

staffing solutions

Difficulties in recruitment and rising temporary staff costs are contributing to the significant financial pressures for NHS providers this year. An HFMA roundtable discussion provided an insight into the challenges and possible solutions. Steve Brown reports

Use of agency staff by NHS providers has exploded onto the front pages of newspapers in recent months amid major concerns about the growing costs of this temporary workforce.

In a survey for the HFMA's *NHS financial temperature check* at the end of 2014, provider finance directors identified staff as their key challenge in the current year, with agency staff

costs a particular problem. Four out of five finance directors said agency staff costs were one of their main cost pressures, closely followed by more general pressures from simple increases in staff numbers.

Monitor's Q3 financial report at the end of February puts this into figures. While foundation trusts collectively planned to cut agency spend by 40% in 2014/15, actual spend by Q3 was 120% higher than plan and 30% higher than the actual spend in the same period last year. Although trusts have saved £524m on vacancies, they have spent £225m on overtime and bank costs. The difference – £299m – of 'planned payroll costs' have been replaced by £697m additional spend on agency staff above the planned levels. Monitor says this suggests a premium of 133% is being paid.

There have been other attempts to quantify the rising cost of agency nurses. A Royal College of Nursing report last month estimated the NHS will have spent 'at least £980m on agency nursing staff by the end of this financial year' – an average of £4.2m per trust. It further claimed that the cost to the NHS of agency nurses had increased by 150% since 2012/13.

At the start of 2015, the HFMA, together with Allocate Software, held a roundtable bringing together finance directors to discuss the staffing challenges and how providers and national bodies could respond to address them.

Paul Briddock, HFMA policy and technical director, chaired the discussion and set out the key issues. 'The staffing pressures facing NHS providers are really acute at the moment and



there are a number of drivers,' he said. 'Rising attendances and admissions above planned levels are contributing to some of the need for additional staff, but it is clear the safe staffing and the quality agenda in general is having a direct impact on establishment levels.'

The Francis report into serious failings at Mid Staffordshire NHSFT is at the heart of the drive to ensure staffing levels meet patient needs. But the focus on adequate staffing has been further enhanced by the subsequent Keogh review of trusts with high mortality rates and the Berwick review of patient safety.

The National Institute of Health and Care Excellence (NICE) is producing guidelines on safe nurse staffing levels for different wards and services. And staffing is now a central aspect of the Care Quality Commission's revised inspection regime.

Quality concerns

All the roundtable participants recognised the safety and quality agenda as a key driver of rising staff and agency costs. But while agency costs were making a clear contribution to rising deficit levels – particularly in acute providers –

finance directors said that having to resort to the temporary market raised its own quality issues. Agency staff are not seen as providing the same quality of service as substantive staff – they don't know the organisation or ward, don't feel the same organisational buy-in and don't always have all the right training or skills.

'Some registered nurses from agencies arrive on site without the skills needed for the posts they are covering. They are then of little use and other staff have to cover or supervise them,' said Malcolm Cassells, director of finance and procurement at Salisbury NHSFT. He cited examples of registered nurses not experienced in IV fluid management and nurses arriving in specialist areas such as ITU lacking skills in activities such as filtration.

Janet Perry, director of operational finance at Barts Health NHST, agreed. 'We are certainly aware that there are times when substantive staff take a much broader share of care and responsibility compared with temporary staff working alongside them. Simply using the number of staff as a proxy for safety or quality will not provide assurance – we need assurance we are providing real safe, quality care, which is

**HFMA
ROUND
TABLE**



Around the table: (front to back) Andy Robinson, Shahana Khan, Malcolm Cassells, Paul Stefanoski and Paul Scandrett

influenced by far more than just head count.’

Ms Perry added that, compared with substantive staff, agency staff do not always have the same loyalty to the trust or fit into the same managerial structure. This means that they often do not take on the same level of responsibility as substantive staff – putting a larger share of the burden on those substantive staff.

