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Temporary Staffing Review – **Hywel Dda University Health Board**

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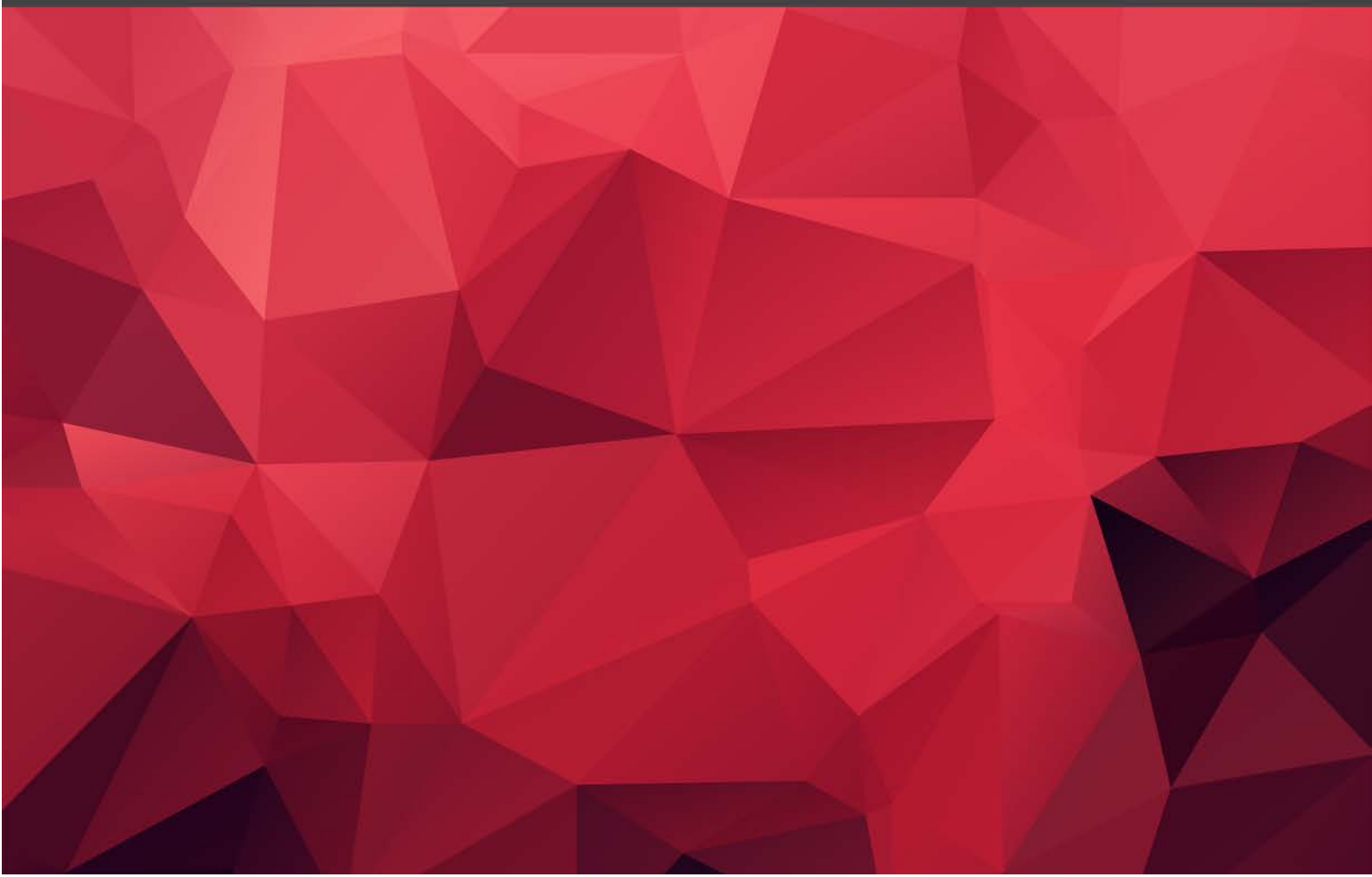

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

The team who delivered the work comprised Tracey Davies, Andrea Williams and Katie Queenan.

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Summary report

Introduction

1 NHS organisations need to be able to respond to fluctuations in demand and staff availability through flexible approaches to staffing. The use of temporary staff forms a key part of this flexibility. When managed robustly, the use of temporary staff can be a positive part of an NHS body's overall approach to workforce planning and staffing, and can help accommodate the increasing number of NHS staff who want to work more flexibly.

2 However, an over-reliance on temporary staff can prove to be extremely costly, and can contribute to problems with the quality and safety of services and the morale of permanent members of staff. Temporary staff may be at least as able as any other member of staff, however, the circumstances in which they work can increase clinical risk. Rushed appointments, poor induction at the start of the post, inadequate supervision and lack of awareness of local processes all increase the chances of something going wrong.

3 Hywel Dda University Health Board (the Health Board) has experienced significant workforce challenges in recent years, particularly in the areas of medical and nurse staffing, with high levels of vacancies, long standing recruitment difficulties increased service demand, and the need to adhere to the European Working Time Directive[1]. While a number of measures are being taken to address these challenges, expenditure on variable pay is increasing at an unprecedented rate. The variable pay bill costs have risen from £1.2 million per month in 2013-14 to £3.7 million per month as at 31 December 2015. This is having a significant impact on the Health Board's overall financial position. At the end of 2015-16 the Health Board reported an overall deficit of just under £31.2 million. During that year, the Health Board's total expenditure on agency staff was £23.45 million, and its expenditure on agency as a percentage of total pay was the highest of all NHS bodies in Wales at 6.7%. Nursing and Midwifery agency spend as a percentage of total pay was 3.2%, and Medical and Dental 2.6%[2].

4 It is against this backdrop that the Auditor General included a review of the use of temporary staff as part of his programme of local audit work at the Health Board. Given that medical and nursing agency costs form the greatest area of variable pay-cost expenditure, the audit focused on these specific groups.

5 The review examined whether the Health Board is managing its use of temporary staff effectively. It looked specifically at the extent to which the Health Board understands the factors which drive demand for temporary staff and the quality of

[1] The directive lays down minimum safety and health requirements for the organisation of working time and applies to minimum periods of daily rest, weekly rest and annual leave, to breaks and maximum weekly working time and certain aspects of night work, shift work and patterns of work.

[2] NHS Wales HB & Trust Financial Report for the Period 1 April 2015 to 31 March 2016.

the information that is available to help manage and control the costs arising from the use of such staff. Auditors also reviewed the Health Board's arrangements for ensuring the quality of the temporary staff it employs.

