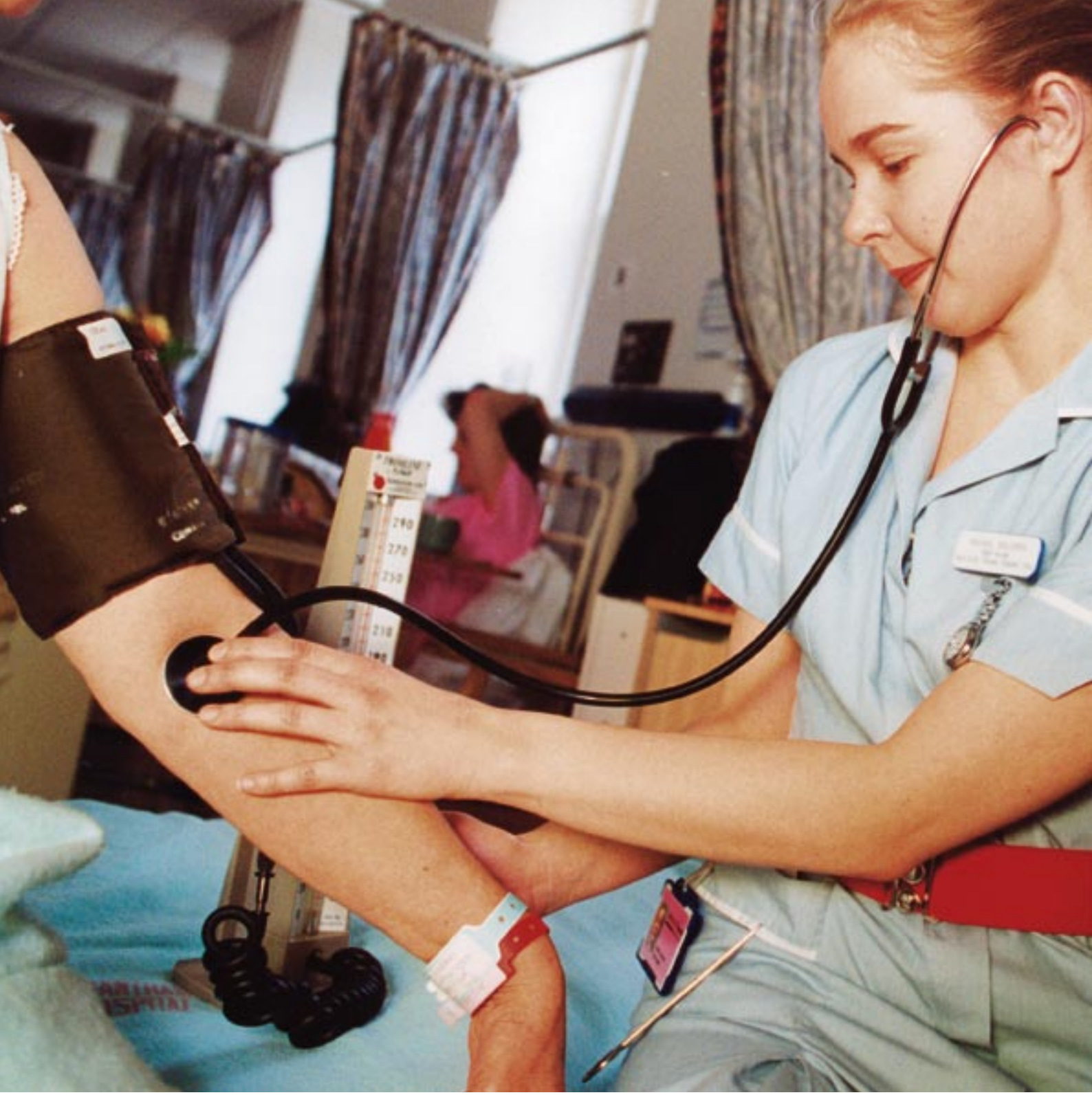

National Audit Office

DEPARTMENT OF HEALTH

Improving the use of temporary nursing staff in NHS acute and foundation trusts

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL | HC 1176 Session 2005-2006 | 12 July 2006

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John Bourn
Comptroller and Auditor General
National Audit Office

6 July 2006

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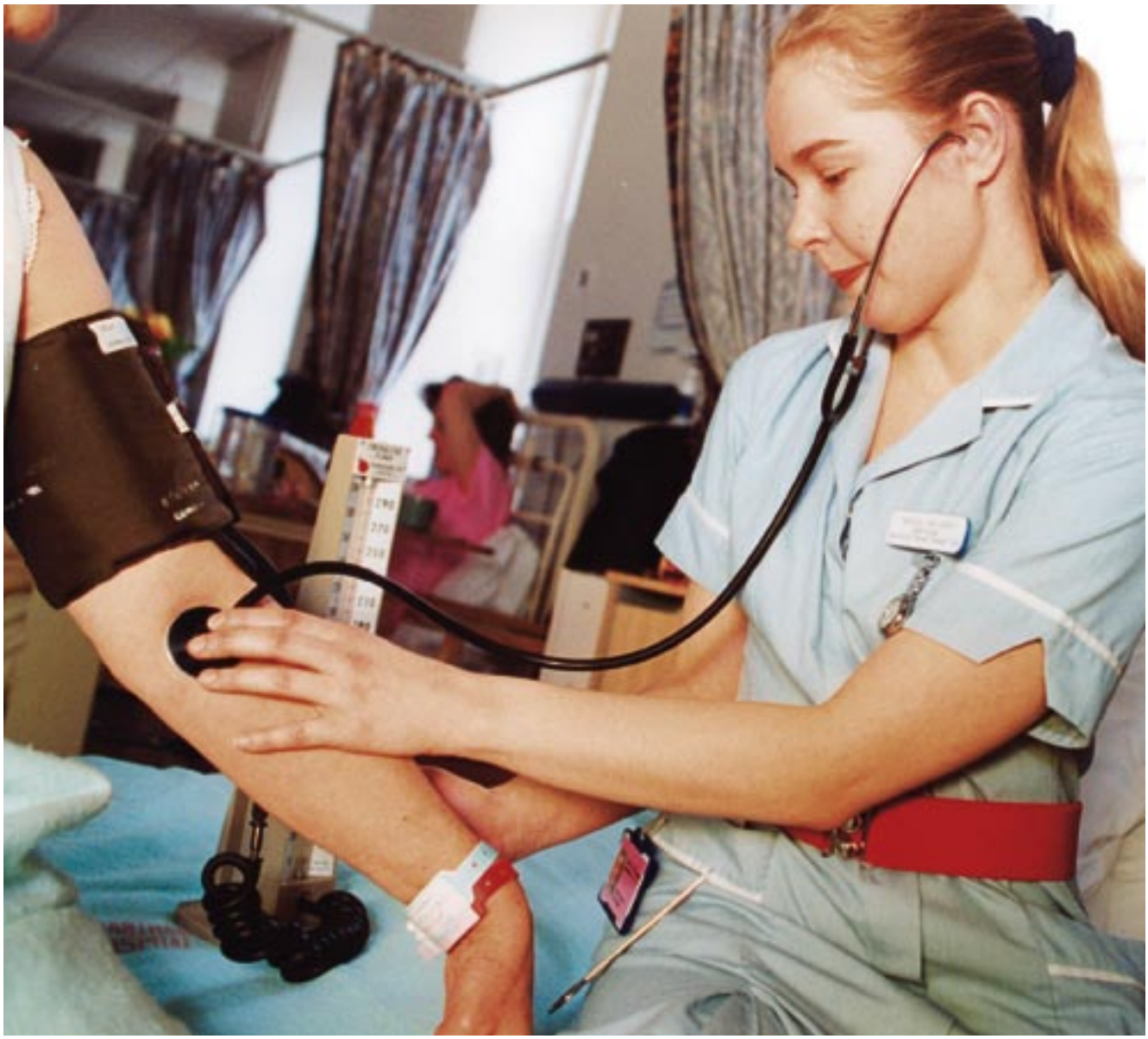
EXECUTIVE SUMMARY



1 The 173 acute and foundation hospital trusts (trusts) in England spent around £8.3 billion on nursing staff in 2004-05.[1] Although the nursing workforce has increased substantially over the last five years, temporary staff remain a key component of trusts' ability to be flexible in order to meet fluctuations in activity levels and to cover vacancies and short term staff absences. In 2004-05 trusts spent £790 million[2] on temporary nursing cover.

2 Traditionally, trusts have met the fluctuations in demand by using staff from their own nursing banks or by procuring staff from independent nursing agencies and, since 2001, from NHS Professionals (an NHS run temporary staffing service). **Figure 1 overleaf** illustrates the main roles, responsibilities and accountabilities in relation to the recruitment and provision of temporary nursing staff. **Figure 2 on page 3** sets out the cycle through which trusts should ideally manage their demand for and procurement of temporary nursing staff.

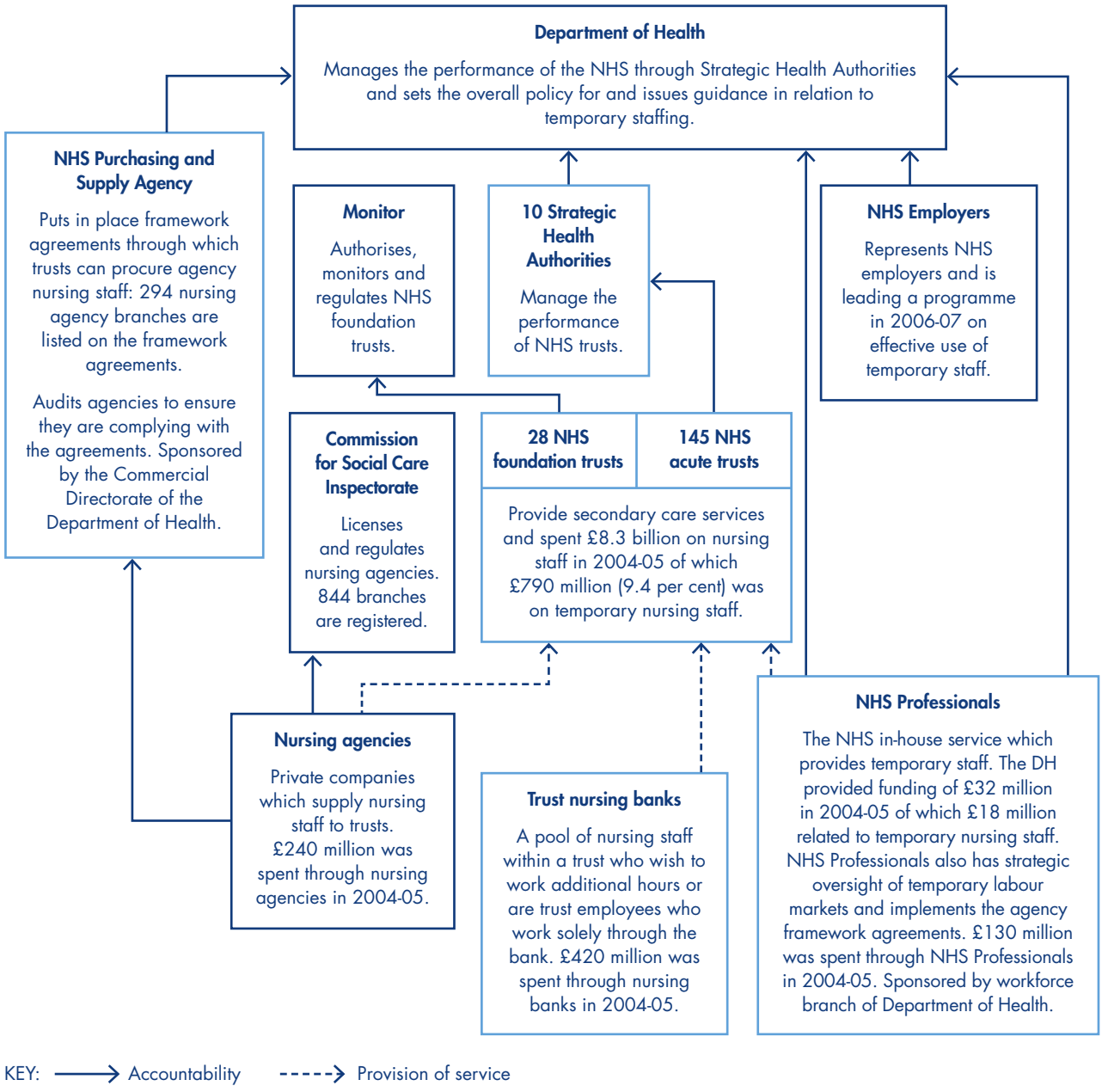
3 NHS trusts have to be able to respond to fluctuations in demand and staff availability through flexible staffing arrangements. The use of temporary staff forms a key part of this flexibility for many trusts. However, high levels of unmanaged use can be costly, particularly when trusts place high levels of reliance on agency staff. There are also implications for patient satisfaction: in 2005 the Healthcare Commission found that trusts with high vacancies and high use of temporary staff tend to score lower than other trusts on patient satisfaction. To be effective and control quality and costs trusts need to manage both demand and supply.

4 The Audit Commission's 2001 report, *Brief Encounters*[3], highlighted that NHS trusts' use of bank and agency staff was growing and that costs were escalating rapidly. It identified inconsistencies in the quality of temporary nursing staff and the lack of reliable information systems to help manage demand. In response to the findings in *Brief Encounters* and in recognition of the fact that some staff wanted to be able to work more flexibly within the NHS the Department launched NHS Professionals, a national temporary staffing service, with the intention that it would reduce dependence on commercial agencies and improve quality by providing safe and well trained staff. It also encouraged the NHS Purchasing and Supply Agency to set up a series of regional framework agreements to improve the quality and reduce the cost of nursing staff procured through nursing agencies.

5 In 2005, the Department again raised concerns that trusts were failing to control their expenditure on temporary nursing staff effectively and, in December 2005, listed as one of its ten high impact workforce changes, the need for "managing temporary staffing costs as a major source of efficiency".[4] More recently, in May 2006, NHS Employers announced a new programme to help trusts make effective use of temporary staff.[5] In response to the Gershon Efficiency Review, the Department highlighted reducing demand for temporary staff as one of the methods it intended to use to achieve efficiency gains and has stated that it believes replacing temporary staff with experienced permanent staff leads to increased productivity and better patient care.[6]

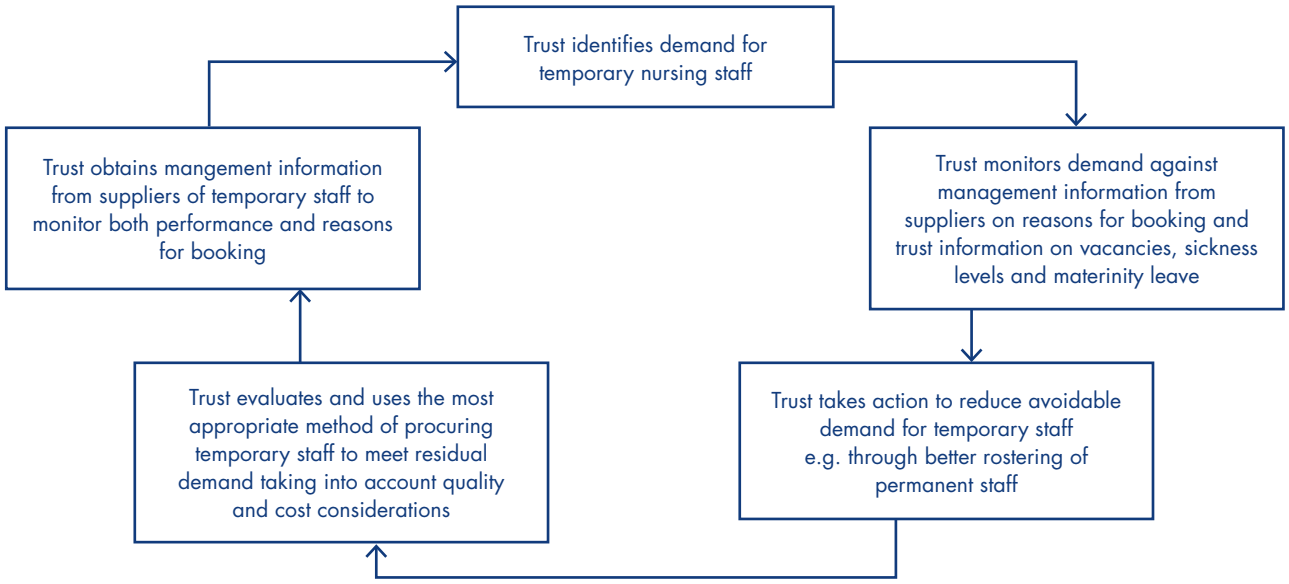
6 Although the Department collects some data on temporary staff, for example on expenditure on agency nursing staff, it does not have sufficient data to fully understand the extent and costs of using temporary nursing staff. Nor have trusts been able to benchmark their performance in any meaningful way. We therefore undertook a census of trusts to derive a national and trust level picture on how trusts determine demand, the extent and costs of procurement and the impact of initiatives to improve quality (further details on our methodology are at Appendix 1).

