Monitor
Making the health sector work for patients

tda Trust Development Authority
Quality. Delivery. Sustainability.

Price caps for agency staff: proposed rules and consultation

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Contents

Introduction

When Monitor and the NHS Trust Development Authority (TDA) engaged with the sector in August on proposed agency rules, a large number of responding trusts signalled that moving as quickly as possible to cap rates paid for agency workers would help them to procure agency staff at more affordable rates. Taking this feedback and further engagement into account, we propose to introduce caps on the total amount trusts can pay per hour for all types of agency staff they procure. The price caps would also apply to bank staff.

This document:

- sets out in detail the proposed rules on price caps for agency staff and bank staff procured by trusts
- launches a consultation on the principle and detail of these rules.

The rules have been developed with the support of clinical and financial leaders across Monitor, TDA, the Care Quality Commission (CQC), NHS England and the Department of Health (DH).

Definitions of the terms used in these proposed rules are given in Annex 2.

Consultation questions are listed in Section 9. All interested parties and stakeholders are invited to respond to the consultation by **5 pm on 13 November 2015.**

To respond, please use the link https://www.research.net/r/C792H72.

If you have any trouble accessing the survey response form through this link, please email agencyrules@monitor.gov.uk.

We will consider all responses to the consultation and decide whether, when and how to implement price caps. Subject to that process, our aim is to introduce the price caps on 23 November 2015.

1. Summary

1.1 Monitor and TDA propose to introduce caps on the total amount trusts can pay per hour for an agency worker.

1.2 The proposed hourly price caps would apply to:

- all staff groups employed by NHS trusts and NHS foundation trusts: nursing, medical, all other clinical and other non-clinical staff
- all agency staff and bank staff

1.3 Price caps would **not** apply to:

- substantive/permanent staff
- staff employed by ambulance trusts.[1]

1.4 The price caps for each agency staff role set out in these proposals have been calculated by adding a percentage to the maximum NHS national pay rate for substantive roles (Agenda for Change (AfC) or basic doctor pay rates).

1.5 The objective is to bring agency workers' pay into line with substantive workers' pay by 1 April 2016. Our aim is to introduce the price caps proposed in this document on 23 November 2015 and then subject to monitoring, reduce them in two further stages so that by 1 April 2016 capped agency rates would be equivalent to national NHS pay rates for substantive staff. The proposed rate caps would therefore significantly reduce the rates trusts pay for agency staff.

1.6 Monitor, TDA, NHS England and CQC would monitor the impact of the price caps on workforce, service performance and service quality to ensure any patient safety concerns are appropriately managed. This would also be crucial to confirming whether and when the price caps could safely be ratcheted down.

1.7 From 1 April 2016, trusts would not be able to pay more than 55% above the relevant national pay rates (AfC or doctor basic pay scales) for an agency worker, employed either via an agency or direct engagement. No additional payments to agency staff or agencies would be permitted. The 55% uplift accounts for employment on-costs including employer pension contribution, employer national insurance, holiday pay to the worker and a modest administration fee/agency charge.

1.8 The price caps would apply to bank staff. This is to ensure the problem of high rates does not transfer from agency to bank. We would monitor the effect of the introduction of price caps on trusts' banks to ensure there is a sufficient supply of temporary workers. Please note there is a consultation question on this proposal.

1.9 Table 1 below sets out how the price caps have been calculated and the proposed phased approach to their implementation. Proposed caps in pound figures are given in Annex 1.

[1] Monitor and TDA are considering how to introduce equivalent measures for ambulance trusts in the future. (Please note there is a consultation question on this proposal.)

