NHS Professionals

Flexible Nursing
Report for NHS Professionals

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Contents

1 Literature Review

1.1 Scope of the review

In line with the research specification, this literature review focuses on flexible resourcing in the National Health Service (NHS) through the three main types of temporary nursing staff: bank nurses, agency nurses and nurses provided through NHS Professionals (NHSP). It also considers flexible working arrangements for permanent nurses within the NHS. The report considers:

- the levels and trends in the use of bank and agency nurses and nurses provided through NHSP, and the levels and trends in flexible working arrangements for substantive staff
- the profile of the temporary nursing workforce and the profile of permanent staff with flexible working arrangements
- the costs and benefits of using bank and agency nurses and flexible contracts
- the impact of bank and agency and flexible working arrangements on patient safety and patient care
- how an effective balance is determined between the use of the substantive and temporary nursing workforce
- potential areas for new primary research in order to address current knowledge gaps.

1.2 Overview

We have broadly structured the literature review into six main sections. In the first two sections we look at the temporary nursing workforce and the flexible working arrangements for substantive nurses. Within these sections we consider the evidence on the levels and trends of use and the profiles of the temporary nursing workforce and substantive nurses requesting flexible working time contracts. In

the third section we consider the costs and benefits of these types of flexible resourcing. In the fourth section we consider the impact of flexible working arrangements and use of bank and agency nursing staff on patient safety and quality of care. In the fifth section we consider the approaches to determining effective nursing staffing levels and identifying the demand for a temporary nursing resource within wards, and finally we provide suggestions for potential areas for new primary research. The primary focus throughout is on the National Health Service (NHS) in England, but relevant international research is also cited.

1.3 Background and definition

Flexible working, in the context of this literature review, has two definitions. Firstly, it refers to the way in which trusts achieve flexibility in their workforce and meet fluctuations in demand for clinical services by using temporary nursing staff. Temporary nursing staff can mean staff supplied through nursing banks, nursing agencies or NHSP – the NHS-run temporary staffing service (NAO, 2006, b). Secondly, the review also considers contract-based flexibility for substantive staff, as outlined in Section 34 of the Agenda for Change NHS Terms and Conditions of Service, which encourages employers to develop flexible working practices, as far as is practicable, that include: part-time working, job sharing, flexi-time, annual hours contracts, flexible rostering, term-time working, school time contracts, tele-working, voluntary reduced working time, fixed work patterns, and flexible retirement (NHS Employers, 2005, Section 34).

Due to spiralling expenditure on agency nursing staff within trusts, in December 2005, the Department of Health (DH) listed the need for 'managing temporary staffing costs as a major source of efficiency' as one of ten high-impact workforce changes. The DH acknowledges that the use of temporary nursing staff can be effective in achieving flexibility in the deployment of staff (NAO, 2006) but there has been an increasing policy focus on the costs of temporary staffing. According to the House of Commons Public Accounts (2007) the estimated spend on all temporary nursing staff (including agency and bank workers) in England was £1,098 million in 2004/2005 and an estimated 9.6 million temporary staff shifts were performed in the same period.

One policy response was the establishment of NHSP with the intention of reducing dependency on agencies and improving the quality of care (NAO, 2006).

The detailed review by the National Audit Office (NAO) in 2005/06 revealed that the level of expenditure on temporary nursing staff varied significantly between trusts. As a percentage of total expenditure on nurses, expenditure on temporary nursing staff in NHS trusts ranged from less than one per cent up to 29 per cent (NAO, 2006). It is difficult to assess more recent trends in use because of a paucity

of published data, but there continues to be a significant level of expenditure. A Parliamentary Questions established, in 2009, that 6,087,209 hours were worked from 1 April 2008 to 31 March 2009 by nursing staff through Agency framework agreements.

In the earlier part of this decade individual trusts focused on reducing expenditure on (although not necessarily the level of) temporary nursing by centralising their nursing banks, often through NHSP, reducing reliance on external agency staff. However, an NHS Employers briefing 'Managing the Costs of Temporary Staffing' in 2006 (NHS Employers 2006) suggested that there was significant variation between Trusts in their use of temporary nurses, that better management of temporary staff was key to reducing the pay bill and improving productivity, and that managing temporary nurses properly could be a major source of efficiency savings.

Flexibility for substantive staff was driven by the Improving Working Lives Initiative, which required NHS employers to provide evidence that their trust's board was committed to certain aspects of flexible working, through the introduction of specialised nursing pools, annualised hours contracts and zero hours contracts (NAO, 2006, p.5). It was reinforced by the Right to Request legislation (which come into force in 2003) giving parents the right to ask for flexible working.

1.4 The temporary nursing workforce

In this section we consider the levels of use of the temporary nursing workforce supplied through nursing banks or NHSP and nursing agencies. We also consider the profile of these temporary workers.

1.4.1 Bank nurses

In the UK, temporary nursing staff are often provided by locally organised nurse banks. These banks allow managers to achieve flexibility in staff deployment and the ability to meet peaks in work loads (Buchan and Thomas, 1995). Nurse banks can provide individual nurses with the opportunity to keep in touch with the profession while working on an occasional basis, while others are supplementing incomes from other employment (ibid.). Bank nurses often have permanent contracts and perform bank working to supplement their incomes, some 55 per cent of nursing staff on trust banks were found by the NAO to have a permanent contract at the same trust (NAO, 2006).

NHSP manages nursing banks for the trusts that have signed up for its services (NAO, 2006). By May 2006 NHSP had increased its penetration of the acute trust

market to 27 per cent. Only three per cent of trusts chose to use agency nurses when flexibility was needed, rather than use a nursing bank or NHSP (NAO, 2006).

1.4.2 Levels of bank nursing

The estimated spend on bank nursing in England was £685 million in 2004/05 with an estimated 6.8 million bank shifts performed by 26,000 bank staff (House of Commons Public Accounts Minutes of Evidence, 2007). Spending on bank staff has increased over the past ten years as shown by Table 1, in part as a result of a deliberate policy of switching reliance to bank nursing and decreasing the level of expenditure on agency staff.

Table 1: Levels of bank nursing

Year	FTE bank staff	Estimated spend on bank staff (£ million)	Estimated number of bank shifts (millions)
1995-96	15,546	325	4.0
1996-97	15,610	337	4.0
1997-98	17,654	393	4.6
1998-99	18,204	415	4.7
1999-2000	18,642	434	4.8
2000-01	20,262	478	5.3
2001-02	22,286	538	5.8
2002-03	27,268	679	7.0
2003-04	28,084	720	7.3
2004-05	26,000	685	6.8

Note: Published data from more recent years has tended not to disaggregate agency and bank expenditure

Source: House of Commons Public Accounts Minutes of Evidence, (2007)

A significant proportion of nurses working on the bank or for an agency do so as their main nursing job. While nearly a half (46 per cent) of nurses working for a bank or agency worked occasional or various hours, over a quarter (27 per cent) report that they do bank or agency work full-time (Ball and Pike, 2009).

In March 2010 the Information Centre published NHS nursing workforce data for the first time. They reported on both the total workforce and the total workforce excluding bank nurses, giving some indication of the level of contribution being made by bank nurses. At September 2009, there were 15,538 whole time equivalent (WTE) bank nurses working as qualified nurses in the NHS in England, out of a total qualified nursing workforce of 322,425 (Information Centre, 2010).

NHSP produce a National Trends report, which is unique in that it presents a real-time view of trends within temporary nursing drawn from a statistically significant sample of the whole NHS Acute and Mental Health Trust population for England. The most recent of these documents (April 2010) reports that:

- demand for temporary nursing shifts is below the previous year, down 6 per cent on March 2009 with agency fill down 10 per cent against March 2009
- in the North and Midlands demand is below 2008/09 (down 7 per cent in March)
- demand in London also continues a downward trend on 2008/09 at 18 per cent below March 2009 with agency fill also down
- in the South demand across the year was broadly in line with 2008/09
- demand is down in all Acute Trusts, 11 per cent lower than in the full year to March 2009
- demand in Teaching Trusts remains relatively flat and unchanged
- Foundation Trust shift demand has decreased against seasonal trends but was 6 per cent up on the full year 2008/09
- Mental Health shift demand is 6 per cent down across the full year but slight up on March last year.

The NHSP report, while not showing individual trust variations, demonstrates a downward trend for temporary staff and that 'Trusts have really got to grips with spend through the final quarter'.

1.5 Agency nurses

Agency staff are supplied to a trust by a private agency and are typically used to cover individual shifts. Agency workers are most often used to cover for maternity leave and sickness absence and as a means of achieving greater numerical flexibility, rather than covering for permanent vacancies (Kirkpatrick et al., 2009).

1.5.1 Levels of agency nursing

It has been recommended that due to the different sizes of NHS trusts, the amount spent on agency staff is best measured as a proportion of the total paybill for each trust (Aston Business School et al., 2009). The average level of agency spend across all NHS trusts was 3.85 per cent of paybill during 2007-2008. Across all trusts, agency spend was highest in PCTs at 5.25 per cent of the paybill (see Table 2).

Table 2: Average level of agency spend in NHS trusts as a proportion of paybill

	%
PCTs	5.25
Mental Health/Learning Disability Trusts	4.13
Acute Trusts	2.61
Ambulance Trusts	1.88

Source: Aston Business School et al., 2009

Actual spend on agency nurses in the NHS has declined over recent years, falling from a peak of £536 million in 2003/04 to £246 million in 2007/08 (NHSP, 2008, cited in Kirkpatrick et al., 2009). There has also been a significant change in the proportion spent on bank as opposed to agency, for example in 2000, 41 per cent of expenditure on temporary staffing was spent on agency staff; by 2004 this had decreased to 30 per cent (Healthcare Commission, 2005). The four main factors that were identified by the NAO as contributing to the relative reduction in agency expenditure were:

1. improvement in the management of temporary nursing staff, and greater use of nursing banks and NHSP as an alternative to agencies
2. the NHS Purchasing and Supply Agency Framework agreements through which trusts are encouraged to procure agency nurses
3. implementation of NHSP which has helped to manage the agency market
4. financial pressure on trusts has encouraged them to impose stricter internal controls on expenditure (NAO, 2006, p.6).

The NAO report highlighted that agency spend was closely linked to both absenteeism and staff turnover. Vacancies were the most common reason for booking temporary nursing staff (accounting for 37 per cent of shifts), followed by staff sickness (25 per cent) and cover for different types of leave (11 per cent) (NAO, 2006).

