NHS England

Agency Rules

February 2024

Contents

1. Introduction

1.1. This document sets out all the rules for trusts on agency expenditure, which are collectively known as the ‘agency rules’. It builds on and supersedes previous rules documents. Trusts should refer to this document for details on how to comply with all the agency rules, including the requirements to:

- comply with a ceiling for total system agency expenditure
- procure all agency staff at or below the price caps
- only use approved framework agreements to procure all agency staff

1.2. Integrated care boards also have oversight and coordination responsibilities which are covered by these rules.

1.3. The agency rules apply to all staff groups (i.e., those listed in section 3).

1.4. The agency rules are designed to:

- significantly reduce agency spend
- improve transparency on agency and bank spend
- bring greater assurance on quality of agency supply
- encourage agency staff to return to permanent and bank working

2. Organisations in scope

2.1. The agency rules directly apply to:

- all NHS trusts
- NHS foundation trusts receiving interim support from the Department of Health and Social Care
- NHS foundation trusts in breach of their licence for financial reasons.

NHS organisations (including all NHS foundation trusts) have a collective duty to seek to achieve financial objectives set by NHS England, which includes the system agency expenditure limits. The agency rules described here are the guidance on which NHS England expects all NHS organisations to meet the financial objectives they set on agency spending.

2.2. Throughout this document 'trusts' refers to 'all trusts in scope of the rules' unless otherwise specified. While these rules apply to trusts and foundation trusts, systems have an important role in monitoring performance.

Trusts should work with their integrated care board to agree plans to meet financial objectives on agency spending and to deliver services in the event of staffing issues. Where appropriate, they should engage wider system partners in developing plans for sustainable temporary staffing across local systems as outlined in NHS England » NHS Oversight Framework 2022/23.

3. Staff groups in scope

3.1. The agency rules apply to all staff groups covered by national pay scales:

- additional clinical services
- administrative and clerical
- allied health professional
- estates and ancillary
- healthcare scientists
- medical and dental
- nursing and midwifery registered

3.2. GPs are not covered by the agency rules, except where they would be employed substantively by a trust (that is, they are on the trust's payroll). Where this is the case, the appropriate equivalent medical price caps should apply.

3.3. Very senior managers are not covered by this set of agency rules. Separate guidance applies to very senior managers. [1]

3.4 Please see Annex 1 for definitions of terms.

[1] https://www.england.nhs.uk/wp-content/uploads/2023/04/Interim-agency-very-senior-manager-approval-process.pdf

4. Expenditure limits

4.1. NHS England sets system agency expenditure limits to ensure NHS organisations are working together and taking collective responsibility for reducing agency spend. These limits are set as financial objectives under NHS England's powers in the National Health Service Act 2006 (Section 223L).

4.2. Each system is given a total amount that it is collectively expected not to exceed on agency staff and reports performance against this limit throughout the financial year. These limits are communicated to systems as part of the NHS planning process.

4.3. System partners are expected to work together to agree plans in line with their limits and should consider any risks against these plans, as well as how they would intend to manage these. Any spending above the limits set is the collective responsibility of all system partners to address.

4.4. NHS England monitors performance on agency spending in line with the approach set out in the NHS Oversight Framework.[2] This is led by regional teams and they work closely with their local systems.

[2] NHS England » NHS Oversight Framework 2022/23

5. Price caps

5.1. The price caps set by NHS England apply to the total amount a trust can pay per hour for an agency worker. Trusts should not pay more than the price caps to secure an agency worker, except in exceptional patient safety circumstances, referred to as 'break glass' (see Section 9).

5.2. The price caps 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)
- an outsourced bank provider releases an unfilled bank shift to be filled by an agency worker (all expenditure, including payments to the worker, fees and on-costs paid to the agency providing the worker, and any additional hourly or introductory fees charged by the bank provider, should be classified as agency expenditure)
- workers are paid through their own limited/personal service company, including where workers are engaged via a third-party limited liability partnership, sole trader, or an umbrella company.