Table 1: Price caps, expressed as percentage uplift to current AfC/basic pay maximum rates

Proposed date of introduction	Group 1: Junior doctors	Group 2: Other clinical staff	Group 3: Non-clinical staff
	Foundation year 1 and 2 doctors, registrars	Consultants, other doctors, nurses (all bands), AHPs, healthcare scientists, other clinical staff	Administration and clerical, infra-structure, other non-clinical staff
23 November 2015	+ 150%	+ 100%	+ 55%
1 February 2016	+ 100%	+ 75%	+ 55%
1 April 2016	+ 55%	+ 55%	+ 55%

1.10 The price caps are intended to support trusts when they procure from agencies and to encourage staff to return to permanent and bank working. They should enable trusts to manage their workforce in a more sustainable way, reduce reliance and expenditure on agency staffing, raise quality and improve the working environment for their staff.

1.11 The price caps represent the absolute maximum that trusts could pay and should not be interpreted as standard or default rates. Trusts would want to, and should, continue to secure the majority of agency and bank staff at rates below the price caps. Where trusts currently pay agency staff below the capped rates, they would be required not to exceed the rates they currently pay.

1.12 These rules would be most effective when there is full compliance from all trusts. They are intended to give boards and management the tools to limit their agency expenditure. Trusts would be expected to use them to significantly reduce agency expenditure over time.

1.13 Trust boards would primary responsibility for monitoring the local impact of price caps and ensuring patient safety.

1.14 The price caps would include mechanisms that allow the rules to be overridden in the interests of patient safety. This would be after all possible alternative strategies have been explored and within an approved escalation process sanctioned by the board.

1.15 The data reporting requirements associated with the price caps would apply to all NHS foundation trusts and NHS trusts. All trusts (even foundation trusts not in breach of their licence conditions) would be required to report at shift level any payments in excess of the price caps and explain why these were necessary in their reporting returns. These overrides would be scrutinised by

Monitor and TDA and trusts inappropriately overriding the price caps would be subject to regulatory action.

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

1.17 Monitor and TDA recognise that trusts and foundation trusts need support to fill permanent positions as well as make best use of their existing workforces. DH, the Chief Nursing Officer for England and Health Education England (HEE) all have workforce programmes for increasing the supply of staff in the short to medium term. The proposed price caps are also intended to work alongside long-term planning to increase retention, training and recruitment of NHS staff, and ongoing support on workforce planning and rota management. Monitor and TDA will continue to work with trusts to better understand their approach to managing agency staffing, to benchmark trusts against best practice and to help them improve workforce management, including retention of substantive staff. Please contact agencyprojectsupport@monitor.gov.uk for more information on support available.

2. Scope

2.1 The proposed rules on price caps would apply to:

- all NHS trusts
- NHS foundation trusts receiving interim support from DH
- NHS foundation trusts in breach of their licence for financial reasons.

2.2 All other trusts would be very strongly encouraged to comply with price caps. The new value for money risk assessment trigger[2] means that Monitor will explicitly take into accounts trusts' inefficient or uneconomic spending practices, including in relation to agency spending, as a measure of governance. In assessing value for money, Monitor is likely to look at the extent to which trusts have followed good practice.

2.3 The data reporting requirements associated with the price caps would apply to all NHS foundation trusts and NHS trusts. All trusts (even foundation trusts not

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

in breach of their licence conditions) would be required to report at shift-level detail any payments in excess of the price caps and explain why these were necessary in their reporting returns. These overrides would be scrutinised by Monitor and TDA and trusts inappropriately overriding the price caps would be subject to regulatory action. See Section 7 on compliance for further detail.

2.4 The price caps and reporting requirements would not initially apply to ambulance trusts. Monitor and TDA are considering how to introduce equivalent measures for ambulance trusts in the future. (Please note there is a consultation question on this proposal.)

3. When would the price caps apply and to which staff groups?

3.1 The caps would apply to the rates trusts pay per hour for an agency worker. They would also apply to the rates paid to bank staff. The price caps would not apply to substantive/permanent staff.