1 The main roles, responsibilities and accountabilities in relation to temporary staff



Source: National Audit Office

2 The ideal strategic management cycle



Source: National Audit Office

Overall conclusions

7 To date, the NHS has focussed mainly on reducing agency costs with less attention being paid to addressing the wider issues of controlling and managing the supply and demand of all types of temporary nursing staff.
In particular:

- The NHS has successfully reduced its expenditure on agency nursing staff from its peak of seven per cent of total nursing expenditure in 2001-02 to three per cent in 2004-05.
- The NHS has reduced slightly its total expenditure on temporary nursing staff from 10 per cent[7] of total expenditure in 1999-00 to 9.4 per cent in 2004-05. In 2004-05 some trusts were spending less than five per cent of total nursing expenditure on temporary staff and others as much as 29 per cent.
- Many trusts do not have adequate and timely information on staffing needs and therefore do not have a clear understanding of the factors driving their demand for nursing staff. The lack of benchmarking information and differing definitions of what constitutes a vacancy make it difficult for some trusts to determine what staffing levels they need to operate safely and effectively. They are also unable to determine whether their general demand for temporary staffing is clearly supported by a demonstrable need to fill vacancies on individual shifts.
- Trusts need also to improve the management of their permanent staff, for example by introducing more effective staff rostering and flexible contracts. We consider that more effective control over demand for all nursing staff could result in savings for the NHS of between £25 million and £50 million.
- The NHS has made some progress in reducing the unit cost of employing temporary nursing staff, by consolidating the numbers of nursing banks per trust thereby cutting overheads, and by reducing reliance on commercial agencies and increasing the use of their own banks and NHS Professionals. However, agency nurses still cost trusts more than other temporary staff. (A "D" grade agency nurse cost around 29 per cent more than a permanent nurse in 2005.) We estimate that trusts could collectively make annual savings of between £13 million and £38 million by better procurement and by driving down still further the unit costs of the different grades of agency nursing staff.

8 NHS Professionals and the NHS Purchasing and Supply Agency framework agreements have contributed to an improvement in the quality of temporary nursing staff by providing some assurance about the employment and training status of staff procured through these arrangements. But more needs to be done to ensure that all temporary staffing suppliers are operating to consistent standards. Nursing banks do not have formal quality assurance procedures in place and by May 2006 the NHS Purchasing and Supply Agency had audited only 54 per cent of agencies on its framework agreements.

Key findings

The NHS has reduced expenditure on agency nursing staff and the increase in nurses under the NHS Plan has led to a slight reduction in the level of use of temporary nursing staff overall.

9 Between 2000 and 2005 the number of whole time equivalent registered nurses working in the NHS increased by 55,000, taking the total to 322,000.[8] This was more than double the NHS Plan 2000 target of an additional 20,000 nurses by 2004. In 2001 the Department stated that it anticipated that the growth in the workforce under the NHS Plan would significantly reduce the NHS's demand for temporary staff.[9] However it has subsequently confirmed that it was only referring to demand for staff employed through agencies which it has been successful in driving down. Expenditure on temporary nursing staff as a percentage of total nursing expenditure has fallen only slightly from the Audit Commission's estimate of 10 per cent in 1999-00[7] to 9.4 per cent (£790 million) in 2004-05.

10 Appendix three shows that there is wide variation in the extent to which trusts rely on temporary nursing staff both within and between regions. Trusts in the south rely more on temporary nursing staff than trusts in the north (the average expenditure on temporary nursing staff was 17 per cent in London compared to five per cent in the Northern and Yorkshire region). However, there is also significant variation within regions with trust expenditure on temporary nursing staff varying between five and 27 per cent in London and less than one and 10 per cent in Northern and Yorkshire.

11 Variation can be caused by a large number of factors including vacancy rates, mobility of the workforce and management decisions and we would expect some variation in levels of use. However, whilst there is no generic "ideal" level of reliance on temporary staff, where a trust spends more than the regional average it may indicate that the trust is experiencing difficulties recruiting and retaining staff and managing sickness absence. These factors combined with high use of temporary staff can have a negative impact on cost, patient satisfaction and staff morale.

12 Recent developments within the NHS such as the introduction of Payment by Results and Commissioning a Patient Led NHS will make it more difficult for individual trusts to predict their annual activity and funding levels. In the future, to remain in financial balance trusts will need to ensure that they can flex their staffing levels according to activity. The Department has stated that the use of temporary staff will play an important part in helping trusts achieve that flexibility.[4] It is therefore very important that trust boards take a planned approach to their use of temporary staff taking into account both cost and quality factors. Despite the recommendations in Brief Encounters that all trust boards should have a senior person to take an overall lead and have board level accountability for the use and quality of temporary staff we found that few trust boards had given the issue strategic consideration.

NHS trusts have poor management information and a lack of understanding of the drivers of demand for temporary nursing staff

13 Our analysis of trusts' usage of temporary staff demonstrates that demand for temporary cover has increased or remained relatively static compared to 1999-00. Demand for temporary nursing staff is related to the total amount of nursing staff that a trust has determined that it needs (the nursing establishment). In some countries, such as parts of Australia and America, hospitals use minimum nurse:bed ratios to determine staffing levels. Other countries, including England, have not adopted this approach because they can be seen as a blunt instrument which does not take account of the numerous differences between hospitals and wards.[10] Instead the most common method for determining the nursing establishment in NHS trusts is a bottom-up approach determined by the professional judgement of nurse managers taking into account budget allocations, which are generally based on historical activity levels.

14 The lack of an evidence base on minimum staff levels has led to wide variations in the average number of nursing staff per bed, particularly in some specialties such as intensive care. Furthermore it increases the risk that at times of financial pressure trusts will reduce their use of temporary staff without giving full consideration to the risks to patient safety and the impact on the morale and well being of permanent staff. Whilst this impact may not be felt immediately it is likely to result in an increase in patient safety incidents, staff sickness absence and turnover putting further pressure on the existing nursing workforce. To underpin nurses' professional judgement on setting establishment levels it is very important that trusts have access to good information, such as benchmarking, to enable them to determine appropriate staffing levels.

15 Whilst trusts do collect information on reasons for needing temporary nursing staff (such as vacancy levels, sickness levels and activity levels) this is rarely brought together in a systematic manner to consider the most appropriate way in which to staff wards. We found that ward managers, human resource managers and finance staff can all have a different understanding of establishment levels and different definitions of what constitutes a vacancy. Consequently bank and agency staff are booked with little consideration of whether cover is actually needed or what alternatives there might be.

16 Trusts told us that vacancies are their primary driver for booking temporary nursing staff. The Department's published figures show that vacancies which trusts are actively trying to fill and which have existed for more than three months in acute, elderly and general nursing posts fell from 4.6 per cent in 2000 to 1.7 per cent in 2005.[11] However, this fall has not impacted on trusts' demand for temporary nursing staff. This may be because trusts are holding vacancies which they are not actively trying to fill. In 2004 the Healthcare Commission found that between eight and nine per cent of hospital ward posts were unfilled.[12]

17 More effective management of sickness and annual leave can also lead to a reduction in the demand for temporary nursing staff. The Healthcare Commission found that the average rate of sickness absence for nursing staff is 16.8 days per year and estimated that £141 million a year could be saved by cutting sickness absence levels by 30 per cent.[12] Our further analysis has identified that there is substantial variation in sickness levels in different grades of staff. Trusts can do more to analyse sickness patterns in their trust and apply sickness management tools to help reduce sickness absence in those grades and specialties with the highest rates.

The NHS has made progress in reducing the unit cost of employing temporary nursing staff through initiatives aimed at improving procurement and supply

18 Once trusts have identified a need for temporary staff they may procure them from a number of different sources. For most trusts, once they have established that they have a shift that they are unable to fill from their own permanent nurse pool, the first contact is usually the trust nursing bank (during 2004-05 75 per cent of trusts ran their own nursing bank and 22 per cent used NHS Professionals as their main provider). If this approach is unsuccessful then the next option is to use a nursing agency on a framework contract. If this fails then most trusts will try one of the other commercial agencies that are not on a framework contract. Three per cent of trusts do not use a nursing bank or NHS Professionals but rely solely on staff from nursing agencies as required.

19 *Brief Encounters* reported that half of trusts had more than one nursing bank and lacked common standards, policies and practices. It noted that this led to higher costs and greater reliance on agency staff.[3] We found that most trusts have reduced their overheads by centralising their nursing banks. Some have also improved their inherent flexibility in line with the Department's Improving Working Lives Initiative, through the introduction of specialist nursing pools, annualised hours contracts and zero hours contracts. However progress in relation to the Audit Commission's recommendation to invest in information technology to modernise bank administration has been patchy, only 70 per cent of trusts who run their own bank reported that they used a bank management software package. Very few trusts use electronic rostering systems although these would help ward managers control demand for temporary nursing staff and could potentially be integrated with bank management systems and payroll systems to reduce overhead costs.

20 Trusts use agency nursing staff because in some situations they are the only method of filling a shift. Although all British qualified nursing staff complete at least part of their training within the NHS some staff choose to work through agencies after qualification because they can earn more money by doing so. Consequently agency staff can be expensive for trusts to use on a long term basis and most trusts wish to keep their expenditure on agency staff to a minimum. The NHS has successfully reduced its expenditure on agency nursing staff from its peak of seven per cent of total nursing expenditure in 2001-02 to three per cent (£240 million) in 2004-05. Early data shows that significant further

reductions have been made in 2005-06 and the Department recently estimated that the NHS could make further savings of £78 million by reducing expenditure on agency staff across all staff groups to the national average.[13]

21 Four main factors have contributed to the fall in agency expenditure:

- Trusts' improvement in the management of temporary nursing staff and encouragement of the greater use of nursing banks and NHS Professionals as an alternative to agencies;
- the NHS Purchasing and Supply Agency framework agreements with their agreed price brackets and quality requirements through which trusts are encouraged to procure agency nursing staff;
- the implementation of NHS Professionals which has helped to manage the agency market; and
- the financial pressure on trusts to break even which has encouraged them to impose stricter internal controls on their agency expenditure. In a January 2006 survey of the 35 trusts predicted to be facing the largest deficits in 2005-06, 90 per cent were using reductions in agency expenditure to try and reduce their deficit.

22 There is scope for further reductions in the cost of agency nursing staff. The NHS can prevent wage inflation and influence the total cost of agency nursing staff by effectively using its position as a major buyer within the agency nursing market. For example a reduction of £1 per hour on the cost of 50 per cent of agency nursing staff would result in savings of around £6 million. In 2004-05 around 20 per cent of acute trust expenditure on temporary nursing did not go through the NHS Purchasing and Supply Agency framework agreements. Even where all expenditure goes through the agreements, pay and commission rates can still vary significantly. However, the NHS Purchasing and Supply Agency is currently re-negotiating its framework agreements for all areas outside London to reduce both the average level and the variation in pay and commission rates and some trusts are working in consortia to achieve savings of up to 50 per cent on commission charges.

NHS Professionals has helped improve the management of the temporary nursing market but could do more

23 The Department's launch of an NHS in-house temporary staffing service, 'NHS Professionals'[14], in February 2001 was in response to the growing concerns about cost and quality of temporary staff. By 2003 the NHS Professionals service was being provided via four main host trusts and there was significant variation between them in terms both of activity and performance. In 2003 one of the host trusts, the West Yorkshire Metropolitan Ambulance Service (WYMAS), was the subject of a Public Interest report by the Audit Commission due to the trust's £10 million operating deficit. Some trusts had also expressed dissatisfaction with the WYMAS service and in particular with the number of shifts that it was able to fill.[15] The Department was concerned about this variability in performance and therefore decided to establish NHS Professionals as a Special Health Authority from January 2004.

24 NHS Professionals has both an operational and strategic role. Its operational role is to supply temporary nursing staff to the trusts in which it is contracted. Its strategic role is to set the standards and policy framework for temporary staffing and to oversee the temporary labour markets. NHS Professionals is currently funded through the commission which it charges trusts that use its service and through central funding from the Department. In 2004-05 the Department provided funding of £32 million of which £18 million related to temporary nursing staff.

25 In the Department's Arm's Length Bodies review in July 2004, the Department announced that NHS Professionals should move outside of the Arm's Length Body sector after two to three years and would be expected to become self-financing by 2007-08.[16] In order to meet this target NHS Professionals will need to significantly increase the number of shifts it is commissioned to fill. There is therefore a potential tension between NHS Professionals' role to make the temporary staffing market more cost effective through strategic management and potentially reducing demand for temporary nursing staff, and its financial requirement to break even.

26 NHS Professionals aims to be the first choice of temporary staffing providers by 2008. However, trusts can choose whether or not to use NHS Professionals to manage their temporary nursing requirements and in 2004-05 NHS Professionals was operating in 22 per cent of acute trusts, employing over 50,000 nurses and accounting for £130 million of trusts' expenditure on temporary nursing staff. By May 2006 it had increased its penetration of the acute trust market to 27 per cent. The main reason why trusts had chosen not to use NHS Professionals was because they believed that their own local arrangements were adequate and that the costs, including the loss of control, outweighed the potential benefits.

27 When NHS Professionals became a Special Health Authority it inherited a collection of regional operations of disjointed and variable quality. It has since invested in staff and technology which have led to an improvement in ability to fill shifts and an increase in operating income, which it expects to yield further future benefits in terms of both the cost and quality of temporary staff. However, some issues remain and both trusts and nursing agencies reported to us perceived problems about the operation of NHS Professionals of which the most common were a lack of effective communication and a continued reliance on nursing agencies to fill some short notice or specialist shifts.

28 Between 2003-04 and 2004-05 (the first year of NHS Professional's existence as a Special Health Authority) there was little difference between the performance of NHS Professionals and non NHS Professionals trusts in terms of reducing expenditure on agency staff: both reduced agency expenditure by around 25 per cent. There was also little difference between trusts using NHS Professionals and other trusts in terms of reducing expenditure on temporary staff overall.

29 NHS Professionals has made some improvements in its strategic role to set the standards and policy framework for temporary staffing and to oversee the temporary labour markets. By the end of 2005, against its strategic objectives (see paragraph 3.16), NHS Professionals had:

- helped increase competition within the temporary staffing market by contributing to the lowering of agencies' commission rates and margins;
- developed robust clinical governance standards for temporary staffing which were being applied in the 36 trusts using NHS Professionals;
- made progress in developing its strategic oversight of temporary labour markets using management information to develop a national picture of supply and demand in the NHS. NHS Professionals has also developed a clinical coding system to improve the transparency of pricing of temporary labour and to standardise the number and names of different nursing roles.

Improvements need to be made to assure the quality of temporary nursing staff

30 In 2002 the Department published a *Code of Practice for the Supply of Temporary Staffing* which set out a framework for the management and performance of temporary staffing providers to ensure the delivery of high quality, affordable and safe care.[17] The code lays out the minimum standards required in the supply of temporary staff to the NHS and states that it expects all NHS employers to use the code when they employ temporary staff. All organisations supplying temporary staff to the NHS, including nursing agencies, nursing banks and NHS Professionals are supposed to abide by the code.

31 Despite the publication of the Code of Practice the quality assurance procedures in place across nursing agencies, nursing banks and NHS Professionals are not standardised. For example it is a condition of the NHS Purchasing Supply Agency framework agreements that all agencies provide their staff with mandatory training and an annual performance assessment. However less than 70 per cent of bank nursing staff received their mandatory training in the 12 months prior to September 2005 and only 22 per cent received a performance assessment. NHS Professionals provides all their staff with mandatory training but not annual performance assessments.

RECOMMENDATIONS

32 There is scope for further improvements in the management and use of temporary nursing staff but the information available to trusts to help determine safe and cost-effective staffing levels is poor and much still needs to be done to understand demand and improve supply. These recommendations are aimed at helping to address the deficiencies we have identified. Alongside this report, in collaboration with the Audit Commission and the Department, we have published a good practice guide which features checklists and case examples and provides further help and guidance, including showing how some trusts have tackled successfully the issues raised in this report.

33 NHS Trusts should:

- Appoint a board member with responsibility for developing and monitoring a trust wide strategy in relation to its use of temporary staff as parts of its people strategy. The board should set budgets on the use of temporary staff against which expenditure can be measured.
- Control demand for temporary staff by bringing together information on activity and dependency levels, permanent nursing staffing levels, vacancies and sickness levels. This information should be benchmarked internally and against other similar trusts using NHS Employers' proposed benchmarking group(s).
- Benchmark their nursing bank(s) against the quality standards published by NHS Professionals. Where their quality standards fall short of NHS Professionals they should undertake a detailed exercise to determine the cost of bringing them up to these standards. Where these costs are higher than those incurred by using NHS Professionals, they should develop a business case which evaluates the costs and benefits of engaging alternative providers including NHS Professionals and nursing agencies.
- Only use nursing agencies on the NHS Purchasing and Supply Agency framework agreements.
- Draw on the work being done by NHS Employers and the NHS Purchasing and Supply Agency in relation to electronic rostering to determine the benefits of adopting such a system within the trust.
- Adopt the NHS Professionals clinical coding system for temporary staff so that all trusts have a common approach to describing roles. This should increase the transparency of pricing and allow local health economies to gain control of their temporary staffing market.

