National Audit Office

Report
by the Comptroller
and Auditor General

Department of Health

Managing the supply of NHS clinical staff in England

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National Audit Office

Department of Health

Managing the supply of NHS clinical staff in England

Report by the Comptroller and Auditor General

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Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

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This report examines whether the supply of NHS clinical staff in England is being managed effectively.

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Contents

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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.

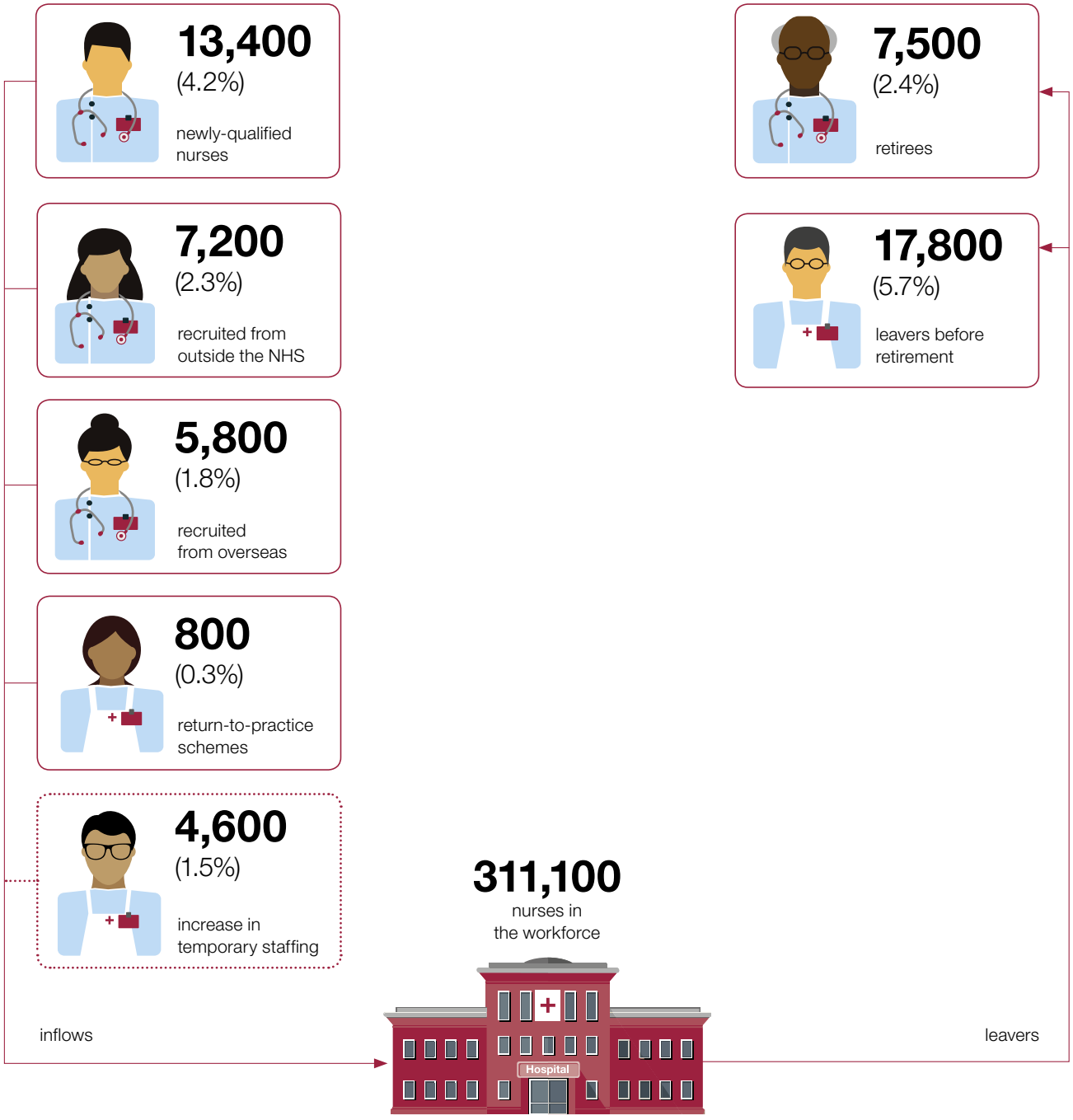
5 It is difficult to assess directly how effectively the supply of clinical staff has been managed in the past. This is because of, for example, unpredictable changes in the demand for healthcare and the time it takes to train staff. However, the level of staffing gaps indicates that the system is not 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.

Part One

The NHS clinical workforce

1.1 This part of the report sets out background information about the NHS clinical workforce and about responsibilities and funding.

Size of the workforce

1.2 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.[6] As well as treating and caring for patients, many clinical staff have other responsibilities, such as supervising more junior staff, managing teams and contributing to organisational leadership.

1.3 Clinical staff make up over two-thirds of the total NHS workforce. They include some 141,000 medical staff (doctors) and 329,000 nurses (including practice nurses), midwives and health visitors (**Figure 2**). Clinical staff cost around £43 billion a year to employ and account for around half of NHS providers' costs.[7] Considerable numbers of clinical staff also work for private and third-sector providers of health and social care.

Maintaining staff numbers

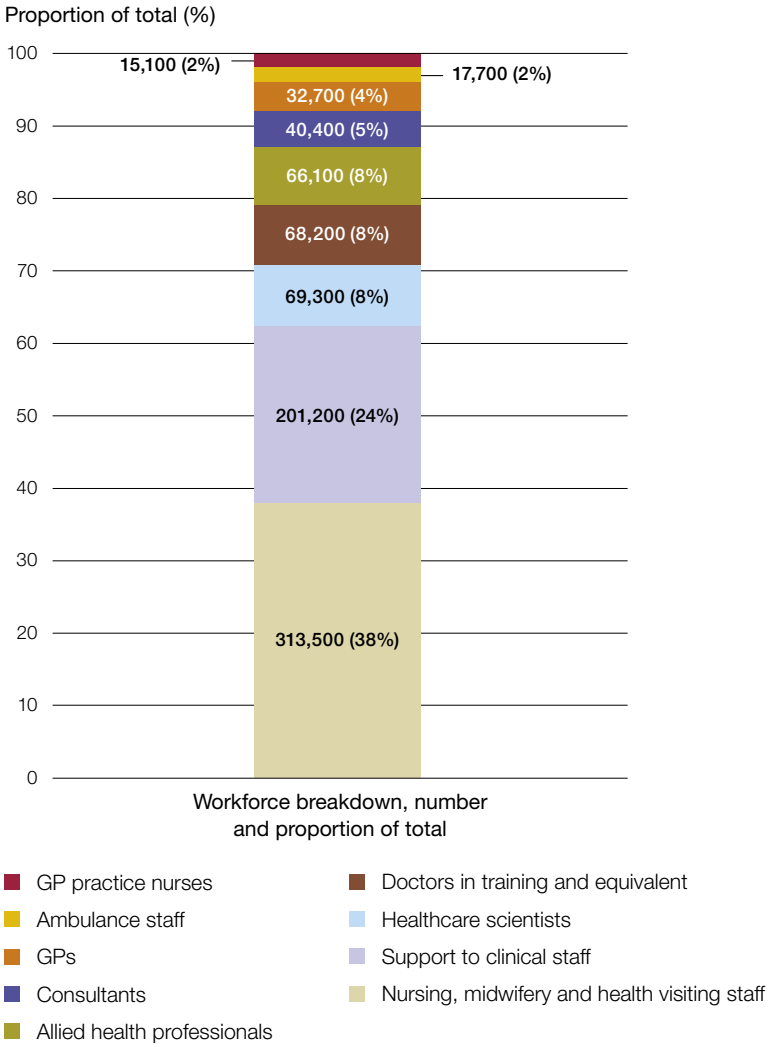
1.4 To maintain staff numbers, the NHS must continually replace the large number who leave each year – this includes those who retire, go to work for a non-NHS employer or leave their profession altogether. Information on the numbers of staff leaving the NHS is incomplete. The limited data that are available suggest that, within NHS hospital and community healthcare services, the proportion of:

- nurses leaving the NHS increased from 6.8% in 2010/11 to 9.2% in 2014/15; and
- all staff (including non-clinical) leaving the NHS increased from 7.9% in 2010/11 to 9.0% in 2014/15.[8]

6 Dental staff are not covered in this report except where explicitly stated.
7 Costs to the NHS include salaries paid to staff and additional on-costs (ie employer pension and National Insurance contributions). Excludes the cost of locum, bank and agency staff.
8 Data from Health and Social Care Information Centre. Data are for headcount.

Figure 2
NHS clinical staff, 2014

GPs and consultants account for 9% of the NHS clinical workforce while nursing, midwifery and health visiting staff are the largest component



Notes

1 Doctors in training and equivalent include all the doctors who are not consultants or GPs. This therefore includes GP registrars.

2 Healthcare scientists can work in hospitals, clinics or laboratories. The category includes 'other qualified scientific, therapeutic and technical staff'.

3 'Support to clinical staff' excludes clerical, administrative and estates staff.

4 These numbers exclude locum, bank and agency staff.

5 Staffing numbers are rounded to the nearest 100.

Source: Health and Social Care Information Centre, *NHS Hospital and Community Health Services Workforce Census England: 30 September 2014*

1.5 As well as replacing staff who leave, the NHS also needs to ensure that the supply of clinical staff, in terms of both number and type, keeps pace with the demand for healthcare. Overall, demand has increased over the last decade with on average hospital admissions rising by 2.8% per year and, according to one widely quoted estimate, consultations in general practice growing by around 3.5% per year. Between 2004-05 and 2014-15, total funding for health services increased by an average of 3.0% per year in real terms.

1.6 Improved ways of working and medical and technological advances have the potential to ease pressure on staff. However, the demand for healthcare and for clinical staff has generally risen for a number of reasons. These include:

- increasing underlying health needs as the population grows and changes – for example, the proportion of patients with long-term health conditions is rising;
- growing public expectations for high-quality and accessible healthcare; and
- legal and policy changes – for example, the European Working Time Directive has meant that more doctors are required to deliver NHS services as staff are no longer able to work for so many hours.

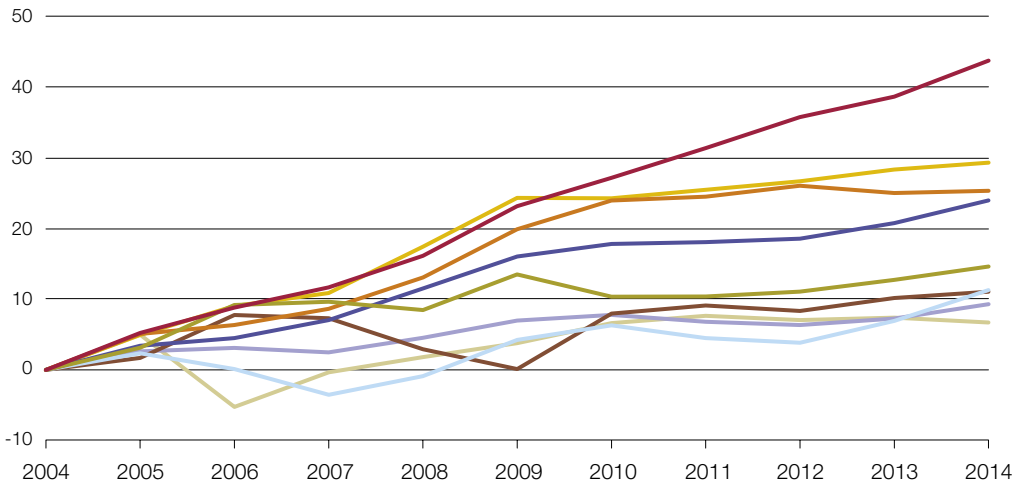
1.7 The need for clinical staff is expected to continue to change in the coming years. For example, the government's commitment to a '7-day NHS' is likely to require more staff but, at the same time, the need to make significant efficiency savings may mean providers look to reduce staff numbers to remain financially sustainable. The new models of care, outlined in the NHS *Five Year Forward View*, may involve changes in the number and mix of staff as more care is provided outside of hospitals and closer to people's homes.[9] In considering the 2015 Spending Review settlement, the Department of Health (the Department) presented a scenario whereby the number of staff in the hospital and community sectors would remain broadly stable between 2016-17 and 2020-21. Within this scenario, the number of doctors was projected to grow slightly while qualified nurses and other clinical staff were projected to fall slightly.