3.2 For example, the price caps would apply when:

- an agency fills a shift directly
- an agency finds a worker to fill a shift, but the trust pays the worker directly for that shift and pays the agency a finder's fee (all of this expenditure including payment to the worker, fees and on-costs should be classified as agency expenditure)
- self-employed staff or staff paid through their own limited company fill a shift
- an in-house bank fills a shift directly
- an in-house bank is unable to fill a shift directly and sources the shift from a third-party agency
- an outsourced bank fills a shift directly (including but not limited to NHS Professionals).
- an outsourced bank is unable to fill a shift directly and sources the shift from a third-party agency (including but not limited to NHS Professionals).

3.3 The price caps would apply to all staff groups covered by national pay scales:

- medical staff (including dental staff where applicable)
- nursing and midwifery staff
- all other clinical staff

- all other non-clinical staff.[3]

3.4 The price caps would apply to all specialities and departments.

3.5 Separately, rules would apply to procuring interim agency very senior managers (VSMs). These are addressed in Section 6.

4. How have the proposed price caps been calculated?

4.1 The caps would determine the maximum total hourly rate trusts can pay an agency for an agency worker. The cap would apply to the total charge and therefore would include:

- worker pay
- worker holiday pay
- employer national insurance
- employer pension contribution
- administration fee/agency charge
- any other fixed or variable fees or payments to the worker or agency or bank (eg travel, accommodation, finder's fee, bonuses)

4.2 As the proposed price caps would reflect the maximum total amount a trust could pay for an agency worker, other sums could not be paid in lieu to agency workers or to agencies.

4.3 Price caps are expressed as a percentage uplift over the maximum salary of a substantive worker at that pay grade (ie relative to AfC/basic doctor pay rates) (see Table 1). For doctors, the proposed uplift has been calculated for eight pay scales, with different capped hourly rates for core and for unsocial hours. On-call hours are capped at core hour rates. For all other staff, the price cap has been calculated for each AfC pay band, with different capped hourly rates for each shift type (ie day, night/Saturday and Sunday/Bank Holiday).[4] All capped rates in pound figures are set out in Annex 1.

4.4 Capped rates are calculated per hour. It is proposed that they must be applied per hour that an agency worker is employed.

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[3] This includes managers paid on an agency basis.
[4] Although some agencies and frameworks may define unsocial hours differently, the caps must be adhered to, with reference to Agenda for Change definitions.

4.5 All capped rates are set out in Annex 1. Tables A3 and A4 (for AfC staff) show the capped hourly rates excluding any high cost area supplements. Where staff are eligible for AfC high cost area supplements, these should be added to the figures in the tables at the appropriate rates (5% for Fringe, 15% for Outer London, 20% for Inner London).

4.6 The caps exclude VAT.

5. Implementation

5.1 Subject to the consultation, it our aim to introduce the price caps on 23 November 2015 and then subject to monitoring, reduce them in two further stages so that by 1 April 2016 capped agency rates would be equivalent to national NHS pay rates for substantive staff. From 1 April 2016, trusts would not be able to pay more than 55%[5] above the relevant national pay rates (AfC or doctor basic pay scales) to secure an agency worker.

5.2 Monitor, TDA, NHS England and CQC would monitor the impact of the price caps on workforce, service performance and service quality to ensure any patient safety concerns are appropriately managed. This would also be crucial to confirming whether and when the price caps could safely be reduced. Monitor and TDA may subsequently review and adjust the price caps based on evidence of impacts on the sector or individual trusts, or as new data become available. The proposed phased approach is set out in Table 1 (see page 5).

5.3 The different trajectories for different staff groups reflect the different agency rates currently paid for these groups, that is the different starting points.

5.4 The price caps represent the absolute maximum that trusts could pay and should not be interpreted as standard or default rates. Trusts would want to, and should, continue to secure the majority of agency and bank staff at rates below the price caps. Where trusts currently pay agency staff below the capped rates, they would be required not to exceed the rates they currently pay.

6. Interim very senior managers

6.1 We plan to introduce changes to the existing consultancy approvals process by requiring advance approval for all spending on interim very senior managers (VSMs) paid on an agency basis. We envisage these changes would also take effect from 23 November 2015. NHS England would put in place an equivalent process for clinical commissioning groups.