5.3. The price caps do **not** apply to:

- substantive/permanent staff
- bank staff (both in-house banks and outsourced banks)
- overtime payments to substantive/bank staff (e.g., waiting list initiatives)
- staff employed by a trust on a fixed-term contract

5.4. The price caps apply to all staff providing NHS services at the trust and to all specialties and departments, subject to paragraph 5.3.

5.5. The price caps also apply to agency workers who are contracted on a sessional or fee-for-service basis, including insourcing solutions.

5.6. The price caps set are the maximum total hourly rate that trusts can pay for an agency worker. The price cap is designed to ensure that agency workers are paid in line with legislation and comply with all regulations, including agency worker regulations.

5.7. The price caps for all staff were calculated at 55% above basic substantive pay rates in 2016. This takes into account holiday pay (annual leave and bank holidays), employer National Insurance contributions, a nominal employer pension contribution and a modest agency fee; see Annex 2 for further details on how the price caps are calculated and Annex 4 for further details on the seven pillars of the price caps. The price caps will not increase in line with substantive pay awards, refer to paragraph 5.6.

5.8. The price caps include worker pay and all other elements of the payment, including all expenses such as travel and accommodation. Trusts cannot pay other additional sums to agency workers or to agencies.

5.9. The price caps represent the maximum that trusts can pay and should not be interpreted as standard or default rates.

5.10. Trusts that currently pay agency staff below the capped rates are expected not to exceed the rates they currently pay, except to comply with legal obligations.

5.11. Price caps, excluding any relevant VAT, are set out on our website. Price caps are based on standard NHS pay scales and may be revised in light of any changes to contracts for substantive workers.

5.12. There are different price caps for high cost supplement areas, in line with standard NHS pay scales.[3] The full set of price caps can be found on our website.

5.13. For medical and dental staff, rates are set for eight pay scales. Two different rates apply for ‘core’ hours and ‘unsocial’ hours. For the purposes of the agency price caps, core hours are defined as 7am to 7pm, Monday to Friday

(excluding bank holidays). Unsocial hours are all other hours. On-call hours should be treated the same as core or unsocial hours, depending on when they fall. Neither high-cost area supplements nor regional supplements are applicable to medical and dental staff.

5.14. Trusts need to be aware of their responsibilities under the Agency Workers Regulations 2010 and Working Time Regulations. This includes ensuring that after the first 12 weeks of their engagement (including workers who a trust has previously engaged in a similar role with a gap of less than six weeks between engagements), agency workers are entitled to treatment equal to an equivalent substantive employee, including pay and annual leave.

5.15. The price caps remain the same regardless of the length of time an agency worker spends on assignment.

5.16. Trusts will therefore need to consider whether long-term reliance on agency staff is appropriate and sustainable at or below the price caps.

5.17. Where trusts have entered into bookings or contracts at the rates above the price caps, they should seek to renegotiate or conclude these arrangements as quickly as possible, taking into account any contractual requirements for notice and/or exit fees. All shifts at rates above the price caps must be reported as overrides to the price caps.

5.18. Appropriate regulatory action may be taken in response to non-compliance with the agency rules.

5.19. NHS England monitor the price caps in partnership with integrated care boards. The rules, including the level of the price caps, may be subject to change as a result of this monitoring.

[3] The London high cost area (HCA) is set out in the NHS terms and conditions of service handbook (Agenda for Change). Annex H outlines the areas covered by the high-cost area payment zones and Annex I outlines the high cost area supplements for Inner London, Outer London, and Fringe.

