



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health

Managing the supply of NHS clinical staff in England

Key facts

824,000

estimated full-time
equivalent clinical staff
employed in the NHS

£4.9bn

total budget of Health
Education England
in 2014-15

1.4%

average annual increase
in NHS clinical staff
between 2004 and 2014

- £43 billion** estimated annual cost of employing NHS clinical staff
- Around half** of healthcare providers' costs are on employing clinical staff
- 5.9%** reported staffing shortfall in 2014, equating to some 50,000 clinical staff
- 140,000** students in clinical training at any time
- 3,106** fewer nurse training places in 2014-15 compared with 2004-05 – a 19% decrease
- £3.3 billion** spent by trusts on agency staff in 2014-15 compared with £2.2 billion in 2009-10
- 61%** of temporary staffing requests were to cover vacancies in 2014-15

Summary

1 Around 824,000 clinical staff – those directly involved in patient care – work in the NHS, including 141,000 doctors and 329,000 nurses, midwives and health visitors.¹ The total number of NHS clinical staff increased by 1.4% per year on average between 2004 and 2014, although the rate of growth varied between different staff groups. New staff need to be continually 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.

2 Managing the supply of NHS clinical staff involves a range of different bodies. In particular:

- 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, education and training. It seeks to ensure that the NHS has the staff and skills it needs to meet the current and future needs of patients. It and its 13 local education and training boards develop national and regional workforce plans and commission the training of new clinical staff. Health Education England spent £4.3 billion on training places in 2014-15 and, in total, around 140,000 students are in clinical training at any one time. Its funding covers payments to higher education institutions, providers for clinical placements (including 50% of the salaries of junior doctors), and students to cover some tuition fees and living costs.
- Healthcare providers, including NHS trusts and NHS foundation trusts, are responsible for employing staff, which may involve the recruitment of temporary or overseas staff, and supporting clinical placements. As employers, providers clearly also influence staff retention and productivity, which affect the demand for staff. They also have a duty to support the collective planning of the future NHS workforce and are responsible, with commissioners, for managing the demand for healthcare. Clinical staff cost the NHS around £43 billion each year to employ, and account for around half of healthcare providers' costs.²

¹ In this report, figures on staff numbers are full-time equivalents unless otherwise stated.

² Excludes the cost of locum, bank and agency staff.

Focus of our report

3 This report focuses on the inflow of clinical staff to the NHS. **Figure 1** shows the inflows and outflows in the NHS clinical staffing model, using data on nurses to give an indication of scale. The workforce model would be working optimally if it were in balance, with the inflows matching the changes in demand and outflows, so limiting any staffing gaps or oversupply. In addition, to be optimal, the flow of staff into and out of the NHS should be influenced, in a cost-effective and timely manner, by:

- balancing the use of different inflows to meet demand sustainably and efficiently – for example, temporary staff, which can be expensive, would be used to provide flexibility and respond to short-term gaps, but not be used extensively or to cover long-term vacancies;
- limiting the number of new staff needed by managing the number of staff leaving the NHS – for example, NHS bodies should prioritise retaining existing staff as this is cheaper than training new staff; and
- influencing the staff needed – for example, NHS bodies would manage the demand for healthcare effectively and use existing staff efficiently.

4 While this report focuses on the inflows (shown on the left of the model), we recognise that managing demand and outflows is also important and that these factors are linked to the inflows. For example, the number of staff leaving the NHS will affect, in general terms, the number of new staff required. It will also, specifically, affect the pool of people who could be attracted back as temporary staff or through return-to-practice initiatives. The limited data that are available suggest around one-in-ten staff leave the NHS each year. The number of new staff required will also be affected by the skill mix and how efficiently staff are used.