[5] This 55% uplift has been calculated to approximate to the non-pay benefits and costs of substantive staff, including employer pension contribution and national insurance, administration fee, etc.

7. Compliance

Trust requirements

7.1 Trusts in scope of these rules would be required to adhere to the price caps set out in this document.

7.2 All trusts (even foundation trusts that are not in breach of their licence conditions) would be required to report at shift-level detail any payments in excess of the price caps and explain why these were necessary in their reporting returns. Overrides would be scrutinised by Monitor and TDA and trusts inappropriately overriding the price caps would be subject to regulatory action. (See Section 8 on the consequences of non-compliance).

7.3 Trust boards would have primary responsibility for monitoring the local impact of price caps and ensuring patient safety. Monitor, TDA, CQC and the Chief Nursing Officer for England emphasise the importance of trusts and commissioners fulfilling their responsibilities for safe staffing, as set out in the joint letter of 13 October from Sir Mike Richards, Mike Durkin, Jane Cummings, Sir Andrew Dillon and Ed Smith and also detailed in the National Quality Board (NQB) guidance (including the ten expectations published in November 2013).[6]

7.4 The rules launched on 1 September 2015 on expenditure ceilings for agency nursing staff and the mandatory use of approved frameworks still apply. That is, trusts will still be required to procure agency nursing staff via approved framework agreements. However, the rate paid via these approved frameworks would also have to comply with the price cap. There are plans to extend agency expenditure ceilings across all staff groups in 2016/17.

Exceptional circumstances and overriding the rules

7.5 Patient and staff safety must be prioritised but we would expect the price caps to be overridden only in exceptional circumstances, after all possible alternative strategies have been explored, and within an approved escalation process sanctioned by the board. Overrides would be scrutinised by Monitor and TDA and trusts inappropriately overriding the price caps would be subject to regulatory action. Overrides that were a result of inadequate staff rostering or poor planning of overall workforce requirements would not be accepted.

7.6 If a trust were to exceed the price caps, it would have to report the following information at shift-level detail in its reporting returns:

[6] www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

- date
- type (medical, nursing, other)
- band/grade
- department
- shift type (weekday, night/Saturday, Sunday/Bank Holiday)
- price paid per hour (including wage and all other charges; excluding VAT)
- reason for exceeding the price caps (and for needing to use agency staff):
    - name of agency
    - name of framework
    - director level approval.

7.7 Overrides reported at shift level in monitoring returns would need to be signed off by a relevant board member, eg director of finance and medical director/director of nursing/director of human resources.

7.8 Trust boards would need to ensure they are following robust and effective governance systems, and the exceptional circumstance could not have been avoided through effective contingency planning.

Support

7.9 Monitor and TDA would support trusts as much as possible in meeting the price controls and other agency rules. Where trusts were struggling to comply with the proposed rules, we would seek to work with them to identify the causes of the issue while gaining assurance that the trusts were doing all they could to apply best practice. We would also support the sharing of best practice in meeting the challenges of these controls. For more information contact agencyprojectsupport@monitor.gov.uk.

8. Consequences of non-compliance with the rules

8.1 These rules will be most effective when there is full compliance from all trusts. If an individual trust overrides the controls, it will be more difficult for other trusts to comply to the price caps. If the price caps cannot be made to work the consequence is continued escalation of agency costs in the sector.

8.2 Monitor and TDA would therefore take appropriate and proportionate action in cases of inappropriate overriding of the rules, or any deliberate action to circumvent the rules.

8.3 For foundation trusts, Monitor would consider compliance in accordance with its enforcement guidance. Under the new risk assessment framework, Monitor may investigate NHS foundation trusts if there is sufficient evidence to suggest inefficient and/or uneconomical spending at a trust, for instance regarding agency and management consultant spend.[7] TDA will continue the work with NHS trusts through application of the accountability framework and will also investigate trusts that are not managing their agency spend effectively.