1.5.2 The profile of the temporary nursing workforce

Understanding the profile of nurses working flexibly, and their commitment to flexible working is important for managers and policy makers. In a profile of bank nurses Buchan and Thomas (1995) suggest ward managers should conduct regular audits of bank nurses in order to use them effectively and to signal a need for recruitment to the bank if a large proportion of bank nurses have moved to permanent posts or are not taking up offers of working on the bank. They identified four types of bank nurse, which impacted on their availability and commitment to temporary work:

1. those that cannot find permanent employment, regard bank working as a 'short term expediency' and will move onto permanent employment as soon as possible
2. those who see bank working as a regular long term commitment which allows them to match work and domestic responsibilities
3. those who are working on the bank to refresh skills prior to re-entering permanent employment
4. those that regard bank working as a means to earn additional income, typically working irregularly in the bank or for short intensive periods to earn income for a particular need. (Buchan and Thomas, 1995)

The varying profiles of the nurses and therefore their shift choice preferences will have implications for managers in terms of their effective deployment.

An online survey of bank and agency nurses commissioned by the Royal College of Nursing found, of nurses working for a bank and/or agency only, some two-thirds had worked as a nurse prior to bank/agency working, one-in-ten was previously on a career break, and one-third were not active in the nursing labour force prior to doing bank/agency work. Some 85 per cent of nurses, working for bank/agency only, performed this type of work regularly; working an average of 13 shifts a month (Ball and Pike, 2006).

For nurses who work only bank/agency shifts, the flexibility and choice over hours is seen as the main advantage of bank/agency work, whilst those also with substantive posts are more likely to see work experience opportunities and the means of supplementing an income as key advantages of temporary work (Ball and Pike, 2006). Nurses who had qualified more recently (since 2000 in the survey) were less likely to choose temporary nursing, with two-thirds preferring to be in a permanent nursing post. Older nurses placed less emphasis on additional income and more value on maintaining skills and sufficient staffing levels (Ball and Pike, 2006).

1.5.3 Choice of bank or agency

For nurses wishing to supplement their incomes, agency work has become a less prevalent source in recent years, dropping to 14 per cent of all respondents who reported second jobs in the RCN Employment Survey in 2009 from 31 per cent in 2001. For comparison, in 1991 a much higher proportion of nurses with second jobs worked for agencies, at 45 per cent (Ball and Pike 2009, p.45).

Ball and Pike (2006) report that bank nursing is often used as a way to return to regular employment. They also note that bank working, as opposed to agency

work, is perceived more positively in relation to various considerations including: the notice given of shift availability, providing the desired volume of work, being able to choose geographical location, and in providing appropriate inductions. Agencies were viewed more positively in terms of fair and timely pay, but less favourably in relation to sufficient notice being given of shifts and the ability to work in chosen geographical areas.

Family circumstances and background

A 2008 survey of 20,000 flexible workers in the NHS (conducted by NHSP) showed that a quarter of temporary nurses have a degree or equivalent qualification other than a nursing diploma, which is an increase from 18 per cent in 2005. (Torjesen, 2009)

The NHSP survey showed that almost four-fifths (79 per cent) of bank workers are responsible for school-age children, up from 71 per cent in 2005; and childcare was the main reason that 64 per cent of bank workers work flexibly, compared with 57 per cent in 2005.

The survey also found that the flexible NHS workforce is made up of mostly people in their late 30s and early 40s, with the average age of a bank worker being 40 (compared with 33 in 2005) (Torjesen, 2009). And an analysis of bank/agency nurses in the UK, conducted by Ball and Pike (2006), showed respondents with substantive posts tended to be younger than those working solely in temporary employment.

1.6 Flexibility of substantive nurses

In this section we consider the levels of use and types of flexible working arrangement among permanent nurses in the NHS.

1.6.1 Levels of flexible working arrangements

Detailed analysis of the 2009 NHS Staff Survey (Health care Commission 2010) showed that just under three-quarters (72 per cent) of NHS staff have taken up flexible working opportunities. The most common types of flexible working among registered nurses (and midwives) in the NHS, according to the survey in 2008 (the latest year for which the figures have been broken down), are teams making their own decisions about rotas, followed by reduced hours working such as part-time contracts and flexi-time, see Table 3.

Table 3: Types of flexible working among registered nurses (and midwives)

Flexible working	% of respondents
Team makes own decision about rotas	37
Reduced hours	33
Flexi-time	30
Annualised hours	21
Home working during normal working hours	8
School term time only	3
Job share	2

Source: National NHS Staff Survey 2008, Healthcare Commission, 2009

The NHS Staff survey showed that about one in five registered nurses and midwives in 2008 (22 per cent) worked up to 29 hours a week and over three-quarters (78 per cent) work 30 or more hours a week (Healthcare Commission, 2009).

Table 4 shows the headcount (HC) and full-time equivalent (FTE), for qualified nurses in the NHS in England, with the FTE shown as a proportion of HC. The nearer to 100 per cent the FTE/ headcount figure is, the lower is the level of less than full-time working among nurses in that area of work.

Table 4: NHS nurses: headcount to FTE ratio, 1998 and 2008

1998	HC	FTE	FTE as % of HC
Acute, elderly and general	161,980	131,271	81
Paediatric	16,266	13,084	80
Maternity	29,174	23,059	79
Psychiatry	38,141	34,627	91
Learning disabilities	10,736	9,329	87
Community services	47,601	35,299	74
Education staff	665	568	85

2008	HC	FTE	FTE as % of HC
Acute, elderly and general	211,223	173,253	82
Paediatric	19,547	15,942	82
Maternity	33,221	25,790	78
Psychiatry	49,113	43,299	88
Learning disabilities	7,197	6,232	87
Community services	64,387	49,746	77
Education staff	1,424	1,147	81

Source: NHS Staff 1998 – 2008 (Non-Medical) March 25, 2009 NHS Information Centre

The key distinguishing feature is that, over 10 years, the proportions in specialties have changed little, with a slight increase in psychiatry and education staff and a slight decrease in community services.

Across all staff in the NHS, some 44 per cent of staff reported their trust was 'committed to helping its staff balance their work and home life', which was a higher proportion than in previous years (Healthcare Commission, 2009), showing a gradual trend towards trusts building commitment to developing flexible working practices.

1.6.2 Part-time arrangements

Ensuring an adequate supply of qualified nursing staff is a very compelling reason for flexible working arrangements in the NHS (Edwards and Robinson, 2004). One 'traditional' form of contractual flexible working is providing part-time contracts for substantive staff. Part-time working can be seen as a strategic element of recruitment and retention strategies, with part-time working potentially able to reduce labour costs through reducing stress and absenteeism (ibid.). This in turn leads to a reduction in agency spend on temporary nursing cover for absent substantive staff.

In the UK, Wales has the highest proportion of part-time nursing employees, with over half (58 per cent) of its registered nurses and 73 per cent of its support staff working part-time. Around two-fifths of the total nursing workforce in England (43 per cent), Scotland (45 per cent) and Northern Ireland (44 per cent) are contracted to work fewer than 37.5 hours a week (Waters, 2008). The high proportion of nurses working part-time is partly reflective of the ageing workforce.

Over the last 10 years there has been a reported increase in rates of part-time working in the health care sectors in the UK, Canada, New Zealand, the United States and Australia (Duffield et al., 2009, p.104). However, there are marked variations in the level of part-time working (and indeed in definition of part time) across countries. The International Council of Nurses reported in 2009 that 53 per cent of nurses work 'part time' in Demark, 25 per cent in the US, 35 per cent in Germany, 72 per cent in Iceland, 30 in Ireland, 23 per cent in Sweden, 57 per cent in Norway and 48 per cent in New Zealand.

1.6.3 Overtime and long-hours working

Overtime is one method of providing shift cover, however it is considered more costly than using bank or agency staff, if paid, and is seen as less popular with staff if unpaid (Kirkpatrick et al., 2009, p.15). A good deal of overtime is unpaid and staff do not always get time off in lieu. The NHS Staff Survey (2008) showed that over half (54 per cent) of registered nurses (and midwives) report working

unpaid overtime each week, compared to just over a third (34 per cent) of nurses reporting they worked paid overtime (see Table 5).

Table 5: Additional hours worked each week on top of contracted hours by registered nurses (and midwives) (% of respondents)

	No hours	Up to 5 hours	6 to 10 hours	More than 11 hours
Paid	66	18	11	5
Unpaid	35	40	11	3

Source: National NHS Staff Survey 2008, Healthcare Commission, 2009

A trend over the last 10 years has been towards the introduction of long day and night shifts, so that only two shifts are worked in any 24-hour period. This is particularly popular with younger staff as fewer days per week are worked as a result (Healthcare Commission, 2005, p.15). Across all nurses in the NHS, three-fifths (60 per cent) work shifts and over one-third (34 per cent) work 'office' hours. Of those NHS nurses working shifts around two-thirds (65 per cent) work a form of internal rotation, over a quarter (27 per cent) work day-time shifts and some 8 per cent work permanent nights (Ball and Pike, 2009). The NHS Staff survey (2008) shows that over one-third (38 per cent) of nurses and midwives reported that they work regularly between 7pm and 7am and some 14 per cent stated they work these unsocial hours occasionally.

Permanent night shifts are most prevalent in the independent sector, rather than the NHS and among bank/agency nurses. Some 7 per cent of NHS hospital nurses work permanent night shifts. Working 12 hour shifts is more common among nurses working in care homes; 63 per cent work 12 hour shifts compared to 41 per cent of NHS hospital nurses and 34 per cent of independent hospital nurses (Ball and Pike, 2009).

1.6.4 Permanent staff providing temporary cover

The RCN Employment Survey (2009) shows that over a quarter (29 per cent) of bank/agency nurses also have employment in permanent nursing jobs (cited in Ball and Pike, 2009, p. 44). The nature of additional work undertaken by nurses however varies by sector and specialty. NHS hospital nurses (64 per cent) are most likely to do bank work with their employer, while independent sector nurses are more likely to do agency nursing (ibid, p. 45).

Over half (55 per cent) of the nurses with substantive posts who also undertake temporary nursing work undertake bank/agency work regularly (Ball and Pike, 2009). On average, respondents with substantive posts do five additional bank/ agency shifts a month. Just over half (54 per cent) of these respondents work full-time in their substantive posts.

A survey conducted by NHSP in 2008, of over 20,000 flexible workers in the NHS, showed that many staff working flexibly full-time are doing so on weekdays, through term-time contracts and contracted or shortened weeks (Torjesen, 2009).

