brief encounters
getting the best from temporary nursing staff
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Bank and Agency Nursing

Bank and agency nursing staff make an enormous contribution to patient care in the NHS, enabling trusts to maintain service delivery by covering for staffing shortfalls and fluctuating workloads. But there are concerns about the effects on patient care and rapidly rising costs.

Assuring the Quality of Care

Trusts need to improve the pre-employment checks, induction, monitoring and performance review of bank staff, and help them to maintain and develop their skills. And they need to assure themselves that agency nursing staff meet the same standards.

Keeping Costs Under Control

Trusts could reduce their expenditure on agency staff through improved contracting and by working in partnership. They also need better internal controls to prevent payment error and fraud.

Managing Demand and Improving Efficiency

Trusts should take action to stop any unnecessary use of bank and agency staff and to minimise the time clinicians spend arranging cover. This means having effective management controls and a modern temporary staffing service that makes best use of information technology.

The Way Forward

NHS Professionals is a new national initiative that could transform the ways in which temporary staffing cover is arranged. To be successful, it needs to address the demand for cover as well as improving the supply.
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Preface

Two years ago the Audit Commission published *Cover Story* (Ref.1), its report on the use of locum doctors in NHS trusts. And last year, Audit Scotland reported on the management of temporary nursing staff by the NHS in Scotland (Ref. 2). *Brief Encounters* continues this work by investigating the costs associated with the use of temporary – or bank and agency – nursing staff by NHS trusts and their effect on the quality of patient care. It shows how trusts can minimise the risks that arise, by reducing demand and improving management arrangements.

Like locum doctors, bank and agency nurses,¹ nursing auxiliaries and healthcare assistants make an enormous and valuable contribution to patient care in the NHS, enabling acute and other trusts to maintain service delivery and ensure continuity of patient care by covering for staffing shortfalls and fluctuating workloads. At its best, such employment can help meet the needs of nurses and others for greater flexibility and control over their working hours and times. But the way cover is arranged can sometimes undermine the quality of patient care. There is also a need to manage rising costs. In 1999/2000, the NHS in England and Wales spent at least £368 million on agency nursing staff – a third more than they spent in the previous year – and a further £440 million on bank nursing staff.

Until now there has been little management information about the use and costs of bank and agency nursing. To help fill this information gap, the Audit Commission’s review included a detailed survey of all hospital and community health trusts in England and Wales. This survey is described in Appendix 1 together with other sources of evidence used. Appendix 2 lists the NHS trusts and other organisations visited by the Commission’s study team.

This report provides advice to trusts about managing bank and agency nursing staff better. Sometimes this means finding ways of doing things more efficiently and more economically, freeing resources that may be used elsewhere in the service. But it also means contributing to improvements in the quality of patient care, by reducing the risks inherent in over-reliance on temporary cover. During this and the next audit year, many trusts will be working with their external auditors, using information from the national survey to benchmark where they stand in relation to these issues and making local recommendations on how they can improve quality and minimise costs.

¹ The term ‘nurse’ is used as shorthand in this report for registered nurses, midwives and health visitors.
One factor that affects the demand for bank and agency staff is the effectiveness with which permanent staff are utilised. The Audit Commission has recently conducted an exercise to collect data on ward staffing costs, the utilisation of permanent staff and the outcomes of care, as part of its Acute Hospitals Portfolio. A short review of the national findings will be published in the autumn.

This report was written by Dr Ian Seccombe with support from Karen Naya, Adrian Rowles, Julie Eacott and Gabrielle Smith (RN). Megan Goodall (RN) from District Audit prepared the accompanying audit guide. The study team benefited enormously from the co-operation of staff in the NHS trusts and nursing agencies that we visited. We are particularly grateful to all the bank co-ordinators, nurses, nursing auxiliaries and healthcare assistants who gave up their time to complete questionnaires or to take part in interviews. An advisory group (Appendix 3) of practitioners, managers and other interested parties provided further assistance and insight. They, and a wide range of others, provided helpful comments on an earlier draft of the report. The Audit Commission is grateful to them all. As always, however, responsibility for the contents and conclusions rests solely with the Audit Commission.
Bank and Agency Nursing

Bank and agency nurses, nursing auxiliaries and healthcare assistants make an enormous contribution to patient care in the NHS, enabling trusts to maintain service delivery by covering for staffing shortfalls and fluctuating workloads. On a typical day, there are about 20,000 nursing staff providing cover across England and Wales, at a cost approaching £810 million a year. In view of the fast rising cost, it is crucial that they are used appropriately. More importantly, it is vital that the quality of care they provide matches the standards achieved by permanent staff.
Trusts need a minimum level of staffing to ensure that patient care can be provided safely and effectively. But shortfalls do arise, sometimes unexpectedly, when posts are vacant, when permanent staff are off sick or on leave, when there is a peak in demand or when clinical services have to be expanded at short notice (for example, in the winter). Managers may then have to arrange for staff to stay on duty at the end of their shift, or for others to come in and provide temporary cover, often at short notice. These staff are usually from an in-house reserve (commonly known as ‘bank’ staff) or from a commercial agency (‘agency’ staff). Bank and agency staff are an important part of the nursing workforce and they deliver a significant amount of patient care. Recent Audit Commission reports have touched on their use in critical care units (Ref. 3) and in community nursing (Ref. 4). This report looks at bank and agency nursing staff right across the NHS.

The nursing workforce is at the core of healthcare provision in England and Wales. It is central to plans for modernisation of the service. But it is acknowledged that the supply of skilled and experienced staff fails to meet current demands and that new vacancies are created as a result of additional investment. The shortfall of registered nursing staff is estimated (in England) at about 10,000. Irrespective of the actual number, a shortage of qualified staff threatens to undermine the effective delivery of healthcare and plans for expansion. There are significant programmes in place to tackle the shortfall by increasing the numbers of training places, by encouraging more nurses to return to the NHS, by recruiting from abroad and by improving retention. These programmes will all take time to meet their objectives.

In the short term, NHS trusts have increasingly turned to temporary nursing staff to help fill the gap. On a typical day, there are about 20,000 nurses, midwives and healthcare assistants providing bank and agency cover in NHS trusts across England and Wales. This currently costs nearly £810 million a year – about 10 per cent of the nursing paybill – and these costs are rising. Temporary nursing also has significant indirect costs when, for example, substantive staff are taken away from patient care duties to arrange cover or to supervise temporary staff. In view of the costs, it is crucial that bank and agency cover is used appropriately. More importantly, it is vital that the quality of care provided matches the best standards achieved by permanent staff.

Temporary nursing cover may be required for a variety of reasons [Exhibit 1], but vacancies and sickness absence account for nearly two-thirds of shifts booked. Cover for shifts can be provided in several different ways. Staff may stay on at the end of their normal shift, taking time off in lieu or receiving payment for their extra hours; or they may be part of a nursing ‘pool’, deployed to work wherever there is a shortfall. But most staff work additional shifts by registering with an in-house trust bank or with an agency.

What is bank and agency nursing?
Bank and agency nursing are established and growing features of staffing provision in the NHS. The NHS nursing workforce has grown over the past five years, but there has also been sustained growth in the number of shifts worked by bank staff. An independent survey of 135 trusts in January 1999 (Ref. 5) reported that the use of bank nurses had increased significantly in most places. The NHS in England used approximately 9,560 whole time equivalent (wte) registered bank nurses in the seven days up to and including 30 September 2000.\(^2\) This was double the number of registered bank nurses used over the same period in 1990 [EXHIBIT 2, overleaf].

The overall numbers of bank and agency nurses\(^3\) are not known with any certainty. Part of the problem is that one in four agency nurses is registered with at least two agencies. And one in six has an NHS job (either a substantive or bank post), undertaking agency work during their time off to earn extra money. Equally, most (six out of ten) bank nurses also have full- or part-time contracts in substantive NHS posts. Reasonable estimates are that about 185,000 nursing staff in England, and roughly 8,350 in Wales, are on NHS banks and that there are about 46,500 registered with agencies.\(^4\)

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**EXHIBIT 1**

Reasons for booking bank and agency nursing cover

Vacancies and sickness absence account for two-thirds of shifts booked.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacancies</td>
<td>37%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
<tr>
<td>Maternity leave</td>
<td>3%</td>
</tr>
<tr>
<td>Study leave</td>
<td>4%</td>
</tr>
<tr>
<td>Peak in workload</td>
<td>10%</td>
</tr>
<tr>
<td>Annual leave</td>
<td>10%</td>
</tr>
<tr>
<td>Sick leave</td>
<td>28%</td>
</tr>
</tbody>
</table>

Note: ‘Other’ includes patient escorts, ‘specialling’ patients and other leave.

Source: Audit Commission survey of bank and agency cover (N=828 bookings)
EXHIBIT 2

Bank nursing, midwifery and health visiting staff in England at 30 September, 1990-2000

The numbers (wte) of bank nurses working doubled between September 1990 and 2000.

Note: Comparable figures for Wales are not available. Figures are for registered nursing staff only.

Source: Department of Health, Non-medical workforce census (annual)

Who are bank and agency nurses?

7. Bank and agency nursing staff are a disparate population. They provide cover at all levels (registered nurses, midwives and health visitors as well as nursing auxiliaries and healthcare assistants) in all specialties and they include students as well as the recently retired. There are at least three types of bank and agency nursing staff [BOX A].

8. Although their demographic characteristics are similar, each of these groups has its own rationale for working in these particular ways. Some are between permanent jobs, trying to keep in touch while on a career break or using it as a stepping stone back to permanent employment; others are seeking to earn additional income. Many want flexibility at work to fit in with their family circumstances. Indeed, in response to the Audit Commission’s surveys, more than four out of ten agency nurses and almost half of all ‘bank-only’ nurses gave flexible hours as their main reason for working in this way. Many trusts are offering greater contract flexibility, working hours and times, to enable staff to combine nursing with other responsibilities (Ref. 6). Few staff have taken up these options compared with the numbers seeking flexibility through bank and agency work.
Nurses’ agencies have been in existence since before the NHS was formed. At the end of December 2000, approximately 845 offices were licensed to operate in England and 38 in Wales. These offices represent between 450 and 500 individual agencies, the 10 largest of which probably account for 40 per cent or more of the market. The main trends in the sector, which are reinforced by current NHS strategies, are for consolidation (as the main operators expand through acquisition) and specialisation.

In England and Wales agencies are currently regulated by the Nurses Agencies Act 1957. This requires each agency to obtain an annual operating licence for each of their offices from the relevant local licensing authority. But inspection is said to be variable in extent and rigour. Where local authorities are proactive, sanctions may be ineffective, and do not necessarily deter agencies from simply shifting operations to a new location. Although the Royal College of Nursing (RCN) has produced useful good practice guidance (Ref. 7), there are no nationally agreed standards for inspection in place.

For simplicity they are referred to as ‘bank-only’ staff in this report.
11. Through the Care Standards Act 2000 the Government has taken action to safeguard the welfare of patients and to promote the employment rights of agency nurses by repealing the Nurses Agencies Act 1957 and removing their exemption from the Employment Agencies Act 1973. From April 2002 nurses agencies will have to be registered with the National Care Standards Commission and to meet the standards (currently the subject of consultation) set down by it.

12. Many agencies already operate to very high standards. The creation of a national register and the enforcement of national standards should ensure that those that do not, either improve rapidly or cease to operate. But, given that there are current legislative arrangements for inspection that do not always work well, it is crucial that the new process is rigorous and consistent nationally. Otherwise NHS trusts cannot assure, as they must under the clinical governance framework, that they are safeguarding patients.

Quality of care

13. The majority of bank nursing staff have substantive contracts in NHS posts, work bank shifts largely in their own area and provide care to a consistent standard. Many agency nursing staff also regularly work in the same wards and units. But when bank and agency staff are asked to work in an unfamiliar area, or only work on an occasional basis, it can be more difficult for them to provide the same standards of care, and the continuity of care for individual patients may be interrupted.

14. The circumstances under which bank and agency staff are sometimes appointed and have to carry out their duties may be less than ideal. Inevitably, bookings for temporary cover are often made at short notice. One in four bank and agency nurses had 24 hours notice or less before working their most recent shift. And they are often employed to provide cover at weekends and at night when direct supervision is less likely to be available. As a result, induction and handover may be non-existent, or inadequate, and nurses may have little time to get accustomed to the workings of the trust. They may be unfamiliar with the patients under their care, with local procedures, practices and equipment, with their surroundings and their colleagues. All these factors, combined with generally poorer attendance at mandatory and clinical practice training, increase the chances of patients receiving care of a poorer quality than they would otherwise get.
EXHIBIT 3
When bank and agency nursing cover is provided
Bank and agency nurses are often deployed at weekends and at night.

BOX B
A link between agency staffing and violence on psychiatric wards?
A study of a 12-bed high-dependency acute ward in a psychiatric unit attached to a general hospital in London suggested that there was an increase in violent behaviour among patients when there were more agency staff on duty. During the 15-month study, the proportion of permanent staff was halved and the number of shifts worked by agency staff trebled. The researchers identified a positive correlation between the number of violent incidents and the number of shifts worked by temporary staff. They suggested that temporary staff may adopt a more custodial, and less therapeutic, role with the patients because of unfamiliarity with the ward, variable amounts of training and limited knowledge of the patients. They observed that there was a noticeable decline in the provision of activities for the patients. This was attributed to the absence of sufficient permanent staff to encourage and organise such events. The lack of familiarity that temporary staff had with the ward and its procedures, their uncertainty and their poor co-ordination in dealings with patients and other staff, were seen as contributing to the rise in violent behaviour.

Source: British Journal of Psychiatry (Ref. 8)

Shift types
- Early – typically 7am-3pm
- Late – typically 2pm-10pm
- Night – typically 9pm-8am

Source: Audit Commission surveys of bank and agency nurses (N=3,614)
NHS trusts in England and Wales spent about £18.9 billion on pay in 1999/2000. Roughly 4 per cent (£743 million) of this expenditure is on non-NHS staff, over half of which is on agency nursing staff. NHS expenditure on agency nursing staff has risen fast in recent years—much faster than, for example, that on locum doctors (EXHIBIT 4) and increased by 32 per cent (to £360 million in England and £8 million in Wales) in 1999/2000 (see Appendix 4). Eight out of ten trusts spent more on agency nursing staff last year than they did in the year before.

Three out of four trusts also increased their expenditure on cover by bank staff in 1999/2000. Figures on bank staff expenditure are not collected centrally, but evidence from the Commission’s survey of NHS trusts in England and Wales suggests that direct employment costs were approximately £420 million (£411 million in England and £9 million in Wales) in 1999/2000, about 14 per cent more than the year before. In addition, approximately £20 million (£19 million in England and £1 million in Wales) was spent on the administration and management of nursing staff banks.

An average NHS trust spent just under £2.5 million on bank and agency nursing in 1999/2000. But some trusts spend two or three times this average and one in ten trusts spends more than 20 per cent of its nursing paybill on bank and agency cover (EXHIBIT 5). It is clearly a major cost in many trusts, but not all trusts have mechanisms in place to achieve best price. Wide variation in the rates charged by agencies suggests that there may be scope for trusts to achieve savings.

EXHIBIT 4
NHS trusts’ expenditure on locum doctors and agency nursing staff (England)

Spending on agency nursing staff has grown much faster than that on locum doctors.

Note: comparable series for Wales not available.
Source: Department of Health Trust Financial Returns
Exhibit 5
Expenditure on bank and agency nursing staff as a percentage of the nursing paybill, 1999/2000

One in ten trusts spends 20 per cent or more of its nursing paybill on bank and agency cover.

Source: Audit Commission survey of NHS trusts (N=256)

18. On average, NHS trusts in London spent more of their paybill on bank and agency staff than trusts elsewhere, and London is the only region where trusts spent more on agency nursing staff than on bank staff. Over half of the national expenditure on agency nursing staff is made by trusts in London. For example, non-teaching acute trusts in London spend, on average, about 11 per cent of their total nursing paybill on agency staff compared with spend of 3 per cent by similar trusts outside London [EXHIBIT 6, overleaf]. Part of the explanation is the higher vacancy rates in the capital but other factors, including agency pay rates, also play a part.

19. While location and trust type influence expenditure on staff cover, the variation between similar trusts is substantial. For example, expenditure on bank and agency staff ranges from 2 per cent to 29 per cent of the nursing paybill across non-teaching acute hospital trusts in London. The variation is so great as to suggest that the main determinants of the cost and use of bank and agency staff are each trust's management decisions and local circumstances – for example, the extent to which cross-cover is possible between specialties or sites – and the effectiveness of their management arrangements.
Exhibit 6
Expenditure on agency nursing staff in non-teaching acute trusts (England), 1999/2000

On average, NHS trusts in London spend more on agency nursing staff than similar trusts elsewhere.

Source: Audit Commission survey of NHS trusts (N=256)

Management arrangements

20. There is considerable diversity in the ways that trusts organise and manage temporary nursing cover. These arrangements include trusts which have:
   - no nurse bank and book agency staff on an ad hoc basis;
   - negotiated a sole provider contract with an agency, or preferred supplier status with a number of agencies;
   - separate banks operating in specialist areas or localities;
   - a centrally managed bank which books agency staff when it cannot meet demand;
   - a central bank but with mini banks in place for specialist areas, typically critical care and theatres;
   - a central bank whose management is contracted out to an external provider, usually from the independent sector but occasionally to another trust or even local Job Centres; and
   - begun to pilot NHS Professionals, an in-house NHS-led ‘agency’ (see below).

21. This diversity makes it particularly difficult to evaluate what works well where. What is clear is that some trusts make more use of agency staff than they need to because the number and mix of staff available through the bank is a poor reflection of demand. Only rarely have trusts taken a strategic overview of their temporary staffing needs and few have adequate management information to enable them to do so. Now the NHS Executive is promoting NHS Professionals, a new direction and a more strategic approach to temporary staffing in England.
22. In February 1999, the House of Commons Health Committee, in its report on future NHS staffing requirements (Ref. 9), raised concerns about trusts’ undue reliance on temporary nursing staff, about the possible effects on the quality of patient care and about the growth in expenditure on nursing agencies. In response, the Government established a working group under the auspices of the NHS Social Partnership Forum, to look at the issues around the use of bank and agency staff and to explore alternative approaches to employment flexibility. This work led to the announcement by the Prime Minister, in November 2000, of the Government’s intention to set up NHS Professionals, an in-house NHS-led ‘agency’ [BOX C].

23. Complementing the NHS Professionals initiative, the NHS Purchasing and Supply Agency is working with NHS Executive Regional Offices to promote a new approach to contracting between NHS trusts and the commercial agencies. The changes that are envisaged through these two initiatives could radically transform the ways in which NHS trusts arrange their temporary staffing cover and work with commercial agencies.

---

**NHS Professionals – a new approach**

**BOX C**

**NHS Professionals**

NHS Professionals (Ref. 10) is a new approach to managing and providing temporary staffing services. Using call-centre technology, and building upon existing bank and other temporary staffing arrangements, it intends, in time, to provide a nationwide service – through a single national telephone number – offering NHS trusts cost-effective, flexible access to staff across the full range of clinical and support roles. The initiative is part of the broader strategy to promote successful recruitment, retention and return to practice. NHS Professionals is not designed as a substitute for offering flexible working on a permanent basis. It seeks to provide more opportunities for those staff who want to work flexibly and will extend the good employment practice in the *Improving Working Lives Standard* (Ref. 11) to staff working in a temporary, locum or bank capacity.

*Source: Audit Commission*
24. Faced with demand pressures and, in many cases, arrangements that do not offer the best value for money, trusts throughout England and Wales need to examine and improve the ways in which they provide temporary nursing staff cover. The development of NHS Professionals means that all NHS trusts in England are being asked to review:

- arrangements for accessing temporary staff and skills;
- agreements with commercial agencies; and
- terms and conditions for bank staff.

These reviews will raise important questions about the most effective ways of meeting the demand for temporary cover, of ensuring consistent quality of the staff supplied and of controlling the costs incurred.

25. In Wales, Improving Health in Wales (Ref. 12) highlights an intention to ‘work in partnership with other bodies to develop co-ordinated recruitment initiatives across the UK including ... bank working.’ The human resources strategy for the NHS in Wales (Ref. 13) includes as one of its aims ‘a demonstrable reduction’ in reliance on agency staff.

26. This report [EXHIBIT 7, overleaf] aims to help by:

- demonstrating the need for trusts to improve their management of the appointment, induction and performance of bank and agency staff; and for them to ensure that all practitioners’ development needs are identified and met (Chapter 2);
- analysing variations in expenditure and showing how costs can be minimised through good bank management, sound contracting and partnership working; and that consistent application of controls can reduce the risks of payment error and fraud (Chapter 3 and 4);
- showing how trusts can improve the ways in which they provide temporary staffing services so that controls are effective and cover is provided as efficiently as possible (Chapter 4); and
- showing that supply-side solutions like NHS Professionals are not enough on their own. Trusts will also need to invest in the better management of inappropriate demand, improved rostering and the deployment of substantive staff (Chapter 5).