8.4 Before considering any action, we would always seek to understand the degree to which a trust is aware of the issue and has a credible plan to address it. While Monitor and TDA have formal powers to intervene at providers, we expect providers to take the lead in developing and implementing workforce solutions.

8.5 The graduated plan in Table 2 below sets out how we would intend to approach non-compliance in a way that supports trusts in articulating the issues and developing solutions.

Table 2: Monitor/TDA's graduated response to non-compliance

1. Test trust's understanding of the issue and the ability to address it	
Trust explains to Monitor/TDA the reasons behind the override(s)	Trust provides: • a clear understanding of the causes of the override • evidence of appropriate and effective governance and workforce management processes, eg activity plans and links between staffing and financial plans • evidence of best practice in considering other options before the trust overrode the controls
Trust develops an evidence-based plan to return to compliance	Plans must be signed off by the trust's director of nursing/medical director/human resources director/director of finance as appropriate, endorsed by the executive team and approved by the board Until the plan for returning to compliance is submitted and accepted as reasonable by the relevant oversight body, the trust may not have access to increased central financing. The plan should reference processes that both control costs and preserve patient safety

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

1. Test trust's understanding of the issue and the ability to address it	
Trust delivers this plan	Monitor and TDA will request information on whether the trust is meeting the plan via the reporting cycle or more frequently
2. If necessary, provide best practice support to develop a solution	
Trust seeks support via relevant best practice teams	If the trust is unable to deliver the plan, or considers that it needs external support immediately, then the trust should work with experts to go through any or all of step 1 above. Experts may include the Monitor and TDA's Agency Rules Team and/or the Agency Intensive Support Team, for example A follow-up plan should be agreed with the central bodies, referencing the gap between actions to date and best practice and how this will be closed
3. Escalation if controls are still being overridden	
Present case to Monitor/TDA	If the trust is still unable to meet the price caps despite following steps 1 and 2 above, then the board may be requested to explain to Monitor/TDA why this is the case. We will use this interaction to identify the degree to which the board understands the problem and has engaged with it

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

9. Consultation

Monitor and TDA would like to hear your responses to the following questions.

- Do you support the introduction of price caps? Please give reasons for your answer.
- Do you agree with the proposed design of the price caps? Please give reasons for your answer.
- Do you agree with including bank staff in the price caps? Please give reasons for your answer.
- Do you agree with the objective to bring agency workers' pay in line with substantive workers' pay by 1 April 2016? Do you think the 55% uplift is appropriate? Please give reasons for your answers.

- Do you agree that in trusts where staff are eligible for high cost area supplements, these uplifts should be added on top of the capped rates? Please give reasons for your answer.
- Is the proposed design of the price caps likely to change agency and/or bank workers' behaviour? Please give reasons for your answer.
- What challenges and risks do you anticipate trusts facing in delivering the price caps (both at the individual level and the system level)?
- Are there any support measures at a national level that would help with compliance with the price caps and with reducing agency spend?
- How should the impacts of these proposals on workforce, quality, access and performance be monitored by trusts and at a national level? What metrics need to be monitored?
- Should similar caps apply to ambulance trusts? What would be an effective approach? Please give reasons for your answer.
- Are you aware of any equality issues or of any particular group for whom the proposals could have either a detrimental or differential impact?
- Please provide any further comments on these proposals.

Responding to the consultation

We ask all interested parties and stakeholders to respond to the consultation by **5pm on 13 November 2015.**

Please use the link: https://www.research.net/r/C792H72 to respond to the consultation.