Keith Griffiths, finance director of Calderdale and Huddersfield NHSFT, said there are problems in key areas. He said: ‘This is a critical and growing area and we need to localise the conversation on where quality could be affected.’

Matthew Lowry, finance director at Doncaster and Bassetlaw Hospitals NHSFT, underlined that agency staff were not always of the required quality. ‘But we all still want them and in the absence of substantive staff, we are all too often desperate to have them,’ he said.

Allocate Software director of healthcare

Paul Scandrett pointed out that agency staff are often used at the times when services are most vulnerable – filling the out-of-hours shifts that substantive staff don’t want to work and when there is less senior management oversight.

‘If you are throwing money at the problem, as you are with excessive use of agency staff, you’d think the quality wouldn’t get any worse,’ he said. ‘But in fact you might be spending more money and not actually getting the improvement you expect.’

Competition worries

Setting an establishment to meet safe staffing requirements is one thing – all trusts report growing establishments on the back of the safety and quality agenda – but recruiting to those preset staffing levels is challenging.

There are shortages in key areas. Cardiac scrub nurses and intensive care nurses were two

areas highlighted in the HFMA temperature check survey last year. And competition between hospitals to attract staff is growing.

‘Other hospitals have advertised outside our trust to recruit staff to their bank, when we are looking to fill our own positions and expand our own bank,’ said Ms Perry. ‘That is not helping. We’re all trying to attract the same limited resource and together are pushing up the cost. A collaborative approach would be much better.’

Retention is also an issue. Higher rates available from agencies are also attractive to some staff and the Commons Public Accounts Committee has recently highlighted concerns that some staff are effectively becoming ‘professional temporary staff’.

Adam Sewell-Jones, deputy chief executive at Basildon and Thurrock University Hospitals NHSFT, underlined the point. Middle grade doctors in A&E were ‘like gold dust’ and there were cases of people ‘hopping between hospitals because they were offered a better deal.’ ‘Theatre staff are a good example,’ he said. ‘They know that if they want to work full time, they can confidently move to an agency.’

Shahana Khan, director of finance and performance at George Eliot Hospital NHST, said there were also problems with substantive staff working alongside agency staff.

‘The staff from agency come in and the substantive staff hear how much they are paid,’ she said. ‘This is perhaps particularly an issue in areas such as theatres, where there can be a significant differential.’

This can lead to demotivation of substantive staff, especially where they feel they are taking more of the burden and responsibility than agency staff. Or it can increase the numbers of staff leaving to work on an interim basis.

There was also concern that staff moves could lead to polarisation of organisations in



Matthew Lowry (left) and Trevor Shipman

Roundtable participants

- Paul Briddock, policy and technical director, HFMA
- Malcolm Cassells, director of finance and procurement, Salisbury NHS FT
- Simon Courage, director of product strategy, Allocate Software
- Keith Griffiths, director of finance, Calderdale and Huddersfield NHS FT
- Shahana Khan, director of finance and performance, George Eliot Hospital NHS Trust
- Nicky Lloyd, director of finance, South Warwickshire NHS FT
- Matthew Lowry, director of finance, Doncaster and Bassetlaw Hospitals NHS FT
- Janet Perry, director of operational finance, Barts Health NHS Trust
- Andy Robinson, director of finance and Performance, Northern Devon Healthcare NHST
- Paul Scandrett, director of healthcare, Allocate Software
- Adam Sewell-Jones, deputy chief executive, Basildon and Thurrock University Hospitals NHS FT
- Trevor Shipman, director of finance, Central North West London NHS Foundation Trust
- Paul Stefanoski, director of finance, West London Mental Health NHS Trust
- Tim Woodhead, director of finance, Birmingham Women’s NHS FT

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the NHS. Organisations with establishments more fully populated by substantive staff were likely to be more attractive places to work, with staff more likely to have the right skills and local knowledge, so sharing the burden more equally. Those with lower levels of substantive staff could find themselves in a spiral of decline as staff leave and exacerbate the problem.

