House of Commons

Committee of Public Accounts

Department of Health: Improving the use of temporary nursing staff in NHS acute and foundation trusts

Twenty-ninth Report of Session 2006–07

Report, together with formal minutes, oral and written evidence

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The Committee of Public Accounts

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Report

Summary

Temporary nurses are employed across the NHS to meet fluctuations in activity levels and to cover vacancies and short-term staff absences. NHS acute and foundation trusts obtain temporary nurses from their own nursing bank, from private nursing agencies or from NHS Professionals (an NHS run temporary staffing service). Properly managed, temporary nurses play an important role in helping hospitals achieve flexibility. Excessive use can be costly, particularly when trusts are heavily reliant on agency nurses. High use of temporary nurses can also have a negative impact on patient care and satisfaction.

In 2001, the Department of Health stated that anticipated growth in the NHS workforce under the NHS Plan would significantly reduce its demand for temporary staff. Between 2000 and 2005 the NHS nursing workforce increased by 55,000, more than double the NHS Plan's target of an additional 20,000 nurses by 2004. Despite this increase in the nursing workforce, however, the Department estimates that total expenditure on temporary nursing rose from £795 million in 1999–2000 to £1,098 million in 2004–05. As a proportion of total expenditure on nursing, the use of temporary nursing has remained at around 9%.

On the basis of a report by the Comptroller and Auditor General,[1] we examined the cost and extent of use of temporary nurses in the NHS; whether the NHS has taken a planned approach to controlling and managing the supply and demand of temporary nurses; and the safety and quality issues associated with the use of temporary nurses. We took evidence from the Department of Health (the Department) and NHS Employers.[2]

In summary, our main conclusions are:

- Despite a significant increase in the number of nurses employed by the NHS the amount spent on temporary nursing staff continued to increase until 2002–03. Whilst it has started to decrease over the last two years, the number of shifts filled and the amount spent is still higher than in 2000–01.

- There is poor information on the drivers of demand for or use of temporary nurses across the NHS and an absence of a planned approach to controlling their use. Since 2001, the Department has introduced a number of initiatives to improve the quality and cost of temporary staff, but it is only as a result of financial deficits that the NHS has taken more co-ordinated action to reduce reliance on temporary cover.

There are safety implications for patients when trusts employ temporary nursing staff that have not received mandatory training or may have worked an unsafe number of hours.

1 C&AG's Report, *Improving the use of temporary nursing staff in NHS acute and foundation trusts*, HC (2005-06) 1176

2 NHS Employers is the arm of the NHS Confederation responsible for workforce and employment issues on behalf of NHS organisations in England.

Conclusions and Recommendations

1. **Between 2000 and 2005 the number of nurses working in the NHS in England increased by 55,000, but expenditure on temporary nursing staff has remained at around 9% of the NHS's total expenditure on nurses.** The Department believes that 6–7% may be a reasonable level for most trusts, but that there will be some, for example in London, where 15% is reasonable. Currently some spend less than 5% while others spend as much as 29%. The Department needs to outline its strategy for the use of temporary nursing staff as part of wider workforce planning and, in conjunction with NHS Employers, should set out guidelines on what it believes are acceptable levels of temporary nursing for the different types of trusts.

2. **Trusts have not taken a strategic and managed approach to controlling the demand for temporary nursing.** Each trust should develop a local strategy to improve its understanding and management of demand for temporary nurses. The strategy should be underpinned by a clear understanding of the requisite establishment levels needed to provide safe and effective care, which IT based workforce management and rostering systems could help to determine. Trusts should use a standard system for recording the reasons why booking temporary cover was deemed necessary. Directors of Nursing should compare booking information with information on staffing needs to determine compliance with the trust strategy on controlling demand.

3. **When booking temporary cover, ward staff do not have sufficient information to determine the most cost-effective procurement route.** Trusts should have arrangements in place to obtain temporary staff at best value, underpinned by performance measures to assess all suppliers (both in-house and external). Trusts should provide guidance to wards on the preferred route for booking temporary cover based on an objective and evidence based assessment of the cost and quality of the different options including: using nurses from its own bank; whether NHS Professionals might provide a more cost-effective option; and the cost and quality of staff from the different nursing agencies.

4. **Trusts do not monitor, in a systematic way, the full costs of using temporary nursing staff.** Trusts should allocate responsibility for monitoring expenditure on temporary nursing to one of its trust board members, including quarterly reports to the strategic health authority on this expenditure. Strategic health authorities should assist trusts to compare their use of temporary nurses and share good practice locally. The National Audit Office's *Good Practice in managing the use of temporary nursing staff* provides practical examples and checklists to help improve aspects of both supply of and demand for temporary staff.

5. **At least 30% of permanent nurses and at least 39% temporary staff are still not receiving mandatory basic life support training.** Other mandatory training for nurses such as Infection Control and Fire Training is also not being refreshed annually. Strategic Health Authorities should manage local NHS Trusts so that all nursing staff receive mandatory training. Trusts should schedule mandatory training at times that encourage maximum attendance or consider, where applicable,

alternative ways of delivering training, for example through e-learning. Trusts should maintain accurate training records which show whether nurses they employ, on both a permanent or temporary basis, have received their mandatory training.

6. **There are no systems or safeguards to enable a trust to know whether a temporary nurse has exceeded the safe level of hours set under the European Working Time Directive.** Long working hours can put at risk the health and ultimately the performance and attendance of employees, thus further increasing the pressure on nurses and exacerbating the existing problems. NHS trusts should have systems to enable them to control and monitor the total number of hours worked by each nurse, whether in direct employment or working for other employees. Specifically the Department should expedite implementation of its electronic staff record so that it can be used to monitor the hours worked by temporary staff.

7. **NHS Professionals faces a tension between its strategic role to improve the quality of the temporary labour market and its operational requirement to make temporary staffing more cost effective.** The Department needs to clarify to NHS Professionals and trusts how the new service model and new financial model that it is working on will reduce this tension. One of the key aims in developing NHS Professionals was to improve the quality of temporary staff. Trusts should therefore compare the performance of their in-house banks with NHS Professionals, in terms of cost and quality standards, to determine whether the bank is operating effectively.

8. **The NHS Purchasing and Supplies Agency (PASA) agreements have moderated the cost and improved the quality of agency nursing staff, but trusts continue to use agencies that are not on the framework agreements.** PASA should use its negotiating powers to obtain greater volume discounts by consolidating its framework agreements. Trusts should only use agencies that are on the PASA framework agreements to assure the quality of temporary nurses and achieve control over their local temporary staffing market.

1 The cost and extent of use of temporary nurses

1. Most NHS trusts experience fluctuations in the numbers of nursing staff available for work as well as variations in activity at different times of the day, week or year. Traditionally NHS trust have met these fluctuations by using temporary nursing cover, either from their own nursing banks or by procuring staff from independent nursing agencies and, since 2001, from NHS Professionals (see **Figure 1**).[3] In 2001, the Department of Health (the Department) stated it expected that anticipated growth in the NHS workforce, under the NHS Plan, would significantly reduce its demand for temporary staff. It subsequently stated that this anticipated reduction related only to the use of agency staff, which it has successfully reduced.[4]

Figure 1. Types of temporary nurses and associated cost per hour

	Description	Average Cost to employ per hour[i]
Permanent Nurse	Part-time or full time nurse employed permanently by an NHS trust. These nurses can work additionally as a temporary nurse through a bank, NHS Professionals or a private agency.	£14.84
Nursing Bank	A nursing bank provides a reserve of nursing staff within the trust. They are normally run by the trust but can be run by an external organisation. Bank nurses are NHS employees who are willing to work extra shifts when needed either for their own or a neighbouring trust bank.	£13.73
NHS Professionals	NHS Professionals is the NHS's "in-house" temporary staffing service, established as a Special Health Authority in 2004. With the agreement of a trust, NHS Professionals takes over the running of the trust bank and manages these as a central operation. NHS Professionals pays its staff NHS terms and conditions, and these staff may have a permanent post in the NHS. The difference in costs is essentially the difference between bank over-heads compared with the NHS Professionals commission rates.	£13.51
Nursing Agency	Nurses can decide to work for nursing agencies which are private companies that supply temporary nurses to trusts. Agency nurses may also have a permanent post in the NHS or other healthcare provider. The commission rate charged by the agencies is the main reason for the cost differentials.	£19.11 (or £16 if agency is on a framework agreement)[ii]

Notes: i) Cost to employ a D Grade Nurse for one hour in a permanent post, through a nursing bank, through NHS Professionals, and through an Agency in 2005. (Figure 17 in the C&AG's Report). ii) Since 2001, The NHS Purchasing and Supplies Agency has operated a number of regional framework contracts aimed at improving the quality and reducing variations in cost of staff supplied by Nursing Agencies.

3 C&AG's Report, para 1.1; Figure 3

4 C&AG's Report, para 9; Qq 75–76, 171

2. In 2000, the NHS Plan identified that the NHS needed to recruit an additional 20,000 nurses by 2004 to meet its needs. As a result of national and local initiatives for example increasing the number of training places and recruiting overseas, between 2000 and 2005 the NHS increased the size of its permanent nursing workforce by 55,000 whole time equivalents (from 267,000 to 322,000).[5] Despite this increase in numbers, the expenditure on temporary nurses fell only slightly as a percentage of total expenditure on the nursing workforce—from 10% in 1999–00 to 9.4% in 2004–05. The NHS has been more successful in reducing its expenditure on agency nursing staff, however, from a peak of 7% in 2001–02 to 3% in 2004–05.[6]

3. The Department was not surprised that the significant increase in numbers of nurses had not made a bigger inroad into demand for temporary cover. The increased levels of nursing staff were used to increase capacity within the NHS system by, for example, reducing waiting times and improving services for cancer and coronary heart disease patients. Increased staffing levels also led to a need for increased cover for extra numbers of temporary absences.[7] Nonetheless, the Department estimate that the level of expenditure on temporary nurses has now fallen to 8.5% in 2005–06, and that the provisional figures for 2006–07 suggests a continuation of this downward trend.[8]

4. The National Audit Office calculated that the average cost of employing a permanent D Grade nurse for one hour was £14.84 compared with, £13.83 for a bank nurse, £13.51 for an NHS Professionals' nurse and £19.11 for an agency nurse although nurses employed by an agency on a framework agreement are likely to cost around £16 an hour (**Figure 1**).[9] Agency staff can be up to 29% more expensive than equivalent permanent nursing staff, the NHS has focussed on reducing expenditure on agency staff (from £330 million in 2003–04 to £240 million in 2004–05). This reduction was therefore a main contributory factor in the fall in total expenditure on temporary nurses (from £830 million in 2003–04, to £790 million in 2004–05).[10] This fall has continued in 2005–06 and 2006–07. Indeed for trust facing deficits, a reduction in temporary staff is a relatively straightforward and convenient way of reducing expenditure.[11]

5. In 2004–05, the NHS employed a total of 404,000 nurses by headcount and 322,000 whole-time equivalent nurses.[12] The Department, however, do not have any exact figures on the number of temporary nurses working in the NHS as the picture is complex. For example, permanent nurses can also work extra hours for a bank or an agency. Nevertheless, the Department estimated that the number of full time equivalent temporary nurses is likely to be around 37,000. The Department's workforce survey shows that in September 2004, there were some 26,000 full time equivalent nurses that also work as bank