If you have any trouble accessing the survey response form through this link, please email agencyrules@monitor.gov.uk

If you have queries relating to the consultation or proposed rules, please contact agencyrules@monitor.gov.uk

Confidentiality

You can request to keep your name and/or that of your organisation confidential and excluded from the published summary of responses on the online form. If you send your response by email or post, please don't forget to tell us if you wish your name or that of your organisation to be withheld from any published documents. If you would like any part of the content of your response (instead of or as well as your identity) to be kept confidential, please let us know and make it obvious by identifying it in your response which parts we should keep confidential. We will do our best to meet your

request, but because we are a public body subject to Freedom of Information legislation we cannot guarantee that we will not be obliged to release your response even if you wish it to be confidential.

Next steps

We will consider all responses to the consultation and decide whether, when and how to implement price caps. Subject to that process, our aim is to introduce the price caps on 23 November 2015.

Annex 1: Price caps reference tables

Tables A1 to A4 set out the maximum total rates for each staff group. The price caps are the maximum total hourly rate payable by a trust to an agency, including worker pay and all other elements of the payment. They exclude VAT. These are maximum rates – trusts are expected to continue to secure lower rates for most transactions. They are based on 2015/16 pay scales and would be revised in light of any contract changes from 1 April 2016.

Tables A3 and A4 state the maximum total rates for Agenda for Change (AfC) staff, excluding any high cost area supplements. Where staff are eligible for high cost area supplements, they should be added to the rates shown below.

Table A1: Maximum total hourly rates for junior doctors – Foundation years 1 and 2; Registrar, core and specialist training; Dentists, core training (£)*

		Relevant maximum basic	Maximum total hourly rate applicable from:		
			23 Nov 2015	1 Feb 2016	1 Apr 2016
			Basic plus	Basic plus	Basic plus
			150%	100%	55%
Foundation year 1	Core hours	13.02	32.55	26.04	20.18
	Unsocial hours	15.63	39.08	31.26	24.23
Foundation year 2	Core hours	16.15	40.38	32.30	25.03
	Unsocial hours	19.39	48.48	38.78	30.05
Registrar (SP1-2)	Core hours	18.32	45.80	36.64	28.40
	Unsocial hours	21.98	54.95	43.96	34.07
Registrar (SP3+)	Core hours	22.84	57.10	45.68	35.40
	Unsocial hours	27.41	68.53	54.82	42.49
Dental core training	Core hours	22.48	56.20	44.96	34.84
	Unsocial hours	26.97	67.43	53.94	41.80

*Note: The price caps are the maximum total hourly rate payable by a trust to an agency, including worker pay and all other elements of the payment. They exclude VAT. These are maximum rates – trusts are expected to continue to secure lower rates for most transactions.

Table A2: Maximum total hourly rate for all other medical staff, excluding junior doctors (£)*

		Relevant maximum basic	Maximum total rate applicable from:		
			23 Nov 2015	1 Feb 2016	1 Apr 2016
			Basic plus	Basic plus	Basic plus
			100%	75%	55%
Consultant	Core hours	48.64	97.28	85.12	75.39
	Unsocial hours	64.70	129.40	113.23	100.29
Associate Specialist	Core hours	41.14	82.28	72.00	63.77
	Unsocial hours	54.71	109.42	95.74	84.80
Specialty doctor/ staff grade	Core hours	33.24	66.48	58.17	51.52
	Unsocial hours	44.21	88.42	77.37	68.53

*Note: The price caps are the maximum total hourly rate payable by a trust to an agency, including worker pay and all other elements of the payment. They exclude VAT. These are maximum rates – trusts are expected to continue to secure lower rates for most transactions.

