Research – supplement

July 2016

Staffing matters; funding counts – Pressure point: Temporary staff

Can the NHS make more effective use of temporary staff?

The Health Foundation

About this supplement

This supplement is produced to accompany the report *Staffing matters; funding counts: Workforce profile and trends in the English NHS.*

During the research to inform the report, six particular pressure points were identified for the workforce of the NHS in England. The pressure points were chosen based on feedback from a stakeholder roundtable, held in October 2015, and analysis of recent policy reports.

The pressure points are:

- the proposed changes to nurse bursaries
- international recruitment to fill vacancies
- the recruitment and retention of GPs
- the potential of physician associates
- the potential of nursing associates
- the use of temporary and agency workers.

These pressure points need to be addressed if the health service is to have access to the staff it needs to deliver high quality care.

In addition to the discussion in *Staffing matters; funding counts*, more detailed information and analysis about each of these pressure points is available as part of a series of supplements, from www.health.org.uk/publication/staffing-matters-funding-counts.

Please note: While the focus of this supplement is on England, some of the national/international data sets are at UK level. Where UK data is reported, it should be remembered that the NHS in England is by far the largest component, employing approximately four in every five NHS staff in the UK.

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Can the NHS make more effective use of temporary staff?

Temporary staff: The issue

Over the last two years, NHS trusts in England have responded to workforce supply shortages by hiring agency workers, which in turn has driven up agency costs. In 2014/15 NHS providers spent £3.3bn on temporary staff. This accounted for 7% of the total staff bill, up from 3.4% in 2011/12. Of this total, NHS Improvement estimated that around £0.7bn was the premium paid for agency staff, while it reported that demand for agency nurses had been a major cause of the overall growth in expenditure on temporary staff.[1]

Monitor stressed in 2015 that 'Such growth is unsustainable, and has contributed to a growing provider deficit, which reached £930m in the first quarter of 2015/16'.[2] Monitor and the Trust Development Authority therefore recommended that price caps be applied to agency and bank staff rates. A range of measures were introduced subsequently in the English NHS in late 2015 to contain the use of temporary staff. An annual ceiling was set for total agency spend for each trust between 2015/16 and 2018/19; mandatory use of frameworks for procuring agency staff was introduced, and limits were set on the amount individual agency staff can be paid per shift.[3]

The National Audit Office (NAO) noted that its analysis suggested that spending on agency nurses tripled in the two years to 2014/15, compared with an 11% increase in spending on bank nurses.[4]

A report in March 2016 highlighted that, because of pressing staffing concerns, acute trusts in England had overridden the price caps for agency nurses more than 60,000 times since they were introduced at the end of 2015.[5]

While there is a place in NHS staffing policy for temporary staff, notably in providing short-term cover, recent trends of growth and subsequent policy responses require examination.

Temporary staff: The evidence

The key issue identified in *Staffing matters; funding counts*[*] is that health workforce policy must consider both staffing and funding if it is to be successful. The problem with recent use of temporary staff in the NHS is that the funding–staffing balance has not been maintained. A shortfall in permanent staffing drove up the use of temporary staff, which pushed up staffing costs, which in turn triggered the cost-containment capping policy. Currently the primary policy driver in relation to the use of temporary staff is cost, with insufficient scope for local employers to respond flexibly to staffing variations. Monitor has highlighted that increased use of temporary staff in the NHS in England reflected a 'fundamental mismatch between demand for clinical staff and supply'.[2]

[*] See www.health.org.uk/publication/staffing-matters-funding-counts.

In 2014/15, some 61% of the shifts requested from NHS Professionals were reported, by trusts, as being to cover unfilled substantive vacancies. Temporary staff are also used to cover sickness absence (which accounted for 12% of requests) or as a result of poor rostering of existing staff.[4]

One issue to clarify is what type of temporary staff are being deployed, as well as how they are deployed. This will in large part determine the cost and effectiveness of deployment. For example, Audit Scotland estimated recently that using external agency nursing staff costs the NHS in Scotland almost three times more than using internal NHS bank staff.[6] In addition, deployment of staff who are already familiar with the care environment is likely to reduce patient safety risks.