The roundtable considered existing and possible solutions. Initially, participants talked about direct solutions to problems with recruitment of nursing, medical and other professional staff. Simon Courage, director of product strategy at Allocate Software, said the first issue was to look at the make-up of a trust's temporary staff.

'There is a difference in quality between bank and agency, with the bank predominantly populated with substantive staff undertaking extra shifts. We could see a lot of improvement if we kept levels of temporary staff use the same, but changed the balance between bank and agency usage. There are wide differences in the percentage of temporary staff from agencies across NHS providers and there are lots of things that can be done to make bank usage more efficient.'

Tackling staff shortages head-on, a number of trusts have looked abroad for extra staff – mostly nursing staff. Mr Sewell-Jones said that Basildon and Thurrock, on the back of recommendations to review staff levels in its Keogh review, had recruited 200 nurses, a large proportion of which were from the Philippines and Spain. He said that being subject to the early Keogh scrutiny had perhaps put the trust ahead of others in terms of recruitment.

'But there was a concern we might lose staff as neighbouring trusts went through quality inspections,' he said. 'We have put a lot of focus

on making the trust a good place to work and we've not seen a mass exodus of nurses.'

The trust had more of a problem with medical staff, he said. For medics, some trusts were now offering a 20% premium for posts that are difficult to recruit to.

Andy Robinson, finance and performance director and deputy chief executive at Northern Devon Healthcare NHST, said the trust was attempting a home-grown solution to nursing shortages. Referring to a joint project with Plymouth University to create a vocational training course for community nurses, he said: 'We're looking to train our own nursing staff because you just can't buy them.'

Other trusts are pursuing this approach. Lancashire Teaching Hospitals NHSFT has recently partnered with the University of Bolton to launch an undergraduate nursing degree course. It claims this is the first in the country to offer student nursing places not commissioned by Health Education England.

On the topic of commissioning the right numbers of nurse and doctor training places, Mr Cassells said there had to be major improvements in workforce planning. While his comments were mostly aimed at the national system of ensuring there are the right numbers to meet the demand for staff in future, local plans also had to work within the number of staff available.

'We've seen local better care fund proposals to keep people in the community that rely on increased numbers of community geriatricians, but with no detail on how these posts will be recruited to, given that these posts are very hard to fill, with not enough community geriatricians being trained,' he said. 'We need reality as to what you want to achieve and can achieve. You can't plough on regardless. If the required staff

aren't out there, we need to look at training and perhaps take a longer horizon.'

While most of the discussion

focused on difficulties with nurse and doctor recruitment, the finance directors said the pressures were not confined to these groups. Tim Woodhead, director of finance at Birmingham Women's NHSFT, said trusts also faced challenges with professions allied to medicine, such as radiology and physiotherapy. 'This is part of our transformation. We were planning to put more resources into these areas for a quality gain,' he said. 'Once you've got that quality gain, you can't pull back without it being seen as a degradation in service.'

Ms Perry was also aware of recruitment issues in disciplines such as IT, HR and finance – particularly in London, where more staff were choosing to work on an interim basis – all of which had their own quality implications.

Assessing value

Attendees said there was full support for the post-Francis commitment that 'targets or finance must never again be allowed to come before the quality of care'. But a much clearer understanding was needed of the improvements delivered from any investment.

They expressed major concern that staffing levels were sometimes being increased without a full understanding of the benefits that would be delivered. Few trusts, they said, were tracking outcome and patient experience improvements after they'd invested in extra staff. Again, they felt trusts were sometimes feeding the inputs in



HFMA
ROUND
TABLE



Nicky Lloyd



Malcolm Cassells



Paul Braddock

response to quality concerns with no certainty that the approach would deliver the anticipated improvements. “The question for boards is: are they doing things to demonstrate compliance or are they seeing improvements in quality – for example, a reduction in falls, pressure ulcers and length of stay and improvements

in patient satisfaction?” said Mr Griffiths. “That is what our core business is about.”

One director said his nursing director had admitted that the investment in establishment hadn’t produced an increase in

quality metrics; another said a board non-executive had asked for the evidence base for staff investment.