5 C&AG's Report, para 2.7 and Qq 31–32

6 C&AG's Report, para 1.7; Q 31

7 Q 9

8 Q 4

9 C&AG's Report, para 3.5, Figure 17; Qq 149–152

10 C&AG's Report, paras 1.7–1.8, 3.5, Figure 17; Qq 34, 104–105, 170

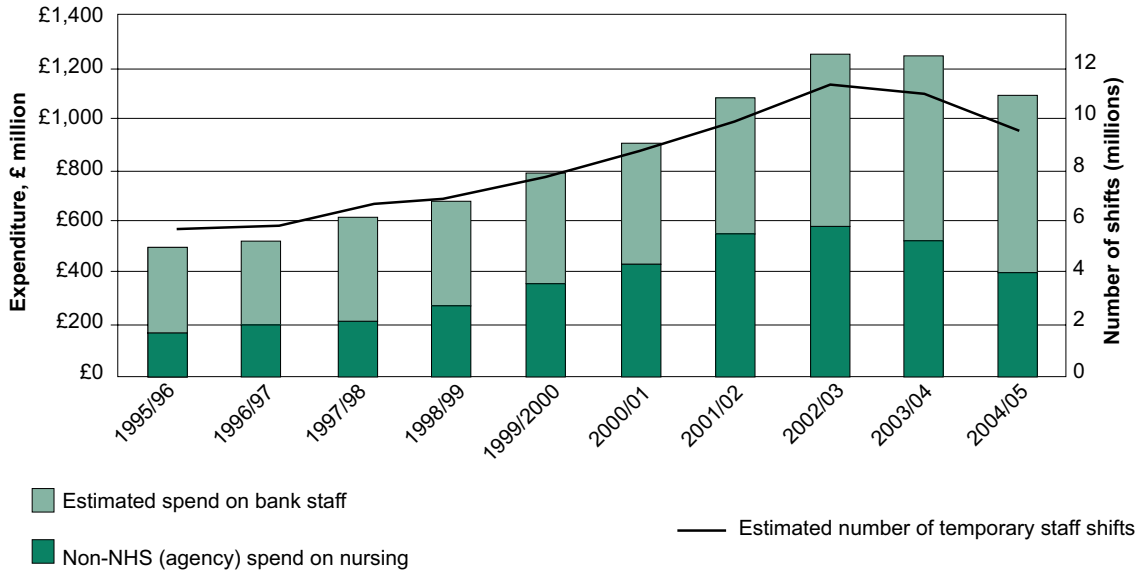
11 C&AGs Report, para 1.16; Qq 2–7, 71–72

12 NHS Workforce Survey 2005, Information Centre, April 2006

nurses, suggesting that 11,000 full time equivalent nurses were working solely as agency nurses.[13]

6. Figure 2 sets out the Department's estimates of the total NHS expenditure on temporary nursing staff in each of the last 10 years, sub-divided into agency and bank spending, together with estimates of the numbers of shifts covered. These show that activity and expenditure rose year on year for the first 7 years, with an increasing proportion spent on agency staff. Since 2002–03 the trend has started to reverse, however, largely because of reductions in the use of agency staff (**Figure 2**).[14] The Department's estimates are higher than the agreed figures in the Comptroller and Auditor General's report as the report focussed only on acute and foundation trusts.[15]

Figure 2. Department of Health's estimate of the number of shifts worked and the estimated expenditure on all temporary nursing staff employed across the NHS



Source: Department of Health[16]

7. In 2005–06, 2.6% of nurses were employed by commercial agencies.[17] The Department stated that its aim was not to eliminate the use of agency nurses, but rather to ensure that it has a cost-effective and good-quality temporary workforce. It noted that there was a role for agency nurses to play and that it would be content for the level of usage to remain at around 2%.[18] However, the Department believed that as they are more expensive to

13 Qq 157–174 and note to Q 174

14 Ev 18–20

15 C&AG's Report, para 1.7, 1.8

16 Ev 18–20

17 Qq 37–39

18 Q 51

employ, agency staff should only be used when there is no alternative option, such as in cases where there is a lack of availability of nurses with a specific expertise.[19]

8. Demand for temporary nurses is driven by factors such as staff vacancies, sickness and poor planning of annual leave.[20] In June 2005, the Healthcare Commission estimated that £141 million could be saved by cutting nursing staffs' sickness absence rates by 30% from 7.5% (6.8 days) to 5.25%.[21] Sickness absence within the NHS overall has been declining over the last eight years, but by a relatively small margin from 4.9% to 4.5%. The Department has been working with NHS Employers to encourage the adoption of good practice to reduce sickness absence levels still further, with a specific focus on tackling the cost of long-term sickness absence (mainly back problems and stress).[22]

9. The National Audit Office report showed that there are wide variations in the use of temporary nursing staff between trusts. These range from less than 1% to 29%.[23] There are also wide variations within and between regions.[24] The Department acknowledged these variations and suggested that they are caused by factors such as poor management, inadequate planning, and specific recruitment difficulties encountered by specialised organisations. It did not believe that it should set a target, but would not normally expect NHS organisations' usage of temporary nursing staff to exceed 15%, while usage of between 6–7% might be reasonable in rural areas.[25] Strategic Health Authorities have been monitoring organisations with temporary nurse levels above 20%.[26]

10. The use of temporary nurses is lower in remote locations and the associated costs are not as high because the staff tend to be drawn from the local bank and are paid at the normal NHS rate, rather than at higher agency rates.[27] The proportion of expenditure on temporary nursing as a percentage of total expenditure on nursing staff is higher in London and the South of England.[28] The Department attributes this higher expenditure to the fact that there is a more transient workforce and more alternative employers in these areas.[29] The Department did not expect its new system of payment for hospitals based on the number of patients treated (Payment by Results) to lead to a variance in staffing or a sudden rise in the use of temporary staff because most of the distribution of work would come through planned activity, or emergencies, which are relatively constant.[30]

11. The Department accepted that the use of temporary nurses was being reduced in certain trusts in response to financial difficulties within the NHS as it was seen as a

19 Qq 131–133

20 Q 77

21 C&AG's Report, para 2.15; *Acute Hospital Portfolio: Ward Staffing*, Healthcare Commission, June 2005

22 Qq 21–24

23 C&AG's Report, para 1.9, Figure 6

24 C&AG's Report, para 10, Appendix 3

25 Q 125

26 Q 126

27 Q 117

28 Q 20; C&AG's Report, para 1.10, Figure 7

29 Q 115–116

30 Q 19

relatively straightforward and convenient way of decreasing expenditure. Nonetheless, reducing the use of temporary nurses would not on its own address the issue of deficits. The causes of deficits are complex and the extent of using temporary nurses is not necessarily linked to deficits.[31] The Department consider that reductions in the level of use of and expenditure on temporary nurses since 2005 were not solely a direct response to financial troubles within the NHS, and that its work to reduce temporary nursing preceded the current financial difficulties.[32] Moreover, it had been working with the highest spending trusts to exchange information on best practice prior to the start of the National Audit Office's investigation.[33]

12. There is a risk that NHS reconfiguration might distort the use of temporary staff. In running an organisation locally, trust management has to take into account what the medium and long-term position of the organisation might be. There might be some circumstances in which the trust needed to increase the number of temporary nursing staff on a temporary basis to maintain services in the short term during reconfiguration. There is no national policy on this issue and local managers and clinicians have to make judgments based on their local circumstances. If it makes sense and is safe for patients then the Department would certainly condone it but not if it was done in an unplanned way or in any way that affected the care of individual patients.[34]

31 Q 69

32 Q 2

33 Q 127

34 Qq 109–114

2 Taking a planned approach to the use of temporary nurses

13. Whilst individual trusts collect information to varying degrees on reasons for requesting temporary cover and on vacancy, sickness and activity levels, this is often not brought together in a systematic manner to consider the most appropriate way to staff wards. As a result there is little strategic planning and control of trusts' demand for temporary cover.[35]

14. The Department did not have comprehensive data on the factors that determined demand as it needed to limit the amount of national information it collected from NHS organisations. There was little information nationally, though more information was available locally.[36] Indeed, NHS trusts generally had poor management information and a lack of understanding of the drivers of demand for temporary nursing staff.[37]

15. Although the Department considered that it was more important for NHS organisations to have the information that they required locally, it was beginning to collect national information which it had not sought to obtain previously. This information included details of the numbers of bank staff and the total amount being spent on agency staff, and was being used to generate productivity matrixes which would allow NHS organisations to benchmark their utilisation of temporary nursing staff. [38]

16. In 2001 the Audit Commission report *Brief Encounters* recommended that all trust boards should have a senior person with overall responsibility and board level accountability for the use of temporary staff.[39] The National Audit Office found that few trust boards had given the issue strategic consideration[40] though the Department believed that it had taken a strategic and planned approach to the use of temporary nurses. Initiatives implemented over the last three years included: the development of NHS Professionals; a series of regional framework agreements set up by the Purchasing and Supply Agency to reduce the cost of nursing staff procured through nursing agencies; and the work carried out by NHS Employers to encourage better management of temporary nursing staff.[41]

17. While aware of the most common reasons for booking temporary staff, the Department found it difficult to understand what was driving the demand for the bookings when using a paper-based ward roster.[42] Organisations using electronic rosters have made significant savings through gaining a better understanding of what is driving their

35 C&AG's Report, para 2.1

36 Qq 77–78

37 C&AG's Report, paras 2.2–2.3; Q 10

38 Q 10

39 *Brief Encounters,* Audit Commission, September 2001

40 Q 67

41 Qq 2, 7

42 Q 77

temporary staffing behaviour, but these systems are not widely used.[43] An electronic staff record is currently being rolled out across the NHS which included an electronic staff rostering component. Trusts were waiting to see how effective the system was before seeking to invest in alternative systems.[44]

18. In 1986 our predecessors concluded that the lack of an evidence base on minimum staff levels was leading to wide variations in the average number of nursing staff per bed.[45] Twenty years later there is still no clear method for determining how many nurses are needed on a hospital ward. In America and Australia, standardised and mandatory nurse to bed ratios are used for different specialties.[46] The Department nevertheless believed staffing levels should be determined by local needs as these could vary significantly between hospitals and wards. For example staffing a ward or clinical area is complicated by the complexities of patients with different needs; by different approaches to clinical practice; and different rates of day case utilisation. Also hospitals organise themselves differently. Some have more support staff on the ward and some use central teams for specific treatments. This variability made it difficult to develop a single method for determining the minimum number of staff needed to deliver safe and effective patient care.[47]

19. The NHS spends considerable amounts of money to train new nurses, yet some nurses are unable to find a job, particularly newly qualified or student nurses.[48] An online survey of 530 nurses published by the Royal College of Nursing (RCN) in August 2006[49] found that 48% of recently qualified nurses took up temporary posts because they were unable to find a permanent job. [50] In the Department's view permanent nursing jobs were available, but in many cases the vacancies were for highly skilled and experienced nurses. A gap between the number of applicants and vacancies was held to be a legitimate way of increasing competition for jobs.[51]

20. Many ward managers use temporary staffing cover as a means of flexing the workforce and choose to hold one or more vacancies so that they can bring in temporary nursing staff as necessary. Poor management practices on the ward can lead to excessive reliance on temporary nursing cover, however, for example poor rota management, lack of control over sick and annual leave, and ineffective use of flexible working.[52] At the same time nurses want flexibility over their working hours, and if they are unable to obtain this flexibility in their permanent job, they are more likely to work for a nursing bank, NHS Professionals or a nursing agency. Although the Department's Working Lives initiative was

43 Q 47

44 Q 49

45 Committee of Public Accounts, Fourteenth Report of Session 1985–86, *Control of Nursing Manpower*, HC 98

46 C&AG's Report, para 2.4–2.6, Figure 10; Q 13

47 Q 13

48 Q 54

49 *Temporary Working: results from an on-line survey of nurses 2006,* Jane Ball and Geoff Pike, Employment Research, 2006.