34 NHS Employers should:

- Develop a new Code of Practice on Temporary Staffing for the NHS to clarify the current discrepancies in the checks required on nursing staff provided by nursing agencies, NHS Professionals and trust internal nursing banks.
- Share best practice in the use of temporary staff across the NHS through the use of benchmarking groups.
- In conjunction with the NHS Purchasing and Supply Agency, review best practice in relation to electronic rostering systems and work with trusts to identify cost effective products which can be integrated with trusts' existing finance and human resources systems.
- Work with NHS Professionals on behalf of trusts to ensure that NHS Professionals' business plan and pricing strategy reflects trusts' expectations.




35 NHS Professionals should:

- Publish details of the quality assurance checks they have in place around recruitment, training and personal development so that trusts are able to benchmark their services against those provided by NHS Professionals.
- Publish details of its clinical coding system from which all trusts could benefit.
- Build on the improvements it has made to its call centres to ensure it is able to deal efficiently with all calls from trusts and nursing agencies.
- Engage positively with nursing agencies to draw on their expertise and build a mutual understanding of how temporary staff can be used effectively within the NHS.

36 The NHS Purchasing and Supply Agency should:

- Audit all of the agencies on the agency framework agreements by March 2007.
- Obtain greater volume discounts on the behalf of trusts by consolidating its regional framework agreements.

37 The Department of Health should:

- In light of the variability in levels of use of temporary nursing staff work with NHS Employers to develop a framework for the effective use of temporary nursing staff within trusts.
- Clarify how it expects NHS Professionals to manage the potential conflict between its strategic role to improve the quality of the temporary labour market, its operational requirement to make temporary staffing more cost effective and its financial requirement to break even.
- As part of its performance management of the NHS Purchasing and Supply Agency set clear objectives and targets for its role and responsibilities in relation to procurement of temporary staffing, and monitor against these, including ensuring that it maintains an effective programme of agency audits.
- Ensure that NHS Professionals work in partnership with the NHS Purchasing and Supply Agency to develop its clinical coding system to take account of all staff groups and that the codes are included in all future NHS Purchasing and Supply Agency contracts to help trusts understand the comparative costs of employing bank, agency and NHS Professionals nursing staff.
- Work with the Healthcare Commission to build the management of temporary staff into their performance assessment criteria.
- Work with the NHS Litigation Authority to ensure that risk management for temporary staff is appropriately built in to the Clinical Negligence Scheme for Trusts.[a]
- Through Strategic Health Authorities, monitor trusts performance against the recommendations in paragraph 33.

a The NHS Litigation Authority is a Special Health Authority which is responsible for handling negligence claims against NHS bodies in England. The Clinical Negligence Scheme for Trusts is a mechanism to allow trusts to pool the risk of having to meet negligence claims through making contributions. Trusts can reduce their level of contributions by up to 30 per cent by demonstrating that they have met specified risk management standards.

PART ONE

The extent and impact of using temporary nursing staff

1.1 There are 173 acute hospital trusts (trusts) in England. Most of these trusts experience fluctuations in the amount of nursing staff that they have available to work on their wards due to various factors such as vacancies, sickness absence and annual leave. Trusts also experience variations in activity at different times of the week and year both within and between specialties. Traditionally, trusts have met these fluctuations in demand by obtaining temporary nursing cover from their own nursing banks or by procuring staff from independent nursing agencies and, since 2001, from NHS Professionals **(Figure 3)**.

1.2 Nursing staff choose to work as temporary nursing staff for a variety of reasons. Many have permanent contracts and wish to supplement their income (on average 55 per cent of the nursing staff on trust banks have a permanent contract at the same trust); others want to be able to work more flexibly or to use temporary nursing as a means of exploring new job opportunities; and some work purely as temporary nursing staff because they believe they will earn more by doing so, this is particularly the case in specialist areas where there are national shortages of staff.

3 The methods which trusts use to achieve flexibility in their nursing workforce

Method	Description	Employment status of nursing staff
Nursing banks	A nursing bank provides a reserve of nursing staff within a trust to supplement staff employed on the wards when needed. Nursing banks are normally run by trusts although they can be run by external organisations such as nursing agencies.	The nursing staff on the bank are employees of the NHS. They may also have a permanent post in the NHS or with another healthcare provider.
Nursing agencies	Nursing agencies are private companies which supply nurses to wards by liaising between nursing staff and NHS trusts and other healthcare providers.	Agency nursing staff are generally employed by a nursing agency. They may also have a permanent post in the NHS or with another healthcare provider.
NHS Professionals (Since 2001)	NHS Professionals is the NHS's "in house" temporary staffing service, established as a Special Health Authority in 2004. NHS Professionals takes over nursing banks, with the agreement of the trusts in which they operate, and manages these banks as one central operation for all trusts that have signed up for its services.	NHS Professionals nursing staff are paid by NHS Professionals as NHS staff. They may also have a permanent post in the NHS or with another healthcare provider.

Source: National Audit Office

1.3 In September 2001, the Audit Commission published its report entitled *Brief Encounters*. The report identified that expenditure on temporary nursing staff, and particularly agency nursing staff, was rising sharply and that the way temporary cover is arranged can sometimes undermine the quality of patient care. It recommended that trusts should reduce their need for temporary nursing staff by recruiting into vacancies, increasing opportunities for flexible working and having board level accountability for temporary staff.[3]

1.4 The Department has acknowledged that the use of temporary nursing staff can be an effective means of achieving flexibility in deployment of staff.[4] However, it believes that reliance on temporary, and particularly agency, nursing staff is excessively high and stated in its response to the Gershon Efficiency Review that replacing temporary nursing staff with experienced permanent staff leads to improvements in cost and productivity and to better patient care.[6] The Department has urged trusts to reduce their expenditure on agency nursing staff (the most costly type of temporary nursing staff) and to make more effective use of all temporary nursing staff.[18] In December 2005, it listed "managing temporary staffing costs as a major source of efficiency"[4] as one of its ten high impact workforce changes.

1.5 In order to obtain an understanding of the changes in the extent and use of temporary staff since the Audit Commission report in 1999-2000 we surveyed all acute and foundation trusts in England. The data collected through this survey was not available centrally from the Department. This Part details our findings on the changes in use and how this is impacting on patients perceptions of quality of care.

NHS acute trusts have reduced expenditure through agencies but overall expenditure on temporary nursing staff has remained relatively constant

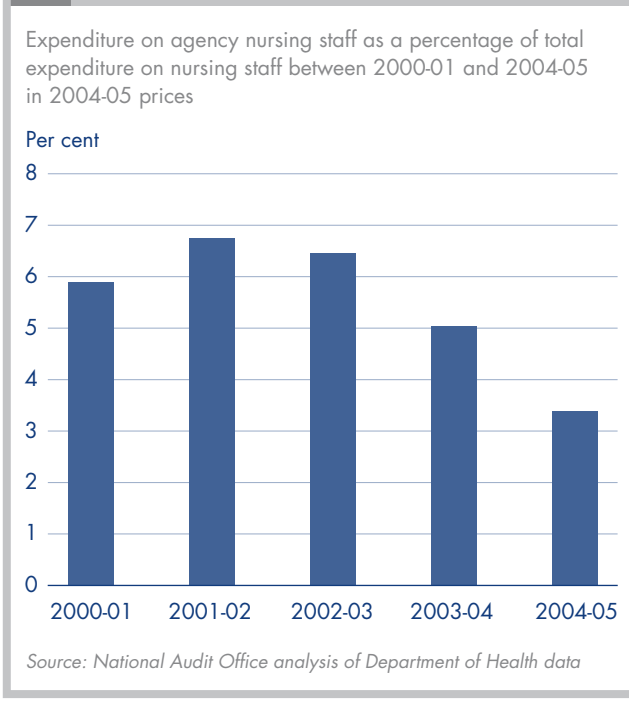
1.6 In 2005 trusts procured their temporary nursing staff in the following ways:

- 75 per cent of trusts ran their own nursing bank to supply the majority of their temporary nursing staff, supplemented with staff from independent nursing agencies;
- 22 per cent used the NHS Professionals nursing service as their main provider of temporary nursing staff, supplemented with staff from nursing agencies; and
- three per cent did not use a nursing bank or NHS Professionals but did use some staff from nursing agencies as required.

1.7 Expenditure on temporary nursing staff as a percentage of total nursing expenditure has fallen slightly from 10 per cent[7] in 1999-00[3] to 9.4 per cent in 2004-05. Between 2003-04 and 2004-05, the total expenditure on temporary nursing staff reduced from £830 million to £790 million.

1.8 Part of this reduction is due to the fact that most NHS acute trusts have successfully reduced their expenditure on agency nursing staff. Data collected by the Department shows that expenditure on agency nursing staff as a percentage of total expenditure on nursing staff peaked in 2001-02 **(Figure 4)**. Between 2003-04 and 2004-05 expenditure on agency nursing staff fell from by 25 per cent from £330 million to £240 million. At the same time, however, the amount spent though nursing banks and NHS Professionals increased by 10 per cent from £500 million to £550 million **(Figure 5)**. Agency nursing staff are generally more expensive to use than the equivalent bank or NHS Professionals nursing staff therefore trusts have made some efficiency gains by transferring expenditure away from nursing agencies.

4 Expenditure on agency nursing staff as a percentage of total nursing expenditure peaked in 2001-02



Source: National Audit Office analysis of Department of Health data

There is significant variation in the extent to which trusts rely on temporary nursing staff

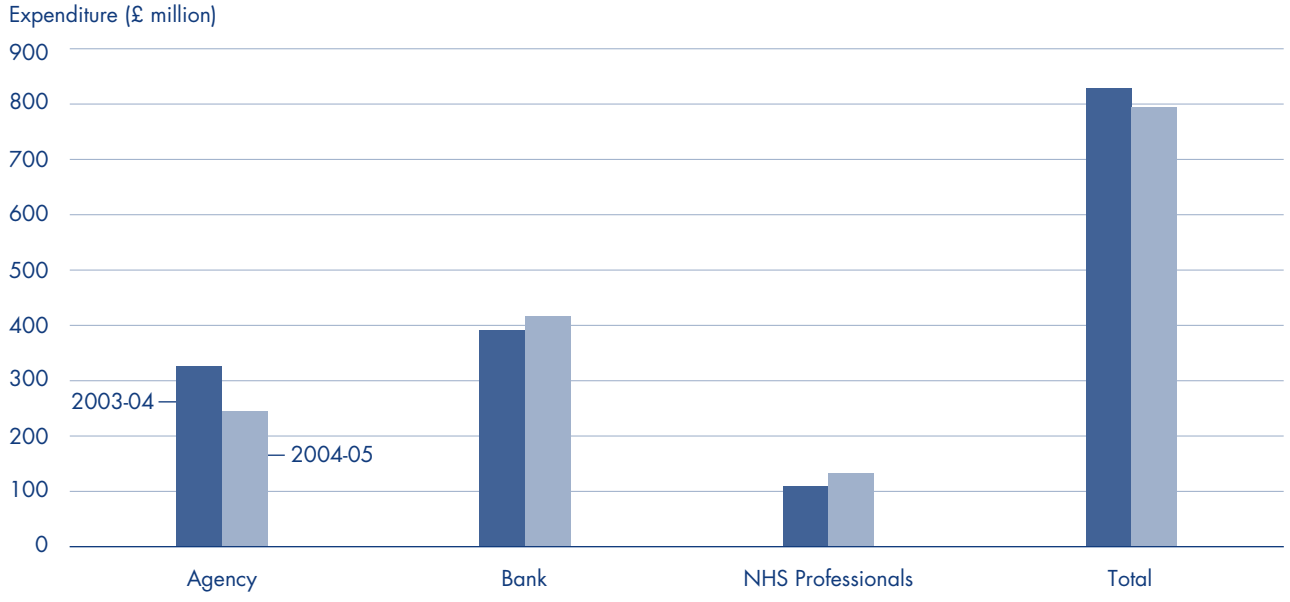
1.9 There is significant variation in the extent to which individual trusts are reliant on temporary nursing staff. **Figure 6 overleaf** shows that expenditure on temporary nursing staff as a percentage of total expenditure on nursing ranged from less than one per cent to 29 per cent.

1.10 Some of the variation in reliance on temporary nursing staff relates to the location of the trust. **Figure 7 overleaf** shows that trusts in the south, and particularly in London, place much greater reliance on temporary nursing staff than trusts in the north. This is partly because vacancy levels are higher in the south: the Department's three month vacancy rate for acute, elderly and general nurses was 3.1 per cent in London compared to 1.7 per cent across the country as a whole.[11]

1.11 However, there is also wide variation within as well as between regions (see Appendix 3). For example, expenditure on temporary nursing staff as a percentage of total expenditure on all nursing staff varies within London trusts between five and 27 per cent which suggests that some of the variation is not due to regional differences. We would expect some variation in levels of use but, whilst there is no generic "ideal" level of reliance on temporary staff, where a trust spends more than the regional average it may indicate that the trust is experiencing difficulties recruiting and retaining staff and managing sickness absence. These factors, combined with high use of temporary staff, can have a negative impact on cost, patient satisfaction and staff morale.

5 Trusts have reduced their expenditure on agency nursing by 25 per cent

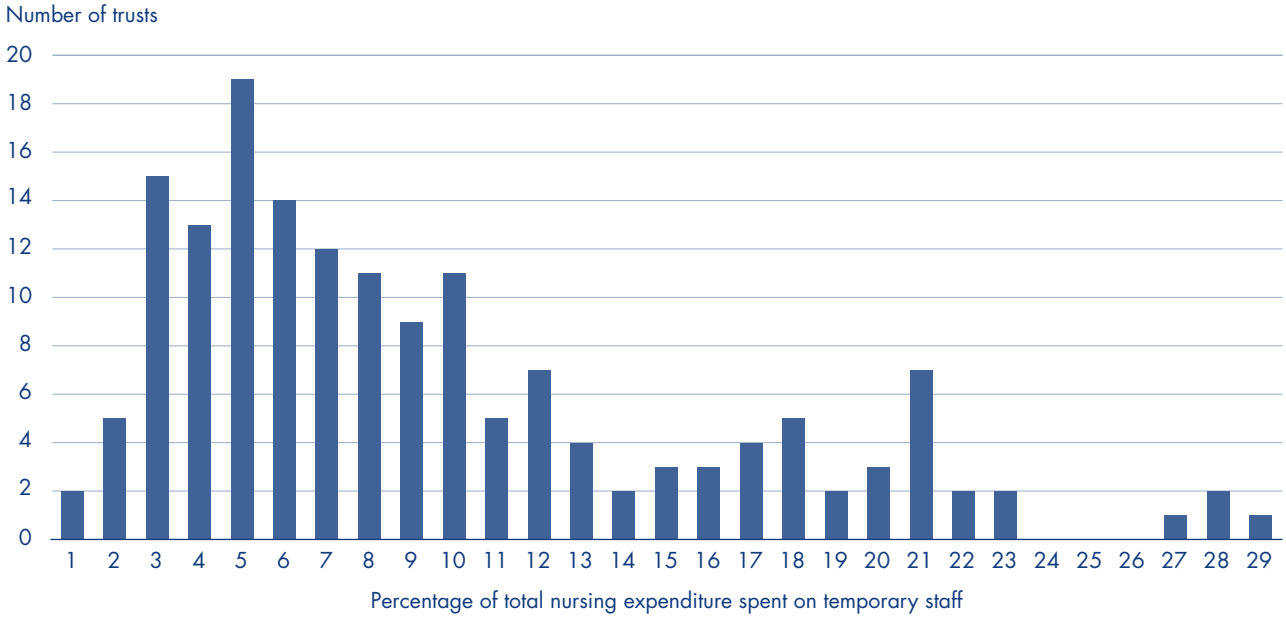
Expenditure on nursing staff procured through nursing agencies, nursing banks and NHS Professionals in 2003-04 and 2004-05



Source: National Audit Office

6 Expenditure on temporary nursing staff as a percentage of total nursing expenditure ranged from less than one per cent to 29 per cent

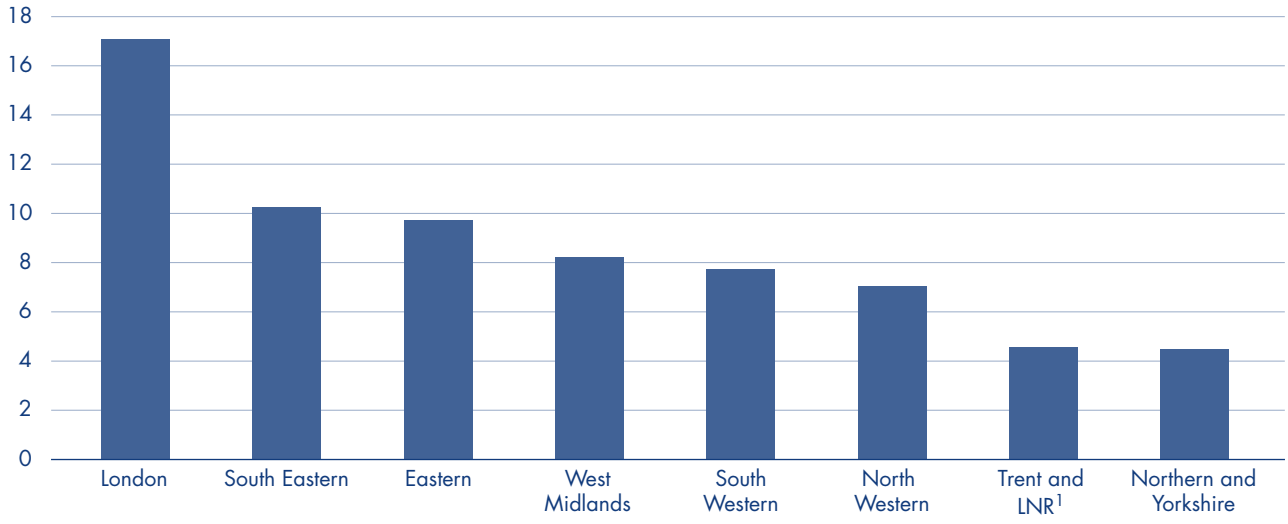
The percentage of total expenditure spent on temporary nursing staff in 2004-05



Source: National Audit Office

7 The proportion of the nursing paybill spent on temporary nursing staff is higher in London than in the rest of England

Expenditure on temporary nursing as a percentage of total expenditure on nursing staff broken down by region



Source: National Audit Office

NOTE

1 LNR is Leicestershire, Northampshire and Rutland.

Increasing use of temporary nursing staff leads to poorer patient satisfaction levels

1.12 Where nursing staff are unfamiliar with the environment in which they are working there is a risk that they will not only be less productive than their permanent equivalents but that patient care could suffer. **Figure 8** summarises the concerns expressed to us by ward managers about using unfamiliar temporary nursing staff.