6. Mandatory use of approved framework agreements

6.1 The following are required to procure all agency staff (nurses, doctors, other clinical and non-clinical staff) via framework agreements we have approved:

- all NHS trusts
- NHS foundation trusts receiving interim support from the Department of Health and Social Care
- NHS foundation trusts in breach of their license for financial reasons
- other NHS foundation trusts and NHS foundation trusts in receipt of financial recovery funding are encouraged to apply the agency rules

6.2 Overrides to this rule are permitted on exceptional patient safety grounds only, this must be approved by an Executive Director

6.3 From April 2023, NHS England and integrated care boards will closely scrutinise compliance with the requirement to procure agency staff through an approved framework for all staff groups. We expect all trusts to introduce robust assurance mechanisms to eliminate the use of off framework agency workers for all roles. Trusts will still be able to 'break glass' and procure off-framework if there is an exceptional risk to patient safety, this must be approved by an Executive Director

6.4 A list of approved framework agreements can be found on our website. We will continue to review framework applications as they are submitted. We will continue to communicate outcomes to framework operators and trusts, including any updates to the list of approved framework agreements.

6.5 Framework agreements that do not meet the conditions in the framework approvals guidance will have their approved status reconsidered by NHS England and risk having that status removed. If approval is removed, we will

notify trusts that they can no longer use that framework agreement and allow trusts a reasonable period, at our discretion, to move to approved framework agreements.

6.6 All procurement from approved framework agreements must comply with the price caps and maximum wage rates, including any updates within the yearly approval letters. We have worked with framework operators to ensure that all approved framework agreements contractually embed the price caps.

6.7 It is the responsibility of framework operators, not trusts, to seek our approval for their framework arrangements.

6.8 We have published guidance[4] on how framework operators can apply for their framework agreements to be approved by us. Framework operators can apply using the application form on our website. We will continue to review applications as we receive them.

6.9 Where contractual arrangements with agencies already exist, trusts are expected to renegotiate or terminate those arrangements where appropriate and as far as legally possible, taking into account any contractual requirements for notice and/or exit fees.

6.10 We require trusts to provide details of all shifts where the worker has not been procured from an agency on an approved framework (where the worker is also paid a rate above the price cap, we also require each shift to be approved by the trust chief executive officer). See Annex 3 for full reporting requirements.

[4] https://www.england.nhs.uk/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/agency-rules-list-of-approved-framework-agreements-for-all-staff/

7. Use of admin and estates workers

7.1 From 16 September 2019 trusts are required to use only substantive or bank workers to fill admin and estates shifts. Trusts should only use agency workers to fill these shifts where they meet one or more of the following criteria. These exemptions are set nationally by NHS England and will be subject to review.

Special projects

7.2 During special projects such as mergers and transactions, digital transformation, RTT validation, and other critical service change, we recognise the need for interim support. Agency workers can therefore help staff these projects. We expect these to be short to medium-term projects of high importance to the trust, requiring resource and specialist skills the trust does not have. We expect the trust to make every effort to use existing or newly recruited bank or substantive staff before turning to agency workers. The trust must use its discretion to decide whether a project meets these criteria.

7.3 Before the project start date, trusts must inform NHS England of the project including cost/spend profile when it will end, and when the workers will leave or move onto bank/substantive contracts using the form on our website. Where a project is longer than six months, the trust must update us on progress and the remaining duration/cost. In this instance the trust is informing us and not requesting approval, though we will challenge excessive or prolonged agency use.

7.4 In some cases, we recognise that the need for these special projects will arise last minute and urgently in response to events – for example, a cyber security attack.

Trusts are able to use agency workers to support these last-minute or responsive projects, where bank or substantive workers are not available. In these exceptional cases trusts can inform NHS England of the project after it has begun.

Exempt specialities

7.5 Clinical coding is a specialist skill in high demand but short supply, and these shifts will therefore be exempt from any restrictions. While clinical coding is currently the only admin and estates exempt specialty, the list of 'exempt specialties' will be kept under review nationally by NHS England.

Patient safety

7.6 Trusts can 'break glass' and procure an agency worker for an admin and estates shift where there is an exceptional patient safety risk, . These shifts are reported to us and are reviewed by central and regional teams. See chapter 9 for further details on the process and expectations.