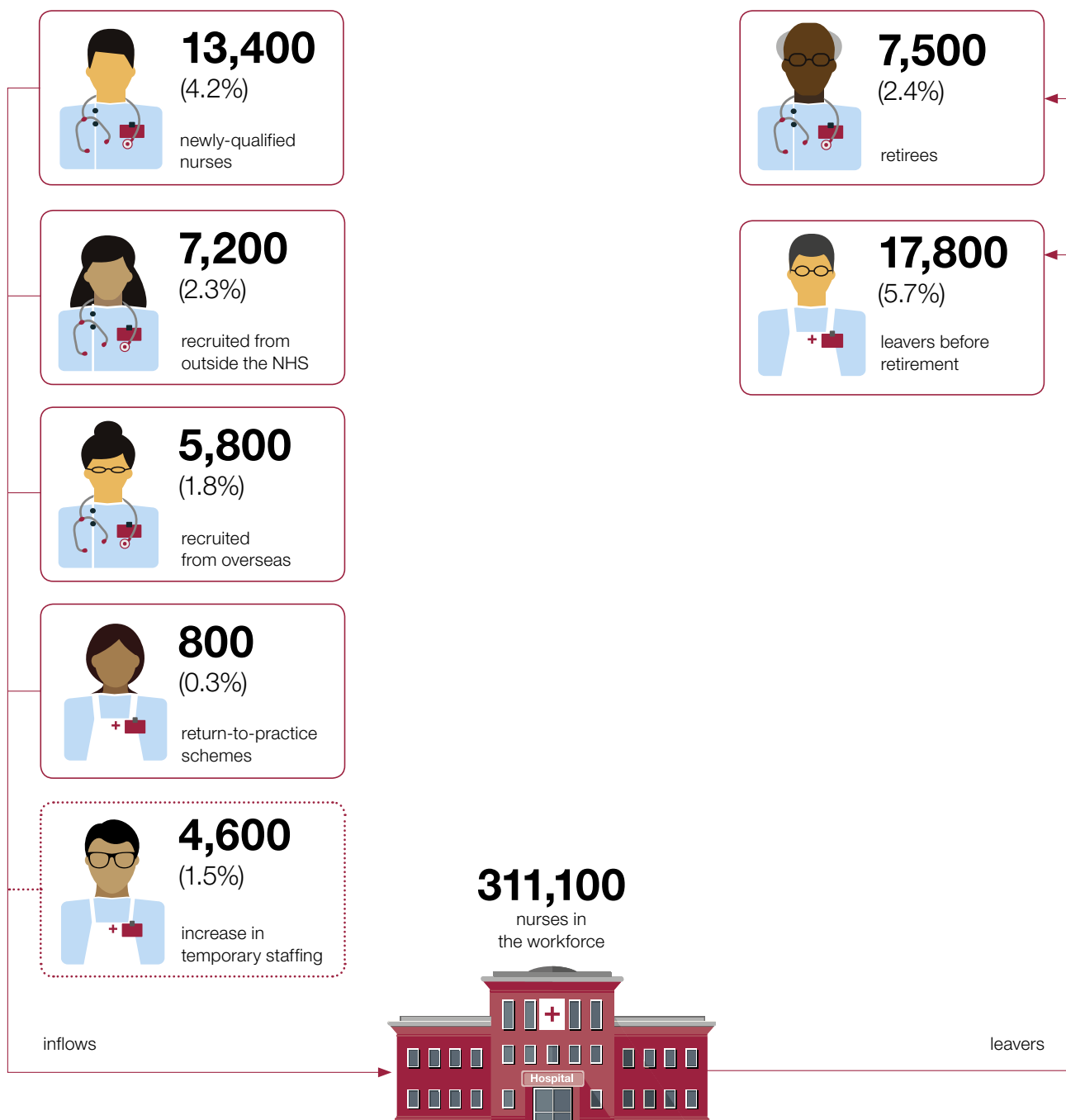
5 It is difficult to assess directly how effectively the supply of clinical staff has been managed in the past. This is because of, for example, unpredictable changes in the demand for healthcare and the time it takes to train staff. However, the level of staffing gaps indicates that the system is not in balance. In 2014, there was a reported overall staffing shortfall of around 5.9%. This equated to a gap of around 50,000 clinical staff. The shortfalls varied between different staff groups and regions.

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. There are risks to both the quality and cost of services if the supply of clinical staff is poorly managed. For example, an undersupply of staff could lead to longer waiting times for treatment or shortcomings in the quality of care and patients' experience. An oversupply could result in highly qualified staff not being employed and money having been spent on training when it could have been used more effectively elsewhere. A failure to manage the supply of staff effectively could also lock the NHS into models of service delivery that may not be either efficient or appropriate for the needs of patients in the future. Conversely a failure to identify the staffing implications of changes to models of service delivery inhibits the effective management of the supply of staff.