1.13 Recent research by the Healthcare Commission has shown that there is a significant triangular relationship between the use of temporary nursing staff, patient satisfaction scores and vacancies.[12] Trusts with higher vacancy levels tended to use more bank and agency nursing staff and have poorer patient experience. The relationship was particularly strong in relation to the ability of nursing staff to answer questions put to them by patients.

8 Ward managers' concerns about using unfamiliar temporary nursing staff

Lack of continuity of care may result in temporary nursing staff not recognising when a patient is deteriorating. Ward managers felt that they are relying on staff on the ward to keep them informed about patient progress but could not be confident that temporary nursing staff would be in a position to do so.

Ward managers felt that they had to supervise unfamiliar temporary nursing staff because they did not know enough about them to be confident in their expertise. This put extra pressure on other nurses on the ward and had a detrimental effect on morale.

Ward managers were concerned that some nursing staff are working too many hours and could be at risk of causing a clinical incident. They would prefer for staff to work additional hours on their own ward so that their hours can be monitored. Ward managers have no way of monitoring how many hours unfamiliar temporary nursing staff have already worked in any given period.

In order to be confident in the expertise of temporary nursing staff it is necessary to spend some time accompanying them around the ward and finding out whether they are familiar with all of the equipment etc. It is normally very busy when temporary nursing staff have been booked and this induction can take a significant amount of time out of the shift. It is only worth it if the ward manager knows that the member of nursing staff is going to return to the ward on a regular basis.

Source: National Audit Office focus groups of ward managers

1.14 The National Patient Safety Agency undertook an analysis of clinical incidents reported to its confidential National Reporting and Learning System to identify incidents relating to agency, bank and locum staff. The National Patient Safety Agency examined a sample of 75 incidents in depth. The analysis showed that 38 per cent of the incidents reported related to poor clinical practice and 13 per cent related to a lack of familiarity with the environment. The other categories were lack of experience/ training (eight per cent); concern about behaviour of staff (eight per cent); and failure to attend a shift (24 per cent).

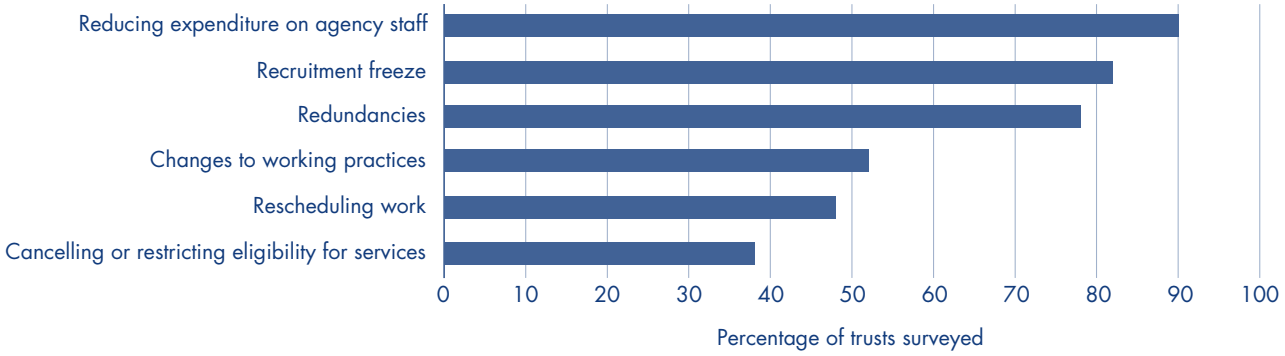
1.15 However the data available on patient safety incidents is a reflection of staff's willingness and ability to report. Agency staff, even if they were willing to report an incident, are not always aware of or do not always have access to trusts' incident reporting systems. Research from other high risk industries has found that people are more likely to make errors when they have received inadequate training, are working in unfamiliar and pressurised surroundings or when they are tired. Such circumstances are typical of the circumstances under which trusts may employ temporary staff.

Reductions in agency expenditure are being used to achieve financial balance but unless properly managed this could place additional pressure on permanent staff

1.16 Most of the trusts which faced financial difficulties during 2005-06 required a reduction in, or indeed an embargo on, using temporary, and in particular, agency staff. In January 2006 the NHS Confederation conducted a survey of 35 of the trusts predicting the largest deficits and found that 90 per cent of them were using reductions in expenditure on agency staff and that 82 per cent were using recruitment freezes as a means of tackling the issue.[19] Other methods are shown in **Figure 9 overleaf**. As at June 2006 the un-audited figure for the total NHS deficit for 2005-06 was £512 million.[20]

9 Reductions in expenditure on agency staff is the most common method used by trusts to tackle their deficits

The methods being used by the trusts surveyed by the NHS Confederation to tackle their deficits



Source: NHS Confederation

1.17 In March 2006, in response to severe financial pressures, some acute trusts announced that they were cutting jobs. The NHS Confederation, which represents over 90 per cent of NHS employers, stated that many of these job losses would be in relation to temporary nursing staff[21]. To be effective, cuts in staffing will need to be accompanied by changes in working practices to try and reduce the risk of permanent staff having to work additional hours. Otherwise this could lead to a rise in sickness absence and turnover.

1.18 This Part has demonstrated that overall NHS expenditure on temporary staff has remained relatively static, with the reductions in expenditure on agency nursing staff being offset by an increase in spending on less expensive bank nurses and NHS Professionals' nursing staff. It also shows that there is significant variation in the extent to which individual trusts use temporary nursing staff and that long term or high levels of use of temporary nursing staff, and in particular agency nursing staff, is costly and can result in lower patient satisfaction levels. In Parts 2 and 3 we consider in more detail how trusts might safely control their expenditure on temporary staff:

- Part 2 looks at how trusts manage their demand for temporary nursing staff; and
- Part 3 looks at the initiatives which the Department of Health, NHS trusts and other NHS bodies have taken to improve procurement and supply.

PART TWO
Improving understanding of demand

2.1 Whilst individual trusts collect information to varying degrees on reasons for requesting temporary nursing staff and on vacancy levels, sickness levels and activity levels, this is not often brought together in a systematic manner to consider the most appropriate way to staff wards. As a result there is little strategic planning and control of trusts' demand for temporary nursing staff.

2.2 Trusts' ability to plan strategically and work flexibly will become increasingly important as a result of new Government policies, such as Payment by Results and Commissioning a Patient-led NHS, which give patients more control over where they receive treatment. The January 2006 Out of Hospitals White Paper is also aimed at reducing the number of hospital admissions. These policies are likely to increase fluctuations in activity level together with associated trust funding. Trusts will need to ensure that they forecast their activity levels effectively throughout the year and consider the most appropriate way to staff their wards to meet demand. Staff flexibility will increasingly be important and trusts may consider that increasing their use of temporary nursing staff is the most efficient way of meeting fluctuating levels of demand. However, unless they anticipate demand and plan for it within their budgets then uncontrolled and costly use of temporary nursing staff may arise.

Trusts do not have robust methods for determining their establishments and often cannot differentiate between demand and need

2.3 Establishment levels determine the minimum numbers of staff needed to deliver safe and effective patient care. Setting the right establishment levels is an effective way for trusts to reduce their demand for temporary staff. The need for effective methods of setting establishment levels has been the subject of much debate over the last twenty years. In 1986 the Committee of Public Accounts reported that unsystematic approaches were leading to wide variation in nurse staffing levels and costs in apparently similar units. In response the Chairman of the then NHS Management Board promoted the use of standardised workforce planning systems in the regions.[22] Academic research commissioned into setting establishment levels at the time recommended a "bottom up" approach which supported the use of professional judgement in setting establishment levels.

2.4 A number of methodologies have been developed to set nurse staffing levels[23] but we found that the most common method used by trusts remains a bottom up approach, based on the professional judgement of nurses operating within budget constraints. It is very important that ward managers have appropriate training to undertake this work and make decisions based on relevant management information. This requires ward managers, finance manages and human resource managers to work together to allocate resources effectively. Information collected and held by wards, finance and human resources often differed in definition making effective decision making about resource allocation difficult, (one trust had reviewed the number of vacancies in its medical and surgical wards and found that the wards believed that there were 108 whole time equivalent vacancies whilst the finance department believed that there were 155).

2.5 Some parts of Australia and America, have in recent years adopted various "top down" approaches, which promote the use of standardised and mandatory nurse: patient ratios for different specialties[10]. These approaches have the advantage that they are transparent and can be used for setting minimum staffing levels. However, they can be seen as a blunt instrument which may fail to take account of the differences between wards and hospitals and changes in patient dependency.[10]

2.6 In the NHS in England, with the exception of certain specialties such as Intensive Care, Maternity and Paediatrics where there are recommended nurse: patient ratios or nurse:bed ratios, there is no common definition of minimum safe staffing levels. Without a clear understanding of the optimum, safe staffing levels for each ward it is difficult for trusts to differentiate between their demand and need for temporary nursing staff and to know whether and what grade of staff is needed to fill a temporary, or indeed permanent, vacancy. Our analysis of the Healthcare Commission's Acute Hospital Portfolio data showed that in some specialties there is wide variation in staff levels on similar wards **(see Figure 10)**.

10 In some specialties there is wide variation in the number of staff to beds

The whole time equivalent number of nursing staff which trusts judged that they needed to employ per bed in 2004-05

Specialty	Lower quartile	Average	Upper quartile
Coronary Care Unit	1.5	2.2	2.6
Cardiology	0.9	1.1	1.2
Ear, nose and throat	0.9	1.1	1.3
Care of older people	0.9	1.0	1.1
General medicine	0.9	1.0	1.1
General surgery	0.9	1.0	1.1
Gynaecology	0.9	1.0	1.1
High dependency unit	2.9	3.3	3.8
Intensive care unit	4.7	5.4	6.2
Medical admissions unit	1.1	1.3	1.5
Neurosurgery	1.2	1.4	1.6
Oncology	1.0	1.1	1.3
Paediatric medicine	1.1	1.5	1.6
Rehabilitation	0.9	1.1	1.2
Stroke unit	1.0	1.2	1.2
Surgical admissions unit	1.0	1.3	1.4
Trauma	0.9	1.1	1.2
Trauma and orthopaedics	0.9	1.0	1.1
Urology	0.9	1.0	1.1

Source: National Audit Office/Audit Commission analysis of Healthcare Commission data collected from 4600 wards in 173 trusts

The increase in nursing staff under the NHS Plan has not reduced the use of temporary nursing staff

2.7 In 2000 the NHS Plan identified that the NHS needed to recruit an additional 20,000 nurses by 2004 to meet its needs. Initially many trusts struggled to recruit permanent nursing staff into these posts and used temporary nursing staff as a means of compensating for their vacancies. However, the NHS has now significantly exceeded the NHS Plan target and between 2000 and 2005 the number of whole time equivalent nurses working in the NHS grew from 267,000 to 322,000, an increase of 55,000.[8] The growth in the nursing workforce was achieved by increasing the number of nurse training places, improving nurse retention rates, encouraging more nurses to return to practice and recruiting nurses from overseas. Over the period since the publication of the NHS Plan some 40 per cent of newly registered nurses have come from overseas, primarily from the Philippines, Australia, India and South Africa.[24]

2.8 In 2001 the Department stated that it anticipated that the increase in permanent nursing staff would lead to a reduction in the use of temporary staff[9] but it has subsequently said that it meant only agency nursing staff. As shown in Part 1, many trusts have continued to use temporary nursing staff. The Department believes that the use of temporary staff will continue to have an important role to play in helping trusts flex their workforce in response to initiatives such as Payment by Results[4] and Commissioning a Patient-Led NHS.

2.9 Some of the reasons for the continued reliance on temporary staff include:

- An increase in planned hospital admissions of 22 per cent between 1997 and 2004.[25]
- NHS initiatives, such as reducing the length of patient stay, mean that patients should only be in hospital when they are acutely ill, thereby increasing the demand for more nursing staff per bed.
- The increase in the number of nursing posts means that there is an increase in the amount of annual leave and other types of leave which need to be covered.
- The drive to improve recruitment and retention by giving staff the opportunity to work flexibly under "Improving Working Lives" has often meant that there are gaps in rotas which trusts cover using temporary staff.

2.10 Indeed, despite the increase in numbers of permanent staff, shortages are still a problem for many trusts. A survey undertaken by NHS Employers in October 2005 with responses from 157 trusts identified that 62 per cent of respondents found it hard to fill posts in nursing and midwifery which 12 per cent attributed to national shortages.[26] We found that 44 per cent of trusts reported that it took them on average longer than three months to fill vacancies in Operating Departments where there are national shortages, compared to only seven per cent reporting a similar time period for general medicine **(Figure 11 overleaf)**.

2.11 For many trusts, recruiting nursing staff into some permanent posts remains a significant problem and on a short term basis these trusts rarely have any option other than filling these shifts with agency staff, which can be very expensive. Some trusts, however, have taken action to reduce the hold over the market that these staff have enjoyed **(Case example 1 overleaf)**.

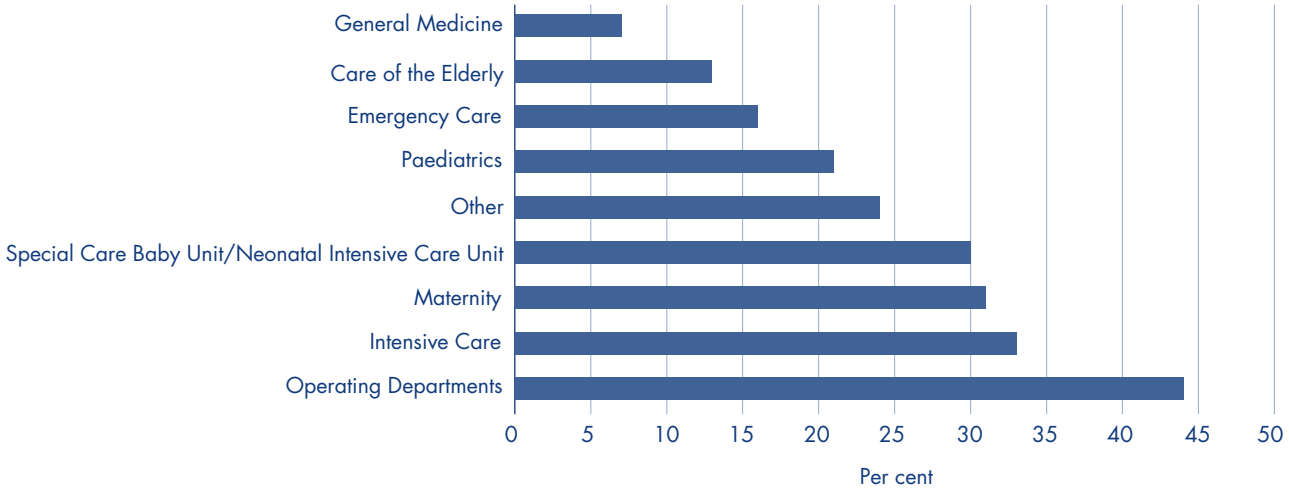
Poor management in some trusts has led to an excessive reliance on temporary staff

2.12 Ward managers have responsibility for managing the demand for temporary nursing staff on a day to day basis. Many ward managers use temporary staff as a means of flexing the workforce and choose to hold one or more vacancies so that they can afford to bring in temporary nursing staff as necessary. **Figure 12 on page 23** illustrates a good practice decision tree used by Guy's and St Thomas' NHS Foundation Trust to determine whether they need temporary staff. A more detailed generic decision tree is attached at Appendix 4.