50 Q 89

51 Q 93

52 C&AG's Report, paras 2.12–2.13, Figure 13

designed to give staff more control over their working lives it has caused difficulties for ward managers trying to reconcile the demands for flexibility with the requirement to run a 24-hour, seven-day a week service.[53]

21. The survey published by the Royal College of Nursing also found that 65% of respondents working solely for banks or agencies did so because temporary working offered greater flexibility.[54] The Department suggested that a survey of 530 nurses from a possible 650,000 was unlikely to be representative.[55] It believed that it had provided nurses with greater flexibility in their working lives,[56] stating that its 2000 initiative *Improving Working Lives Standard* initiative[57] had been successful.[58]

53 C&AG's Report, paras 2.19–2.20; Q86–87

54 Q 97

55 Q 102

56 Royal College of Nursing press release, *Lack of flexibility drives nurses' move to temporary working*, 30 August 2006

57 *Improving Working Lives Standard*, Department of Health, 2000

58 Q 100

3 Safety and quality issues in the use of temporary nurses

22. NHS Professionals, the NHS run temporary staffing service, was established in 2001 to reduce the cost and improve the quality of using temporary staff. By 2006 it was still used in only 24% of trusts. There were concerns that there might be a conflict between reducing demand for temporary nursing and making NHS Professionals self-financing. The Department acknowledged that NHS Professionals had a troubled history as a result of managerial and financial difficulties associated with rapid expansion, but did not agree that there was a contradiction between the target for NHS professionals to be self-financing by 2008–09 and its role to drive down the inappropriate use of temporary staff.[59] To support the need to be self-financing, the Department was working on a new service model and a new financial model, but considered utilisation of NHS Professionals by 25–30% of trusts would be sufficient to be self-financing at this lower level of workload, and at the same time have a beneficial impact on quality and cost.[60]

23. In 2002, the Department published a *Code of Practice for the Supply of Temporary Staffing*[61] which set out a framework for the management and performance of temporary staffing to support providers in ensuring the delivery of high quality, affordable and safe care. This code sets out minimum standards required in the supply of temporary staff to the NHS and applies to all organisations supplying such staff, including nursing agencies, nursing banks and NHS Professionals.[62] It includes a framework for the achievement of mandatory training targets.[63]

24. The National Audit Office found that in the twelve months prior to September 2005 only 61% of bank nurses had received basic life support training, and 59% had received infection control training. Also not all permanent staff had received their mandatory training, only 70% had received the basic life support training and 69% had been given infection control training during the same period. [64]

25. The Department conceded that it has been difficult for the NHS to achieve the provision of mandatory training across the board and acknowledged that the current levels could be improved.[65] It also recognised that there was less evidence of a robust appraisal process with temporary staff.[66] Nonetheless, it did not believe that temporary nursing staff provided a lower quality of care to patients or that lower Healthcare Commission ratings in the South of England were directly linked to their higher use.[67]

59 Qq 53, 194

60 Qq 53, 196

61 *Code of Practice for the Supply of Temporary Staffing*, Department of Health, July 2002

62 C&AG's Report, para 3.1, 3.32; Qq 63–64

63 Q 185

64 Q 179; C&AG's Report, Figure 23

65 Qq 179–180

66 Q 145

67 Qq 28–30, 121

26. The National Audit Office report found that the majority of bank and NHS Professional staff did not have performance appraisals or personal development plans which was also true for a significant minority of permanent staff. NHS Employers were using the NHS Purchasing and Supply Agency framework agreements as a way to ensure that private agencies provided performance appraisals, including testing aspects such as linguistic ability, in order to minimise risks to patients. NHS Professionals were intended to be become a benchmark for trusts to assess their in-house bank against as a basis for identifying and promulgating best practice work to trusts.[68]

27. Quality assurance procedures require a series of checks to be run on individual nurses before they are allowed to work on NHS nursing banks or for NHS Professionals, including whether they are registered with the Nursing and Midwifery Council which has specific standards for membership.[69] Agency staff are also regulated by the Commission for Social Care Inspection and must comply with the Department's Minimum Standards for Nursing Agencies. Agencies on the Purchasing and Supply Agency framework agreements must also comply with the requirements of these agreements.[70]

28. In order to provide more certainty about the quality of staff NHS Professionals have introduced a new clinical coding system, similar to those used by private agencies. The system ensures that when an NHS trust asks for a nurse with specific competencies there is a transparent and consistent process across the NHS. This in-turn ensures that temporary staff provided to trusts have the requisite experience.[71]

29. Most nurses engaged in temporary work also have permanent nursing jobs.[72] Under the European Working Time Directive nursing staff are allowed to work a maximum of 48 hours per week.[73] None of the trusts visited by the National Audit Office during its investigation, however, had robust systems for monitoring the number of hours being worked by nursing staff.[74] The Department was anxious that nursing staff might be working more than 48 hours a week, potentially putting their health at risk, but it was difficult to monitor this limit. Poor health could impact on the performance and attendance of employees, thus further increasing the pressure on nurses and exacerbating the existing problems. There was no single database for tracking the number of hours worked by nursing staff, and whilst trusts are able to monitor the number of extra hours worked by in-house bank staff, it is more difficult to do the same for a member of staff working at a different site or for a private agency.[75]

68 C&AG's Report, para 3.32, Figure 23; Qq 57–66, 144

69 Qq 58, 121

70 C&AG's Report, para 3.12

71 Qq 122–124

72 Q 42

73 C&AG's Report, para 3.33

74 Q 190

75 Qq 14–16

Formal Minutes

Monday 14 May 2007

Mr Edward Leigh, in the Chair

Mr Philip Dunne
Mr Austin Mitchell
Mr Alan Williams

Draft Report

Draft Report (Improving the use of temporary nursing staff in NHS acute and foundation trusts), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 29 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Twenty-ninth Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned until Wednesday 16 May at 3.30 pm.

Witnesses

Wednesday 6 December 2006

List of written evidence

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Oral evidence

Taken before the Committee of Public Accounts

on Wednesday 6 December 2006

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon	Mr Sadiq Khan
Annette Brooke	Dr John Pugh
Mr Ian Davidson	Mr Don Touhig
Mr Philip Dunne	Mr Alan Williams

Mr Tim Burr, Deputy Comptroller and Auditor General, and **Ms Karen Taylor,** Director, National Audit Office, gave evidence.

Mr Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, was in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

IMPROVING THE USE OF TEMPORARY STAFF
IN NHS ACUTE AND FOUNDATION TRUSTS (HC 1176)

Witnesses: **Mr David Nicholson CBE,** Chief Executive, **Mr David Moss,** Director of Temporary Staff, and **Ms Janice Sigsworth,** Deputy Chief Nursing Officer, National Health Service; and **Ms Siân Thomas,** Deputy Director, NHS Employers, gave evidence.

Q1 Chairman: Good afternoon, ladies and gentlemen, and welcome to the Committee of Public Accounts, where today we are looking at the Comptroller and Auditor General's Report on *Improving the use of temporary staff in NHS acute and foundation trusts*. I should welcome members of the Public Accounts Committee of the Kenyan Parliament. We also welcome back for the second time this week, they must be gluttons for punishment, the Chairman and members of the Commission for Budgetary and other Public Finance Control of the Slovenian Parliament. I and two of my colleagues met with them yesterday and we are very grateful for the interest they are showing in our deliberations. As I say, we are looking at the subject today of improving the use of temporary staff in NHS acute and foundation trusts, and Mr David Nicholson, the Chief Executive of the National Health Service, is here with colleagues. Would you like to introduce your colleagues?
Mr Nicholson: On my left is Janice Sigsworth, who is the Deputy Chief Nursing Officer for England; David Moss, Deputy Director of Workforce in the Department of Health; and Siân Thomas, who is the Deputy Director of NHS Employers, which is an employers' organisation which represents NHS organisations.

Q2 Chairman: Thank you, Mr Nicholson. Perhaps you could start by looking at paragraph 5 of the Comptroller and Auditor General's Report which you can find on page 1. It says: "In 2005, the Department again raised concerns that trusts were failing to control their expenditure on temporary nursing staff." Presumably you are now going to tell us that since this Report started to be written you have indeed managed to reduce the number of temporary staff, but why did it take a financial crisis in the NHS for trusts to take this issue seriously? Why was there not a more planned strategic approach which could have ensured a softer landing for many trusts?
Mr Nicholson: I think there was both a strategic and a planned approach to this. If you look at the activity that is being taken in relation to managing temporary nursing staff, you will see it predates the latest, relatively modest financial difficulties that the NHS is in. We set up NHS Professionals six years ago and they have been working very hard to get the management of temporary nursing staff onto a proper footing. We have had the PASA (Purchasing and Supply Agency) framework developing a mechanism by which we can purchase agency staffing at reasonable levels. We have had a whole series of initiatives with NHS Employers to encourage NHS organisations to better manage temporary nursing staff, and we have seen some benefits of that over the last two or three years, as you will see both in terms of percentages where the amount of temporary nursing staff being utilised by the NHS has gone down, and in terms of over the last couple of years the total amount we have spent in cash has also gone down.

Q3 Chairman: Right, so this Report which we are looking at is dated Wednesday 12 July 2006. If we look at paragraphs 13 and 14 which you can find on pages 4–5, it says there: "Our analysis of trusts' usage of temporary staff demonstrates that demand for temporary cover has increased or remained relatively static compared to 1999-00". So what has happened since July then?
Mr Nicholson: The changes had already started.

Q4 Chairman: What has happened since July? What has been the reduction in temporary staff since July since this Report was published?
Mr Nicholson: We collect information now on the basis of agency staff spend quarterly across the NHS and we collect information about the total number of bank staff used in that period.
Mr Moss: In 2005–06 on the basis of this Report—that is temporary nursing staff in acute and foundation trusts—it came down from 9.4% to 8.5% in 2005–06, and we have recently written to the National Audit Office with an update of our figures. Our provisional figures in the current year 2006–07 are still being validated but the indications are that the trend is further downward movement in 2006–07.

Q5 Chairman: This is the point I am trying to make to you. You are trying to convince us that this has all been planned, but the Government has increased spending on the NHS from £36 billion in 1997 to £89 billion in 2006. We know that many trusts have been undergoing financial difficulties in the last year. We know that they have been responding to these financial difficulties by cutting the use of temporary nurses. That is right, that is going on at the moment?
Mr Nicholson: Absolutely.

Q6 Chairman: So I am not sure that it was planned. Well, I am sure it has always been planned but we are making very little progress apparently until this year, but now in response to these deficits they are panicking and they are responding to financial deficits by cutting the use of temporary nurses. That is right, is it not?
Mr Nicholson: I do not think they are panicking at all.

Q7 Chairman: That may be too strong a statement but they are undoubtedly cutting the use of temporary nurses, are they not?
Mr Nicholson: There is no doubt that for some organisations the incentive to look at this in greater detail is already there, but the tools that they can use to do that have been developed over the last two or three years, whether it be NHS Professionals, the PASA framework or the work that NHS Employers do.

Q8 Chairman: As a result of these cuts, are there not safety implications for staff and nurses? I have just been briefed that there is worrying evidence of there being increased pressure on nurses, as a result more having to take time off because they feel under pressure, they become ill, and that of course exacerbates the problem. That must be happening, is it not?
Mr Nicholson: I certainly do not accept the issue around safety. Do not forget we discussed at a previous PAC there is a minority of NHS organisations who are in significant financial difficulties. Clearly the nursing workforce is a major part of the resource of any organisation and it has to be managed carefully. Most of the people who run our clinical areas are clinical staff themselves and they have to use their judgment around staffing levels and the use of temporary nursing staff. We think we have got systems in place now to do that effectively. We have seen no evidence that there has been an increase in sickness in the first part of this year.

Q9 Chairman: You have recruited an additional 55,000 nurses since 2000. If we look at paragraph 9 we see despite the fact that you have recruited an additional 55,000 nurses since 2000, for which you and the Government should be congratulated, why according to this paragraph has the percentage of expenditure on temporary nursing staff (and this may now have changed because things are moving very fast) barely reduced?
Mr Nicholson: Partly you would expect it. Most of the increase in nursing staff has been about increasing capacity in the system to deliver more services, to reduce waiting times and improve services for cancer and coronary heart disease and the rest of the improvements that we are making. If most of the utilisation of temporary staff is around vacancies and sickness and absence and holidays, then you would expect in those circumstances there to be a broadly similar trend to take place. What we have seen more recently though is a change in that trend and that is because of the initiatives that we talked about earlier.

Q10 Chairman: According to paragraph 13, you are spending £800 million on the use of temporary nurses. It says here: "NHS trusts' poor management information and a lack of understanding are the drivers of demand for temporary nursing staff." If this is true and the information available to you is poor, how do we know that we are getting value for money?
Mr Nicholson: There is a relatively narrow amount of information available to us nationally. I think that is right because we do not want to continuously expand the amount of information we collect from organisations, I think that would be counter-productive. The important thing is that NHS organisations themselves have the information that they require, and there is good evidence to suggest that they are doing that, whether it has been through the work with NHS Professionals or whether it is work being encouraged by NHS Employers as they roll out their good practice guide. We are collecting some information nationally that we had not before—the numbers of bank staff and the total amount being spent on agencies—and we are producing information through the productivity matrixes; information that organisations can then use to benchmark their own performance and activity. I think we are in a position now for organisations to demonstrate that they are getting value for money out of their temporary nursing staff utilisation.

Q11 Chairman: Do you take seriously the Reports of this Committee?
Mr Nicholson: Of course.

Q12 Chairman: Good because way back in 1986—this is a long time ago and you may have forgotten—the Committee of Public Accounts concluded in their 14th Report of Session 1985–86 that unsystematic approaches were leading to wide variation in nurse staffing levels and costs in apparently similar units. So if we look at paragraph 14 we read, the very first line: "The lack of an evidence base on minimum staff levels has led to wide variations in the average number of nursing staff per bed . . . " So why is there still apparently no clear method of determining how many nurses are needed on a ward, 20 years after we made that Report?
Mr Nicholson: In the mid-1980s I was running a hospital in the north of England as it happens.