1.8 The total number of NHS clinical staff increased by 1.4% per year on average between 2004 and 2014. The rate of growth varied between different staff groups (**Figure 3**). By far the highest rate of growth was in the number of hospital consultants (3.7% per year on average) and 'doctors in training and equivalent' (2.6% per year). In contrast, the number of nurses, midwives and health visitors, the largest staff group, increased by 0.9% per year.

9 Care Quality Commission, Health Education England, Monitor, NHS England, NHS Trust Development Authority and Public Health England, *Five Year Forward View*, October 2014.

Figure 3
Growth in clinical staff groups, 2004 to 2014

The number of consultants grew significantly faster than other staff groups



Notes

1 Data on the number of full-time equivalent staff are at 30 September each year.

2 Due to changes in data collection, the comparisons should be treated with caution. In particular, from 2006, data on both GPs and ambulance staff were collected differently and so are not directly comparable with previous years.

Source: National Audit Office analysis of the Health and Social Care Information Centre's workforce census 2004 to 2014

Current workforce pressures

1.9 The supply of NHS clinical staff does not currently match the demand. Available data on vacancies are poor. However, the limited data held by Health Education England suggest that, in 2014, there was a shortfall of some 5.9% between the number of staff providers said they needed and had budgeted for (the establishment), and the number of staff in post. This shortfall would have equated to an overall gap in the region of 50,000 for the staff groups covered. All major clinical staff groups with data available had shortages in 2014, although the reported shortfall varied, with particularly high levels for nurses, midwives and health visitors (7.2%), and ambulance staff (7.0%) (**Figure 4**).

1.10 There is also considerable geographic variation in the extent of staffing shortfalls. For example, in 2014, medical and dental shortfalls varied from 2% in Yorkshire and Humber to 8% in the West Midlands (**Figure 5**). Shortfalls for other clinical staff were much higher in the three London regions (all more than 12%) than elsewhere (all less than 8%).

1.11 There are also regional imbalances in the ability of areas to train staff to address workforce pressures. For example, the North East filled 73% of new specialty training posts for doctors (a shortfall of 118) in 2015, while in Kent, Surrey and Sussex the fill rate was 100%.

Figure 4
Shortfalls for selected staff groups, 31 March 2014[1]

Staffing shortfalls vary between different staff groups

	Staff establishment	Staff in post	Shortfalls as at 31 March 2014[2]	
			(Number)	(%)
Nursing, midwifery and health visiting staff	386,200	358,220	-27,980	-7.2
Support to clinical staff[3]	306,480	291,970	-14,500	-4.7
Allied health professionals	68,630	65,100	-3,530	-5.1
Junior doctors and equivalents	59,110	56,560	-2,550	-4.3
Healthcare scientists	38,670	36,140	-2,530	-6.5
Consultants	42,970	40,640	-2,330	-5.4
Ambulance staff	18,980	17,650	-1,330	-7.0

Notes

1 Data on staff establishment for GPs and GP practice nurses are not collected.

2 The data source for this Figure is not the same as the source for Figures 2 and 3, and the data and staff categories are not directly comparable.

3 Shortfalls are calculated as 'staff in post' less 'staff establishment', with percentage figures representing shortfalls as a proportion of establishment. These shortfalls may or may not be advertised and could be recent or long-standing.

4 Health Education England's data are not sufficiently detailed to exclude administrative and estates staff from the 'support to clinical staff' group, meaning that this group includes non-clinical staff.

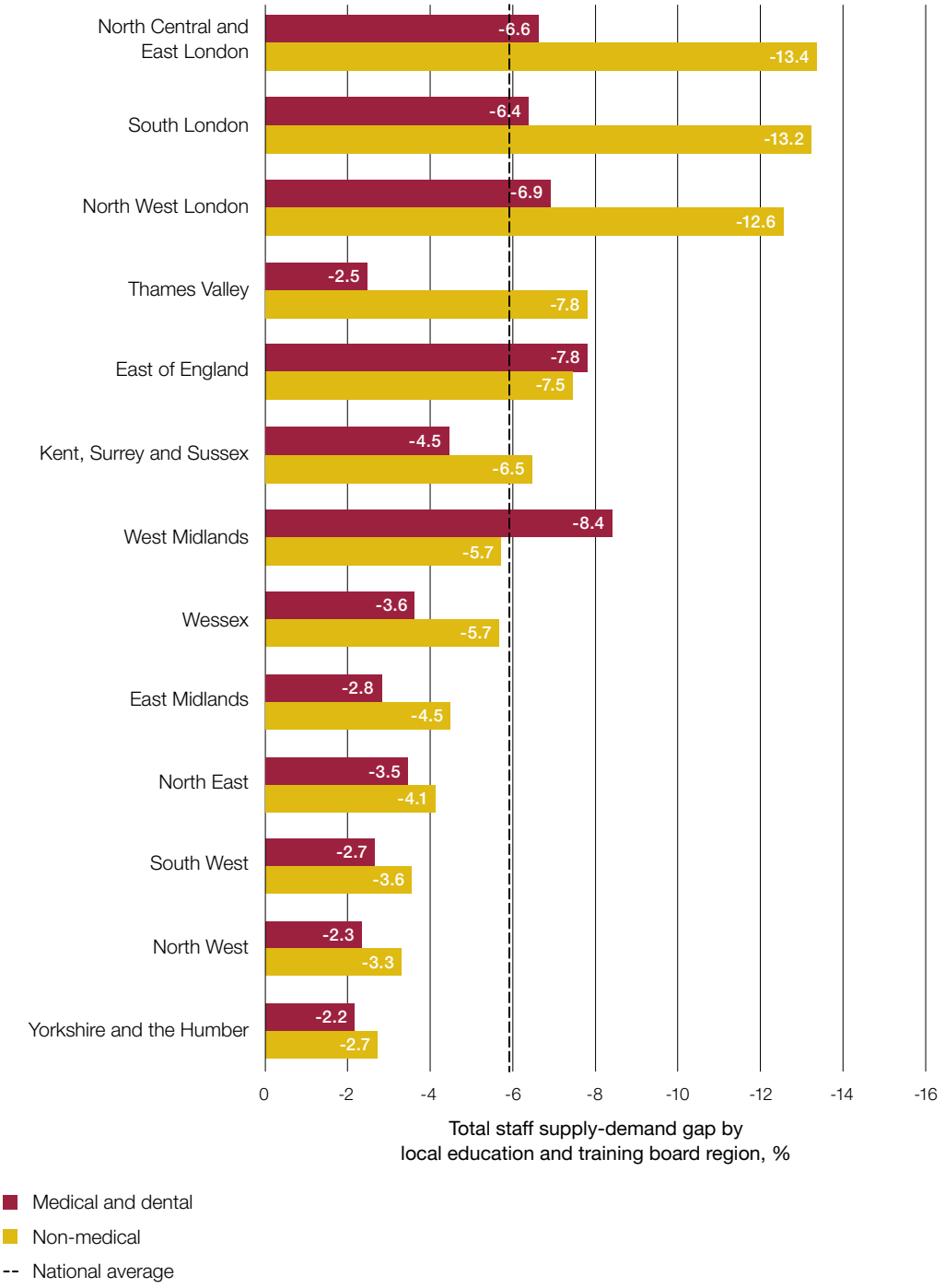
5 Staffing numbers are rounded to the nearest 10.

Source: National Audit Office analysis of Health Education England data

Figure 5

Shortfalls for medical and other clinical staff groups by region, April 2014

There is considerable geographic variation in the extent of staff shortfalls



Source: Health Education England data

Responsibilities and funding

1.12 The arrangements for managing the supply of clinical staff are fragmented, involving 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 the number of parties with an interest increases the risk of duplication and inconsistent priorities. **Figure 6** gives an overview of the organisations with a role in managing the supply of clinical staff.

1.13 As the steward of the health and care system, the Department is ultimately accountable for securing value for money from spending on healthcare, including spending on educating and training the NHS workforce. The Department set up Health Education England as an arm's-length body in 2013 as part of the reforms to the health system, recognising that the future workforce would need to evolve in the face of demographic and technological change. Before 2013, responsibility for planning and commissioning education and training rested with the ten regional strategic health authorities.

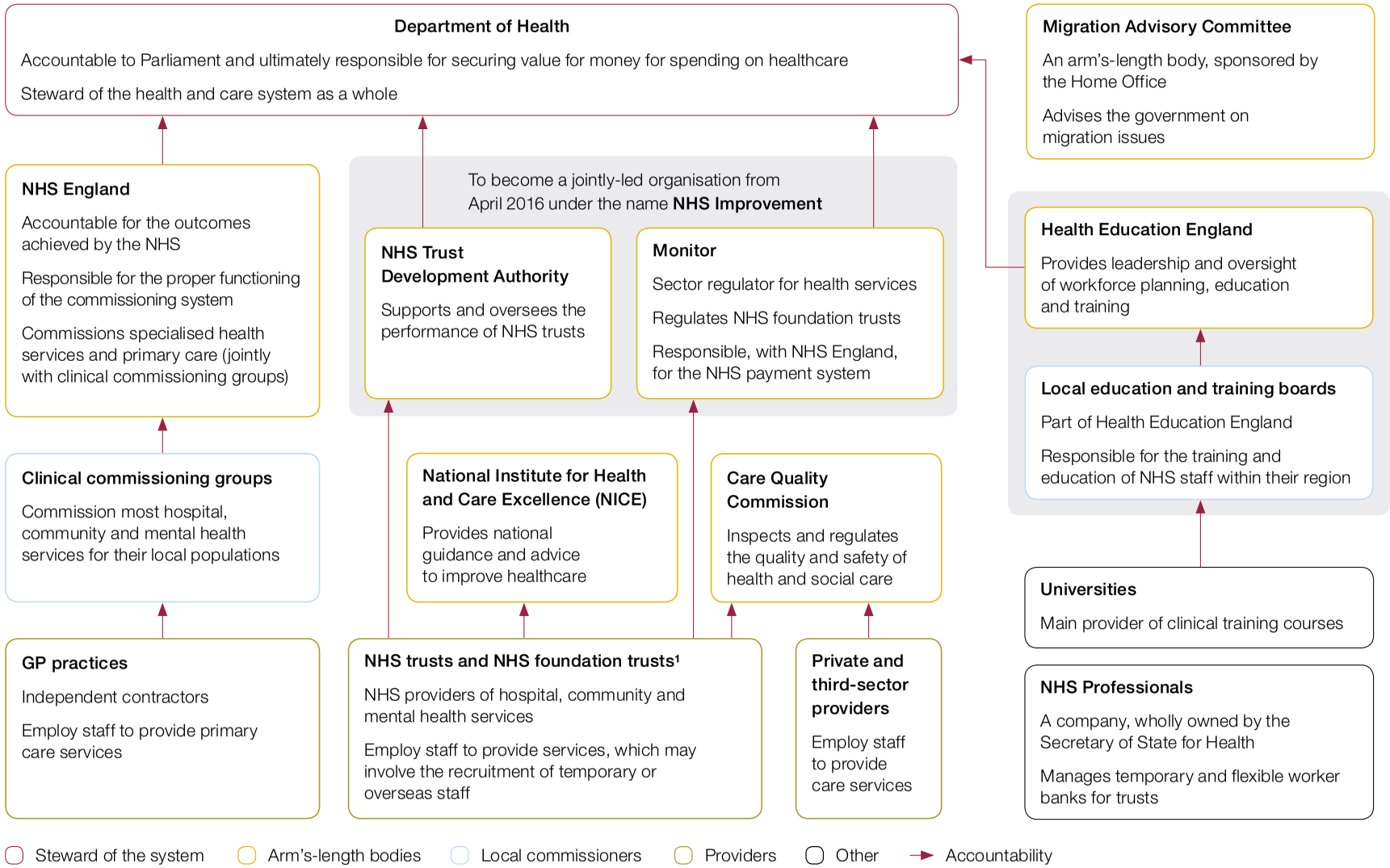
1.14 Health Education England is responsible for providing leadership and oversight of workforce planning, education and training, with the aim of improving the quality of care that patients receive. It seeks to ensure that the NHS has the staff and skills it needs to meet the current and future needs of patients, by bringing together the interests of providers, commissioners, professionals and the education sector. The Department sets objectives for Health Education England through an annual mandate and holds it to account for meeting the commitments in the mandate. Among other things, providers are responsible for employing staff, which may involve the recruitment of temporary or overseas staff, and supporting clinical placements.