27. The report has a number of audiences:

- bank co-ordinators, human resources, supplies and finance specialists who administer and manage bank and agency staff, and the senior clinicians who use their services. They will be most interested in how they compare with other trusts and the detailed findings of Chapters 2, 3 and 4 on improving efficiency and minimising financial and clinical risks;
• trust boards and senior clinicians with responsibilities for clinical governance. They will be especially interested in Chapter 2, which deals with improving quality. They will also be interested in the main messages of Chapters 3 and 4 and will wish to assure themselves that those managing cover arrangements are minimising risks and pursuing improvements in efficiency; and

• project managers with responsibility for taking forward the NHS Professionals initiative. They can draw on the material to help them in establishing the scale of operation that will be required in their areas, and can use Chapters 4 and 5 in considering what else they need to do to control demand.

EXHIBIT 7
A map of the report
This report is structured to help trusts review the quality, costs and management of their temporary nursing.

Source: Audit Commission
Assuring the Quality of Care

The circumstances in which bank and agency staff are booked and carry out their duties are sometimes less than ideal. They may be unfamiliar with their surroundings, the patients they are caring for, or with local procedures and practices. Induction may be inadequate and bank and agency staff may have little time to get accustomed to the area they are working in. These factors all increase the risks of something going wrong and the likelihood of patients receiving poorer quality of care than they would otherwise get.
28. A common view expressed by NHS staff and managers to the Audit Commission is that bank and agency staff provide patient care of a poorer quality, or behave in ways that may be considered less professional, than those in permanent posts. But there is no systematic evidence to confirm or disprove this view and few trusts have recording systems that can accurately distinguish adverse incidents involving temporary nursing staff.

29. All registered nurses – regardless of their employment circumstances – have a responsibility under the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) Code of Professional Conduct (Ref.14) to maintain and improve their professional knowledge and competence, but those who work on a temporary basis can find it more difficult to address changing professional development and skill needs. The circumstances in which they are appointed and carry out their duties are also sometimes less than ideal. They may be unfamiliar with their surroundings, the patients they are caring for, or with local procedures and practices. Induction may be inadequate and temporary staff may have little time to get accustomed to the area they are working in. As one agency nurse told the Commission:

“...agency nurses are coerced to work in areas when they’re not clinically competent to do so and promised supervision and support that doesn’t materialise... on numerous occasions I have been left for two or three hour periods alone with clients that I know little or nothing about... leaving us both vulnerable...”

Of course, this may also happen to bank staff and to substantive post holders temporarily re-deployed to unfamiliar areas. These circumstances all increase the risks of something going wrong and the likelihood of patients receiving poorer care than they would otherwise get.

30. To minimise the risks to the quality of patient care and to promote the best standards, trusts – working in partnership with agencies – need to have effective systems in place to ensure that all temporary staff:

- are appropriately qualified, experienced and fit for the roles they are asked to perform;
- receive effective local, as well as general, induction;
- have access to training and development opportunities; and
- receive regular, timely and objective feedback, so that any problems with their performance are recognised at an early stage and are dealt with promptly.

31. This chapter examines what happens in practice. It shows that the ways in which some trusts organise and manage temporary staff fail to minimise these risks and it shows what can be done about it. It opens with an examination of the pre-employment checks that need to take place before temporary staff have access to patients. It then goes on to describe how some trusts have successfully tackled the key issues of induction, performance review and training.
It is essential that proper checks are made to ensure that all prospective nursing staff are:

- registered with the appropriate statutory body (for qualified nurses, midwives and health visitors, this is currently the UKCC);
- checked against police records – especially where staff may have significant unsupervised access to children and vulnerable adults;
- holding valid permits to work in the UK (where appropriate);
- competent to perform the duties that the job may require; and
- fit for duty.

These requirements apply as much to staff who join an NHS bank as to those recruited by agencies. It should be normal practice for trusts to employ the same recruitment procedures for bank as for substantive posts. These include obtaining satisfactory written references, including one from the immediate previous employer. Not only will this ensure a consistent approach to appointment, and should alert them if an applicant has been suspended from a trust, but also it will minimise the risk of ‘bogus’ nurses and others being appointed. Problems can arise if these checks are not carried out and the risks of deception should not be underestimated.

The Audit Commission reviewed the personal files of nearly 200 nurses on bank-only contracts at seven trusts. Not all of the checks needed to ensure the suitability of temporary staff were undertaken and those checks that were carried out were not always properly documented. Important checks are not documented and may not have been completed.

Source: Audit Commission review of personal files (N=192 bank-only nurses at 7 trusts)
UKCC registration

35. NHS trusts and agencies must confirm the status and expiry date of practitioners’ entries on the UKCC professional register before offering them employment on a substantive or temporary basis. The UKCC has published guidance on how this can be done [BOX D]. Failure to follow this guidance and to implement adequate checking procedures may put patients at risk.

36. At one trust, the Audit Commission’s review of 20 personal files of registered bank nurses found that:
   - none had any evidence that practitioners’ registration status had been verified with the UKCC;
   - 6 had no record of the UKCC personal identification number;
   - where records did exist, they were either photocopies of PIN cards or copies of the statement of entry – neither of which is proof of registration; and
   - 8 did not record the date on which the applicant’s UKCC registration would expire.

37. At another trust, 5 out of the 20 files examined held copies of UKCC PIN cards that had expired prior to the application (in one case the expiry date was more than three years earlier). There was no evidence that registration had been confirmed on appointment or that it had subsequently been renewed.

BOX D

The UKCC registration confirmation service

This is a free service enabling employers to check the registration status of nurses, midwives and health visitors. The UKCC issues professional identification number (PIN) cards to registered nurses, midwives and health visitors as a receipt for payment of their registration fee and as a convenient way for practitioners to remember their PIN and the expiry date of their registration. A new card is issued every three years when practitioners renew their registration. But, according to the UKCC, many employers mistakenly accept PIN cards or statement of entry reports as proof that a practitioner’s registration is in good standing. The only way to ensure valid registration – and therefore legitimate employment as a registered practitioner – is to check each practitioner’s details with the confirmation service available from the UKCC. The confirmation service enables employers to check which part(s) of the register a practitioner is on, when current registration(s) expire and to confirm additional registered qualifications.

Source: UKCC (Ref.15)
38. It is impractical and unrealistic for trusts to perform recruitment checks on agency staff; this should be done by the agencies. NHS staff cannot assume that agencies have checked the registration details of the nurses provided, even if this is specified in their contract [CASE NOTE A], unless trusts assure themselves, through regular audit, that agencies have made these checks.

**Identity checks**

39. Staff should be informed of the practitioner’s name and, for registered staff, UKCC PIN number, prior to their arrival in order to check it against the PIN card and other identification that they should be asked to produce. When these simple checks are overlooked, serious problems can occur.

40. Despite rare but widely publicised examples of deception, these checks are still carried out infrequently. In spot checks conducted on wards at five acute hospitals, the Audit Commission found that more than half the temporary nursing staff were not wearing identity badges – despite trust and agency policies to the contrary. The Commission’s

### CASE NOTE A

**Lapsed registration**

**Details**

When an agency nurse reported for duty at a pre-operative assessment clinic the manager asked her for identification and her UKCC PIN card. The nurse could produce neither. The clinic manager told her that she would call the agency to seek verification of her identity and UKCC registration. The nurse then admitted that her registration had expired.

**Outcome**

The nurse was asked to leave the clinic. The agency was informed that her registration had expired and that she should not be assigned work as a registered nurse until it had been renewed.

**Lessons for trusts**

- Trusts must assure themselves that agencies verify UKCC registration.
- The nurse bank or agency should notify wards/teams of the identity of the staff booked to work and, where applicable, the UKCC PIN number and its expiry date.
- When new bank or agency nurses report for duty, the staff in charge should confirm their identity and UKCC PIN number.
- Trusts should issue photo identity cards to all staff working on temporary assignments and should require agencies to do the same.

*Source: Audit Commission*
surveys show that, even when bank and agency staff were previously unknown to the wards where they worked their most recent shift, most were not asked for any identification and few were asked for their UKCC PIN card. A standard procedure to make a positive identity check would avoid putting trusts and patients at risk from the actions of unauthorised staff.

Criminal Records checks

41. Employers have a responsibility to prevent unsuitable persons from having unsupervised access to children and other vulnerable people [CASE NOTE B]. In some trusts, police checks are requested for all staff recruited to the bank. As a minimum they should be requested of all temporary staff deployed in posts where health service employees would normally be checked, and a record should be kept that such checks have been made.

CASE NOTE B

Police checks

Details

A nursing auxiliary was dismissed by a trust following a conviction for causing actual bodily harm to an elderly patient. Following his release from prison he was taken on by an agency, gave a false name and failed to disclose his previous conviction. The agency did not follow up his references. He was subsequently deployed at another trust in the same area, again working with elderly patients. There were complaints from several patients about his ‘threatening’ behaviour and his identity was discovered when he was recognised by a nurse with whom he had previously worked.

Outcome

He was dismissed by the agency for giving a false name and for failure to disclose his conviction.

Lessons for trusts

- Trusts should ensure that criminal records checks are conducted, where appropriate, on prospective bank staff.
- Satisfactory written references must be obtained, including one from the immediate previous employer.
- Trusts should ensure that their contracts with agencies specify that these checks are to be made by the agency on the staff that they supply and Trusts should ensure compliance.

Source: Audit Commission
42. The Audit Commission reviewed the personal files of samples of
registered nurses, nursing auxiliaries and healthcare assistants employed
on bank-only contracts who regularly worked with vulnerable adults or
on children’s wards at five hospital trusts. None of the trusts could
demonstrate unequivocally that police checks had been completed on all
of these staff and in one trust there was no evidence that any of them had
been subject to such checks.

43. The police are not specifically resourced for this work and the volume
of requests is known to have grown substantially in recent years. As a
result, some forces have found it increasingly difficult to meet the demand
within reasonable timescales. To get over this problem, some trusts adopt
their own procedures so that bank staff can start work, under close
supervision, while checks are pending. But these safeguards are not
always entirely reliable [BOX E].

44. New arrangements for criminal records checks are due to come into
effect in August 2001. The new Criminal Records Bureau (CRB)\(^{15}\) will
widen access to checks so that all employers, including commercial
agencies, will be able to ask successful applicants to apply for a check.
These changes should ensure better protection for patients in the future.

**BOX E**

**Police clearance checks in children’s services**

An audit at one children’s hospital found that the trust had created ‘police
check supervisory forms’ – signed by the supervising ward sister – to be used
in the event of police clearance not being obtained before staff commenced
work. The system was intended for use with newly recruited permanent
staff working on a named ward. But bank staff were sometimes employed
on the same basis. The auditor found that, because there was no
monitoring, some bank staff had unsupervised access to children without
police clearance and in the absence of supervisory forms relating to the
ward to which they were sent.

*Source: external auditor’s report*
Competence

45. Trusts are accountable, through the clinical governance framework, for ensuring that the clinical care they provide is current and effective, and that nursing staff are up to date in their practices. They also have a responsibility to protect patients from incompetent staff and to take action when the standards of care fall short of those expected [CASE NOTE C].

46. If bank and agency staff are not competent, they can actually increase the workload of staff on the ward. Typical of the comments made by ward managers at trusts visited by the Audit Commission were:

“...often staff with no experience are sent to cover gaps... We have to pay for them but they are a liability...”

“...too many bank staff come without experience... They can’t move and handle patients, make beds, do bed baths, all the simple things ... we don’t have time to show them what to do, it’s not our job...”

CASE NOTE C

Poor clinical skills

Details

The trust’s central bank office booked a D grade bank nurse to work the night shift on an oncology ward. The ward sister subsequently reported that the bank nurse was unable to operate the infusion pumps used on the ward and seemed unsure about drug administration.

Outcome

The ward sister felt that she was unable to take a break during the shift as she could not leave the bank nurse unsupervised. The bank was asked by the ward not to provide this nurse again.

Lessons for trusts

- Trusts should have an effective booking system that ensures that temporary staff are competent to work in the areas where they are deployed.
- Wards/teams must ensure that temporary staff are made familiar with any equipment that they need to use.
- Trusts have to address performance issues directly and not simply accept a ward’s refusal to use an individual again.

Source: Audit Commission
47. An effective recruitment process will help trusts minimise the problems that sometimes arise when people without previous NHS experience are employed on the bank [CASE STUDY 1].

48. The onus must be on senior nurse managers to ensure that the people they deploy are suitably competent to carry out the work required. With temporary staff there can be a temptation simply to avoid booking particular individuals in the future, rather than tackling the performance issue. As one ward manager told the Commission: “Bank and agency staff who were asked not to come back to our ward were often seen working on adjacent wards the next day.” In its review, the Audit Commission came across many examples [CASE NOTE D] of permanent nursing staff telling the bank or agency that they did not want particular individuals to be booked for shifts in their area again. This approach may be understandable, but it is not helpful to the practitioner (who may be unaware of the problem), to the agency (which continues to place them), or to the trust (if the bank simply moves them elsewhere). It also runs

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**CASE STUDY 1**

**Dartford & Gravesham NHS Trust**

The trust set up an enhanced recruitment process so that it could respond effectively to the large number of enquiries it was receiving from people without previous NHS experience. This involves the following steps:

- an application form is completed;
- two references are taken up;
- an informal discussion is held with the applicant;
- three days are spent on different shifts observing the work of a healthcare assistant;
- a senior nurse completes a questionnaire on the applicant’s suitability at the end of the third day;
- applicant has a formal interview followed by a medical;
- newly appointed bank staff have three days (unpaid) induction training;
- applicant works an orientation shift (paid) in which a teaching programme is completed (this lists what they should know or find out);
- bank nursing auxiliaries are given a competence card which must be signed by a trained nurse prior to them carrying out observations, procedures or documentation; and
- new bank healthcare assistants are only allowed to work on day duty where they can be monitored.

This system has enabled recruits to gain ward experience and in some cases to get substantive posts in the trust or to embark on an education and training programme leading to qualification.

*Source: Audit Commission*
counter to the provisions of the UKCC *Code of Professional Conduct* (Ref. 14). This makes it clear that a practitioner’s first duty of care is to safeguard and promote the interests of patients and clients. Two provisions of the Code are particularly relevant here:

- Registered practitioners should always act ‘*in such a manner as to promote and safeguard the interests and well-being of patients and clients*’
- Registered practitioners should ‘*ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients*’.

### CASE NOTE D

**Poor clinical skills and unacceptable behaviour**

#### Details

A ward requested a D grade nurse to cover short-term sickness absence on a night shift. The trust’s central bank was unable to find anyone at short notice and offered the shift to a local agency. The agency provided a D grade nurse but she was said to be unable to complete a fluid balance chart or to carry out a simple urine test independently and she was unable to use the monitoring equipment on the ward. Eventually the nurse walked off without telling anyone that she was leaving. Only one qualified nurse was left on duty and the ward was unable to admit further patients.

#### Outcome

The agency was told not to provide this nurse again.

#### Lessons for trusts

- Shifts offered to commercial agencies should clearly specify the competences expected and the types of experience required.
- Trusts should tell agencies why they do not want a particular nurse to be provided again.
- From April 2002 NHS trusts should only use agencies that comply with the standards set out by the National Care Standards Commission.

*Source: Audit Commission*
49. Risk management information systems are one way of pinpointing common problems with temporary staff, which can then be addressed through induction, training or discussion with the bank or agencies involved. But few trusts use them in this way because the employment status of staff involved is not always recorded. One trust that has made use of risk management information is University Hospital Birmingham NHS Trust [CASE STUDY 2].

Fit for duty

50. Trusts have a responsibility to ensure that all staff – including students [BOX F] – are fit for duty. This includes ensuring that they do not pose a risk to patients, themselves or colleagues through infection, injury, ill-health or excessively long working hours. It is important that occupational health screening is a standard part of the pre-employment checks routinely undertaken by NHS trusts and agencies, and systems should be in place to monitor working hours, rest periods and leave. Some trusts, for example University Hospital Birmingham, have introduced a policy preventing nursing staff from working on the bank for 48 hours following a day off sick from their substantive post.

CASE STUDY 2

University Hospital Birmingham NHS Trust – incident reporting system

University Hospital Birmingham NHS Trust uses its risk management system to monitor incidents involving bank and agency nursing staff. The information was used as one indicator of improvements in quality and performance following the return of the central bank to internal management in December 1999.

In the three months January to March 1999, 41 incidents related to temporary nursing staff were recorded. These ranged from nurses being late or not turning up at all, to nurses being sent home unfit for duty, leaving the wards understaffed. In the same period a further 88 incidents due to staff shortage were reported; of these, almost half (37) identified problems with temporary staff, for example booked cover not turning up. A similar number of incidents were identified between July to September immediately prior to the termination of the contract with the external agency which ran the bank. But in the first three months of 2000 only 8 incidents involving temporary nursing staff were recorded and only 24 out of 67 entries concerned with staff shortages mentioned temporary staffing.

Source: Audit Commission study site visit
Occupational Health

51. Occupational health screening and the completion of a health questionnaire should be a standard part of pre-employment checks for all nursing staff, regardless of their employment status. Employers are responsible for assessing the risk to health from patient handling and for reducing the risk of injury or ill-health to the lowest level practicable. It is important that employers detect problems such as existing back injuries and make sure that prospective staff do not have a history of illness that would pose a risk to patients or other staff through contagious diseases (for example Tuberculosis, Hepatitis B) or from Methicillin Resistant Staphylococcus Aureus (MRSA).

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**BOX F**

**Student nurses and bank work**

It is common practice for student nurses and midwives to work as nursing auxiliaries via an agency or an NHS trust bank during their training. The benefits of such experience need to be carefully balanced against the possible effects that excessive hours could have on their studies and the fact that they may be used in areas where poor practice is evident. Only one of the trusts visited by the Commission had a formal policy on the employment of students as bank nurse auxiliaries. Practice across the NHS is inconsistent:

- Not all NHS trust banks ask the student’s university for a reference.
- In some trusts students could work as an auxiliary provided they had completed the first year of their course; in others they could only work if they were in the final year.
- In some trusts students can only work during the vacation.
- In most trusts students could not work on wards where they were doing their clinical placements; but in some there were no limits on where they could work.

Most of the banks did not set explicit limits on the number of hours that students could work on the bank. Students were said to be ‘self-limiting’ in this regard. In general this seemed to work well. On average, students worked slightly fewer hours than other nursing auxiliaries on the bank; about a third worked 7.5 hours or less in the week. But one in ten did a full 37.5 hours and a significant minority (one in four) had other jobs as well. These included agency work, other bank work and part-time employment in a trust or nursing home. Among these students, a third had worked more than 37.5 hours in the previous week. Trusts should monitor the number of hours that students work and should liaise with local universities to ensure that such work does not interfere with their education.

Source: Audit Commission
The Audit Commission’s survey shows that the majority (98 per cent) of practitioners joining agencies in the last 12 months completed health questionnaires and most (80 per cent) recall having had their immunisation status checked. Although all the trusts visited had a policy of obtaining occupational health clearance for externally recruited bank staff, more than half (59 per cent) the personal files of registered bank nurses reviewed at seven trusts had no evidence that occupational health had declared them fit for duty. And sometimes staff employed by the trust in a substantive but non-nursing post were recruited onto the bank as nursing auxiliaries without occupational health screening. By failing to ensure that all bank staff undergo appropriate health checks, trusts place patients at risk clinically and themselves at risk financially.

Infection control is of particular concern. Patients in certain healthcare settings, for example intensive care, theatre, neonatal and renal units, may be particularly vulnerable to MRSA infection and some trusts have a policy of not employing temporary staff known to be colonised or to have cared for a known MRSA-positive patient. However, there is no consensus on the desirability of screening NHS staff for MRSA and there are no figures on the numbers screened. Available evidence suggests that few bank or agency nursing staff are screened. And it has been suggested that agency staff, in moving frequently from one place of work to another, may act as carriers for infection. These are important concerns that warrant further investigation.

Monitoring working hours

Nursing staff on duty should not be tired, for the safety of patients, themselves and their colleagues. But several of the trusts visited had experienced problems when nursing staff with full-time substantive posts were also working an excessive number of additional bank shifts.

The Working Time Regulations came into effect on 1st October 1998. The Regulations aim to protect employees from excessive demands from their employers, who must now ensure that they have systems in place to monitor the hours worked, rest periods and leave. Again, the provisions of the UKCC Code of Professional Conduct are also relevant.

Under the Working Time Regulations, employees will normally not be expected to work more than 48 hours in each seven-day period over an averaging period of 17 weeks. There is widespread concern about staff employed by the NHS who also work for agencies, because of the problem in tracking the hours they have worked, but in practice it appears that staff with NHS and bank contracts are more likely to be working excessive hours than are those with NHS and agency contracts.
CASE NOTE E

Monitoring working hours

Details
A nursing auxiliary with a full-time substantive and bank contract at the trust was found asleep while working an early shift on a surgical ward. Prior to the shift in question she had just come off duty, having completed back-to-back late and night shifts (the latter as bank work) in two other parts of the hospital. Subsequent reconciliation of off-duty records and bank booking sheets found that she was regularly working in excess of 60 hours per week.

