



House of Commons

Committee of Public Accounts

Managing the supply of NHS clinical staff in England

Fortieth Report of Session 2015–16



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*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons
to be printed 27 April 2016*

The Committee of Public Accounts

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Summary

Over 800,000 clinical staff work in the NHS. Managing the supply of these staff effectively is vitally important as it involves frontline staff—doctors, nurses and others directly involved in treating and caring for patients. However, the extent of staffing gaps in the NHS indicates that the supply of staff is not meeting demand. In 2014, there was an overall shortfall of around 5.9% between the number of clinical staff that healthcare providers said they needed and the number of staff in post, equating to a gap of around 50,000 staff. This undersupply of staff inhibits trusts' ability to provide services efficiently and effectively, and could lead to longer waiting times for treatment and shortcomings in the quality of care.

In recent years, NHS trusts and NHS foundation trusts have focused on reducing staff costs in order to meet efficiency targets. This has led to them consistently understating how many staff they will need and resulted in gaps in staffing. At the same time, trusts had to ensure they had enough nurses in light of the failings in care at Mid Staffordshire NHS Foundation Trust and the publication of safe staffing guidelines. Trusts met their need for more staff, in part, by using more costly agency staff; thereby increasing the financial pressure on the NHS. The Department of Health and its arm's-length bodies have provided ineffective leadership and support, giving trusts conflicting messages about how to balance safe staffing with the need to make efficiency savings. In addition, overseas recruitment and return-to-practice initiatives, which could help address current shortfalls, have been poorly coordinated. The national bodies need to get a better grip on the supply of clinical staff in order to address current and future workforce pressures.

Introduction

The NHS employs around 824,000 clinical staff, including doctors, nurses, midwives and allied health professionals, such as physiotherapists. Clinical staff cost around £43 billion each year to employ and account for around half of NHS providers' costs.

The Department of Health (the Department) is ultimately accountable for securing value for money from spending on health services, including on training and employing clinical staff. Health Education England is responsible for providing leadership and oversight of workforce planning. It develops national and regional plans and commissions the training of new clinical staff. It spent £4.3 billion on training places in 2014–15 and 140,000 students are in clinical training at any one time. Healthcare providers, including NHS trusts and NHS foundation trusts, are responsible for employing staff and supporting clinical placements. Trusts are overseen by NHS Improvement, which brings together the NHS Trust Development Authority and Monitor.

Conclusions and recommendations

1. **National bodies have set trusts unrealistic efficiency targets. This has caused the development of overly optimistic and aggressive staffing profiles which have subsequently led to staffing shortfalls. These have had to be met by increased use of agency staff.** The Department and more recently Monitor and NHS England set trusts efficiency targets of 4% in real terms each year from 2012–13 to 2014–15, and expected trusts to submit financial and workforce plans that would meet these challenging targets. NHS Improvement acknowledged to us that the 4% efficiency target in 2014–15 was unrealistic. Trusts forecast that significant efficiencies, around £1 billion annually, would come from reducing their pay bill (although in practice they achieved less than two-thirds of this amount). To align with these financial plans, trusts' workforce plans typically understated how many staff they would need. Over the same period, trusts were also under pressure to ensure they had enough staff following the failings in care at Mid Staffordshire NHS Foundation Trust. However, trusts could not recruit as many permanent nursing staff as they considered they needed and so filled the gaps, in part, with more costly agency staff. NHS Improvement referred to trusts' "perception" that they needed to increase staff to meet the safe staffing guidelines published by the National Institute for Health and Care Excellence, and suggested that trust boards needed to exercise more judgement in setting staffing levels. The Department told us that trusts should be aiming to achieve quality in a sustainable way within the resources available.

Recommendation: *The Department, NHS Improvement and Health Education England should provide greater national leadership and co-ordinated support to help trusts reconcile financial, workforce and quality expectations. They should report back to us in December 2016 summarising what actions they have identified and implemented.*

2. **Efforts to retain existing clinical staff are not well managed, which may further increase shortfalls.** The cheapest and best way of ensuring the supply of staff is to retain the valuable staff that have already been trained. The limited available data suggest that, within NHS hospital and community healthcare services, the proportion of nurses leaving increased from 6.8% in 2010–11 to 9.2% in 2014–15. Trusts are responsible for managing the staff they employ but it is not clear who is accountable nationally for controlling departure rates. NHS Improvement told us that it aims to support trusts to manage staff effectively. The Department accepted that there is not enough data on why clinical staff leave the NHS and where they go when they leave.