6 The work was undertaken between October 2015 and May 2016. The key findings are set out below and are considered further in the more detailed section of the report.

Conclusions

7 We concluded that while the Health Board is managing its use of temporary staff, related costs and quality arrangements better, there is more that it can do in all areas and it is not yet clear if there will be sustained improvements. We reached this conclusion because:

- The Health Board understands the factors that drive the use of temporary staff and is attempting to reduce demand although difficulties remain in filling posts, avoiding unnecessary use of temporary staff and making the best use of permanent staff:
  - through a focused programme of work the Health Board has developed a good understanding of the factors driving its demand for temporary staff; and
  - while the Health Board is taking action to reduce demand for temporary staff, difficulties remain in filling posts, avoiding unnecessary use of temporary staff and making the best use of permanent staff.
- The Health Board has good information on temporary-staffing costs and largely sound arrangements for preventing fraud, and although new cost control measures are starting to work, it is too early to say whether this will be sustained and significant financial challenges remain:
  - the Health Board has good financial information to support scrutiny and management of temporary staff costs;
  - the Health Board has implemented new control measures that are succeeding in reducing agency nursing staff costs but it is too early to know whether this will be sustained and reducing medical temporary staffing costs is proving challenging; and
  - the Health Board has a generally sound approach to detecting and preventing fraud but there are opportunities to strengthen this further.
- The Health Board has reasonable arrangements to assure the quality of temporary staff before their employment, although there is scope to improve induction and temporary-staff patient-safety concerns need to be reported more systematically:

- the Health Board is taking reasonable measures to assure the quality of temporary staff before their employment although there are opportunities to strengthen this further;
- the Health Board is taking action to strengthen the induction of temporary nursing staff but needs to do more to strengthen induction of short-term temporary medical staff; and
- while the Health Board responds to individual issues as they arise it does not use temporary-staff incidents and complaints information systematically to inform the management of safety risks.

Recommendations

8 We make the following recommendations to the Health Board. These are intended to complement the wider set of improvement activities that are being taken to reduce variable pay costs as part of the Health Board's Quality, Innovation, Productivity and Prudent Healthcare Programme (QIPP) and its wider programme of work aimed at reducing variable pay.

Effectively managing temporary staff demand

R1 In strengthening measures to make best use of permanent staff:

- Until wards can demonstrate that they have earned autonomy, the Health Board should put in place a more robust and effective roster approval process. For those wards that continue to produce poor nursing rosters, a formal improvement process of support, action plans and improvement tracking should be put in place.
- The Health Board should use the Intrepid workforce system to introduce routine monitoring and reporting of compliance against the six-week leave rule for medical staff. Where there are persistent offenders, the Health Board should put in measures to address this.
- The Health Board should examine whether there is a relationship between the quality of medical staff rotas and higher demand for temporary staff. If any such relationships are identified, remedial action should be taken to improve the quality of the rotas, which draws from best practice.

Effectively controlling temporary staffing costs

R2 Strengthen, simplify and unify processes throughout the pathway of authorising and approving temporary staff, through to the checking and invoicing of shifts particularly for medical locums and agency. Document and communicate the revised processes.

R3 Undertake a cost benefit analysis of the e-rostering system that is being considered to determine whether the benefits outweigh the costs.

R4 Progress work to automate the bank system to enable the e-rostering team to undertake more audits to enable them to examine and identify errors and potential areas of fraud.

Effectiveness of arrangements to ensure patient safety when using temporary staff

R5 Agree and implement consistent induction principles for short-term medical locums and agency staff.

R6 To further strengthen employment controls the Health Board should:

a. require MEDACs to update their Service Level Contract to include full details of their vetting process; and

b. ensure that all new staff appointments regardless of whether previously employed complete the relevant checks and have new appointment letters and contracts.

R7 To better understand and manage temporary staffing safety risks the Health Board should produce a thematic report of concerns and incidents involving temporary staff at least twice a year. The Quality, Safety and Assurance Committee should consider and discuss the identified issues at least once per year.

Detailed report

The Health Board understands the factors that drive the use of temporary staff and is attempting to reduce demand although difficulties remain in filling posts, avoiding unnecessary use of temporary staff and making the best use of permanent staff

Through a focused programme of work the Health Board has developed a good understanding of the factors driving its demand for temporary staff

The Health Board is continually strengthening its information base to further understand reasons for temporary staff demand

9 The Health Board has a good understanding of the drivers of demand at a local level for both temporary nursing and medical staff use. This includes the causes of demand, for example, the numbers of vacancies, staff turnover and sickness absence.

10 To help it effectively manage the demand for temporary staff, the Health Board has in the past year strengthened its workforce information base. In the past few months, focused work has been undertaken to understand nursing and medical temporary staff usage and expenditure. From a nursing perspective this included, ward-by-ward analysis of establishments, rotas, vacancies and temporary staff usage with ongoing monthly discussions between service managers, ward managers and senior nurses. Work has also been undertaken within each service area to gain a better understanding of the true extent of medical staffing establishment and vacancies. This was felt necessary to enable it to build a clear and complete picture of the medical staff vacancy risk for each hospital and service area to inform its recruitment activity.

11 The workforce report, which has now been incorporated into the Integrated Performance report, provides a comprehensive measure of performance on which to inform its actions. Measures include sickness absence, training, recruitment, turnover, bank/agency usage and variable staff expenditure. More detailed narrative is provided on performance against targets, challenges, actions being taken and expectations for improvement.

12 Various detailed directorate workforce reports are also produced on a weekly and monthly basis and issued to directorate managers to support management accountability, challenge and improvement actions. For example, detailed sickness absence information enables managers to determine the extent of and areas

where sickness absence presents staffing challenges. Also MEDACs[3] produce comprehensive agency and locum medical staffing trend information that includes usage, expenditure by area and grade, reasons for spend, agency used, average rates of pay and fill rates. The various reports and discussions usefully help the Health Board target any specific actions for particular areas to address.

Factors behind temporary staffing usage are similar to those affecting other NHS organisations although there are specific local issues

13 In common with many parts of the UK, the main drivers for temporary staffing usage are high levels of nursing and medical staff vacancies, difficulty recruiting sufficient staff to fill these vacant posts, sickness absence and unplanned demand.