Outcome
The nursing auxiliary was suspended from duty for a week and the trust re-specified its computerised shift booking system to detect such bookings in advance.

Lesson for trusts
IT or manual booking systems should prevent staff with substantive posts from being booked on back-to-back shifts.

Source: Audit Commission

EXHIBIT 9

Hours worked by bank and agency nurses in all jobs
Bank nurses tend to work more hours per week than agency nurses.

Source: Audit Commission surveys of bank and agency nurses (N=3,614)
57. Recording this information for those who work bank or agency shifts can be complex, especially if they also have a substantive contract, because it can be difficult to track the total hours worked. There are no simple solutions to the problem. Some trusts have set limits, which can help to minimise the risks. For example, at King’s Healthcare NHS Trust bank staff could work no more than two shifts in any 36-hour period, with a maximum of 24 hours in any 48-hour period, and at University Hospital Birmingham NHS Trust bank staff with a full-time substantive post were not permitted to work more than two 7.5-hour bank shifts per week, even if they had chosen to opt out of the Working Time Regulations.

58. So far this chapter has shown that concentrating closely on key employment checks before temporary staff are recruited or arrive on duty can reduce risks to patient care. The NHS could follow the lead of some agencies in issuing electronic ‘smart cards’, holding practitioners’ qualifications, employment history, health status and photograph, to streamline and improve some of these processes. It is unrealistic to expect busy ward staff to do anything more than simple checks on identity. They need to rely on there being robust systems in place elsewhere to prevent unsuitable individuals from having access to patients. Trusts must also assure themselves, through regular audit, that agencies have made these checks. Ward staff do, however, have a crucial role in the induction of temporary staff, which is considered in the next section.

**Induction**

59. Any nurse, however well qualified or experienced, is likely to perform below their best in an unfamiliar setting. Induction is key to overcoming that lack of familiarity and reducing the risk to quality of care. By ensuring that induction is appropriate and effective, trusts enable bank and agency staff to rely less on substantive staff for guidance and make them more able and more likely to comply with local policies and procedures.

60. The Clinical Negligence Scheme for Trusts (CNST) and the Welsh Risk Pool (WRP) accreditation schemes [BOX 6] require proper arrangements for the induction of all staff as well as setting specific standards for temporary staff. All the trusts visited by the Commission had trust-wide induction programmes for newly recruited staff, including those recruited on bank-only contracts. But overall only two out of every five staff recruited on bank-only contracts in the last 12 months could recall attending an induction event. Some bank staff do not attend the induction provided because some trusts (one in four) do not pay for their time.

61. Even when bank staff have attended a general induction, it is important that they – and agency staff – get appropriate induction to the particular area they are working in. It is especially important to communicate local arrangements for the administration of intravenous and oral medication, since some trusts do not allow temporary nursing
staff to do this or to be involved in drug rounds. These limits vary from trust to trust and even between parts of the same trust, and temporary staff need to know the limits of their responsibilities.

62. There is no standard procedure for induction at local level. In some places temporary staff are attached to a nursing team and given a brief tour – which may or may not explain procedures specific to that area in a structured or clear fashion – in other cases temporary staff are handed an induction pack. At worst, they are simply expected to fend for themselves. As one agency nurse told the Commission: “I don’t think anyone really cared ... I was given a caseload and just told to get on with it.”

**BOX G**

**Clinical Negligence Scheme for Trusts (CNST) & the Welsh Risk Pool (WRP)**

The CNST and WRP are designed to improve the effectiveness of risk reduction and risk control in NHS trusts and to provide a means of funding the cost of clinical negligence litigation. External auditors make annual assessments using a set of risk management standards. The promotion of effective clinical risk management is a key component of both schemes.

**CNST Scheme**

Standard 7 deals with induction, training and competence. It contains several relevant criteria, including: ‘The trust has an induction system covering all temporary (locum, bank or agency) clinical staff to ensure that such employees are competent to perform the duties of their post.’

**WRP Scheme**

Standard 9 deals with the supervision of junior clinical staff. It includes a requirement to evidence formal procedures for the ‘...induction and supervision of locum, agency and bank staff’.

To satisfy the assessors, trusts must demonstrate that there are appropriate arrangements in place to safeguard patients. For example, the CNST scheme states that all temporary staff should have a personal handover by the regular post holder or a more senior person, who will ensure that the basic requirements of the post are explained, and each specialty should have a ‘locum’ pack giving basic details of the work of the specialty, the chain of command and the location of key departments, communication systems and resuscitation arrangements. Information on where to seek clinical help should also be included.

Source: NHS Litigation Authority (Ref.16) and Welsh Risk Pool (Ref.17)
63. The experiences of bank and agency staff on their most recent shift suggest that the quality of local induction can be unsatisfactory, and in some places, irresponsible [EXHIBIT 10]. At one trust, a community services manager told us that when new agency staff go out on the district nursing service “we just take a deep breath and close our eyes”.

64. Comprehensive induction is especially important when staff join the bank in an area where they have had little, or no, experience. For example, hospital-based nurses commonly join the bank of a community trust to gain experience before looking for a substantive community post [CASE STUDY 3].

EXHIBIT 10

**Induction provided to agency nurses on unfamiliar wards**

Local induction can have significant gaps.

Source: Audit Commission survey of agency nurses (N=1005)

CASE STUDY 3

**Priority Healthcare Wearside NHS Trust – induction for community bank nurses**

Nurses joining the community nurse bank at Priority Healthcare Wearside NHS Trust attend a 10-day induction programme. This includes nine treatment room sessions (five with a facilitator and then four sessions across the trust to broaden experience). Potential bank staff are then assessed by a district nurse for their competency in record keeping, venepuncture, ear syringing, ECG, immunisations and catheterisation. If bank staff have been out of nursing, they are asked to do a ‘re-orientation’ programme of two days per week for six weeks with an experienced district nurse. During this time they are paid at D grade.

Source: Audit Commission study site visit
65. Equally, nursing auxiliaries whose experience may have been confined to nursing homes need appropriate induction when they join the bank of an acute hospital [CASE STUDY 4].

66. Some trusts have made real progress in this area [CASE STUDY 5, overleaf]. But the fact that temporary staff are not inducted with any degree of consistency at a local level in many trusts means that employers cannot be confident that all staff are able to comply with operating policies and procedures.

**CASE STUDY 4**

**University Hospital Birmingham NHS Trust – buddy shifts**

University Hospital Birmingham NHS Trust has introduced a system of ‘buddy’ shifts linking nursing auxiliaries in substantive posts with new nursing auxiliaries joining the bank. Nursing auxiliaries joining Locate – the in-house bank – must have had a minimum of six months’ work experience in the NHS before they can work on the bank and they must be able to measure and record basic observations. New recruits attend a one-day workshop on basic observations and their competency is assessed against 12 areas. They must achieve a set level of competence in all 12 areas before they can carry out basic observations unsupervised. They work in a supernumerary capacity (paid for from the bank rather than the ward budget) alongside their ‘buddy’ for anything up to two weeks until they are confident on their own.

In some cases an E grade support nurse employed by Locate will act as a buddy and work alongside bank auxiliaries to assess their performance, particularly if concerns have been raised by ward staff. In one example, a nursing auxiliary was suspended from the bank following several complaints about her poor attitude and clinical skills. The support nurse worked alongside her, supervising and assessing her practice, and, following two buddy shifts, she was successfully reinstated.

*Source: Audit Commission study site visit*
The fact that temporary staff may work a variety of hours, sometimes across several different settings, makes consistency and continuity of performance review and assessment of development needs difficult. But even when bank staff consistently work on the same ward, performance review can be neglected. As one bank nurse told the Commission:

“...I have worked on the same ward as a bank nurse for nearly two years. I haven’t had any assessment of my performance despite asking for it...”

Feedback is more likely to be given on an ad hoc basis and usually only when the practitioner has performed poorly.

Few of the trusts visited by the Audit Commission maintained systematic records of bank staff’s performance and in many trusts they are not yet fully involved in performance appraisal arrangements. More than two-fifths of trusts were unable to say how many of the staff on bank-only contracts had appraisals in the previous 12 months or had personal development plans. More than a third said that none of their staff had had a performance review in the previous 12 months. Feedback on performance and development needs was unlikely to be given to bank staff unless they had performed poorly.

CASE STUDY 5

King’s Mill Centre for Health Services NHS Trust – induction programme

King’s Mill Centre for Health Services NHS Trust was committed to developing an in-house bank and reducing its reliance on agency nursing staff. Induction was seen as central to the success of the new bank. Trust staff understood that bank nurses and healthcare assistants would provide better quality care for patients by being familiar with trust procedures and standards and having up-to-date skills that matched the requirements of the wards. Effective induction was seen as essential to this and the trust has developed a comprehensive programme designed to minimise clinical risks to patients and to ensure that bank staff feel valued and supported.

Recruits to the bank now attend a standard induction programme – for which they are paid at their normal bank rate. This consists of attendance on a trust orientation day and completion of a supervised practice period in a named clinical area. This should be between two and five days’ duration. The programme has some tailored orientation and training, based on the experience and preferences of the bank recruit and the needs of the trust for temporary staff. The induction package has task- and knowledge-based objectives, with performance standards that are assessed on placement wards. These objectives must all be completed and signed off by a ward manager before the first ‘live’ shift. Bank recruits shadow a nominated preceptor and are supervised by them while they work through the induction pack on the ward. If a recruit fails to complete the induction programme within a three-month period, their employment on the bank will be reviewed.

Source: Audit Commission study site visit

Training, development and performance review

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...Absence of performance monitoring places patients at risk...

Bank-only staff had been appraised. In some cases the low achievement levels are not because trusts fail to include bank staff in their appraisal process – rather that bank staff fail to attend.

69. The national figures are borne out by nursing staff in the trusts visited by the Audit Commission. Overall, fewer than one in four of those on bank-only contracts at these trusts said that they had their performance assessed in the last year. When performance review does take place, it is often little more than a tick-box checklist that does not make explicit reference to the skills and competences required.

70. Nevertheless, some trusts have recently introduced more systematic and thoughtful processes [CASE STUDY 6], and one trust (King’s Mill) visited by the Audit Commission had been commended by Investors in People for the ways in which it has included bank staff in its training and development programmes.

71. The absence of formal systems for monitoring and appraising the performance of temporary staff places patients at risk if poor performance is not identified and measures are not taken to ensure an optimum level of care is provided [CASE NOTE F]. Among those with bank-only contracts, only 12 per cent of registered nurses and 18 per cent of nursing auxiliaries reported having their training needs assessed in the last year. This compares with figures of 66 per cent and 52 per cent respectively for permanent nursing staff.21

CASE STUDY 6

Newcastle City Health NHS Trust – preceptorship programme

The trust recognised that there has been little professional support and guidance available to nurses new to working on the bank. It has set up a preceptorship framework providing a supportive and safe period of four months to consolidate learning for newly qualified nurses, nurses working in unfamiliar areas of care or new positions, and nurses returning to practice.

Nurses whose main employment is with the bank are registered and linked to work within one specific care area for the majority of their shifts. Prior to registration, the nurse bank clinical co-ordinator liaises with the care area to identify an appropriately experienced nurse to take on the role of preceptor.

Source: Audit Commission visit
Fifty-seven per cent of agency nurses and 20 per cent of bank nurses do not have permanent (full- or part-time) nursing posts in the NHS, the independent sector or elsewhere. These nurses have fewer opportunities to maintain their technical competence and knowledge, and to address changing skill needs, than those in permanent posts. Although most trusts report that training opportunities are available to all staff, in practice those on bank-only contracts appear to miss out or not take advantage of them. Only 23 per cent of registered nurses on bank-only contracts attended any clinical practice training in the last year. In time this will deplete their skills and undermine their ability to perform new or extended roles.

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**CASE NOTE F**

**Lack of training**

**Details**

An agency nurse who usually worked in a nursing home was assigned by the agency to work as a registered nurse in a busy A&E department. She was asked to take an ECG (heart tracing) of a 70-year-old man admitted with chest pain. The nurse failed to tell anyone that she did not know how to do it. Shortly after his arrival in A&E the patient suffered a heart attack and stopped breathing. The nurse was unable to resuscitate him and had to wait for assistance. She had not attended any training in basic life support in the last three years.

**Outcome**

The patient recovered and the agency was informed that the nurse was unsuitable for A&E work and must update her basic skills before any other placements.

**Lessons for trusts**

- Trusts must assure themselves that the agency assigns nurses with appropriate skills. Equally, the nurse bank or agency should notify the ward or team of any relevant gaps in key skills before the shift starts.
- There must be appropriate delegation of work to temporary staff who will work unsupervised.
- Bank and agency nurses who do not update their basic life support training on a regular basis should not be used until they do so.

*Source: Audit Commission*
Recognising and addressing these concerns is key to maintaining the quality of care for patients and helping individuals to enhance their careers. One of the main issues is who pays for this training. Although the training events are usually free, the majority (55 per cent) of bank-only nurses who attended clinical practice training did so in their own time, unlike staff in substantive posts. Many of these practitioners are unhappy with the lack of information they have about training and about the absence of pay when they do attend training events. This is particularly difficult when they have to pay for childcare. A frequent comment to the Commission was: “...attending study days means that I can’t accept paid work”. Trusts need to make better use of on-the-job training opportunities for bank staff. Some trusts are addressing this issue in innovative ways [CASE STUDY 7].

CASE STUDY 7

Staff Direct – paid training days

Staff Direct (the Oxfordshire Consortium NHS Staff Bank) offers all bank-only nursing staff paid training days. Nursing staff are paid to attend study days according to their level of service input. Those working less than 12 hours a week on average will be entitled to one paid day per year, those working between 15 and 25 hours a week can get two days and those working more than 25 hours a week can have three days paid training. Registered nurses are paid at the mid-point of D grade, and non-registered staff at the mid-point of A grade, for these training days. Applications for these developmental training days have to be supported by a manager and have to address a clearly identified training need. Bank-only nursing staff also receive a payment for attending mandatory training courses on back awareness, fire safety and resuscitation.

*Source: Audit Commission visit*
...the uptake of ... training is higher among agency ... nurses.

74. Bank staff are also less likely than permanent staff to attend mandatory training events. As one bank nurse told the Commission: “...for us with no experience of a crash [emergency requiring resuscitation skills] we need some sort of course. I shouldn’t have been put in that situation ... I could have helped...”

Recent work by the Audit Commission (Ref.18) on education, training and development found that, on average, two out of three nursing staff had training to update basic life support, and moving and handling skills, in the previous 12 months. In the Commission’s surveys of bank staff, attendance was found to be lower. Less than two in five bank-only nursing staff had updated their basic life support and just under half attended moving and handling training. In some other mandatory training areas the position is even poorer. For example, only one in five registered nurses on bank-only contracts had attended any training in infection control in the past 12 months.

75. Again, the lack of pay is a barrier. One in five trusts do not pay bank staff when they attend ‘mandatory’ training. Typical comments from bank nurses were:

“...not being paid to attend mandatory training is unsatisfactory as I have to pay for childcare in order to attend...”

“...I’m bullied into attending training days at a loss to me ... I’m not paid to do it.”

76. However, the uptake of clinical practice and mandatory training is higher among agency (excluding those with other nursing jobs) than bank-only nurses. Over half (57 per cent) reported that they had done some clinical practice training in the last 12 months, and higher proportions attended update training in moving and handling (71 per cent), basic life support (59 per cent) and infection control (40 per cent). Much of this training is provided by the agencies, many of which have set up training departments. For example, over half (54 per cent) the agency nurses said that moving and handling training, and more than a third (35 per cent) that basic life support training, was provided by the agency. Trusts should use training provision as a criterion when deciding which agencies to work with.

Reducing clinical risk

77. This chapter has identified a number of issues affecting the quality of patient care where trusts need to improve their performance. These range from having effective recruitment and induction processes in place to ensuring that bank staff get equitable access to training. Some improvements will be harder to achieve than others – for example, ensuring that all bank staff have an annual performance appraisal is likely to be more difficult to achieve than introducing positive identity checks – and some of the quality improvements described will cost the NHS more money. However, the next chapter shows that there is scope for savings in the way that the NHS currently pays for temporary staff that will enable some of these improvements to be funded.
Assuring the Quality of Care

To ensure that temporary nursing staff are appropriately qualified, fit for duty and suitable for the roles they perform, trusts need to:

1. Operate the same pre-employment checks as they apply in recruitment to substantive posts and maintain adequate documentation to confirm that necessary checks have been undertaken.

2. Make full use of the UKCC confirmation service to verify the status and expiry date of practitioners’ professional registration and confirm which part(s) of the register they are on.

3. Use the CRB to inspect the records of all temporary staff who may be deployed in posts where they may have contact with vulnerable people and where health service employees would normally be checked.

4. Include occupational health screening as a standard part of the pre-employment checks for all bank staff.

5. Only use staff from agencies that are registered with the National Care Standards Commission (from April 2002).

6. Make it clear, in contracts with agencies, what pre-employment checks are delegated, and that the trust’s auditors should be allowed to undertake periodic spot checks to ensure compliance.

7. Introduce positive identity checks as a standard procedure for any temporary staff reporting to work for the first time on a ward or unit.

8. Monitor the working hours of temporary nursing staff, especially those with substantive posts, and if necessary, limit the number of additional shifts that can be worked.

To minimise risks to the quality of patient care, trusts need to:

9. Ensure that staff have the means to report legitimate concerns about the performance of bank and agency staff (and vice versa) and agree a process with agencies for dealing with poor performance by staff supplied by them.

10. Use critical incident reporting forms that enable managers to identify temporary staff involvement and address specific issues relating to them.

11. Ensure that all temporary staff have an effective induction before starting work.
Assuring the Quality of Care

12 Provide support and guidance to temporary staff who are newly qualified or working in unfamiliar roles.

13 Give bank staff regular feedback on their performance and support to address their development needs.

14 Guarantee that bank staff attend annual update training in basic life support, moving and handling, fire safety, infection control and other health and safety skills as appropriate.

15 Pay bank staff for their time in attending mandatory training, and work with partner organisations to ensure that bank staff are not discriminated against in accessing funding for continuing development.

16 Keep bank staff well informed about training opportunities and ensure that they keep their clinical skills up to date.

17 Work with agencies to ensure that agency nursing staff also receive regular performance feedback and attend appropriate training.
Keeping Costs Under Control

On average, agency nursing staff are paid about 20 per cent more than NHS bank staff, but there are wide variations in the hourly rates of pay and in the commission charged by different agencies. This suggests that there is scope for trusts to achieve savings: firstly, by using bank rather than agency staff when possible; secondly, by negotiating formal contracts and working in partnership with a small number of agencies. The promotion of better internal controls can also reduce the unnecessary payments that sometimes occur through error and fraud.
Theoretically, trusts can minimise their use of, and expenditure on, temporary nursing staff by flexibly deploying the optimum number and mix of permanent staff. In practice this is far from easy to achieve and it would be naïve to think that it can be anything other than a long-term aim. Some of the necessary improvements will be harder to achieve, and will take longer, than others – for example, better aligning the permanent nursing staff with patient workloads may be more difficult to achieve than ensuring that recruitment procedures are streamlined so that vacant posts are filled as quickly as possible. But there is much that trusts can do to contain temporary staffing costs in the short term. This chapter focuses on three areas: managing the rates paid; improving contracting; and preventing payment error and fraud.

One of the main arguments put forward by the NHS Executive for developing NHS Professionals is the need to ‘unlock the costs’ tied up in using agency staff and directing them into better employment for NHS staff. Underlying this is the assumption that agency staff are more expensive and that trusts can make savings on the temporary staffing paybill by making greater use of NHS bank staff. The commercial agencies and their representative organisations challenge this assumption. The Recruitment and Employment Confederation’s (REC) Nurses & Carers Division has questioned whether the NHS Professionals initiative will reduce the £350 million, as cited by the Prime Minister, that the NHS spends on agency fees. The REC argues that this is misleading because 88 per cent of it represents staff pay and National Insurance contributions. Others from the industry have suggested that most NHS expenditure is with agencies that pay close to the NHS norm and no more than 5 per cent above it even in non-contracted situations. This chapter examines the evidence.

The chapter begins by comparing the hourly rates paid to NHS bank and agency nursing staff and examining the commission rates charged by agencies. It then considers how trusts can reduce their expenditure on temporary staff through improved contracting. Finally, it argues that the promotion of better internal controls can reduce the unnecessary payments that sometimes occur through error and fraud.

NHS expenditure on agency nursing staff comprises two components. First, NHS trusts pay an hourly rate for the agency nurse together with employer’s National Insurance contributions. The hourly rate should include an element for annual leave entitlement under the Working Time Regulations and is what, after tax, the nurse will usually take home. In addition to the hourly pay, some agencies will also include a charge for the nurse’s travelling time.
Second, NHS trusts also pay a ‘commission’ fee to the agency. This is to cover the administrative costs incurred by the agency in providing nursing cover, and its profit margin. Most agencies charge commission as a percentage of the nurse’s hourly rate.