Recommendation: *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.*

3. **The shortage of nurses is expected to continue for the next three years.** Trusts have not been able to recruit the nurses they need, and Health Education England told us that it expects the supply of nurses will not meet the demand until 2019–20. The shortage of nurses has been caused by a number of factors. First, fewer new nurses have been trained as the Department cut the number of training places in four consecutive years, with 3,400 fewer places commissioned in 2012–13 compared

with 2008–09. Second, the number of nurses recruited each year from outside the European Economic Area fell by 10,700 in the decade to 2014–15. Third, fewer nurses are returning to practice than previously—on average 2,700 fewer returned each year between 2010 and 2014, compared with a decade earlier. The shortages of nurses and other non-medical staff are highest in London (over 12%), where staff turnover is higher than in other parts of the country. In October 2015, the Home Office added nurses to the ‘shortage occupation list’, which should make it easier for trusts to recruit from overseas as, for example, applicants are prioritised a visa. However, there has been little coordination of overseas recruitment and return-to-practice initiatives, with trusts potentially competing for the same staff.

Recommendation: *The Department, NHS Improvement and Health Education England should set out a plan for how the shortage of nurses will be addressed over the next three years, including how they will better coordinate overseas recruitment and return-to-practice initiatives and how they will attract nurses to those areas with the highest shortfalls.*

4. **The significant increase in agency costs is mostly due to higher volumes not higher rates. This is largely the consequence of inaccurate headcount planning within both the trusts and the centre.** Spending on agency staff increased by half from £2.2 billion in 2009–10 to £3.3 billion in 2014–15. At both this session and our session in January 2016 on the sustainability and financial performance of acute hospital trusts, the witnesses gave the impression that the rise in agency spending was mainly due to increased hourly rates. For example, NHS England told us that some agencies had taken advantage of trusts’ need for staff to charge “rip-off” fees. In fact, the rise in spending is mostly the result of trusts needing to use more agency staff, often to cover vacancies. The National Audit Office’s analysis suggests that around three-quarters of the increase in spending on temporary nurses from 2012–13 to 2014–15 was due to greater use of such staff. The Department and NHS Improvement have introduced new rules that seek to control spending on agency staff, including mandatory caps on the hourly amount that trusts can pay agencies. However, they have not addressed the underlying causes of the increased demand for agency staff. The Department aims to save the NHS £1 billion by March 2018 through the caps on agency rates, although NHS Improvement acknowledged that achieving this ambition in that timeframe would be challenging.

Recommendation: *As well as capping hourly rates, the Department and NHS Improvement also need to address the fundamental issue of the increased demand for agency staff; they should report back to us in December 2016 on progress in reducing use of agency staff and achieving the intended savings.*

5. **We are concerned that a lack of affordable homes in some parts of the country is affecting the supply of permanent NHS staff.** For example, nurses and healthcare assistants find it virtually impossible to afford to live in some parts of London and other areas where it is expensive to rent and buy property. Trusts can pay staff recruitment and retention premiums and high-cost area supplements, but these are unlikely to enable many clinical staff to become permanently based in the areas where they work. NHS Improvement told us that some land being disposed of as part of the NHS estates rationalisation plan had to be sold for homes for nurses and other healthcare staff. We are not convinced, however, that the availability

of affordable homes for NHS staff has been adequately considered as part of the Department's plan to generate £2 billion from disposing of surplus land. We remain of the view that ultimately, until the NHS addresses the lack of affordable homes, it will remain reliant on agency staff.

Recommendation: *The Department should set out how it will take account of the housing requirements for NHS staff, particularly in high-cost areas, in order to support permanent staffing.*

6. **We are concerned about the impact that the proposed changes to the funding system could have on applicants for nurse, midwifery and allied health professional training.** In the 2015 Spending Review, the Government announced plans to reform the funding system for health students by replacing grants with student loans. Nurses and other non-medical undergraduates do not currently pay tuition fees and receive a grant towards their living expenses and a mean-tested bursary. The proposed changes also involve abolishing the cap on the number of student places for nursing, midwifery and allied health subjects. We heard that there are currently about three applicants for each nurse training place. However, there is no guarantee that this position will continue if the funding system is reformed and the changes could have a negative impact on both the overall number of applicants and on certain groups, such as mature students or those with children. Health Education England told us that it had not assessed whether the changes would deter prospective students from applying.