Q13 Chairman: Good.
Mr Nicholson: I think there are different approaches across the world and we know that there are some parts of the world where they have gone down the road of identifying particular nurse to bed ratios and nurse to bed targets. I have to say that is predominantly in America and Australia and there is evidence around to suggest that they are having significant difficulties and are having to move away from that over the last two or three years or so. Staffing a ward and staffing a clinical area is a very complicated business, as you can imagine. Different wards have different complexities of patients on them with different acuity; they can be very sick or less sick. There are different specialities on each of the wards, there is different clinical practice, different rates of day case utilisation, and the kind of operations that we have, so it is a highly complicated picture to come up with a simple number. On the other hand, hospitals organise themselves quite differently. Some hospitals have more support staff on the ward—ward clerks, catering staff, domestic staff—some have less. Some hospitals have central teams that deal with things like phlebotomy or outreach services for high dependency. All this makes it extraordinarily difficult to get down to one particular number.
Chairman: I will stop you there, you have made a very good answer. Dr Pugh?

Q14 Dr Pugh: Can I ask you about the EU Working Time Directive because, quite clearly, some of the temporary agency staff are also permanent staff moonlighting. It is perfectly possible, I think, under those circumstances for a good number of those staff to be working beyond their hours. I think the Report makes clear there has not been a great deal of monitoring of that. Is that not an anxiety for you?
Mr Nicholson: It is an anxiety—

Q15 Dr Pugh: And for patients?
Mr Nicholson: Absolutely an anxiety both for us and for patients, but I think there are some difficulties in the way that we can monitor that.
Mr Moss: You can check it if you have got people on your in-house bank who are working extra hours. NHS Professionals also check the working hours. Where it is more difficult of course is if you have got a member of staff who is working for a commercial agency perhaps in a neighbouring town. I have also been in hospital management, like David, and my practice was to ask the nurses to declare their hours of work. However, you do depend on them declaring that honestly.

Q16 Dr Pugh: There could, in theory, be a lot of very tired nurses who have done a full day's work somewhere else appearing at another hospital and looking after patients in a critical situation?
Mr Moss: I think it unlikely that given the vast majority of temporary staff are working in in-house banks or for NHS Professionals where they have got pretty good checks in place, or for the responsible commercial agencies, which also take the Working Time Directive seriously. I agree with you that it is impossible to totally aggregate that. There is no single database for how many hours nurses work.

Q17 Dr Pugh: We hope they take it seriously. We assume they take it seriously but we do not know for a fact that they do take this as seriously as they ought to.
Mr Moss: I think that is a reason for having a well-run NHS in-house bank or joining NHS Professionals so you can get that control over the number of working hours that the nurse does.

Q18 Dr Pugh: There are two uses a hospital can make of agency staff. There is the necessary use to substitute for staff who are training, planned absence and so on, and there is what you might call the unnecessary use which stems from poor workforce planning, unplanned absence, and so on. There must be a kind of bottom line for agency staff, an ideal limit which they ought not go beyond in terms of reducing the number of agency staff. The statistics indicate that agency staff are often a cheaper alternative when it comes to covering planned absence. What is that bottom line either in terms of a hospital's payroll or in terms of the whole NHS budget?
Mr Moss: We do not think there is a single figure answer to this but I very much take your point the important thing is to have a planned approach to this, a planned approach not just to temporary staff but to permanent staff, and to set budgets and to monitor the individual use of temporary staff against that. One thing the NAO Report does draw attention to is the big shift that has taken place in the balance of temporary staff between bank and agency. Proportionately we were using a lot more agency four or five years ago. We are now using much more bank. The important thing is the quality assurance of the staff you have and a proper planning of the numbers you have. So there could be circumstances where a trust in a London area might be planning to have 10% or 15% temporary nursing staff; in a more rural area you might plan to have 3% to 5%, but the important thing is to define the criteria for which you are employing temporary staff and making sure that you have got proper quality assurance.

Q19 Dr Pugh: So if they plan for workforce and they plan for proper use of agency staff, they have obviously got to think ahead. A lot of hospitals are now facing payment by results, and it would not be sensible to hire a lot of permanent staff if you were not going to get any business. Would you not expect payment by results to lead to a sudden rise in the use of agency staff?
Mr Nicholson: No, I do not think we would expect that because we do not expect the results of payment by results to be quite as volatile as you imagine. Most of the distribution of payment by results will come through either planned activity, through elective activity, or through emergencies, which are relatively constant. There will be some marginal changes in year and you would expect organisations to be able to respond to that, but most of the use of temporary staff that you can see in the NAO Report is around vacancies and around sickness absence, not around the volatility of the work.

Q20 Dr Pugh: You would not expect big fluctuations in a hospital but the acute trusts would expect big fluctuations?
Mr Nicholson: I do not think you would expect big fluctuations, no, but you would expect some fluctuations. If you look around, there are very few organisations that use less than 6% or 7% of temporary staff, so that might be an area that you might look to.

Q21 Dr Pugh: Going back to workforce planning for a second, the NAO calculate that if they could get the absence rate down by 30% they would save £141 million, which is a lot of money. If you could get workforce planning significantly improved or best practice right across the NHS, what sort of figure do you think would come out then? What sort of figure in terms of saving could be engineering from improved workforce planning?
Mr Nicholson: I think that is very difficult to judge, to be frank.

Q22 Dr Pugh: Guess.
Mr Nicholson: I do not think I will guess. I would not want to guess in those circumstance.

Q23 Dr Pugh: Can we take staff absence then. Staff absence is very high in the NHS, surprisingly high in some respects, and one could question why. Obviously nursing staff are in touch with a lot of sick people and therefore more prone, I guess, to acquiring contagious diseases but they are also working in stressful occupations and so on. Have we any idea how NHS absence rates among staff, among nursing staff in particular, compare with European averages or, for that matter, compare with the averages found in private health care provision?
Mr Nicholson: What we do know is that the sickness absence rates in the NHS are too high, although I have to say they have been reducing over the last eight years by a relatively small margin.

Q24 Dr Pugh: By what sort of percentage?
Mr Nicholson: Reducing from 4.7% to 4.5%.
Ms Thomas: 4.9% to 4.5%.
Mr Nicholson: That is lower than the public sector average but it is higher than the private sector average. The private sector average is about 3.7% and we are working with NHS Employers to encourage good practice to get that down over the next period because you are absolutely right, it is an important issue, not only for the organisations but also for the staff themselves. It seems to us that the most progress we are likely to make in terms of getting that number down is to deal with people on long-term sick, which seems to be a bigger proportion for the NHS than outside. That often relates to two issues: one musculo-skeletal problems, back pain and all the rest of it; and also stress, and we are working with NHS Employers to get things into place to reduce those two areas.

Q25 Dr Pugh: In terms of workforce planning the Government obviously got things badly wrong in terms of over-supplying trained nurses who now cannot get jobs. Do you expect to see that reflected in decreased agency costs because agencies can pick from these nurses that are currently not required by the NHS? Are you expecting a reduction in agency costs as a result of that?
Mr Nicholson: I do not know whether we are looking for a reduction specifically in agency costs because of that, but certainly there is some early good evidence that NHS Employers, particularly NHS Professionals and NHS banks, are starting to employ newly qualified nursing staff in the banks in order to—

Q26 Dr Pugh: At lower rates than the other two?
Mr Nicholson: You mean the rates of pay?

Q27 Dr Pugh: Yes?
Mr Nicholson: The same rates of pay that they would pay NHS staff generally.

Q28 Dr Pugh: Finally can I conclude by asking a quality assurance question. Quality assurance is an issue. You often find that the nurses hired as temporary staff are not as good as the nurses that are there permanently. I notice that there is a greater use of agency staff in the south of England than in the north of England. I notice also that some of the Healthcare Commission marks for hospitals in the south of England look rather poor compared with many hospitals in the north of England. Are those two facts connected, in your view?
Mr Nicholson: What was the first fact?

Q29 Dr Pugh: There are more agency staff used in the south, for a variety of reasons which I will not go into now—
Mr Nicholson: That is true.

Q30 Dr Pugh: But if you look at the whole profile of southern hospitals versus northern hospitals, northern hospitals, generally speaking, have more

stars and better performance ratings and so on. What I am asking you is whether these two facts are connected.
Mr Nicholson: I do not think they are connected in the direct way that you might imagine having said it in that sort of way. There is no doubt that in the past there have been significant vacancies in the south of England and it has been more difficult to recruit nursing staff. There is good evidence to show that that is less and less the case as we go through. Just because someone is an agency nurse or a bank nurse does not mean necessarily that the quality is poor. In fact, there are lots and lots of good examples of really high-quality agencies and nurse banks that perform extremely well and patients should be satisfied with the services that they provide.
Chairman: Thank you Dr Pugh. Mr Khan?

Q31 Mr Khan: Mr Nicholson, do you find it shocking that in the last five years as a result of increased Government investment we have 55,000 more nurses yet the percentage we spend on temporary nursing has only reduced from a 10% figure of total expenditure to 9.4%?
Mr Nicholson: I do not find it shocking.

Q32 Mr Khan: Do you understand why some colleagues around this table who argued for increased revenue from the taxpayer to have increased investment in the NHS are depressed when, although the fruits of the investment are for example 55,000 extra nurses, the expenditure is still phenomenally high on temporary nurses?
Mr Nicholson: As I have described, in the last four or five years we have done quite a lot to manage—

Q33 Mr Khan: So you think it is unreasonable for us to be depressed about that?
Mr Nicholson: I do not think you should be depressed about investment in the NHS and what has happened in the NHS—

Q34 Mr Khan: Can you tell me of the £790 million spent last year on temporary nurses, what is the number of temporary nurses that pays for?
Mr Nicholson: I cannot give that, I do not have access to that information.
Mr Moss: But we could find it for you.[1]

Q35 Mr Khan: Mr Moss, this is not meant to be a rude question but what does the Director of Temporary Nursing do?
Mr Moss: My job is to oversee national work programmes—

Q36 Mr Khan: So do you cover both trusts' own nursing banks, private agencies and also NHS Professionals?
Mr Moss: And the central agencies, NHS Professionals—

Q37 Mr Khan: In percentage terms, of the number of temporary nurses we have, what percentage are made up of private nursing agencies?
Mr Moss: Currently it is very low. In 2005–06, 2.6% were commercial agencies.

Q38 Mr Khan: 2.6% are private nursing agencies?
Mr Moss: And 5.8% are bank, making a total of 8.5%.

Q39 Mr Khan: Which means 92-ish% are NHS Professionals?
Mr Moss: 92% are permanent.

Q40 Mr Khan: Good. So why can you not tell me the aggregate figure?
Mr Moss: You asked for the number of staff and we would have to research that for you because the bank staff is obviously made up of pieces of overtime, part-time, people doing extra hours.

Q41 Mr Khan: You have led me to my next question, which is do we have a central database of all the nurses registered to practise in this country?
Mr Moss: Yes, we do.

Q42 Mr Khan: You do, good. What percentage of those nurses who are temporary also have a full-time permanent job as nurses?
Mr Moss: A large percentage, two-thirds of the people who work for NHS Professionals also work for a host trust. The other third just work in a bank for the NHS.

Q43 Mr Khan: Let me ask that another way: the Report talks about temporary nurses, so are you telling me that some of our permanent nurses who are doing overtime are included in the temporary nurses figures that we have been given there?
Mr Moss: Yes.

Q44 Mr Khan: I said overtime as opposed to moonlighting for an agency.
Mr Nicholson: What will happen in those circumstances is that you will have a permanent member of nursing staff who may work 20 hours or whatever. When they are looking to staff the ward the first thing they would say is can that person work more hours. If they work more hours then that is overtime and that would be part of the ward establishment and not counted as part of the temporary nursing staff.

Q45 Mr Khan: Exactly, that is my point.
Mr Nicholson: If they cannot get an existing member of staff to do it and they go to the bank, then there may be a member of staff who currently works in that hospital who registers for the bank who will then come and work on that ward, and that is when it is counted as bank staff.

Q46 Mr Khan: That is my point. Why is a hospital not utilising those members of its staff who are permanent employees who could do overtime for the hospital?