1.15 In setting up the current system for workforce planning in 2012, the Department highlighted the importance of a proper balance of national and local leadership and decision-making. Much of the process has been devolved in line with the general policy direction. Health Education England has 13 local education and training boards that are responsible for training and educating NHS staff within their region. The boards are intended to help make workforce planning responsive to local needs, and are made up of representatives from local providers of NHS services. A national workforce advisory board was set up in March 2015 to coordinate system-wide action on workforce challenges. It is chaired by Health Education England and includes representatives from relevant national bodies.

1.16 In 2014-15, Health Education England's total budget was £4.9 billion, including £83 million for running costs. It employs 2,100 full-time equivalent staff, with most (around 90%) based in the local education and training boards. Health Education England told us its national workforce planning team currently consists of 13 staff, having increased from seven.

Figure 6

Organisations with a role in managing the supply of clinical staff



Note

1 NHS trusts and NHS foundation trusts have different accountability arrangements – NHS foundation trusts are directly accountable to Parliament rather than via the Department of Health.

Source: National Audit Office

1.17 In 2014-15, Health Education England spent £4.3 billion (88% of its total spending) on training places. Of this, 21% (£0.9 billion) was on undergraduate medical and dental; 42% (£1.8 billion) on postgraduate medical and dental; and 37% on other clinical staff groups (£1.6 billion). The funding covers payments to higher education institutions, providers for clinical placements and students to cover some tuition fees and living costs (**Figure 7**). Some of the implications of these funding arrangements are covered in paragraph 3.5.

1.18 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. It noted that the reforms would allow universities to provide additional training places. We have not examined the implications of the proposed changes.

Figure 7
Funding for clinical training places, 2014-15

Higher education institutions

Where they do not receive tuition fees from students, higher education institutions are paid by Health Education England in line with a set of benchmark prices. For non-medical undergraduate courses these are:

- between £8,313 and £11,360 per student per year, depending on the course and location.

Payments to providers for clinical placements[1]

Providers are paid in line with an education and training tariff. This is designed to cover the direct costs of training, including staff teaching time. Providers are paid:

- £3,175 per placement per year for non-medical placements;
- £34,623 per placement per year for undergraduate medical placements; and
- £12,400 per placement per year for postgraduate medical placements, plus 50% of each junior doctor's basic salary.

These amounts may be increased by up to 30% to account for local cost pressures.

Payments to students

Financial support is offered to non-medical undergraduates throughout their training course, and to medical undergraduates in the fifth and subsequent years of their course.[2]

These students do not have to pay tuition fees (which are covered by Health Education England's payments to higher education institutions) and are given:

- a £1,000 grant for living expenses (if studying full-time); and
- a means-tested bursary of up to £3,159 in London or £2,617 elsewhere.

Notes

1 The clinical placement provider tariff is currently subject to transition arrangements to manage the impact of funding changes. This means that some providers will be moving towards, rather than paid at, tariff rates.

2 For the first four years of their course, undergraduate medical students have to pay tuition fees and do not receive individual student support from Health Education England. They are instead entitled to claim support from Student Finance England. Data are for the 2014/15 academic year.

3 In November 2015, the government announced changes to how student places are funded. From 1 August 2017, Health Education England will not cover tuition fees for new students on nursing, midwifery and allied health professional undergraduate courses. These students will instead be able to take out tuition loans and a higher level of maintenance loans through the standard student loan system.

Source: National Audit Office review of documents from Health Education England

Part Two

Estimating local need for staff

2.1 This part of the report covers how local healthcare providers estimate their staffing needs.

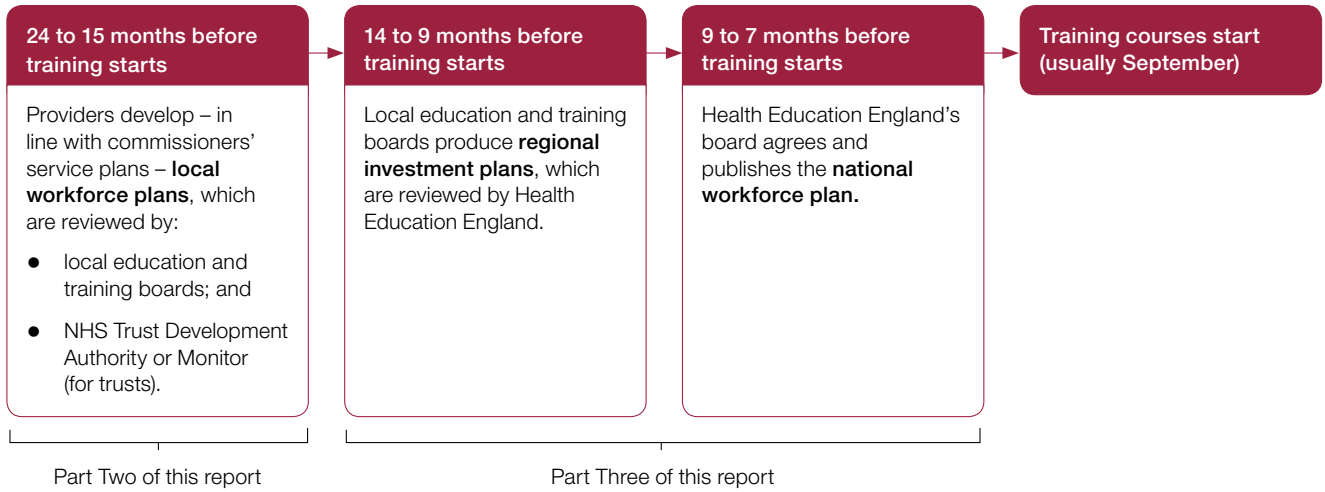
Developing local workforce plans

2.2 All health service providers have a duty to support the collective planning of the future NHS workforce. Health Education England asks providers to forecast their future staff requirements based on current supply and expected demand. These local workforce plans form the basis of regional and national plans (**Figure 8**).

2.3 Each year NHS trusts and NHS foundation trusts submit local workforce plans to their local education and training board for review and challenge. Our case studies of local areas showed that a considerable amount of work goes into this process, both at trusts and local education and training boards. Health Education England and the local education and training boards have developed a variety of tools to help providers understand their staffing needs. The process now involves more engagement from senior clinicians and managers.

Figure 8
Workforce planning processes

Providers' local workforce plans are used as the basis for regional and national workforce plans



Note
1 Timings presented here are indicative only.

Source: National Audit Office based on Health Education England's guidance

2.4 However, Health Education England has recognised that information on local staffing needs is not complete because not all providers submit workforce plans. For instance, local education and training boards do not routinely obtain plans from general practices, local authorities or private and third-sector providers. This means that the needs of some sectors, such as community services and primary care, may be misrepresented in the regional plans. As an indication of the size of this workforce, an estimated 51,000 nurses work in adult social care and a further 24,000 in general practices.[10]

Challenges in developing local workforce plans

Assessing how many staff are needed to provide a safe service

2.5 The NHS Constitution sets out that patients have the right to be treated with a professional standard of care by appropriately qualified and experienced staff. Each local provider must judge how many staff are needed to provide high-quality and safe care. They can draw on guidance including from the Royal Colleges, the NHS Litigation Authority, the National Quality Board (chaired by NHS England and the Care Quality Commission) and the National Institute for Health and Care Excellence (NICE). The Care Quality Commission's fundamental standards – that everybody has a right to expect when they receive care – include that providers must have enough suitably qualified, competent and experienced staff to make sure they can meet the standards.

Effect of Mid Staffordshire

2.6 In recent years, a greater focus on care quality and safety has led acute hospital trusts to increase their demand for nursing staff in particular. Reports on the failings at Mid Staffordshire NHS Foundation Trust highlighted the importance of staffing to the quality of care. Specifically, the 2013 public inquiry reported that the steps taken by the Trust to address its shortage of nursing staff were ineffective and prolonged.[11]

2.7 The financial impact of the response to what happened at Mid Staffordshire is unclear. In 2014, acute hospital trusts estimated that they needed around 24,000 more adult nurses than they had forecast two years before, in 2012, which would have an additional annual cost of around £1 billion. However, 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. In the event, we estimate that the overall increase in trusts' annual spending on permanent and temporary nurses was £740 million over the period, including to cover rising activity.[12]

10 These staff numbers reported as headcount.
11 The Mid Staffordshire NHS Foundation Trust Public Inquiry, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Volume 1: Analysis of evidence and lessons learned (part 1*), HC 898-I, February 2013.
12 The increase covers acute, elderly and general permanent nurses and all temporary nurses.

2.8 Due to difficulties in separating out the impact of different factors affecting demand for staff, we were not able to estimate the specific effect of the response to Mid Staffordshire. To cover the specific costs associated with responding to Mid Staffordshire, Monitor and NHS England increased the national tariff prices paid by commissioners for healthcare by the equivalent of £150 million in 2014-15. The Department set the 2013-14 tariff prices before the public inquiry into Mid Staffordshire was published and did not provide extra funding for trusts to respond to the report's recommendations.

Effect of NICE guidance

2.9 In 2013, the Department of Health (the Department) and NHS England asked NICE to develop evidence-based guidelines on safe staffing. By June 2015, NICE had published guidance on adult nursing and midwives, and was developing five more guidelines. At this point, NHS England asked NICE to suspend development of further safe staffing guidelines, as it looked at alternative ways of helping NHS providers to achieve the right levels and mix of staff. Several organisations are now involved in developing minimum staffing guidelines (**Figure 9** overleaf).