Recommendation: *The Department and Health Education England should assess the likely effect of the new funding system on rates of applications for nursing, midwifery and allied health training courses, including whether the impact is consistent across different demographic groups and courses and how the changes are expected to affect the relative number of overseas students to home students. We also expect them to monitor the effects in real-time and report back to us in autumn 2018 after the first year of the new funding system.*

7. **No coherent attempt has been made to assess the headcount implications of a number of major policy initiatives such as the 7-day NHS.** The Department has mandated NHS England to implement 7-day services in the NHS by 2020, and the NHS Five Year Forward View envisages more care being provided outside of hospitals and closer to people's homes. Both of these initiatives are expected to involve changes in the number and mix of clinical staff. However, the Department has not adequately assessed the impact on the clinical workforce of implementing 7-day services, and so does not know if there will be enough clinical staff with the right skills. The 2015 Spending Review committed an additional £10 billion in funding for the NHS by 2020. The Department reported that this amount was intended to cover 7-day services, alongside meeting the other objectives set out in the *Five Year Forward View*. However, the £10 billion is a pot that the Department seems to expect will cover everything—despite not having separately costed 7-day services and other initiatives. We are therefore far from convinced that the Department has any assurance that the increase in funding will be sufficient to meet all of its policy objectives.

Recommendation: *All major health policy initiatives should explicitly consider the workforce implications, and specifically the Department should report back to us by December 2016 with a summary of the workforce implications of implementing the 7-day NHS.*

8. **Limitations in the data on staffing pressures make it difficult for health bodies to make well-informed decisions about workforce planning.** The National Audit Office's report highlighted a range of gaps in the available data on the NHS clinical workforce, which mean the data are not sufficiently reliable or comprehensive to support Health Education England's workforce planning decisions. An electronic staff records system is used by nearly all trusts, but there are limitations in the data that are collected and reported. These include poor information on vacancy rates, leaver rates and course completion rates, which are important indicators of workforce pressures. There is also no systematic information on why clinical staff leave the NHS, where they go when they leave, or why they transfer between providers. The Department and Health Education England told us that they were reviewing the workforce data that they would like to have available.

Recommendation: *The Department, working with its arm's-length bodies, should set out how it will ensure there is systematic reliable data on workforce pressures, including vacancy rates and reasons why staff leave the NHS, to help them manage the supply of clinical staff more effectively.*

1 Staffing shortages

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department), Health Education England, NHS England and NHS Improvement¹, on managing the supply of NHS clinical staff in England.²
2. In 2014, some 824,000 full-time equivalent clinical staff were employed in the NHS in England, providing hospital care, ambulance services, community health services, mental health services and primary care. Clinical staff make up over two-thirds of the total NHS workforce, and include some 141,000 doctors and 329,000 nurses, midwives and health visitors. Clinical staff are needed to treat and care for patients, and may have other responsibilities such as supervising more junior staff, managing teams and contributing to organisational leadership.³
3. New staff need to be supplied to replace those who leave, to meet changing demand for services and to cover shortfalls. The supply of staff can involve, for example, training new staff, recruiting from overseas, or using temporary staffing. The total number of NHS clinical staff increased by 1.4% per year on average between 2004 and 2014.⁴
4. The Department is ultimately accountable for securing value for money from spending on health services, including on training and employing clinical staff. Health Education England is responsible for providing leadership and oversight of workforce planning, education and training. It and its 13 local education and training boards develop national and regional plans and commission the training of new clinical staff. It spent £4.3 billion on training places in 2014–15, and around 140,000 students are in clinical training at any one time.⁵
5. Healthcare providers, including NHS trusts and NHS foundation trusts, are responsible for employing staff and supporting clinical placements. The cost of employing enough staff to meet the demand for healthcare has a significant impact on providers' financial position and sustainability. Clinical staff cost around £43 million each year to employ and account for around half of healthcare providers' costs, so the need to manage the supply of these staff effectively is particularly important given the financial pressures that the NHS is currently facing.⁶
6. Ensuring there are enough clinical staff with the right skills to meet the demand for high-quality, safe healthcare is essential to the operation of the NHS. However, the staffing gaps in the NHS indicate that the supply of staff is not currently meeting demand. In 2014, there was a reported overall staffing shortfall of around 5.9%. This equated to a gap of around 50,000 clinical staff, with shortfalls varying between different staff groups and regions. This undersupply of staff could lead to longer waiting times for treatment and shortcomings in the quality of care and patients' experience.⁷

1 NHS Improvement brings together the NHS Trust Development Authority and Monitor.

2 C&AG's Report, [Managing the supply of NHS clinical staff in England](#), Session 2015–16, HC 736, 5 February 2016

3 [C&AG's Report](#), paras 1.2–1.3

4 [C&AG's Report](#), paras 1.4–1.6, 1.8

5 [C&AG's Report](#), paras 1.13–1.15, 1.17, 3.7

6 [C&AG's Report](#), paras 7, 1.3, 1.14

7 [C&AG's Report](#), paras 5–6, 1.9

7. NHS bodies should prioritise retaining existing clinical staff as this is cheaper than training new staff. The limited available data suggest that the proportion of all staff (including non-clinical) leaving the NHS increased from 7.9% in 2010–11 to 9.0% in 2014–15; and, within NHS hospital and community healthcare services, the proportion of nurses leaving increased from 6.8% in 2010–11 to 9.2% in 2014–15.⁸ The Department told us that there is no simple answer to who is responsible for managing the staff they employ. NHS Improvement said that it aimed to support trusts in terms of staff satisfaction, productivity and retention. The Department accepted that there was not enough data on why clinical staff leave the NHS and where they go when they leave, and that a more systematic approach was needed to obtaining feedback and doing exit interviews when people leave trusts.⁹