IT roles

7.7 Where there is no bank, fixed term or substantive alternative available, trusts can use agency workers to fill IT roles as a last resort.

Interim very senior managers

7.8 Interim VSMs will continue to be covered by the separate rules.[5]

[5] https://www.england.nhs.uk/publication/interim-very-senior-manager-pay/#heading-1

8. Tax

8.1 In some circumstances, trusts may choose to engage workers directly and not via PAYE. In these instances, it is the responsibility of the trust to ensure compliance with current HMRC legislation including IR35. Please refer to the latest guidance.[6]

[6] Understanding off-payroll working (IR35) - GOV.UK (www.gov.uk)

9. Overriding the agency rules

9.1. The agency rules include a ‘break glass’ provision for trusts that need to override the price caps or framework rules on exceptional patient safety grounds only, this must be approved by an Executive Director.

9.2. Overrides should be used within a robust escalation process sanctioned by the trust board. Trust boards have primary responsibility for monitoring the local impact of the agency rules and ensuring patient safety.

9.3. All trusts, including foundation trusts that are not in breach of their licence conditions, are expected to report monthly to NHS England the number of shifts and all shifts which override the rules, and to complete a short qualitative survey. The monthly monitoring return should be signed off by a voting board member, e.g., chief executive, finance director, medical director, nursing director, human resources director. Further detail on trust reporting requirements is set out in Annex 3.

9.4. Overrides to the price caps rule are where a trust procures an agency worker at a rate that exceeds the price caps.

9.5. Overrides to the framework rule are where a trust procures an agency worker via any mechanism other than an approved framework agreement or arrangement, for example:

- via an agency that is not on or formally subcontracting to an agency that is on an approved framework
- via an agency that is on an approved framework agreement, but a worker not procured in line with the framework terms and conditions.

9.6. Where trusts override the agency rules, they should indicate in their monthly returns the main mechanism for overriding the rules.

9.7. Where trusts have needed to override the agency rules, they should report the following information on the overrides at shift level in their monthly returns:

- staff group (aligned to ESR staff group classification)
- type of rule (e.g., price cap, off framework, or both)
- number of shifts where a rule(s) has been overridden.
- total number of agency shifts worked
- the time the shift was worked (e.g., core hours, night-time/Saturday, etc.)

9.8. NHS England expects trusts to have in place the necessary governance to scrutinise and challenge use of agency staff, in particular where it does not comply with the agency rules. We therefore require trusts to ensure that:

- All agency shifts at £100 an hour or more and above price cap must be signed off by the chief executive and reported to NHS England via monthly reporting prior to the shift.
- Where an agency shift has an hourly rate agreed below £100 but is 50% above the published price cap rate, the shift must be signed off by an executive director and reported to NHS England via monthly reporting.
- All bank shifts over £100 an hour must be signed off by the chief executive and reported to NHS England via monthly reporting.
- Where the shift is also above the price cap it must be signed off by the chief executive prior to the shift.
- All agency shifts where the worker has not been supplied by an agency on an approved framework must be reported to NHS England via monthly reporting. Where the shift is also above the price cap it must be signed off by the chief executive prior to the shift.

10. Governance

10.1. We expect all trust boards, including the boards of all foundation trusts, to ensure that they are following robust and effective processes for managing the implementation of the agency rules. We expect:

- accurate and timely reporting to NHS England:
  - data submitted monthly by agreed dates
  - submissions signed off by a voting board member
- board accountability:
  - one accountable officer in place for agency expenditure and compliance with the agency rules
  - chief executive sign off for all shifts as required (see Section 8)
- escalation process for sourcing agency staff which ensures:
  - appropriate review of agency use taking into account safety, quality, and finances
  - appropriate use of the override mechanism
  - appropriate use of escalation rates within framework agreements prior to engaging workers through high-cost, off-framework suppliers
- regular internal review panels for monitoring trust overrides and reviewing agency rules monitoring data
- regular board review of agency expenditure and overrides to ensure compliance with system agency ceiling.