[1] See footnote 4 (pg Ev 16).

Mr Nicholson: They are and they do.

Q47 Mr Khan: Quite clearly not enough. There is an example given in Bedfordshire where the electronic monitoring is well utilised and they save millions of pounds in doing so. Why is that not rolled out across the country?
Mr Nicholson: I have been to Bedford Hospital recently.

Q48 Mr Khan: Not as a patient I hope!
Mr Nicholson: No, no, although I would be happy to be a patient there if I was ill, but to see the electronic staff roster system, and it is a fantastic system.

Q49 Mr Khan: The question was why has it not been rolled out?.
Mr Nicholson: There is a series of reasons why that has not been rolled out and I can go through them if you want. Part of it is that we are rolling out the electronic staff record at the moment and there is a part of that electronic staff record which does rostering which some people are waiting for to see what it is like.

Q50 Mr Khan: Can I just ask you about your role, Mr Moss. Ideally is it right to say that we would like to have no private nursing agencies around?
Mr Moss: No, we would like to have cost-effective and good-quality temporary staff. There is going to be always a role—we think a smaller role—for good-quality agency staff, so we do not believe—

Q51 Mr Khan: So what percentage should we in a year's time when we invite you back—and currently it is 2.6%—live with?
Mr Moss: If it is still around 2% we would be quite happy, provided the quality assurance is in place because, as David Nicholson has said, there are some good-quality private agencies. We have reduced the price that they are the supplying services at and we are increasing the quality checks.

Q52 Mr Khan: As I understand it, NHS Professionals by next year needs to be self-financing.
Mr Nicholson: By the beginning of 2008–09.

Q53 Mr Khan: Is there not a conflict between our wishes to reduce the demand on temporary staff and the need of NHS Professionals to be self-financing and your recent comment that you would be happy with a 2.6% percentage spend on private agency work?
Mr Moss: I think we recognise there is a tension between the role of NHS Professionals to be self-financing and its role to drive down the inappropriate use of temporary staff. We are working with NHS Professionals on a new service model and a new financial model for them with 2008–09 in mind because we want them to be self-financing by that time. It will be self-financing at a lower level of workload.

Q54 Mr Khan: Can I direct my next question to Ms Sigsworth, which is I get constituents approaching me—and I have a fantastic hospital in my constituency, St George's which has a deficit of the £21 million plus—and I get students and nurses approaching me telling me they cannot find a job. I do not understand. We are spending almost £800 million on temporary nurses. We have students who are given a golden handshake to do nursing degrees who cannot find a job. How do you explain that?
Ms Sigsworth: The situation with student nurses currently across the country is that many of them have successfully found jobs in organisations and trusts, both in primary care and in the acute trusts. The situation with student nurses is that often they are newly qualified and inexperienced and large numbers of the vacancies that we have now got across the NHS are for more highly skilled and experienced nurses.

Q55 Mr Khan: So are you saying that some of these temporary nurses who do not have appraisals, who do not have regular training updates, who we have no way of monitoring how good they are—and I have heard the comments about the excellent temporary nurses Mr Nicholson made and I have also heard the concerns raised by Dr Pugh—are you trying to say that they are a better bet than newly qualified nurses who have just recently had the latest training and hopefully know what they are doing?
Ms Sigsworth: The vast majority of staff who work for bank and agencies are experienced and are highly skilled.

Q56 Mr Khan: How many of them can speak English fluently?
Ms Sigsworth: I would not know the answer to that question.

Q57 Mr Khan: I am concerned with my experience of hospitals and my constituents' experience of temporary nurses—who tend to do night shifts, for whom English is not their first language, who frankly appear to be "too posh to wash", who do not seem to be as keen at helping elderly patients eat their own meals—because a common thread running through all these experiences is they tend to be temporary nurses. Is that an unfair caricature?
Ms Sigsworth: Yes I think it is an unfair caricature.

Q58 Mr Khan: How do you monitor that? How can you reassure me that it is unfair? Where is the monitoring? How many nurses who go to St George's Hospital are checked to make sure they have up-to-date qualifications, they have received up-to-date training, they have had regular appraisals, and they are fit and able to treat my patients?
Ms Sigsworth: The Nursing and Midwifery Council holds the central database for registered nurses and has very strict standards and systems in place to ensure that English language is spoken.

Q59 Mr Khan: So all the temporary nurses working today in St George's have had a recent infection control training course updater?
Ms Sigsworth: I would not know the answer specifically for St George's.

Q60 Mr Khan: How do you monitor it?
Ms Sigsworth: It is likely, based on the findings of the audit report and the comparative between permanent nurses and those nurses working temporarily, that the vast majority of them will have had an update.

Q61 Mr Khan: Whose job is it to assess and make sure that temporary nurses are suitably qualified and have had the most recent health and safety training, training on life support, training on fire regulations? Whose job is it to make sure that a nurse that comes into a hospital has had that training?
Ms Sigsworth: If the nurse is working for the internal bank, it is the individual organisation, the individual trust.

Q62 Mr Khan: For the private agencies, the 2.6%?
Ms Sigsworth: There is a very clear code of practice for both the PASA agency agreement and—

Q63 Mr Khan: The question was whose job is it to monitor?
Ms Thomas: If a nurse came from a private agency, the whole point of the PASA framework, which was a recommendation from the previous report by the Audit Commission *Brief Encounters*, was to put in place a quality assurance framework.

Q64 Mr Khan: Easy question; whose job is it to monitor?
Ms Thomas: The Purchasing and Supply Agency audits the private agencies on the framework regularly and those audits include pre-employment checks of the nature you are describing. What we would say to employers who go outside the PASA framework is that is part of managing the risk because those agencies will not be audited by PASA but they will be expected to comply with the code of practice, and it is then the trust's responsibility to make sure they do that.

Q65 Mr Khan: So it could fall between three different stools?
Ms Thomas: No, it is clearly the trust's responsibility.

Q66 Chairman: You must speak up.
Ms Thomas: It is either the individual employer's responsibility or PASA's responsibility, depending on which agency has been supplying the nurse.
Mr Khan: My time is up. You have not reassured me and I doubt you have reassured any of those patients who have received what they think is sub-standard care.
Chairman: Thank you Mr Khan. Mrs Brooke?

Q67 Annette Brooke: It is referred to throughout the Report really and I understand that in *Brief Encounters* there were recommendations that all trust boards should have a senior person to take an overall lead and have board level accountability for the use of temporary staff, and yet the Report found that few trust boards had given the issue strategic consideration. I wondered perhaps, Mr Nicholson, if you could explain to me in the hierarchy of the organisation; there is you, there are the strategic health authorities and then the trust boards. Given that this was identified some time ago, has information been disseminated on this issue and what monitoring has taken place? Is there a change since the writing of the Report?
Mr Nicholson: Every organisation will have got a copy of the Report and the DVD and the good practice guide that has been sent out to them. The strategic health authorities are responsible for following up with organisations who have had particular problems in relation to this, and they have been doing that. NHS Employers have been working with organisations to develop both a good practice guide with them but also working with groups of hospitals and trusts to make sure that good practice is spread and understood across the system as a whole.

Q68 Annette Brooke: But how can we be sure that is happening? On a school governing body there are requirements for governors to be responsible for different aspects. Seeing as this has been a recommendation, why are you or your management or the inspection teams that are going in not actually checking up that this is happening ?
Mr Nicholson: Obviously there are a large number of boards in the NHS and we are, as far as we possibly can, devolving as much responsibility to them. The important issue is whether there is board level engagement in this whole issue of temporary nursing staff which is linked to workforce planning in general. I think there is good evidence around, certainly from our experience, that most organisations are engaged in this. In fact, we would not have got the results that we have in terms of reduction in temporary nursing staff across the country had they not been engaged in that particular activity.

Q69 Annette Brooke: It does not seem a very proactive way of going about things, if I might say. Can I just return to the Chairman's initial point about this apparent correlation between the 35 trusts facing the largest deficits actually attempting to reduce those deficits by reducing agency staff. Is there a correlation between the number of agency staff used and the size of the deficit? Is that an indication that there is not good financial management across the board?
Mr Nicholson: I do not think there is necessarily a correlation between those two things but what is true is that in organisations who are faced with financial difficulties, often the reduction in temporary nursing staff is a relatively straightforward and convenient way of reducing the amount of money that you

spend. Clearly you have to balance that off against your ability to deliver the service. You would expect in those organisations which have got the biggest deficit where the turnaround directors and turnaround teams are in to have a much closer examination of the real utilisation of temporary nursing staff. That is probably what is happening.

Q70 Annette Brooke: The fact they have not addressed the problem earlier suggests they may have a whole host of other problems that they have not addressed either. That could have been reduced to a minimum with all these recommendations over the years, so why have these hospitals got deficits which apparently can be addressed through this route, even in this year?
Mr Nicholson: I do not think any of the deficits can be addressed just by this particular route. Even at the proportions we are looking at—

Q71 Annette Brooke: It is significant sums of money.
Mr Nicholson: It is absolutely significant sums of money. We expect organisations to take on board the recommendations of the Report and implement them, and that is exactly what those 30 organisations are doing. If you are asking me why have they not done it in the past, I think it will vary between different organisations. Some organisations in the south of the country have had little scope to do it given the amount of vacancies that they have had and our inability two or three years ago to increase the supply of nursing staff to them. Now we have got that supply moving forward they can do that.

Q72 Annette Brooke: Given that there are commitments to reduce the financial deficits, can you actually assure the Committee that the use of temporary staff is not being used as part of a tool to eliminate the deficits? For example, there seems to be evidence that in some hospitals permanent vacancies are not advertised immediately. I am pretty sure that is in the Report. Therefore, you are saving all your on-costs of the job and taking the temporary staff on for about three months. If you were very clever you could operate this to make sure that you are picking up your higher costs in a subsequent financial year rather than perhaps the financial year you are working with. I would like your assurance that you are watching overall this balance between the job vacancies that are not actually being advertised, where positions are being frozen (which we all know is happening) where it might be a short-term fix to take in agency staff, which might not be the best thing for the patient as we have heard, to watch particularly what might take place at critical points in the financial year?
Mr Nicholson: There are two things about that. One is the way we count vacancies is vacancies that have been available for three months or more, and that has gone down significantly over the last couple of years or so. It is less than 1% now from a relatively high number in the past. That is going down. Secondly, in the quarterly monitoring that we do of agency spend we can see that going down as well. Presumably in the circumstances you have described it would go up and that is certainly not the case, so we are not finding those two things coming together in the way you have just described.

Q73 Annette Brooke: I made the comment because again in the Report it suggests that 82% of the trusts facing the largest deficits are freezing recruitment and presumably the jobs have to be done. It just seems to me that you could be addressing the deficit so that the Secretary of State is saved on the given day and you could actually be pushing the costs into the next year, given that permanent staff are actually more expensive when we look at the overall figure, and that is in the Report too.
Mr Nicholson: That would presumably show itself in an increase in agency spend, which we are not seeing. We are seeing the opposite of that, it is going down.

Q74 Annette Brooke: So we should actually watch agency spend over the next few months.
Mr Nicholson: I think you will see it going down.

Q75 Annette Brooke: On page 4, I was particularly struck with this in paragraph 9: "In 2001 the Department stated that it anticipated that the growth in the workforce under the NHS Plan would significantly reduce the NHS's demand for temporary staff. However it has subsequently confirmed that it was only referring to demand for staff employed through agencies which it has been successful in driving down." Was this a question of changing the goalposts to meet the target?
Mr Nicholson: I am sure it was not.

Q76 Annette Brooke: It sounds like it.
Mr Nicholson: I am sure, as it says here, when the Department made the statement its assumption was that it was talking about agency staff, which it was predominantly at the time, rather than in-house bank staff.
Chairman: Thank you Mrs Brooke. Don Touhig?