Efficiency targets and safe staffing

8. Each year trusts submit local workforce plans to Health Education England and financial plans to the NHS Trust Development Authority or Monitor. NHS Improvement told us that the link between financial plans and workforce plans had historically been poor, and that trusts were challenged when plans were inconsistent. The National Audit Office reported that trusts' workforce plans were determined to a large degree by financial considerations.¹⁰

9. In recent years trusts have been under pressure to make efficiency savings. The Department and more recently Monitor and NHS England set trusts efficiency targets of 4% in real terms each year from 2012–13 to 2014–15, and expected trusts to submit financial plans and workforce plans that would meet these challenging targets. Trusts had forecast that significant efficiencies would come from staff costs, which account for around two-thirds of their costs. Each year acute hospital trusts planned for around £1 billion in recurrent pay savings, although in practice they achieved less than two-thirds of these efficiencies.¹¹

10. NHS Improvement said that the efficiency targets created downward pressure on trusts' workforce plans. Trusts typically understated how many staff they would need in order to align their financial plans and workforce plans. NHS Improvement accepted that the 4% efficiency target in 2014–15 was unrealistic.¹² We also concluded in our recent report on the sustainability and financial performance of acute hospital trusts that the efficiency targets for providers set by NHS England and Monitor were too optimistic. The 4% efficiency target was driven by the shortage of resources available across the NHS overall, and historically the NHS has only been able to achieve efficiency savings of 1%–2%.¹³

11. At the same time as trusts were under pressure to meet efficiency targets, a greater focus on care quality led them to increase their demand for nurses in particular.¹⁴ Reports in 2013 on the failings at Mid Staffordshire NHS Foundation Trust had highlighted the

8 [C&AG's Report](#), paras 3, 1.4

9 [Qq 8–10](#)

10 [Qq 27–28, 36](#); [C&AG's Report](#), paras 2.3, 2.11

11 [C&AG's Report](#), paras 2.14–2.15

12 [Qq 30, 35, 45](#); [C&AG's Report](#), paras 13, 2.11, 2.18

13 Committee of Public Accounts, [Sustainability and financial performance of acute hospital trusts](#), Thirtieth Report of Session 2015–16, 15 March 2016

14 [Q 32](#)

importance of staffing to the quality of care. Subsequent safe staffing guidance published by the National Institute for Health and Care Excellence (NICE) in July 2014 had noted there was increased risk of harm associated with a registered nurse caring for more than eight patients during daytime shifts.¹⁵

12. The Department told us that many trusts had interpreted the ratio of one nurse to eight patients as a requirement, when it was not intended to be. NHS Improvement said that trusts felt under particular pressure to commit to additional staffing before or after an inspection, and the Department noted that trusts' perception of what the Care Quality Commission expected led them to feel that quality was more important than managing cost. Health Education England said that trusts could not recruit as many permanent nursing staff as they considered they needed and so filled the gaps, in part, with bank, locum and agency staff. NHS Improvement explained that trusts' perception of the inspection regime and that they needed to meet NICE safe staffing guidelines had been the main driver of cost increases.¹⁶

13. The Department told us that decisions about the staffing needed to provide high-quality care had to be taken within each trust. NHS Improvement said that trust boards needed to exercise judgement when setting staffing levels and that in recent years boards may have been too risk averse.¹⁷ The Department told us that trusts should be aiming to achieve "sustainable quality". It accepted that it should have questioned how aligned workforce plans and financial plans were, but steps were now being taken to consider finance and quality together. NHS Improvement and the Care Quality Commission had written to trusts about the need to achieve quality in a sustainable way within the resources available.¹⁸

14. The Department also told us that Lord Carter's review of productivity in the NHS had highlighted huge variation in the way trusts approached staffing.¹⁹ NHS Improvement said that it was building stronger regional teams to support trusts, and suggested closer working was required to understand what level of savings was reasonable.²⁰