10.2. NHS England will scrutinise any overrides. Inappropriate use and failure to make rapid improvements to workforce management may lead to regulatory action as appropriate. This could include trusts boards being required to develop a clear workforce strategy on how the overrides will be avoided in the future.

11. Support

11.1. Trusts are encouraged to work closely with commissioners to:

- agree plans for continuing or suspending services in the event of staffing issues
- understand potential patient safety concerns and their impact on delivery of trust/clinical commissioning group contracts

11.2. Trusts are also encouraged to work closely with framework operators who can support trusts to comply with the agency rules.

11.3. NHS England will support trusts as much as possible in complying with the agency rules. Where trusts are struggling to comply, we will seek to work with them to identify key issues, develop and prioritise actions, and implement solutions. We have developed a series of toolkits to help NHS providers move to best practice and reduce their use of agency staff; these are available on our website. We strongly encourage all trusts to use the toolkit and to develop robust action plans to better manage agency spend and compliance with the agency rules.

11.4. NHS England's Temporary Staffing Team develops products and tools to support trusts and provides improvement support where needed. Please see our website for more information, support tools and webinars[7] in issues such as rota management, developing a bank and explaining the agency rules.

[7] Slide packs and recordings - Temporary Staffing Hub - FutureNHS Collaboration Platform

12. Enforcement

12.1. Inappropriate overriding of the rules, or any deliberate action to circumvent the rules, will have a bearing on NHS England's regulatory judgements, on the basis that a trust may not be achieving value for money, which may indicate wider governance concerns. This includes the use of off framework.

12.2. NHS England will consider compliance in accordance with the provider licence and NHS Oversight Framework. NHS England may investigate trusts if there is sufficient evidence to suggest inefficient and/or uneconomical spending at a trust, for instance agency and management consultant spend, which indicates wider governance concerns.

12.3. Before considering any action, we will seek to understand the degree to which a trust is aware of the issue and has a credible plan to address it. We expect providers to take the lead in developing and implementing workforce solutions.

12.4. While trust boards are ultimately accountable for compliance with the rules, we will seek to support trusts in implementing them and addressing issues. The plan in Table 1 sets out how we intend to approach non-compliance.

Table 1: NHS England's response to non-compliance

1. Test trust's understanding of the issue and the ability to address it	
Trust explains to NHS England the reasons behind its level of override(s)	Trust provides: • a clear explanation of the causes of the override(s) • evidence of appropriate and effective governance and workforce management processes, e.g., 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 nursing director/ medical director/human resources director/director of finance as appropriate, endorsed by the executive team and approved by the board The plan should reference processes that both control costs and preserve patient safety
Trust delivers this plan	NHS England will request information on whether the trust is meeting the plan via the reporting cycle or more frequently

Where trusts have deep-seated or complex staffing issues driving their agency spend, the regional workforce teams may carry out diagnostic work with the trust to better inform its recovery plans.

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 NHS England's Temporary Staffing Team and/or the Workforce Efficiency Team 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 rules are still being overridden	
Present case to NHS England	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 NHS England why this is so. We will use this interaction to identify the degree to which the board understands the problem and has engaged with it

12.5. NHS England considers that all elements of the approach above – developing and implementing plans, leveraging regional and central support, identifying necessary exceptions – can be achieved via routine engagement with trusts. If, however, we consider that trusts are not doing all they can to meet all the agency rules in a timely manner, then we may consider regulatory action to formally direct trusts to apply the steps described above.