Rates of pay

Comparing the pay of bank and agency nursing staff is complicated by the fact that the rates vary depending on the shift time, the day of the week, grade, specialty, location and so forth. The Audit Commission’s national survey collected figures for the main grade (D) at which bank and agency nurses are booked, for the commonest shift times and for nurses working in non-specialist areas.

Agencies tend to pay rates that are higher than those paid by NHS banks. For weekday daytime shifts, reported hourly rates at D grade ranged from:

- NHS bank nurses – £6.58 to £13.39, with an average (median) of £8.18; and
- agency nurses – £7.28 to £19.43, with an average (median) of £9.20.

Comparing hourly rates paid between bank and agency nurses at each trust, the survey shows that:

- eight out of ten trusts, pay bank nurses filling this type of shift less than the hourly rate for agency nurses; one in twenty pays the same and one in eight pays bank nurses more than the hourly rate for agency nurses [EXHIBIT 11, overleaf];
- at those trusts which used both bank and agency nurses, the latter were, on average, paid nearly 20 per cent more;
- at one in seven trusts, agency nurses are paid at least £4 per hour (50 per cent) more than bank staff working the same shift; in a handful of trusts they are paid twice as much; and
- the differences in pay between bank and agency nurses are marginally lower at night and at the weekend (agency nurses getting roughly 10 per cent more than bank). But on public holidays they are considerably greater, with agency nurses getting on average 35 per cent more. In some trusts visited by the Commission this difference was even larger [TABLE 1, overleaf].
EXHIBIT 11
Rates of pay for bank and agency nurses, winter 2000/2001

Most trusts pay bank nurses less than agency nurses working comparable shifts.

Note: rates quoted are for D grade nurses working daytime weekday shifts in non-specialist areas.
Source: Audit Commission survey of NHS trusts (N = 256)

<table>
<thead>
<tr>
<th>Hourly rate of pay (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank nurses</td>
</tr>
<tr>
<td>Agency nurses</td>
</tr>
</tbody>
</table>

Many trusts pay significantly more per hour for agency nurses
A few trusts pay bank nurses more than agency nurses

TABLE 1
At one trust visited by the Audit Commission, agency rates of pay for a D grade nurse, working in a non-specialist area on a weekday, were between 5 and 18 per cent higher than those paid by the bank, depending on which agency was used. On Sundays and public holidays, agency rates of pay were significantly higher than in the week.

| Hourly rate of pay for a D grade nurse in a non-specialist area |
|---------------------|---------------------|---------------------|---------------------|---------------------|
|                     | Weekday             | Nights              | Sunday              | Public Holiday      |
| Bank                | £8.50               | £11.22              | £13.85              | £13.85              |
| Agency 1            | £8.95               | £11.70              | £14.80              | £23.40              |
| Agency 2            | £10.00              | £12.50              | £15.00              | £20.00              |

Source: Audit Commission study site visit
Some of the variation is because the rates of pay (comparing the same weekday daytime shifts) for both bank and agency nursing staff tend to be higher in the London region [EXHIBIT 12]:

- on average, NHS bank rates are 16 per cent higher in London (median £9.44 per hour) than elsewhere – reflecting London allowance payments – but two out of five London trusts pay more than this; and

- the average (median) hourly rate for D grade agency nurses in London (£10.75) is also higher than elsewhere (£8.90). But this difference is more than can be explained simply by a London allowance equivalent.

As agency pay rates increase, NHS bank pay can become increasingly uncompetitive, leading to problems for trusts in recruiting and retaining bank staff. This is particularly the case where trusts do not pay bank staff enhancements for unsocial hours or where bank staff are automatically paid at the mid-point of D grade, irrespective of their normal grade or pay point. The Audit Commission’s survey of bank staff found, for example, that one in four nurses with a substantive post at E grade was paid at D grade or below on their most recent bank shift. Not surprisingly, many nurses looking for temporary, or additional, work prefer to do so via an agency.

EXHIBIT 12
Range of hourly rates paid for agency nurses by NHS region (England)
The variation in rates charged by agencies is large, but – other than in London – is not explained by regional differences.

Note: rates quoted are for D grade nurses working daytime weekday shifts in non-specialist areas.
Source: Audit Commission survey of NHS trusts (N=256)
Some trusts respond to these problems by paying bank staff at their substantive pay point or by adjusting their bank rates. Other trusts fail to take account of the local labour market when setting bank pay rates. The difficulty is that trusts need to strike a balance between increasing bank pay sufficiently to attract and retain staff but not to a level which either:

- leads substantive staff, particularly those working part time, to leave permanent posts and join the bank to benefit from enhanced pay; or
- leads to undue inflation of the overall paybill or an upward bidding spiral with commercial agencies.

In order to compete more effectively with agencies, some trusts have targeted enhanced bank pay at those grades and specialties where they are most dependent. To be successful, this strategy must be accompanied by stricter controls over demand and should be time limited (see Chapter 4).

Commission charges

Not only do some trusts pay higher hourly rates for agency nursing staff than others, they may also pay significantly more in commission. The average commission rate is 20.5 per cent, but one in three trusts pays commission at 25 per cent or more while one in six trusts pays commission at 10 per cent or less. Agencies may charge different commission rates to NHS trusts in the same local health economy. One community trust visited by the Audit Commission had an exclusive contract with an agency, but the trust’s different localities were charged different commission rates depending on which branch office of the agency they made their request to.

There are wide variations in the rates of pay and commission charges [Exhibit 13]. Trusts should be aware that some agencies with low commission charges might seek to maintain their margins by paying nurses lower hourly rates. They may then not be able to attract sufficient staff to maintain acceptable fill rates.

In specialist areas like theatres, intensive care and mental health, the total hourly rate that trusts pay for agency staff can be hugely variable [Table 2].

So far, this chapter has shown that there are wide variations in the hourly rates of pay and in the commission charged by different agencies. This suggests that there is scope for trusts to achieve savings by reviewing the effectiveness of local contracting arrangements, working in partnership with a small number of agencies and with other purchasers.
EXHIBIT 13
Commission charges and hourly rates of pay
There are wide variations in the rates of pay and commission charges.

Note: rates quoted are for D grade nurses working daytime weekday shifts in non-specialist areas.
Source: Audit Commission survey of NHS trusts (N=256)

TABLE 2
Agency rates for nurses working in specialist areas
Inclusive rates (including nurse’s pay, NI, Working Time Regulation allowance and commission) for 15 trusts outside London (daytime, weekday shifts).

<table>
<thead>
<tr>
<th></th>
<th>£ per hour (min)</th>
<th>£ per hour (max)</th>
<th>£ per hour (median)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theatre/ITU £ per</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade D</td>
<td>8.90</td>
<td>24.76</td>
<td>14.62</td>
</tr>
<tr>
<td>Grade E</td>
<td>10.16</td>
<td>33.00</td>
<td>17.26</td>
</tr>
<tr>
<td><strong>Paediatrics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade D</td>
<td>8.99</td>
<td>18.05</td>
<td>13.63</td>
</tr>
<tr>
<td>Grade E</td>
<td>10.16</td>
<td>20.79</td>
<td>14.75</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade D</td>
<td>10.21</td>
<td>24.00</td>
<td>13.98</td>
</tr>
<tr>
<td>Grade E</td>
<td>10.93</td>
<td>24.76</td>
<td>15.61</td>
</tr>
</tbody>
</table>

Source: NHS Purchasing and Supply Agency
Most trusts use more than one agency to supply nursing staff, and one in six uses ten or more. The number of agencies used is not dependent on the size of the trust, the specialties covered, the volume of agency staff used or whether temporary staffing is organised through a central bank. Using a large number of agencies is more commonplace in London, where the average trust has 12 agency suppliers (compared with 3 to 4 outside London) and where two acute hospital trusts reported using 30 nursing agencies in 1999/2000.

Competition between agencies is important in ensuring that they endeavour to provide a good service at competitive prices, but using a large number of suppliers can also bring problems. Most day-to-day orders cost much the same to process, whatever the value. So a preponderance of small-value orders with a large number of suppliers increases the transaction costs for the trust as well as making it more difficult to build up an effective working relationship with the supplier, to obtain cost savings and to ensure quality standards. By failing to co-ordinate orders, by ordering too frequently and by using a large number of suppliers, some trusts fragment their purchasing power. For example, one of the trusts visited by the Commission used 21 agencies in 1999/2000. Each of these agencies had different hourly charge rates, but ward managers did not generally know these differences when they were booking agency staff. Consequently, departments paid different prices for the same staff and the trust spent more than it needed to.

One of the ways in which trusts can reduce costs is by contracting with one or a small number of agencies and working in partnership with them rather than hiring temporary nursing staff on the more expensive daily market. But despite the volume of business involved and its growth, only two out of five trusts have contracts with agencies for the supply of nursing staff. In general, those trusts with contracts tend to be the major users, but one in three trusts spending more than £1 million a year on agency nursing staff – and in one case nearly £8 million – does so on a non-contract basis.

Not having a contract is more expensive. Not having a contract is more expensive. Trusts with contracts benefit from lower hourly rates of pay and from lower commission charges. On average, the hourly rate paid for a D grade agency nurse working a daytime weekday shift is roughly £1.60 lower for nurses supplied under contract. And commission rates paid by trusts with an agency contract average just over 15 per cent compared with 27 per cent for those trusts without a contract. On the average expenditure of £673,000, trusts without agency contracts could expect to save over £100,000 on commission simply by putting contracts in place.

Traditionally, trusts have contracted for services in isolation. They could increase value for money by co-operating with other trusts to increase their purchasing power through joint tendering for services. In practice, fewer than one in ten trusts has been involved in joint contracting for the supply of agency staff.
EXHIBIT 14

Commission charges

Trusts with contracts tend to benefit from lower charges.

Note: rates quoted are for D grade nurses working daytime weekday shifts in non-specialist areas.
Source: Audit Commission survey of NHS trusts (N=256)

CASE STUDY 8
Pan-Birmingham Contract

In 1997, a working group of senior and middle managers was convened across seven acute hospital trusts in Birmingham to resolve common problems around theatre staffing. Each hospital identified escalating costs due to increased use of agency theatre staff (operating department assistants and theatre nurses). Commercial agencies were said to be taking advantage of the fact that there were severe shortages of theatre staff and were recruiting from the trusts by offering enhanced pay rates. There were also concerns about the skill levels and experience of the staff being provided. Faced with having to pay up or to cancel operating lists, the trusts took collective steps to manage the market better.

Commercial agencies were invited to tender for a Pan-Birmingham contract for the supply of temporary theatre staff. The aim was to control the costs of temporary cover by reducing competition between the hospitals and agreeing standard pay rates. A three-year contract was awarded to a single supplier in September 1999. The contract is managed by one of the consortium members and user group meetings take place three to four times a year. Overall performance of the contract is said to be good and fill rates average 97.5 per cent across the consortium.

The contractor appointed a full-time ‘account’ manager who liaises and visits the participating trusts on a regular basis. Trust representatives visit the agency once a year to validate the agreed standards and processes.

The contract synchronised bank and agency pay rates at Whitley plus 50 per cent and subsequent uplifts have been in line with NHS inflation increases. The commission rate is approximately 10 per cent less than that charged by agencies for other specialist placements and has been held constant. Savings of around £200,000 per year have been made across the group.

Source: Audit Commission visit
The NHS Purchasing and Supply Agency is currently undertaking a procurement exercise on behalf of NHS trusts in England. Through this exercise, ‘Framework Agreements’ for the supply of agency nursing staff will be concluded in each region, starting with London [BOX H]. The Framework Agreement details service standards and contract monitoring arrangements. Under these agreements one or more commercial agencies will be appointed, following a tendering process, to supply services to the trusts participating in the Framework. The agreements will be in place for an initial period of three years. Agencies awarded a place in the Framework Agreement may then be invited by one or more of the participating trusts to enter into a Service Level Agreement establishing additional terms including prices. The effect of these new agreements remains to be seen. Responsible agencies recognise and support the principle of obtaining value for money through contracting. However, many agencies comment on the ‘adversarial’ style of negotiations that they have had with NHS trusts. The negotiation of future regional contracts should be used as an opportunity to improve such relationships.

Procurement needs to focus on value as much as price. And as well as cost savings, contracting should bring other benefits. In particular, trusts should be assured that the staff supplied are suitably experienced, qualified and competent. To realise these benefits, service specifications for the supply of agency staff should be formally tendered and should clearly set out the respective responsibilities of the trust and the agency. In practice, four out of ten contracts in place at the end of 2000 had not

**BOX H**

**The London Agency Project**

The London Agency Project was launched in February 2001. It aims to adopt a partnership approach with commercial agencies to:

- gain consistency across the region in purchasing critical care, accident and emergency and theatre nurses, operating department practitioners and assistants;
- ensure that the NHS in London is receiving value for money in the acquisition and deployment of these temporary staff; and
- achieve consistently high standards in the overall quality of temporary nursing staff supplied by agencies.

The NHS Purchasing and Supply Agency is supervising contracting for the procurement, on behalf of the London Regional Office and London’s Chief Executives. Implementation of the new contract is expected in September 2001.

*Source: Audit Commission*
been market tested and therefore trusts cannot be sure that they are getting best value – in terms of price or performance. Where contracts do exist, they are sometimes standard ones supplied by the agency, rather than being a clear specification of the particular trust’s needs.

**101.** Trusts have a responsibility to actively monitor and manage contracts with commercial agencies to ensure that performance and standards are being met. In practice this is not necessarily being done. At one major NHS hospital trust in London, the agency running the in-house bank repeatedly failed to meet the contracted fill rate (that is, the proportion of shift requests for which cover was provided) over a nine-month period. The external auditor identified more than £110,000 that the trust could have recovered from the agency if it had invoked the penalty clause set out in its £3 million-a-year contract. Trusts need to put in place a clear and active contract monitoring process through which agencies’ (and their own) performance can be assessed against explicit and agreed criteria. Where these criteria exist, they tend to focus on shift fill rates, but they should be more widely defined to encompass service quality measures such as response times, errors, complaints and training inputs.

**102.** In the absence of contracts with agencies, trusts may be paying more than they need to. Many trusts could take further steps to contain costs by ensuring that controls over payments to bank nurses and to agencies minimise the risk of financial loss. The final section of this chapter considers this issue.

**Improving controls**

**103.** Unnecessary costs can be incurred through error, irregularity and fraud in connection with bank and agency payments. These range from receipt and payment of duplicate invoices, to the submission of fraudulent timesheets by individuals. Senior managers should know how much is being spent, where and why, and mechanisms should be in place for monitoring and controlling it.

**104.** Trusts should have in place adequate controls for the authorisation of timesheets and the payment of creditors to minimise these risks. Clearly, the extent of checking should be commensurate with the costs and risks involved. But in some trusts it is apparent that weak or inconsistently applied controls contribute to the problem or are exploited [BOX I, overleaf].

**105.** In some trusts, the systems operating at ward level and elsewhere may not provide adequate assurance that timesheets and invoices have been properly authorised. Of the 71 agency invoices reviewed by the Audit Commission:

- on one in six invoices the hours claimed did not match the timesheet supposedly showing the number of hours that were worked;
- one in five of the timesheets had not been signed by an authorised signatory; and
- in two out of five cases there was no separation of duties between the person confirming the hours worked and authorising payment.
Some trusts had systems in place to identify and query any invoices where the number of hours worked did not match the payment claimed; in others these invoices were paid without verification.

Good timesheet design should minimise the risk of fraud and duplicate payments. Poorly designed timesheets can make small-scale fraud relatively easy. For example:

- changing the number of hours worked, after authorisation, is easier where hours are only recorded in numerals and not in words;
- adding extra unworked shifts is simple if the space left for unworked days is not crossed through;
- submitting apparently authorised but fraudulent timesheets for shifts that have not been worked is easier when timesheets only have space for initials rather than signatures; and
- handing timesheets back to bank staff following authorisation is also common practice and can lead to fraud.

106. Some trusts had systems in place to identify and query any invoices where the number of hours worked did not match the payment claimed; in others these invoices were paid without verification.

107. Good timesheet design should minimise the risk of fraud and duplicate payments. Poorly designed timesheets can make small-scale fraud relatively easy [CASE NOTE G]. For example:

In one trust spending about £400,000 a year on bank and agency staff, the external auditor identified a number of problems with payment procedures that left the trust exposed to potential fraud.

In one three-month period:

- 11 of 280 bank timesheets were not signed by anyone the bank nurse had worked with;
- 102 bank timesheets were not countersigned for payment by the team leader or manager;
- 7 bank timesheets were not authorised for payment by either the team leader or the person the nurse had worked with;
- 5 of 77 agency invoices had no accompanying timesheet, one had a timesheet that had not been authorised and one had a timesheet ‘authorised’ by another agency nurse; and
- none of the 6 invoices (amounting to £7,300) submitted by one agency tallied with the timesheets – payment was requested for 715 hours but the timesheets showed only 567 hours had been worked.

In none of these cases did the trust investigate the discrepancies or stop payment.

Source: external auditor's report
CASE NOTE G

Timesheet fraud

Details

A nurse with a substantive post who also worked bank shifts on an elderly care ward committed two different timesheet frauds. First, changing dates and times on timesheets meant that she was paid for shifts that attracted enhanced rates. Second, she completed multiple timesheets for the same shifts and had them authorised by different signatories. During the investigation it was discovered that the salaries and wages department could not compare certifying signatures on timesheets against the authorised signatory list, as no current list was available. Reconciliation of weekly timesheets to the staff roster identified 21 discrepancies over 14 weeks.

Outcome

The nurse was dismissed and the trust instigated a detailed review of systems controls.

Lessons for trusts

- Timesheet design should prevent alterations after signature.
- Checks should be in place to prevent multiple payments.
- Authorised signatories lists should be available, up to date and used.

Source: Audit Commission

108. The Audit Commission reviewed the design of thirteen different timesheets in use at the trusts visited:

- None had instructions to cross out unused days or lines.
- Only two required the number of hours worked to be written in words as well as numerals.
- Only two required the counter signatory and authorising signatory to print, as well as sign, their name; one only required someone to initial the timesheet.
- Four did not have a space for anyone to confirm the hours worked.
- Only five of the timesheets were multi-part (i.e. copies for the ward, the nurse, finance, the agency or bank office).
- Three did not record start or finish times.
- Four did not ask for the name of the ward or team where the shift was worked.
Not only are some timesheets poorly designed, they may also be inadequately completed [EXHIBIT 15]. Bank and agency nursing staff should not be paid for rest breaks. But timesheets typically record one start and one finish time. As a result, the total hours claimed usually includes breaks. In most cases these are deducted from the payment, but this does not always happen.

Significant numbers of timesheets are processed despite not having a counter-signatory confirming the hours worked or being authorised for payment, and in some cases there was no separation of these duties. Poor design and the failure to institute basic checks can result in significant fraud over prolonged periods [CASE NOTE H].

EXHIBIT 15
Checks on timesheets
Some timesheets are processed without proper authorisation.

Source: Audit Commission review of completed bank and agency timesheets (N=150 timesheets)
A particular problem concerns the payment of National Insurance contributions and VAT. All-inclusive invoices make it impossible to calculate whether National Insurance and VAT have been charged correctly and whether commission has been added at the agreed rate. The Audit Commission examined 71 invoices at six trusts. Only 40 of these invoices identified the commission rate. One in ten invoices did not specify the rate of VAT, while others charged VAT on the full invoice value rather than on the agency’s commission. Although NHS trusts can recover VAT, paying money not due will affect the trust’s cash flow, and Customs and Excise may refuse to make refunds on VAT that was not properly payable in the first instance.

CASE NOTE H

Timesheet fraud

Details

Over three months a final year student nurse working on the bank as a nursing auxiliary submitted timesheets for 30 bank shifts on seven different wards, including those on which she was doing her clinical placements. In practice she had only worked 2 of the shifts. In some cases she forged the authorising signature, in others she used fictitious names. The fraud was possible because she had access to blank timesheets and because bank staff were allowed to pre-book shifts direct with the bank co-ordinator.

Outcome

The fraud was discovered when one ward manager queried an invoice and found that the timesheet had apparently been authorised by a member of staff who was terminally ill and on long-term sick leave. The trust was defrauded by almost £1,380 plus £271 paid in lieu of annual leave accrued through bank hours worked. Subsequent enquiries uncovered further frauds by the same student over a three-year period amounting to more than £15,000. The student was suspended from the trust and from the university and was subsequently convicted. The trust changed the design of its timesheets and altered its bank shift booking policy.

Lessons for trusts

- Timesheet design and processing should minimise the risk of fraud.
- Bank shift bookings should be made or confirmed by a ward manager.
- Authorised signatures should be checked on a regular basis.

Source: Audit Commission
112. Auditors’ investigations at several trusts have shown that some agencies have charged a blanket National Insurance Contribution to the trust, routinely at the maximum rate, even though the nurse’s pay did not reach this level. In other cases, National Insurance Contributions were based on the commission as well as on the nurse’s pay. Of the 71 invoices examined by the Commission, only 41 specified the National Insurance Contributions.