Supply of nurses

15. The number of new nurses being trained has not been sufficient to meet increased demand. In light of the economic downturn and predictions about reduced demand, the Department cut the number of nurse training places in four consecutive years; 11,500 places were commissioned in 2012–13 compared with nearly 14,900 in 2008–09.²¹ However, by 2014, trusts' needed 24,000 more nurses than they had forecast two years earlier in 2012. Therefore, as it takes three years to train a nurse, fewer nurses were qualifying as demand was increasing.²²

15 [C&AG's Report](#), paras 2.6, 2.10

16 [Qq 32, 35, 37](#)

17 [Qq 44, 55, 91](#)

18 [Qq 40–41](#)

19 [Q 56](#)

20 [Qq 57, 60](#)

21 [Q 129; C&AG's Report](#), Figure 13

22 [Q 37; C&AG's Report](#) para 2.7

16. Health Education England increased the number of training places from 2013–14 onwards. It told us that these nurses would soon start to enter the system, with 800 more newly qualified nurses in 2016.²³ However, it predicted that until 2019–20 there would be a gap between the demand for additional nurses and those finishing their training.²⁴

17. The supply of nurses has also been affected by reductions in the numbers returning to practice and being recruited from overseas. The National Audit Office found that there is limited regional or national coordination of overseas recruitment or return-to-practice initiatives, despite the fact that providers may be competing for the same staff.²⁵

18. Recruitment from outside the UK has been an important source of clinical staff for the NHS. However, the National Audit Office found that the number of nurses newly registered from outside the European Economic Area fell from 11,359 in 2004–05 to just 699 in 2014–15, a drop of 94%.²⁶ The Department highlighted that, in October 2015, it had agreed with the Home Office and the Migration Advisory Committee a temporary measure to put nurses on the shortage occupation list. This should make it easier for trusts to recruit from overseas as it allows them to employ nurses from outside the European Economic Area without first needing to show that there are no settled UK workers who could fill the role, and allows applicants to be prioritised a visa. However, the Department was unclear what the long-term solution to this issue would be.²⁷

19. The National Audit Office also reported that relatively little use is currently made of return-to-practice schemes: 4,800 former nurses and midwives completed return-to-practice courses between 2010 and 2014, compared with 18,500 between 1999 and 2004.²⁸ The Department told us that Health Education England had taken action on return-to-practice, which was a much cheaper route for getting nurses into employment than training new staff. Health Education England also said that it was consulting on creating a new post of ‘nurse associate’ to provide more support to the nursing workforce.²⁹ Subject to the consultation, it intended to start training the first 1,000 nurse associates later in 2016.³⁰

20. Health Education England told us that staffing shortages were not evenly spread across the country and the rate of vacancies was specialty-specific and profession-specific. For nurses, the highest vacancy rate was about 15% in North, Central and East London. In London, the workforce tended to be younger, more diverse and more transient, and this higher turnover made London more susceptible to staffing shortages. In contrast, Health Education England also highlighted that, by and large, it had been more difficult to fill GP training places in the north and east of the country, while 100% of these places had been filled in London, Kent, Surrey and Sussex.³¹

23 [Q 96](#)

24 [Q 129](#)

25 [C&AG’s Report](#), paras 12, 4.23

26 [C&AG’s Report](#), para 4.21

27 [Qq 117, 122–123](#)

28 [C&AG’s Report](#), para 4.27

29 The proposed nurse associates are expected to work alongside care assistants and registered nurses to deliver care.

30 [Qq 123, 132–133](#)

31 [Qq 80, 124–125, 132](#)

Use of agency staff

21. The use of temporary staff, including from agencies, can provide trusts with flexibility to respond to short-term fluctuations in demand or in the availability of their existing workforce. However, the demand for temporary staff has risen significantly, and spending on agency staff increased from £2.2 billion in 2009–10 to £3.3 billion in 2014–15.³²

22. At our evidence session on the sustainability and financial performance of acute hospital trusts in January 2016, the witnesses gave the impression that the rise in agency spending was mainly due to increased hourly rates, and blamed the agencies for charging excessive commission. NHS England said that agencies were taking advantage of the situation to charge “rip-off” fees, and the Department argued that no one had foreseen the scale of “exploitation” by agencies.³³ NHS Improvement repeated this view in our session on managing the supply of clinical staff, saying there had been “abuse of the system” with “extortionate rates” charged. However, the National Audit Office reported that the rise in spending was mostly the result of trusts needing to use more agency staff, often to cover vacancies. Its analysis suggested that three-quarters of the increased spending on temporary nurses from 2012–13 to 2014–15 resulted from greater use and the rest was due to higher average hourly rates. NHS Improvement accepted that the biggest benefit would come from reducing the use of agency staff.³⁴