But in most cases, attendees said most investment in extra staff – which is only one element that contributes to quality – had been undertaken in the hope (not certainty) of quality improvements and with no follow-up to understand the impact on outcomes.

Mr Briddock summed up a general concern that there had been a knee-jerk response to Francis that more staff were needed and trusts hadn’t looked at the resulting value.

Nicky Lloyd, director of finance at South Warwickshire NHSFT, highlighted the finance function’s role in this. ‘It’s our duty as directors of finance to join the dots on quality and finance.’ She added: ‘If spending the most money equated to delivering the highest quality care, the providers with the highest reference costs would have the safest care, which is absolutely not the case.’

There was consensus that the question ‘Is

your care safe and of high quality?’ could not be answered by pointing at staffing levels. Instead the focus should be on outcomes. This requires the right data and being able to link it to actual staff levels on wards and the demands placed on those staff by the specific patients on the ward.

The work by NICE on safe staffing levels should help. Its recommendations suggest NHS bodies should be recording patient acuity and nursing dependency both to inform the setting of establishments and then monitor staffing levels on a day-by-day and shift-by-shift basis.

Trusts may have undertaken acuity measuring exercises on a sample basis in the past to inform establishment setting – for example, using the Safer Nursing Care Tool. But the requirement to monitor how acuity changes from shift to shift means data collection will need to become real time.

Mr Scandrett said this should help make staffing decisions more evidence-based. “The agenda post Francis has all been about quality and safety, but the focus on staffing has all been about numbers and not about the activity they can deliver. Worse, the numbers being reported monthly by nursing directors [as a result of the government’s *Hard truths* report] have been averaged over the month. So a ward could be understaffed at weekends and overstaffed in the week, but look fine on average.’ He said

“The question for boards is: are they doing things to demonstrate compliance or are they seeing improvements in quality”

Keith Griffiths

the NICE requirements, particularly the focus on nurse hours per patient day, were a useful opportunity to put the debate around staffing levels onto a more informed basis. In the US, finance teams were driving the issue as much as clinicians as the metric gave a view on productivity as well as safety and quality.

The participants agreed that simply throwing money at the problem was not the answer. Addressing specifically the difficulties with recruiting and retaining nurses, Mr Lowry said the key issue was reducing demand rather than just focusing on supply.

‘Are boards as focused on reducing length of stay as they are on nurse numbers and vacancies?’ he asked. ‘In some cases, we’ve lost sight of the breadth of inputs to care, and our view of the inputs is an increasingly narrow view of trained nursing staff. How many of us talk about releasing time to care, the productive ward and skill mix? We are all increasingly fixated simply on nurse staffing numbers and comparing against the ratio.’

Targeting demand

Mr Griffiths agreed there had to be a shift in focus. The problem was demand and workflow. ‘It’s not just nurses that affect workflow,’ he said. ‘That also happens at admission and discharge. We need to look at an alternative workforce group – the clinical decision-makers. How they flex their working day and the decisions they take can have a bigger impact on nurse levels than anything else.’

This could involve more consultants at a hospital’s front door – accident and emergency – to get better decisions made earlier.

He said most trusts were probably running with consultant job plans similar to when they were drawn up. These needed to be assessed for their appropriateness. ‘We’ve found examples of patients for a four-hour clinic being booked within a two-hour window – then we have problems when the clinic overruns and we get complaints. Alternatively there is not enough demand for a four-hour clinic, but we still put on four-hour sessions.’

The challenge, he said, was to identify opportunities to get better value from the clinical expertise and see how it might be applied to improve patient care and patient flow. ‘It is at the margins, but if you can pool medical resources, it can be possible to free up a few hours a week in some specialties on a 10-12 PA contract. Then you can start to think about how you can use the additional capacity.’