14 From a nursing perspective across Wales, health boards are competing, broadly within the same talent pool. The effect of the implementation of the 2012 All Wales Nursing Principles guidance[4] has clearly placed additional pressures on the availability of the registered nursing resource. Nursing recruitment pressures are not limited to Wales and this impacts on the ability to recruit from other parts of the United Kingdom and, increasingly, internationally.

15 In March 2015, the Health Board uplifted the budgets of all acute medicines and surgery wards with the aim of supporting safe nurse staffing levels. The justification for the uplift was an expectation that variable pay would reduce. This has not happened as the Health Board has not been able to substantively fill the posts to meet the uplifted establishment levels. These gaps alongside existing staff turnover and vacancy pressures contributed to the 250 whole-time equivalent (WTE) nurse vacancies in 2015-16, which is resulting in greater temporary staff usage.

16 From a medical staff perspective, a national UK-wide shortage of medical staff has exacerbated an already challenging local situation with long standing difficulties recruiting the right numbers to various specialities particularly in the western and northern fringes of the Health Board. This was further aggravated by acute medical staffing pressures experienced in Withybush General Hospital in the summer of 2015. This led to an unplanned service position, whereby other hospitals in the Health Board needed to open medical bed capacity in order to receive acute medical patients from Pembrokeshire where capacity has reduced. The staffing requirements for these additional beds were met by temporary staff, which has resulted in significant additional variable pay costs.

17 Turnover of staff has been high, with the Health Board's total turnover between the periods of June 2014 to March 2015 of 9.5%, the second highest in Wales. Average registered nursing and midwifery turnover in the past three years has

[3] MEDACs is the preferred on-framework locum doctors' medical agency supplier to the NHS in Wales. It provides the Health Board with an on-site managed service that provides support, data collection and analysis.

[4] National Assembly for Wales – Nurse staffing levels on hospital wards, July 2013.

been 6.5%, with medical and dental (excluding doctors in training) being 15%. However, overall turnover rates fell to 6.8% by February 2016 and have remained around that level since. The Health Board has analysed reasons for high turnover and the top three reasons are age retirement, voluntary resignation (known and unknown reasons) and relocation. It has undertaken a detailed analysis of the age profile for these two professional groups, and acknowledges that it presents a significant risk and recognises that actions are needed to address this.

18 The Health Board has experienced delays to its recruitment process which prompted it to examine the reasons for delays. While there were delays from a Shared Services perspective the Health Board also found that ward managers were not as responsive as they needed to be, with as long as 10 weeks being taken to shortlist candidates and several week delays to interviews. A key factor has been the high volume of recruitment, with ward managers struggling to find sufficient time to fulfil their recruitment responsibilities such as job application short listing.

19 The Health Board's sickness absence rates have increased in the past two years. In December 2015, the Business, Planning and Performance Assurance Committee (BPPAC) was informed that sickness absence was the highest in Wales. The Health Board has not met the Welsh Government 4.79% target for some time, despite previously being the best performer in Wales between 2012 and 2014. Sickness remains high with a rate of 5.45% reported in the August 2016 integrated performance report.

20 In common with other parts of the NHS the Health Board is experiencing higher-than-planned levels of demand with older, more dependant and sicker patients. This along with an increasing need for one-to-one support for some patients has increased pressure on substantive staff, with wards increasingly using bank and agency nursing staff, particularly Health Care Support Workers (HCSWs) to support delivery of care.

While the Health Board is taking action to reduce demand for temporary staff, difficulties remain in filling posts, avoiding unnecessary use of temporary staff and making best use of permanent staff

The Health Board is taking a number of actions to increase permanent staff numbers but recruitment is difficult and significant shortfalls remain in some areas

21 The Workforce and Organisational Development 2015 Annual Plan acknowledged that the Health Board experienced significant problems with recruitment and retention. As a result, the approach to recruitment has been strengthened and while this has been successful in a number of areas, the extent of the problem means that there remain ongoing challenges. The need for a sustained recruitment

drive is recognised by the Health Board. The Workforce and Organisational Development Strategy March 2016[5] provides detailed analysis of the recruitment issues by professional group, the challenges and clear actions needed to be addressed as well as the associated timescales.

22 Recruitment activity includes innovative approaches in the way that jobs are advertised, the established, ongoing cycle of local recruitment exercises as well as career fairs, recruitment open days and overseas recruitment. Recruitment from a number of European countries, in addition to recruitment from the Philippines, has successfully secured 246 registered nurses. Recently, the Health Board has successfully recruited a number of Italian nurses. There are also plans for a recruitment campaign in Australia and New Zealand for mental health and learning disabilities staff.

23 Building on last year's success in recruiting newly qualified nurses, a total of 81 newly registered nurses have been appointed since September 2015, with 78 students given conditional offers of employment in February 2016. The Health Board is attempting to over-recruit, to secure more recruits than current vacancy numbers being held, because of known drop-out rates of candidates and to reduce the variable pay bill. The Health Board predicted that based upon detailed analysis of joiners, leavers and current long-term vacancies, that by Quarter 3 of 2016-17 they will have filled the majority of their nursing vacancies. However, the Health Board has acknowledged language-skill competencies with the Philippines nurses means that they will not be able to fill majority of nursing posts until Quarter 4.

24 The use of a bank pool of registered and unregistered nurses provides a flexible workforce which can reduce the use of expensive agency staff. However, the bank pool needs to be sufficient to meet the needs of the service. The bank can consist of 'bank only' staff who are not employed substantively by the organisation and substantive staff who make themselves available to work on the bank when not working their substantive hours.

25 The Health Board has a well-established bank pool which it continuously works to sustain through a rolling programme of recruitment. Despite this, the high level of nurse vacancies and recruitment from the pool into substantive posts, particularly registered nurses means that the pool does not fulfil the Health Board's short-term temporary nurse staffing needs. As part of its Workforce Enabling Plan within the Interim Integrated Medium Term Plan, 2016/17 to 2018/19, the Health Board proposed increasing capacity on the internal nurse bank to eradicate HCSW agency usage, and reduce reliance on nurse agencies. The Health Board has set up a pool of HCSWs that will be site based but which can be moved around as required. To the end of June 2016, 60 HCSWs have been recruited to the bank covering all four hospital sites.

[5] Hywel Dda University Health Board: Enabling supporting plan: Annex 8 to the Interim Integrated Medium Term Plan 2016-17 to 2018-19.

The Health Board is yet to fully cease use of HCSW agency staff, but says that this will be enforced from September 2016.