2.13 Poor management practices on the ward can lead to an excessive reliance on temporary nursing staff. These include the inability to recruit and retain staff, poor rota management, a lack of control over sick leave and annual leave and ineffective use of flexible working. Our census of acute trusts identified that 37 per cent of temporary nursing shifts booked during 2004-05 related to covering vacancies, 25 per cent to staff sickness and 11 per cent to covering different types of leave **(Figure 13 on page 24)**.

11 Trusts are still experiencing difficulties recruiting into some specialties

The percentage of trusts who reported that it took them on average longer than three months to recruit nursing staff into specific specialties



Source: National Audit Office

CASE EXAMPLE 1

Reducing expenditure on specialist agency nursing staff at St Mary's NHS Trust

In April 2004 St Mary's NHS Trust in Paddington was spending £80,000 a month on agency nursing staff in its operating theatres and surgical wards. A new head of nursing was appointed in the surgical, cardiovascular sciences and critical care directorate who decided to address this issue and undertook a review of the rotas and employment positions of the nursing staff and Operating Department Practitioners working in the division. She found that several of the staff in the theatres were from nursing agencies but had been used on such a regular basis over a three year period that many permanent staff had not realised that they were not employed by the Trust. She also found that poor rota management resulted in many of the permanent nursing and Operating Department Practitioners choosing to work only weekday shifts. The Trust was therefore having to bring in agency nursing staff to cover the more expensive night and weekend shifts.

In order to address this issue the directorate undertook a recruitment drive to fill the vacant positions in the wards and theatres. At the same time they gave notice to the agency nursing and Operating Department Practitioners they used on a regular basis that they would no longer be employing them through the agency and that, if they wanted to work with the Trust on a regular basis, then they would need to apply for a substantive post or join NHS Professionals. The Trust had particular difficulty in filling vacancies for Operating Department Practitioners as there are national shortages of these staff. They therefore decided to offer training to registered nurses to fill these positions as anaesthetic nurses. They also introduced booking guidelines for NHS Professionals and agency nursing staff and strict rota management guidelines to ensure a fair distribution of less popular shifts. These combined actions have led to a reduction in agency nursing expenditure in the surgical division of around 60 per cent. The Trust now spends around £30,000 a month on agency nursing staff in the surgical division and made savings of around £500,000 in 2005.

12 Decision tree used by Guy's and St Thomas' NHS Foundation Trust to determine whether or not to procure temporary staff

1 Identify staff shortage

Staff shortage may be caused by:

- Maternity leave
- Staff vacancy (longer than a week)
- Sickness

↓

2 Immediate considerations (how urgent is the booking?)

- Can this shortage be accommodated within existing resources and skill mix?
- What is the anticipated workload for the period in question?
- How will the shortfall affect patient care/delivery?
- Can less important work be postponed until more staff become available?

↓

3 Explore all options

- If it is considered vital that an additional person is needed can they be sourced from within the organisation?
- Have you contacted all of your permanent staff to see if they can fill the shortage?
- Have you contacted your manager to inform them of your staff shortage allowing them to try and source from elsewhere within the Trust?

↓

4 If additional staff cannot be found through the above options

Proceed to request staff from the staff bank. The decision to request staff must be validated by a second person.

↓

5 Book temporary staff

Complete booking form including:

- Details of shift time and date;
- Name of person making booking and person validating booking;
- Location and contact number of ward/area;
- Professional/grade/experience required;
- Reason for booking request;
- Position management number.

Source: Guy's and St Thomas' NHS Foundation Trust

The most common reason given for booking temporary staff is staff vacancies

2.14 Thirty-seven per cent of reported bookings of temporary nursing staff in 2004-05 were to cover vacancies. Whilst the Department's published figures show that vacancies which trusts are actively trying to fill and which have existed for more than three months fell from 4.6 per cent in 2000 to 1.7 per cent in 2005 in acute, elderly and general nursing posts, research by the Healthcare Commission indicates that the full vacancy rate in trusts is significantly higher than this. However, this fall has not significantly impacted on trusts' demand for temporary nursing staff. This may be because trusts are holding vacancies which they are not actively trying to fill. For example, in 2004 between eight and nine per cent of hospital ward posts in trusts were unfilled.[12]

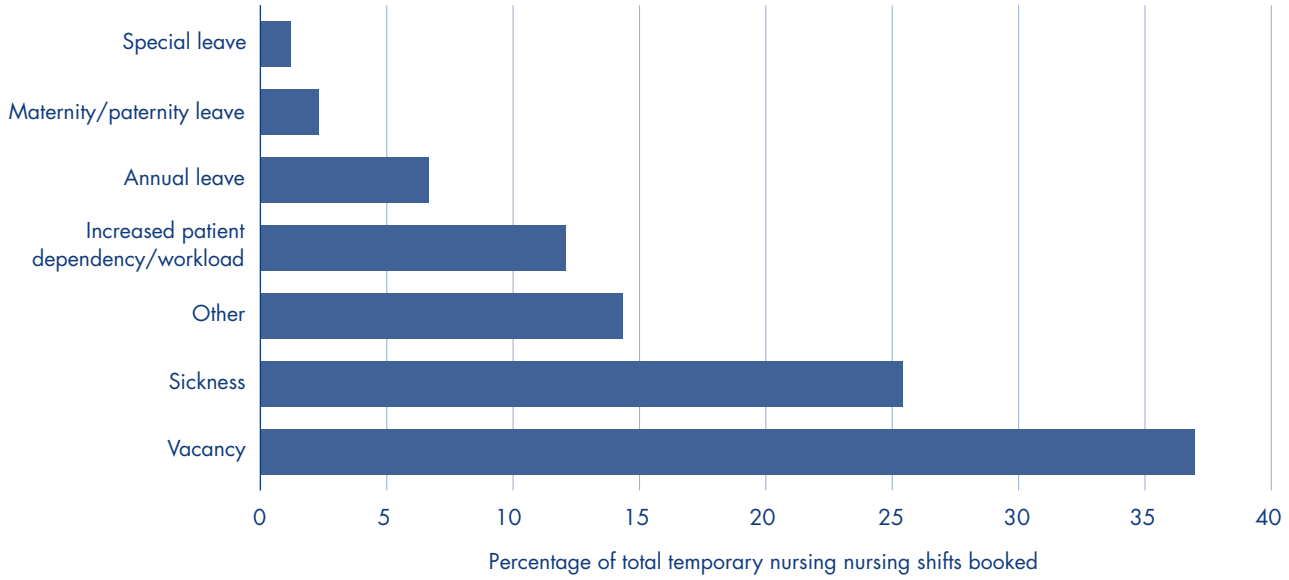
Temporary staff cover is often used to cover sick leave, annual leave and maternity leave

2.15 The second most widely reported reason for booking temporary nursing staff is to cover sickness absence. Within staffing budgets, trusts' plans generally allow around four per cent of the budget to cover sickness absence. However, the Healthcare Commission found that the average rate of sickness absence for nursing staff is 7.5 per cent (16.8 days per year) so ward managers often need to look outside their own permanent staff to cover sickness. The Healthcare Commission also found that average rates of sickness absence for nursing staff are higher than the average of five per cent for the rest of the public sector and estimated that £141 million could be saved by cutting sickness absence by 30 per cent.[12]

2.16 Trusts' understanding of how sickness absence impacts on their demand for temporary nursing staff requires them to collect and analyse detailed information on sick leave by grade and ward. Our analysis of Healthcare Commission data has shown that there is significant variation by grade in the percentage of time lost to sickness absence **(Figure 14 overleaf)**. This indicates that there is greater potential to reduce sickness absence in some grades of nursing staff and hence reduce expenditure on temporary nursing staff.

13 Temporary nursing staff are most commonly booked to cover vacancies

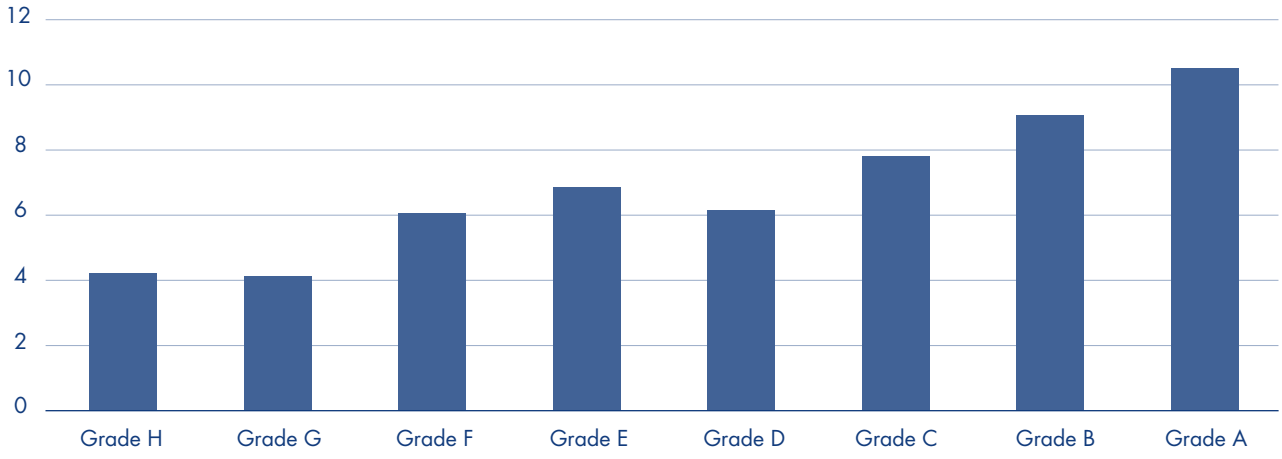
The percentage of total temporary nursing shifts booked by trusts during 2004-05 broken down by reason



Source: National Audit Office

14 There is wide variation in the percentage of time lost to sickness absence by grade of nursing staff

The percentage of time lost to sickness absence by nursing in trusts in England during one month in 2004



Source: National Audit Office/Audit Commission analysis of Healthcare Commission data

2.17 Poor management of annual leave budgets can also increase reliance on temporary nursing staff. Ten per cent of the nurse staffing budget is allowed for Annual Leave. Agenda for Change has increased the annual leave entitlement of many full time NHS nursing staff by up to five days (two per cent) but ward managers told us that this had not been reflected in their budgets. The additional cover required is likely to drive up the demand for temporary nursing staff.

2.18 Maternity leave causes particular problems for most trusts as the budget to cover maternity leave is often allocated equally across wards rather than being held centrally and allocated to wards as required. This leads to wards which have higher than average levels of maternity leave, increasing their reliance on temporary staff and exceeding their budgets.

The Improving Working Lives initiative has led to an increase in demand for temporary nursing staff

2.19 Nurses, like many other employees, want flexibility over their working hours in order to balance work with other responsibilities. If they are unable to obtain the flexibility they require in their permanent job they are more likely to work for a nursing bank, NHS Professionals or a nursing agency. The NHS Plan, which was launched by the Department in 2000, introduced an Improving Working Lives Standard.[27] One of the six key messages in the Standard was that NHS employers should accept joint responsibility with staff for developing a range of working arrangements that balance the needs of patients and services with the needs of staff.

2.20 The primary purpose of the Improving Working Lives initiative was to improve recruitment and retention in the NHS by giving staff more control over their working lives and many staff have benefited from this initiative. However, Improving Working Lives has caused difficulties for many ward managers who have found it hard to reconcile the demands for flexibility from their staff with the requirement to run a 24 hour, seven day a week, service. This is particularly difficult during school holidays where the expectations of staff to flex their working hours, means wards have to be run below permanent establishment levels for long periods of time. In some cases trusts have no option but to fill these shifts with temporary nursing staff.

2.21 The use of self rostering can also help individuals balance their work and caring responsibilities and help reduce unplanned absenteeism. We noted that self rostering worked best on wards where rules had been imposed to ensure that there was a fair allocation of unpopular shifts and that temporary nursing staff were only used on week day shifts (which are less expensive and where there will be more people around to supervise them). Only 27 per cent of the staff who responded to the Healthcare Commission's National Staff Survey said that their team made its own decisions about rotas.[28]

2.22 We estimate that trusts can make annual total savings of between £25 million and £50 million by improving their management of demand for temporary nursing staff. Further details of how these savings can be achieved are set out in Appendix 2 and in the good practice guide published in conjunction with this report.

PART THREE

Improving procurement and supply

3.1 In 2002 the Department published a *Code of Practice for the Supply of Temporary Staffing* which set out a framework for the management and performance of temporary staffing providers to ensure the delivery of high quality, affordable and safe care.[17] The code lays out the minimum standards required in the supply of temporary staff to the NHS and states that it expects all NHS employers to use the code when they employ temporary staff. All organisations supplying temporary staff to the NHS, including nursing agencies, nursing banks and NHS Professionals are supposed to abide by the code.

3.2 The Department, NHS trusts and other NHS bodies have undertaken a number of other initiatives to try and reduce the cost and improve the quality of temporary nursing staff. These include:

- Setting up framework agreements and associated Service Level Agreements for NHS trusts acting independently or as part of a consortium for purchasing agency nursing staff (paragraphs 3.8 – 3.13).
- Establishing an "in house" temporary staffing service, NHS Professionals (paragraphs 3.14 – 3.26).
- Improving controls around using temporary nursing staff within trusts' own banks (paragraphs 3.27– 3.34).

Whilst these initiatives have resulted in improvements as demonstrated in Part 1 there is more that still needs to be done. One key area is the need for trusts to have information to enable them to benchmark their performance and compare the relative costs of the different options for staffing the temporary vacancy.

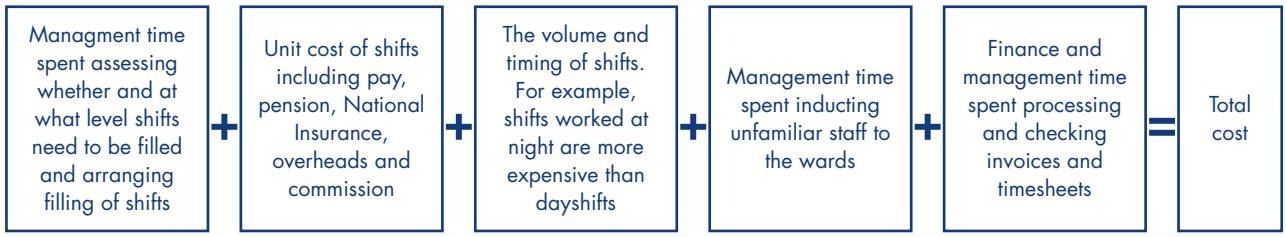
This Part explores our findings on the relative costs and examines the impact of the above initiatives in the light of these findings.

Trusts do not have the information they require to benchmark the cost of the different options for procuring temporary nursing staff

3.3 Trusts do not have the information they need to understand the relative costs of the different temporary staffing options or to benchmark these costs against costs in other trusts. Traditionally, bank and NHS Professionals staff have been paid in accordance with the national pay scales that apply to permanent staff but agency staff have not. Consequently pay rates can vary significantly. In 2004, NHS Professionals found that in London alone there were over 1,500 different classifications of role for NHS Professionals and agency nursing staff which could potentially all have been paid at slightly different rates. Furthermore, pay is only one of the costs of employing temporary nurses; others include pensions, National Insurance, commission rates for NHS Professionals and agencies and bank overheads for nursing banks **(Figure 15 overleaf)**. Few trusts have information on total costs when procuring temporary nursing staff.

3.4 In order to compare the relative costs of permanent, bank, agency and NHS Professionals nursing staff we analysed the rates that trusts told us they were paying Grade D nurses working in a General Medical ward on a weekday **(Figure 16 overleaf)**.

15 The total cost of using temporary nursing staff



16 Agency nursing get paid more per hour than other types of nursing staff

The average rates that trusts reported that they were paying to nursing staff working in General Medicine, Intensive Care and Maternity on week days during 2005 (£ per hour)

	Grade D General Medicine	Grade E Intensive Care	Grade E Maternity
Permanent	£9.84	£11.14	£11.53
Bank	£10.06	£12.26	£12.50
NHS Professionals	£11.32	£14.32	£13.07
Overtime	£14.15	£15.97	£16.51
Agency	£14.70	£20.92	£19.58

Source: National Audit Office

NOTE

These are the rates that trusts reported to us that they were paying staff but we know that some trusts have mistakenly included on-costs such as commission and national insurance and we have therefore adjusted for this fact in Figure 17.