He added that if this resource could be concentrated at the front end of hospitals – at ward level, especially first thing in the morning – it could start to make a difference. By late afternoon the hospital is already at capacity,



Adam Sewell-Jones



Keith Griffiths

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we've almost automatically got an extra day's stay or discharge is late at night, which may be far from ideal for the patient. We need to work with the medics to remodel what they do and to use technology so we don't have to keep putting more and more demands on nurses,' he said.

New models

New ways of working in general were seen as key to addressing the staffing challenge. Paul Stefanoski, finance director at West London Mental Health NHST, said implementing transformation also exacerbates the issue in the short term. 'Service redesign delays mean you don't fill places substantively, so you carry on filling with bank and agency staff and this can go on sometimes for years,' he said. 'The key is to get better at implementing service change.'

The HFMA's Mr Briddock agreed, adding that transformation had to be system-wide. 'At a previous organisation, we did work to reduce length of stay and we did a lot around weekend therapy and diagnostics, but we ended up simply shifting the patients to the back door,' he said. 'We should have reduced our bed capacity and the nurse staffing for the equivalent of three wards, but we ended up reducing capacity by only one ward. Although the remaining patients were clinically fit for discharge, the supporting services weren't in place to support that discharge.'

Trevor Shipman, finance director at community and mental health provider Central and North West London NHSFT, said this underlined the system-wide nature of the problem. 'We are desperate to recruit district nurses,' he said. These nurses were key to supporting discharged patients. He added: 'We've got the funding, but we can't bring them in and so we can't support discharge.'

Mr Robinson recognised the issue – similar challenges had led to the trust's 'in-house' nurse training programme. But in some cases the solution might be to change the staff mix. 'How much do some of the activities need to be supported by registrants and how much could be undertaken by a non-registered healthcare assistant with the right competencies?' he asked. With district nurses hard to come by, the Devon trust has tried to maximise the value of its workforce. 'We've looked at increasing the admin and clerical posts to take over some administration functions usually done by district nurses,' he said.

Changing job roles and broadening capabilities were seen as potential solutions in other areas. Mr Griffiths said greater flexibility in medical staff could help ease some staffing pressures. 'The issues can be compounded by sub-specialisation,' he said. During winter activity pressures, for example, all clinically trained personnel, regardless of specialty, need to be encouraged to triage and discharge.

Others agreed. Mr Shipman said Central and North West London had child and adolescent mental health service junior doctors working adult rotations. It was the only way the rotations could be operated viably and it helped in recruiting to the posts. Others added that the general skills acquired by doctors in their training should be tapped into more.

There was agreement the service needed to find a way – with the royal colleges – of managing specialisation. The NHS was understandably risk averse but Mr Woodhead said it needed a better understanding of appropriate risk. 'We need to find a way to ensure we are taking reasonable risk for the benefits of patients,' he said.

Other central policy initiatives might be

having a secondary impact on staffing, he added. 'Look at the competition from market testing. We're seeing key colleagues – for example, in orthopaedics – reducing their commitment to the NHS and doing more private work in GP surgeries or private hospitals. This has implications for the 18-week target and is spreading a thin workforce even thinner.'

Acceleration of the seven-day services agenda could both improve patient services and ease local staffing problems. 'Some sub-specialties simply aren't sustainable on a seven-day basis,' said Mr Briddock. While some services were viable as a weekday, daytime service, the balance shifted when the service had to be run out of hours. 'They are often financially unviable if we try to run historic rotas and we can't recruit to these rotas,' he said. 'So the services become dependent on locums, which can undermine the quality and consistency of service and adds to the affordability issue.'

Much greater collaboration was needed to make these services viable across broader populations, he added – producing hub-and-spoke models and some 'trading' of services between providers. This would have the add-on benefit of easing staffing pressures. However, he said that while these decisions were being driven by providers to address staffing, quality and tariff considerations, ideally they should be part of more strategic plans led by commissioners.