Q77 Mr Touhig: Mr Nicholson, pages 19 and 20 of the Report, paragraphs 2.1 to 2.6, make it quite clear that there is very little information known about what drives the demand for temporary nurses. Why is there so little information?
Mr Nicholson: There is little information nationally but there is quite a lot of information available locally.
Ms Thomas: We do welcome the Report by the way and I think for employers it does provide a strategic focus, as did *Brief Encounters,* and we are very pleased that it does show a significant reduction in agency staff spend, which was the aim of *Brief Encounters,* and I think it is a good thing for the NHS if we manage to do that. In the point about demand and what drives demand, it is certainly true that without tools such as electronic rosters and without electronic mechanisms locally at ward level, it is very difficult in a paper process during the very complicated process of setting up a ward roster to understand what is driving demand for bookings. In the NAO Report it certainly shows that vacancies, sickness and poor planning for annual leave all drive

those sorts of bookings. Certainly what we are doing with trusts is improving the awareness locally that trusts have of the best practice around and places like Bedford and other places that have managed to drive down demand—and Portsmouth is another example I could give, which saved £1 million by simply better understanding what is driving their temporary staffing behaviour.
Chairman: May I stop you there; we need short answers.

Q78 Mr Touhig: I get your point. You say you welcome the Report. The Report makes it quite clear there is poor quality and limited information collected on temporary nurses. You are the "National" Health Service and you are supposed to do it nationally.
Mr Nicholson: We also have to balance what we ask organisations to deliver to us in terms of national information. We have increased the amount of information we need. We now get the total amount of money for individual organisations to deliver on agency staff and the total number of bank staff.

Q79 Mr Touhig: If I understand the Report correctly, reducing the use of temporary staff is one of your national objectives and yet you do not hold the information centrally. One trust might have something and another one might not. Are you not responsible for the whole of the NHS?
Mr Nicholson: We do have information about what each individual organisation spends on agency staff.

Q80 Mr Touhig: Ms Thomas has just said that you welcome the Report and it is made clear in the Report there is poor quality and limited information collected on temporary nursing.
Mr Nicholson: The point I am trying to make is the reasons that an individual organisation might use temporary nursing staff vary by organisation depending on the circumstances—the type of organisation, the type of labour market arrangements within there, and the tools that they have at their command. What is absolutely true is that those organisations that have things like electronic rostering and the electronic staff record are in a much better position to make those sorts of decisions.

Q81 Mr Touhig: It is better they take those decisions locally?
Mr Nicholson: Absolutely.

Q82 Mr Touhig: What do we need you for?
Mr Nicholson: Is that a general point? As far as we are concerned nationally we do a number of things. First of all—

Q83 Mr Touhig: You do not collect the information centrally.
Mr Nicholson: We collect benchmarking information centrally on productivity, on agency staff and bank staff.

Q84 Mr Touhig: We are talking about what drives the need for temporary nurses. I am sure you know the Royal College of Nursing produced a report last August and that said "a lack of flexibility in permanent jobs drives nurses to bank and agency work." Are they correct in that?
Mr Nicholson: For some individuals they do prefer to work in the very flexible way that a bank allows them.

Q85 Mr Touhig: You have read their report, have you, produced last August?
Mr Nicholson: I read it at the time. I have not read it in the last—

Q86 Mr Touhig: It says that it is the lack of flexibility in permanent jobs which drives nurses to bank and agency work. Is that the core of the problem?
Mr Nicholson: No, I do not think it is at all. It is not supply driven in that sense. Just because there are lots of people who want to work flexibly will not necessarily mean that an organisation will have more temporary staff; it will just have a bigger supply.

Q87 Mr Touhig: Have you got information that counters what the RCN has said then, to dispute what the RCN says? They say that the core of the problem is the lack of flexibility that drives nurses into agency and bank work.
Mr Nicholson: First of all, there are lots of examples around the country as a whole of increasing flexibility in the way we employ staff, particularly nursing staff. I am sure that David will be able to tell you all about that. There has been a big explosion in the NHS of much more flexibility, term-time working, flexible hours, contracts, a whole range of things that we have done in the NHS today. I question this issue about that driving people into banks.

Q88 Mr Touhig: You said you read the report.
Mr Nicholson: To be fair, we do need people working in the banks. It would be perfectly reasonable, if someone wants the flexibility of working in a bank to choose when they are going to work rather than being part of the formal roster. It seems to me that is a perfectly reasonable choice for someone so make.

Q89 Mr Touhig: They surveyed 500 nurses and almost 48% of newly qualified nurses said that working as a temp was not their preferred choice of work, so there is not much job satisfaction there if they are being forced to become temps because of the way you are operating.
Mr Nicholson: I do not think anybody forces people to be temporary nursing staff; it is a choice that people make.

Q90 Mr Touhig: The report of the RCN says that nurses are being driven into bank and agency work because of the lack of flexibility for permanent staff. It is pretty simple.

Mr Nicholson: I do not think it is true.

Q91 Mr Touhig: So have you told the RCN it is not true?
Mr Nicholson: I did not at the time because it was not my responsibility.

Q92 Mr Touhig: You will tell them now?
Mr Nicholson: I will tell them now.

Q93 Mr Touhig: One in 10 of those who took part said that they became temps because there were no permanent jobs. We are not short of sick people and, as the Chairman and other colleagues have pointed out, the Government has put in plenty of money. Why are there no permanent jobs?
Mr Nicholson: First of all, there are permanent jobs available.
Ms Thomas: Can I say that I think it is a legitimate aim to have a small gap between the number of people we need and the number of people we are able to recruit. Compared to five years ago that gap is now very narrow. That means there is much more competition for jobs and we should be pleased that we have reached that position. We need to support students and graduates to be able to work in the hospitals that they choose to work in. I support David's point that we know through working with NHS Professionals that some people choose to go through NHS Professionals for specific reasons, including flexibility.

Q94 Mr Touhig: Because they say, according to the survey of the RCN, there is not enough flexibility in permanent jobs.
Ms Thomas: All employers have to balance the employees' desire for flexibility with the needs of patients, and that is an on-going, everyday role for ward managers and employers that is very challenging. I do believe the evidence we have got on staff surveys in the NHS shows that we are a flexible employer. I think that the RCN and Unison would both support that general statement.

Q95 Mr Touhig: Is this not a bit of a chicken and egg because people are saying, according to the RCN survey, they are taking up temporary jobs because there is a lack of flexibility in permanent jobs and therefore there are fewer permanent jobs because they are being filled by temps? Clearly if you do not resolve that, you are going to have this continual dissatisfaction amongst nursing staff, are you not? They want flexibility, they want the ability to have flexible working.
Ms Sigsworth: In a large majority of cases they do have flexibility. The on-line survey you are referring to was 500 nurses and 50 nurses, so one in ten nurses, so that particular survey seems to me to be a very small number.

Q96 Mr Touhig: I fully accept that but at least they have got some central information. You do not have any central information, you have just got it trust by trust.

Ms Sigsworth: In the vast majority of cases nurses would say, certainly from the days when I started my training, it has changed considerably in terms of flexibility and many of the schemes that David has described, including term-time working, night-working, part-time working, have all come in over the last five to ten years to make sure that we can keep nurses in permanent employment.

Q97 Mr Touhig: 65% of those who responded to the survey said they took up temporary work because they could not get flexible hours working permanently.
Ms Sigsworth: I think we have increased the number of people that are working flexibly across the NHS, but we can only do that to a certain degree because at the end of the day the clinical priority for patient care takes precedence, and there are situations on wards and in community settings—

Q98 Mr Touhig: I fully accept that the patient is at the heart of this. This Report is being produced because of your failure to reduce the number of temporary staff you are using at the present time.
Mr Nicholson: We have not failed to reduce—

Q99 Mr Touhig: One of those who responded to the survey said: "Bank and agency nurses get a poor press as the 'money grabbers' of the National Health Service when in reality many of us are doing it because of the lack of other options. No trust in this area offers family-friendly hours. I have had seven job offers retracted when I have asked about it." It is not a good record, is it?
Ms Sigsworth: Again I just reiterate, in the vast majority of cases nurses are working in very very family friendly ways and we have improved that situation.

Q100 Mr Touhig: You had an initiative in 2000 called *Improving Working Lives*; how successful has that been?
Mr Nicholson: It has been extremely successful in the sense that all organisations now have got to the standard of *Improving Working Lives* and there are practice plus standards which are exceeding them.

Q101 Mr Touhig: Janet Davies, the Executive Director of the RCN does not agree with you. She says that "many nurses are not afforded flexibility in their permanent roles and are forced to move to temporary roles. The Government is committed to ensuring that nurses have greater flexibility in their working lives yet these findings clearly show that this has not happened."
Ms Sigsworth: I do not think it is the case that the findings "clearly show".

Q102 Mr Touhig: That is what she says.
Ms Sigsworth: That is her view but I do not think the findings from a survey of 500 nurses out of a workforce of 650,000 nurses in England—

Q103 Mr Touhig: I accept it is a small number but at least they have done some work nationally which is more than you have done.
Mr Nicholson: We have done a huge amount of work.

Q104 Mr Touhig: My time is coming up and I have one final question. How much more does it cost you to employ a temp than a permanent nurse?
Mr Moss: It costs us less.

Q105 Mr Touhig: The anecdotal stories I get that trusts are paying out more for temps than they are for permanent staff are not accurate?
Mr Nicholson: For temporary nursing staff which are on their own bank or for NHS Professionals, it costs less for the organisation than to employ a permanent member of staff. It costs more to employ member of staff from an agency but, as we can see, the numbers in agency staff are coming down quite significantly.

Q106 Mr Touhig: It is still a considerable amount.
Mr Nicholson: Both in terms of the total amount of cost but also the unit cost that we have managed to negotiate through the PASA framework.

Q107 Mr Touhig: My time is up. I just hope in the future you might get some centrally co-ordinated information. That is what the National Health Service is about.
Mr Nicholson: I think we have.

Q108 Mr Touhig: You just said earlier, with respect, that you did not hold this information, it was held by the trusts; you cannot have it both ways.
Mr Nicholson: We need to collect—
Mr Touhig: Thank you.
Chairman: Thank you Mr Touhig. Philip Dunne?

Q109 Mr Dunne: Mr Nicholson, is there a policy, whether formal or informal, for the use of temporary nursing staff for those NHS trusts who have hospitals or services under reconfiguration consultation at the moment? Where a trust has a hospital or a service which is currently in the process of public consultation on reconfiguration, ie under threat of closure, do you have a policy at NHS level, either formal or informal, for those wards or hospitals that are under threat of closure to employ temporary staff in preference to full-time staff when vacancies occur?
Mr Nicholson: There is no national policy in relation to what you have just described. Just because a hospital is going through some kind of reconfiguration consultation does not necessarily mean it is going to close. One does not necessarily follow the other.

Q110 Mr Dunne: It may not be a formal consequence but it is quite often the case.
Mr Nicholson: But I would accept that running an organisation locally you have to take into account what the medium and long-term position of that organisation might be, and you could consider some circumstances whereby you might want to increase the number of temporary nursing staff on a temporary basis in order to get you over a big service change. I could see how that would happen but it is certainly not a national policy to do that.

Q111 Mr Dunne: So you condone that practice?
Mr Nicholson: What I would say is that local managers and clinicians have to make judgments based on their local circumstances. If it makes sense and it is safe for patients and good for patients, then I would certainly condone it. I would not condone it if it was done in any kind of unplanned way or in any way affecting the care of individual patients.

Q112 Mr Dunne: Do you monitor this practice at all?
Mr Nicholson: What we monitor is the amount of money people spend on agency and we monitor the number of bank staff that they use. We would have that information nationally and we would expect the strategic health authorities to follow up if they saw trends that would affect patient care in those circumstances.

Q113 Mr Dunne: So it would be possible to do a back analysis of those wards or hospitals that have closed to see whether their agency costs rose in the period prior to closure?
Mr Nicholson: I do not know when we started collecting the bank and agency information because I cannot think of any hospitals that closed in the last period.

Q114 Mr Dunne: Perhaps I could write to you and suggest a couple and maybe you would like to do an analysis based on those?
Mr Nicholson: I would be very happy to.

Q115 Mr Dunne: Thank you, I will do that then. Do you recognise that in remote rural areas where there may be a smaller pool of talented existing nursing staff that the incidence of temporary nursing staff is higher than in metropolitan areas? Do you collect such data?
Mr Moss: It tends to be the other way round. The incidence is higher in the big conurbations.

Q116 Mr Dunne: Because of more rapid turnover of personnel?
Mr Moss: Because there is a more transient workforce, a lot of alternative employers, different structures.

Q117 Mr Dunne: Do you find you have to may more per hour for agency staff in remote locations?
Mr Moss: No, because they tend to be on the local bank and so they are paid at the normal NHS rate.