3.5 We used data on pay from our survey to develop an illustrative example of the average relative costs of employing staff on a permanent and temporary basis in 2005 **(Figure 17)**. We have adjusted the data relating to NHS Professionals and agency nursing staff because we know that some trusts included on-costs such as National Insurance and commission in the rate that they reported to us. The analysis shows that, even when using the lower rate, it cost trusts on average around 29 per cent more to employ a D grade agency nurse than a D grade permanent nurse on a general medical ward during a week day. This differential is also likely to be higher if the agency was not on a framework agreement or if it related to a higher grade or specialist nurse.

3.6 Our analysis also shows that, in reality, on a £ per hour basis, employing bank and NHS Professionals nursing staff is actually cheaper than employing permanent nursing staff. This is because there are overhead costs such as sick leave, annual leave, training leave and training costs which are incurred in relation to permanent staff but not in relation to temporary staff. However, it would not be possible or advisable to try and staff wards exclusively with bank staff. This is because staff could not be trained and encouraged to take on the new roles and responsibilities necessary to deliver an effective service. In addition, apart from any impact on patient care, temporary staff employed routinely would by law become permanent staff and incur all of the same employment rights and costs as permanent staff.

17 On average agency nursing staff are the most expensive type of temporary staff

The average cost of employing a D grade nurse for one hour in a permanent post and through a nursing bank, through NHS Professionals and through a nursing agency in 2005

	Permanent £	Bank £	NHS Professionals £	Agency £
Pay rate per hour	9.84	10.06	10.04	13.23
European Working Time Regulation Payment at 8.33%	–	0.84	0.84	1.10
Total	9.84	10.90	10.88	14.33
Pay per week (based on 37.5 hour week)	**369.00**	**408.67**	**407.86**	**537.45**
Employer's National Insurance Contributions at 12.8% on earnings between £91 and £610 per week	35.58	40.66	40.56	57.15
Employer's pension contributions at 14% (40% coverage assumed for bank and NHS Professionals, 100% assumed for permanent)	51.66	22.89	22.84	0.00
Agency commission at 19.3% of basic pay plus VAT	0.00	0.00	0.00	121.88
NHS Professionals commission at 7.5% of pay, tax and pension	0.00	0.00	34.83	0.00
Bank overheads at 9% of pay, tax and pension	0.00	42.50	0.00	0.00
Overhead costs to cover annual leave, sick and study leave at 22%	100.37	0.00	0.00	0.00
Total	**556.62**	**514.72**	**506.61**	**716.48**
Cost per hour	**14.84**	**13.73**	**13.51**	**19.11**

Source: National Audit Office

NOTES

1 Some trusts included elements such as National Insurance and commission in the survey data they provided in relation to NHS Professionals and nursing agencies. We have adjusted for this by obtaining independent pay rate information from NHS Professionals and substituting this in the table and by reducing the reported agency rate in our cost comparison by 10 per cent from £14.70 to £13.23.

2 The average overhead cost of running a bank was reported by trusts to be four per cent. However our analysis showed that many trusts do not account for the full cost of running a bank (see paragraph 3.28). We therefore estimated a more realistic bank overhead rate of nine per cent based on the survey data and other independent sources of evidence.

3 NHS Professionals trusts are based primarily in London and the South East.

3.7 Since this data was collected a new pay structure, Agenda for Change, has been implemented which has changed pay rates for permanent and bank nursing staff. Some agency rates have also been renegotiated by the NHS Purchasing and Supply Agency and will consequently have reduced. Results across individual trusts are also likely to be different from the average calculation and trusts need to conduct similar analyses using their own up to date figures.

The NHS Purchasing and Supply Agency framework agreements have led to an improvement in the cost and quality of agency nursing staff

3.8 Since 2001, the NHS Purchasing and Supply Agency has been operating framework agreements through which NHS trusts can procure temporary nursing staff from nursing agencies. We used the results of our survey to compare the pay rates of those trusts which put more than 75 per cent of their agency nursing expenditure through the framework agreements with those that put less than 75 per cent through. The average pay rate for a D grade nurse on a general medical ward was £14.33 per hour for the first group and £17.05 for the second. This shows that the framework agreements have had a positive effect on lowering the price of agency nursing staff. The London Agency Project is the longest established of the framework agreements and has been the most successful in terms of controlling cost. Trusts reported that basic pay rates were six per cent lower and commission rates were 13 per cent lower in London than in the rest of the country.

3.9 The Department encourages all trusts to procure temporary staff from agencies which are on the framework agreements.[18] Approximately 83 per cent[29] of expenditure on nursing agencies by trusts went through the framework agreements but this varied from 93 per cent in the Eastern region to 67 per cent in the North West region **(Figure 18)**. Trusts told us that the main reason why they procure outside the framework agreements is because they cannot always obtain specialist or last minute nursing staff through the framework agencies.

3.10 The NHS can prevent wage inflation and influence the total cost of agency nursing staff by effectively using its position as a major buyer within the agency nursing market. Our analysis of the amounts paid to Grade D nurses through three of agencies who operated on all of the regional framework agreements in 2004-05 shows that even within the framework agreements trusts could be paying significantly different amounts for the same grade of nurse **(Figure 19)**.

18 There is wide regional variation in the percentage of expenditure going through framework agreements

The percentage of expenditure on nursing agencies going through the framework agreements in each region in 2004-05

Region	Percentage of agency expenditure going through the framework agreements
Eastern	93
London	92
Northern and Yorkshire	88
South Western	87
West Midlands	81
South Eastern	75
Trent and Leicestershire, Northamptonshire and Rutland	74
North Western	67

Source: National Audit Office

NOTE

This analysis has been carried out on 47 per cent of the population because information provided from the remainder of trusts was not presented in a form that could be used to undertake this calculation.

19 There remains significant variation in basic pay and commission rates within the framework agreements

The lowest and highest pay and commission rates paid by three agencies which operated across all regional framework agreements in relation to Grade D nurses in 2004-05

	Pay		Commission	
	Lowest £	Highest £	Lowest %	Highest %
Day	10.65	15.01	15	33
Night/Saturday	12.93	18.48	15	29
Sunday	15.75	21.66	16	33
Bank Holiday	21.99	31.96	16	33

Source: National Audit Office analysis of NHS Purchasing and Supply Agency data

3.11 In 2005 the NHS Purchasing and Supply Agency re-negotiated three of the eight regional contracts to introduce Agenda for Change job profiles and to reduce total agency cost, whilst also reducing the variation in rates for the same role. It plans to re-negotiate the remaining five contracts in 2006 and aims to make a saving of ten per cent of the total cost of employing agency nursing staff through the agreements. However, even after the renegotiation variation will remain and trusts can achieve control over their local temporary staffing market by only using agencies appointed to the agency framework agreements and by working collaboratively within local health economies to minimise competition for nursing staff between trusts.

3.12 All nursing agencies are regulated by the Commission for Social Care Inspection and must comply with the Department's Minimum Standards for Nursing Agencies. However, those agencies on the NHS Purchasing and Supply Agency framework agreements must also comply with the requirements of these agreements, which are more detailed than the National Minimum Standards.

3.13 The majority of trusts rely on nursing agencies to carry out recruitment checks on nursing staff and to provide training and performance assessment. They also rely on the NHS Purchasing and Supply Agency to audit the nursing agencies and ensure that they are fulfilling their responsibilities under the agreements. However, only 54 per cent of agencies were audited by the Purchasing and Supply Agency in the period between April 2004 and May 2006. This comprised 70 per cent of agency bookings by expenditure. There was also significant regional variation. For example 100 per cent of the agencies on the London agreement had been audited compared with only 18 per cent of those on the North West agreement **(Figure 20 overleaf)**. This is because the NHS Purchasing and Supply Agency prioritised the audit of agencies in the London and Southern region as part of the process of renegotiating the framework agreements.

NHS Professionals was established to reduce the cost and improve the quality of using temporary staff

3.14 The Department set up NHS Professionals in 2001 in an attempt to address growing concerns about the cost and quality of temporary staff. The intention was that NHS Professionals would set the standards to which locally run temporary nursing banks within trusts ought to work towards and be accredited against. The initiative was intended to build on existing temporary staffing arrangements rather than supplant them. The Department's intention was that by April 2003, all trusts would be operating NHS Professionals accredited temporary staffing services.[9]

3.15 Four main trusts hosted the NHS Professionals service and there was significant variation between them in terms both of activity and performance. By 2003 one of the host trusts, the West Yorkshire Metropolitan Ambulance Service, had an operating deficit of £10 million and some trusts had expressed a high level of dissatisfaction with its service, particularly in relation to fill rates. In response to concerns over these financial difficulties, the District Auditor issued a Public Interest Report which concluded that the original vision had not been supported by a robust business plan to ensure that the roll out met the intended objectives.[15]

3.16 In order to tackle the variability in activity and performance the Department announced that NHS Professionals would be given a stronger management structure and from January 2004, established it as a Special Health Authority. It became operational in April 2004, with Parliamentary funding of £32 million for 2004-05 (£18 million to cover temporary nursing staff) and a further £23 million for 2005-06. Its remit is:

- the operation of the NHS Professionals Service in partnership with the local NHS;
- the implementation of the agency framework agreements on behalf of trusts;
- the setting of standards and the policy framework for NHS temporary staffing; and
- the strategic oversight of temporary labour markets.

20 There is significant regional variation in the percentage of agencies that the NHS Purchasing and Supply Agency has audited on each framework agreement

Audits completed on agencies on the NHS Purchasing and Supply Agency regional framework agreements between April 2004 and May 2006

Regional Framework Agreement	Number of agencies on agreement as at 31 December 2005	Number of agencies audited between 1 April 2004 and 31 March 2006	Percentage of agencies audited
London	43	43	100
Southern[1]	41	38	93
South West	32	21	66
West Midlands	40	25	63
Trent and Leicestershire, Nottinghamshire and Rutland	52	15	29
Northern and Yorkshire	53	11	21
North West	33	6	18
Total	**294**	**159**	**54**

Source: National Audit Office

NOTE

1 The South East and Eastern framework agreements have been merged into the Southern agreement.

The operational management of the NHS Professionals Service

3.17 The aim of NHS Professionals is to be the first choice temporary staffing provider to the NHS by 2008. However, trusts can choose whether or not to use NHS Professionals to manage their temporary nursing service and in 2004-05 it was operating in 22 per cent of acute trusts, employing over 50,000 nurses and accounting for £130 million of trusts' expenditure on temporary nursing staff. By 2006 NHS Professionals' penetration of the acute trust market had increased to 27 per cent. The main reasons why trusts had chosen not to use NHS Professionals were because they believed that their own local arrangements were adequate and that the costs, including the loss of control, outweighed the potential benefits.

3.18 Trust banks provide services of variable content and quality. The services which NHS Professionals provides to trusts are similar to those provided by a trust nursing bank but are intended to be of a consistently high quality across all trusts. NHS Professionals also intends to achieve efficiency gains through economies of scale and the use of up to date information technology to support its shift filling operations. Further intended benefits are that, by providing nursing staff with the opportunity to work flexibly under NHS pay and conditions, NHS Professionals will improve recruitment and retention rates across NHS trusts and that the implementation of NHS Professionals in individual trusts will lead to a reduction in expenditure on agency nursing staff. **Case study 2** demonstrates the benefits experienced by one trust which used NHS Professionals.

3.19 When NHS Professionals became a Special Health Authority it inherited a collection of regional operations which were disjointed and of variable quality. In the period since April 2004 it has brought together these operations into a national structure and has invested in staff and technology to improve the efficiency and effectiveness of its performance. Some of these changes are still in the process of being implemented and there has not yet been sufficient time to assess their full effect. However, it has the potential to yield future benefits in terms of both the cost and quality of temporary nursing staff.

CASE STUDY 2

Using NHS Professionals to manage demand for temporary staff

The **Royal Berkshire NHS Foundation Trust,** one of the largest acute trusts in England, has been working with NHS Professionals to manage its temporary nursing staff since April 2004. The Trust looks to NHS Professionals to provide a good quality, well trained temporary workforce to cover annual leave and sickness and to provide cover in times of high demand such as during winter pressures.

During 2005-06 the Trust was concerned about the level of requests it was receiving for temporary staff. From September 2005 it introduced a new web-based internal control system for booking all temporary staff. This included the requirement for pre-authorisation codes to enable better financial control and management of working patterns. It also set all wards a weekly budget for temporary staff. Ward managers could only make bookings in excess of this budget with authorisation from a senior manager. The Trust worked with NHS Professionals to ensure both organisations' processes worked smoothly together.

Through working with NHS Professionals and introducing the new control system the Trust's demand for temporary staff dropped substantially from 3,300 shift requests in December 2004 to 2,200 in November 2005. Over the same time period NHS Professionals improved the number of shifts it was able to fill both with its own staff and in total. In December 2004 NHS Professionals filled 88 per cent of shifts requests with its own staff, 1 per cent with agency staff and 12 per cent of shifts went unfilled. The comparable figures in November 2005 were 93 per cent, 2 per cent with 5 per cent of shift requests going unfilled. Overall the weekly cost to the Trust has reduced by approximately 50 per cent and these improvements have been maintained.

The Trust now uses the management information produced by its own system and NHS Professionals on reasons for booking to make the best use of its permanent staff and better understand its requirements for temporary staff.

3.20 In examining the impact that NHS Professionals has had on costs we found that between 2003-04 and 2004-05 there was little difference between the performance of NHS Professionals and non NHS Professionals trusts in terms of reducing expenditure on agency staff: both reduced agency expenditure by around 25 per cent. There was also little difference in terms of reduction in expenditure on temporary staff overall.

3.21 Trusts and nursing agencies have reported a number of perceived problems in the operation of NHS Professionals, including a lack of effective communication between NHS Professionals, trusts and nursing agencies which, in some instances, has resulted in shifts going unfilled or in more than one nurse turning up for the same shift. In our survey, five out of the 36 trusts using NHS Professionals expressed concern that they are often unable to fill short notice requests for staff or requests for more specialist nursing staff such as Intensive Care nurses or Operating Department Practitioners.

3.22 In order to make the temporary staffing market more transparent and competitive, NHS Professionals has introduced a new pay system for its staff from spring 2006. The new system incorporates a national clinical coding system based upon Agenda for Change bands. The system is intended to bring about a more consistent definition of clinical roles for all shifts placed through the NHS Professionals service, whether through agencies or NHS Professionals itself. It also significantly reduces the number of different rates at which NHS Professionals nursing staff can be paid. Trusts using the NHS Professionals service will be able to access the rates of all other trusts using the service and can make decisions about pay which are informed by the rates paid by other trusts. Nursing staff will also be able to compare the rates paid by different trusts which use NHS Professionals for the same role.

NHS Professionals is also responsible for ensuring that trusts in which it operates only use agencies on framework agreements

3.23 Part of NHS Professionals' remit is to implement the NHS Purchasing and Supply Agency framework agreements with nursing agencies by ensuring that all bookings for nursing staff which they are unable to fill with NHS Professionals nurses, are filled with nurses from agencies on the framework agreements. The results of our survey showed that in 2004-05 trusts who use NHS Professionals did not place a greater amount of agency bookings through framework agreements than trusts which did not use NHS Professionals: both placed around 80 per cent through the agreements on average. Compliance has improved since 2004-05 and in April 2006 trusts using NHS Professionals put 97 per cent of their bookings through agencies on the framework agreements.

NHS Professionals has developed a clinical governance strategy to ensure its staff provide safe high quality care

3.24 NHS Professionals has published a clinical governance strategy that seeks to promote a consistent high standard of care and protect patients from outdated practices and poor practitioners. They are implementing this strategy in the trusts to which they supply temporary nursing staff but also intend to influence the provision of temporary nursing staff across the whole NHS by acting as a benchmark against which internally run banks can measure themselves. The strategy includes the introduction of a complaints and incidents management system which will allow detailed monitoring and analysis of complaints and should increase trusts' understanding of the clinical risks they face when using temporary nursing staff.

3.25 When a complaint is made against a temporary nurse, there is a danger that the ward manager or trust simply refuses to use that nurse again and the complaint will not be followed up. The nurse may then be employed at another trust without the issue which caused the complaint being addressed. NHS Professionals seek to avoid this by ensuring that all complaints are investigated thoroughly and, where a complaint is serious, ensuring that the nurse is not employed at any trust in which they manage the temporary staffing service. They believe that this approach has contributed to a drastic reduction in reported serious incidents within trusts using the NHS Professionals service **(Figure 21)**.