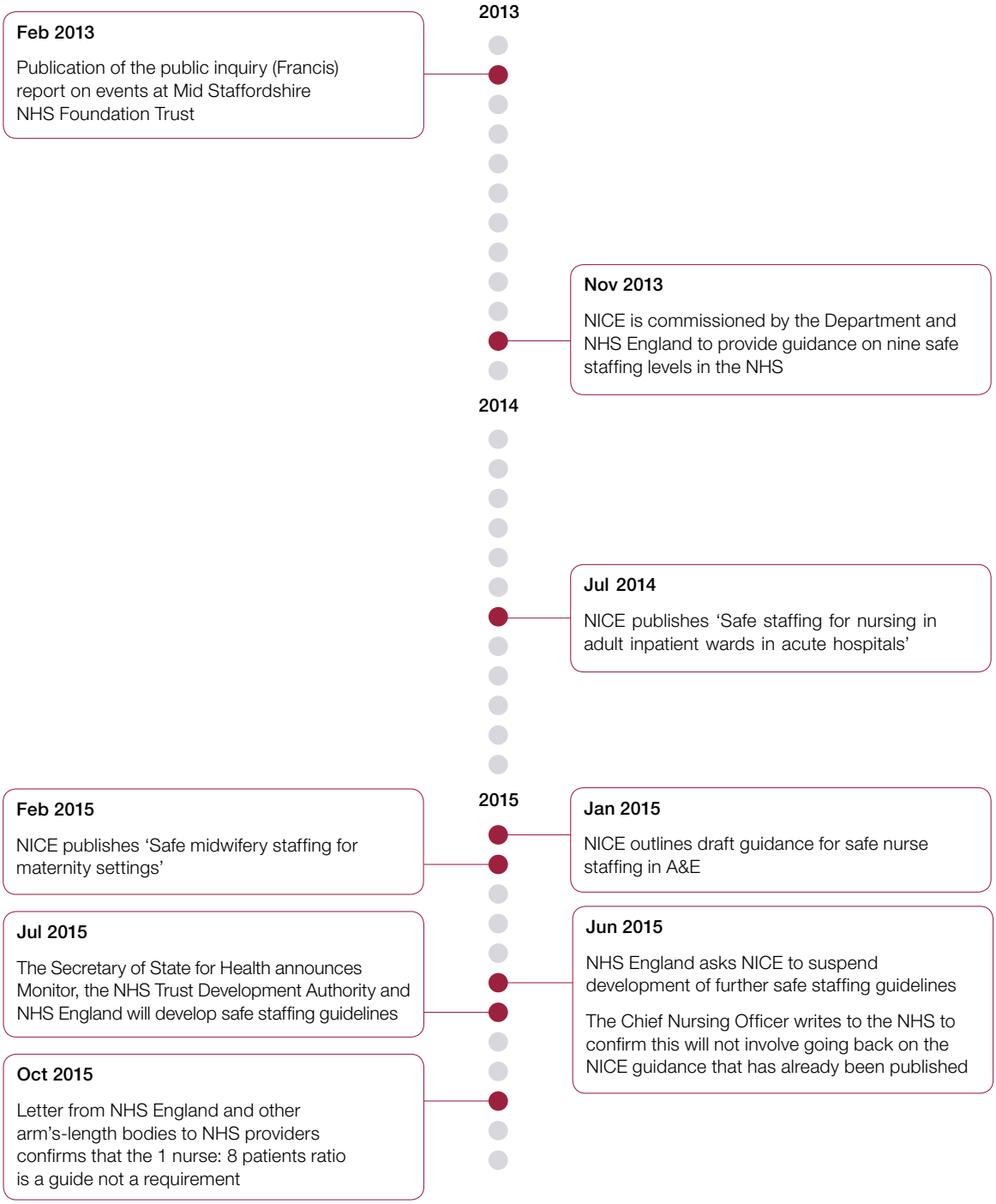
2.10 NICE's first guideline, on adult nursing, was published in July 2014. It concluded that there was no single nurse-to-patient ratio that could be applied across all acute adult inpatient wards. It noted, however, that there was evidence of increased risk of harm associated with a registered nurse caring for more than eight patients during daytime shifts. The likely impact of the safe staffing guidelines was not well understood by all parties:

- NICE provided a wide range for the estimated impact of the adult nursing guideline, from £0 to £414 million, and did not consider how appropriate staffing levels could be achieved in a timescale that considered the available supply of staff.
- 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.
- Trusts' workforce plans after the guidance was published did not reflect a material increase in demand for nurses compared with their previous submissions. However, our analysis suggests there was a significant increase in the demand for temporary nurses (paragraph 4.6).
- The overall increase in trusts' annual spending on permanent and temporary nurses was around £350 million between 2014 and 2015.[13] Part of this increase was due to other factors such as rising admissions, and this figure is therefore not comparable to the other estimates. Due to difficulties in separating out the impact of different factors affecting demand for staff, we have not been able to estimate the specific effect of the guidelines.

13 See footnote 12.

Figure 9

Timeline of development of national safe staffing guidelines



Source: National Audit Office

Reconciling financial and service sustainability

2.11 In developing their local workforce plans, trusts need to take account of the cost of employing staff and their wider financial position. The evidence indicates that the workforce plans that trusts submit to the local education and training boards are determined to a large degree by financial considerations, in part to ensure they align with the plans they prepare for the NHS Trust Development Authority or Monitor. This increases the risk that the workforce plans may underestimate the need for staff in the event that the forecast cost of employing staff exceeds the funding that is expected to be available.

Financial considerations

2.12 Local education and training boards ask trusts to provide information on the number of staff they expect to need. But they recognise that in practice these forecasts may be moderated by trusts' financial position. Trusts may adjust the number of staff they need in order to present a financial plan that is, or is closer to being, in balance. Evidence we gathered suggests that some providers themselves felt that workforce planning was too closely aligned to demonstrating that the trust was going to achieve a path to financial balance rather than considering long-term patient demand, commissioners' intentions and labour supply characteristics.

2.13 In the 2015-16 planning round, the NHS Trust Development Authority rated over a quarter (27%) of the 89 plans submitted by NHS trusts as 'red' or 'red-amber' (ie unaffordable, significantly misaligned with financial projections or significant clinical workforce reductions planned), and a further third (36%) as 'amber' (ie not aligned with financial projections).

2.14 In recent years the tariff prices paid by commissioners for healthcare have been adjusted as part of the drive to secure efficiency savings. Tariff prices were reduced by 4% in real terms each year from 2012-13 to 2014-15, and by 3.5% in 2015-16. This has reduced the income that trusts receive, in real terms, for each unit of activity, and aims to make them become more efficient. The efficiency adjustments to prices were in addition to adjustments made to recognise any inflation in pay and other costs.

2.15 Trusts have forecast that a significant amount of their planned efficiencies will come from staff costs, which account for around two-thirds of their costs. For example, from 2012-13 to 2015-16, acute hospital trusts consistently planned annual recurrent pay savings in the region of £1 billion. In practice, however, they have achieved less than two-thirds of these efficiencies in the last three years (**Figure 10** overleaf).

2.16 The pressure on providers to make efficiency savings will continue. The NHS *Five Year Forward View*, published in October 2014, estimated there could be a £30 billion gap between resources and patient needs by 2020-21. The government has committed to increasing funding by £8 billion by 2020, meaning the NHS will need to make further efficiencies to close the gap of £22 billion by 2020-21.

Figure 10

Acute hospital trusts' planned and actual recurrent pay savings since 2012-13

	Total planned cost savings (£m)	Planned recurrent pay savings (£m)	Actual recurrent pay savings (£m)	Proportion of planned recurrent pay savings achieved (%)
2015-16	2,072	988	n/a	n/a
2014-15	2,121	1,113	633	57
2013-14	2,181	1,206	746	62
2012-13	2,225	1,181	748	63

Source: National Audit Office analysis of NHS trust and NHS foundation trust cost improvement programme plans

Effect of workforce plans

2.17 There are risks associated with trusts not taking an even-handed approach to balancing financial and service demands in their workforce plans. Nationally, this could result in too few training places being commissioned. In the 2015-16 national workforce plan, Health Education England suggested that local forecasts for adult nurses and mental health nurses were mainly driven by affordability. It made an adjustment with a view to ensuring enough staff would be trained to meet future need. For 2016-17, the Department and its arm's-length bodies aim to align their planning processes further. In December 2015, they published joint guidance intended to clarify the priorities, challenges and planning assumptions that NHS providers and commissioners need to consider when developing plans.[14]

2.18 At trust level, underestimating service needs could lead to staff gaps or additional costs as a result of trusts having to use more expensive temporary staff to address shortfalls. Our evidence suggests that trusts' workforce plans typically forecast smaller short-term increases in their staff establishment numbers, for some groups, than actually occur. For acute, elderly and general nurses (the only staff group for which data were available) trusts predicted growth in the forthcoming year of 2.0% between 2012 and 2015 compared with actual increases of 5.2%.

14 Care Quality Commission, Health Education England, NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), NICE and Public Health England, *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21*, December 2015.

Assessing the impact of changes in services

2.19 In developing their local workforce plans, providers should take account of how they expect services to be delivered in future. Predicting changes in services is difficult and reliant on assumptions. The NHS *Five Year Forward View* envisages considerable change in how the NHS will provide healthcare in future but, as we reported in December 2015, the redesigned models of care are new and untested. The workforce advisory board (paragraph 1.15) was set up to consider the workforce implications of these changes in health services.

2.20 Evidence suggests that trusts are more able to assess the impact of changes in services over the medium term, one or two years ahead, but that changes further into the future are less likely to be reflected in their plans. Some trusts have not focused on long-term solutions to workforce planning. This is, in part, because they felt they lacked the capability and capacity within their teams to carry out analysis and develop solutions. Our case studies also indicated that local workforce plans tend not to reflect changes in commissioning that may occur over the longer term.

2.21 In 2014-15, clinical commissioning groups set out their commissioning intentions – five years ahead at strategic level and for the next two years at operational level.[15] These indicated the services they expected to commission, and were intended to help trusts to estimate likely activity levels and income and therefore staff needs. We have not audited whether these intentions provided an accurate assessment of actual commissioning patterns. NHS England, which commissions specialised healthcare, did not provide similar information, reducing the level of assurance around trusts' workforce plans.

2.22 Our analysis suggests that difficulty in estimating the workforce implications of longer-term or more significant service changes means that providers' local workforce plans may tend to underestimate future staffing changes. For example, in their workforce plan submissions in 2012 to 2015, trusts predicted, on average, virtually static adult nursing numbers, with three of the four forecasts suggesting the numbers would decrease over the long term. In comparison, the long-term trend is for average annual increases of 1.1% per year, based on data for 2004 to 2014. In 2012, trusts forecast that they would require some 164,000 full-time equivalent adult nurses by 2015; in the event, there were 177,000 in June 2015, around 13,000 (7%) more than had been predicted. Health Education England does not have a similar time-trend on providers' long-term forecasts for other clinical professions. The conservative approach that trusts are adopting increases the risk that too few staff will be trained to meet future need.

15 Operational plans may include, for example, expansions or reductions in volumes of services or introducing new service standards. Clinical commissioning groups refreshed these operational plans in 2015-16.

Part Three

Commissioning training places

3.1 This part of the report covers how Health Education England and its local education and training boards develop the national workforce plan and commission training places.

3.2 The costs and time taken to train clinical staff vary from, for example, 14 years to train a hospital consultant at a cost of over £720,000 to three years to train a nurse at a cost of nearly £80,000 (**Figure 11**). The significant length of time it takes to train means inadequate workforce planning now could result in shortfalls or inappropriate skill-mix for many years.

Developing the national workforce plan

3.3 Local education and training boards are responsible for developing regional workforce investment plans by taking assurance over, and consolidating, local providers' workforce plans. They review and challenge providers' plans using data to model the supply of, and demand for, staff. The process also involves input from local clinical commissioning groups and other stakeholders.

3.4 Health Education England's central team is then responsible for producing a national workforce plan by aggregating the regional workforce investment plans. **Figure 12** gives an overview of the process. It is collaborative with input from a range of experts. For example, Health Education England reported receiving over 100 submissions from medical colleges, physician and nursing organisations, the Centre for Workforce Intelligence and other bodies in its annual 'call for evidence' in 2014.

Figure 11
Costs and time to train for selected staff groups

	Staff in post in 2014, headcount[1]	New training places available, 2014/15, number (Percentage of total workforce)[2]	Estimated cost of training, £ per person[3]	Number of years to train[4]
Acute, elderly and general nurses	195,000	13,228 (7%)	£79,000	3
Consultants	43,000	4,801 (11%)	£727,000	14
GPs	36,000	3,049 (9%)	£485,000	10

Notes

1 Staff in post figures are rounded to the nearest 1,000.

2 New training places refer to the number of places commissioned for students to start their undergraduate level nurse course, and the number of core or specialist training year 1 places for GPs and consultants. A training place is a place in a university at undergraduate level and in a hospital at postgraduate level.