Q118 Mr Dunne: Thank you. On a different tack what has been the cost to the NHS of placing recruitment ads, say in the last year?
Mr Nicholson: I am sorry I have not got that information.[2]

[2] Ev 18

Ms Thomas: I think I can come back to you on specific figures but the figures we have on recruitment/advertising market show that the market was probably worth around £120 million a year, two years ago or so. This year the market will be worth around £30 million and that is predominantly because of the use of NHS Jobs, the electronic jobs service, which we believe at the moment is saving the NHS at least £40 million a year, although it is an under-estimate, so there has been a huge reduction.

Q119 Mr Dunne: On-line recruitment?
Mr Nicholson: Yes, NHS Jobs.

Q120 Mr Dunne: I am pleased to hear that. That was going to be the tenor of most of my remaining questions as to how far you have moved down that track. Does that apply at local trust level as well?
Ms Thomas: 620 trusts are now using NHS Jobs, which is the fourth largest job site in England, and at the moment on NHS Jobs there are 5,000 jobs advertised on any one day and NHS Jobs recruits 10,000 people a month into the NHS. We have seen the use of recruitment press advertising drop dramatically. The value of that market now and the work we are doing with PASA dropped from over £100 million—I should think five or six years ago it was probably double that figure—to around 30 million this year.

Q121 Mr Dunne: You are to be congratulated for achieving that. That is encouraging. Turning to the questions that Mr Khan was asking about whether you have concerns about the quality of care for patients occupations being reduced through the use of temporary staff, do you have such concerns?
Mr Nicholson: We do not have those concerns. Obviously individual organisations that use temporary nursing staff put their own arrangements in place to assure the quality of them. They are obviously supervised on the wards they work on by trained, qualified and experienced ward sisters. There is a whole series of checks now that are run on individuals before they are allowed to work on banks or for NHS Professionals. Agencies are regulated by the regulation bodies and also audited by PASA. There has been a significant improvement in that level of supervision over the last three or four years and this Report was part of that.

Q122 Mr Dunne: Do you assess individual members of staff that come on to wards against these criteria that you have? Are people only eligible to take up a job if they meet certain standards?
Ms Thomas: Yes. That is what NHS Professionals has been used for as part of their role. There is very strong governance going on, a very good orientation programme and locally ward managers are asked to complete questionnaires and assessment forms which give feedback to NHS Professionals on the quality of their nurses. The number of complaints about individual nurses to NHS Professionals is very low; similarly through the agencies. That is PASA's role as well, to make sure that agencies have similar governance arrangements.

Q123 Mr Dunne: Are these assessments made on individuals?
Ms Thomas: Both on individuals and on the system of framework of governance.

Q124 Mr Dunne: Would it be possible, for example, if you take mental health, which is an area of interest to me, for a temporary nurse to come on to a mental health ward having had limited prior experience of working on such a ward?
Ms Thomas: What NHS Professionals have done is implement what is called a clinical coding system which is now the same coding system as the private agencies. When nurses locally ask for a booking, there is now a very clear process for what particular nurse they are asking for and it is a very transparent and consistent both across private agencies and NHS Professionals and banks.
Mr Moss: There would be a clear check whether the person was a registered mental nurse. We would supply somebody if that was what the requirement was for the trust.

Q125 Mr Davidson: Could I ask about the table in appendix three on page 41 which gives the costs or expenditure of temporary nursing as a percentage of total nursing expenditure? There seems to be quite a wide variation between individual trusts. Can you clarify for me whether there is, if not a target, a good practice figure that trusts ought to be aiming at? Why is there this wide variation? Some of these really are quite wide.
Mr Nicholson: There is a wide variation and there are some outliers in that variation. There is not a good practice target that we are saying people should go to but we do say that we do not expect any organisations to go beyond 15% as a total figure. We seem to be moving around towards the 6% or 7% figure as being reasonable. These circumstances are sometimes because they are not managing very well, sometimes because they have not done the planning very well but also because different organisations have different needs. Some highly specialised organisations have had real difficulty in recruiting people and that is why they have gone to agencies.

Q126 Mr Davidson: The indication of the 15% figure is helpful but there are a number of trusts, particularly in London but elsewhere, which are over and above the 15. That is presumably a snapshot but it is unlikely to be a snapshot that is out of kilter with what happened in previous years. Is this monitored centrally and then is advice given?
Mr Nicholson: Yes.
Mr Moss: When this analysis was done there were 18 trusts in the country that were over 20% and we thought they were at the upper end of outliers. They have been followed up through the Strategic Health Authority. We have been looking at the trends. It is encouraging that the outliers are coming back towards the norm. Some in the London area are still

at quite high levels but we are pretty confident that if we did the analysis again there would be a smaller range than was found in 2004–05.

Q127 Mr Davidson: Was this collective action in the outliers being pursued before the National Audit Office started investigating this?
Mr Moss: Yes. We welcome the National Audit Office Report in raising the profile of this. Last year, we got together the 27 highest spending trusts in terms of agency staff. It was called the National Agency Staffing Project. We exchanged best practices and information. We put them under the spotlight. We did start the scrutiny of the outliers. I forget when the NAO investigation started but it was late in 2005.

Q128 Mr Davidson: If private agencies are much more expensive than a nursing bank or NHS Professionals, why should anybody use private agencies at all?
Mr Nicholson: There may be a whole range of reasons. One reason might in the past have been habit and that has been significantly squeezed out.

Q129 Mr Davidson: These are the new days; you are the manager and presumably you have sorted all that out now so old habits have been broken.
Mr Nicholson: I am sure it predated me coming here.

Q130 Mr Davidson: It is no longer an issue then.
Mr Nicholson: What we have tried to do—

Q131 Mr Davidson: No. Tell me: why should anybody employ private agencies when they are clearly more expensive than any other solution?
Mr Nicholson: For example, I was in Leeds last week. There was no alternative provision for particular types of theatre nurses. They had essentially cornered the market.

Q132 Mr Davidson: The only circumstances in which you would envisage it being acceptable for people to employ the private sector is when there is no alternative available? Is that correct?
Mr Nicholson: That has increasingly been the practice.

Q133 Mr Davidson: Is that correct? That is the position? People should only be employing from the private sector when it is demonstrably the case that there is no alternative?
Mr Nicholson: I think that is what we would say, yes.

Q134 Mr Davidson: In terms of the balance between hospitals' own banks and NHS Professionals, what should be the first port of call for an individual hospital as well as taking the balance with overtime, because overtime is more expensive, is it not?
Mr Nicholson: It depends whether it is over and above the 37 hours that they work or whether it is a part time member of staff going to a bigger—

Q135 Mr Davidson: If a part time member of staff goes to additional hours but still below the $37\frac{1}{2}$, that would not be at overtime rates?
Mr Nicholson: That is right.

Q136 Mr Davidson: Unless it was at a time which attracted premium rates?
Mr Nicholson: Yes.

Q137 Mr Davidson: The balance between your own bank and NHS Professionals: what would make that sort of decision?
Mr Nicholson: What normally happens is that NHS Professionals would come in and take over the bank.

Q138 Mr Davidson: They would not be working in any particular location in competition with each other?
Mr Nicholson: No. They would essentially run the bank.

Q139 Mr Davidson: Mr Khan made a point about quality, the lack of language skills and the level of concern sometimes shown by agency nurses and the level of training being deficient. Despite what you are saying, we do pick up these stories fairly regularly. Not all of them can be incorrect. If what you are telling us is true, I would be entirely satisfied but it does not seem to be on the basis of what we are hearing. Can you explain why there seems to be a discrepancy?
Mr Nicholson: Between what we are saying about the quality of staff and—?

Q140 Mr Davidson: The sort of situation that Mr Khan outlined should never occur where staff do not seem to be bothered all that much and all the rest of it. All of that should be corrected by the system. These stories do seem to come up and I am not quite sure how we can be assured that it does not continue.
Mr Nicholson: In terms of the members of staff who are not bothered, not putting the effort in or not doing what they need to do, that is clearly a local management issue. That is how those staff on the ward are managed. The language skills I have not come across so I cannot really comment on that.

Q141 Mr Davidson: There should be no situation.
Mr Nicholson: They should be properly managed by the people in charge of the ward.

Q142 Mr Davidson: Quite often, as a result of these hearings, we have people communicating with us. Nobody should be getting in touch with us after this saying that they have had an example recently of nurses from an agency or on a temporary basis with poor language skills. Is that correct?
Mr Nicholson: As an issue I am unaware of it.

Q143 Mr Davidson: Is that yes, nobody should be getting in touch with us?
Mr Nicholson: I would prefer the opportunity to explore the particular issue that you have just described.

Q144 Mr Davidson: Life is short and I want to be clear on this particular question. You are saying we should not be getting contacted?
Ms Thomas: I would like to distinguish between what we are trying to do which is improve the quality of the supply of nurses through the PASA agency framework agreements. If there is a private agency supplying nurses through those agreements, that is absolutely fundamentally one of the things we are trying to improve. The performance appraisal process happens and these things are in place. Things like language are tested. There certainly will be complaints about nurses coming through agencies. I have not myself come across evidence of those in large numbers of the type you are referring to. I suppose what we are trying to do is make sure that where there are systems in place to make sure these things are minimised in the risk, that is what we do, which is minimising the risk of that happening to patients.

Q145 Mr Davidson: I understand that. This is work in progress rather than work that is complete?
Ms Thomas: The NAO Report was true. It found that there was less evidence of robust performance appraisal with temporary staff, bank and agency staff. That is something we are trying to improve which would pick up the points that you are describing.

Q146 Mr Davidson: This Report is covering England. In terms of Scotland, Wales and Northern Ireland, are there different patterns there from which you believe you could learn or is your pattern of development and provision better than the service that is provided in those other areas?
Mr Nicholson: I am sure that there are things we can learn from Scotland and Wales. I have not had that conversation with my colleagues in those other parts of the UK.

Q147 Mr Davidson: Can I ask the National Audit Office whether or not any comparisons were done in regard to all of this with Scotland, Wales and Northern Ireland?
Ms Taylor: We do normally look at what is happening in other countries. We talk to other countries and there are similar findings. NHS Professionals are only England so they do not have that. They rely on either on agencies or their own bank nurses. There are similar issues because they come from a similar point of reference.

Q148 Mr Bacon: Mr Nicholson, could I ask you to turn to page 31, paragraph 3.16? It says, "In order to tackle the variability in activity and performance the Department announced that NHS Professionals would be given a stronger management structure and from January 2004, established it as a Special Health Authority. It became operational in April 2004, with Parliamentary funding of £32 million for 2005–05, (£18 million to cover temporary nursing staff) . . .". What was the other 14 million for?
Mr Moss: It covers other types of staff, medical staff, other health professionals and administrative staff.

Q149 Mr Bacon: In other words, locums of various kinds and consultants?
Mr Moss: Yes.

Q150 Mr Bacon: What is the average daily cost of employing a temporary nurse? There might be a range but there will be an absolute average, I am sure.
Mr Nicholson: We have the hourly rate.
Ms Thomas: Is it a bank nurse or an agency nurse?

Q151 Mr Bacon: You have £790 million. I was very surprised that you were not able to answer Mr Khan's earlier question about the number of people who were being employed in this way, whether they are agency or whether they are bank. I would like to get some sense of how this £790 million that is being spent is cut up. My question relates to agency and bank, people who are working as temporary nursing staff. Plainly, if a nurse is newly qualified and only earning, say, £19,000 a year, that pro rata rate will be lower.
Ms Thomas: I can give you a comparison of the hourly rate which might give you an indication of the daily rate. For a newly qualified nurse doing temporary staffing through a bank, the average hourly rate from the NAO Report was around £14.50 an hour. The comparison with the new agency framework agreement is about £2 to £3 an hour more expensive.

Q152 Mr Bacon: £14 an hour?
Ms Thomas: £14 an hour for a bank nurse and that compares to nearly £16 an hour on the new PASA framework for an agency nurse. Obviously if you are outside the agency framework of PASA that would be even more expensive.

Q153 Mr Bacon: Typically on average how long would a shift be? Would it be eight hours? Would it be ten hours?
Ms Thomas: It would be between eight and 11/12 hours, depending. It could be less than eight hours, but typically it is between eight and 12 hours.

Q154 Mr Bacon: If you have £14 times eight, it is costing you £112?
Ms Thomas: Yes.

Q155 Mr Bacon: If you have £14 times 11, it is costing you £154. Is that right? That is the average?
Ms Thomas: Yes.