Figure 1

Flow of nurses into and out of the NHS workforce, 2014

Large numbers of staff join and leave the NHS each year



Note

1 Due to limitations in the underlying data, these figures should be treated with caution and are presented for indicative purposes only. Limitations include that temporary staffing figures are based on a sample of trusts.

Source: National Audit Office analysis of data from Health Education England, the Health and Social Care Information Centre, The King's Fund and NHS Professionals

7 The need to manage the supply of clinical staff effectively is particularly important because of the financial pressures that the NHS is currently facing. The cost of employing enough staff to meet the demand for healthcare has a significant impact on providers' financial position and sustainability. As we reported in December 2015, the financial performance of acute hospital trusts has deteriorated, and their financial position is forecast to worsen still.³ One reason for this is their increasing reliance on agency staffing. At the same time, making substantial efficiency savings in their spending on staff is an important part of trusts' financial plans.

8 This report covers the overall arrangements for managing the supply of NHS clinical staff, covering a range of different bodies, not just Health Education England. We did not seek to compare the current arrangements with those that were in place before the reforms to the health system in 2013. In terms of long-term workforce planning, we assessed the processes that are in place, as the outcomes (ie whether there are enough staff with the right skills) will not be evident for a number of years.

9 Specifically, this report examines whether the supply of clinical staff in the NHS is being effectively managed. We assessed value for money by evaluating whether:

- responsibilities and accountabilities for managing staff numbers are clear (covered throughout the report);
- the process for developing a long-term national workforce plan is robust (Parts Two and Three); and
- short-term shortfalls in staffing are being addressed efficiently (Part Four).

We set out our audit approach in Appendix One and our evidence base in Appendix Two.

Key findings

Responsibilities and accountabilities

10 The arrangements for managing the supply of clinical staff numbers are fragmented, increasing the risk of duplication and incoherence. The arrangements involve many different national and local bodies, including the Department, various arm's-length bodies, and healthcare commissioners and providers. Responsibilities and accountabilities are generally clear, but in practice bodies have different priorities and incentives. This increases the risk that decisions, for example about the balance between different staff groups, may not be made for the benefit of the system as whole. Health Education England chairs a workforce advisory board, which was set up in 2015 to coordinate system-wide action on workforce challenges (paragraphs 1.12 to 1.15).

³ Comptroller and Auditor General, *Sustainability and financial performance of acute hospital trusts*, Session 2015-16, HC 611, National Audit Office, December 2015.

11 With the creation of Health Education England, there is a national body tasked with making strategic decisions about workforce planning but, as intended, the process is locally driven. The Department set up Health Education England in 2013, recognising that the future workforce would need to evolve in the face of demographic and technological change. The Department sets objectives for Health Education England through an annual mandate and holds it to account for ensuring that the future workforce is the right size and has the right skills. Health Education England works through its 13 local education and training boards. The system for workforce planning is collaborative. The national workforce plan is developed from the bottom up, based on plans prepared by local providers, including NHS trusts and NHS foundation trusts. This means the national plans should be based on a detailed understanding of local circumstances (paragraphs 1.13 to 1.15, 2.2 to 2.4 and 3.3 to 3.4).

12 A more coordinated and proactive approach to managing the supply of staff could result in efficiencies for the NHS as a whole. Central oversight and intervention are needed to ensure that decisions are sufficiently strategic and made for the benefit of the overall system. However, there has been, for example, 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. These initiatives could be cost-effective ways of dealing with short-term shortfalls in staffing. For example, estimates suggest that recruiting a nurse from overseas costs between £2,000 and £12,000 and return-to-practice costs some £2,000 per nurse, while training a new nurse costs around £79,000 (paragraphs 4.21 to 4.29).⁴

Developing a long-term national workforce plan

Estimating local need for staff

13 Trusts' workforce plans appear to be influenced as much by meeting efficiency targets as by staffing need. Our evidence indicates that trusts' workforce plans are often driven by the financial plans that they prepare for the NHS Trust Development Authority or Monitor. These plans envisage significant recurrent pay savings. Between 2012-13 and 2015-16, trusts planned to make recurrent pay savings of around £1 billion each year, although actual savings consistently fell well short of this amount. By focusing on efficiency targets when balancing financial sustainability and service requirements, trusts risk understating their true staff needs. This in turn could result in Health Education England commissioning too few places to train new staff. At trust level, it may also lead to gaps in staffing or additional costs from using more expensive temporary staff to address shortfalls (paragraphs 2.11 to 2.18).