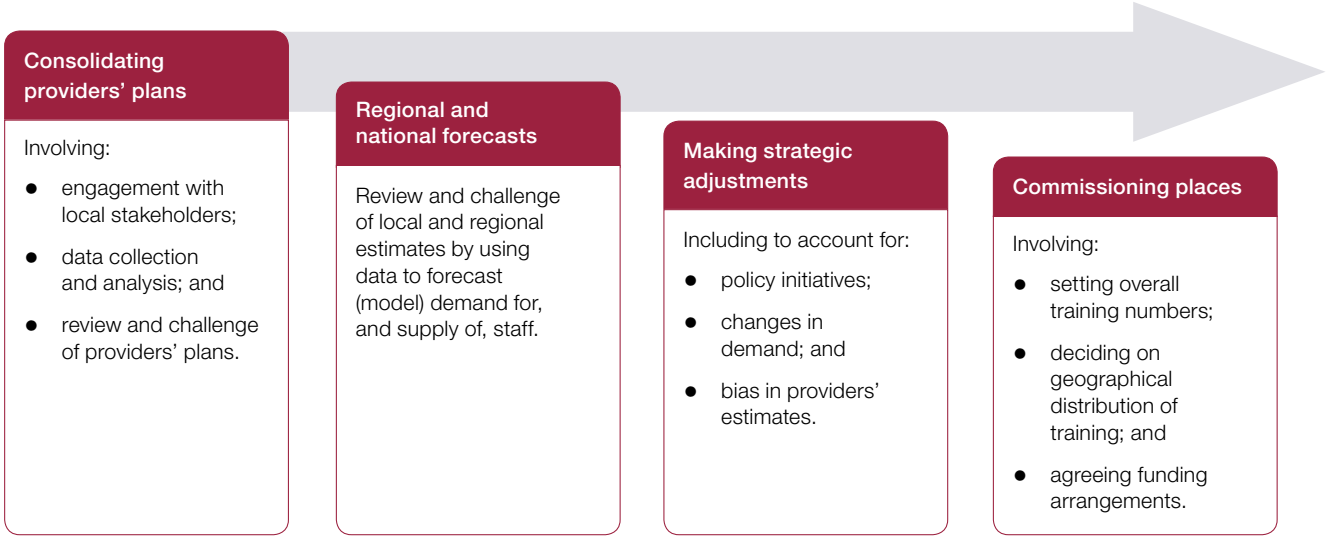
3 Estimated costs of training are calculated for both undergraduate and postgraduate training, and consist of: tuition, living expenses, clinical placement and lost production cost during the period of training where staff are away from their posts.

4 Length of training is influenced by, for example, the specialty and so figures given are indicative only.

Sources: Health and Social Care Information Centre workforce census; Health Education England data; Personal Social Services Research Unit, *Unit Costs of Health and Social Care 2014*

Figure 12
Overview of process for commissioning training places

The process for commissioning training places involves regional and national challenge of local workforce plans



Source: National Audit Office

3.5 The process for assuring staffing needs is iterative and involves a range of stakeholders at regional and national levels. This makes it difficult to take an overall view on its efficiency and effectiveness. However, we observed several shortcomings, reducing the level of assurance there is at national level about current and future workforce pressures:

- 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, there are shortcomings in its model; it has not been reviewed externally and some of the assumptions appear unrealistic. For example, the model assumes a retirement rate of 1.6% for adult nurses in 2015, although alternative data from the Health and Social Care Information Centre suggest approximately 2.4% of nurses retired in 2014.

- Health Education England has not comprehensively modelled the supply of, and demand for, doctors. It has, with the Department of Health (the Department), commissioned the Centre for Workforce Intelligence to produce medical workforce projections.[16] However, these models do not cover junior doctors. In addition, the Department has not reviewed how many medical undergraduate training places are needed since an exercise in 2011.

  Trusts may be incentivised to plan to use junior doctors rather than other staff. This is because trusts receive funding to cover half of the basic salary costs of junior doctors from Health Education England, which also pays providers for their training placements. For instance, trusts typically pay a minimum of £11,300 for a first-year junior doctor, with a further £23,700 of costs covered by Health Education England. This compares with a newly-qualified nurse and entry-level consultant, where trusts pay a minimum of £21,700 and £75,200 respectively, and do not receive financial support from Health Education England.[17]

- The data used to monitor workforce numbers are not sufficiently reliable or comprehensive to support Health Education England's decisions. Specific data gaps are outlined in Appendix Three and relate to both certain care settings and particular types of data. For example, there are no accurate, real-time data on vacancies. The main source of workforce data are electronic staff records systems which are used by nearly all trusts. However, the processes for checking whether these data are sufficiently accurate and complete to support workforce planning are limited. During 2015, the Health and Social Care Information Centre consulted on possible changes to the way staffing information for hospital-led services is defined and presented in NHS workforce statistics.

16 The Centre for Workforce Intelligence has been commissioned by the Department, Health Education England and Public Health England to look at specific workforce groups and to provide materials, tools and resources to inform policy decisions on workforce planning at national and local level. The contract ends in March 2016.

17 Data are for the lowest pay point for first-year foundation doctors, consultants and band 5 nurses. They include only basic salary costs and Health Education England placement fees. They exclude additional costs such as National Insurance and pension contributions, payments for working unsocial hours or on call, and overheads. Figures are rounded to the nearest £100.

3.6 The changing demand for healthcare and the limitations in forecasting mean there is a high degree of uncertainty in the estimates of future workforce pressures. For example, Health Education England's previous analysis suggested that the difference between supply and demand for adult nurses in 2015 could range from a shortfall of 63,700 to an oversupply of 7,900 depending on different scenarios. Health Education England has not undertaken a comprehensive investigation into the level of uncertainty, including the relative risks and implications of over or undersupply. It is therefore unclear how the uncertainty is feeding into risk management across the health system.

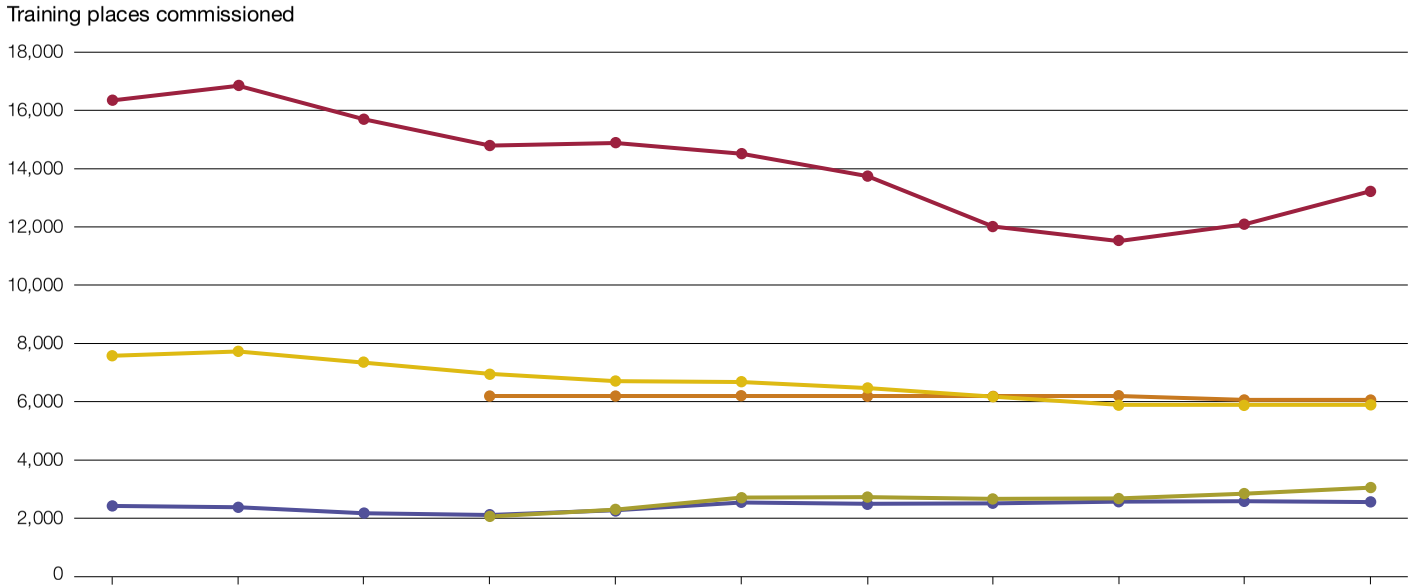
Commissioning decisions

3.7 Each year Health Education England commissions 130 education and training programmes. In total, around 140,000 students are in clinical training at any one time. Over the last decade, the number of midwife and undergraduate medical training places has remained relatively stable. From 2006/07 to 2014/15, the number of undergraduate medical places decreased by just 2.0% and for seven of these years the number remained at 6,195. However, there have been other significant changes in the number of training places, with around 1,000 more for GPs (an increase of 48% since 2007/08); 3,106 fewer for adult nurses (a decrease of 19% since 2004/05) and 1,682 fewer for allied health professionals (a decrease of 22% since 2004/05) (**Figure 13** overleaf).

Figure 13

Number of training places commissioned for selected staff groups, 2004/05 to 2014/15

In 2014/15 there were 3,106 fewer adult nurses training places than a decade earlier



	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Adult nurses	16,334	16,850	15,687	14,796	14,873	14,506	13,744	12,017	11,509	12,092	13,228
Allied health professionals	7,574	7,732	7,339	6,955	6,714	6,683	6,466	6,182	5,902	5,900	5,892
Undergraduate medical				6,195	6,195	6,195	6,195	6,195	6,195	6,071	6,071
Midwives	2,425	2,380	2,170	2,115	2,274	2,537	2,493	2,507	2,578	2,588	2,563
GPs				2,067	2,301	2,719	2,732	2,672	2,687	2,850	3,049

Note

1 No data were available for GP and undergraduate medical places before 2007/08.

Source: Health Education England data and Department of Health data

Constraints on commissioning decisions

3.8 Health Education England's ability to change the pattern of commissioning to address workforce pressures is constrained by a number of factors:

- **Stable total funding coupled with large existing financial commitments**
  Between 2006-07 and 2014-15, real-terms funding for education and training remained at around £4.9 billion (in 2014-15 prices). It fell as a proportion of total health spending, from 5.1% to 4.3%. Therefore, any increases in training places for some staff groups would have been likely to require decreases for other groups. Following the 2015 Spending Review, the Department expects Health Education England's budget will remain the same in cash terms until 2020-21 and that it will have to make difficult prioritisation decisions to live within this budget.

  In addition, over 60% of Health Education England's budget is already committed. In 2014-15, it forecast costs of £0.9 billion on non-medical courses and £1.3 billion on postgraduate medical placements which had been commissioned in previous years, and a further £0.9 billion on undergraduate medical places, for which numbers are decided by the Department.

- **Contractual obligations and training capacity**

  We understand that Health Education England's training contracts with university medical schools, for example, can be adjusted by only 10% for any one programme and by no more than 5% in aggregate each year. The capacity of the training programmes themselves depends on the availability of work placements with providers. However, the ability of trusts and other providers to offer the mentoring and support that students need may be limited, particularly at a time of financial and service pressure.

- **Imbalances in current and future need for doctors**

  The way in which the NHS is staffed means that Health Education England faces an inherent challenge in seeking to reconcile current and future demand for doctors. Trusts rely heavily on having large numbers of junior doctors to provide services. As a result, there is a potential mismatch between the number of doctors completing their foundation training and the number of specialist posts available for them to fill. There is a risk that, if Health Education England commissions fewer training places to prevent a possible future oversupply of senior clinicians, the reduction could cause shortages within the junior grades and destabilise current services.

3.9 These constraints may mean the true workforce pressures are not reflected in regional investment plans and lead in the long term to costly over or undersupply of staff. We heard that, in one region, restrictions on spending and capacity meant that the initial estimate of demand for adult nurse training places was suppressed by 5 percentage points. Some trusts have started – or are considering – funding their own training places to supplement those commissioned nationally. For example, Lancashire Teaching Hospitals NHS Trust has contracted with the University of Bolton to train its own nurses. Health Education England provides no funding for these places.

Strategic adjustment of training places

3.10 Although much of the responsibility for workforce planning is devolved to local level, our view is that strong national oversight is needed to ensure that planning is efficient, consistent and achieves best value for the system as a whole. When it reviews regional investment plans, Health Education England may make strategic adjustments. There are a number of examples of where it has used this power to increase the number of training places for particular staff groups. In these cases, it considered more staff would be needed to implement government policy initiatives or change the way services were delivered. For example, for 2015/16, Health Education England increased from 24 to 205 the number of training places for physician associates. This is a new role designed to supplement the doctor workforce and thereby improve patient access to care. Overall, however, the adjustments that Health Education England has made have been small in absolute terms.