26 Medical staff recruitment continues to be a challenge. While some progress has been made with successful appointments to junior and senior medical staff posts, significant gaps remain particularly in some specialities, such as Accident and Emergency, Radiology and Dermatology. Key successes include 25 consultant appointments since January 2016, the permanent recruitment of four medical staff previously employed in the Health Board in an agency capacity and 10 overseas junior doctors. In addition to its standard recruitment approaches, the Health Board is focusing medical recruitment around specific work streams which link to its key strategic aims such as diagnostic services and respiratory services. There is a targeted programme aimed at attracting overseas medical staff. It is also working with medical agencies to help promote the Health Board to wider audiences across the UK and overseas, and has developed links with Eastern European Universities. In addition, to help new overseas doctors, the Health Board has put in place support structures including peer support and additional educational opportunities.

27 In terms of timely recruitment, the Health Board is taking a number of actions to address the slow pace of time from a post being made vacant to the point of starting in post. These include:

- provision for ward managers to be released from clinical practice for 0.4 WTE of their time to protect time for them to undertake their management function, including recruitment activities such as short listing applications. Although, ongoing recruitment challenges and associated pressures on staffing make this difficult to achieve.
- working with NHS Shared Services to improve the pace of central recruitment through better understanding of the reasons for delays and the use of a detailed weekly tracker system produced by Shared Services. The new tracker system (TRACC) was put in place in April 2016. The Health Board has full access to the system which, amongst other functions, highlights any recruitment that falls outside the agreed time scales. The Health Board plans to undertake routine monitoring of two aspects, time taken from receipt of request to advertise to request to appoint and percentage of posts with recruitment process post interview completed within target.

28 A number of actions are also being taken to reduce the high sickness rates. These include:

- increased focus on sickness auditing to ensure that managers are adhering to the All Wales policy requirements, and also support, help and training for line managers involved in the process. Additional and dedicated workforce resources have been put in place to support improved sickness management.
- expansion of wellbeing initiatives to reduce in particular stress related sickness rates which at 25% of the current total sickness rate are high. The

Health Board has invested in Occupational Health to help promote staff welfare and healthy activity.

Wards do not always maximise the use of their substantive staff despite rostering systems to enable them to do so

29 All wards in the Health Board use an electronic rostering (e-rostering) system called Roster Pro for rostering their nursing staff. E-rostering is an effective tool which, when fully implemented, allows improved workforce management of both substantive and temporary staff. The system brings together, in one place, management information on shift patterns (including individuals' preferred shift patterns), annual leave, sickness absence and staff skill mix. It helps ward managers to roster staff more effectively in order to produce balanced rotas that ensure the Health Board fully meets its service requirements. If used well this should reduce demand for temporary staff.

30. Roster Pro has been in place for a number of years. At the outset, the Health Board agreed with each clinical area key parameters or 'Roster Rules'. For example, shift start and finish time, shift skill-mix requirements and the maximum and minimum number of hours that can be taken as annual leave by each registered nurse and Health Care Support Worker. Ward managers or their deputies are required to complete ward rotas in line with agreed parameters.

31. As part of the rolling programme to introduce e-rostering, the dedicated e-rostering workforce team trained and supported ward managers on a one-to-one basis to enable them use the system effectively. As the system is linked to pay, rigorous testing was applied before each ward could use the system live. The intention was to support wards initially during the project phase with wards increasingly becoming self-sufficient and the e-rostering team providing ad hoc support and training. This has not happened. While some wards are using the system effectively many wards are not using the system as they should. The central team routinely audit rosters and they told us of a number of examples of poor rostering resulting in expensive temporary staff being used when better rota management may have meant that fewer temporary staff would be needed. Examples of poor roster management include:

- late creation of rosters: Electronic rotas should be created and signed off at least four weeks in advance for staff to be aware of what shifts they are working but some are left until the week before with some ward managers creating rosters on paper before inputting into the electronic system. Late creation is leading to short-term requests for temporary staff which are difficult to fill often leading to the use of more expensive premium non-framework contract agency staff.
- rotas not being 'balanced': The system allows managers to see whether each shift is under or over the required parameter. With long-term and short-term staffing gaps it is not always possible to balance the rotas across the weeks and months. However, audit evidence showed examples of poor

balancing of rosters, for example, wards being short of staff one week followed by a week that has more resources than planned parameters.

- contracted hours not being fully allocated: Due to the different shift patterns, there are often occasions when individual nurses owe hours which should be accounted for within future rotas. The workforce team found examples where staff owed hours but the hours worked were not allocated with a specific example of a nurse working additional paid hours, yet this nurse still owed the Health Board 69 hours. The use of time-owing books rather than the electronic system is thought to have contributed to these anomalies.

32. There are a number of factors that may be leading to poor rostering. All ward managers should have two protected days per week where they do not work clinically on the ward to enable them to fulfil the necessary management requirements. Due to the establishment shortfalls and gaps many are not able to protect sufficient time for this, which can impact negatively on the quality of the rotas. The Health Board has been considering whether ward receptionists could provide ward managers with additional administrative support to ease the administrative burden. While day-to-day staff deployment is the responsibility of the ward manager, senior nurses are accountable for the quality of the nursing staff roster. The poor quality of rosters suggests that more could be done by senior nurses to support ward managers by ensuring better-quality nursing rosters.

33. At the beginning of April 2016, all ward managers were contacted and informed that the use of paper or books to support time owing was no longer acceptable and electronic rotas would be the formal Health Board document. In addition, by the end of April, exception reports would be produced where sign-off or payment errors would be identified as result of poor roster management. These would be sent to the responsible director and senior managers with the expectation that action would be taken to address poor roster practices. The Health Board needs to ensure this is now fully implemented.

34. Recently, the Health Board has been considering alternative e rostering systems as the current system in use is around eight years old and is judged to have limitations. Different systems in use across other parts of NHS Wales are deemed to be more responsive and enable links to social media, which would simplify and streamline. However, there is a significant difference in the cost of the contract for the original system which is £25,000 per year compared to the new system, which is reported to be £100,000 per month or £1.2 million a year. The Health Board would need to do a cost-benefit analysis to assess whether the benefits outweigh the costs.

The current approach to the management of medical staffing rotas means the Health Board does not have a systematic means of assessing whether the medical staffing resource is optimised

35 Common to the rest of Wales, medical rotas within the Health Board are compiled manually. The Health Board believes that electronic medical staff rotas would

provide a key efficiency opportunity but currently they are not in use across Wales. In 2014, NHS Employers, England, published Five High Impact Actions[6]. These identified key actions that NHS organisations should complete to ensure the most effective use of a temporary and flexible workforce. High-impact change 1 was to increase understanding of the issue. In enabling this, a number of NHS England Trusts have introduced one e-rostering system for all staff including medical staff. The Trusts which have implemented this approach have reported a number of benefits, more transparent decision making, optimised use of the staffing resource, reduction in workforce expenditure, in particular agency staff, freed-up management and clinical time for service delivery.