There is a tension between the two objectives that the Departments' Arm's Length Bodies Review has set for NHS Professionals

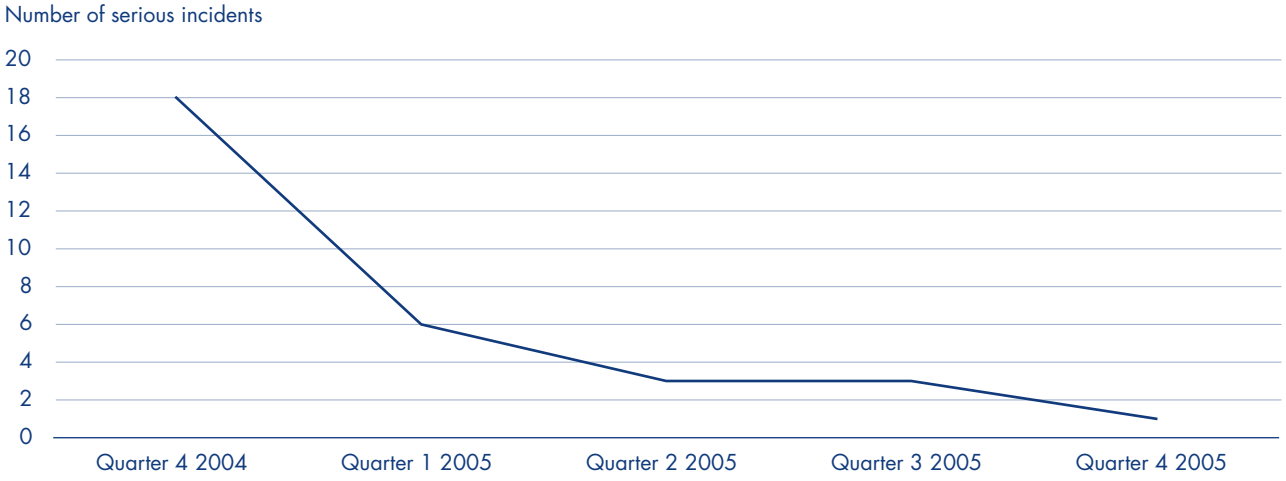
3.26 Under the Arm's Length Bodies Review published in July 2004 it was announced that NHS Professionals should move out of the Arm's Length Body sector after two to three years. It was also noted that NHS Professionals was expected to become self-financing by 2007-08.[16] In order to become self financing NHS Professionals will need to significantly increase the number of shifts that it is commissioned to fill. There is therefore a potential tension between NHS Professionals' role to make the temporary staffing market more cost effective through strategic management and potentially reducing use of temporary nursing staff, and its financial requirement to break even. Although the strategic work around clinical governance and clinical coding which NHS Professionals is undertaking could potentially be beneficial for all trusts, after 2007-08 NHS Professionals will only receive income through the commission charged to trusts that use their temporary staffing placement service.

Most trusts now operate a single nursing bank and have introduced controls to reduce costs and improve the quality of bank nursing staff but risks remain

3.27 *Brief Encounters* reported that half of trusts had more than one nursing bank and lacked common standards, policies and practices and that that this led to higher costs and greater reliance on agency staff.[3] Many trusts have now centralised their nursing banks and the average number of nursing banks being run by trusts not using NHS Professionals in 2004-05 was 1.46 in comparison to 2.15 in 1999-00. There is however potential to improve the efficiency with which nursing banks are run. Only 70 per cent of trusts reported that they used a bank management software package and none of the nursing bank systems that we saw were integrated with rostering, timesheet, payroll or accounts payable systems. This reliance on inefficient paper based systems reduces control over the process and leads to high back office costs.

3.28 The resources devoted to running the nursing bank varies significantly between trusts. Running costs of banks as a percentage of expenditure on bank nursing staff varied widely from one per cent to 14 per cent. The reported average cost was four per cent but the vast majority of trusts did not provide complete information about the total cost of running their bank and therefore this figure is understated. Some of the variation in the cost of running the nursing banks relates to the range of services provided by the nursing bank. For example, around a quarter of nursing banks do not account for the cost of processing timesheets or provide a payroll function. Even well resourced banks do not provide all of the services provided by NHS Professionals. For example, NHS Professionals checks and processes agency invoices on behalf of trusts. The variation also relates to the extent to which trusts are prepared to invest resources into managing risk.

21 Incidents entered on NHS Professionals' serious incident register between October 2004 and December 2005



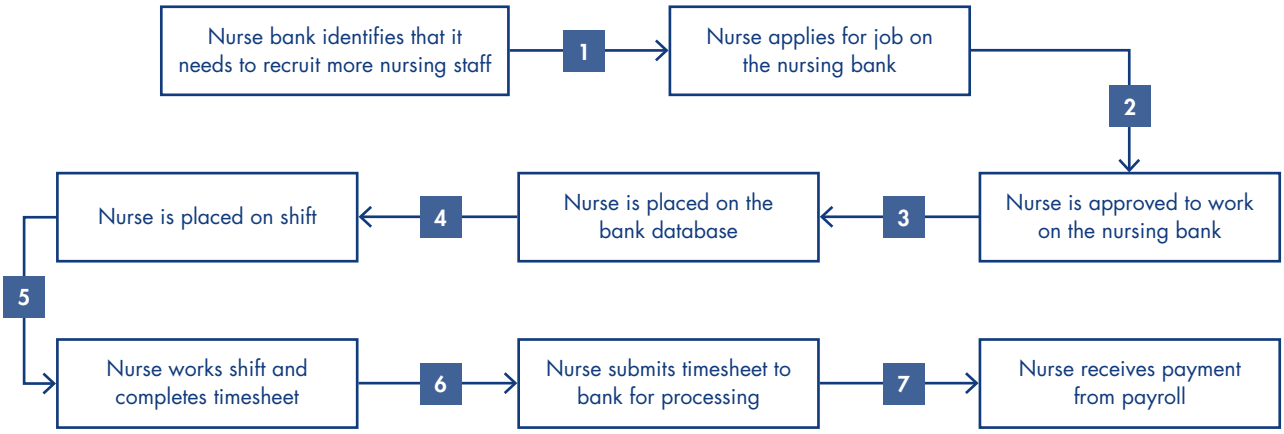
Source: NHS Professionals

3.29 There are several risks inherent in using bank nursing staff and some trusts have more highly developed systems in place than others to manage those risks. **Figure 22 overleaf** sets out the key risks associated with using bank nursing staff and the controls that effectively organised nursing banks have in place to manage those risks. The risks that we found that had not been fully addressed by one or more of the twelve trusts that we visited during the study related to the processing of timesheets, the induction and performance monitoring of nursing staff, and the monitoring of the number of hours worked by nursing staff.

3.30 During our visit to NHS trusts we found that some timesheets were poorly designed and that very few nursing staff crossed through hours on the timesheet which they did not work. This would potentially allow nursing staff to add hours on to their timesheets after they had been authorised by ward managers. In 2003-04 the Counter Fraud and Security Management Service ran an exercise during which they reviewed the nurse banks of 128 NHS bodies for system weaknesses. They found that many timesheets had not been designed with fraud prevention or investigation in mind. As a result they have designed a "fraud proofed" timesheet with attached guidance on how this should be completed. This timesheet has already been adopted by NHS Professionals. All other NHS bodies and external nursing agencies who supply the NHS through the NHS Purchasing and Supply Agency framework agreements are being encouraged to adopt this timesheet as standard.

3.31 Insufficient induction to the ward can place patients and nursing staff at risk. Many ward managers told us that they did not have the time to conduct in depth induction to the wards for temporary nursing staff and, that this would only be worthwhile if the member of nursing staff returned repeatedly to the ward. Some had tried to overcome this difficulty by designing written induction sheets or induction checklists. Some also allowed bank Healthcare Assistants and equivalents new to the ward a couple of shifts in which they "shadowed" other members of staff before being expected to work autonomously. Registered nurses were expected to be able to work autonomously and without supervision but in reality many ward managers felt that they had to spend part of their time supervising unfamiliar nurses which diverted them away from their own responsibilities.

22 The risks of running a nursing bank and the associated controls



	Risk	Controls used by trusts to mitigate risks
1	The nursing bank is unable to recruit sufficient nursing staff on to the bank. Consequently the proportion of shifts filled is low and there is a risk that many shifts will need to be filled with agency staff or go unfilled.	Co-ordinated recruitment activity including: ■ holding stands at local events ■ periodically holding stands within the trust ■ poster campaigns ■ encouraging nursing staff considering returning to work through the bank ■ encouraging suitably qualified nursing staff who cannot currently obtain a permanent post in the trust to work through the bank.
2	The nursing bank recruits an incompetent, unqualified or unsuitable member of staff.	A thorough recruitment screening process including: ■ an application form ■ an interview ■ written references from two previous employers ■ checks upon professional qualifications ■ Criminals Records Bureau checks ■ Occupational Health checks
3	Nurse is unaware of hospital policy and has not received up to date training.	Nursing staff new to the bank receive an induction to the bank and, if necessary, any updates to mandatory training and an induction to the trust.
4	Nurse is placed inappropriately in an area in which she does not have the necessary skills, experience or qualifications.	The nursing bank computer system can note the areas in which nursing staff have specific skills and experience and will only place them in these areas.
5	Nurse is unaware of the policies and emergency procedures on the ward.	Nursing staff are given a full induction to the ward including a checklist against which they can tick and sign to show that all necessary equipment and procedures have been identified and explained to them. Healthcare assistants and equivalents spend one or two shifts "shadowing" staff on the ward.
6	Nurse completes timesheet incorrectly either erroneously or fraudulently.	Nursing bank uses the Counter Fraud and Security Management Service's "fraud proofed" timesheet. Ward manager checks the timesheet before signing it off.
7	Nursing bank pays nurse incorrectly.	Payroll checks that the signatory on the timesheet is on the authorised signatory list before paying the nursing staff.

Source: National Audit Office

3.32 The absence of regular performance assessment and mandatory training poses a risk to patients. The Department's *Code of Practice for the Supply of Temporary Staffing*, by which all providers of temporary nursing staff to the NHS are supposed to abide, states that providers should ensure that a personal development plan is in place between the member of temporary staff and the provider and that they should meet regularly to discuss the staff member's work and any issues arising. Our survey identified that many of the nursing staff on the nurse banks had not received up to date mandatory training and that the majority did not have performance appraisal or a personal development plan. This was also true of a significant minority of permanent members of nursing staff **(see Figure 23)**. NHS Professionals nursing staff have mandatory training but do not have performance appraisals. There is therefore a risk that the development needs of bank nursing staff and NHS Professionals nursing staff will not be identified and addressed.

3.33 None of the trusts we visited had robust systems for monitoring the number of hours being worked by nursing staff across different trusts. Under the European Working Time Directive nursing staff are only allowed to work 48 hours per week. Although 88 per cent of trusts were able to monitor the number of hours that nursing staff worked for them permanently and on their bank, none were able to monitor the additional hours worked by nursing staff on the banks of other trusts or through nursing agencies. This is because data protection legislation prevents trusts from sharing information on nurses' working hours.

3.34 We estimate that trusts can make annual total savings of between £13 million and £38 million by improving their procurement of temporary nursing staff. Further details of how these savings can be achieved are set out in Appendix 2 and in the good practice guide published in conjunction with this report.

23 Less than 70 per cent of bank nurses received all of their mandatory training

The percentage of substantive and bank nurses who had received a performance assessment and mandatory training in the twelve months prior to September 2005

	Permanent %	Bank %
Performance appraisal	69	22
Personal development plan	67	18
Assessment of training needs	71	43
Moving and handling training	64	64
Basic life support training	70	61
Infection control training	69	59
Fire training	67	66

Source: National Audit Office

APPENDIX ONE

Methodology

1 We designed this study to assess whether the NHS is using its temporary nursing staff in the most economic and effective manner. We used the following to methods to address this issue.

A census of all NHS acute trusts (Foundation and non-Foundation)

2 We contracted York Health Economics Consortium to carry out a census of all acute trusts (Foundation and non-Foundation) and analyse the data collected. The report is published on the National Audit Office website at www.nao.org.uk. The data forms the basis for the majority of the quantitative analysis in this report. We received responses from 169 of the 173 trusts to which we sent the survey. We have extrapolated expenditure figures in the report to cover the remaining trusts.

Case study visits to twelve NHS acute trusts (Foundation and non-Foundation)

3 We visited twelve trusts in order to undertake detailed case studies of their use of temporary nursing staff. At each trust we spoke to a variety of staff including the Chief Executive, the Director of Nursing, ward managers, finance managers, human resources managers and bank, NHS Professionals and agency nursing staff. The trusts that we visited were:

- East Sussex Hospitals NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Guy's and St Thomas' NHS Foundation Trust
- North Cheshire Hospitals NHS Trust
- Oxford Radcliffe Hospitals NHS Trust
- Portsmouth Hospitals NHS Trust
- South Tyneside NHS Foundation Trust
- St Mary's NHS Trust, Paddington
- University Hospitals of Coventry and Warwickshire NHS Trust
- University Hospitals of Leicester NHS Trust
- West Dorset General Hospitals NHS Trust
- Winchester and Eastleigh Healthcare NHS Trust

We are extremely grateful to all of the staff that we met for the support that they gave to us during our visits.

Meetings with key stakeholders

4 We consulted a variety of external stakeholders during the study to gain a range of perspectives on the issues which we examined. Stakeholders included the Royal Colleges, relevant NHS bodies and nursing agencies.

Focus group meetings with ward managers

5 We hold two focus groups with 25 ward managers from a range of trusts across England in order to fully understand the issues which they face when trying to manage their use of temporary nursing staff.

A web-based survey of nursing agencies

6 We posted a survey on our internet site and invited nursing agencies registered with the Recruitment and Employment Confederation and the Nurses Agencies Association to provide us with their views on the use of temporary nursing staff within the NHS.

Data analysis

7 We carried out analysis of data provided from NHS trusts, the Healthcare Commission, the NHS Purchasing and Supply Agency, NHS Professionals and the National Patient Safety Agency.

Literature review

8 We reviewed existing literature and research from a variety of sources including academic journals and official Department of Health and other publications.

Gaining expert input

9 We contracted Professor James Buchan from Queen Margaret University College, Edinburgh and Nick Mapstone and Michael Yeats from the Audit Commission to provide expert input into the study. All three carried out case study visits to NHS trusts and assisted with the preparation of the draft report. Nick Mapstone and Michael Yeats prepared a draft of the Good Practice Guide on behalf of the National Audit Office.

10 We engaged an expert panel to provide advice to us during the study process. The expert panel consisted of the following people:

- Neil Callow (University Hospitals of Leicester NHS Trust)
- Chris Day (NHS Professionals)
- Carmel Flatley (NHS Professionals)
- Laurence Gilks (North East London Strategic Health Authority)
- Brenda Hibell (NHS Purchasing and Supply Agency)
- Maggie Maxwell (Oxford Radcliffe Hospitals NHS Trust)
- Sandra Meadows (National Patient Safety Agency)
- Debbie Mellor (Department of Health)
- David Moss (Department of Health)
- Gerry O'Dwyer (Royal College of Nursing)
- Alison O'Rourke (South West London Strategic Health Authority)
- Sue Osborn (National Patient Safety Agency)
- Alan Pilgrim (Match Group)
- Marcia Roberts (Recruitment and Employment Confederation)
- Steven Rubel (Nurses Agencies Association)
- Ian Seccombe (Healthcare Commission)
- Sarah Thewlis (Nursing and Midwifery Council)
- Ursula Ward (Portsmouth Hospitals University Trust)
- Mike Wright (Bromley Hospitals NHS Trust)

We are very grateful to everybody on the panel for giving up their time to assist with the study.

APPENDIX TWO

Financial impacts

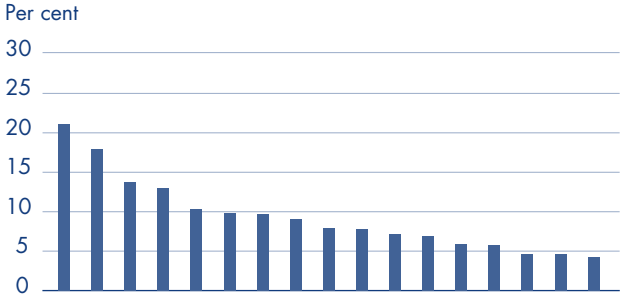
1 It is at this stage difficult to predict the effect of recent policy developments within the NHS on trusts' future use of temporary nursing staff. Trusts may choose to increase their reliance on temporary staff as a mechanism for dealing with fluctuations in activity levels and funding. Irrespective of whether reliance on temporary nursing staff increases trusts can make savings by better management of their whole nursing workforce and by improving procurement of temporary staff. We estimate that annual savings of between £38 million and £83 million could be made across the NHS in England with little or no investment from trusts. On a long term basis further savings could be achieved through the introduction of electronic rostering; however this would incur development costs.