⁴ Cost of training new nurses includes costs borne by the wider NHS and individuals undertaking the training.

14 Trusts' workforce plans are also unlikely to provide a reliable forecast of long-term staffing needs because they do not take full account of possible changes in how services are delivered. Predicting future staffing needs is challenging given the degree of uncertainty involved. As we reported in December 2015, the redesigned models of healthcare are new and untested.⁵ The evidence we gathered suggests that some providers do not have the capacity to plan for the long term. There is a risk that local workforce plans do not take account of the intention to transform the way services are delivered, such as by providing more care outside hospitals. Health Education England seeks to address this risk by drawing on input from a range of parties, including medical colleges and other experts, in developing the national workforce plan. In addition, in December 2015, the Department and its arm's-length bodies published joint guidance intended to clarify the priorities, challenges and planning assumptions that commissioners and providers should consider in developing plans (paragraphs 1.7, 2.17 to 2.22 and 3.4).

15 The increased focus on care quality and safety has increased the demand for nurses, although the extent of the impact on demand and the likely cost have not been well understood:

- In 2013, reports into the failings at Mid Staffordshire NHS Foundation Trust highlighted the importance of staffing to the quality of care. In 2014, acute hospital trusts estimated they would need 24,000 more nursing staff than they had forecast two years earlier in 2012, which would cost around an extra £1 billion. Trusts' response to Mid Staffordshire was not the only factor contributing to this increase in demand, which would have also been affected for instance by more admissions than expected.
- The National Institute for Health and Care Excellence (NICE) subsequently published guidelines on minimum staffing for adult nursing. The likely impact on spending of these guidelines was not well understood. NICE itself estimated the impact as between £0 and £414 million. Monitor and NHS England did not increase the prices used by commissioners to pay for healthcare to provide extra funding for any additional costs specifically associated with safe staffing requirements incurred in 2015-16 (paragraphs 2.5 to 2.10).

Commissioning training places

16 Health Education England has acted to gain assurance about future workforce pressures but there remain shortcomings in this process.

Health Education England and its local education and training boards review and challenge regional and local estimates of staffing need. Health Education England has modelled the supply of, and demand for, non-medical staff (clinical staff other than doctors) to help assess how reasonable the regional investment plans are; however, at the time of our work there was no comprehensive model of the supply of, and demand for, doctors. In addition, a lack of sufficiently reliable or comprehensive data to monitor staff numbers increases the uncertainty around Health Education England's commissioning decisions (paragraphs 3.4 to 3.6).

⁵ See footnote 3.

17 Health Education England has intervened at national level to make small adjustments to the training places it commissions to reflect national priorities and emerging pressures. For example, for 2015/16, Health Education England increased the number of places for physician associates, a new role designed to supplement the doctor workforce. Overall, however, the adjustments have been small in absolute terms and there has been little change in the number of training places for some staff groups, such as undergraduate medical students. To some extent, Health Education England's ability to make significant changes is constrained, for example by providers' limited capacity to support staff in training. It is also difficult to meet the current demand for junior doctors without creating an oversupply of senior doctors in some specialties in the future. Health Education England could help to reduce regional variations in staffing gaps by commissioning more places in areas where the shortfalls are greatest as many students take up jobs in the area they trained. So far the distribution of places across the country has changed little from year to year (paragraphs 3.7 to 3.14).

Addressing short-term shortfalls in staffing

18 Trusts' use of temporary staff has increased significantly, putting pressure on their financial position. Temporary staffing gives trusts the flexibility to address short-term workforce pressures and can be an attractive option for staff due to the flexibility and financial reward it offers. However, high levels of temporary staff are costly and an inefficient use of resources. Spending on agency staff increased by half from £2.2 billion in 2009-10 to £3.3 billion in 2014-15. Agency staff tend to be relatively expensive – for example, in 2015 agency nurses cost, on average, an estimated £39 per hour, compared with £27 per hour for bank nurses. Our analysis found that there was a statistically significant relationship between spending on agency staff in 2014-15 and the size of acute trusts' financial deficits (paragraphs 4.2 to 4.3, 4.8 and 4.11).