23. In 2015, the Department and NHS Improvement introduced new rules aimed at controlling spending on agency staff, including new arrangements for procuring temporary staff and caps on how much trusts can pay per shift. The caps mean that an agency worker should not be rewarded more than exiting permanent staff at that grade.³⁵ The Department aims to save the NHS £1 billion by March 2018 through the price caps, although NHS Improvement raised doubts as to whether this amount could be achieved within that timeframe. NHS Improvement told us that nine in ten organisations had breached the cap at some point, but around three-quarters of locum and agency shifts were paid within the cap. It also said that from 2016–17 providers would be mandated to use framework suppliers, who would have to pay NHS rates.³⁶

Affordable homes

24. We asked what was being done to ensure that the lack of affordable homes was not impeding the supply of permanent key workers in the NHS, particularly in parts of London and other areas where it is expensive to rent and buy property. The Department told us that there were no specific housing bursaries for particular workers within the NHS, but that trusts could pay staff recruitment and retention premiums and high-cost area supplements. In our report on the sustainability and financial performance of acute hospital trusts in March 2016, we concluded that ultimately, until the NHS solves its workforce planning issues, including the lack of affordable homes for NHS staff, it will not solve the problem of reliance on agency staff. We also noted that the Department was looking to generate £2 billion from disposing of surplus estate during this parliament, but

32 [C&AG’s Report](#), para 4.8

33 Committee of Public Accounts, [Sustainability and financial performance of acute hospital trusts](#), Thirtieth Report of Session 2015–16, 15 March 2016

34 [Q 90](#); [C&AG’s Report](#), paras 4.4, 4.9

35 [Q 81](#); [C&AG’s Report](#), paras 4.12–4.13

36 [Qq 84, 86](#); [C&AG’s Report](#), paras 4.13

there was little detail on how this would be realised.³⁷ NHS Improvement told us in our session on managing the supply of clinical staff that the NHS estates rationalisation plan required some land to be sold for homes for nurses and other healthcare staff, although the plan was still being developed.³⁸

37 Committee of Public Accounts, [Sustainability and financial performance of acute hospital trusts](#), Thirtieth Report of Session 2015–16, 15 March 2016

38 [Qq 154–155](#)

2 Informed decision-making

Funding training places

25. Health Education England provides funding to higher education institutions, to providers for clinical placements and to students to cover some tuition fees and living costs. In the 2015 Spending Review, the Government announced plans to reform the funding system for health students by replacing grants with student loans and abolishing the cap on the number of student places for nursing, midwifery and allied health subjects.³⁹ Written submissions to us from a number of royal colleges and other bodies raised concerns that replacing grants with loans would deter many people from applying. In particular, they suggested the change might act as a disincentive to applicants from lower income backgrounds, women, mature students, people with caring responsibilities, and those from black and minority ethnic communities. They also pointed out that people training to become health care professionals had to attend clinical placements, and therefore had less time for part-time or seasonal paid work.⁴⁰

26. Health Education England told us that it did not know whether the funding changes would deter people from applying, or whether the changes would disproportionately affect certain groups such as mature students or those with children. It said that currently there were about three applicants for every nurse training place and that the introduction of student tuition fees for other courses had not deterred people from applying. It intended to use the £150 million it spent each year on clinical placements for nurses and allied health professionals to incentivise people to work in geographical areas or specialisms that may be less popular.⁴¹

27. Trusts also receive funding from Health Education England to cover half of the basic salary costs of junior doctors.⁴² Health Education England told us it considered it was appropriate to pay a proportion of salary costs to cover the time junior doctors spent training; individual employers paid for the time junior doctors spent providing patient care.⁴³ However, it also highlighted that the amount of time junior doctors had available for patient care varied significantly by specialty and stage of training. For example, a new trainee in anaesthetics could not be left without a more senior doctor supervising them, while an anaesthetic trainee in their last year of training was able to do almost everything that a consultant could do. Health Education England explained that it was conducting a review of the funding arrangements for junior doctors to assess whether the system was fair or whether it should be adjusted to reflect the time different trainees had available for patient care.⁴⁴

Implications of policy initiatives

28. The need for clinical staff is expected to change in the coming years. New models of care outlined in the NHS *Five Year Forward View* may involve changes in the number and

39 HM Treasury, *Spending Review and Autumn Statement 2015*, November 2015

40 Unison, Royal College of Midwives, British Dental Association, Society of Chiropractors and Podiatrists, Royal College of Nursing, Chartered Society of Physiotherapy and the National Union of Students ([NSC0004](#))

41 [Qq 149–152](#)

42 [C&AG's Report](#), para 3.5

43 [Q 75](#)