Annex 1: Definitions

Term	Definition
Price caps	Price caps are the maximum total amount of money, exclusive of VAT, that a trust can pay per hour for an agency worker. These include all related costs (e.g., employer pension contribution, employer National Insurance, holiday pay for the worker, administration fee/agency charge). These can be found on NHS England's website.
Ceilings	Ceilings refer to the total amount an ICB can spend on agency staff (as defined by the agency rules) in that financial year, excluding capitalised expenditure.
Framework agreements	All framework agreements must be procured in accordance with the EU public contracts directives as implemented by the Public Contracts Regulations 2006 or the Public Contracts Regulations 2015. The Regulations define a framework agreement as: "an agreement or other arrangement between one or more contracting authorities and one or more economic operators which establishes the terms (in particular the terms as to price and, where appropriate, quantity) under which the economic operator will enter into one or more contracts with a contracting authority in the period during which the framework agreement applies."
Medical staff	Medical staff are defined as all practicing doctors who are registered with the General Medical Council, who are employed in that capacity. GPs are included when they are employed substantively by trusts, i.e., on a trust's payroll.
Other clinical staff	Other clinical staff are defined as those registered clinical staff who are not already included as part of 'medical staff', e.g., nurses, allied health professionals, etc.

Non-clinical staff	Non-clinical staff include but are not limited to estate and maintenance staff, and administration and clerical staff. Non-clinical positions also include managers.
Agency staff and agency expenditure	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. 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). 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.
Bank expenditure (not in scope of agency price caps or trust agency expenditure ceilings)	Expenditure on shifts through both in-house and outsourced banks should be classified as bank and not under the scope of the price caps rules. 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, and all fees relating to the agency worker are included within the price caps. 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 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 (AfC)	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.
Medical and dental pay scales	This Pay and Conditions circular informs employers of the pay arrangements for staff covered by the national medical and dental terms and conditions of service.
Very senior managers (VSMs)	VSMs are defined as those who are not subject to AfC; they are above band 9. They are currently paid at the discretion of the provider they work for. They are not in scope of this set of agency rules. There is published guidance for NHS employers on VSM pay; NHS England published guidance for the use of off-payroll interims on 20 December 2016,[8] and introduced a system for seeking approval for interim VSMs on 31 October 2016.[9] VSMs are usually chief executives, executive directors or other senior directors.
High-cost areas	The London high-cost area (HCA) is set out in the NHS terms and conditions of service handbook[10] (Agenda for Change). Annex H outlines the areas covered by the HCA payment zones and Annex I the HCA supplements for Inner London, Outer London and Fringe.

[8] https://www.england.nhs.uk/wp-content/uploads/2023/04/Interim-agency-very-senior-manager-approval-process.pdf

[9] Interim very senior manager remuneration approval form

[10] NHS Terms and Conditions of Service Handbook | NHS Employers

Annex 2: How the price caps are calculated

This annex illustrates the methodology behind the calculation of the price caps. Price caps are calculated based on a percentage uplift on substantive salaries.

Baseline calculation

The baseline was calculated from the substantive annual pay for each band or grade and converted to an hourly equivalent figure. This assumes a 52.18-week year for all staff. It also assumes a 37.5-hour week for Agenda for Change (AfC) staff and a 40-hour week for medical staff.

Core hours for junior doctors receive the Band 1C uplift (20%) and unsocial hours receive an uplift at the mid points of bands 1B and 1A (45%). Unsocial hours for other medical staff receive an uplift of 33.3%.

Price caps for AfC staff take into account existing AfC rules on unsocial hours for substantive staff.

Price caps for AfC staff also take into account existing AfC high-cost area (HCA) supplements, at 5% for Fringe, 15% for Outer London and 20% for Inner London. These are subject to the annual minimum and maximum payments, converted to hourly rates.