Staff pools

Mr Briddock highlighted a model he had seen on a recent study tour to Australia. 'They were training staff to work across specialties and had created a pool of these nurses – additional staff to the establishment level.' The idea was these staff were used to cover for inevitable sickness and absence in key shifts across the whole



Tim Woodhead



Paul Scandrett



Shahana Khan

nursing workforce. Describing them as a ‘nimble infantry’, he said they were paid more than other staff, trained to a high standard so they felt they were competent to work in different contexts, and then rapidly deployed as needed.

Mr Scandrett said it was also a model used in the US, where establishments were often set to deliver the minimum service needed, with the pool of staff used to increase numbers above this or cover absences. ‘They pay a premium to get their best nurses in and use the pool in different ways to how they use bank staff,’ he said.

Ms Lloyd cited the model now used in other sectors, where staff are trained and rewarded to be able to undertake more than one role and be redeployed to other tasks, enabling nimble responses to customer flows. Ms Perry said the pooling model had appealing elements, including ‘bringing in your best staff just when you need them most’.

Many staff tended to be ‘tied to a specific ward,’ said Ms Lloyd. And while there was recognition that established ward teams added their own experience and value, ‘we need to make it more usual and comfortable for staff to work in more than one area and to move around.’ This had to happen when the pressure was off as well – using one day per week secondments, for example – so that staff were not just removed from their usual area and urgently redeployed to a new ward or environment only when ‘things got red hot’.

Mr Sewell-Jones said he had visited one trust using itinerant staff to support dementia patients. It recruited band 3 rather than band 2 staff and it became a more skilled job. ‘They became their own team of trained itinerant staff and achieved a high conversion rate for these staff moving on to nurse training,’ he said.

Mr Courage gave other examples. One trust

had created a specialising team – for patients needing one-to-one support – that covered this requirement for all trust wards. This avoided the problem of having ward establishments set to cover average special demand, but either being over or under that demand each day.

This kind of model, again, depended on having good data. ‘To do this you need a good grip on your daily activity, to understand where these staff need to be deployed,’ he said.

Mr Stefanoski reinforced the point. ‘For these new delivery models, or to move staff to meet pressures in other areas, we need to understand activity data every day, not on a sample basis,’ he said. ‘How much intelligence goes into understanding and predicting peaks and flows, how much is just based on a finger in the air?’

Self-management

The roundtable also discussed patients having a role in managing their own care while in hospital. ‘We aren’t great at promoting self-management of conditions and health promotion,’ said Ms Khan. ‘Improving these areas, and getting patients and families more involved, has to be part of the solution to staffing problems.’

Mr Woodhead described a model for neonatal care in some developing countries, where the parents are used to monitor their baby’s vital signs. ‘They are told what to look for and, guess what, they do a great job instead

“For these new delivery models we need to understand activity data every day, not on a sample basis”

Paul Stefanoski


of having one nurse looking after four babies, where something could be missed,’ he said.

Ms Khan said if long-term condition patients are encouraged to self-manage, but given access to specialist support when they need it, it could ‘make them braver’ and mean they can ‘get back on track’ and avoid hospital admissions downstream. But the directors agreed this was a massive cultural change for the NHS.

While staffing problems mostly needed to be tackled locally, the directors said there was also a role for the centre, especially where issues were outside trusts’ control. They backed HFMA calls for a review of the national workforce planning system to ensure there were enough staff available to meet service provider requirements.

Mr Cassells also pointed out that nursing and medical staff had benefited from significant amounts of investment in their training and education. He said the government should review whether there should be some way of recognising this investment – would some form of tax on agencies be appropriate, he wondered, or a link between clinicians’ training grants and an expected amount of service in the NHS?

Mr Cassells said other initiatives could also be explored. Changes to staff terms and conditions, extending the working week from 37.5 to 40 hours, for example, would make a big difference to capacity. He recognised this would be a significant step and would need to be taken forward with staff unions and royal colleges but that all options should be considered.

The directors were clear that staffing was likely to remain a key pressure in the short to medium term and that transformation of service delivery was the ultimate solution. In the meantime, however, organisations needed to work cooperatively and share solutions and approaches across the whole service. 



Janet Perry



Paul Stefanoski



Simon Courage