Action	Lower limit	Upper limit
Better management of demand for all nursing staff, for example through: ■ Benchmarking of nurse staffing levels; ■ Improvements in rostering; ■ Managing flexible contracts to meet service requirements as well as the needs of staff; ■ Better planning for the use of temporary and permanent nursing staff.	At current activity levels a reduction of 0.3 per cent of expenditure on total nursing staff in England would result in savings of £25 million.	At current activity levels a reduction of 0.6 per cent of expenditure on total nursing staff in England would result in savings of £50 million.
A reduction in the rates charged by nursing agencies through more effective leverage of national volumes and ensuring that all agency expenditure goes through framework agreements. This would result in more transparency in the agency nursing market and discount structure.	A reduction of £1 per hour on 50 per cent of expenditure on agency nursing would result in savings of £6 million.	A reduction of £2 per hour on 75 per cent of expenditure on agency nursing would result in savings of £19 million.
Converting agency expenditure to bank/NHS Professionals expenditure.	Converting 10 per cent would results in savings of £7 million.	Converting 20 per cent would result in savings of £14 million.
Total estimated savings	**£38 million**	**£83 million**

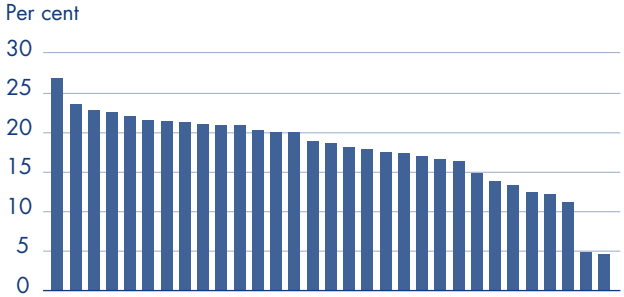
APPENDIX THREE

Expenditure on temporary nursing as a percentage of total nursing expenditure

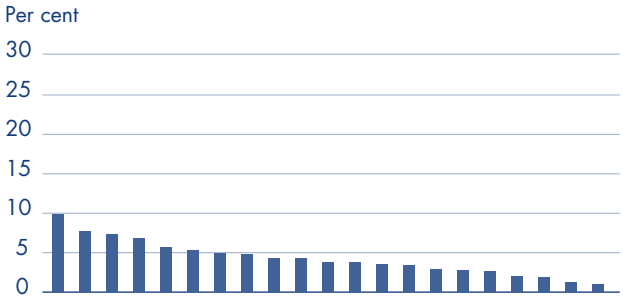
Trusts in the Eastern region



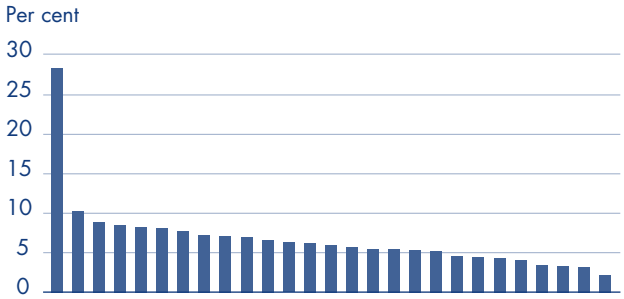
Trusts in the London region



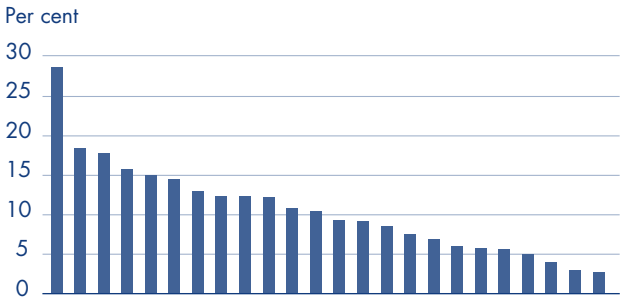
Trusts in the Northern and Yorkshire region



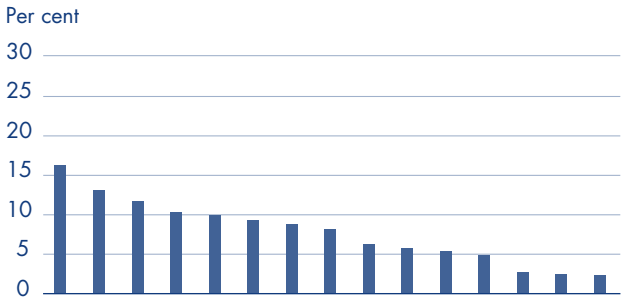
Trusts in the North West region



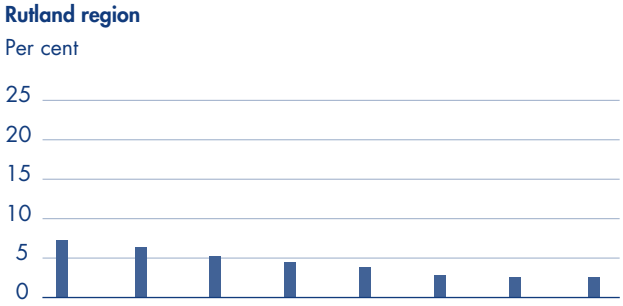
Trusts in the South East region



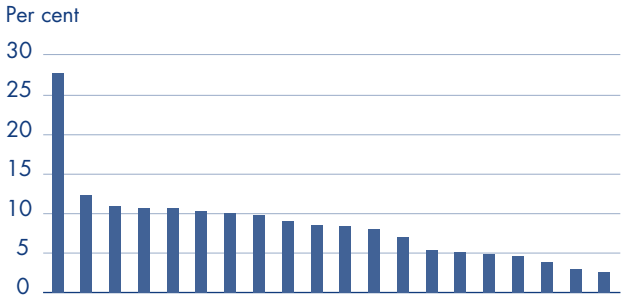
Trusts in the South West region



Trusts in the Trent, Leicestershire, Northhamptonshire and Rutland region

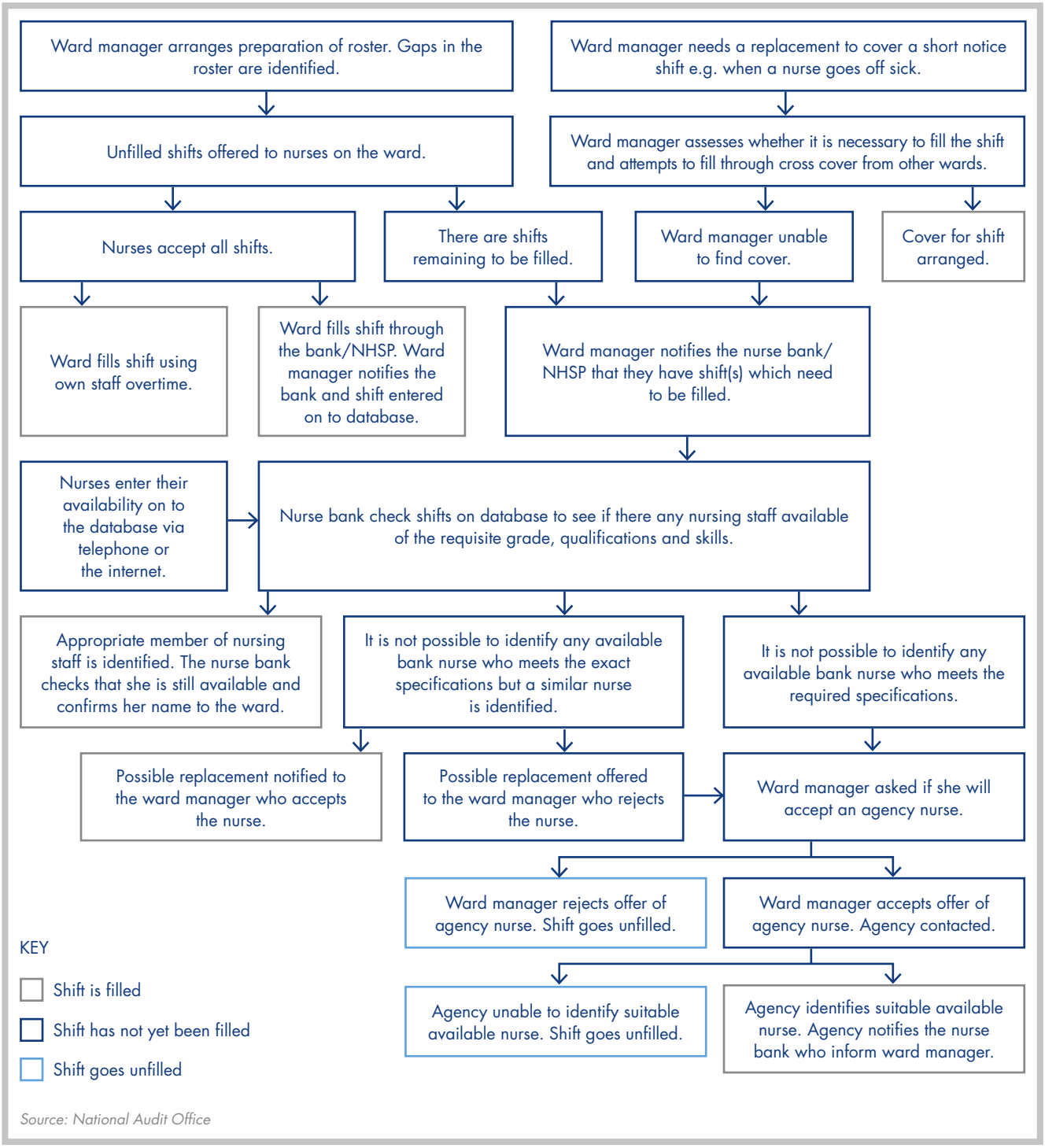


Trusts in the West Midlands region



APPENDIX FOUR

The temporary nursing "decision tree"



Source: National Audit Office

APPENDIX FIVE

Summary of progress since Brief Encounters

In September 2001 the Audit Commission produced a report on temporary nursing which highlighted the growing expenditure on temporary staffing. They concluded that whilst temporary staffing have a role to play in covering for staffing shortfalls their use can sometimes undermine the quality of patient care and showed that unnecessary costs were being incurred. They made several recommendations to hospital trusts and the government on how efficiency and effectiveness could be improved.

1 At the time of the report the NHS expenditure on agency staff in all trusts in England and Wales had grown to £370 million and bank staff to £440 million and represented approximately 10 per cent of nursing expenditure.

In 2004-05: expenditure on temporary staffing as a percentage of total nursing expenditure has only reduced by 0.6 percentage points to 9.4 per cent. However trusts have significantly reduced their expenditure on agency nursing staff from 7 per cent of the nursing paybill in 2001-02 to 3 per cent in 2004-05.

2 The report showed that the use of temporary staff can undermine quality and pre-employment checks were not always completed; induction was inadequate; and clinical training was limited.

In 2004-05: quality has improved although trusts need to develop further training and induction for temporary staff. The framework agreements, NHS Professionals' protocols and the Department of Health Code of Practice all incorporate quality standards for pre-employment checks, induction and training.

3 Unnecessary costs were being incurred and the report highlighted that some trusts paid higher commission rates to agencies than others and that trusts could contract with these agencies more effectively. It showed that trusts could do more to prevent fraud as they were failing to make basic checks on timesheets.

In 2004-05: the Department has used the NHS Purchasing and Supply Agency to develop framework agreements with the agencies. Progress has been made in reducing agency costs and expenditure but more could be done by some trusts to fully comply with the framework agreements. There has been little progress in implementing measures to prevent timesheet fraud and trusts often rely on paper based systems.

4 The report showed trusts could improve efficiency by centrally coordinating staff cover, eliminating unnecessary bookings and investing in electronic systems for planning staff rotas.

In 2004-05: trusts have made very little progress in reducing demand for temporary nursing staff through better management and coordination. Trusts often do not have the information to manage demand. We also found that few trusts used staffing pools or have invested in electronic systems to help better plan staff rotas.

5 The report highlighted that the Department had set up NHS Professionals to reduce dependency on commercial agencies, improve quality and risk management, and provide safe and well-trained staff. It also suggested that for NHS Professionals to be successful it must aid trusts to reduced demand for cover.

In 2004-05: NHS Professionals has helped reduce agency expenditure although our survey showed that trusts using NHS Professionals are likely to use similar amounts of staff from agencies to those who have their own nursing banks. NHS Professionals has helped improve quality and training in the trusts which use its services.

APPENDIX SIX

Glossary

Acute Hospital Portfolio	A collection of acute care topics which are used by the Healthcare Commission to measure trust performance. It includes indicators of quality of care, efficiency and effectiveness.
Acute Trust	An NHS trust which provides secondary or hospital based health care services. An acute trust can cover one or more hospitals.
Agency framework agreements	Regional agreements, negotiated by the NHS Purchasing and Supply Agency, through which NHS trusts can procure agency nursing staff which meet agreed cost and quality standards.
Annualised hours contract	A contract under which staff are contracted to work for a specified number of hours during the year but the dates when the hours are worked can be agreed between the employer and the member of staff.
Arm's Length Body Review	A review by the Department of Health of the work undertaken by the stand alone national organisations it sponsors to undertake its executive functions, carried out in 2004.
Brief Encounters	A report written published by the Audit Commission in 2001 that examined the use of temporary nursing staff in England and Wales.
Commission for Social Care Inspectorate	A Non-Departmental Public Body which inspects and reports on social care services in England including independent nursing agencies.
Commissioning a Patient-Led NHS	A policy document published in July 2005 by the Department of Health which focuses on how the Department of Health will develop commissioning throughout the whole NHS system.
Committee of Public Accounts	A Parliamentary Select Committee which examines the economy, efficiency and effectiveness with which government bodies use funds voted to them by Parliament.
Counter Fraud and Security Management Service	An independent division of the NHS Business Services Authority with responsibility for all policy and operational matters in relation to the prevention, detection and investigation of fraud and corruption and the management of security in the National Health Service.
European Working Time Directive	A directive from the Council of the European Union which lays down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers.
Foundation Trust	A new type of NHS body which was created under the Health and Social Care (Community Health and Standards) Act 2003 with the purpose of devolving decision making away from central government to local organisations and communities. Foundation Trusts have greater management and financial freedoms to retain surpluses and invest in delivery of new services than other NHS trusts.

Gershon Efficiency Review	A review carried out by Sir Peter Gershon in 2004, at the request of the Prime Minister and the Chancellor, which concluded that the public sector could achieve annual efficiency gains of £20 billion by 2007-08.
Healthcare Commission	A Non-Departmental Public Body which reports directly to Parliament on the state of healthcare in England and Wales.
Improving Working Lives	The Improving Working Lives Standard provides a model of good human resources practice against which NHS employers and their staff can measure the organisation's human resources management and against which NHS employers are kite-marked.
Mandatory Training	Training which registered nurses should receive annually in subjects such as moving and handling, basic life support, infection control and fire training.
Monitor	The Independent Regulator of NHS Foundation Trusts responsible for authorising, monitoring and regulating NHS Foundation Trusts. It is independent of the Department of Health and accountable to Parliament.
National Patient Safety Agency	A Special Health Authority created to improve patient safety by reducing the risk of harm through error.
NHS Employers	Part of the NHS Confederation with specific responsibility for representing the views of NHS employers in England on workforce matters to the Department of Health.
NHS Litigation Authority	A Special Health Authority which administers schemes under Section 21 of the *National Health Service and Community Act 1990*. This enables the Secretary of State to help NHS bodies pool the costs of any "loss or of damage to property and liabilities of third parties for loss, damage or injury arising out of the carrying out of [their] functions".
NHS Professionals	A Special Health Authority which acts as the NHS "in house" flexible staffing service and sets the standards and policy framework for temporary staffing within the NHS.
NHS Purchasing and Supply Agency	An executive agency of the Department of Health which acts as the centre of advice and expertise on matters of purchasing and supply and negotiates contracts for goods and services on behalf of the NHS.
Nurse bank	A reserve of nursing staff within a trust (or trusts) which is used to supplement staff employed on the ward as needed.
Nursing agency	A private company which supplies nursing staff to trusts as needed.
Nursing staff	A registered nurse, registered midwife, operating department practitioner, operating department assistant or healthcare assistant or equivalent.
Payment by results	A financial framework in which providers are paid according to the level of activity undertaken. Payment is based upon a national tariff system.
Temporary nursing staff	A member of nursing staff supplied by either a nursing bank, NHS Professionals or a nursing agency.
Zero hours contract	A contract under which a member of staff is employed by the trust but the number of hours to be worked is not specified. The timing and duration of the hours worked can be decided at the convenience of the trust and the individual.

END NOTES

1 For the purposes of this report "nursing staff" includes Registered Nurses, Registered Midwives, Operating Department Practitioners, Operating Department Assistants, Healthcare Assistants, Nursing Assistants and Nursing Auxiliaries.

2 These results have been extrapolated to take account of the six per cent of trusts who did not provide complete information on expenditure. The figure of £790 million does not include the £32 million subsidy which NHS Professionals received from the Department of Health in 2004-05.

3 *Brief Encounters*, Audit Commission, September 2001.

4 *A National Framework to Support Local Workforce Strategy Development*, Department of Health, December 2005.

5 http://www.nhsemployers.org/workforce/workforce-1024.cfm

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7 Refers to expenditure on temporary nursing staff in all trusts in England and Wales.

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18 Department of Health press release, *Drive to reduce spending on agency staff*, 19 May 2005.

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25 John Reid, Parliamentary Questions, 24 March 2004.

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29 These results are based on the returns of the 47 per cent of trusts which provided data in a form which made it possible to conduct this analysis.

REPORTS BY THE COMPTROLLER AND AUDITOR GENERAL, SESSION 2005-2006

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