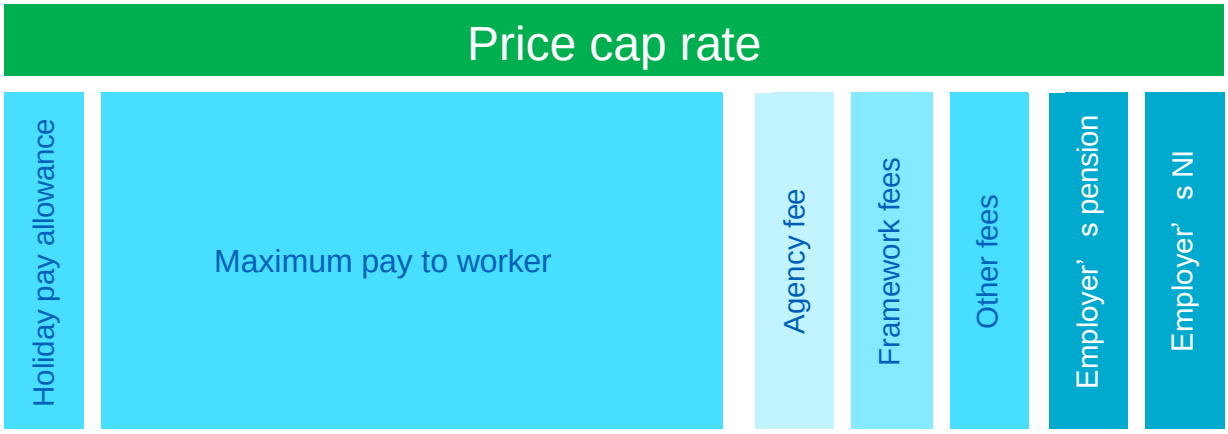
Uplift calculation for cap on total charge

Price caps for all staff from 1 April 2016 are calculated at 55% above this hourly rate. The price caps will not increase in line with substantive pay awards, refer to paragraph 5.6.

Annex 3: Trust reporting requirements

Data submission requirements	Frequency	Reporting mechanism
Agency expenditure, by staff group	Monthly	Finance returns
Number of agency shifts, by staff group, breaking any combination of the agency rules	Monthly	Agency return
Report all safety issues, service closures or patient experience issues that are attributable to the agency rules	Monthly	Agency return
Details of all shifts worked by staff from off-framework agencies with those at rates above the price cap signed off by the chief executive	Monthly	Agency return
Details of all shifts worked by staff that are charging the trust £100 per hour or more, including agency fees but not including VAT, with confirmation of chief executive sign-off	Monthly	Agency return
Agency shifts worked at an hourly rate below £100 but 50% above the price cap rate, with confirmation of executive director sign-off	Monthly	Agency return
Details of the 10 highest paid agency workers, by hourly rate (including agency fee but not including VAT) working at the trust during the reporting week	Monthly	Agency return
Details of the 10 longest serving agency workers working at the trust during the reporting week	Monthly	Agency return
Details of bank shifts, by staff group	Monthly	Agency return
Details of bank shifts worked by staff at rates of pay over £100 per hour, with confirmation of chief executive sign off	Monthly	Agency return

Annex 4: Seven pillars of the price cap



Component	Definition
Holiday pay allowance	All agency workers are entitled to the same holiday benefits as substantive NHS staff after 12 weeks.
Pay to worker	The pay to the worker element of the price cap is equal to the maximum a substantive worker can earn at that grade/band as an hourly rate.
Agency fee	Agencies charge a fee to supply workers. This is the only fee the agency should charge and should not increase when the trust 'breaks glass'.
Framework fee	The approved frameworks charge an hourly fee for each worker. This must be paid by the agency directly to the framework.
Other fees	Any other fees related to procurement of agency workers. This includes the apprenticeship levy and direct engagement fees.
Employer's pension contribution	As per all employees, agency workers are entitled to a workplace pension. The employer's contribution is set at maximum 3% of the worker's pay and holiday pay allowance.
Employer's NI contribution	The price cap includes a 13.8% employer's National Insurance contribution.

The definitions above are subject to any change to employment legislation or NHS contracts.

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This publication can be made available in a number of alternative formats on request.