113. Irregularity, error and fraud are more likely to be detected if internal auditors regularly review controls over payments [BOX J]. But internal auditors at many (46 per cent) trusts have not reviewed bank or agency payments in the last three years.

**BOX J**

**Internal audit**

A recent review of bank staff arrangements by the internal audit service in one major teaching hospital trust found widespread evidence of inadequate controls and poor value for money. The nursing bank for one half of the trust was managed (off-site) by a commercial agency under a five-year facilities management contract. The review was undertaken in the final year of the contract. It found that:

- between 75 and 80 per cent of bank staff requirements were self-booked by ward staff, but the agency were charging commission fees, in excess of £150,000 a year, for all shifts;
- a significant number of bank shifts were costed for recharge to the wards at a higher grade than the staff were actually paid, thus inflating the commission earned by the agency running the bank;
- the agency re-charged National Insurance to the trust at a flat rate of 8.5 per cent for all bank staff even though the actual employer’s National Insurance paid through the payroll for individual bank staff rarely approached this level;
- the rates used by the agency to invoice the trust for bank staff were based on outdated Whitley Council scales, leading to underpayments by the trust; and
- invoices for agency staff were checked and authorised for payment by an administrative assistant from the outsourced agency and not by a trust employee.

*Source: internal audit reports*
Strengthening internal controls requires clarity about roles and responsibilities across different parts of the trust, and these arrangements need to be communicated clearly and effectively to all involved in the management of temporary staff.

This chapter has demonstrated that it does cost the NHS more – in paybill terms – to use agency nursing staff than bank staff, and that there are opportunities for cost containment, through improvements in contracting and contract management, and by taking action to strengthen internal controls. If all NHS trusts benefited from the lower charges that those with contracts have secured, the NHS could save approximately £20 million a year.

Resourcing more cover from NHS banks rather than agencies could generate further savings. But these potential savings have to be offset against the set-up and operating costs that are involved in providing an NHS nurse bank service. They can only be realised if NHS trusts are more efficient than the agencies in providing cover. How NHS trusts can improve the efficiency of their bank services, and minimise these costs, are key themes of the next chapter.
Keeping Costs Under Control

To reduce their expenditure on bank and agency nursing, trusts need to:

1. Pay bank staff at the appropriate grade for the duties they are undertaking and review local labour market conditions to assess what, if any, time-limited premium should be added.

2. Co-ordinate orders for agency nursing staff and limit the number of suppliers they use.

3. Establish proper contractual arrangements with one (or a few) preferred suppliers to secure lower hourly rates and commission charges and promote quality improvements.

4. Increase their purchasing power by collaborating with other trusts, and liaise with the NHS Purchasing and Supply Agency in procuring services from agencies.

5. Work with agencies to actively monitor and manage contracts so that agreed performance standards can be achieved by all parties.

6. Maintain a clear picture of all spending on temporary staffing with clear accountability for monitoring and control.

To minimise the risk of error, irregularity and fraud, trusts need to:

7. Put in place adequate controls for the authorisation of timesheets and payment of creditors.

8. Make certain that their timesheet design minimises the opportunity for fraud.

9. Require creditors to separately identify National Insurance, VAT and commission charges on invoices.

10. Ensure that their internal auditors undertake regular reviews of payments to bank and agency staff as part of their audit programme.
Managing Demand and Improving Efficiency

Some of the demand for nursing cover is generated by poor operational management. Trusts should take action to reduce unnecessary bank and agency use and minimise the time senior nurses spend arranging cover. This means having effective management controls and a modern staff bank service making best use of information technology.
There are many occasions when the use of temporary nursing cover is entirely appropriate to maintain service delivery. But some of the demand for cover is generated by poor operational management. For example, temporary staff are sometimes used to cover for planned leave when full prospective cover is built into the establishment and the unit is fully staffed. Trusts can reduce their use of bank and agency nursing staff by ensuring that effective controls are in place to prevent unnecessary bookings and that alternative cover arrangements are considered.

In some trusts, senior nurses spend significant amounts of time trying to arrange staff cover. Trusts need to minimise this cost to patient care by ensuring that staff banks operate as efficiently and effectively as possible. This means being open at the right times, understanding the requirements put to them by wards and units, and having sufficient bank staff in the right mix to meet those requirements. Reliable information systems are crucial in making such operations work effectively and efficiently.

This chapter examines each of these issues in turn. It shows: firstly, that having guidelines in place can reduce unnecessary use of temporary staff; secondly, that trusts need to review the size and composition of their bank to ensure that it reflects the patterns of demand; and thirdly, that investment in information technology can help to improve quality and reduce costs.

Bank and agency staff are sometimes booked with little or no consideration of whether cover is actually justified by the number or dependency of patients and whether there might be alternatives to bringing someone in. In over half of the 800 or so bookings recorded in the Audit Commission’s prospective survey, the ward managers said that they did not contemplate any alternatives.

Trusts could manage demand for temporary staff better by putting in place protocols which offer clear guidance on when it is appropriate to book bank or agency nursing cover and provide a reminder of alternative cover options.

Protocols can make a difference. For example, one trust visited by the Audit Commission had almost eliminated the use of bank and agency staff to cover for annual leave by having a clear set of operational policies and procedures which were communicated to all staff involved in arranging temporary cover. But nearly one in three trusts report that they do not have protocols in place. In some trusts the Commission found that not only was there no booking policy in place, but that requests were not subject to any authorisation. This can lead to abuse, with individuals arranging rosters to provide themselves, or colleagues, with opportunities to work bank or agency shifts. Many trusts now prohibit substantive post holders from working agency shifts in their own trust. But 40 per cent of
agency nurses with an NHS job told the Commission that they do work agency shifts in their trust, some on a regular basis.

123. Clearly there is an important balance to be struck between the need to minimise financial risks and the need for the nursing staff in charge to have discretion over the use of resources. Having clear operational policies, and auditing compliance with them, would go some way to meeting both aims.

**Better rostering**

124. Successful rostering is critical to the delivery of patient care, to effective resource utilisation and to improved working lives for staff, but achieving a balance between the needs of patients and staff has long been acknowledged as a difficult, time-consuming and unenviable task. A poorly designed roster can leave a ward over- or under-staffed and may lead to an inappropriate competency mix (for example, when a shift has a full complement of staff but they are all newly qualified). This can have critical implications for the quality of patient care, for costs and the need for temporary cover [BOX K]. In the Audit Commission’s prospective survey of temporary staff bookings, almost a third of the requests received at short notice (under 12 hours) were to cover for vacancies, annual leave, study leave and even maternity leave – most of which ought to have been known well enough in advance to be covered by the duty roster.

125. The Improving Working Lives Standard (Ref.11) requires trusts to have in place a range of workforce scheduling systems (for example, self- or team-rostering) that enable staff to have greater control over the times and hours they work. In keeping with this, trusts have increasingly turned towards more participative styles of rostering. A number of pilot schemes have been publicised, although the effect on the use of temporary staff is not widely reported.**25**

126. Recent research (Ref.20) claims that self-rostering may not suit all areas and can be problematic in medium or large wards with more complex staffing requirements. The researchers suggest that the more discretion staff have, the more likely it is that the roster will be based on their own, rather than patient, priorities. Crucially, the quality of rostering is directly related to the management skills and experience of the person(s) constructing the roster. Computer systems are available to aid this process, but in most cases rosters are still developed manually. Whatever approach is adopted, there is an urgent need for practical advice and guidance on how to do it successfully.
Poor Rostering
On a 14-bed admissions unit, 15 staff were rostered to cover 21 shifts a week across a ‘traditional’ pattern of early, late and night shifts. The usual staffing level is described as ‘4/3/2’, that is four staff on early, three on late and two on the night shift. Two registered nurses are usually rostered on early and late shifts and one on the night shift. But, one week in June poor rostering resulted in:

- five shifts where the number of staff rostered did not match the ideal;
- eight shifts where the grade mix did not match the ideal mix;
- the deployment of temporary staff at the weekend when costs are highest;
- the deployment of temporary staff at a grade higher than the staff rostered.

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<th>Staff</th>
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Temporary staff

| RGN 1 | L | L | E | E |
| RGN 2 | N |   |   |   |
| NA 1  | L | E |   |   |
| NA 2  | E |   |   |   |

*Registered General Nurse; ** Nursing Auxiliary
Source: Audit Commission study site visit
Alternative cover arrangements

Bank and agency staff are not the only ways of providing temporary cover. And they may not always be the best in terms of continuity and quality of care or cost. The alternatives include:

- asking permanent staff to swap shifts;
- sharing staff between wards, teams or units;
- using additional plain-time hours – part-time staff paid at their normal rate for working in excess of their normal contracted hours; and
- using overtime – permanent staff (full- and part-time) working more than 37.5 hours per week at overtime rates or for time off in lieu.

Informal and often last minute swapping of shifts between colleagues is probably the commonest way in which the NHS manages to juggle the needs of the service and those of staff. Together with asking substantive staff to work extra hours, the Audit Commission’s survey found that this was the main alternative that ward sisters tried before booking bank or agency cover. Provided there are safeguards to prevent nursing staff from working excessive hours and to ensure that they are rewarded appropriately, this pragmatic approach should continue.

Cross-cover and support teams

Short-term staffing shortfalls can also be covered cost-effectively if wards or community teams ‘borrow’ staff from less busy areas or have reciprocal cover arrangements. In some places separate teams of community nurses have been set up to take patient referrals from those that are short staffed. An unforeseen consequence of devolving budgets to ward and community team levels has been to make the exchange of staff more difficult to arrange. Some ward managers say they are reluctant to loan staff even when they are less busy, because it might be the only chance that staff have to catch up with administration, teaching and training. And widespread vacancies and high occupancy levels means that in many trusts there are no staff to be borrowed. The extensive movement of staff between wards or across sites may also be unrealistic because of the specialist nature of many clinical areas. But equally, the absence of a detailed overview of the day-to-day deployment of staff can act against this kind of exchange even between general wards or related units. At times this leads to unnecessary use of bank and agency staff. For example, one acute hospital trust visited by the Audit Commission had two general intensive care units on sites less than two miles apart. In one unit, nurses were being stood down because two of the six beds were unoccupied; at the other, specialist agency nurses were being booked to cover for sickness absence among the permanent staff.
CASE STUDY 9

South Downs Health NHS Trust – Nurse Support Team

One community trust has set up a Nurse Support Team to back up district nursing teams in the Brighton and Hove area. The core team comprises 6 bank staff, increasing up to 16 to cover main school holidays and 12 weeks over the winter period when demand is highest. They are employed on flexible contracts. Referrals come in from district nursing teams and are prioritised by the Nurse Support Team using five criteria:

- to support teams in maintaining patients at home who would otherwise require hospital/nursing home admissions;
- to support teams in accepting early hospital discharge or patients with short-term intensive needs;
- to provide cover for nurse prescribing;
- to provide cover for short-term sickness absence; and
- to meet any increase in unplanned patient care contacts.

The team are also piloting flexible working arrangements including: annualised hours, self-rostering and flexible shift start and finish times. One of the team is a recently retired district nurse. Central to the development of the team has been the identification of professional development and training needs to meet the core nursing skills required for community nursing practice.

Source: Audit Commission visit

CASE STUDY 10

Newcastle City Health NHS Trust – mental health cover

The trust has identified a list of nurses registered with the bank who are trained in mental health nursing and prepared to be contacted at short notice and outside working hours. These nurses help on medical and general wards by providing therapeutic observation and ongoing mental health nursing assessment to patients who require medical in-patient attention but are also diagnosed with a psychiatric condition or are thought to be a risk to themselves or others.

Source: Audit Commission visit
At the trusts visited by the Audit Commission, few (one in five) ward managers considered borrowing staff from elsewhere and in practice there is little cross-cover between wards or teams. In London, for example, cross-cover accounts for less than 0.5 per cent of the temporary hours worked on acute hospital wards, and in more than half of the trusts no staff cross-cover was recorded at all. But it can be done. At one of the acute hospital trusts visited by the Commission, cross-cover accounted for nearly 7 per cent of all temporary hours worked, saving the trust approximately £1,350 per month. And there are electronic time and attendance systems that can give trusts a better day-to-day overview of staff deployment and help to promote more efficient staffing patterns [CASE STUDY 11].

**CASE STUDY 11**

Swansea NHS Trust – time and attendance management

Poor data on work attendance led Swansea NHS Trust to adopt an electronic time and attendance management system at Morriston Hospital in 1999. The off-duty roster for each ward/unit is entered on a weekly basis. When substantive staff arrive for work they swipe their ID card through an electronic terminal. Their time of arrival and departure are recorded against the shift the system expects. This provides accurate attendance data, eliminating paper timesheets and manual payroll processing. The system enables easier monitoring of working hours in line with the Working Time Regulations, provides an overview of staff deployment around the hospital at any given time of the day and an overview of ward rosters. Reasons for extra hours worked and hours lost are also recorded.

*Source: Audit Commission visit*
Pool arrangements

132. Another way of using the establishment to cover fluctuations between areas is to operate a formal staff pool. Nationally, about one in four trusts currently has nurse staffing pool arrangements, but comparatively few staff are involved – typically less than 1 per cent. In these schemes, pool staff are allocated on a daily basis to particular wards where there is a shortfall [CASE STUDY 12]. In some schemes staff can be moved to any ward or team. More typically, they are assigned to a particular team or group of wards, thus lessening any unfamiliarity and uncertainty. This kind of approach can work particularly well for those with young families who are returning to nursing and want a flexible work commitment.

CASE STUDY 12

Mid Essex Hospitals Services NHS Trust – Flexipool

The flexipool was set up in August 1999 and currently comprises about 40 healthcare assistants and registered nurses. The trust encourages pool staff to take up flexible employment on the wards, and since it started about 100 nursing staff have been through the pool.

Flexipool staff have flexible, permanent contracts but decide the hours and days they want to work a month in advance. All have annualised hours contracts so that they have some flexibility if, for example, they cannot work an arranged shift. The scheme got funding from the local education consortium and from the NHS Executive regional office so that registered nurses from the Return to Practice course could be supernumerary in the first six weeks while they got to know the wards.

Wards put in their requests for bank staff four weeks in advance. Flexipool staff are allocated shifts first. Between 700 and 800 shifts are filled each week by bank, agency and flexipool staff; flexipool staff account for about 10 per cent. The trust plans to employ about 60 of its 1,600 nursing staff under the scheme and cut back on the use of bank and agency staff.

North Tees and Hartlepool NHS Trust – Nursing Resource Initiative

The Nursing Resource Initiative was set up in October 1998 to provide cover and ensure consistent quality of care on acute wards at Hartlepool General Hospital. The resource team comprises 20 part-time (20 hours a week) healthcare assistants recruited from existing bank staff at the hospital. These staff work rotational day and night duty so that they can be allocated when the wards are at their busiest. In June 2000 a resource team of 30 healthcare assistants was set up at the trust’s site in North Tees. A new initiative starting this year is the recruitment of Nursing Cadets to work within the resource team while they are completing NVQ training.
CASE STUDY 12 (continued)

Healthcare assistants recruited to the resource team have a two-week induction period on one ward as a supernumerary member of the ward team. Payment for this is shared between the wards which utilise the nursing resource.

The resource staff are allocated to wards where utilisation is predicted (using GRASP, a nursing workload measurement system) above 110 per cent for the next 24 hours. The staff are required to work on any wards within the surgical, medical and elderly care, orthopaedic and gynaecological directorates. Resource team members need a flexible approach to work but there is some guarantee as to the shifts they will be working, based on a two-week rota that is produced about a month in advance.

Source: Audit Commission

Using additional plain time hours and overtime

Information on the use of additional plain time hours payments is not readily available in most trusts. But it can be a cost-effective way of providing temporary cover [BOX L] especially where a small number of hours are needed. For example, a nurse contracted to work five-hour shifts may be able to stay on for an extra two hours when a bank or agency nurse would want a full shift. And because the staff are familiar with the work areas and the patients, it has the added advantage of promoting continuity and quality of care.

BOX L

Additional hours

At one trust providing community nursing, mental health and learning disabilities services, local auditors collected figures on additional hours, overtime hours, bank and agency working over a three-month period. Overall, the trust used about 180,000 hours of additional nursing cover at a cost of over £410,000 a year. The two directorates had similar levels but very different ways of organising cover. In mental health and learning disabilities, three out of four shifts were provided by agency nurses or worked as overtime. In contrast, cover in community nursing was mainly provided by part-time staff working additional plain time hours and by bank staff. Consequently, temporary staffing costs per nurse were 36 per cent higher in the mental health and learning disabilities directorate.

Source: external auditor's report
The amount of time available will depend in part on the number of part-time staff employed. But it may also be influenced by the bank pay rates. Where trusts pay the mid-point of grade D for all registered nurses on the bank, any part-time staff above that point will be better off working additional plain time hours. Unlike additional plain time hours, overtime is significantly more expensive. In its 1999 report, the House of Commons Health Committee (Ref.9) recommended: ‘overtime payment should replace undue reliance on agencies as soon as possible’. Overtime – if it has to be booked for a full shift – is usually (with the exception of public holidays) more expensive than agency cover. But overtime may be more cost-effective and easier to arrange when cover is only required for part of a shift. Many trusts only use paid overtime in exceptional circumstances, and overall it accounts for only 1 per cent of the temporary cover worked. However, in areas like learning disabilities, overtime may sometimes be preferable because of the continuity of care it enables.

So far this chapter has shown what trusts can do to reduce unnecessary demand for bank and agency staff. The next part looks at how they can improve the efficiency with which cover requests are met. Three key issues are considered:

- matching the profile – size, composition and availability – of staff on the bank to demand;
- improving booking systems to minimise the time (and cost) spent by clinical staff arranging cover; and
- investing in information technology to improve efficiency and reduce costs.

**Profiling trust banks**

Several key factors combine to determine whether a trust can meet expressed demand for nursing cover from its own bank staff. These include:

- the number of banks operating;
- the number of staff on the bank;
- the skill mix of staff on the bank;
- the availability of staff on the bank; and
- the efficiency with which demand for cover is matched with supply.

This section considers each of these factors in turn. Getting the combination right is crucial to reducing the numbers of unfilled shifts and the reliance on agency staff to fill the gaps, but many trusts seem to recruit staff to their bank with little regard for how big the bank should be or whom they should be recruiting. Consequently the staff bank may seem large compared with the number of staff in permanent posts, but there may be a mismatch between the bank and the need for staff cover. The optimum size of a nurse bank cannot be determined simply by considering ratios of bank staff to permanent staff or measures of bank staff utilisation. Other local factors, such as caseload, specialty mix,
workload fluctuations, organisational structure, bank nurse availability and the efficiency with which demand for cover is matched to supply, will also play a part in determining the appropriate size of the bank.

Number of banks

139. Almost half (45 per cent) of trusts have more than one nurse bank. One in four trusts has four or more banks; nearly one in ten has ten or more. Multiple banks are most common in community and multi-service trusts, where they may provide staff with quite dissimilar skills or may be covering large geographic areas.

140. Where specialties demand specific skills and experience of the particular environment or types of patients (such as critical care or theatres), having specialist banks can be an advantage. But if these banks are managed in isolation from others, inefficiencies arise when they:

- lack staff to work in support roles;
- are too small to always have staff available when cover is required; and
- have staff available who could be deployed effectively in other clinical areas.

141. Inevitably, multiple banks can mean a lack of common standards, policies and practices, and can lead to different pay rates and higher overall costs. Merging multiple banks should bring economies of scale, in terms of bank management costs, and provide the trust with a bigger overall pool of bank staff. And this can be done successfully without necessarily losing the benefits of specialist banks [CASE STUDY 13, overleaf].
Collaboration between NHS organisations at local levels also presents a major opportunity to promote cost-effective temporary staffing services. But prior to the NHS Professionals initiative there were very few examples of successful partnership. One prominent model was NHS Staff Direct, an in-house staff bank run as a partnership by the NHS trusts in Oxfordshire [CASE STUDY 14]. In primary care, where employment of temporary staff is managed by general practices and by community trusts, there is also a strong case for local Primary Care Groups and Primary Care Trusts to commission a single service.

CASE STUDY 13

Newcastle City Health NHS Trust – nurse bank clusters

The mental health nurse bank was set up in 1993. Several reviews evidenced a lack of professionalism and inadequate controls that posed risks to service users, staff and the trust. There was a significant increase in expenditure during the mid-1990s and over 800 staff were registered with the bank. In 1999-2000 a senior nurse was appointed to lead the necessary changes to the bank service.

Traditionally, bank nurses were employed to work across the trust. But this could give rise to problems of lack of familiarity with the working environment or with local policies and procedures, leading to poorer continuity and consistency of care for clients, and made it more difficult to support bank staff through supervision and performance review. For example, bank staff were being booked to work in the forensic units even if they had no experience of the security issues.