1.7 The costs and benefits of the flexible nursing workforce

In this section we consider the cost implications and the benefits associated with using a flexible nursing workforce, both for the employer and for the flexible nurses themselves.

1.7.1 The costs of using a temporary nursing resource

Financial costs

According to the House of Commons Public Accounts (2007) the estimated spend on all temporary nursing staff (including agency and bank workers) in England was £1,098 million in 2004/2005.

Agency nursing staff are usually also more expensive than the equivalent permanent, bank or NHSP staff. In 2005/2006 the NAO estimated that an agency nurse cost about 29 per cent more than a permanent nurse (NAO, 2006, p.3). The NAO report also estimated that trusts could collectively make annual savings of between £13 million and £38 million by 'better procurement and by driving down still further the unit costs of the different grades of agency nursing staff' (ibid).

The Public Accounts Committee report 'Improving the use of temporary staff in the NHS Acute and Foundation Trusts' (2007) found the following average costs per hour of employing nursing staff:

Permanent Nurse	£14.84	
Nursing Bank	£13.73	
NHSP	£13.51	
Nursing Agency	£19.11	(or £16 if agency is on a framework agreement)

The costs demonstrate the benefits of reducing agency costs and also of directing additional shifts through the bank rather than paying overtime to staff.

Indirect costs

There are also indirect costs associated with employing temporary nurses when, for example, substantive staff are taken away from patient care duties to arrange cover or to supervise temporary nurses. The Audit Commission attempted to quantify these costs by studying the average amount of time spent by senior

nursing staff arranging temporary cover. This 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. These timings generated estimated costs of around £5,100 a month in a typical acute trust in 2001 (Audit Commission, 2001), and it could be assumed that almost ten years on, this estimate would have to be revised upwards.

There are indirect costs associated with the drivers for employing a temporary workforce. Absenteeism due to staff sickness accounts for 25 per cent of the demand for temporary staff (NAO, 2006), and the cost of these replacement workers and potential lost productivity due to replacement workers is a pricey consequence of this absenteeism. Overall NHS use of agency and other temporary staff to cover for staff absences is estimated to cost £1.45 billion a year (Boorman, 2009).

As the NAO reports, '… recruitment and retention difficulties and higher rates of sickness absence … combined with a high use of temporary staff can have a negative impact on cost, patient satisfaction and staff morale' (NAO, 2006, p.4).

Performance

Although some agency staff are regarded as highly skilled, others are seen as less so. This problem is heightened by many agency workers' lack of continuing professional development and the tendency of some agencies to embellish agency workers experience and training (Kirkpatrick et al., 2009).

There can also be additional pressure on permanent nurses, due to the level of supervision required for these temporary staff (Manias, 2003). Ward managers have reported that they felt that they had to spend part of their time supervising unfamiliar nurses which diverted them from their own responsibilities (NAO, 2006). Agency workers may lack organisation-specific knowledge and there is often little familiarity with local procedures or recent patient history. Kirkpatrick et al states that agency nurses are often expected to 'hit the ground running', but in reality they are often 'less efficient initially' (Kirkpatrick et al., 2009, p.12). The literature suggests that ward managers think there is a strong business case for achieving better integration of agency staff as 'part of the team'. A matron within a UK case study trust stated 'the more welcome they [agency nurses] feel, the harder they'll work' (Kirkpatrick et al., 2009, p.20).

In case study trusts, ward managers ran through compressed inductions with agency nurses covering health and safety regulations and emergency procedures. These inductions lasted only between 15 and 30 minutes (ibid). The NAO report found that inductions are only considered 'worth it' if the agency nurse is going to return to the ward on a regular basis, as inductions take a significant amount of time out of the shift (NAO, 2006). Therefore managers need to weigh up the costs of taking substantive staff time to integrate the agency nurse into the team against the

'cost' of potential poorer performance on the part of the agency nurse if this is not done.

NHSP flexible workers tend to work regularly on wards thus reducing the need for induction and increasing familiarity and confidence with procedures. NHSP report from their management information that 'whilst 7.5 per cent of bank shifts worked by NHSP flexible workers are first time at a ward, this then goes on to 81 per cent working on the ward again within the next month, and 71 per cent working regularly on the ward for up to 3 months and 43 per cent for greater than 4 months'. This is supported by 64.4 per cent of NHSP bank shifts undertaken having the person nominated by the ward at the time of request.

The NAO reported that ward staff do not always report poor performance by bank, NHSP and agency nursing staff but simply do not ask these staff to return (however NHSP do now offer a performance evaluation survey, as described below). This increases the risk that the poor performance will be repeated elsewhere on a different ward. Therefore the NAO recommends that trusts encourage ward managers to make complaints about temporary nursing staff to the provider so that any issues can be addressed. Performance appraisals are an issue amongst agency workers. Kirkpatrick et al. (2009) argues the shorter tenure of most agency nurses means there is less scope for performance appraisals to be conducted. Manias (2003) also found that hospital managers perceived that if nurses had chosen to perform agency work, then it was their own responsibility to address individual learning needs. The role of ward nurses was to ensure the 'competence of agency nurses to carry out their work rather than to fulfil their continuing education needs' (Manias, 2003, p.463).

Internal bank nursing staff are also less likely to receive training and performance assessments than substantive staff. The NAO reported that less than 70 per cent of bank nursing staff had received mandatory training in the 12 months prior to the report and only 22 per cent had received a performance assessment (NAO, 2006). Therefore there is a risk that the development needs of bank nurses are not addressed. It has been reported that NHSP, however, provides all staff with mandatory training (ibid.) and NHSP confirm that all their flexible workers are offered CPD. NHSP has also developed a performance evaluation survey undertaken by Ward Authorisers as part of the shift authorisation process; feedback is obtained on the performance and development requirements for the bank staff. This has been developed to be completed for every X shifts that a bank member works, so it is not too onerous on the wards, yet enables NHSP to ensure that their bank has the highest possible commitment to patient care.

Permanent bank staff may slip though the performance management net and not receive a Knowledge and Skills Framework (KSF) review.

There have been attempts to internalise flexibility within trusts through the use of bank staff and to promote the use of nurse banks in preference to agency nurses when covering shifts (Kirkpatrick et al., 2009). However, such 'bank first' policies can carry certain risks, such as when bank nurses are used in situations where specialist agency nurses would be more appropriate, or where it pushes substantive staff who also work through the bank into working too many hours for their morale.

Working time regulations and staff preferences for certain shifts or for particular clinical units also affects the ability of the banks to respond to demand, which limits the flexibility of bank nursing and creates a tension between the work-life balance requirements of staff and the requirements of management (Kirkpatrick et al., 2009, p.22).

Staff management

Excessive reliance on agency nursing staff is often contributed to by poor staffing management. The NAO recommends that trusts reduce their reliance on agency nursing staff through introducing policies that do not allow substantive nurses to work in its hospitals through an agency. Agency nurses should be encouraged to join the nursing bank or NHSP in preference to nursing agencies, and recruitment and retention premia should be considered to encourage hard to recruit staff to work in substantive posts. The NAO also recommends introducing specialist rates for hard to recruit bank nursing staff and training up staff in areas where there are national shortages to avoid reliance on nursing agencies to fill posts (NAO, 2006, b).

Impact

The literature suggests that the use of agency nurses can impact on the morale of substantive staff. Kirkpatrick et al. (2009) suggests agency nurses are typically assigned easier tasks, leaving substantive nurses with more complex cases and it is recognised that it is difficult to 'achieve a stability in skill mix and to develop effective teams with an over reliance on bank and agency staff' (Creegan et al., 2003, cited in Massey, 2009, p.917). Therefore health providers have to 'develop creative approaches to the management of a workforce that will increasingly incorporate casual staff' (Massey, 2009, p.917).

The Health and Wellbeing of NHS Staff – a Benefit Evaluation Model (Work Foundation et al., 2009) reports a direct correlation between the expected proportion of staff costs spent on agency and level of turnover intentions of staff (ie staff saying they were planning to leave), suggesting again that, in some way, a high use of agency nurses impacts on the morale of the substantive core. The difference between a trust with high proportion of staff saying they intended to leave and one with an average proportion was reportedly associated with a 0.63 per cent

difference in the proportion of total costs spent on agency staff. There therefore appears to be a cycle with agency staff used to fill shifts for staff who are absent or where posts are vacant, but the increased use of agency staff leading to greater absence among substantive staff.

The NHS Health and Wellbeing survey in 2009 investigated the issue of presenteeism, whereby staff work when they are not really well enough to do so. Staff reporting pressure to return to work when unwell, as well as staff working for more than eight hours a day, report higher levels of presenteeism. Those who work for long hours had 18 to 24 per cent higher rates of presenteeism (Stolk, 2009). Presenteeism can have adverse effects on the staff themselves, their colleagues and on patients who may be put at risk. Some 71 per cent of qualified nurses and midwives in the 21 to 30 age group report presenteeism (Boorman, 2009) and focus group research states that a reason for presenteeism is distrust around the use of temporary staff:

> *'We come in when we're unwell because temp staff mess things up – they're not the solution they're claimed to be: they just cost more, without delivering more.'*
>
> (Boorman, 2009, p.33)

The issues identified with using temporary cover from various research papers (Buchan and Thomas, 1995; Mayer and Siegel 1996; Manias et al., 2003; Berney et al., 2005; Peerson et al., 2002, cited in North et al., 2006) are summarised by North et al., (2006) as resulting in:

- reduced continuity of care
- variable quality of temporary staff and concerns over continuing education
- reduced quality of care and increased risk of liability
- increased management time to arrange cover
- reduced morale of permanent staff
- fatigue and burnout of permanent staff working overtime and assisting temporary nurses
- irregular and unknown participation in continuing education.

Flexibility and choice over working hours is valued by NHS workers, however, the variability of the work supply is considered a problem for some. One-in-five nurses feel they are not given enough warning of available shifts and almost a quarter cannot acquire the volume of work that they want (Ball and Pike, 2006).

Davey et al. (2005) suggests 'flexible working in the NHS often involves work patterns that suit the requirements of employers rather than employees; in

particular, internal rotation from day to night shifts is always a requirement for clinical-based posts providing a 24-hour service, and many jobs will preclude flexibility in starting and finishing times' (Davey et al., 2005, p.344).