36 Within the Health Board, there is not a standardised approach to how medical rotas are managed with rotas being managed in different ways and by different types of staff. Rotas tend to be managed by rota co-ordinators who can be Band 5 staff, service managers, middle-grade doctors, or a combination of these and other staff. During our fieldwork, managers told us that the quality of medical rotas varies with some very good examples and others that could be improved, although we were not informed of specific problems. Those areas deemed to be good-practice examples, such as women's and children's services and anaesthetics were reported to be relatively self-sufficient and tightly controlled. We did not examine whether these good-practice areas had a lower usage of temporary staff, and the Health Board may benefit from examining whether there is a relationship between practice and demand. If there is, it may want to consider adopting a standardised approach across the Health Board that draws from best practice.

37 Late requests for medical staff leave can increase demand for temporary staff. All medical staff are required to comply with a six-week rule for requesting any type of leave, such as annual or study leave. Senior HR staff informed us that a process of different levels of authorisation was in place for junior medical staff and, while each department differs slightly in their processes, they had no concerns that the rule was being breached. However, as the Health Board does not routinely monitor and report on six-week performance it is unable to say whether there are issues. We were informed that a system in use by HR, Intrepid, has the functionality to run reports which the Health Board may want to consider.

[6] NHS Employers, England, published Five High Impact Actions.

The Health Board has good information on temporary staffing costs and largely sound arrangements for preventing fraud and although new cost control measures are starting to work it is too early to say whether this will be sustained and significant financial challenges remain

The Health Board has good financial information to support scrutiny and management of temporary staff costs

38 Addressing variable pay expenditure and its associated factors are a high priority for the Health Board. The Interim Integrated Medium Term Plan (2016-17 to 2018-19) identifies that the service and workforce challenges manifest in significant vacancies and premium variable pay of just over £35 million in 2015-16. The Health Board recognises that this is neither economically sustainable nor does it provide the highest quality of care.

39 The Health Board knows its variable pay costs and routinely discusses and scrutinises them at its Business, Planning, Performance and Finance Committee. The Board and Audit and Risk Assurance Committee (ARAC) regularly receive and discuss reports on variable pay costs. In early September 2016, ARAC held an extraordinary meeting to discuss and scrutinise the financial handling plan and recommended actions to support this. With the financial deficit largely driven by variable pay, much of the meeting focused on this. The discussion was informed by comprehensive financial and related workforce information. It was evident from the information presented and the discussion that the Health Board had a strong understanding of the financial and workforce-related issues.

40 The Health Board routinely produces financial information that provides detail showing annual monthly trends on agency and premium locum costs broken down by the different elements, it also provides nursing bank and overtime expenditure trends. This is supplemented by contextual supporting information to enable the committee members to understand the reason for the trends and what is being done to address.

41 The Workforce, Education and Organisational Development Strategy and Plan, March 2016[7] shows the various strands of variable pay trends for both registered nurses and medical staff. Cumulative spend for registered nursing from April 2015 to January 2016 was just over £10 million and medical staffing £12 million. The nursing information shows very low and relatively static overtime and bank

[7] Hywel Dda University Health Board Workforce, Education and Organisational Development Strategy and Plan, 2016.

expenditure but significant and steeply increasing agency expenditure over the course of the year. From a medical perspective, the information shows month by month expenditure increases on locum and premium locum doctors[8] with a threefold increase in the latter. Agency expenditure was significantly lower and the trend was relatively static. Since that date, although we have not seen the variable pay performance reported in the same way, overall variable pay has continued to increase.

42 The July 2016-17 Integrated Performance Assurance report shows that average monthly variable pay spend rose from £1.195 million in 2013-14 to £3.260 million in 2015-16, on average three times more per month. However, this continued to rise with a variable pay spend in month 12, 2015-16 of £5.203 million. This has significantly contributed to the Health Board's adverse financial position. While there has been an improvement, with an average monthly cost of £4.715 million at month three, 2016-17, this is still higher than the 2015-16 average monthly spend.

43 Services are expected to deliver to budget and with significant numbers of vacancies it could be thought that this would release savings. But since 2013-14, while the substantive pay position has been relatively static, it is more than outweighed by an increase in variable pay, which is resulting in a significant overspend. Premium agency and locum rates are a key contributor of this overspend.

44 To support management of expenditure detailed financial information is used to enable managers to track and monitor trends in expenditure over time, and take action where required. Each budget holder receives their detailed budget each month and General Managers and Service Delivery Managers receive a written report showing the summarised budget variances. There are regular meetings between General Managers and the Assistant Director of Finance to go through the high-level position and meetings are held on a monthly basis with Service Delivery Managers and department heads.

[8] NHS Locum pay rates are the same as if the person was employed. Premium locums are paid at a much higher rate of pay.

The Health Board has implemented new control measures that are succeeding in reducing agency nursing staff costs but it is too early to know whether this will be sustained, and reducing medical temporary staffing costs is proving challenging

The Health Board has developed a programme of work aimed at reducing variable pay expenditure with further focused work planned to secure the required savings

45 The Health Board has identified 10 strategic objectives to enable it to meet its long-term objectives. Strategic Objective 10 focuses on returning the Health Board to a sound financial footing. This is underpinned by Strategic Objective 9 that focuses on the productivity and quality of services. A QIPP programme, in place since March 2016, aims to support delivery of the plan. Specifically, in relation to temporary staff, the Chief Executive Officer has set a target of reducing the variable pay by £17 million over three years.

46 To support this, in February 2016 the Health Board established a Variable Pay Reduction Programme and Group as a sub-group of the executive team. It is accountable to the Executive team. Its duties are to:

- provide assurance to the executive team that actions are being taken to reduce variable pay spend by £11 million by March 2017. The initial target of £11 million by March 2017 is broken down into a reduction in agency nurse spend of £4.5 million, medical agency spend of £3 million, medical locum spend of £2 million, eradication in HCSW agency securing £1 million and reduction in overtime by £1 million.
- develop and monitor the implementation of a series of initiatives, controls and measures to support better utilisation of its workforce and reduce reliance on variable workforce and introduce a sustainable workforce.

