes and better use of public money.

None of this new, back in the 1990s I did some work with the London Borough of Croydon and the then Croydon Health Authority on improving mental health by use of NHS money to fund crime prevention initiatives, e.g. installing spyholes in and security chains for older people’s front doors, to enable the elderly population to be more relaxed in their own home which improved their mental health, as well as protecting them potentially from the risk of physical harm by intruders.

With the fairly recent change of public health responsibilities to local authorities, there is still a long way to go on this agenda. Much has been said about the Better Care Fund and whether it is delivering the outcomes that have been hoped for. However, there is no doubt that a joined up public sector approach, utilising whatever sources of funding can be accessed, will deliver more for the population.

The NHS and local authorities are still tackling the Winterbourne View legacy. Nearly all of the original institutions were closed some time ago, but it is clear that there is work to be done in reconfiguring and possibly reproviding facilities for the next generation of people with learning disabilities. This is an area where registered providers have an excellent track record, both in the provision of specialist accommodation, and in some cases, appropriate care and support packages for supported living. The rent reductions and potential cap of rents at LHA levels are a challenge to this provision, but also present opportunities for innovation and alternative investment models.

NHS capital grant funding has been made available in these schemes over the years and NHS England have recently launched a new application procedure for capital grant funding and standard form documents which should speed up investment through the business cases. However, with the change in responsibilities for revenue funding, going back to the implementation of the NHS and Community Care Act 1991 on 1 April 1993, largely revenue responsibilities fall to the responsibility of the local social services authority, or the individual themselves should they have sufficient assets. There is no objection to a mixed economy and indeed many people with learning disabilities do have substantial assets, or relatives willing to contribute towards the cost of their accommodation and care.

We are seeing an exciting development now in connection with the next generation of HOLD projects (Home Ownership for People with Long-term Disabilities). This is in essence a shared ownership model, which helps to tackle some of the difficulties resulting from the recent government benefits changes. Again, it may be possible to obtain NHS capital grant funding to support these projects, and it would be well worth investors and RPs approaching their local Clinical Commissioning Group to ascertain the needs of people with learning disabilities in the area, with a view to putting together a business case to apply for this funding.

In addition, there is the old topic of “bed blocking”. This applies both for physical infirmity, e.g. elderly people being discharged from hospital, but not really being in a position to go home without an intensive package of care, and for those cases where people are essentially stuck in mental health institutions because of the lack of availability of suitable step down care in the community. One Housing Group have been running a very successful service in conjunction with Camden and Islington Mental Health NHS Foundation Trust at Tile House in the London Borough of Camden for some time, with a resulting saving to the NHS and local authority on the cost of psychiatric inpatient care and aftercare. In addition, the research shows that people are moving on faster from Tile House out into more suitable settings in the community. This is just one example of how a joined up approach can both utilise the skills and resources (financial and otherwise) of the various parties to deliver patient care improvement and costs savings. Retirement community and housing with care development is another product which can fill the space between hospital and care home, an area where the Law Commission will, we believe, soon clarify funding models to the benefit of operators, occupiers and investors.

In the challenging world of ever tightening public finance, there is no reason not to pursue these initiatives, or variants on them, and indeed every reason to do so.

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