44 [Q 77](#)

mix of staff as more care is provided outside of hospitals and closer to people's homes. In addition, the Department has mandated NHS England to implement 7-day services in the NHS by 2020, which is likely to require more staff.⁴⁵ The Department explained that the focus of 7-day working within hospitals was on urgent and emergency care and ensuring that senior clinical decision makers were available at weekends.⁴⁶

29. However, the Department was not able to provide us with an indication of the workforce that would be needed to implement 7-day services. It told us that the workforce implications were complex, and would differ substantially from one local area to another. It was working with eight trusts to assess what the implications would be. It said that, for these reasons, it would be difficult to quantify implications precisely. It could not give us an approximate answer either.⁴⁷

30. We also asked whether the NHS had the necessary funding to implement 7-day services. The Department told us that the 2015 Spending Review had committed an extra £10 billion for the NHS between 2014–15 and 2020–21, and that this included funding to meet the Government's objectives for 7-day services as well as delivering the *Five Year Forward View*.⁴⁸ The Department told us there is no separate pot set aside for something specifically labelled 7-day services. It said that there was considerable overlap between initiatives and that it had not separated out the money for 7-day services from the funding for the Government's other objectives.⁴⁹

Gaps in information

31. The National Audit Office reported that the data used to monitor workforce numbers are not sufficiently reliable or comprehensive to support Health Education England's decisions. It highlighted a range of limitations in NHS clinical workforce data, including poor information on vacancy rates, course completion rates and leaver rates.⁵⁰ The Department accepted that there were gaps in the data underpinning workforce planning.⁵¹ In particular, there was a lack of data on why clinical staff leave the NHS, where they go when they leave, or why they transfer between trusts, in part because exit interviews were not used to collect feedback in a systematic way.⁵²

32. The Department and Health Education England said they were planning to fill these data gaps, through what the Department called a "workforce information architecture process".⁵³ For primary care, NHS England explained that it had commissioned a review of the available evidence on why GPs were leaving earlier than their retirement age. It said the review had not been asked to look specifically at the impact of changes to pension arrangements on GPs retiring early, but it had run focus groups to explore the impact of the 'pension pot' limit.⁵⁴

45 Department of Health, [The Government's mandate to NHS England for 2016–17](#), January 2016; [C&AG's Report](#), para 1.7

46 [Qq 113–114](#)

47 [Qq 106–111](#), [141–143](#)

48 [Q 107](#); HM Treasury, [Spending Review and Autumn Statement 2015](#), November 2015

49 [Qq 109](#), [136](#), [140](#)

50 [C&AG's Report](#), Appendix 3

51 [Q 144](#)

52 [Qq 10](#), [126](#)

53 [Qq 126](#), [145](#)

54 [Qq 11–12](#)

33. The main source of workforce data are electronic staff records systems, which are used by nearly all trusts. However, the National Audit Office reported that there was a lack of detail for some staff and that the processes for checking the accuracy of the data were limited.⁵⁵ The Carter review of productivity in the NHS found that inaccuracies in the electronic staff record meant that trusts did not have a full picture of where all their staff were and what they were doing.⁵⁶

34. Health Education England draws on input from a range of experts in developing the national workforce plan. It told us it received many different sources of information and advice, including from the Centre for Workforce Intelligence, medical royal colleges and individual employers. In all, it received over 100 submissions in its annual 'call for evidence' in 2014.⁵⁷ The National Audit Office concluded it was unclear how Health Education England had used the workforce projections submitted by the Centre for Workforce Intelligence in deciding how many training places to commission. For example, the projections showed a large oversupply of infectious disease consultants in the next five to ten years, but Health Education England did not adjust how many training places it commissioned for this speciality.⁵⁸ Health Education England told us it did not make adjustments based on the advice of single organisations, but instead weighed the balance of opinion and evidence to come to a conclusion.⁵⁹

55 [C&AG's Report](#), para 3.5 and Appendix 3

56 Lord Carter of Coles, [Operational productivity and performance in English NHS acute hospitals: Unwarranted variations](#), February 2016

57 [Q 62](#); [C&AG's Report](#), para 3.4

58 [C&AG's Report](#), para 3.11

59 [Qq 63, 65](#)

Formal Minutes

Wednesday 27 April 2016

Members present:

Meg Hillier, in the Chair

Mr Richard Bacon	Nigel Mills
Deidre Brock	David Mowat
Chris Evans	Karin Smyth
Caroline Flint	Mrs Anne-Marie Trevelyan
Kevin Foster	

Draft Report (*Managing the supply of NHS clinical staff in England*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 34 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Fortieth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 3 May 2016 at 2.00 pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 23 February 2016

Question number

Professor Ian Cumming, Chief Executive, Health Education England, **Jim Mackey**, Chief Executive, NHS Improvement, **Charlie Massey**, Director General, Strategy and External Relations, Department of Health, and **Rosamond Roughton**, Director of NHS Commissioning, NHS England

[Q1-155](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

NCS numbers are generated by the evidence processing system and so may not be complete.