Edwards and Robinson (2004) also found part-time staff work fewer additional hours than full-timers, reducing managers' ability to deal with staff shortages through overtime. Duffield et al. (2009) also states that an increase in part-time employees increases a nursing unit manager's workload as it increases their span of control, and coordinating guidance, performance management and learning activities becomes more difficult, particularly when there is a greater reliance on temporary nursing staff. Particular patterns of flexible working are often considered provisional by managers and flexible contracts have to be 'managed and controlled to balance the needs of the service'. Healthcare managers have reported feeling constrained to limit the number of flexible contracts that they make available as they have to fulfill 24-hour care commitments (Curtis et al., 2006).

A comment from an RCN steward, addresses a consequence of part-time working and bank shifts (cited in Waters 2008):

> *'We are seeing more nurses take part-time contracts and top that up with bank shifts. It suits the employer who wants a cheap, flexible workforce. But bank nurses have casual contracts and whenever there is an element of casual employment, that can undermine the number of permanent contracts available.'*
>
> (Waters, 2008, p.15)

This pattern suggests that, prior to the request, little management thought has gone into the overall pattern of flexibility on the ward or in the trust, what can be borne, where and by whom. To this extent flexible working is actually more about suiting the employee than the employer.

1.7.2 Benefits of a flexible nursing workforce

There will also be benefits of flexible working for the employee and for the employer.

Primarily, the temporary nursing workforce provides numerical flexibility and a method of responding to labour market shortages for key staff or maintaining services by covering vacancies or staff absences (Kirkpatrick et al., 2009).

The literature also recognises the benefits of organisational learning and acquiring new knowledge from highly qualified and experienced agency nurses. In case studies conducted at three NHS trusts, managers referred to a subset of agency workers as being of 'fantastic quality', 'committed' and 'an asset' (Kirkpatrick et al., 2009, p.12)

Kirkpatrick et al. (2009) found agency staff were being used in a planned way to cope with the 'ebbs and flows in the demand for services, activity rates and levels of patient dependency'. Due to this an informal policy was in place which kept a vacancy level to reduce the possibility of over staffing if demand for a particular service fell (Kirkpatrick et al., 2009, p.10).

Some clinical practices in the UK have moved away from single manager rostering towards team-based self-rostering. Many studies over the years, in all sectors, show a correlation between staff feelings of control over their working lives and a reduction in absenteeism. An Australian study by Sullivan (2002) found the introduction of flexible rostering and 12-hour shifts in a private hospital reduced sick leave by 41 per cent and improved retention of skilled nursing staff (Sullivan, 2002).

Improved levels of job satisfaction, recruitment, retention and general wellbeing have also been found to occur as a direct result of introducing compressed schedules for full-time staff (Lea et al., 2003). Hoffman and Scott (2003; cited in Greene, 2007) claim that 12-hour shifts maximise cost-effectiveness. This was supported by a case study of St Giles Hospice where following the introduction of compressed schedules there was a reduction in the demand for bank and agency staff (Greene, 2007).

Lea et al. (2003) have provided further evidence from a case study of a trial shift pattern on an acute medical ward in Nottingham. They found that a compressed shift system, consisting of two 12-hour shifts and two six and a quarter hour shifts a week, increased nurses' job satisfaction and enhanced the management of patient care, due to improved continuity of care and extended opportunities to monitor patients (Lea et al., 2003). Other studies have suggested more caution over the 12 hour shift. Susan G Lorenz in the Journal of Nursing Administration (June 2008) questions the 12 hour shift, as do studies which link long hours working to sickness absence. An NHS Health and Wellbeing survey conducted in 2009 looked at the factors associated with absenteeism in the NHS, which is a major cause of agency spend. It found that those staff working more than eight hours a day for any numbers of days in one month (74 per cent of employees) had much higher absence rates than those who never worked more than eight hours a day in total (13 per cent of employees) (Stolk, 2009).

There is evidence that engagement of NHSP has improved the communication and continuity between trust's sites, and that it provides trusts with a consistent standard of temporary nurses who have attended mandatory training or a trust induction course. This can have the effect of reassuring substantive nurses about the quality of their temporary team members. There is also evidence that NHSP has provided new career opportunities for staff wanting experience in specialist areas and many substantive appointments have been made from within NHSP flexible workers (NAO, 2006, b).

NAO also reported that NHSP has increased competition within the temporary staffing market by contributing to lowering agencies' commission rates and has developed 'robust clinical governance standards for temporary staffing' to be applied in the trusts using NHSP (NAO, 2006, p.7).

1.8 Patient safety and quality of care

While temporary staff are a means of achieving numerical flexibility and covering for staff shortages within wards, there is some limited evidence available that the use of temporary nurses also has an impact on patient safety and the quality of patient care delivered. The interim Boorman report stated that 'trusts which have lower rates of sickness absence, turnover and agency spend nearly always scored better on measures of patient satisfaction, quality of care and use of resources' (Boorman, 2009, p.11). In this section we consider the existing research around the impact of the temporary nursing workforce and flexible contractual working arrangements in the NHS on ensuring patient safety and quality of care.

1.8.1 Patient safety

Some reports have attempted to measure the impact of temporary staff on patient safety, while others have examined indirect factors, such as hours worked, which may impact on nurse performance and therefore patient safety.

The literature shows that good working arrangements are needed to manage the use of temporary staff and ensure patient safety and quality of care. In the UK, the National Patient Safety Agency undertook an analysis of clinical incidents relating to agency, bank and locum staff, looking at a sample of 75 incidents. This showed 13 per cent of incidents were related to a lack of familiarity with the environment and some 8 per cent were due to a lack of experience or training. Poor clinical practice accounted for 38 per cent of incidents and failure to attend a shift accounted for 24 per cent of incidents. Concern about the behaviour of staff accounted for eight per cent of incidents (NAO, 2006).

The NAO report claimed that research has found that:

> *'People are significantly more likely to make errors when they have received inadequate training, when they are working in unfamiliar or pressurised environments or when they are tired. These ingredients can be typical of the circumstances in which temporary nursing staff may find themselves. Trusts need to implement proper induction, training and performance review procedures for temporary staff and monitor compliance with the European Working Time Directive in order to minimise risks to patient care.'*
>
> (NAO, 2006, b, p.30)

NHSP offer CPD to all their temporary nurses and, as reported above, place many nurses in familiar wards regularly, reducing the lack of familiarity which other temporary nurses might experience.

The DH has found evidence of a link between the use of temporary staff and MRSA rates within trusts. It found that in the period 2001/2002 to 2003/2004, if a trust had twice the national average level of temporary nurses it could expect, other things being equal, to have around a seven per cent higher MRSA rate (DH, 2007). The Department's explanations for this were that temporary nurses may be less familiar with local infection control procedures and also may move around more, within and between hospitals causing higher numbers of patient contacts per nurse and therefore increasing the potential to spread bacteria. Also, patients on wards with temporary staff may come into contact with more staff since temporary nurses often work shorter shifts than permanent nurses (DH, 2007, p. 14). However, MRSA rates in trusts with high levels of temporary nursing have been reduced significantly and in 2006/07 there was no longer any significant relationship between the use of temporary nursing and MRSA rates (DH, 2007).

The use of temporary staff was also linked to infection control in a census by the NAO (2009). The census asked Directors of Infection Prevention and Control in all 170 acute and foundation hospital NHS trusts about what they saw as the barriers to their trust achieving improvements in infection prevention and control. Over a quarter (27 per cent) stated high levels of temporary or agency nurses was a barrier. However, with regards to the significance of this group in reducing infection rates in the Trust, 12 per cent stated they were either a 'very significant' or 'significant' problem; 37 per cent said they had 'some problems', but over half (51 per cent) stated this group was 'not a problem' (NAO, 2009).

The DH states that measures such as the establishment of NHSP and the NHS Employers Code of Practice have sought to improve the quality, training and appropriateness of temporary staff and may have helped reduce the correlation between the use of temporary nursing staff and infection rates (DH, 2007).

A UK research study (James, Fineberg, Shah et al., *British Journal of Psychiatry*, Vol. 156, 1990, cited in Audit Commission 2001, p.11) found a correlation between the use of agency staff and safety concerns. In a high dependency acute ward in a psychiatry unit there was found to be an increase in violent behaviour among patients when there were more agency staff on duty. Factors contributing to the rise in violent behaviour were seen to be a lack of familiarity with the ward and procedures, and poor co-ordination in dealing with patients.

The Audit Commission (2001) also found that pre-employment checks on temporary staff, such as qualifications, registration and occupational health are not always completed, which can jeopardise patient safety. NHSP reports its compliance as 100 per cent.

Under the European Working Time Directive nursing staff should work at most 48 hours each week. The NAO found that over four-fifths (88 per cent) of trusts were able to monitor the number of hours that nursing staff worked permanently and on the bank, but none were able to monitor additional hours worked on the banks of other trusts or through agencies, due to data protection legislation, which is a cause of concern and could potentially put patients at risk (NAO, 2006). NHSP report that they use the European Working Time Directive (EWTD) as a guideline for reviewing hours worked with the emphasis on patient safety.

1.8.2 Quality of care

The limited research available on the quality of care suggests that temporary nursing staff can adversely impact on quality, but that there is a need to take account of contextual factors.

Levels of staffing and thereby the flexibility of nurses to maintain appropriate staffing levels has been found to have direct implications for the quality of care of patients. Over two-fifths (42 per cent) of NHS nurses say that short staffing compromises patient care at least once or twice each week, with one-in-four saying it is compromised on most or every shift (Ball and Pike, 2009). Research also supports the assumption that appropriate nurse staffing levels will be correlated with improvements in the efficiency and productivity of health care. The Agency for Healthcare Research and Quality in the United States found that lower nurse staffing levels are associated with higher rates of poor patient outcomes (Agency for Healthcare Research and Quality, 2004, cited in Goodman-Bacon and Omen, 2007) and evidence from the United States has shown that each additional patient assigned to a nurse increased the risk of death within 30 days of admission and failure to rescue by seven per cent (Aiken et al., 2002, cited in North et al., 2006).

While low or reduced staffing has an impact on quality of care, it has been found that high levels of usage of temporary staff, in order to achieve appropriate staffing levels, is strongly linked to low levels of patient satisfaction (Healthcare Commission, 2005). The Healthcare Commission found that trusts with high vacancy levels tend to use more bank and agency staff and they also have poorer patient experience ratings. The NAO found this relationship was particularly notable in the ability of nursing staff to answer patients' questions (NAO, 2006). Using data from a national survey of inpatients, patient satisfaction was higher where a smaller proportion of ward staffing budgets was spent on bank and agency nurses, and there was also a small correlation found between the level of complaints and the level of staff vacancies – the more vacancies, the more complaints were received (Healthcare Commission, 2005, p.22).