47 There are four supporting work streams and the group will oversee these:

- Bank and Agency
- Recruitment
- E-rostering
- Medical Workforce

48 Variable Pay Reduction Programme key performance indicators have also been developed that cover each of the four workstream domains by month. In light of the continuing workforce and recruitment challenges, the Health Board has acknowledged that it will be very difficult to meet the £11 million savings target by March 2017.

At the Extraordinary ARAC meeting held on 7 September 2016, the Health Board presented various options aimed at securing financial savings. From this, further work was to be undertaken and a paper produced for the Public Board meeting to be held on 22 September.

The Health Board's new programme of expenditure controls is showing encouraging results for reducing nurse agency spend but reducing medical staffing agency and locum spend remains a challenge and it is unclear if the cost reductions will be sustained

Processes are being put in place to strengthen approval and authorisation controls for nursing temporary staff

49 At an operational level, staff and managers told us that before requesting temporary staff, internal means of cover are sought in the first instance. For example, at ward level alternative cover options are considered before the electronic rota is finalised, such as shift cover by ward staff, extra hours in lieu or paid as overtime or other staff known to be available by the ward manager, including bank nurses. Although discussions at the Extraordinary ARAC meeting suggest that more could be done to source cover from wards and areas that may have more flexibility to release and deploy staff.

50 The nursing e-rostering system is an effective control system for assessing need and filling gaps. The system has a free-text function which allows ward managers to input requests or information in relation to filling rota gaps. The bank team have full access to the e-rosters and the bank system interfaces with the e-roster system with a weighted search which will identify the best match. Although our audit identified a number of barriers for ensuring that temporary staff are only used when necessary and if they are needed, filling with the most appropriate and economic option. These include:

- as discussed in paragraphs 31 to 32 the full benefits of the e-rostering system not being realised;
- examples of ward managers requesting specific non-contract agency nurses by name to fill specific shifts;
- central bank team staff finding it difficult to challenge ward managers on their requests as they are banded at a lower level; and
- senior nurses defaulting to use of temporary staff before all other options have been explored to fill the gap in staffing.

51 From a medical perspective, there are weekly meetings with senior managers, workforce and MEDACs to discuss gaps and cover solutions. However, we were told by managers and operational staff that finding internal cover from other areas has become increasingly more difficult due to the level of vacancies. In the first instance, internal staff are offered additional paid hours if internal cross cover cannot be found. The next step will be to source a medical locum from the locum bank. The approach to this differs across the different sites and sometimes within sites. For example, within Carmarthenshire, there is a hybrid approach where some directorate service managers or rota co-ordinators source the locum cover, whilst in other areas HR staff are required to source the cover. If HR cannot fill a gap, they go back to the service. During our interviews, we were told that Hywel Dda is the only health board in Wales that used HR staff to source locum staff.

Concerns were raised that this was not appropriate, as HR did not have access to all the required information and often have to go back to the service. The process of securing locum staff was described as time consuming, not only by HR but also by rota co-ordinators and service managers who said that it was not uncommon to e-mail 100 doctors a day to try to fill a gap.

52 When all other avenues are exhausted the service manager or rota co-ordinator would contact MEDACs' client relationship manager to source an agency doctor. MEDACs will attempt to source an appropriate doctor at the agreed standard rate. However, we were told by managers that it can be difficult to secure doctors at the standard rate in specialised or typically difficult-to-fill areas such as Accident and Emergency. Increasingly the Health Board has found it difficult to secure medical staff at the standard MEDACs rates with some doctors negotiating significantly higher rates even for areas that have traditionally not been difficult to cover. For example, the standard rate for a Foundation 1 doctor should be from £30 to £35 per hour but we were given examples of some doctors asking double that. The Workforce Expenditure Controls Guidance (see next paragraph) draft states that no non-standard rates should be approved without prior approval of the Executive Team. The Health Board is undertaking further work aiming to standardise rates although it recognises that this may prove challenging and needs sensitive handling and engagement.

53 The Health Board has lacked documented procedures or protocols for the application, approval and authorisation of temporary staff. As a result there has been inconsistency across the Health Board. The variable pay reduction programme includes the development and implementation of booking and approval mechanisms. In addition, in early 2016 the Health Board produced its Workforce Expenditure Controls guidance. This document which was approved and issued in May 2016 articulates appropriate levels of controls including approval and authorisation. There is evidence in the August Integrated Performance report that temporary nursing staff approval processes have been put in place and are starting to take effect. These include changes to the booking process so that all shifts are filled wherever possible by Bank staff or via the non-premium rate agencies. Any unfilled shifts have to be submitted to the Director of Workforce and Organisational Development and if there is a specific service risk the Director of Nursing, Quality and Patient Experience, for approval prior to going to a premium rate agency. It is not clear whether similar executive controls have been put in place for medical staff.

The Health Board has taken positive action to reduce its use of off-contract agency nurses

54 In 2006, NHS Wales set up an All Wales Agency Nurse Framework Contract to support better quality and financial controls when using agency nurses. The contract stipulated charging mechanisms with prices mid-point of the NHS pay scale. This divided nurses into different types, general, theatres and mental health, but did not differentiate critical-care nurses, which was seen by some as a contract weakness. Across Wales, this worked well for some time but over the years there has been a steady growth in the numbers of nurses joining premium, off-contract agencies, in particular critical-care nurses, with a corresponding reduction in the numbers of bank nurses. Sheer supply-and-demand factors have led to health bodies increasingly having to resort to use of these off-contract agencies when they have needed temporary nursing staff, with an associated increase in costs. In response to this, the all Wales Nurse Directors group agreed a programme of work aimed at eradicating all non-framework contract agency use by 1 September 2015.

55 The Health Board has previously done a lot of work to reduce reliance on non-framework contract agencies, including proactive engagement with six framework contract agencies and offers of incentives such as block booking. However, this was not successful, as the majority of these contract agencies could not supply sufficient nurses to meet demand, largely due to the location of the Health Board. One contract agency did provide a small supply of nurses, but reliability was an issue with booked shifts cancelled at late notice. This meant the Health Board had to resort to high-cost off-contract agencies that could provide nurses, albeit at a significantly higher cost.

56 Consequently, over 90% of the expenditure for registered agency nurses has been with an agency supplier for which the Health Board had no contract. Between April 2015 and January 2016, the number of shifts provided from a framework contract supplier was 1,086 compared to 13,683 provided by a non-framework contract supplier. The overall cost for the off-contract agency being £7,459,230 as opposed to £134,653 for the framework contract supplier.