The trust has addressed these concerns by developing a series of ‘nurse bank clusters’. These are:

- Adult acute mental health
- Elderly care
- Neuro Behavioural
- Neuro Rehabilitation
- Forensic
- Special care
- Young People
- Drug and alcohol
- Rehabilitation
- Learning Disabilities

Based on their competencies and preferences, each nurse bank member is registered to work within one or more nominated cluster. The senior nurse for the bank worked with ward managers and others to draw together core responsibilities and a person specification for bank nurses in each of the clusters. Bookings are made centrally and, if necessary, bank staff can still be asked to work outside their usual cluster to meet clinical demands. The cluster system has enabled the trust to address clinical governance issues, reducing risk to patients and developing a sense of team membership among bank staff.

Source: Audit Commission visit

142. Collaboration between NHS organisations at local levels also presents a major opportunity to promote cost-effective temporary staffing services. But prior to the NHS Professionals initiative there were very few examples of successful partnership. One prominent model was NHS Staff Direct, an in-house staff bank run as a partnership by the NHS trusts in Oxfordshire [CASE STUDY 14]. In primary care, where employment of temporary staff is managed by general practices and by community trusts, there is also a strong case for local Primary Care Groups and Primary Care Trusts to commission a single service.
The typical approach to bank nurse recruitment – effectively to have continuous open recruitment – means that similar-sized trusts can have very different numbers of staff on their bank(s) [EXHIBIT 16, overleaf]. For example, in trusts with around 2,000 nursing staff, the number of bank staff ranges from under 500 to 2,000. But some trusts have used recruitment to the bank in more innovative ways to support return to practice for registered nurses [CASE STUDY 15, overleaf].

**CASE STUDY 14**

**Staff Direct – the Oxfordshire Consortium NHS Staff Bank**

Staff Direct is an in-house staff agency hosted by Oxfordshire Mental Health Trust but providing nursing and other staff to all NHS trusts in Oxfordshire. It handles approximately 11,000 shifts per month. Since July 2001 it has been managed – through a service level agreement – as a collaborative venture between a consortium of trusts. The consortium was formed to help trusts address the staff shortages in the county, to reduce their reliance on agency staff and to improve the quality of temporary staff supplied.

Staff Direct is managed by an operational board supported by human resources, occupational health, finance, training and development, marketing and communication committees, with representatives from the partner trusts. These report to a consortium board made up of partner trust members and senior managers from Staff Direct. The board monitors fill rates, has an overview of governance issues and reviews progress against the business plan. Local user groups have been set up within each trust to review the operational effectiveness of the service.

Staff Direct operates on a not-for-profit basis. A commission fee is charged to the consortium members to cover costs and any surplus or deficit is then shared pro rata between the member trusts or, by agreement, re-invested in the service. In addition to handling shift bookings, Staff Direct provides an occupational health service, induction, mandatory training and clinical practice updates.

*Source: Audit Commission visit*

**Numbers of bank staff**

143. The typical approach to bank nurse recruitment – effectively to have continuous open recruitment – means that similar-sized trusts can have very different numbers of staff on their bank(s) [EXHIBIT 16, overleaf]. For example, in trusts with around 2,000 nursing staff, the number of bank staff ranges from under 500 to 2,000. But some trusts have used recruitment to the bank in more innovative ways to support return to practice for registered nurses [CASE STUDY 15, overleaf].
Similar sized trusts can have very different sized banks.

Source: Audit Commission survey of NHS trusts (N=256)

144. The size of the bank may not relate to the expected demand for nursing cover. Some nurse banks appear overly large when compared with the number of bank staff used. In some trusts fewer than 10 per cent of the bank staff may actually be used. An inappropriately sized bank – whether it is too large or too small – can cause problems and additional costs for trusts, and is not a good advertisement for trusts seeking to promote the bank as a way back into nursing for returners. Where banks are too small, they may be unable to meet demand without relying on agency staff, and some bank staff may be contacted and used excessively. Equally, when the bank is too large, some staff may be used infrequently and others not at all.
It is important that trusts maintain a ‘live’ bank. Some trusts try to minimise the problem by making it a condition of joining the bank that recruits are available for a minimum number of shifts. But even so, trusts need to regularly audit bank staff, to investigate those staff that have not worked bank shifts over a specified period – typically six months – and, if necessary, to remove them from the bank. This needs to be done carefully, since some staff join the bank specifically to do seasonal work. Periodically removing and subsequently re-instating them can be demotivating and increases administration costs. Nevertheless, a review of staff on the bank can sometimes produce cost savings [CASE STUDY 16, overleaf].
Grade mix

146. Not only must the overall number of bank staff be appropriate to likely levels of demand, but the mix of staff available – in terms of their skills and experience – also needs to be related to demand. There is little point in having a large bank predominantly staffed with healthcare assistants if the shortfalls requiring cover are among registered nurses. In most trusts between 60 and 85 per cent of the nursing staff are registered nurses. But the profile of bank staff can be quite dissimilar [EXHIBIT 17]. In two-fifths of trusts, less than half the bank staff are registered nurses. In most trusts the mix of staff on the bank does not match the pattern of requests for cover [EXHIBIT 18]. The mismatch can mean that appropriately qualified staff are not available. In the Audit Commission’s survey, one in six requests for D grade cover were provided at a different (usually higher) grade. In one trust visited, more than three-quarters of bank staff are registered nurses but only two-fifths of requests are for registered nurses. This may lead to more requests for agency healthcare assistants or to using bank staff of a higher grade than necessary.

CASE STUDY 16

Newcastle City Health NHS Trust – avoiding unnecessary payroll charges

In April 1999 Newcastle City Health NHS Trust had over 800 nurses registered with its bank. A review found that a substantial number of these nurses had retired or moved away from the area, and others had not worked any bank shifts in the last six years. There is an annual charge by payroll for administration costs of £54.25 per bank nurse. The trust contacted all nurses who had not worked in the last six months, informing them that if they were unable to work in the next three months they would automatically be removed from the bank. Approximately 300 names were removed; an implied saving of £16,275.

The trust now stipulates that staff on bank-only contracts must be available to work a minimum of one to two shifts a week, while those with substantive posts have to be available for at least one shift per month. And all bank staff are required to inform the nurse bank on a monthly basis of their availability to work particular shifts.

Source: Audit Commission visit
EXHIBIT 17

Grade mix of bank and substantive nursing staff

The mix of staff available on the bank may not reflect that elsewhere in the trust.

Registered nurses as a percentage of nursing staff

Source: Audit Commission survey of NHS trusts (N=256)

EXHIBIT 18

Registered nurses on the bank and requests for registered nurses

In most trusts the mix of staff on the bank does not match the pattern of requests.

Source: Audit Commission survey of NHS trusts (N=256)
Staff availability

148. The effectiveness of trust banks can also be influenced by who is recruited to the bank. Some trusts have a much higher proportion of substantive post holders working on the bank than others [EXHIBIT 19]. On average, about a third (29 per cent) of nursing staff have bank contracts as well as substantive posts. But there is considerable variation around these averages, and in some regions, notably London and the South East, it is much higher (60 per cent), perhaps reflecting the demand for nursing cover.

149. Having a large proportion of permanent staff on the bank may offer some patient benefits in terms of continuity of care – especially if bank staff are deployed in their usual work areas – but it can also lead to a shortfall in staff available to provide cover. This shortfall arises because permanent staff, particularly those already working full-time, have less flexibility about when they work bank hours, because of their pre-existing shift pattern. The Audit Commission’s surveys of bank staff at eight trusts found that more than one in four (27 per cent) bank staff with a substantive NHS post had either never worked a bank shift or had not worked one in the last three months. This compares with one in ten staff on bank-only contracts not working a shift.

EXHIBIT 19
Substantive post holders with a bank contract
Some trusts rely on permanent staff to work on the bank.

Source: Audit Commission survey of NHS trusts (N=256)
150. Trusts also have to minimise the risks of staff working excessive hours. By working more than 10.5 hours on the bank on top of their standard 37.5 hours, almost half (47 per cent) of the bank staff with a full-time substantive NHS post worked more than 48 hours in their last full working week.\textsuperscript{30}

151. These factors help explain why some trusts underutilise their bank staff while making significant use of agency staff. Overall, three out of four bank staff worked at least one bank shift in the last three months. But in one London trust over a third had not worked even though the trust had made substantial use of agency staff. This may be because bank staff had not been asked to work – with ward staff requesting agency cover rather than going through the bank office – or because bank staff had been asked but were not available as most had full-time substantive contracts. Comparing the number of hours staff say they are available for bank work with the number of hours they actually worked in the last week [EXHIBIT 20] shows that trusts used only a third of the available hours.

152. Increasing the utilisation of bank staff depends in large part on improving the efficiency with which staff are matched to available shifts. This is examined in the next section.

EXHIBIT 20

Available hours and actual hours

Most bank staff worked fewer hours than they were available.
If trusts do not have appropriate booking arrangements, then the bank may still not be able to respond effectively to either the identified need for staff cover or to the requirements of bank staff for work. As a result, the costs of providing cover may be higher than necessary. Two main costs are involved:

- the indirect costs of clinical staff time arranging cover; and
- the operating costs of providing a bank service.

### Indirect costs

Few trusts have calculated the indirect costs of arranging temporary cover. But these costs can be significant, particularly where there is no centralised system for booking bank and agency staff [BOX M].

#### BOX M

**Co-ordinating bookings**

One trust with three main acute hospital sites, each with its own nurse bank, had different arrangements for booking bank staff at each site. The indirect costs of arranging cover were estimated at £170,000 per year.

**Hospital A**

Bank management is contracted out and ward staff spend minimal time booking cover.

**Hospital B**

Has a centrally co-ordinated bank but the bank office is only staffed on weekday mornings. Senior nurses and ward staff spend much time contacting bank staff and arranging cover themselves. In the Medical Directorate, the directorate nurse and an H grade nurse each spend between 10 and 12 hours a week arranging cover. Separate arrangements for night cover add to the management time. A ward diary exercise found that in 35 per cent of cases over two hours was spent booking cover and that in 71 per cent of cases more than one person was involved in booking the cover.

**Hospital C**

Day-to-day booking of bank nurse staff is devolved to directorates. Secretarial staff are employed to contact and book bank staff; senior nursing staff are involved to a minimal extent. In only 3 per cent of cases was more than two hours spent booking bank staff and 93 per cent of bookings involved only one person.

*Source: external auditor’s report*
At the trusts visited by the Audit Commission, the average amount of time spent by senior nursing staff arranging cover for each booking they had to make ranged from nine minutes, where there was a centrally co-ordinated bank, to half an hour at a multi-service trust with no co-ordinated bank. In the latter, team leaders already under pressure because of staff shortfalls had to spend valuable time using an out-of-date list to telephone people who may already be working or no longer available.

Using the mid-point of grade E as a benchmark, these timings imply costs of between £1.38 and £4.61 for each shift that needed cover [TABLE 3]. For a typical acute trust, making about 2,000 bookings per month, indirect costs (assuming the average of 17 minutes per booking) would be approximately £5,100 per month. Reducing the time per booking to that of the best would nominally save the average trust about £2,340 per month and release this time for patient care. Knowing what these costs are (even though they are not bankable) is important in appraising options for providing cover and in judging the performance of current bank arrangements.

### TABLE 3

<table>
<thead>
<tr>
<th>Trust</th>
<th>Cover arrangements</th>
<th>Average time per booking (minutes)</th>
<th>Cost per booking</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Centrally co-ordinated bank; significant use of agency staff organised via bank office</td>
<td>9</td>
<td>£1.38</td>
</tr>
<tr>
<td>B</td>
<td>Central bank but lots of areas still making their own arrangements, including use of agency staff</td>
<td>26.5</td>
<td>£3.99</td>
</tr>
<tr>
<td>C</td>
<td>Centrally co-ordinated, minimal use of agency staff, extensive use of additional hours and some cross-cover working</td>
<td>23</td>
<td>£3.50</td>
</tr>
<tr>
<td>D</td>
<td>Six separate local banks plus extensive agency use via sole provider contract</td>
<td>16</td>
<td>£2.42</td>
</tr>
<tr>
<td>E</td>
<td>Externally run bank plus additional hours and overtime</td>
<td>18</td>
<td>£2.76</td>
</tr>
<tr>
<td>F</td>
<td>Split site with separate banks on each site (one in-house, one externally run); local arrangements in specialist areas</td>
<td>16</td>
<td>£2.41</td>
</tr>
<tr>
<td>G</td>
<td>Individual banks in four separate directorates, minimal agency use</td>
<td>21</td>
<td>£3.20</td>
</tr>
<tr>
<td>H</td>
<td>No central bank; each directorate and locality makes its own arrangements</td>
<td>30.5</td>
<td>£4.61</td>
</tr>
<tr>
<td>I</td>
<td>Centrally co-ordinated bank; reducing use of agency staff organised via bank office</td>
<td>No figures available</td>
<td></td>
</tr>
</tbody>
</table>

Note: salary cost based on mid-point of grade E; excludes London weighting in three trusts

*Source: Audit Commission prospective survey of bank and agency cover (N=828 bookings)*
Even with centrally co-ordinated bank bookings, the amount of time which ward staff spend arranging cover varies between trusts. The main problems tend to revolve around communication:

- A history of poor bank performance can lead to wards contacting both bank and agency offices to ensure that they get staff (at one trust visited by the Commission, nearly 15 per cent of shift bookings were later cancelled).
- The staff bank may be manned during office hours only, with an answer-phone or other arrangements made outside these times.[TABLE 4] This can pose problems when areas urgently need cover in the evenings, at night or weekends, particularly if there is no access to the bank management IT system.
- The bank may itself be understaffed, leading to poor response to incoming requests, a failure to deal with bookings notified in advance and delays in informing staff that cover has been arranged.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Opening hours</th>
<th>Out-of-hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Mon-Fri 07.00-22.00, Sat-Sun 09.00-22.00</td>
<td>none; wards refer to site manager; urgent requests are passed direct to agencies</td>
</tr>
<tr>
<td>B</td>
<td>Mon-Fri 08.00-18.00, Sat-Sun none</td>
<td>none; wards refer to site manager who contacts bank staff from weekly availability sheet or refers calls to agency</td>
</tr>
<tr>
<td>C</td>
<td>Mon-Fri Sat-Sun 09.00-17.00, none</td>
<td>none; requests are managed by senior nurse; lists of available bank staff provided</td>
</tr>
<tr>
<td>D</td>
<td>no formal bank office</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Mon-Fri 08.00-18.00, Sat-Sun 09.00-17.00</td>
<td>on-call until 22.00 with access to the bank IT system; after 22.00 requests left on the answer-phone</td>
</tr>
<tr>
<td>F</td>
<td>Mon-Fri 08.00-19.30, Sat-Sun none</td>
<td>none; refer to site manager at the weekend from a list of available bank staff</td>
</tr>
<tr>
<td>G</td>
<td>–</td>
<td>no formal bank office; each directorate makes its own arrangements either via an on-call roster or a list of available bank staff held by the senior nurse on duty</td>
</tr>
<tr>
<td>H</td>
<td>–</td>
<td>no formal bank office</td>
</tr>
<tr>
<td>I</td>
<td>Mon-Fri Sat-Sun 07.00-20.00, 08.00-18.00</td>
<td>on-call until 22.00 then requests via site manager; no access to bank IT system</td>
</tr>
</tbody>
</table>

Source: Audit Commission study site visits
158. Trusts can take action to minimise these costs by:
- standardising the booking procedure;
- reviewing the patterns of demand and using this to set appropriate bank office hours;
- making appropriate arrangements for out-of-hours bank service provision; and
- using the latest information technology to enable wards to notify their shifts requirements and to view the status of their requests.

**Operating costs**

159. The reported capital and staff costs of running an NHS bank range from under £500 per month to more than £20,000, with an average (median) cost of £6,245 per month. Bank office staff costs are typically 80 per cent of this total. Across the NHS as a whole, bank management costs are approximately £20 million.32

160. The cost per shift filled varies enormously – from under £1 per shift to more than £20 per shift – around an average (median) of £2.83 per shift filled. This variation is partly because some (one in three) banks also process payroll (and have higher median costs – £4.06) and some (two out of five) deal with staff other than nurses. Among banks that only deal with nursing staff and do not process the bank payroll, the average (median) cost per shift filled is £2.45 [EXHIBIT 21].

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**EXHIBIT 21**

Cost per shift filled

Cost per shift filled varies widely.

Note: excludes those banks which deal with non-nursing staff and those which process the bank payroll.

*Source: Audit Commission survey of NHS trusts (N=256)*
Some staff banks are still administered using manual records.

161. Operating costs per shift filled are highest where banks are inefficient in filling shifts. Some staff banks are still administered using manual records. This makes the task of finding appropriate staff to fill shifts cumbersome and time consuming, and if the bank staff do not complete availability forms, bank co-ordinators can end up making large numbers of unnecessary telephone calls.

162. Trust banks (and agencies) have a better chance of filling shifts, and of filling them with appropriate staff, if they get advance notice of likely requirements [TABLE 5]. Much of the demand for temporary cover can be predicted days, and even weeks, in advance. But fewer than half the requests for bank cover are made with more than a week’s notice.

163. More than one in five requests for cover are made within 24 hours of the shift start time. Two-thirds of these last minute requests are made within 12 hours of the shift start time. At some trusts over half the requests were made at such short notice.

164. Advance bookings are associated with higher fill rates [BOX N] and with more consideration being given to alternative cover arrangements. Some trusts make use of regular ‘prospective demand’ returns from ward or team managers that can help them plan and book cover in advance. But trust banks differ in the amount of notice they ask for planned cover requirements.

165. By increasing the amount of notice they have, trust banks can raise their overall fill rates, reduce the use of agency staff and increase the likelihood of alternative cover arrangements being made. Trusts’ bank offices need to be staffed to a level that enables them to make use of the advance booking information, and bank staff need to indicate their availability on a regular basis.

### TABLE 5

**Advance notice increases the likelihood of shifts being filled**

<table>
<thead>
<tr>
<th>Amount of notice given</th>
<th>Percentage of cover requests</th>
<th>Percentage of shifts unfilled</th>
<th>Percentage of shifts filled by agency staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 hours or less</td>
<td>22.1</td>
<td>14.4</td>
<td>18.6</td>
</tr>
<tr>
<td>1-2 days</td>
<td>9.1</td>
<td>10.4</td>
<td>16.4</td>
</tr>
<tr>
<td>3-7 days</td>
<td>24.0</td>
<td>6.3</td>
<td>14.8</td>
</tr>
<tr>
<td>More than a week</td>
<td>44.8</td>
<td>2.4</td>
<td>4.3</td>
</tr>
</tbody>
</table>

Source: Audit Commission prospective booking survey of bank and agency cover (N=828 bookings)
Some banks have a much more informal and ad hoc approach, with little (if any) advance warning of likely demand. They also rely on bank office staff phoning around lists of bank staff to find out who is available. While trusts will always need such flexibility to provide emergency cover, and smaller banks may not see the need to formalise their day-to-day operations, it is likely that most would benefit from a more systematic approach. The core requirements of temporary staffing operations lend themselves to IT solutions.

Reliable information systems are crucial in making the operation of an NHS trust bank work effectively and efficiently. Computerised information systems holding the names, skills and work preferences of bank staff can help to identify the person who best matches the needs of a particular ward or shift and ensure that clinical governance checks such as UKCC registration, working hours and mandatory training requirements are made [CASE STUDY 17, overleaf]. And the best of these systems can be integrated with trusts’ patient administration and workload systems, with roster management, human resources and payroll.33
IT systems can also improve efficiency by reducing the number of unsuitable shift requests that bank staff might get. Overall, around one in five bank staff said they had been offered unsuitable work in the last six months. But in two trusts visited by the Audit Commission this figure rose to over half of all bank staff. In many cases the shift offered was regarded as unsuitable because of the timing or the location – factors that can readily be built in as filters to bank management IT systems.

Currently, fewer than one in five trusts use a computerised bank management system. These tend to be the trusts with highest demand for cover, but some trusts with bank staff expenditure in excess of £5 million a year and handling more than 5,000 shifts a month are still using manual systems.
Where trusts have an IT system, the cost per shift filled is about 10 per cent lower. Overall fill rates are similar but the proportion of shifts filled by agency staff, rather than bank staff, is reduced, reflecting the better matching of supply and demand and improved response times. Some systems will automatically contact agencies in a predetermined order, providing comparative costs to help the user select the most cost-effective option if the bank is unable to fill the shift. A few trusts have begun to turn the whole process around by making use of intranet systems to provide a ‘self-service’ approach [CASE STUDY 18]. Shift requirements can be communicated over the web, enabling bank nurses to see what is available, to apply on-line for the shifts that suit them best and to update their future availability without having to telephone the bank office. The development of such systems will improve the efficiency of trust banks and will enable the areas needing cover to monitor the progress of their bookings.

To get the best from their temporary staffing services, trusts need to take a strategic overview. In many NHS trusts temporary staffing is a multi-million pound enterprise. And yet all too often it is run as a day-to-day clerical operation with little, if any, board level input. As a result, the emphasis is inevitably on filling the next shift rather than on reducing demand. The final chapter of this report considers the need for change and looks specifically at the NHS Professionals initiative, a new direction and a more strategic approach to temporary staffing.