3.11 The evidence we collected suggests that Health Education England has not been consistent and comprehensive in making strategic adjustments to training places. This could lead to shortages in some staff groups and wasted resources in training too many in others. In addition, some commissioning decisions lack transparency. For example, it is unclear how Health Education England used the workforce projections from the Centre for Workforce Intelligence (paragraph 3.4) in 2014 to help it decide how many training places to commission. This analysis predicted large estimated over and undersupply over the next five to ten years in some medical specialties including, at the extremes, an 80% oversupply of infectious disease consultants and a 30% undersupply of old age psychiatric consultants. However, training places commissioned for these two specialties remained unchanged for 2015/16.

Addressing geographical disparities

3.12 We also considered whether Health Education England has adjusted the location of training places to reduce geographic variation in staffing shortfalls (Figure 5) but found limited evidence of this. Health Education England is mandated to work with local education and training boards to understand geographical imbalances and take action to correct them.[18]

3.13 In part, geographical differences may be explained by factors beyond the control of workforce planning processes, such as pay scales and differences in the cost of living across the country. However, commissioning more training places could help areas with larger shortfalls as many students take up work in the area where they trained. Previous analysis undertaken for the NHS suggests that 86% of senior doctors stayed in the region where they completed their specialty training after qualification.[19] We calculated that 71% of registered nurses who trained between 2004 and 2014 started working in the region they trained in. For example, only 1% of nurses who trained in London over the last decade started working in the North West and vice-versa.

3.14 We examined the relationship, at a regional level, between nurse and midwifery vacancies in 2014 and relative numbers of training places.[20] We did not observe any consistent relationships and found that there were only limited changes in the distribution of training places, although the increase in adult nursing places was higher in regions with more vacancies than in areas with fewer vacancies. Health Education England has recognised that there is no clear link between the location of training places and the need for staff.

Influencing course completion rates

3.15 To provide enough staff in future, Health Education England needs to base its commissioning decisions on an understanding of how many training places result in someone joining the NHS workforce. This involves estimating the proportion of:

- training places offered that are taken up (fill rate);
- people finishing their course (completion rate); and
- graduates entering the NHS (participation rate).

18 Department of Health, *A mandate from Government to Health Education England: April 2014 to March 2015*, May 2014.
19 NHS Workforce Review Team, *Migration Patterns of the Recently Trained Medical Workforce*, 2010.
20 Specifically, we compared nurse shortfalls to both the relative level of training places (measured as places per existing nurse in each region) and change in number of training places between 2014/15 and 2015/16 (measured as variation in places per existing nurse).

3.16 From the data that are available, it is clear that these factors have a substantial impact on the number of qualified staff that eventually join the NHS. For example, around 60% of the nurse training places commissioned for 2016 (8,100 out of 13,800) are expected to result in someone entering the NHS workforce. And the proportion of doctors completing their foundation training who progressed directly into specialty training in the UK fell from 71% in 2011 to 52% in 2015.[21]

3.17 However, Health Education England's commissioning decisions are not supported by a robust understanding of the likely number of new entrants that will join the NHS. Its forecasting in this area is limited. For example, it does not use data on whether graduates for non-medical courses go on to work in the NHS. Important assumptions, such as those on completion and participation rates, are based on averages of just two years' worth of past data.

3.18 The Department has set Health Education England an objective to reduce the number of people avoidably leaving their training programmes by 50% by 2017, by providing the right financial incentives and payment mechanisms. Currently nurses, midwives and allied health professionals receive free university education, but individuals training for other professions are generally not exempt from tuition fees.[22] The rationale for this distinction is unclear and the effect it has on completion rates has not been assessed.

21 UK Foundation Programme Office, *F2 Career Destination Report 2015*, 2015.

22 From 1 August 2017, new students on nursing, midwifery and allied health professional undergraduate courses will not receive financial support through the NHS bursary scheme. These students will instead be able to take out further loans through the standard student loan system. See Figure 7 for more details.

Part Four

Addressing short-term shortfalls in staffing

4.1 This part of the report covers the use of temporary staffing, overseas recruitment and return-to-practice initiatives to address shortfalls in staffing.

Temporary staffing

4.2 Providers need some flexibility in their staffing to be able to respond to short-term or unexpected fluctuations in the demand for healthcare or in the availability of their existing workforce. The use of temporary staff forms an important part of this flexibility. Providers can access temporary staff from their own staffing 'banks' or by obtaining staff from commercial agencies or other providers such as NHS Professionals.[23] There are limited data available on the temporary staffing market but it is clearly extensive, with over 400 agencies on one list produced by NHS Employers.[24]

4.3 The cost of temporary staff varies. For example, data from a sample of trusts suggest that on average, in 2015:

- bank nurses cost £27 per hour (ranging from £19 to £36 after excluding the highest and lowest 10% of bookings). In comparison, agency nurses cost £39 per hour (£30 to £49); and
- for doctors, the hourly costs were £60 (£38 to £86) for bank and £68 (£51 to £99) for agency.[25]

4.4 Trusts often use temporary staff to cover vacancies. In 2014-15, some 61% of the shifts requested from NHS Professionals were reported, by trusts, as being to cover unfilled substantive vacancies. Temporary staff are also used to cover sickness absence (which accounted for 12% of requests) or as a result of poor rostering of existing staff.

23 NHS Professionals manages temporary and flexible worker banks in partnership with trusts. It is a company, wholly owned by the Secretary of State for Health.
24 NHS Employers' recruitment agency list includes the recruitment agencies that operate in accordance with the code of practice for international recruitment of healthcare professionals.
25 Analysis based on data from NHS Professionals covering 62 trusts. Nurse data are for qualified nurses only. Figures in this paragraph are the average of hourly rates for each shift (and not weighted by the lengths of shifts).

Trend and variation

4.5 The demand for temporary staffing has increased. For example, the number of nursing hours that 62 trusts requested per month from NHS Professionals doubled in three years (from around 650,000 in April 2012 to 1.3 million in April 2015) (**Figure 14**). This suggests, across all trusts, requests for temporary staff were equivalent to around 30,000 full-time equivalent nurses (or 11% of total nursing hours) in 2014-15.

4.6 Some of the increase in temporary staffing coincided with providers' responses to the report on failings in care at Mid Staffordshire NHS Foundation Trust and the National Institute for Health and Care Excellence safe staffing guidelines for adult nurses. Specifically, based on a sample of trusts, we found that, in addition to a generally upward trend, the total nursing hours requested increased by an estimated 12% after the safe staffing guidelines, equivalent to a cost of £230 million annually for the whole NHS.

4.7 Our analysis also showed that trusts' use of temporary staff clearly peaks in March each year. We interpreted this, at least to some extent, as trusts needing cover for permanent staff taking leave at the end of the annual leave year. This suggests that trusts may not be managing leave well throughout the year. We estimated that, for 2014-15, requested hours for temporary staff were around a fifth higher in March than expected. These extra hours are equivalent to a cost of around £25 million when extrapolated to all trusts. In June 2015, the interim report of the review of operational productivity in NHS providers noted that tight management of annual leave, sickness and use of appropriate training can account for differences of up to 4% in productive time.[26]

4.8 Between 2009-10 and 2014-15, trusts' expenditure on all temporary staffing, including non-clinical roles, increased from £2.9 billion to £4.7 billion (10% of their pay bill in 2014-15).[27] Within this, spending on agency staff increased by a half from £2.2 billion to £3.3 billion (7% of their pay bill).

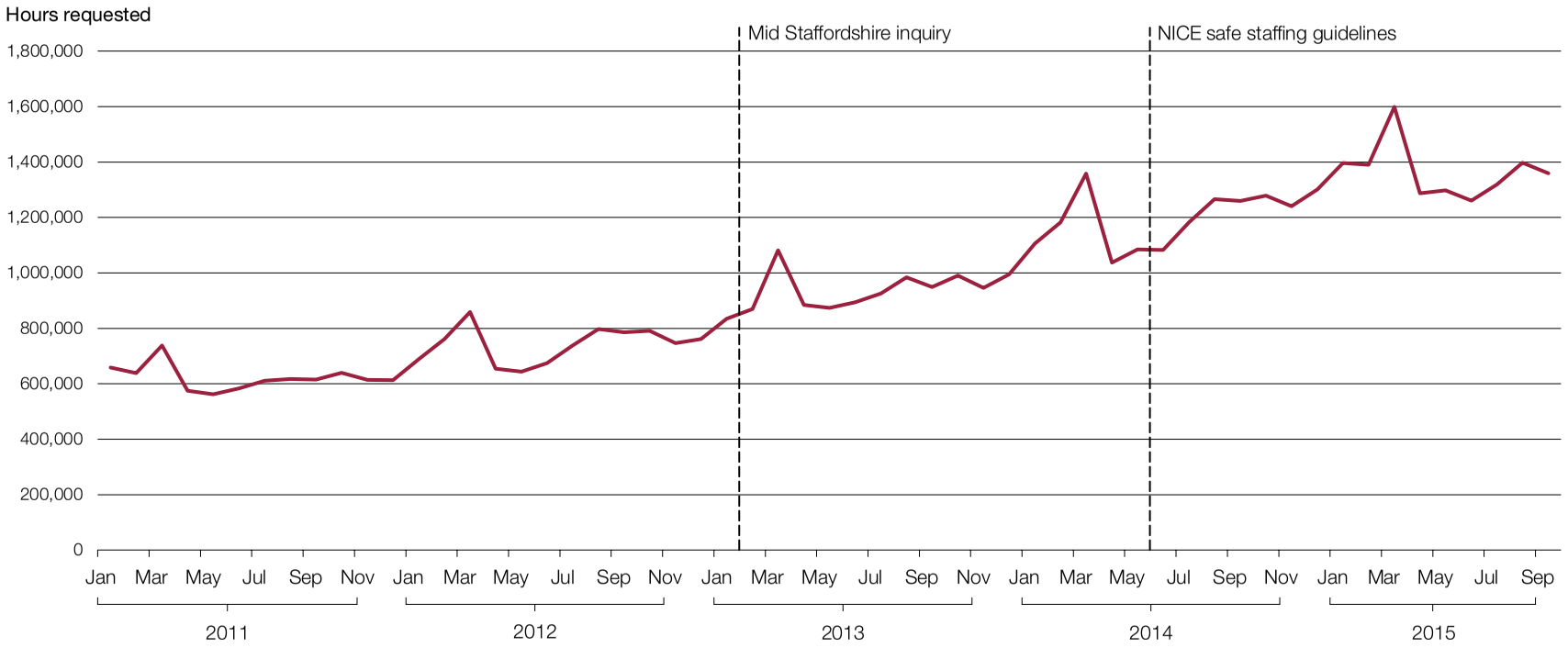
4.9 Data from a sample of trusts suggest that the majority (around three-quarters) of the increase in spending on temporary nurses from 2012-13 to 2014-15 was due to greater use of such staff, with hours increasing by 52%, while average hourly rates increased by 16%. Around a quarter of requested hours for nurses remained unfilled, raising questions about whether these services had sufficient staff.[28]

26 Department of Health, *Review of Operational Productivity in NHS Providers – Interim Report*, June 2015.
27 The exact increase is not clear as the data collections for 2009-10 and 2014-15 were different.
28 See footnote 25.

Figure 14

Demand for temporary nurses, 2011 to 2015

The number of temporary nursing hours requested per month from NHS Professionals doubled between April 2012 and April 2015



Note

1 NHS Professionals covers 62 acute, mental health and community trusts.

Source: National Audit Office analysis of NHS Professionals data

4.10 Spending on agency nurses increased by more than spending on bank nurses. In the two years to 2014-15, data from a sample of trusts suggest spending on agency nurses tripled (comprising a 178% increase in use and a 9% increase in the hourly rates charged by agencies). This compares with an 11% increase in spending on bank nurses. Agency work can be an attractive option for staff due to the flexibility and financial reward it offers, and some permanent NHS staff also work additional shifts as agency staff. Previous reports suggest that agency doctors routinely earn 50% more than permanent staff,[29] and hospitals might pay up to £3,500 for a doctor to work a single shift.