57 However, following negotiations late last year the Health Board successfully secured on-contract agency nurse providers to work with them. This has been particularly successful with one agency that previously did not supply agency nurses to the area. Following a recruitment drive this on-contract agency is supplying increasingly more nurses to the Health Board. This has enabled a significant shift away from high cost off-contract agencies and moved the Health Board closer to its target of only 15% of shifts being from an off-contract agency provider, see Exhibit 1.

Exhibit 1: in recent months the Health Board has significantly reduced its reliance on expensive off-contract nursing agencies

	July 2015	January 2016	March 2016	July 2016
Percentage of total agency shifts filled by off-contract agency workers	97.6%	84.6%	76%	27%

The Health Board has a generally sound approach to detecting and preventing fraud but there are opportunities to strengthen this further

58 The Health Board has a good record of identifying incidents of fraud, and has worked with the Local Counter Fraud team to raise awareness amongst staff of whistle-blowing mechanisms, procedures and subsequent actions.

59 The Health Board recognises that fraud incidence is negligible for agency staff and that most cases identified relate to the Health Board's substantive staff. For example, there are small a number of cases either recently concluded or currently under investigation, which relate to allegations of staff absenting themselves through sickness from their employer, only to work in other locations outside of the Health Board. The ARAC routinely receives and discusses counter fraud issues and cases and resulting actions taken.

60 Specifically, from a temporary staffing perspective, the Health Boards e-rostering team routinely audits a small sample of electronic rosters. This has identified some rota and pay anomalies which have been investigated. For example:

- a substantive member of staff worked 7am to 3pm but also claimed bank shift for 1pm to 9pm; and
- one ward where the Band 6 and Band 7 rostered themselves for extra weekend shifts when the rota was not final.

61 Unfortunately, the high level of support provided by the e-rostering team to ward managers and the lack of automated systems means that the team are not able to undertake as many audits as they would like. As such, errors or, indeed, examples of fraud may be missed with the potential financial loss to the Health Board.

62 As part of this audit, we undertook specific controls testing of a sample of 20 high value payments of temporary staff codes from the ledger and sourced documents such as rotas, payroll records and agency invoices. We checked employee hours worked back to authorised timesheets and rotas and payments. There were a number of common issues largely around timesheet authorisation signatures. These included illegible authoriser signatures and signatures not printed as required in the verification section of the additional duty form. In the absence of an agreed and up-to-date signatory list containing specimen signatures, there is nothing to check that the right person is authorising the timesheet. The current

claim form states that it requires the name, signature and date of the person verifying the work and a different one authorising the payment. For one payroll sample, which tested 11 locum forms for one payment, there was no name printed, no verification date and the verified by and authorised appear to be the same person. The Health Board may feel that one signature is acceptable and if so the claim form should be amended.

63 Specifically, we tested payments authorised back to the rotas or equivalent. Fourteen out of 20 matched; of the remainder we found:

- in one case, the timesheet was missing, which meant we were unable to confirm the period of time worked. In addition, the supporting rota did not show the doctor's name within the listing.
- in three cases, mismatches between the hours and shifts claimed as worked by the doctors and the content of the rotas.
- in one case, difficulty confirming doctors' hours worked and claimed against the rota as the shift times were not stated, only the dates.
- in one case, additional hours claimed by the doctor outside agreed rota shifts and even though additional hours were stated to have been agreed by the rota co-ordinator there was still a discrepancy between the timesheet and the rota.

64 We were informed that when the doctor has completed their work in that week, they will then submit timesheets electronically. Medical Staffing receives this and will check the hours against rotas with co-ordinators and match them up with the timesheet. If they do not match up these should be queried and resolved before the process goes any further. Once agreed, Medical Staffing will enter approval of the timesheet. The examples above suggest that this process as described does not always happen.

65 Our audit found processes from authorisation and approval through to invoicing – particularly for medical locums and agency – inconsistent, confusing and at times overly complicated. This is not only inefficient but could also potentially create an environment in which individuals could take advantage and commit fraud. The Health Board needs, wherever possible, to simplify and unify processes, document and communicate the updated processes and, if required, enforce them.

The Health Board has reasonable arrangements to assure the quality of temporary staff before their employment, although there is scope to improve induction, and temporary-staff patient-safety concerns need to be reported more systematically

The Health Board is taking reasonable measures to assure the quality of temporary staff before their employment although there are opportunities to strengthen this further

66 From an external agency and locum perspective, the Health Board largely places reliance on the checks undertaken by the agencies themselves or regulation and inspection by others. This tends to be the standard approach adopted by most NHS bodies.

67 From a nursing agency perspective, the agency supplier conducts the employment checks and training for the registered nurses it engages. The Health Board only requires the agency to provide full details of each individual employed including their live registration PIN number. For framework contract agencies this forms part of the agreed Service Level Agreement (SLA). However, until the earlier part of this year over 90% of the Health Board's registered agency nursing provision was from non-framework contract agencies with which the Health Board did not have an SLA. We were informed that the non-framework contract agencies used by the Health Board, namely Thornbury, Richmond and Direct Nursing Services, were regulated by the Care and Social Services Inspectorate Wales (CCSIW) under the Care Standards Act, 2000.

68 Our audit evidence found that both Richmond and Direct Nursing Agency were registered with CSSIW. Baseline reviews of each agency had been undertaken by CSSIW in the past year and no areas of non-compliance were found. The baseline reviews include employment and training checks. These include an examination of whether agencies have correctly checked full employment history, undertaken Disclosure Barring Service (DBS) checks and undertaken qualification and registration checks using the Nursing and Midwifery Council (NMC) online confirmation service. It also includes checks of evidence in the nurses' files that they had completed required mandatory training.

69 As an English care organisation, Thornbury Nursing Agency is inspected by the Care Quality Commission and the last inspection was in August 2013. The inspection focus differs to that of CSSIW and although there was evidence of checks on training there was no information to show that an inspection of employment checks had been undertaken, which is a potential risk. However,

information on the Thornbury Nursing Services website and information provided by Thornbury for clients states that staff are only supplied where experience has been proven with staff having received enhanced level DBS checks, face-to-face interviews, two references, pre-registration occupational health checks, NMC registration confirmation and verification of immigration status. It also shows that the agency uses an independent auditor that specialises in quality checking framework agencies. The last audit of 50 recruitment files and 50 timesheets reports that recruitment, induction, compliance and training processes were largely sound.