CASE STUDY 18

St Mary’s NHS Trust – internet café

One of the ways in which St Mary’s NHS Trust is trying to demonstrate that it values its staff is to provide free access to the internet for personal, as well as professional, use. With funding from the special trustees, internet and intranet access will be provided at eight terminals in a newly refurbished cafeteria. Shift requirements will then be communicated over the trust’s intranet (both in the cafeteria and on the wards), enabling bank staff to see what is available, to apply on-line (within strict controls) for shifts that suit them and to update their future availability. This will enable the bank co-ordinators to spend more time on other things, for example visiting the wards they provide staff to.

Source: Audit Commission visit
Managing Demand and Improving Efficiency

To reduce any unnecessary bank use and minimise dependence on agency staff, trusts should:

1. Provide guidance on when it is appropriate to book bank and agency cover.
2. Remove barriers to cross-cover support and encourage movement of staff between areas where this promotes good patient care and reduces costs.
3. Invest in training and guidance to promote more effective rostering of available staff.
4. Use additional hours and overtime when these are cost-effective and will promote continuity of patient care.

To maximise the efficiency with which cover requirements are filled, trusts need to:

5. Review, and if necessary alter, the number and mix of staff on the bank in relation to the level and types of demand for cover.
6. Minimise the amount of time spent by clinical staff arranging cover by centrally co-ordinating cover arrangements, standardising booking processes and promoting good communications between clinical areas and bank services.
7. Ensure that bank services are staffed appropriately, that bank office services are open at appropriate hours and that arrangements for handling requests outside of these hours are effective.
8. Make modest investments in bank management software to speed up shift bookings, modernise bank administration and provide robust performance management information.
The Way Forward

Faced with demand pressures and, in many cases, arrangements that do not offer the best value for money, trusts need to improve the ways in which they provide nursing cover. NHS Professionals is a new national initiative that could radically alter the ways in which NHS trusts arrange temporary staffing. However, efforts to reduce the need for cover have to be addressed alongside improvements in supply.
NHS trusts can better manage the clinical and financial risks set out in this report in two ways:

- By improving the quality and efficiency with which temporary nursing cover is provided. Trusts have been tackling this in a variety of different ways, as illustrated by the case studies in this report. Others have yet to make the changes that are needed. The approach provided by NHS Professionals is one way forward.

- By reducing the need for temporary staff by tackling the underlying causes.

This final chapter considers these two issues.

**Improving quality and efficiency – NHS Professionals**

173. NHS Professionals is a new approach to managing and providing temporary staffing services. It recognises that many nurses, nursing auxiliaries and healthcare assistants want to work for the NHS on a casual or seasonal basis while NHS trusts often require staff at short notice. Using call centre technology, and building upon existing bank and other temporary staffing arrangements, it intends, in time, to provide a nation-wide service – through a single national telephone number – offering NHS trusts cost-effective, flexible access to staff across the full range of clinical and support roles. Although NHS Professionals is being set up in England, there may be scope to apply the approach in Wales.

174. NHS Professionals is modelled on an initiative (NHS Trust Professionals) developed by West Yorkshire Metropolitan Ambulance Service and based at the West Yorkshire NHS Direct site in Wakefield [CASE STUDY 19]. NHS Professionals started by working in partnership with Pinderfields & Pontefract Hospitals NHS Trust and later with Burnley Health Care NHS Trust.

**CASE STUDY 19**

**NHS Professionals – Wakefield**

The NHS Professionals service based in the same building as NHS Direct (with whom they share technology support staff) in Wakefield operates a call centre on the same principle as 0845 telephone calls. This is the single point of contact for managing NHS trusts’ demands for staff. The centre currently has 170 telephone lines and handles about 5,000 calls per week – although it has the capacity to manage a much larger quantity – and the number of operators on duty is varied with predicted call volumes. Requests are handled by trained call centre staff who use an on-screen database to identify the best match with available staff. If no nursing staff are available, the operators book cover from a preferred list of commercial agencies.

*Source: Audit Commission visit*
175. Starting in April 2001 with 15 pilot schemes, NHS Executive Regional Offices were asked to manage an implementation programme to develop local services to NHS Professionals standards [BOX 0] over the next two years. Up to £4 million has been made available to support the start-up of NHS Professionals. The service is expected to become self-sustaining by recouping costs from the NHS trusts using its services. Ultimately it is intended that NHS Professionals will be used by all NHS organisations as the primary supplier of all temporary healthcare staff. The long-term aim is for NHS self-sufficiency, and agencies will only be used under tight contract terms. The changes that are envisaged could radically transform the ways in which NHS trusts arrange their temporary staffing cover.

176. Staff working through NHS Professionals (as their sole contract or in combination with other employment) will receive similar benefits to those of full-time NHS employees, including holiday pay and membership of the NHS pension scheme. They will be paid weekly and will receive compensation for shifts cancelled at short notice. Their training needs will be assessed and they will be able to access opportunities for meeting their continuing professional development needs. This will help to reduce clinical risk.

BOX 0

NHS Professionals – key characteristics of accredited services

Seven key characteristics have been set out by the NHS Executive as distinguishing temporary staffing arrangements operating to NHS Professionals standards:

- accessibility – using the best modern IT systems and call centre technology
- equity – an agreed national framework for terms and conditions of service complying with the Improved Working Lives Standard
- collaboration – NHS employers working together to design, implement and operate services across local labour markets
- quality – high quality patient care assured through clinical governance arrangements
- national – nationally accredited service accessible through a single national telephone number
- teamwork and staff involvement; and
- integrated – included as part of overall workforce planning.

Source: NHS Executive (Ref. 10)
There is an important lesson to be learnt from the early schemes operated by NHS Trust Professionals. Ward staff report that it has been successful in terms of improving the quality of temporary staff provided and in enabling a switch from agency to bank staff. At Pinderfields & Pontefract NHS Trust, for example, there was a 20 per cent reduction in the number of agency hours booked between October 1999 and March 2000. But the overall demand for temporary nursing cover has continued to rise. For example, a comparison of figures for February 1999 and February 2000 showed a 28 per cent increase in the amount of temporary cover used. Part of this can be explained by problems in filling vacancies in some areas. It seems that better supply can generate additional demand, resulting in further pressure – as has been found elsewhere in the health service.

The combination of a simpler and more reliable booking process with a switch from ‘expensive’ agency to ‘cheaper’ bank staff, may mean that ward managers are less likely to consider alternatives. Evidence from the Audit Commission’s prospective bookings survey showed that over half the ward staff at Pinderfields & Pontefract Hospitals NHS Trust did not seek alternatives before booking cover from NHS Professionals. This is despite the fact that three out of four bookings were known about at least three days in advance. To be successful, NHS Professionals needs to help trusts tackle inappropriate demand at the same time as meeting genuine needs more cost-effectively.

Any shortfall between a trust’s permanent nursing staff and service needs will increase the pressure to employ temporary staff. Trusts can minimise that pressure in four main ways:

- by reviewing, and where necessary changing, establishments;
- by improving recruitment and retention;
- by managing attendance proactively; and
- by ensuring the effective rostering of available staff.

Trusts may be using more temporary staff because staffing levels were set historically. Significant changes in patient dependency and throughput, combined with the rapid pace of change in healthcare provision, mean that ward establishments need frequent reviewing to ensure that they are in line with patient needs.

An allowance of about 20 per cent has traditionally been built into establishments to compensate for annual leave, sickness absence and study leave. But on average 24 per cent of available hours are lost, so the current allowance may be too little in some trusts [EXHIBIT 22]. If staffing levels are below funded establishment because of vacancies, then trusts will use more temporary staff to make up this shortfall.
EXHIBIT 22

Built in cover and hours lost

Cover built into staffing levels may be inadequate.

Source: Audit Commission Acute Hospitals Portfolio, Ward Staffing Review (N=193 trusts)

182. Improving recruitment and retention, and ensuring that vacancies are filled quickly, will help reduce bank and agency use. There is a whole series of national and local initiatives in this area [BOX P]. By providing opportunities for staff that want to work flexibly, NHS Professionals is an important feature of this broader strategy to promote successful recruitment, retention and improved working lives.

183. If these initiatives are successful and the scale of nursing shortages reduces over time, the demand for temporary staff to cover for vacancies will diminish. But nursing shortages are not the only reason why trusts use bank and agency nursing staff, and an expanded workforce will generate additional demand for cover. Indeed, a number of the trusts visited by the Audit Commission saw a continued rise in the use of temporary staff despite having significantly reduced their nursing vacancy levels.
In the past, bank staff have been regarded as a temporary measure to fill inevitable shortfalls. As such, these staff have tended to be treated differently to those in substantive posts. They have had poorer access to training and development, a lack of performance review and different pay and benefits.

This traditional approach sits uneasily with health service policy in England and Wales. To achieve the vision of a modern patient-centred service, the NHS has to make radical changes in the ways that staff are employed. Improving Health in Wales (Ref.12) and the NHS Plan (Ref.23) in England set out ambitious programmes of reform and expansion across the health service. Both recognise that there are several critical staffing challenges:

- recruiting and retaining sufficient staff;
- improving service flexibility and access;
- using staffing resources flexibly and cost-effectively;
- creating working environments that meet the needs of individuals for greater flexibility and control over the hours they work;
- providing fair and supportive employment conditions; and
- developing the skills and competencies of all staff.

The way forward

184. In the past, bank staff have been regarded as a temporary measure to fill inevitable shortfalls. As such, these staff have tended to be treated differently to those in substantive posts. They have had poorer access to training and development, a lack of performance review and different pay and benefits.

185. This traditional approach sits uneasily with health service policy in England and Wales. To achieve the vision of a modern patient-centred service, the NHS has to make radical changes in the ways that staff are employed. Improving Health in Wales (Ref.12) and the NHS Plan (Ref.23) in England set out ambitious programmes of reform and expansion across the health service. Both recognise that there are several critical staffing challenges:

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- creating working environments that meet the needs of individuals for greater flexibility and control over the hours they work;
- providing fair and supportive employment conditions; and
- developing the skills and competencies of all staff.

Source: NHS Executive (Ref. 21 & 22)

**BOX P**

**Tackling the nursing shortage**

National and local initiatives have been set up to tackle the nursing shortage by:

- increasing pay and introducing cost of living supplements for those in the most expensive parts of the country;
- increasing pre-registration nursing and midwifery training commissions so that at least 5,500 more nurses are being trained each year by 2004;
- encouraging more qualified nurses to return to the NHS;
- recruiting more nurses from abroad;
- improving the quality of working lives by increasing the availability of flexible working practices (self-rostering, flexi-time, annual and reduced hours), childcare and carers’ support;
- promoting flexible retirement; and
- improving the supply of affordable housing in areas where accommodation costs are high, particularly in London and the South East.

Source: NHS Executive (Ref. 21 & 22)
There is now an opportunity to change the traditional approach and to recognise that, properly managed and developed, bank staff can be a part of the solution. In order to do this, trusts need to identify a senior person to take an overall lead and have board level accountability for the quality of care that temporary nursing staff provide.**[CASE STUDY 20]**.

CASE STUDY 20

King’s Mill Centre for Healthcare Services NHS Trust – modernising the nurse bank

Despite having had a nurse bank for more than ten years, the trust was becoming increasingly dependent on agencies to ensure safe staffing levels and avoid closing beds. But agencies were unable to meet all demand, operations were cancelled, beds were closed and permanent staff were under pressure to work additional hours and overtime that they did not always want. The trust’s ability to meet its contracted activity and respond to additional demands at short notice was threatened. Following an option appraisal, the trust’s senior management team decided to re-launch the internal bank in August 1999.

**February 1999...**

The bank is co-ordinated by one clerical staff member based in the personnel department, who has other duties as well as making bank staff bookings.

Communications with bank staff are ad hoc and bank staff are not included in team briefings.

The bank office is only open in office hours.

There are no formal operating policies in place.

Bookings are made using paper records.

Shift fill rates are poor. Over the last three months 68 per cent of the requests for registered nurses were unfilled.

One in seven shifts are filled by agency staff at a cost of approximately £117,000 a year.

No management information is routinely compiled.

**February 2000...**

A full-time nurse bank co-ordinator has been appointed, together with a full-time administrator. The bank co-ordinator is an experienced nurse. Additional secretarial/clerical support is under consideration. A self-contained bank office has been created.

All bank staff and wards receive a monthly bank newsletter, helping to keep them up to date (including team briefings) and to create an identity for the bank.

Out of hours, a list of available bank staff is provided to the senior nurse on duty.

Formal operating policies and procedures have been agreed and communicated to all staff, providing a consistent trust-wide approach.

A computerised bank management system is in place.

Shift fill rates have improved despite a 70 per cent increase in demand. In the last three months only 16 per cent of requests for registered nurses went unfilled.

No shifts were filled by agency staff in the last three months.

The computerised bank management system enables tailored monthly reports to be compiled for unit general managers, nurse managers and ward leaders.
Improving recruitment, retention and rostering will reduce the need for bank and agency nursing staff. However, temporary solutions will always have an important role in ensuring that clinical services are maintained and in providing a valuable stepping stone back into NHS employment for those wanting to resume their careers.

CASE STUDY 20 (continued)

<table>
<thead>
<tr>
<th>February 1999...</th>
<th>February 2000...</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no monitoring of bank work.</td>
<td>103 of the 265 nurses on bank-only contracts have been removed as they had not worked in the last six months; 68 new staff have been recruited to the bank and 40 bank staff have obtained substantive posts in the trust.</td>
</tr>
<tr>
<td>Bank staff do not have appraisals.</td>
<td>Annual appraisals have been introduced for all staff on the bank, reviewing clinical competence, identifying development needs and improving communication between the line manager and bank staff.</td>
</tr>
<tr>
<td>There is no performance monitoring.</td>
<td>A staff evaluation form has been introduced so that clinical staff can provide structured feedback on individuals’ performance. These are used in the appraisal process.</td>
</tr>
<tr>
<td>Induction of new bank staff is organised by the in-service training department. But there is no monitoring of, or provision for, ongoing training needs.</td>
<td>Regular liaison between the nurse bank and in-service training promotes continuing professional development. The IT system allows training to be monitored. In October the trust was commended by Investors in People for the quality of appraisal and personal development plans in place for bank staff.</td>
</tr>
<tr>
<td>There is no strategic overview of temporary staffing.</td>
<td>Temporary staffing issues are regularly reported to the Board. Proposals to extend the service to neighbouring community hospitals and the PCT are being considered.</td>
</tr>
</tbody>
</table>

Source: Audit Commission study site
The Way Forward

Trusts should reduce their need for temporary nursing staff by:

1. Systematically reviewing establishments and workloads, minimising the duration of vacancies and proactively managing attendance.

2. Promoting recruitment, retention and return by deploying staff flexibly and providing a range of flexible employment options.

3. Identifying a senior person to take an overall lead and have board level accountability for the use and quality of temporary nursing staff.
**Glossary**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Additional plain time hours (APH)</strong></td>
<td>Staff contracted to work part-time can work additional hours paid at normal pay up to standard full-time hours (37.5).</td>
</tr>
<tr>
<td><strong>Annualised hours contract</strong></td>
<td>Staff are contracted to work an agreed number of hours during the year. When the hours are actually worked is dependent on the demand created by workload and staff preferences.</td>
</tr>
<tr>
<td><strong>Clinical governance</strong></td>
<td>A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.</td>
</tr>
<tr>
<td><strong>Clinical Negligence Scheme for Trusts (CNST)</strong></td>
<td>The Clinical Negligence Scheme for Trusts (CNST) is a financial pooling arrangement administered by the NHS Litigation Authority that helps NHS trusts and health authorities in England to manage their clinical negligence liabilities. Annual contributions are assessed on the basis of the type of activities carried out. Discounts can be obtained if the member reaches certain standards of risk management.</td>
</tr>
<tr>
<td><strong>Healthcare assistant</strong></td>
<td>Support staff trained, or undertaking training, in job-related competencies through NVQs or other local training. They work under the supervision of registered nurses.</td>
</tr>
<tr>
<td><strong>Nursing Auxiliary</strong></td>
<td>Nursing staff (not on the UKCC Register) who provide basic nursing care under the supervision of a registered nurse. They may or may not hold NVQs.</td>
</tr>
<tr>
<td><strong>Off-duty roster</strong></td>
<td>A weekly or monthly listing of the shifts, dates and times that each member of staff is scheduled to work.</td>
</tr>
<tr>
<td><strong>Overtime</strong></td>
<td>Hours worked in excess of the standard (37.5 hours) full-time working week.</td>
</tr>
<tr>
<td><strong>Pool</strong></td>
<td>Staff working in a pool scheme are usually contracted for a guaranteed minimum number of hours and may be deployed to work anywhere in the organisation.</td>
</tr>
<tr>
<td><strong>Registered nurse, midwife, health visitor</strong></td>
<td>An individual who has successfully completed training and education for a qualification that is recognised by the UKCC and whose name appears on the UKCC Register.</td>
</tr>
<tr>
<td><strong>Self-rostering</strong></td>
<td>Rostering system where individuals choose their pattern of work, within agreed parameters, and allocate themselves to shifts.</td>
</tr>
<tr>
<td><strong>Team rostering</strong></td>
<td>Staff are divided into teams and a member of each team is responsible for drawing up the roster in consultation with team members; team leaders then discuss the overall roster before authorisation by a senior manager.</td>
</tr>
<tr>
<td><strong>Time in lieu</strong></td>
<td>Hours worked in excess of contracted hours may be ‘paid’ by taking time off in lieu of monetary payment.</td>
</tr>
<tr>
<td><strong>Welsh Risk Pool</strong></td>
<td>See CNST</td>
</tr>
</tbody>
</table>
Whitley Council

‘Whitley Council’ is a generic term for the system of functional staffs councils in the NHS. The Nursing and Midwifery Staffs Negotiating Council is responsible for determining the pay and conditions for nursing staff, midwives and health visitors. Its role is under review as part of wider talks about Agenda for Change, the Government’s pay modernisation proposals for the NHS.

Whole time equivalent (wte)

Term used to describe calculations that express the hours of part-time employees as a proportion of a full-time (37.5 hours) post.
Appendix 1

Sources of evidence

National surveys

Two surveys were conducted as part of this study. These were:

- a survey of all NHS trusts (excluding ambulance trusts and Primary Care Trusts) in England and Wales that employ nursing staff; and
- a national survey of agency nurses in England and Wales.

Audit Commission survey of NHS trusts

In November 2000 a nine-page pro forma was sent to all (344) eligible trusts in England and Wales.

The pro forma requested data for 1998/1999 and 1999/2000 relating to:

- contracting arrangements with nurses’ agencies, including recruitment and performance management;
- expenditure on nurses’ agencies;
- commission rates;
- rates of pay for agency nurses;
- whole time equivalent number of agency staff used;
- management arrangements for in-house and externally contracted banks;
- running costs of in-house banks;
- rates of pay for bank nurses;
- numbers of bank staff;
- expenditure on bank staff;
- whole time equivalent number of bank staff used; training and performance management for bank staff;
- information systems used to manage bookings for bank and agency cover;
- numbers of shifts needing cover and actual fill rates;
- availability of written policies about using bank and agency staff;
- availability and uptake of flexible working arrangements;
- numbers of clinical incidents involving nursing staff;
- future arrangements for managing temporary staff cover;
- whole time equivalent number of nursing staff in post; and
- whole time equivalent number of vacant nursing posts.

265 completed questionnaires were returned: a simple response rate of 77 per cent. Many of those who did not complete the form were working towards dissolution on 1 April 2001.

All data from the survey are self-reported by trusts. Extreme and inconsistent values were checked by the Audit Commission with the trusts concerned in an extensive validation exercise conducted in spring 2001.
Audit Commission survey of agency nurses

An eight-page questionnaire was sent to the home addresses of all (3,261) RCN members in England and Wales who indicated in their membership application (or renewal) that they did agency work. A letter of endorsement from the General Secretary of the RCN accompanied the questionnaires. The survey form was in four parts. These concerned:

- respondents’ biographical details;
- current employment;
- working for an agency, including aspects of recruitment, training and performance appraisal; and
- respondents’ most recent agency shift, including induction received when arriving for work.

By the close of the survey, 1,068 questionnaires had been returned. This represents a simple response rate of 33 per cent. Excluding questionnaires returned as undeliverable by the post office and those returned as inappropriate by the recipient, the usable response rate was 31 per cent.

The Audit Commission is grateful to the RCN for their help with the organisation of the survey.

Data collection at Audit Commission study sites

The following exercises were conducted at most of the main study sites:

Bank nurse survey

The survey was in four parts and was concerned with respondents’ biographical details, current employment, working on the bank, in particular the training received and support that they got, and respondents’ last bank shift. A questionnaire was sent to all (7,982) nurses listed on the bank at eight trusts. 2,840 forms were returned. Excluding questionnaires returned as undeliverable by the post office and those returned late, the usable response rate was 34 per cent.

Prospective survey of bookings for bank and agency cover

The aim of this exercise was to find out about bookings for bank and agency cover, for example the reason why cover was needed, the hours and grade of cover required, the length of time it took to arrange cover and alternatives tried before booking bank or agency staff. The survey was conducted over one week (two to three weeks in the community trusts). 44 ward managers/team leaders completed 828 diary forms.