19 There is room for trusts to reduce their use of temporary staff. Trusts report that temporary staff are often used to cover unfilled vacancies for permanent jobs (some 61% of temporary staff requests in 2014-15). In addition, use of temporary staff peaks each March at the end of the annual leave year, suggesting that trusts may not be managing staff leave well throughout the year. Our analysis suggests that three-quarters of the increased spending on temporary nurses from 2012-13 to 2014-15 resulted from increased use and the rest was due to higher average hourly rates. In October 2015, the Secretary of State for Health announced mandatory caps on how much trusts can pay per shift to help control spending on agency staff. However, these measures are unlikely in themselves to address fully the underlying causes of the increased demand for temporary staff (paragraphs 4.4 to 4.14).

20 At the same time as use of temporary staff has increased, the NHS has made much less use of overseas recruitment and return-to-practice initiatives to address staffing shortfalls. Previously, overseas recruitment made a significant contribution to the supply of clinical staff. However, the number of overseas nurses has fallen. The number of entrants to the UK from outside the European Economic Area decreased from 11,359 in 2004-05 to just 699 in 2014-15. Some of this decline may have been due to tighter immigration rules for nurses between 2009 and 2015. The decrease was partly offset by a large rise in recruits from within the European Economic Area, which increased from 1,192 to 7,232. The NHS has also made less use of return-to-practice initiatives to increase the supply of staff – between 2010 and 2014, on average around 1,000 former nurses and midwives returned to work each year, compared with 3,700 each year a decade earlier. This drop coincided with a fall in the number of adult nurse training places (paragraphs 3.7, 4.15 to 4.29).

Conclusion on value for money

21 Having the right numbers and types of clinical staff is crucial to the efficient and effective operation of the NHS. The time taken to train staff, and the scale of the exercise, mean that workforce planning for the NHS is complex and will never be an exact science. The creation of Health Education England means that, for the first time, there is a national body specifically tasked with making strategic decisions about planning the future workforce, working collaboratively with local healthcare providers. Providers remain responsible for ensuring they have enough clinical staff with the right skills to deliver high-quality, safe healthcare.

22 Across the health system as a whole, there are shortcomings in how the supply of clinical staff is managed, in terms of both planning the future workforce and meeting the current demand for staff:

- While responsibilities and accountabilities are generally clear, more regional or national coordination and oversight, coupled with ensuring priorities and incentives are aligned, would benefit the NHS as a whole.
- The process for developing the national long-term workforce plan could be made more robust. Local plans are unlikely to be a reliable forecast of staffing need, and national interventions to reflect priorities and emerging pressures are constrained and have been minor to date. Overall, there is limited assurance that the number and type of training places being commissioned is appropriate.
- The way that current shortfalls in staffing are being addressed is, at times, costly and inefficient, putting pressure on providers' financial position.

23 We therefore conclude that the current arrangements for managing the supply of NHS clinical staff do not represent value for money.

Recommendations

- a Health Education England should be more proactive in helping to address the variations in workforce pressures in different parts of the country.** The Department has attributed the considerable geographic variation in vacancies partly to students taking up work close to the areas they trained in. Health Education England should help address these imbalances by gathering evidence on the movement of staff. It should use this information to inform its decisions on the distribution of training places which, to date, has changed relatively little.
- b The Department, working with other bodies, should ensure that there are timely, comprehensive data to monitor the capacity of the NHS workforce.** There are significant gaps in the data that are needed to make well-informed decisions. The Department should lead a project to ensure that Health Education England and other bodies have the data they need for forecasting and monitoring.
- c All key health policies and guidance should explicitly consider the workforce implications.** Past developments have not fully assessed how the necessary staff will be made available and funded. When major changes to services are proposed, such as the '7-day NHS', the various national oversight bodies – including the Department, NHS England, NHS Improvement, the Care Quality Commission and the National Institute for Health and Care Excellence – need to work together to understand the staffing implications and financial impact.
- d The Department and Health Education England should review the funding arrangements for training clinical staff.** The review should involve evaluating the effect of current and planned funding arrangements for higher education institutions, clinical placements and students. Specifically, they should ensure that the right incentives, including financial reimbursements, are in place to supply sufficient staff with the right skills in the right locations.
- e The Department, Health Education England and NHS Improvement should provide greater national leadership to support trusts in using the different ways of addressing shortfalls in staffing.** Providers face a real challenge in providing safe staffing, meeting efficiency targets and reducing their reliance on temporary staff. However, there has been limited regional or national coordination of measures such as overseas recruitment or return-to-practice initiatives which could help to address shortfalls.