4.11 There is substantial variation in spending on temporary staff. Trusts' spending as a percentage of their total expenditure varied by 5.7 percentage points in 2014-15, from 1.7% to 7.4%, even after excluding the top and bottom 10% of trusts. The variation was wider than in 2011-12 when it was 3.6 percentage points. Some of the variation may be the result of factors outside trusts' control, such as local labour market conditions. 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.[30]

Controlling spending

4.12 In September 2015, in light of concerns about the increasing spending on agency staff, Monitor and the NHS Trust Development Authority introduced the following rules on using staff from nursing agencies:

- an annual limit for how much each trust can spend on agency nurses (as a percentage of total spending on nursing staff); and
- mandatory use of approved frameworks for procuring agency staff.

The rules apply to all NHS trusts and to NHS foundation trusts that are in breach of their licence for financial reasons or receiving interim support from the Department of Health (the Department). Monitor expects other NHS foundation trusts to comply with the rules.

4.13 In October 2015, the Secretary of State for Health announced that mandatory caps would be introduced on the hourly amount that trusts can pay agencies for all temporary staff, with the aim of reducing NHS spending by £1 billion by March 2018. The caps are being introduced gradually from November 2015 and will mean that, by April 2016, an agency worker should not be rewarded more than existing permanent staff at that grade. It is too early to evaluate the impact of these new measures.

4.14 While these measures may encourage some agency staff to return to permanent NHS positions, our view is that they are unlikely in themselves to address fully the underlying causes of the increased demand for temporary staff. Reducing trusts' reliance on temporary staff in a sustainable way is likely to require a broader, more strategic plan which also covers actions arising from the review of operational productivity in NHS providers.

29 Based on analysis by Liaison, a financial services company, on data from the first three quarters of 2014-15.
30 Comptroller and Auditor General, *Sustainability and financial performance of acute hospital trusts*, Session 2015-16, HC 611, National Audit Office, December 2015.

Overseas recruitment

4.15 Recruitment from outside the UK has been an important source of clinical staff for the NHS. NHS Employers lists 40 international recruitment agencies for healthcare professionals.[31] The proportion of staff who trained overseas varies between staff groups. In 2014, they accounted for around 35% (14,600) of hospital consultants, 22% (8,000) of GPs and an estimated 14% (47,000) of nurses.[32]

4.16 The Department advises all healthcare organisations to adhere to its code of practice for international recruitment. The code is intended to promote ethical practice including that any recruitment should not prejudice the health system of developing countries.

Legal framework

4.17 The right to work in the NHS depends on nationality:

- Individuals from most European Economic Area countries and Switzerland are not subject to worker restrictions in the UK, as they are covered by the European principles of free movement.[33]
- Immigration for individuals from elsewhere is governed by a number of rules. The most common route for NHS recruits is known as a 'tier 2' visa, which entitles the individual to stay for up to six years.

4.18 There is a pool of 20,700 tier 2 visas available annually. For a person to get a tier 2 visa, the prospective employer must ensure that there are no suitable settled UK workers who could fill the role. Employers can bypass this requirement, and applicants be prioritised a visa, if the roles they are recruiting for are included on the Home Office's list of occupations for which there are not enough resident workers to fill vacancies. The government regularly asks the Migration Advisory Committee (an arm's-length body sponsored by the Home Office) to review this 'shortage occupation list' and the Committee seeks evidence on which occupations should be added or removed.

4.19 For clinical staff who have qualified overseas, employers need to check, among other things, that the qualification is equivalent to the relevant UK qualification. All doctors and nurses trained outside the European Economic Area who want to join the NHS must provide evidence that they have an acceptable level of English language skills. From January 2016, nurses and midwives from within the European Economic Area will also have to provide evidence of their English language skills.

31 See footnote 24.

32 Analysis of headcount data from the Nursing and Midwifery Council and the Health and Social Care Information Centre. As the data are categorised by country of primary medical qualification, a doctor whose initial medical qualification is from overseas and their specialty qualification is from the UK is counted as an overseas recruit.

33 There is an exception for Croatian nationals who are subject to worker authorisation requirements. The European Community Association Agreement with Turkey provides Turkish nationals who are already legally employed in the UK with certain rights when they want to extend their stay.

4.20 Since 2012, in line with tier 2 visa rules, any individual who entered the UK after April 2011 may only remain for a maximum of six years if they do not reach a minimum earnings threshold of £35,000. The Royal College of Nursing estimated that up to 3,365 nurses currently working in the UK would have to leave the country from 2017 as a result of these changes. In October 2015, the Home Office included nurses on the shortage occupation list, on an interim basis, for the first time since 2009. This should make it easier for trusts to recruit nurses from overseas and also means that the minimum earnings threshold will not apply. The Migration Advisory Committee is reviewing whether nurses should remain on the list and is due to report to the government in February 2016.

Trend and variation

4.21 The recruitment of overseas staff has varied over time, particularly from countries outside the European Economic Area **(Figure 15** on pages 46 and 47):

- 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%. During this period, in 2009, nurses were removed from the shortage occupation list (paragraph 4.18). The decrease was partly offset by a large rise in recruits from within the European Economic Area, where the number of entrants increased from 1,192 in 2004-05 to 7,232 in 2014-15.
- The number of doctors newly registered from outside the European Economic Area fell from 6,313 in 2004 to 2,528 in 2014, a drop of 60%. Postgraduate doctors were removed from the shortage occupation list in 2006, although some specialties have since been added back to the list.

4.22 Most trusts have recruited staff from overseas although the extent to which they have done this varies. In the 12 months to September 2014, nearly three-quarters of trusts are thought to have undertaken overseas recruitment rounds.[34] In 2014-15, most nurses from overseas came from Spain, Romania, Italy or Portugal.[35] According to data from the Home Office, around half of the nurses recruited by the NHS and entering the UK under tier 2 visas in 2014-15 were recruited by just three London trusts.

4.23 Overseas recruitment was previously coordinated regionally but responsibility now rests with individual providers. This means that trusts are potentially competing for the same staff. In addition, as previous research has highlighted, some international recruits transfer between trusts soon after being recruited (on average around a fifth of overseas nurses leave their trust within the first two years of employment).[36]

4.24 The cost of overseas recruitment varies. The Royal College of Nursing estimates that the cost of recruiting a single nurse from overseas can range from £2,000 to £12,000. This compares with some £79,000 to train a nurse in England.[37]

34 S Lintern, 'Staff shortage fuels recruitment of nearly 6,000 overseas nurses', *Health Service Journal*, December 2014.
35 Based on Nursing and Midwifery Council's Initial Registrations data.
36 N Merrifield, 'Some trusts have lost more than half of overseas nursing recruits', *Nursing Times*, February 2015.
37 This comparison should be treated with caution. For example, the estimated costs of training includes wider costs such as living expenses (see notes in Figure 11).

Return-to-practice initiatives

4.25 The NHS can increase the supply of staff by encouraging people who have left – including those who have retired, moved to work for a private provider or taken a career break – to return to work. One estimate suggests that in 2012-13, 6.5% of nurses left the nurse register (23,952 out of 369,868), for example to retire from practice or change career.[38] Return-to-practice initiatives derive value from the money that was previously spent on an individual's training.

Trend and variation

4.26 Relatively little use is currently made of return-to-practice schemes. In 2014-15, some 900 nurses enrolled on return-to-practice courses.[39] The number of nurses returning to work ranged from 159 to 0 across the 13 local education and training boards. The nature of return-to-practice schemes varies significantly from making information available to job guarantees.

4.27 Past initiatives have attracted many more nurses back to the NHS. A centrally funded programme between February 1999 and March 2004 resulted in 18,500 former nurses and midwives returning to work.[40] This was some four times the number who completed return-to-practice courses a decade later (4,800 from 2010 to 2014).[41]

4.28 Health Education England considers that the ongoing staffing pressures warrant concerted and special action. Therefore it has sponsored return-to-practice initiatives, even though they go beyond its role in relation to the future NHS workforce. In 2015-16, it has allocated £1.3 million to retraining the current qualified workforce to return to work, in addition to £1.5 million in 2014-15.

4.29 The extent to which return-to-practice initiatives could be used to address staffing shortfalls is unclear as, for instance, there are no comprehensive data on why clinical staff leave the NHS. In addition, data on the use, cost and success of these initiatives are no longer collected centrally, although the cost is clearly small and the time short compared with the cost and time of training new staff. A national scheme supporting nurses to come back to the NHS takes three months at a cost of £2,000 per person. There is also evidence of the benefit of using staff who come back to the NHS. Health Education England has recognised the advantages of nurses returning to work, noting that they typically: complete their course (70–80% of participants actually return to nursing); are experienced workers; and go on to be employed by the trust in question.

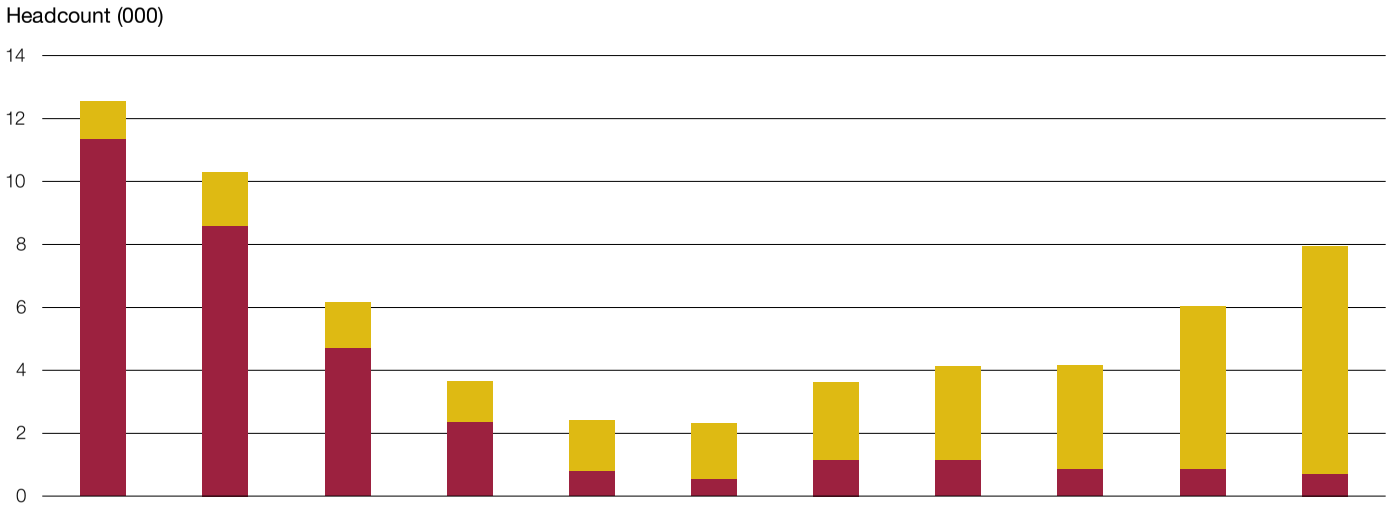
38 Health Education England, *Growing Nursing Numbers*, July 2014.
39 Health Education England data, reported as headcount.
40 Health Education England, *Nursing Return to Practice: Review of the current landscape*, April 2014.
41 Health Education England and Nursing and Midwifery Council data, reported as headcount. Data for 2010 to 2014 are for the whole of the UK. Due to differences in the data sources, this longitudinal comparison should be treated with caution.