Review of personal files

At seven of the NHS trusts visited, the personal files of 20 to 30 bank-only nursing staff who worked on medical, surgical or paediatric wards (in acute hospitals) or in community nursing services and psychiatric or learning disability units (in non-acute trusts) were requested. The aim of the review was to assess whether the necessary checks, such as verifying nursing qualifications, obtaining references, occupational health...
screening, police checks and eligibility to work in the UK, had been completed when nurses were recruited to the bank. A total of 205 personal files were reviewed.

**Review of timesheets**
At each trust, 10 bank and 10 agency timesheets were requested. The aim of the review was to assess completion against 13 items, such as start and finish time, clinical grade and confirmation of hours worked, and to review whether timesheets were designed in ways that minimise potential for errors and fraud. A total of 90 bank timesheets and 71 agency timesheets were reviewed.

**Review of agency invoices**
At each site, 10 agency invoices were requested. The aim of the review was to assess whether the trust was correctly charged for the right grade, the hours worked, at the agreed pay and commission rates, to check that NI and VAT were correctly applied and to review the authorisation of payments. A total of 71 agency invoices were reviewed.

**Spot checks of bank and agency staff**
The aim of this exercise was to provide a reality check on whether procedures were in place to minimise clinical risk when bank and agency staff report for duty. For example, they were asked the location of cardiac arrest equipment, the telephone number to dial in case of a cardiac arrest and the fire safety procedures. In total 38 spot checks were carried out on 25 wards.

**Review of IT systems**
IT systems used to manage bank and agency bookings were assessed against a checklist of items. These included: UKCC registration; monitoring of Working Time Regulations; bank staff availability; reasons for request; monitoring shifts put out to agencies; verifying invoices; timesheets, matching hours claimed against hours requested; calculating payroll costs; and generating management reports and letters to staff.

**Review of Contracts**
Copies of agency contracts were reviewed to check whether they included references to the relevant employment and health and safety legislation and the respective responsibilities of the contracting parties.

**Other sources of information**
Published and unpublished data from a number of sources were obtained and used in this study. These were:
- unpublished data from the UKCC on the use of the confirmation service;
- published data from the Department of Health Vacancy Survey for March 2001, and unpublished figures from the non-medical workforce census on the numbers of bank staff;
unpublished data from Trust Financial Returns made to the Department of Health and the National Assembly for Wales;
unpublished data from a survey of NHS supplies managers conducted by the NHS Purchasing and Supply Agency in autumn 2000 covering NHS trusts in England;
unpublished data from other work by the Audit Commission – in particular the Acute Hospitals Portfolio, ward staffing review. This provides a national comparative dataset (numbers of staff in post, bank and agency staffing, staff costs, shift patterns, clinical risk and workload) collected from more than 3,500 wards at 193 trusts in England and Wales during May 2000;
more than 30 external auditors’ reports on bank and agency nursing at individual NHS trusts from the audit years 1998/1999 and 1999/2000; and
unpublished figures from the RCN’s annual membership survey for spring 2000.
Appendix 2

Study sites

Main NHS Trust visits

We are grateful to all the staff who assisted with data collection, documentation reviews, interviews and pilot audits at the following NHS trusts:

- King’s Healthcare NHS Trust;
- King’s Mill Centre for Healthcare Services NHS Trust (now part of The Sherwood Forest Hospitals NHS Trust);
- Leeds Teaching Hospitals NHS Trust;
- Parkside Health NHS Trust;
- Pinderfields and Pontefract Hospitals NHS Trust;
- Powys Healthcare NHS Trust;
- Priority Healthcare Wearsides NHS Trust;
- University Hospitals Birmingham NHS Trust;
- West Middlesex University Hospitals NHS Trust; and
- West Yorkshire Metropolitan Ambulance Service NHS Trust (NHS Trust Professionals).

Data were collected at these trusts by direct enquiry of their personnel, finance and bank management information systems, by wide-ranging semi-structured interviews and through documentation reviews. A number of data collection exercises were conducted following each visit. These included prospective surveys of bookings for bank and agency cover and surveys of bank staff. These exercises are described in Appendix 1.

Other NHS Trust visits

Additional visits were made to a number of other NHS trusts and organisations, either to help with the early development of the study or, subsequently, to investigate specific aspects of bank and agency nursing. These trusts were:

- Birmingham Heartlands & Solihull NHS Trust;
- Brighton Healthcare NHS Trust;
- Camden & Islington Community Health Services NHS Trust;
- Mid Essex Hospital Services NHS Trust;
- Newcastle City Health NHS Trust (now part of Newcastle, North Tyneside and Northumberland Mental Health Trust);
- Royal Berkshire & Battle Hospitals NHS Trust;
- Royal Free Hampstead NHS Trust;
- South Downs Health NHS Trust;
- Staff Direct, the Oxfordshire Consortium NHS Staff Bank;
- Swansea NHS Trust; and
- University College London Hospitals NHS Trust.
We are also grateful for informal discussions with managers at many other NHS trusts, and with local auditors.

**Agencies**

Visits were also made to the following agencies:

- Allied Healthcare;
- BNA;
- BUPA Nursing;
- Grosvenor Group;
- MATCH;
- Nightingale Nursing;
- Nurses Direct;
- Prestige Nursing; and
- Thornbury.

**Other organisations**

- Department of Trade & Industry;
- Federation of Independent Nursing Agencies;
- Recruitment and Employment Confederation;
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting; and
- Westminster City Council.
Appendix 3

Membership of the Advisory Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Armstrong</td>
<td>Director of Finance, St Mary’s Hospital NHS Trust (until December 2000)</td>
</tr>
<tr>
<td>Dr Barbara Bale</td>
<td>Nursing Officer, National Assembly for Wales (until November 2000)</td>
</tr>
<tr>
<td>Jayne Barnes</td>
<td>Director, NHS Professionals, Wakefield</td>
</tr>
<tr>
<td>Kate Bradley</td>
<td>National Project Manager, NHS Professionals, NHS Executive (from January 2001)</td>
</tr>
<tr>
<td>Mark Britnell</td>
<td>Director of Operations and Deputy Chief Executive, University Hospitals Birmingham NHS Trust (until October 2000)</td>
</tr>
<tr>
<td>Dr James Buchan</td>
<td>Professor of Management Studies, Queen Margaret University College, Edinburgh</td>
</tr>
<tr>
<td>Caroline Fox</td>
<td>Project Manager, London Agency Project, NHS Executive London (from January 2001)</td>
</tr>
<tr>
<td>Alyson Gerner</td>
<td>Purchasing Executive, NHS Purchasing and Supply Agency (from September 2000)</td>
</tr>
<tr>
<td>Grace Gibbs</td>
<td>Director of Nursing and Deputy Chief Executive, West Middlesex University Hospitals NHS Trust</td>
</tr>
<tr>
<td>Georgina Gordon</td>
<td>Executive Nurse Director, Swansea NHS Trust</td>
</tr>
<tr>
<td>Colin Holden</td>
<td>Director of Human Resources, Sandwell Healthcare NHS Trust</td>
</tr>
<tr>
<td>Margaret Hughes</td>
<td>Nursing Division, National Assembly for Wales</td>
</tr>
<tr>
<td>Josie Irwin</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>Jenny Kay</td>
<td>Nursing Division, Department of Health</td>
</tr>
<tr>
<td>Jo Lennox</td>
<td>Senior Buyer, NHS Purchasing and Supply Agency (until September 2000)</td>
</tr>
<tr>
<td>Karen Parsley</td>
<td>Director of Nursing, Brighton Healthcare NHS Trust</td>
</tr>
</tbody>
</table>
Appendix 4

Estimating expenditure on agency nursing

Expenditure on agency nursing is based on Trust Financial Return No.3 (TFR3). This is a compulsory annual return made by NHS trusts to the Department of Health in England and to the National Assembly for Wales. The full costs of agency nursing staff are not always identified on TFR3. Money to pay for them may come from other pay and non-pay budgets without virement (for example where a supplier provides other staff or services to the trust and agency nursing staff costs are aggregated under a different expenditure heading). The figures quoted here also exclude expenditure on those healthcare assistants who work across several areas. In the TFR3 return these are grouped as ‘healthcare assistants and other support staff’. According to TFR3, the NHS spent £34 million on this group in 1999/2000.

The Audit Commission’s survey of trusts collected figures for expenditure on agency nursing staff in the year to 31 March 2000. Trusts were asked to report a single figure to include registered nurses, midwives and health visitors together with nursing auxiliaries and healthcare assistants. Comparing TFR3 and the Audit Commission’s survey shows that, in England, a third of trusts reported the same figure on both returns. One in four reported a higher figure (in aggregate 31 per cent more) to the Commission than they recorded on TFR3. This group included five trusts that reported zero expenditure on their TFR3 return. In one case the figure returned to the Commission was £1.3 million compared with zero on TFR3. The remaining trusts reported a lower figure (in aggregate 16 per cent less) to the Commission than in their TFR3 return. In Wales, the figures for six trusts matched the TFR3 return, in four trusts TFR3 was higher than the Commission survey (in two cases by more than 90 per cent) and in two trusts the TFR3 figure was lower.

Overall, these figures suggest that, for significant numbers of trusts, the TFR3 figures for agency nursing may not be complete and should only be used as a broad indicator of trends in expenditure.
References


Endnotes

1. This figure is based on returns to the Audit Commission’s survey of NHS trusts. It is estimated from the number of shifts filled by bank and agency nursing staff in September 2000. It was adjusted for non-response by grouping trusts using the quartile values for the NHS nursing paybill and applying the mean number of shifts filled for each quartile.

2. Approximately 9,150 (wte) bank nursing auxiliaries were used in the same week. Trend data are not available for bank nursing auxiliaries.

3. Figures on the wte numbers of agency nursing staff used by the NHS were collected by the Department of Health Non-Medical Workforce Census until 1996. They were based on a request, made to each department in each trust, for the number of agency staff who worked in the week ending 30 September. The returns were believed to have had a low level of completion and accuracy, rendering them unsuitable for robust trend analysis.

4. The estimates for bank staff are based on figures returned in the Audit Commission’s survey of NHS trusts. They are adjusted for non-response by applying the median figure for each NHS trust type, discounting for trusts without a bank and for just under 1 per cent of bank staff being on more than one trust bank. The figure for Wales is based on the returns from 12 trusts. The estimate for agency staff is based on the annual RCN membership survey and the Labour Force Surveys (Office of National Statistics). The RCN survey shows that about 2 per cent (8,725) of registered nurses work for agencies as their main employment. The figure is consistent with the Labour Force Survey, which estimates the number for Spring 2000 at 8,400. Added to this are those who work for agencies in addition to holding other nursing and non-nursing jobs. The RCN surveys show this to be approximately 8 per cent of registered nurses in employment. This gives a total for registered nurses of 43,000. The Labour Force Survey shows a further 3,500 temporary staff working as ‘assistant nurses and auxiliaries’ (not covered by the RCN membership survey).

5. The Audit Commission’s survey found that one in three nurses on bank-only contracts expected to be in a substantive NHS post in a year’s time.

6. For example: 29 per cent of trusts reported offering annualised hours but only 3 per cent of nursing staff in these trusts were employed on such contracts. 44 per cent of trusts offer term-time working, but less than 1 per cent of nurses in these trusts took it up.

7. The number of agency offices is drawn from the Thornbury Nursing Services List (www.nursing-list.com/stats). Local authorities provide the figures. Although unvalidated, they tie in well with unpublished figures from the UKCC showing the number of agency offices using the registration confirmation service. 86,500 registrations were checked in the year ending 31 March 2000 by 900 agency offices (including recruitment agencies) across the UK. A recent report by Laing & Buisson (Flexible
8. Part of the increase relates to the implementation of the Working Time Regulations 1999 provision of paid annual leave for temporary staff. This is estimated to have added approximately 6 per cent to the wage bill for agencies in the year to October 1999 and 8 per cent in subsequent years. Agencies have passed most, if not all, of the cost on to trusts (Source: Flexible Staffing Services in UK Health & Care Markets 2001, Laing & Buisson Publications, May 2001).

9. 2000/2001 figures for NHS trusts in Wales show a 21.5 per cent increase (to £9.72 million) in expenditure on agency nursing staff over the 1999/2000 figure. Comparable figures for NHS trusts in England are not available yet.

10. The figure of £420 million is based on returns to the Audit Commission survey of NHS trusts. It is adjusted for non-response by applying the mean spend by trust type, discounting for trusts without a staff bank. Direct costs exclude the costs of bank nurse recruitment, bank administration and clerical staff salaries, set up costs (office space, equipment, IT), running costs (e.g. stationery and telephone charges), induction and mandatory training costs, and clinical staff time on booking temporary cover.

11. The Department of Health Vacancies Survey for March 2001 identified just over 9,000 long-term (3 months or more) vacancies for qualified nurses, midwives and health visitors at NHS trusts in England – a vacancy rate of 3.4 per cent. London had the highest vacancy rate (6.5 per cent) but there was considerable variation across the capital.

12. Ultimate authority – in terms of protecting the public by maintaining and promoting professional standards – rests with the UKCC’s Professional Conduct Committee (PCC). Comparatively few of the cases that reach the Committee involve bank or agency nurses. In 1999-2000 the PCC considered 136 cases of alleged misconduct. Of these, only 7 (5 per cent of the total) clearly concerned practitioners working as bank or agency nurses. And with the exception of 2 cases involving false claims for payment, the nature of the charges paralleled those of other practitioners rather than relating to their employment status as bank or agency nurses.

13. The Department of Health is preparing a recommendation to overhaul the Alert Letter system that should go some way towards tackling this situation.

15. The CRB will increase access to criminal record checks for employment and other purposes. Its primary aim is to provide protection for children and vulnerable adults against those who might wish to harm them. The CRB will act as a central access point for criminal records information as well as (by mid-2002) drawing on the Department of Health’s Consultancy Services Index (which lists people considered unsuitable to work with children), and a new Department of Health list of people who are unsuitable to work with vulnerable adults. Registered employers will be able to ask successful job applicants to apply for one of three types of disclosure if they consider that such a check is necessary.

16. In 1995 a national survey (I Seccombe, C Jackson, A Patch, *Nursing: the next generation*, Institute for Employment Studies, Report 274) of student nurses found that one in three pre-registration nursing diploma students had paid employment, mainly as nursing auxiliaries or healthcare assistants. A follow-up survey (Royal College of Nursing, *Hardship among nursing and midwifery students*, RCN, January 2001) conducted in December 2000 found that not only had the proportion of students in paid work risen to 60 per cent but the average hours worked per week had nearly doubled.

17. Only 5 per cent of agency nurses responding to the Commission’s survey had been screened for MRSA. Figures from District Audit suggest similar levels for bank staff.


19. Overall, only 10 per cent of agency nurses reported working – in agency and any other jobs – in excess of 48 hours in the last week and only 8 per cent worked more than 48 hours as an agency nurse. 70 per cent had at least 12 hours off between their most recent shift and finishing work in any other paid job.

20. Some agencies also perform poorly in this regard, with only one in six agency nurses saying that they had a performance appraisal in the last 12 months.

21. Unpublished figures from a survey of healthcare staff at seven NHS trusts conducted as part of the Audit Commission’s study of non-medical education and training (Ref. 18).

22. See: *UK nursing agencies and the NHS. Evidence from UK nursing agencies to the Commons Select Committee on Health*, February 1999. Available at www.british-nursing-agenci.com

23. This is slightly lower than the minimum rate for a newly qualified nurse under the Whitley agreement. From April 2000 this would have been £7.64 an hour (dividing the annual £14,890 salary by 52 weeks and by 37.5 hours to get a standard hourly rate).
24. Trusts with contracts have an average agency spend of £1.8 million compared with an average of just under £673,000 for those without contracts.

25. The NHS Executive’s evaluation of self-rostering at 19 sites was inconclusive on this question. 58 per cent of ward managers concluded that their use of bank staff was unchanged, and a third thought it had reduced. NHS Executive, *Self Rostering Software: Time Care Pilot Evaluation*, March 1999.

26. Overtime should also be paid to bank staff working more than 37.5 hours a week. In trusts without a centrally co-ordinated nurse bank, several managers may be asking the same bank staff member to work for them without knowing what other duties they have agreed to work. This increases the likelihood of unnecessary overtime payments being incurred. The Audit Commission’s survey of bank staff found that 5 per cent had worked more than 37.5 hours on the bank in the last week and would therefore be entitled to pay at overtime rates.

27. A survey conducted by the Royal College of Nursing (*All part of the Plan? A stock-take of registered nurses in the year 2000*, RCN, 2000) in spring 2000 found that 58 per cent of NHS nurses worked more than their contracted hours. One in five said they did this most weeks; on average for six hours. One in four nurses did not expect to get overtime pay or time off in lieu for these extra hours. Among the rest, twice as many expected time off in lieu as anticipated payment.

28. These are unpublished figures for May 2000 from the Audit Commission’s Acute Hospitals Portfolio, ward staffing review.

29. Figures from the Audit Commission’s Acute Hospitals Portfolio, ward staffing review, show that across England and Wales only one in eight acute hospital trusts used overtime in May 2000.

30. In contrast, only 8 per cent of those full-time NHS nurses who did additional hours through an agency worked in excess of 48 hours in the last week, and only 2 per cent of the bank-only nurses worked more than 48 hours in the last week.

31. Actual costs will depend on who cover arrangements are made by. These will be significantly higher where ward or team managers make the bookings, and lower where bookings are made by clerical staff.

32. The figure of £20 million is based on returns to the Audit Commission survey of NHS trusts. It is adjusted for non-response by applying the average expenditure by trust type, discounting for trusts without a bank. Monthly spend in England is estimated at £1.59 million and in Wales at £73,200.
33. Over the next two years the NHS plans to introduce a new integrated human resources and payroll system. The system being piloted from autumn 2001 will contain a module to support self-rostering with national roll-out to be concluded in 2004. Trusts purchasing bank management systems in the interim need to ensure that they will be able to interface with the new NHS HR/payroll system when it is introduced. The NHS Shared Services Initiative also aims to take advantage of these and other technological advances to provide financial information and services more efficiently. Two pilot centres were established in April 2001. They will have to demonstrate any effectiveness of shared financial services before any national implementation.

(See www.doh.gov.uk/sharedservices/about/intro.htm)
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**First Assessment**  
**A Review of District Nursing Services in England and Wales**

As hospital services adapt to meet patient's changing needs and rising expectations, the latest NHS white paper challenges district nursing services to review crucial aspects of their role. Examining multidisciplinary assessment, implementing and managing care packages, and relations with social services and other groups, this report advocates the need for strong leadership, a clearly defined role and effective measures to ensure the quality of patient care. With practical recommendations and examples of good practice in caseload management, staff activity and resource allocation, this report will help trusts to balance patient demand with resources and workloads, and to prepare for primary care groups.


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**Cover Story**  
**The Use of Locum Doctors in NHS Trusts**

In August 1997, the NHS Executive produced a code of practice on the use and deployment of locum doctors that outlined the minimum targets for trusts to achieve. Drawing on statistical data and a unique survey of locum doctors, this report looks at the use and deployment of locum doctors in NHS trusts. Highlighting the wide variation in spend by trusts on locums, the findings of this report show that the proper management of locums does not just save money, it also enhances the quality of patient care by reducing clinical risk. Drawing on best practice, the report offers guidance on minimising financial and clinical risk, and maximising the effective use of locum doctors.


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**Critical to Success**  
**The Place of Efficient and Effective Critical Care Services within the Acute Hospital**

Critical care is of vital life saving importance. But within this service the issues of quality, costs and lack of data pose challenges for management. Costs are high; the figure for England and Wales approaches £0.75 billion and is increasing at a rate of 5-10 percent a year. Mortality rates and the rehabilitation of surviving patients is variable and there is a lack of useful management information about critical care resources and their use. With examples of best practice and recommendations for improvements, this report will be of interest to all those involved with critical care services.


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Bank and agency nurses are vital to the NHS. They enable acute hospitals and other services to maintain service delivery and ensure continuity of patient care despite staffing shortfalls and fluctuating workloads. But there are sometimes concerns about the quality of care provided, and there is a need to manage rising costs. In 1999/2000 the NHS in England and Wales spent at least £368 million on agency nurses – almost a third higher than in the previous year. A further £440 million was spent on bank staff.

These concerns led the NHS Executive to launch (in November 2000) NHS Professionals, a nationally accredited service providing a new direction and approach to temporary staffing across the NHS.

*Brief Encounters* investigates clinical and financial risks associated with the use of temporary nursing staff and identifies how such risks can be minimised. It highlights the problems that have occurred because of ineffective management and has important messages for those implementing the NHS Professionals initiative.

The report provides a wealth of new management information drawn from the Audit Commission’s national survey of temporary staffing arrangements. The practical examples of how services are tackling these problems will be of interest to all those who co-ordinate temporary staffing as well as to executive and non-executive board members with responsibility for clinical governance, to senior clinicians with management responsibilities and to finance and human resources specialists.