70 From a medical staffing perspective, in-hours medical staffing receive information on each doctor from the medical staffing agency. This compliance check includes the General Medical Council (GMC) check, occupational health check, DBS, immigration status and references. The senior clinician is notified about the temporary staff details and they will decide if suitable. When rarely there is an out-of-hours need, there is an on-call manager who would be contacted. If a longer-term locum doctor appointment is made then the Health Board follows the recruitment process and pre-employment procedure as it does for permanent posts.

71 As part of our controls audit of a sample of 20 temporary staff, we reviewed the vetting procedures to ensure staff have adequate qualifications and experience. Fourteen of the sample were medical staff and the remainder nursing. We found:

- of the six agency nurses vetting was undertaken by the relevant agencies as outlined above in paragraphs 67 to 69. We did not source this information.
- two relate to MEDACs which provides a managed service for the recruitment of all medical staff. The SLA with MEDACs, jointly signed by the Health Board in 2014, states that a standard vetting procedure is undertaken on staff. The SLA does not outline what that vetting procedure consists of.
- five relate to the Personal Service Company (PSC) SLA[9] in connection with Liaison STAFF*flow*[10], which carries out regulatory checks on the temporary employee such as the right to work in the UK, registered medical practitioner who holds a licence to practice, holds DBS and medical checks. We did not source this information.
- the remaining seven reviewed by the Health Board HR department were payroll contract staff employed directly by the Health Board as fixed term temps (as per ESR status). We found that in all seven cases, personnel file cover notes or medical staff appointment checklists were not fully nor clearly

[9] Personal Service Company (PSC) is a company set up by doctors to 'sell' work to agencies or clients.

[10] STAFF*flow* is Liaisons staff agency procurement outsourcing service, run in partnership with PWC. It allows health boards to engage temporary workers rather than employing via agencies. STAFF*flow* is used to run payroll and gain improved information on temporary medical staff.

completed and were not signed or dated to confirm that all relevant checks were completed. In one case, there was no DBS or ID confirmation on file. This individual had previously been substantively employed by the Health Board as a consultant and as such many of the questions on the form were known. However, as this is a new episode of employment there should be an appointment letter and contract. Also, it provides an opportunity for the Health Board to consider and justify whether or not a new DBS is required.

72 Substantive staff are permitted to work for agency suppliers, provided that the shifts they work are not for the Health Board in which they are substantively employed. The Health Board does not currently gather information regarding numbers/names of staff that currently hold a second job with a private agency/hospital. This makes it impossible to determine if its own staff members are breaching the EWTD, or working excessively to a degree that might impact on the well-being and safety of that staff member and/or quality of care. This is a Wales-wide problem and solutions are being considered in partnership with NHS Shared Services.

The Health Board is taking action to strengthen induction of temporary nursing staff but needs to do more to strengthen induction of short-term temporary medical staff

73 At the time of the audit, operational induction arrangements for bank and agency nurses were informal and inconsistent. Some areas such as operating theatres had developed their own checklist for bank and agency nurses. Most other areas did not have a formal checklist and were reliant on local practice. During interviews, ward managers described how, on arrival, a nurse agency worker's proof of identification and PIN numbers were checked with routine familiarisation taking place, with key aspects of undertaking a shift also covered: the cardiac arrest trolley and emergency procedures, for example. They also said that many of the temporary staff would have previously worked on the wards and would therefore be familiar with procedures and processes.

74 In late 2015, the Health Board developed an induction checklist for specialist wards and a separate one for general wards aimed at both bank and agency nurses. An information sheet had also been designed to help all bank and agency workers familiarise themselves with Health Board expectations, policies and the geography of the clinical area. Following feedback, the Health Board is in the process of enhancing these further.

75 From a medical perspective, external providers such as MEDACs provide doctors with general induction information. We were not made aware that the Health Board had developed its own medical orientation checklists and guidance for short-term temporary staff. Information provision and induction is reliant on local arrangements and appear to be informal and therefore liable to be inconsistent and of variable quality. We were told that as most of the temporary medical staff would

have previously worked on the wards they would be familiar with procedures and processes. However, the Health Board needs to ensure that local induction processes for new temporary medical staff meet standard requirements.

76 Longer-term locums and bank staff undergo the standard Health Board recruitment and induction processes.

While the Health Board responds to individual issues as they arise it does not use temporary staff incidents and complaints information systematically to inform management of safety risks

77 In the past few years, the Health Board has undertaken a lot of work with ward managers and other staff to instil a positive reporting culture to ensure that quality and safety incidents are routinely reported. As part of our audit, we asked for information on the numbers and trends that relate to the use of temporary staff. We were told that no specific reports on incidents relating to this had been produced. This makes it difficult to determine patterns of risk and incidents related to agency and temporary staff use.

78 We were informed of informal mechanisms for reporting temporary staff issues or incidents. From a nursing perspective, these include a monthly log kept by a member of the workforce team which identifies the incident/issue by date, employment status, detail of the issue, current status and outcome. Issues related to agency staff are referred back to the suppliers who are reported to be responsive to the feedback.In addition, the main 'off contract' nursing agency (Thornbury) provides a feedback mechanism in their timesheet that enables senior Health Board staff to rate and comment on an agency nurse's performance during the shift. Ward managers also have regular dialogue with resource bank managers, to feed back any low-level performance issues in respect of agency or bank staff, for example, if they demonstrated poor attitude, flexibility or quality concerns. While the ward staff that we interviewed did not report major concerns regarding the quality of agency staff received from the off-contract supplier, workforce staff told us that the numbers of issues and incidents with agency temporary staff had increased. A key contributing factor was thought to be the higher volume of temporary agency use. Issues identified included poor documentation, errors with administration of medication and an increasing number of POVA (Protection of Vulnerable Adults) issues. There had also been cases with agency nursing staff falling asleep on duty. These are worrying examples of lapses in the quality of care and highlight the need for a rigorous approach to the reporting of incidents and concerns relating to temporary staff.

79 From a medical staff perspective, end of placement forms for agency medical staff are sent to the MEDACs lead, although we were assured that if there was a problem this would be fed back before the end of placement. We were informed of a small number of cases in the previous 12 months where placement was not completed. We were not made aware of any process of logging incidents or issues.

80 While the Health Board responds to, and addresses, individual issues as they arise, the way in which incidents are recorded means that it is not possible to clearly identify specific incidents and safety risks associated with temporary staff. This needs to be addressed to inform management both in terms of any specific remediation but also more broadly to inform supplier selection processes.

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