Manias et al. (2003) found the main obstacle to quality of care concerned agency nurses' lack of familiarity with institutional policies and protocols, and their inability to follow role models who demonstrated exemplary practice: This was summed up through an interview with a nurse manager:

> *'You cannot guarantee that everyone is going to have the same high standard of skill. At this hospital we have got nurses who can model themselves along the way, to a specific standard. But with them [agency nurses], you can't do that.'*
>
> (Manias, 2003, p. 464)

The literature stresses that there are a number of contextual factors that contribute towards the quality of nursing care delivered by flexible workers. FitzGerald and Bonner (2007) state that temporary nurses are predictably sent to understaffed areas and are therefore working in a pressurised work setting. As we have seen, adequate time is rarely given to temporary nurses for orientation or to access information about the ward and shifts can become 'uncomfortably paced and patient care hurried but at the worst, mistakes are made'. Fitzgerald and Bonner (2007) state it is:

> *'… incumbent on all parties – managers, clinical teams and temporary nurses – to work to create a context or an environment that is conducive to safe practice on shifts where temporary nurses are employed.'*
>
> (ibid, p.654)

The Healthcare Commission found that employing staff with more experience and skill, as opposed to simply more staff, has the most positive influence on the patient experience (ibid.).

Changes in working patterns to accommodate flexible working practices need not negatively impact patients. In Australia, Sullivan (2002) found flexible rostering systems and 12-hour shifts resulted in no increase in the number of reported incidents or patient complaints, with nurses and patients both recognising improved continuity of care following the introduction of the new shift system. Indeed, if flexible working practices retain experienced staff and make sickness absence less likely then they should impact positively on patients through greater continuity of care.

Achieving continuity of care has been linked to a number of factors including increased patient satisfaction, decreased hospitalisations and emergency department visits, lower mortality rates, improved quality of care and cost effectiveness (Duffield et al., 2009, p.104). Substantive staff are more likely to be aware of the skills, expertise, strengths and weaknesses of colleagues when they work with them regularly (Duffield et al., 2009, p.103) and nurses that work well as a team are less likely to leave or be absent from work and are generally more

supportive of each other, which will impact well on the continuity of patient care Kalisch and Begeny, 2005, cited in Duffield et al., 2009).

1.9 Achieving a balance between substantive staff and the temporary nursing workforce

In this section we consider the approaches to determining effective nursing staffing levels and identifying the demand for a temporary nursing resource within wards.

1.9.1 Setting nursing staff levels

The NAO report recognised that 'the use of temporary nursing staff is inextricably linked to the use of permanent nursing staff. Hence setting an appropriate nursing establishment is essential to the management of temporary nursing staff'. It recommends nursing establishments are reviewed frequently to avoid them becoming the 'product of accretion offset by budget constraints rather than a true reflection of the number and skill-mix of nurses that are needed. Consequently ward managers may feel that they need to routinely bring in temporary nursing staff to operate their ward safely' (ibid.).

There are different approaches to determining effective nursing staffing levels, following the recognition of linkages between staffing levels and outcomes such as patient safety. Several of the main approaches were outlined in Selecting and Applying Methods for Estimating the Size and Mix of Nursing Teams – a systematic review of the literature (DH, 2002). In the UK, there is no standard ratio for determining appropriate staffing levels for wards, nor is there significant evidence to link a particular mix or size of workforce to patient experience. The most common method of staffing in the NHS is a 'bottom-up' approach with staffing levels determined by local management who take into account local workloads (NAO, 2006, p.4), but some trusts make variable use of workload tools to track changes in requirements and ensure consistency of staffing levels (Healthcare Commission, 2005, p.13).

In order for managers to make effective staffing decisions, ward managers must be supported and informed by the necessary information from the finance and human resource functions in order to determine how best to allocate resources. The NAO found information collected by wards, finance and HR regularly differed in definition, making effective decisions about resource allocation difficult (NAO, 2006). With the exception of certain specialties such as intensive care where there are recommended nurse:patient ratios or nurse:bed ratios, there is not a common definition of minimum staffing levels. Without an understanding of safe staffing levels in a ward it is difficult for trusts to determine their need for temporary staff and what grade of staff is needed to fill a vacancy (NAO, 2006). However, the

'bottom up' approach to staffing levels is being challenged by the use of a 'top-down', mandatory nurse:patient or nurse:bed ratio, being advocated in Australia, New Zealand and the USA (Buchan, 2005, p.239.) Those in favour of this top down approach argue that it is effective in terms of improving staffing levels, reducing nurse turnover and absenteeism and improving patient care, however, opponents of the approach argue it is 'inflexible, inefficient and raises staffing costs'. Buchan argues the impact of ratios will be 'most pronounced when ratios are mandatory and where they offer a mechanism to improve and then to maintain staffing levels at some pre-determined level' (ibid, p.243).

In an attempt to control the use of temporary staff, trusts have to understand why they are booked and should have systems in place to record reasons for all temporary staff bookings and 'verify this information against independently collected information for example on vacancies and sickness absence' (NAO, 2006, b, p.9).

Case studies conducted by Kirkpatrick et al. (2009) found trusts were managing to internalise flexibility through 'stressing the system', ie through extending the requirement for substantive staff to respond to changes in activity levels without having to seek additional staff (Kirkpatrick et al., 2009, p.15). These studies found ward managers often exaggerated the need to fill shifts and overbooked bank and agency nurses. As a consequence, Kirkpatrick et al. reports senior nurse managers are now challenging requests more frequently (ibid).

1.10 Effective rostering

The NAO report found that ward managers, HR managers and finance staff have different understandings of establishment levels and varying interpretations of what constituted a vacancy, consequently bank and agency staff are booked 'with little consideration of whether cover is actually needed or what alternatives there may be' (NAO, 2005, p.5).

If a nursing establishment level is agreed, it is easier to 'optimise the use of permanent nursing staff by effective operational management' (NAO, 2006, b). Trusts can make the best use of substantive staff and manage the demand for temporary nursing staff through effective rostering. This includes the use of self-rostering which allows staff to express their preferences for shifts and take ownership of the roster, providing the flexibility to fit shifts with domestic or caring responsibilities. By always rostering substantive staff onto expensive weekend or night shifts, this ensures that temporary nursing staff cover the less costly shifts and work under supervision, meaning there is greater protection for patient care (NAO, 2006, b). The NAO also found self-rostering worked best on wards where rules had been imposed to ensure a fair allocation of unpopular shifts.

Interviews conducted with hospital nursing managers found that they attempted to make arrangements with permanent nursing staff to balance nursing requirements. These arrangements were made if agency nurses could not be secured for a particular shift. On these occasions, permanent nurses were asked to change rosters or work additional shifts (Manias, 2003).

Trusts are using IT rostering packages that can determine minimum staffing levels and grade and skill mixes required for each shift, which makes it easier for staff to self-roster and reduces the administration burden for ward managers (NAO, 2006, b). The NAO advocated applying a strategic approach to the use of temporary nurses. This approach 'requires data on work arrangements and staff usage; on usage patterns and trends, costs and reasons for use' (cited in North et al., 2006).

The literature also shows that the use of IT and IT-based workforce management databases are effective means of achieving an appropriate balance in staffing levels (Massey et al., 2009; NAO, 2006, b). Such systems can generate cost savings as staff are not rostered unnecessarily and patient safety can be better assured by ensuring that there are always sufficient staff to cope with the volume and dependency of the patients on the ward (NAO, 2006, b). IT systems can also allow managers to access trends data, which enables them to increase current establishment levels within wards and reduce the need for agency staff. A study of a Welsh Healthcare Trust suggested this has 'the potential to improve quality and safety of health service provision with continuity of known nursing staff at ward level' (ibid, p.918).

However, the NAO report, based on fieldwork in 2005, found less than three-quarters (70 per cent) of trusts, who run their own bank, use a bank management software package and few trusts use electronic rostering systems although these help ward managers control their demand for temporary nursing staff (NAO, 2006, p5). (Our case studies with trusts, report that this situation is changing.)

The NHS Employer's publication *Electronic rostering: helping to improve workforce productivity. A guide to implementing electronic rostering in your workplace* (2007) also outlines the significant benefits of e-rostering for trusts who need to get better at workforce planning. The guide states that 'The workforce configuration (skill mix) will need to be responsive to the key drivers of change over the next 20 years'. Drivers include more older people, advances in medical technology, pressures on the healthcare system through such things as rising birth rates and levels of obesity, the increasing popularity of flexible working, new health and social care partnerships, and new types of commissioning which will require more effective people management. E-rostering can help trusts to use temporary staff only when they are needed, quickly obtain authorisation for necessary bookings, make bookings, deploy all staff including temporary staff effectively, and check invoices. E-rostering also supports staff to select their own shifts and gives a clear

indication of the types of flexible working that can be managed, all of which contribute to staff satisfaction and commitment.

1.11 International examples

Throughout the literature search we have found international examples. We have included them in the body of the text above, only where they add to something already reported in the UK. Below we add our further international findings.

1.11.1 Australia/New Zealand

Agency nurse use is widespread in Australia, as is use of float pools. Some studies in Australia have also highlighted high levels of 'casual' employment in nursing (see for example Creegan et al., 2003; de Ruyter, 2004) and more recently have focused on high turnover 'churn' and casual nurses as a factor contributing to lower care outcomes (Duffield et al, 2009). Similar findings have been reported in New Zealand where a national survey of nurse turnover concluded that the use of temporary cover in nursing was largely driven by 'considerations of costs, not strategic and professional considerations' (North et al., 2006).

One flexible working initiative for nurses and midwives was 'Nurse West' in Western Australia, where a centralised system to source temporary and short term employment opportunities has been set up. The state health system in Australia has been attempting to reduce reliance on external agency provision, primarily because of concerns about cost; Nurse West 'a government nursing pool' was set up in 2003 by the health department in Western Australia. It was established as the central point for all temporary nurses in public health systems, initially within the metropolitan area (Perth), and was then extended to the rural areas and now covers all public hospitals in West Australia. Nurse West is promoted as a way of improving the working lives of nurses, with choice of hours and location, access to professional development and a single point of contact for work opportunities in all public hospitals and health services. It offers flexible work arrangements and other benefits including:

- a central point of contact for nurses and midwives to work at all public hospitals and health services
- priority access to any temporary vacancies
- access to continued support to further enhance skills and experience (this includes applying to public health service educational programs as an internal applicant)
- salary packaging
- rural placements.