Figure 15

Entrants to the UK-wide registers for nurses and doctors from within and outside the European Economic Area, 2004 to 2014

The number of doctors and nurses registered from countries outside the European Economic Area has fallen

Nurses added to the Nursing and Midwifery Council register

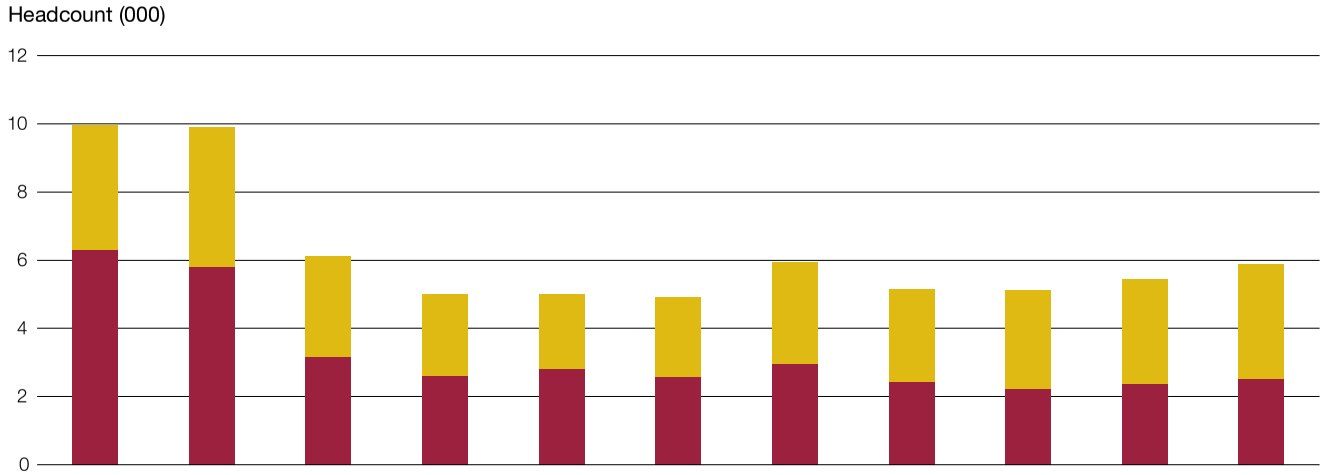


	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
Non-EEA trained	11,359	8,590	4,731	2,347	806	567	1,157	1,163	875	875	699
EEA trained	1,192	1,685	1,439	1,305	1,606	1,761	2,470	2,960	3,292	5,168	7,232

Figure 15 *continued*

Entrants to the UK-wide registers for nurses and doctors from within and outside the European Economic Area, 2004 to 2014

Doctors added to the General Medical Council register



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Non-EEA trained	6,313	5,798	3,147	2,587	2,825	2,574	2,958	2,435	2,219	2,355	2,528
EEA trained	3,659	4,089	2,962	2,410	2,164	2,346	2,961	2,716	2,893	3,081	3,351

Notes

1 Classifications by world region are based on the country in which the clinician completed their primary medical or nursing qualification, which is not always the same as country of origin.

2 Registers are UK-wide and so cover some staff who work in Scotland, Wales and Northern Ireland.

3 To allow for comparisons over time, we have used the same country members of the European Economic Area (EEA) as in 2014-15 across the whole period.

4 Nursing and Midwifery Council data are presented by financial year and General Medical Council data are presented by calendar year.

5 Data are based on headcount.

Source: Nursing and Midwifery Council's Initial Registrations data and General Medical Council's List of Registered Medical Practitioners statistics

Appendix One

Our audit approach

1 This report examines whether the supply of NHS clinical staff in England is being managed effectively. We reviewed:

- responsibilities and accountabilities;
- the process for developing a long-term national workforce plan; and
- how short-term shortfalls in staffing are being addressed.

In this report we set out workforce pressures including trends and variations between different areas and staff groups. We also highlight limitations in the available data. In looking at short-term shortfalls in staffing, we focused on temporary staffing, overseas recruitment and return-to-practice initiatives.

2 In reviewing these issues, we applied an analytical framework with evaluative criteria which consider the arrangements that would be optimal for achieving value for money. By 'optimal' we mean the most desirable possible, while acknowledging expressed or implied constraints. A constraint in this context is that demand for healthcare and, as a result, the number of staff required is unpredictable to some extent.

3 The optimal approach would be a joined-up system that:

- has robust processes to maximise the likelihood that the supply of clinical staff can meet the demand for NHS services in a cost-effective way; and
- responds to emerging workforce pressures efficiently.

4 This report focuses on clinical staff – those directly involved in patient care – employed in the NHS in England. Our report includes data on doctors, nurses, midwives, ambulance staff, healthcare scientists (who work in hospitals, clinics or laboratories) and staff providing support to other professions. Dental staff are not covered, except where explicitly stated.

5 We did not examine the quality of training or continued professional development, and did not seek to advise on 'correct' staffing levels.

6 Our audit approach is summarised in **Figure 16**. Our evidence base is described in Appendix Two.

Figure 16
Our audit approach

The Department of Health and NHS England's objectives

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. The need for effective management of the supply of clinical staff is heightened by the financial pressures that the NHS is currently facing.

How this will be achieved

The Department of Health (the Department) is ultimately accountable for securing value for money from spending on health services, including educating and training the NHS workforce. Health Education England was set up in 2013, as an arm's-length body of the Department, to provide leadership and oversight of workforce planning, education and training. The Department sets objectives for Health Education England through an annual mandate. Health Education England has 13 local education and training boards intended to help make workforce planning responsive to local needs, and are made up of representatives from local providers of NHS services. Among other things, providers are responsible for employing staff, which may involve the recruitment of temporary or overseas staff, and supporting clinical placements.

Before 2013 responsibility for education and training rested with the ten regional strategic health authorities.

Our study

This report examines whether the supply of NHS clinical staff is being effectively managed.

Our study framework

Are responsibilities and accountabilities for managing the supply of clinical staff clear?	Is the process for developing a long-term national workforce plan robust?	Are short-term shortfalls in staffing being addressed efficiently?
Our evidence (see Appendix Two for details)		
Interviews with organisations involved in, or with an interest in, the supply of clinical staff. Review of key policy and strategy documents.	Analysis of NHS workforce data to identify the staffing position. Review of the oversight bodies' reviews of local workforce plans. Review of a sample of local workforce plans. Sensitivity analysis on national workforce plans. Comparison of location of training places and shortfalls.	Analysis of data on temporary staffing from trusts that work with NHS Professionals. Analysis of data on the use of overseas recruitment and return-to-practice initiatives. Review of existing information on the cost and timeliness of short-term measures to cover shortfalls in staffing.

Our conclusions

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.

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.

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

Appendix Two

Our evidence base

1 We reached our independent conclusion on the management of the supply of NHS clinical staff by analysing evidence collected between May and November 2015. Our audit approach is outlined in Appendix One.

2 **We analysed data on the NHS workforce.** We collated data from bodies including Health Education England, the Health and Social Care Information Centre, and the Nursing and Midwifery Council. We used these data, for example, to identify the staffing position for different staff groups and in different areas. Limited data were available on vacancies (staff shortfalls). We report data aggregated from submissions by local providers by Health Education England in 2014. These data were not published as official statistics. There were no other sources of data on vacancy rates between 2010 and 2014.

3 We analysed data from NHS Professionals on the demand for, and supply of, temporary staffing by 62 trusts. The data also included details of requests from five other providers. For nursing figures we excluded unqualified nurse data. To estimate the possible national impact, we multiplied the figures from the sample by 3.5. We used the data to undertake regression analysis to investigate the possible impact of the Francis report into the failings at Mid Staffordshire NHS Foundation Trust and safe staffing guidelines published by the National Institute for Health and Care Excellence on demand for temporary nurses. We also investigated whether there was a significant peak in demand in March.

4 **We carried out sensitivity analysis on Health Education England's national workforce plans.** We evaluated the impact of changing assumptions in Health Education England's model on staff supply. The assumptions tested were rates of attrition from training courses, participation of the workforce and graduates joining the NHS. The alternative assumptions we applied included using the Royal College of Nurses' labour market review and its data on the number of newly qualified nurses that entered the NHS from 2012 to 2015. We also looked at whether the assumptions in previous models had proved accurate to help us assess whether current assumptions were likely to be reasonable.

5 **We profiled trends and variations in the use of mechanisms to address short-term staffing shortfalls.** Specifically, we looked at temporary staffing, overseas recruitment and return-to-practice schemes. For temporary staffing, we requested data from NHS Professionals on the use of bank and agency staff at the trusts it covers. We also analysed the costs and timeliness of the different mechanisms.

6 **We carried out four case studies of local areas, including reviewing a sample of local workforce plans.** These plans were from two acute trusts, one specialist trust and one teaching trust, across Health Education England's four regions. Our case studies included one NHS trust and three NHS foundation trusts. We examined the plans and spoke to representatives from the trusts and their relevant local education and training boards to understand how the plans were put together, what assurance processes were applied, and how the plans fed into aggregated regional plans.

7 Our review of the trusts' plans helped us to understand the extent that Health Education England, Monitor and the NHS Trust Development Authority amend or intervene in the local workforce plans. We were also able to explore some of the competing priorities between different bodies operating at a local, regional and national level.

8 **We reviewed key documents.** The documents included: the Department's mandates to Health Education England and *Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery*; Health Education England's workforce plans; board minutes; National Institute for Health and Care Excellence safe staffing guidelines; internal audit reports; and The King's Fund report *Workforce planning in the NHS*.

9 **We interviewed staff at the Department of Health and Health Education England.** The people we interviewed were responsible for: oversight of the supply of clinical staff, medical and non-medical staff workforce planning, workforce transformation, workforce development strategy and workforce statistics. The interviews helped us to identify key datasets and evidence sources, as well as understand how responsibilities and accountabilities were spread across different organisations.

10 **We interviewed a range of other organisations involved in, or with an interest in, the supply of NHS clinical staff.** The organisations included:

- Arm's-length bodies – the Care Quality Commission, Monitor, NHS England, the NHS Trust Development Authority, the National Institute for Health and Care Excellence and the Migration Advisory Committee.
- Royal colleges – the Royal College of Midwifery, the Royal College of Nursing, the Royal College of Physicians and the Royal College of Surgeons.
- Other bodies – the Centre for Workforce Intelligence, the General Medical Council, The King's Fund, NHS Employers, NHS Professionals and the Nursing and Midwifery Council.

11 The interviews were designed to help us understand:

- the complexity of supplying a workforce with the right number and skills to meet the demand for NHS services;
- the strengths and limitations of the current arrangements for workforce planning and meeting short-term staffing shortfalls;
- the pressures on recruiting, training and retaining certain staff groups at regional and national level; and
- how the organisations involved in the supply of NHS clinical staff interact with each other.

Appendix Three

Limitations of NHS clinical workforce data

1 **Figure 17** lists the main limitations in data on the NHS clinical workforce. Health Education England and the Health and Social Care Information Centre have been seeking to address some of these limitations.

Figure 17
Data limitations

Setting	Limitation
NHS trusts and NHS foundation trusts	An electronic staff records system is used by nearly all NHS trusts and NHS foundation trusts, but there is a lack of detail for some staff. The processes for checking whether the data are sufficiently accurate to support workforce planning are limited.
General practice	A lack of recent data on activity (the latest available data on the number of consultations are from 2008-09) makes it difficult to assess the demand for general practice. Data on staff establishment for GPs and GP practice nurses are not collected.
Community services	These services are increasingly delivered by a range of different providers, some of which are not providing data on workforce pressures.
Independent and third sectors	The Health and Social Care Information Centre's data include some information from these providers, but it is unclear which providers are included and how many staff, and whether the coverage changes over time.
Specific workforce pressures	
Vacancy rates	There are no readily accessible, comprehensive data on vacancy rates.
Course completion rates	There are limited data covering important supply factors, such as on training course completion and graduate participation rates.
Leaver rates	The Health and Social Care Information Centre's data on why staff leave the NHS are limited.
Temporary staff	The Health and Social Care Information Centre's data do not include information on staff employed by agencies.

Sources: National Audit Office; The King's Fund, *Workforce planning in the NHS*, April 2015; Health Group Internal Audit, *Health Education England, Workforce Planning*, April 2015

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