Table A3: Maximum total hourly rate for all other clinical staff, including all nursing staff (£)*

		Maximum AfC rate	Maximum total rate applicable from:		
			23 Nov 2015	1 Feb 2016	1 Apr 2016
			AfC plus	AfC plus	AfC plus
			100%	75%	55%
Band 1	Day	7.86	15.72	13.76	12.18
	Night/Saturday	11.79	23.58	20.63	18.27
	Sunday/Bank Holiday	15.71	31.42	27.49	24.35
Band 2	Day	9.10	18.20	15.93	14.11
	Night/Saturday	13.11	26.22	22.94	20.32
	Sunday/Bank Holiday	17.11	34.22	29.94	26.52
Band 3	Day	9.95	19.90	17.41	15.42
	Night/Saturday	13.64	27.28	23.87	21.14
	Sunday/Bank Holiday	17.32	34.64	30.31	26.85
Band 4	Day	11.37	22.74	19.90	17.62
	Night/Saturday	14.78	29.56	25.87	22.91
	Sunday/Bank Holiday	18.20	36.40	31.85	28.21

		Maximum AfC rate	Maximum total rate applicable from:		
			23 Nov 2015	1 Feb 2016	1 Apr 2016
			AfC plus	AfC plus	AfC plus
			100%	75%	55%
Band 5	Day	14.41	28.82	25.22	22.34
	Night/Saturday	18.74	37.48	32.80	29.05
	Sunday/Bank Holiday	23.06	46.12	40.36	35.74
Band 6	Day	17.84	35.68	31.22	27.65
	Night/Saturday	23.19	46.38	40.58	35.94
	Sunday/Bank Holiday	28.54	57.08	49.95	44.24
Band 7	Day	20.95	41.90	36.66	32.47
	Night/Saturday	27.24	54.48	47.67	42.22
	Sunday/Bank Holiday	33.52	67.04	58.66	51.96
Band 8a	Day	24.32	48.64	42.56	37.70
	Night/Saturday	31.62	63.24	55.34	49.01
	Sunday/Bank Holiday	38.92	77.84	68.11	60.33
Band 8b	Day	29.19	58.38	51.08	45.24
	Night / Saturday	37.94	75.88	66.40	58.81
	Sunday / Bank Holiday	46.70	93.40	81.73	72.39
Band 8c	Day	34.68	69.36	60.69	53.75
	Night/Saturday	45.08	90.16	78.89	69.87
	Sunday/Bank Holiday	55.49	110.98	97.11	86.01
Band 8d	Day	41.74	83.48	73.05	64.70
	Night / Saturday	54.27	108.54	94.97	84.12
	Sunday / Bank Holiday	66.79	133.58	116.88	103.52
Band 9	Day	50.35	100.70	88.11	78.04
	Night/Saturday	65.46	130.92	114.56	101.46
	Sunday/Bank Holiday	80.57	161.14	141.00	124.88

*Note: The price caps are the maximum total hourly rate payable by a trust to an agency, including worker pay and all other elements of the payment. They exclude VAT. These are maximum rates – trusts are expected to continue to secure lower rates for most transactions

Table A4: Maximum total hourly rate for all non-clinical staff (£)

		Maximum AfC rate	Maximum total rate applicable from: 23 Nov 2015 AfC plus 55%
Band 1	Day	7.86	12.18
	Night/Saturday	11.79	18.27
	Sunday/Bank Holiday	15.71	24.35
Band 2	Day	9.10	14.11
	Night/Saturday	13.11	20.32
	Sunday/Bank Holiday	17.11	26.52
Band 3	Day	9.95	15.42
	Night/Saturday	13.64	21.14
	Sunday/Bank Holiday	17.32	26.85
Band 4	Day	11.37	17.62
	Night/Saturday	14.78	22.91
	Sunday/Bank Holiday	18.20	28.21
Band 5	Day	14.41	22.34
	Night/Saturday	18.74	29.05
	Sunday/Bank Holiday	23.06	35.74
Band 6	Day	17.84	27.65
	Night/Saturday	23.19	35.94
	Sunday/Bank Holiday	28.54	44.24
Band 7	Day	20.95	32.47
	Night / Saturday	27.24	42.22
	Sunday / Bank Holiday	33.52	51.96
Band 8a	Day	24.32	37.70
	Night/Saturday	31.62	49.01
	Sunday/Bank Holiday	38.92	60.33
Band 8b	Day	29.19	45.24
	Night/Saturday	37.94	58.81
	Sunday/Bank Holiday	46.70	72.39
Band 8c	Day	34.68	53.75
	Night/Saturday	45.08	69.87
	Sunday/Bank Holiday	55.49	86.01
Band 8d	Day	41.74	64.70
	Night/Saturday	54.27	84.12