(source: www.nursing.health.wa.gov.au/nursewest/index.cfm)

1.11.2 Japan

The 'Nurse Centre' organised by the Japanese Nursing Association (JNA) (the largest nursing union in the world) supports free job placements for nurses using a nationwide computer network. Each prefecture (region) has its own online 'centre' for matching jobs with online registered applicants, and a Central Nurse Centre in Tokyo supports the prefectures by gathering information on occupational trends and analysing research findings on job placement and job qualifications (see Nakata and Miyazaki, 2008; Kawaguchi et al., 2008, for more information on 'inactive' nurses in Japan).

The budget to support the centre network is provided by federal government and local government. In mid decade about 20,000 nurses per annum were being hired through the system – either permanent posts or longer-term temporary posts. Short-term temporary nursing staff tend to be sourced via nursing agencies.

The prefecture centres act as matching agencies – listing employment opportunities for nurses; and nurses looking for employment opportunities. The National Centre is at www.nurse-center.net.

1.11.3 USA

Many nurses in substantive posts in the private sector US health care system are employed on contracts which mean they are paid by the hour and may be sent home if not required; agency staff are used in a manner similar to the UK.

One feature of flexible working in the US that is not used in the UK is 'travelling nurses'. This exploits the sheer geographical size and variety of work locations available for nurses within the one country. Travel nurse agencies place qualified nurses, and other health care professionals in jobs around the USA (and in some instances, internationally). Assignments for travelling nurses vary, depending on the contract, but usually last between 13 weeks and a year. The nurses normally get paid a higher hourly wage than permanently employed nurses, with additional housing/living expenses also being paid. Travelling nurse agencies exploit seasonal variations in demand in different regions and states, such as offering winter work in warm climates such as Nevada (Babula, 2002).

The agency usually also organises accommodation and other specifics of the assignment (like relocation or registering with state authorities). Most travel nurse employment agencies offer a set pay rate and assist with travel expenses, as well as sometimes assisting with accommodation (often this is staff housing). As each US state has its own rules and regulations regarding licensure of nurses, travel nursing companies usually employ staff who will work with the nurse to ensure that they obtain the required license for assignment in state. See eg www.travelnursing.com

2 Findings from Interviews: The Past, Present and Future of Flexible Nursing

Ten years ago, the DH anticipated that growth in the NHS workforce would reduce the demand for temporary staff. Despite a significant increase in substantive NHS staffing over the decade, the demand for temporary nursing remains high, but there have been significant changes in the overall profile of the types of temporary nursing staff being deployed in the NHS, and also in the patterns of flexible working. This raises several critical policy questions. Why has demand remained high? What has driven the shift from agency nursing to other forms of temporary staffing? What is the impact on cost and quality of care of these changes? What will drive changes in flexibility in next few years, and what will the impact on profile and delivery of flexibility in nursing be? In order to begin to answer these questions and to identify likely future key trends we have spoken to a small cross section of those responsible for flexible nursing policy and deployment: four trusts, an SHA, the DH, NHS Employers, NHSP, and the RCN to gather their views. Anonymised notes from the discussions are presented in an appendix to this report. The remainder of this report is structured into a review of changes in NHS nurse staffing in recent years, what is happening currently and what the future is likely to bring. The report is informed by the reported literature and the discussions we have had with health managers and professionals.

2.1 Recent years

Since the Audit Commission's 2001 report 'Brief Encounters' there has been an almost continuous spotlight on the spend, control, quality and performance of temporary nursing staff. The Audit Commission noted significant variations in the quality of nurses provided by agencies, with a lack of training and performance management given to these staff. It also identified poor procedures in use in many trusts in terms of how local level workload assessment was used to project staffing requirements, staff allocation and to identify temporary staffing requirements. The

NHS plan at this time anticipated significant growth in the NHS workforce, which was exceeded. The overall use of temporary nursing, over the same time period, remained relatively static. Within this overall level, however, there has been a major shift in the source of temporary nursing staff, with an associated reduction in costs. The spend on staff obtained through agencies has reduced with an increase in staff obtained through nursing banks, particularly NHSP, set up in 2001 to achieve a cost driven reduction in external agency staff and an increase in the quality control in the provision of temporary nurses (according to the Public Accounts Committee (PAC) report, *Improving the use of temporary staff in the NHS Acute and Foundation Trusts*, 2007).

The post 'NHS plan' NHS also saw an increased emphasis on flexible working practices as a response to staffing shortages and in order to raise the profile of the NHS as a 'good place to work'. Flexibility for permanent nurses was a central feature of the DH's 2000 Improving Working Lives (IWL) initiative. There were views in trusts that with an aging nursing workforce and in a workforce dominated by women, flexible working would be key to retaining the levels of staffing required. Most trusts developed flexible working policies, and acceded to individual requests for flexibility, sometimes with little overall assessment of the impact on staffing of shifts leading the PAC report to suggest 'it (IWL) has caused difficulties for ward managers trying to reconcile the demands for flexibility with the requirement to run a 24-hour, seven-day a week service' (p.14). The introduction, in 2003, of the 'Right to Request' flexible working legislation gave further confidence to staff requesting flexible working and a further challenge for managers, many of whom were unsure whether they could turn requests down.

This theme of flexibility for the nurse employee, or the employer of the nurse (or ideally for both) will be re-examined in this report, with one main point being that the condition of the external nursing labour market is a major determinant of where the flexibility focus has been most pronounced over time: as a recruitment/ retention enabler, or as a factor in improving productivity.

Another policy drive that impacted on nurse staffing and on flexibility was the implementation of the European Working Time Directive (EWTD), which reduced the availability of junior doctors, created a demand for more nurses working in advanced roles, and also stimulated new working practices and ways of working. The implementation of the EWTD has driven a range of local innovative responses. Trusts have developed new ways of working and introduced new ideas to help them achieve compliance with WTD 2009. The approaches range from whole system reforms and new roles, to information technology tools and new rotas (Skills for Health, 2010)[1].

[1] Skills for Health (2010) WTD Case Studies, www.healthcareworkforce.nhs.uk/wtdcasestudies

The NAO conducted the largest recent study on the use of temporary staff in the NHS in England. They examined practice, surveyed nurses and trusts, and made a series of key recommendation for improvement in the management and deployment of temporary nurses in the NHS. The NAO report (2006) reported that trusts were still failing to control their expenditure on temporary staffing with the related PAC report in 2007 suggesting 'there is little strategic planning and control of trusts' demand for temporary cover' (p.12). Trusts were attempting to gather information and data on the reasons for requesting temporary cover, such as vacancies, sickness absence and activity levels but with little co-ordination of the data and a lack of systematic overview of how to deal with the issues.

The NAO report occurred at the time (2005/2006) of a previous funding constraint in some NHS trusts which had led to vacancy freezes and a co-ordinated attempt to reduce the use of external agency staff. More recent initiatives and events in the NHS have drawn further policy attention to the cost and quality implications of flexibility.

Lord Darzi's report, *High Quality Care for All*, was published in June 2008 and recommended making high quality care the organising principle of the NHS, including provider quality reports and the production of formal Quality Accounts which will become a statutory requirement for all providers from this year. It placed renewed emphasis on clinical decision making, and focused the attention of employers on standards of delivery, patient safety and the continuity of care, including taking greater the views of patients on these issues.

Most recently, the events at Mid Staffordshire NHS trust have drawn attention to issues of nursing workload, staffing levels and the use of temporary staff, within the context of serious failures of an NHS trust to meet basic minimum standards of patient care (Mid staffs Inquiry: www.midstaffsinquiry.com/news.php?id=30). The policy response to the events at Mid Staffs has very clearly pushed staffing, quality and costs firmly to the centre of the NHS agenda, at a time when cost containment and the so called 'productivity agenda' (described in more detail below) is also shaping policy.

These issues were summarised in the recent report from the Prime Minister's Commission on Nursing and Midwifery, which set out a range of recommendations to improve the status and contribution of NHS nurses and midwives, including an emphasis on flexible roles and career structures: 'Nurses must become competent to work across the full range of health and social care settings, and career structures must enable them to move easily between settings and posts' (DH, 2010)[2].

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[2] Department of Health (2010), *Front Line Care*. http://cnm.independent.gov.uk/wp-content/uploads/2010/03/front_line_care.pdf

This dual theme of flexibility for nurses, ie attempts to contain costs of temporary staff combined with attempts to improve flexibility of permanent staff, has continued through to the present day, but it must be stressed that the definition of what 'flexibility' has meant has shifted somewhat, particularly in the last two years, and as noted earlier, there is now greater emphasis on flexibility as a contributor to improved organisational performance.

2.2 The present

2.2.1 The quality agenda

The findings of the Mid Staffs inquiry, published in March 2010 were very much in the minds of the respondents who were contacted to provide context and background for this report. One trust we spoke to reported 'Our main focus now is on justifying spend on quality [of temps]'.

The Mid Staffordshire situation is forcing managers and health professionals in trusts to ask themselves critical questions, described by one trust as '… how safe are temporary staff, do they have the right specialist knowledge, do they have the organisational memory?' Another commented 'we need to focus on what commissioners want and focus on quality improvements in terms of the world class commissioning agenda'. In essence, the use of temporary nursing, particularly where these nurses were not receiving mandatory training or performance management, was being linked to lower levels of patient care and satisfaction, and as such was being viewed as a potentially high risk factor in meeting the quality agenda.

NHSP report that they have been retained by Mid Staffordshire to ensure that temporary nurses have the appropriate training in place and are of the appropriate quality. Therefore good quality temporary nurses are being seen as part of the solution.

2.2.2 The productivity agenda

Coupled with a renewed focus on the quality agenda, the other main current policy driver is the so called productivity agenda ie the need for NHS trusts to make cost containment efforts as the NHS moves into a period of relatively tight funding. Given the labour-intensive nature of NHS activity, staffing is a major focus. All those we interviewed were in agreement that the NHS was entering a period of unprecedented cost containment, and that staffing was an inevitable focus for looking at costs savings.

In acute trusts this means a drive to reduce patient length of stay, bed reductions and a commensurate increase in patient acuity which will make new demands on nurses, along with new ways of working, some of which relate to skill mix, some to different working patterns. The objective of driving down staffing costs per patient or per bed will be happening at a time when workload per patient or per bed is likely to increase.