While there will be a need to monitor the hours worked by individual staff, there is a clear benefit for the NHS organisation if it can resource more of its temporary staffing requirement internally, or share with other local employers in an in-house bank, rather than on a shift-by-shift basis using external agencies. Local protocols for dealing with short-term absence and cover for workload peaks should favour internal temporary resourcing over external agency use.

The varying use of temporary staff is in part a reflection of varying workload levels; the extent to which workload and workflow can be predicted varies in different work areas of the health sector, but often the current approach is rudimentary. This means that temporary staff use is often last minute and reactive, and that overall staffing decisions at local level, including when to use temporary staff, are poorly informed. The Carter review on productivity in NHS England stated: 'We were struck by the immaturity of trusts' use of such technology from e-Rostering systems'[7] and concluded that more effective use of e-rostering would reduce dependency on bank and agency staff and it could improve predictability and consistency of deployment for staff even where recruitment is a challenge. The Carter review recommended that all NHS trusts use an e-rostering system and implement an effective approval process by publishing rosters six weeks in advance and reviewing them against trust key performance indicators, such as proportion of staff on leave, training and appropriate use of contracted hours.[7]

As with many other current national health workforce issues, we have been here before. In response to rising costs and a NHS efficiency review in 2005, the Department of Health highlighted it intended reducing demand for temporary staff, as one of the methods to be used to achieve efficiency gains. It stated that it believed replacing temporary staff with experienced permanent staff led to increased productivity and better patient care. In 2006, the NAO analysed temporary nursing staff, and made recommendations on improved use – which also focused on the need to develop more effective protocols, combined with better understanding of workload and workflow variations.[8] Similar findings, and recommendations, had been made even earlier by the Audit Commission in 1991[9] and elsewhere in the UK, by Audit Scotland[10] and the Audit Commission Office in Wales[11] in respect of the use of locum doctors.

The NHS in Scotland has recently established a central 'managed staffing network' team to work with NHS employers to develop a clearer understanding of their temporary staffing requirements, backed up by best practice guidance and support tools to manage bank and agency spend, and workforce planning. Key elements of the new initiative include:

- additional resources to develop local strategies and interventions aimed at system improvements for the use of temporary agency workers[12]
- a nationally coordinated programme for the effective management of temporary medical staffing appointments
- national coordination of staff banks to facilitate the movement of temporary workers between different NHS employers
- a dedicated team to work at national and local levels to integrate with other programmes relating to workforce management and e-rostering.

The NHS Scotland initiative is a response to a critical analysis by Audit Scotland which noted that 'Using temporary staff provides short-term flexibility to workforce plans but it does not address the underlying problems of recruitment and retention, skill shortages and sickness absence'. Following its aforementioned estimate that using agency nursing and midwifery staff costs the NHS almost three times more than using NHS bank staff, Audit Scotland recommended that a national approach to managing current and future workforce pressures was needed.[6]

Temporary staff: Conclusions

The effective use of temporary staff can increase the responsiveness of NHS organisations to changes in workflow, can allow them to meet unpredicted 'peaks' in workload, and can provide cover for unanticipated short-term absence of staff. In short, it can support flexibility in staffing.

But shorter-term staffing flexibility can become a longer-term cost driver when temporary staff are used inappropriately, or long term, to cover for unfilled permanent staff posts.

To achieve a sustainable balance between the competing pressures of staffing flexibility, safe staffing levels and cost-containment, two different priorities need to be met.

- Firstly, local flexibility must be supported. While the costs of temporary staffing should be contained by the use of appropriate protocols for requesting temporary staff cover, supported by procurement frameworks, there should also be scope for individual NHS employers to respond flexibly and rapidly to changes in workflow and patient dependency levels. An arbitrary top-down national cap on costs risks undermining this flexibility.
- Secondly, temporary staffing use needs to be effectively integrated into day-to-day workload assessment and staff rostering, and monitored in the context of longer-term workforce planning. Focusing only on containing the costs of temporary staff, rather than addressing the underlying reasons for their use, is unlikely to be a sustainable approach.

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