		Maximum AfC rate	Maximum total rate applicable from: 23 Nov 2015 AfC plus 55%
	Sunday/Bank Holiday	66.79	103.52
Band 9	Day	50.35	78.04
	Night/Saturday	65.46	101.46
	Sunday/Bank Holiday	80.57	124.88

*Note: The price caps are the maximum total hourly rate payable by a trust to an agency, including worker pay and all other elements of the payment. They exclude VAT. These are maximum rates – trusts are expected to continue to secure lower rates for most transactions.

Annex 2: Definitions

Price caps	Price caps are the maximum total amount of money, exclusive of VAT, that a trust can pay for an agency worker. These include all related costs (eg employer pension contribution, employer national insurance, holiday pay for the worker, administration fee/agency chare), whether paid to the worker or the agency. The price caps also apply to paying bank staff.
Medical staff	Medical staff are defined as all practising doctors who are registered with the General Medical Council, who are employed in that capacity.
Nursing and midwifery staff	Nursing and midwifery staff are defined as registered general and specialist nursing staff, midwifery staff and health visitors, healthcare assistants and other support staff.
Other clinical staff	Other clinical staff are defined as those registered clinical staff who are not already included as part of 'Medical staff' or 'Nursing and midwifery staff', eg radiographers, psychologists, physiotherapists, etc. This group also includes dentists.
Non-clinical staff	Non-clinical staff include but are not limited to healthcare scientists, social workers, estate and maintenance staff, and administration and clerical staff. Non-clinical positions also include managers.
Agency staff	Agency staff are defined as those who work for the NHS but who, for the purposes of the transaction, are not on the payroll of an NHS organisation offering employment. Where trusts employ a method of direct engagement (or 'finder's fee') for individual shifts or periods of employment, all costs associated with this supply (including the pay to the worker and on-costs through the NHS provider) should be classified as agency spend. Procurement should be classified as agency expenditure where: • an in-house bank is unable to fill a shift directly and sources the shift from a third-party agency • an outsourced bank (including but not limited to NHS Professionals) is unable to fill a shift directly and sources the shift from a third-party agency • an agency fills a shift directly • an agency finds a worker to fill a shift, but the trust pays the worker directly for that shift and pays the agency a finder's fee (all this expenditure including payment to the worker and on-costs should be classified as agency expenditure).
Bank staff	Expenditure on shifts through both in-house and outsourced banks should be classified as bank expenditure. This includes outsourced banks that are provided by organisations including, but not limited to, NHS Professionals. However, where these organisations are used to

	source shifts from a third-party agency, expenditure on those shifts should continue to be classified as agency expenditure. For the avoidance of doubt, agency shifts supplied through neutral or master vendor arrangements should continue to be classed as agency spend. Procurement should be classified as bank expenditure where: • an in-house bank provides a shift directly • an outsourced bank (including but not limited to NHS Professionals) provides a shift directly.
Agenda for Change	Agenda for Change (AfC) allocates posts to set pay bands (1 to 9) based on the principle of equal pay for equal value and harmonising uplifts for unsociable and geographical regions. All staff working for providers are subject to AfC except doctors, dentists and very senior managers.
Doctor basic pay rates	Doctor basic pay rates identify the applicable pay scales for medical and dental staff; for full time and part-time staff.
Very senior managers	Very senior managers (VSMs) are defined as those who are not subject to AfC; they are above band 9. They are currently paid on the discretion of the provider they work for. There is published guidance for NHS employers on VSM pay; however this is not currently enforced for providers. VSMs are usually chief executives, executive directors or other senior directors.

Monitor

Making the health sector work for patients

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