In this context there will be challenges to current patterns of flexibility, as well as an impetus for new forms. Managers and others we spoke to felt it would be difficult for the traditional patterns of temporary staffing and flexible working to continue unaltered in the acute sector in this scenario. What is needed, all interviewees concluded, is 'flexible and maximum use of substantive staff' with temporary staff providing a supporting role in a model of deployment which is nearer that set out in the classic 'core/periphery' approach than in the traditional NHS approach, where temporary and flexible staff have tended to be used in a short-term and reactive way to cover staff absence.

2.2.3 Activity analysis and workforce planning

The key message emerging from all we spoke to in the course of this project, is the recognition that the constraints on NHS expenditure will require more effective activity analysis and a greater focus on proper workforce planning to support greater workforce flexibility targeted at improving productivity. However, at this stage, although they acknowledged the productivity agenda, the majority of trusts we spoke to still used their temporary staff in the 'traditional' reactive manner rather than in a planned and strategic way, primarily as a response to vacancy and sickness absence.

As such, the reported methods used had not changed much, if at all, since the NAO reported in 2006. One respondent in 2010 spoke of nurse managers' planning 'being paper based with arrows all over it'. Another suggested 'even good managers have struggled to really understand the hours that people were working'. There had been a focus on cost control and monitoring of temporary staff use, including periodic reporting at Board level, but not an emphasis on analysing the day to day patterns and variations, and changing the type of use.

However, our assessment, based on the discussions with key respondents in March 2010 is that it does appear that the NHS may be at the cusp of change in how it uses its nursing staff in a flexible manner. For example, managers in all four of the trusts we included were responding to the productivity agenda by trying to develop a better understanding of the reasons for use of temporary staffing and all had, or were in the process of, introducing e-rostering to improve staffing allocation, and to generate 'real time' information to consolidate and expand their knowledge of

flexibility. Whilst driven by the immediate pressures of the productivity agenda, the implementation of e-rostering also reflects a longer term perspective of the need to improve activity and quality data to support more effective rostering of permanent staff as well as more efficient use of temporary staff. For example, NHS Employers published a guide on e-rostering in 2007 (*Electronic rostering: helping to improve workforce productivity*) before the urgencies of the current financial problems, but it is now that the content of that report is being acted on at trust level.

The trusts we spoke to had been able to develop a better understanding of the reasons for use of temporary staffing (through piloting of e-rostering) and had revealed patterns of variable, but sometimes predictable, levels of use across the year. For example, one manager noted 'bank usage up in the school holidays, half term and the financial (and holiday) year end'. Similar patterns were reported by others. In part, this is a legacy of the situation early in the decade when 'flexibility' was primarily for the employee. At a time of skills shortage and policy support through IWL, many individual nurses were supported in obtaining a shift pattern that was the best 'fit' for them; this led to a situation in some trusts of multiple shift patterns and working patterns, which raised significant challenges for day to day effective allocation of staff.

Analysis reported by management interviewees also revealed some interesting patterns in the work of some individual nurses, such as:

- identification of substantive nurses who have not worked all their shifts 'owing' time and then booking shifts to make up this time to suit themselves when they are not actually needed operationally
- some consistent underbooking of time amongst some staff, eg one member of staff under-rostered for an average of 25 hours a month.

Data and work patterns revealed by the piloting and fuller roll out of e-rostering were, as one trust suggested, 'giving a real picture of what is going on. The Director of Nursing consistently suggests that the wards are understaffed yet there are no vacancies'. The e-rostering approach is highlighting the number of nursing hours that are required and when they are required, and is also identifying where staff are not being deployed effectively nor managed appropriately. For example, the application of e-rostering in one large foundation trust has highlighted the need for more planning in the approval of staff leave to 'smooth' staffing levels across time: '11-17 people should be on leave each week otherwise leave will be taken in a glut, which the service cannot cope with'.

2.2.4 Demand-led work patterns

As noted above, e-rostering data has alerted managers in the trusts to the true work patterns and requirements of each ward and highlighted that the flexibility offered to staff 'has shifted too far towards employee demand'. The IWL initiative, introduced at a time when trusts were finding it more difficult to attract and retain nurses and when the requests for flexible working left some managers feeling they could not say no, was coupled with a lack of a full appreciation of what the service delivery requirements were, and what working pattern and method of staff allocation would best meet these needs. This had meant that the traditional uses of temporary nursing staff – covering for short term absence – were often both a symptom, and a cause, of greater inflexibilities. Reactive, and often poorly managed, use of temporary staff was masking the scope and potential for more strategic and flexible use of permanent staff. One interviewee explained that 'term time and zero hours contracts had been offered as a recruitment/retention initiative but these create difficulties in staff availability in school holidays, leading to higher use of temporary staff.'

An improved understanding of the match or mismatch between demand and staff working patterns has been coupled with the impact of recession on the labour market leading to more nursing hours being made available, as part time nurses increase the hours they want to work, and full timers look for overtime or extra shifts. This loosened labour market has led in turn to a focus on demand-led needs rather than those of the supply side, and a shift from employee-led flexibility to one dictated by the employer and the needs of service delivery. Whilst it is clearly not the case that it is 'either/or' in terms of flexibility for employee or employer, it is equally evident that the current increased availability of nursing hours, the end of the rapid NHS nurse staffing growth seen earlier in the decade, and the reduction in level of skills shortages have given NHS trusts' management greater scope and potential flexibility in getting their substantive staff in the right place at the right time.

2.2.5 New technology

New technology and techniques, particularly e-rostering, and development of benchmark and 'dashboard' staffing and quality indicators is enabling trusts to begin to develop live reporting and to get a much clearer grip on the meaning of their management information. As well as an understanding of sickness, absence and vacancy levels, managers are now more informed about such things as 'different local level custom and practice in terms of shifts and availability of flexible work' ie different ways of organising work and shifts in different wards and specialties which undermine or prevent any trust-wide cross-section flexible working and cover. One manager in a trust described how previously the absence

of up to date and localised staffing and activity data meant that 'trusts were working blindly'.

New technology and improved metrics are also giving managers scope to better understand the links between staffing and outcome/quality indicators. Two interviewees spoke of trying to improve their understanding of the relationship between temporary workers and the quality of patient care and patient safety, suggesting an 'increased use in metrics in relation to assessing the impact of temps – linking to indicators such as medical errors, falls, complaints etc.'

The demand-led approach to staffing and the application of new technology to improve the timeliness and relevance of management information have real potential to give trusts a much clearer picture of their staffing profile and its variation across time in relation to their identified service delivery needs. The question that management in trusts are now asking is how can they best use technology and a flexible approach to staffing to support the demand-led approach?

2.3 The future

Looking across the next 5 to 10 years, and considering what the main trends in flexible working in NHS nursing will be, there are several issues that are 'given' they are unlikely to change irrespective of broader socio-political and economic changes. One such issue is a much tighter approach to cost control in the NHS; it is evident that NHS funding will be constrained over the next few years. A second factor is that, in the short term at least, there will continue to be a good level of supply of nursing hours, but that the underlying issue of an ageing profile of the UK nursing population will begin to impact with more retirements, and changes in nurse priorities. Those older nurses who wish to, or have to, continue in work will have different objectives for their work than younger nurses. A third factor is that from the middle of the next decade, the shift towards all graduate entry for the education of the profession will begin to have an impact, although it will be much longer before a significant proportion of the working nurse population have come from this new training regime. The fourth is that improved supply from training, combined with a cost-containment-driven skill mix change, will increase the use of the relatively new role of assistant practitioner (AP) – providing employers with an additional role to deploy, and as such also increasing the scope for flexibility in the broader nursing workforce. It is difficult to assess the current numbers of APs in the workforce because data is not available centrally, but there are probably a few thousand now at work in the NHS, with uneven geographic distribution, but with new impetus as a result of the development of national core standards (Skills for Health, 2010, www.skillsforhealth.org.uk/~/media/Resource-Library/PDF/Core-Standards-for-APs.ashx).

2.3.1 Intelligent use of workforce and activity information

Having a clear view of staffing establishment and service demands is an excellent foundation but it is just the beginning. Managers we spoke with highlighted that developing this clarity makes new demands of nurse and line managers, and can challenge custom and practice in terms of some current flexibilities. It is evident that e-rostering and similar innovation will place demands on management, both in terms of effective use of data, and in terms of how to make the changes that e-rostering highlights or requires. In relation to the former, one trust spoke about the need 'to train nurse managers in how to use it [the data] effectively and to interpret the information' and another suggested 'what ward managers and staff lack is knowledge of how creatively to deal with the information they have to fill gaps and to share resources to make the hospital as efficient as possible'. This flags the need for support and training to enable management to make effective and sustained use of e-rostering. In relation to organisational change linked to e-rostering, one manager pointed to 'the breaking down of silos' and another of the 'root and branch assessment of local practice'.

Within this context of potential change, understanding what is possible and achievable is the key. How to make substantive staff flexible, how off-duty will be arranged, what hours and shift patterns will fit, how cover can be arranged, all will require managers to think laterally and creatively in a way that they might not have had to think before. Most of the trusts we spoke to felt that they would need help with this: in terms of having access to best practice and commissioned case study research; in training and implementation support from suppliers (including from NHSP to help in procuring e-rostering on the trusts behalf with its preferred supplier); with the collation and dissemination of evidence-based good practice; and with the linking of local networks of trusts to support and learn from each other.

2.3.2 Delivering the productivity agenda

It is evident that the productivity agenda will dominate policy and practice over the next few years, and will place greater focus on the need to contain staff costs, undertake effective national regional and local workforce planning, and enable 'smarter' front line working. This last point will mean both an increased use of some flexibilities (which are seen to contribute to furthering the costs containment/ quality improvement agenda) and a likely roll back of others (which are seen as primarily existing for the employee and which have a real impact on raising overall staff costs and/or impacting negatively on the quality agenda).

Sustained cost containment/quality improvement flexibility in the nursing workforce will not be achieved without the wide-scale roll out of e-rostering and

the associated factors of changing working practices and more informed management. As well as the requirement for trusts to control their spending on temporary staffing, following the March 2010 budget the DH announced that £555 million would be saved from its budget through the reduction of sickness absence within the NHS (announcement 25 March 2010). To achieve this NHS managers will need to know where sickness absence is occurring, why and how the absence is being covered, and what is the most effective way of absence cover.