- 1 British Medical Association ([NCS0001](#))
- 2 Cass Business School, University of London ([NCS0006](#))
- 3 Chartered Society of Physiotherapy ([NCS0010](#))
- 4 Department of Health ([NCS0008](#))
- 5 HCL Workforce Solutions ([NCS0007](#))
- 6 Royal College of Midwives ([NCS0005](#))
- 7 Royal College of Nursing ([NCS0003](#))
- 8 Royal College of Speech and Language Therapists ([NCS0002](#))
- 9 The Shelford Group ([NCS0009](#))
- 10 Unison, the Royal College of Midwives, the British Dental Association, the Society of Chiropodists and Podiatrists, the Royal College of Nursing, the Chartered Society of Physiotherapy and the National Union of Students ([NCS0004](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2015–16

First Report	Financial sustainability of police forces in England and Wales	HC 288 (Cm 9170)
Second Report	Disposal of public land for new homes	HC 289 (Cm 9170)
Third Report	Funding for disadvantaged pupils	HC 327 (Cm 9170)
Fourth Report	Fraud and Error Stocktake	HC 394 (Cm 9190)
Fifth Report	Care leavers' transition to adulthood	HC 411 (Cm 9190)
Sixth Report	HM Revenue & Customs performance 2014–15	HC 393 (Cm 9190)
Seventh Report	Devolving responsibilities to cities in England: Wave 1 City Deals	HC 395 (Cm 9190)
Eighth Report	The Government's funding of Kids Company	HC 504 (Cm 9190)
Ninth Report	Network Rail's: 2014–2019 investment programme	HC 473 (Cm 9220)
Tenth Report	Care Act first-phase reforms and local government new burdens	HC 412 (Cm 9220)
Eleventh Report	Strategic financial management of the Ministry of Defence and Military flying training	HC 391 (Cm 9220)
Twelfth Report	Care Quality Commission	HC 501 (Cm 9220)
Thirteenth Report	Overseeing financial sustainability in the further education sector	HC 414 (Cm 9220)
Fourteenth Report	General Practice Extraction Service	HC 503 (Cm 9220)
Fifteenth Report	Economic regulation in the water sector	HC 505 (Cm 9237)
Sixteenth Report	Sale of Eurostar	HC 564 (Cm 9237)
Seventeenth Report	Management of adult diabetes services in the NHS: progress review	HC 563 (Cm 9237)

Eighteenth Report	Automatic enrolment to workplace pensions	HC 581 (Cm 9237)
Nineteenth Report	Universal Credit: progress update	HC 601 (Cm 9237)
Twentieth Report	Cancer Drugs Fund	HC 583 (Cm 9237)
Twenty-first Report	Reform of the rail franchising programme	HC 600 (Cm 9260)
Twenty-second Report	Excess Votes 2014–15	HC 787 (Cm 9260)
Twenty-third Report	Financial sustainability of fire and rescue services	HC 582 (Cm 9260)
Twenty-fourth Report	Services to people with neurological conditions: progress review	HC 502 (Cm 9260)
Twenty-fifth Report	Corporate tax settlements	HC 788 (Cm 9260)
Twenty-sixth Report	The Common Agricultural Policy Delivery Programme	HC 642 (Cm 9260)
Twenty-seventh Report	e-Borders and successor programmes	HC 643
Twenty-eighth Report	Access to General Practice in England	HC 673
Twenty-ninth Report	Making a whistleblowing policy work: progress update	HC 602
Thirtieth Report	Sustainability and financial performance of acute hospital trusts	HC 709
Thirty-first Report	Delivering major projects in government	HC 710
Thirty-second Report	Follow-up on transforming contract management	HC 711
Thirty-third Report	Contracted out health and disability assessments	HC 727
Thirty-fourth Report	Tackling tax fraud	HC 674
Thirty-fifth Report	Department for International Development: responding to crises	HC 728
Thirty-sixth Report	Use of consultants and temporary staff	HC 726
Thirty-seventh Report	Financial management of the European Union budget in 2014	HC 730
Thirty-eighth Report	Extending the Right to Buy to housing association tenants	HC 880
Thirty-ninth Report	Accountability for taxpayers' money	HC 732

First Special Report	Unauthorised disclosure of draft Report in the previous Parliament	HC 539
Second Special Report	Network Rail's 2014–2019 investment programme: Office of Rail and Road Response to the Committee's Ninth Report of Session 2015–16	HC 905