The consistent application of new technology and information can enable more flexible use of permanent staff which, in turn, will drive down use of agency and bank staff where there is no clear business case for using them. However, temporary staff will continue to be a part of the future 'smarter' working. Although managers in all the trusts we spoke to envisaged a reduction in the use of temporary staff as a natural consequence of flexible substantive staff, one trust spoke of the possibility of 'flexing whole wards' if that was the right response at the right time, while another interviewee suggested that building an element of contingency into workforce planning rather than maintaining higher staffing overheads throughout the year could be a more productive use of the total staffing spend. As such there is not, and may never be, an overall consensus on what is the optimum core/ periphery model. Managers also highlighted the high technology end of nursing (theatre nursing, ICU, etc.) where there continued to be supply problems and other care areas with ongoing skills shortages as areas where the need for temporary staff would remain.

2.3.3 Other new innovations

One respondent spoke of piloting further staff flexibility through the use of a 'staff passport'. In this scheme staff will be the substantive primary employees of one trust, but on a contract that enables them to work across other trusts as required to do so. A credit card type electronic 'passport' holds all the necessary information about the nurse, such as their KSF outline and training, experience and pay band, with information linked to the Electronic Staff Record (ESR). Although reportedly currently a pilot scheme there are plans to roll the staff passport out with the support of the unions.

Another innovation is the idea of a 'talent bank' of staff. This would provide a pool of permanently employed staff who would be deployed across a health economy, as required, depending on workload variation. Reportedly this was first introduced for newly qualified physiotherapists that could not find permanent jobs and the talent bank was set up to retain them in NHS employment and give each a part-time job of a few hours each week, giving an overall equivalent of a few full time jobs. The physiotherapists gained experience while waiting for permanent jobs to become available. This concept and model is now being rolled out to cover other

staff groups, giving permanent contracted employment but with some at reduced hours and across a range of care settings, as required. The development of a collaborative approach across health economies, particularly in urban areas where trusts share nursing labour markets, will enable such pooling and temporary re-distribution of staff.

2.3.4 Community care

It is evident that another major policy focus is on expanding community services, in part as a productivity improvement measure. Several interviewees talked about how work would be transferred from acute to community, or would be supported **across** the community and acute sectors. More delivery is being done jointly with the community sector, and the care pathways of multiple, chronic and long-term illnesses will mean more joint delivery. However, several interviewees suggested that a focus on community-based care will expose this sector as being less well developed in the use of flexibilities for nursing staff and that more effort is required to examine how technology can enable flexibility in this sector. Staff will need to be able to bridge the community/acute sectors, community staff will have to be geographically mobile, and more may have to work what are currently regarded as 'out of hours' in order to support delivery across a longer time continuum than '9 to 5'.

2.4 Conclusion

NHS trusts have been under pressure to reduce their use of temporary staff, and while they have reduced the level of agency provided staff, reliance on bank staff is still high. Trusts have not always been able to get to grips with developing effective ways of managing temporary staff and achieving flexibilities. In general, flexibility has been a tactical response to dealing with sickness absence and uneven patterns of annual leave or has been a recruitment/retention driven response to external labour market driven skills shortages, which generally no longer exist. While NHSP, as a provider of temporary staff, has been able to provide trusts with data on their temporary staff use and trusts have routinely been considering these figures at board level, trusts report that their use of temporary staff is still ad hoc and non-strategic.

With a majority of nursing staff being women, flexible working has had quite an impact on nursing staff. IWL, coupled with the 'Right to Request' flexible working enabled more requests for some types of flexible working such as term time working, short shifts, and staggered start times. Nursing managers who were unsure of the exact demand and pattern of work of their ward or specialty often acceded to the demands for this type of flexible working, without always having a clear understanding of the likely implications for service delivery. Subsequent gaps

in staffing caused by these flexibilities – through, for example, term-time working, have been filled with temporary staff, as have sickness absences and peaks in demand.

However, two major new factors have now impacted to force and enable trusts to get to grips with their staffing levels and needs. Firstly, the increased testing and rollout of e-rostering and secondly, a demand-led economy enabling flexible working to be employer dictated according to the needs of service delivery. The trusts we spoke to face a variety of custom and practice work patterns, such as differing shift lengths and start and finish times which hinder flexibility, and also a variety of unhelpful habits such as booking owed hours just because they were owed and at a time to suit the employee regardless of service requirements. E-rostering has the potential to enable trusts to get to grips with the data on activity and staffing, to see with greater clarity and timeliness exactly what is happening, and to then identify where there is scope for more effective flexible working. The challenge is to interpret the data and to be imaginative and intelligent about solutions using substantive staff more flexibly, such as in the use of the 'staff passport'. There will be a need to continue to use temporary staff but this should be in a more planned manner, such as to provide specialist cover or to cover a planned peak in activity rather than paying overtime to permanent staff. There is the chance then to give temporary staff better inductions and to include them more fully. This will facilitate perceived improvements in the quality of temporary staff which is vital with more data and analysis of quality and patient care attached to all staff including temporary ones. Temporary staff can then become a vital part of a true core/periphery model.

3 Potential Areas for New Primary Research and Associated Interviewee Suggestions for NHSP

In this section we outline where we found gaps in the research literature, which might be considered the primary focus for future research on flexible nurse staffing. We also gathered some comments from those we interviewed about the future service from NHSP and, in places, these suggestions tie in with suggestions for further research and activity.

- **Distinction between different types of flexible nursing.** Much of the literature talks about flexible nurses and agency nurses as if they were interchangeable, whereas in reality there is a marked difference between a nurse provided to an unfamiliar trust by an agency and 'multi-post holders' as NHSP term those provided through their bank back into the trust which employs them, for additional hours. In considering the benefits and disadvantages of flexible nursing future research could examine this distinction.
- **Impact of agency staff on care.** The review of the literature highlighted a paucity of evaluation of the impact of the use of agency nurses on patient care, patient communication, and continuity of care. Whilst an area where additional research would add value to policy making, it is also a complex issue to explore – which is one of the reasons for the limited research conducted so far.
- **Flexible/temporary nurses.** The concept of a team ethos and its perceived impact on patient safety could be explored further, examining the involvement of temporary nurses as part of the 'team'. Literature exists around permanent nursing staff perceptions of agency workers contributions to the team and its impact on patient care but these challenges must also be considered from the perspective of the temporary nurse.

- **Impact of 'presenteeism' on staff and care outcomes.** The interim Boorman report also recommends that further research should be undertaken into the issue of presenteeism, in order to identify in more detail its causes, variations between occupational groups and the impact on patient care and safety (Boorman, 2009, p.32).
- **The impact and potential of e-rostering.** Our report has highlighted a rapid pace of introduction of e-rostering, with several broader organisational implications such as the need for effective training and preparation of nursing and ward managers to best utilise the new approach, the need to involve staff in these changes, and how best to link e rostering to other new developments such as staff passports, KSF information, ESR data, local information on patient dependency/ acuity, and 'dashboards' of care indicators etc. Research is needed to understand what difference e-rostering has made and can make, the impact on temporary and flexible nurses, and how successful managers are being in understanding and acting on the data they now have access to; how 'intelligently' the data is being responded to.
- **Networking and training support for e-rostering.** Managers require support with doing this and raised the possibility of local networks and links. NHSP, it was suggested, could be well placed to be a facilitator of such links and could act as a provider of training to those nurse managers who will have day to day responsibility for managing e-rostering. One interviewee suggested that exploring the potential for different ways of working with e-rostering ought to form part of a 'consultancy role' for NHSP in helping trusts to procure e-rostering through their preferred supplier.
- **Flexibility in community nursing.** An issue linked to current critical policy priorities, is how to ensure that the benefits of new approaches to nurse flexibility are extended and embedded in the community sector, which several of our interviewees cited as a sector that was not yet as well developed in its use of 'traditional' and new flexibilities. Given the central policy focus of shifting care into community settings, and the fact that nursing in the community is often organised in different ways and working to different patterns, there is a specific need for more work to illuminate the contextual differences pertaining to community sector nursing, and also to then identify effective good practice in flexibility in the sector.
- **Optimizing the core/periphery model in staffing.** There are no UK data or information that give an idea of what that balance might look like. Whilst it is likely that there is no single 'optimum' balance, given differences in care environments and in organisational parameters, more work is needed to set out what might be the parameters and key criteria for effective balance, and what key indicators need to be factored in to support effective local decision making

on this issue. This could be achieved by undertaking case studies in trusts which have been making greater use of technology to support innovative models of flexibility, to synthesise key findings for wider dissemination.

- **Improving the data on the use of flexible working in NHS nursing.** There are big gaps in what data is available at a regional and national level to inform policy makers about trends in use of flexible nurses. In recent years in NHS England there has been a diminution in published data, and in March 2010, the published NHS non-medical staff census (for September 2009) gave only a broad brush indicator of the level of use of bank nursing as a whole-time equivalent measure. It should be feasible to support better benchmarking of levels of use of flexible nurses by developing ESR data, or using NHSP databases as a primary source. In comparison, policy makers in NHS Scotland have national and organisational level data published annually, which gives information on bank and on agency use and registered and unqualified nursing staff, by three measures – hours worked, whole time equivalents, and costs. The most recent data available, for 2008/09 can be found at www.isdscotland.org/isd/5685.html.
- **Labour market changes.** Another issue of relevance is the marked changes that are occurring, and will occur in the nursing labour market, as a result of the impact of economic recession, constraints on public sector funding, changing demographics within the profession, and changes in the way that nurses are educated. These changes will impact on nurses' labour market behaviour over the next five years in terms of their levels of engagement in different types of flexible working. A review and analysis of relevant labour market and workforce profile data, combined perhaps with focus groups or a survey, would give insights into key trends and the scale of this change.

Some interviewees made specific suggestions:

- Two interviewees mentioned the benefits that might be gained from retaining those coming up to retirement and attracting retired nurses onto NHSP's books. The NHS pensions allows people to draw their pension and to keep working and more should be done, the interviewee suggested, to make it attractive for retired people and those approaching retirement to be on the bank. Approaches to making joining the bank attractive were suggested, such as the first pick of shifts, a range of shifts and types of work offered.
- Two interviewees talked about the attraction of getting all of a trust's staff registered with NHSP (including doctors and therapists). This prevents overstaffing permanent staff and gives the ability to reduce expensive paid overtime (although the literature made clear that much overtime is unpaid).
- Two interviewees also talked about 'longer lines of work' and the attraction of being able to book temporary staff for short term contracts, such as three

months linked to maternity cover for a specialist type of nurse, or because of organisational change, or waiting list initiatives. Such availability would improve a trust's ability to workforce plan and to control cost and quality.

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