Q156 Mr Bacon: Why are you having such difficulty then in figuring out the answer to Mr Khan's much earlier question about how many people are doing this?
Mr Moss: The question how many is difficult because it is a mixture of part time people working extra hours and full time people working overtime. We can give you the number of bank staff that are employed. I am sorry if we did not pick up the question.

Q157 Mr Bacon: That is basically my question. I would like to know how many people are involved in doing this. What proportion of nurses working in the UK are doing it?
Mr Moss: What proportion?

Q158 Mr Bacon: Why not answer the first bit of the question which is how many bank staff are there and then we can get on to how many agency staff there are. Then we can get on to how many nurses there are in the UK and what proportion of people working in some form of temporary work represents of the whole.
Mr Moss: Would you like us to give you a note?

Q159 Mr Bacon: I do not mind having a note as well but I would quite like to know right now. How many bank staff are there?
Mr Moss: We do not have that with us.

Q160 Mr Bacon: How many agency staff are there?
Mr Moss: We do not know the number of agency staff. We do know the cost of agency staff nationally. People are often employed for one shift, for two nights. Whole time is less meaningful.

Q161 Mr Bacon: Nonetheless you must have some notion of how many of the population of nurses in the UK, which I understand to be—correct me if I am wrong—450,000—
Ms Sigsworth: It is greater. We would be able to give you a figure for England.

Q162 Mr Bacon: It is about 500,000. Of the nurses in England, at least 500,000 or 550,000, how many of those 550,000 are engaged to a greater or lesser extent in doing temporary work? That is what I am trying to get to. Nobody seems to know the answer.
Ms Sigsworth: I think it is a very difficult answer to give because I could say to you over what time period.

Q163 Mr Bacon: In any given year. NHS Professionals were set up as a Special Health Authority, operational from the beginning of April 2004 so in that case I would be asking 2004–05. You could compare it, could you not, with 2005–06 and now with 2006–07? It is not difficult at all.
Ms Sigsworth: If I had a calculator to hand—

Q164 Mr Bacon: I have one.
Ms Sigsworth: Perhaps you can do the sum then.

Q165 Mr Bacon: Tell me what you want me to calculate.
Ms Sigsworth: You take the total spend and divide it by the cost of the shift. That would at least give you the number of shifts.

Q166 Mr Bacon: That is exactly what I did but I was so surprised by the answer to Mr Khan's question or rather the fact that nobody could tell Mr Khan how many people were doing this that, in the last 10 minutes, I nipped off to my office and that is exactly what I did. I got a spreadsheet and I put £790 million down here. I did not know the cost but I guessed somewhere between an annual salary of a nurse at £19,000 up to a very top nurse at £80,000, perhaps taking a consultant nurse or something, and then I divided it by £365. I came up with a figure somewhere between £15 and £219 a day. You said £154, did you not?
Ms Thomas: Yes.

Q167 Mr Bacon: If it were £150, that would buy you 5.2 million nurse days. Obviously if you had nurses working 10 days each that would buy you 524,000. You would have 524,000 nurses doing that—that would imply that every nurse in England was doing at least some—down to the other end. If you had the nurses doing 300 days each, it would be 17,000 nurses. We know that it is somewhere between 17,000 nurses engaged in this activity and 524,000. What I am hoping is that you, on the basis of slightly more than ten minutes' work that I was able to do just now in my office, would be able to give this Committee a rather more accurate figure and answer both mine and Mr Khan's question.
Ms Sigsworth: The most important calculation for nurses at the coal face who are putting these patient priorities first is that the quality assurance framework is in place. I think you have heard that it is. Secondly, how much a shift would cost so that you can make a judgment as to how much—

Q168 Mr Bacon: That is probably another important question but it is not my question. My question is how many nurses in England are engaged in this temporary work. Is it every nurse in England doing one shift? Is it 200,000 nurses doing two and a half shifts? What is it? It amazes me that somebody is going out and spending £790 million. An awful lot of thought has gone into this for several years and you have set up NHS Professionals. If I were interested in this area in detail and I spent my working life doing it, it is a question to which I would be curious to know the answer. We have X number of nurses in this country. How many of them are doing this? Nobody seems to know. Why not?
Mr Nicholson: The focus of our attention has been on improving the quality of the provision of services to patients on the one hand and to manage and reduce the costs on the other. The total number of nurses that are currently employed by the NHS who do temporary work has not been relevant to that.

Q169 Mr Bacon: I will tell you who it is relevant to. My constituents are coming to my surgery. They sit down and complain that when they have had to go and see their elderly relatives dying in many cases, because they are in for terminal conditions and they are very elderly, very frail and they are often going to die eventually anyway, sadly, they never see the same nurse twice. There is an increased use of agency nurses and one constituent, describing the last few days of her elderly father, said she had scrumped up a tissue, dropped it on the floor below the bed, slightly under the bed but not completely, and it was still there four days later because nobody had swept it up. You get stories of people having to be there on

hand themselves to make sure that the care is of the right quality. I have had a nurse herself who had this experience with her own husband attributing this to a decline in the nursing culture which, she tells me, is directly correlated with the increased use of agency nurses. That is why it is relevant.
Mr Nicholson: I cannot comment on the individual case that you describe. There are lots of other cases where people have been extraordinarily satisfied with the service they have had from the NHS. You will know from the NAO Report that the amount of money being spent on agency nurses is going down.

Q170 Mr Bacon: It is going down from £830 to £790, is it not?
Mr Nicholson: Yes, but you just said it was going up.

Q171 Mr Bacon: The last time I saw a piece of paper from the National Audit Office on this, which was not that long ago, it was £540 million. Could you send us a note, please, showing the expenditure of money on NHS temporary nurses, either bank or agency, in each of the last 20 years so that we can see the cash figure and what has been happening? £790 is good compared with £830. I agree with you there but I would like to see the trend over a long period of time.[3]
Mr Moss: It has been going down over the last six years.

Q172 Mr Bacon: Good. Is it possible you could send us a note on that?
Mr Moss: We have some figures going back ten years certainly.

Q173 Mr Bacon: Would you be able to find them going back further?
Mr Moss: I would need notice on that but we will try.

Q174 Mr Bacon: If you could send us a note with your best estimate of how many nurses within the total nursing population in England are engaged in temporary work, I would be very interested to see that.[4]
Mr Nicholson: What I can tell you is that between 26,000 and 28,000 whole time equivalents are being used as bank nurses over the last couple of years.

Q175 Chairman: You will now read this transcript, Mr Nicholson. You will see the questions that Mr Bacon has put to you. I have heard of MPs putting questions based on calculations on the back of a fag packet but he used a spreadsheet. You were unable to answer so you can now in a note answer these questions?
Mr Nicholson: Yes. Could we have the spreadsheet, to avoid further questions?
Mr Bacon: You are very welcome to it.

Q176 Mr Williams: Mr Nicholson, why is mandatory training mandatory?
Mr Nicholson: Because it is mandatory.

Q177 Mr Williams: What does it mean to you?
Mr Nicholson: It means we expect people to have it.

Q178 Mr Williams: It is essential?
Mr Nicholson: It is essential.

Q179 Mr Williams: It does not seem to be in the organisation you cover. You issued a code of practice back in 2002. If you look at page 37, there is a table 23 there. This is following on this point about whether or not you have concerns about quality. You said you had no concerns about quality. You have just admitted that mandatory training means essential training. If you look at table 23, for bank nurses 61% had basic life support training but that is mandatory training, is it not? Four in ten of them had not had training in the previous 12 months. If you look at infection control—we think of MRSA and the other bugs we are all concerned about—59% had not had mandatory training in the previous 12 months. That is not very good, is it?
Mr Nicholson: We can certainly do better. That is true.

Q180 Mr Williams: You could do a lot better, could you not?
Mr Nicholson: Yes.

Q181 Mr Williams: You do not entirely control the bank people, do you? You do control the permanent ones. Look at the first column. These figures are slightly more helpful to you. On permanent, instead of it being 61% who had had mandatory training, it was 70% of the permanent. Even the permanent were not much better than the temps and the same with infection control: 59% for the bank; 69% for the permanent had had training in the previous 12 months. Therefore, four in ten of the bank in both categories had not and three in ten in both categories for the permanent had not. That does not sound very mandatory to me. Does it sound mandatory to you?
Mr Nicholson: It is getting better.

Q182 Mr Williams: Do you mean it was worse?
Mr Nicholson: It is getting better.

Q183 Mr Williams: How much worse was it then and when was that?
Mr Nicholson: Part of this is the responsibility of the organisations to make sure that their staff go through their training and it is the responsibility of individual staff as well. We have set up a framework by which we can monitor it. We set up a code of

[3] Ev 18–20

[4] Note by witness: The Information Centre's non-medical workforce census showed there were 26,000 full time equivalent (FTE) bank nurses working in September 2004.
Using trust (TFR), PCT (PFR) and SHA (HFR) financial returns data, an estimated 11,100 FTE agency nurses were used in 2004–05
The total spent on agency nursing in 2004–05 was £413m (Table 2—Ev 19).
The estimated hourly rate was calculated from this figure using the agency hourly rate specified in the NAO Report (£19.11 per hour) and assuming one FTE is 52 weeks of 37.5 hours.
This leads to an estimated whole time equivalent of 37,100 temporary nurses working in the NHS in 2004–05.

practice. We have set up training and support to make organisations do this and we monitor whether they do it.

Q184 Mr Williams: So you are monitoring it. Were you aware of these figures as a result of your monitoring?
Ms Sigsworth: We knew through the Health Care Commission audits and reports that mandatory training has always been difficult for the NHS to achieve, particularly in some of these areas. The areas where we have achieved good scores are exactly the areas where we should.

Q185 Mr Williams: In 2002 you were sufficiently concerned to introduce a code of conduct. Was that to protect the patient or was it to protect your backs? You could say you laid down the rules and it is for someone else to apply them. That is what you are saying.
Ms Sigsworth: The code of conduct was to provide a framework for organisations to achieve the mandatory training targets. It always has to be, particularly for mandatory training, to protect the patient in the first instance.

Q186 Mr Williams: In an individual hospital, for example, who is responsible for ensuring that the mandatory training is, as it says, mandatory and fulfilled?
Ms Sigsworth: It would be devolved to the ward sister in, say, clinical practice, if we are talking about nurses, through the appraisal of the performance review process. An annual check is made as to whether staff have undertaken the mandatory training. There are situations where—let us take basic life support, for example—where you are eligible to go off for your yearly life support training and yet you have resuscitated 10 or 20 patients during the course of the year. There are discussions between the ward sisters and staff that say, "I am up to speed. I am competent. I am capable."

Q187 Mr Williams: When you look at things like MRSA and infection control, it is no better, despite all the publicity. We produced several reports on this subject, making recommendations. There has been no lack of public attention to it, and yet even on infection control no one is responsible. You are quite happy because you have laid down that it is mandatory. Therefore, you can sit here and say, "Please, guv, we did what we could. It is their fault." What happens to those whose fault it is? What action is taken and what about when patients have died because nurses who have not been on the relevant mandatory training were dealing with them?
Ms Sigsworth: We know particularly with infection control that recently organisations will be assessed not only on mandatory training around infection control but generally their infection rates. A notice of improvement would be issued to organisations to improve on the training and on infection control. These improvement notices are very serious. Failure to follow them and achieve the targets that are set will result—

Q188 Mr Williams: You do realise that you only have just slightly better than a one in two chance if you are going to have a contemporarily trained nurse. It should be a matter of concern to a patient and a matter of concern to the hospital management. When you look at it that way, your chances of coming across untrained nurses, nurses who are not contemporarily trained, are very high indeed, are they not?
Ms Sigsworth: I am not sure that you could specify that not having been trained within the year would mean that you were not contemporarily trained. There are certain advances in technology and clinical practice that would need you to attend perhaps even more frequently than in certain cases yearly.

Q189 Mr Williams: That would make it worse, would it not? It is very honest of you to say so but that alarms me even more. Would you give us examples of each of these categories—you can put a note in—where training should be more than in one year?
Ms Sigsworth: I meant it in the general sense. I did not mean it with anything specific in mind. I am just thinking that technologies and clinical practices change all the time.

Q190 Mr Williams: Mr Nicholson has no concerns about quality but we discover that you are possibly coming across people who are not up to date on their training, which we have already established. You also come across people who are not only not up to date on their training but are not monitored to see whether they are working more hours than they should. According to the NAO, none of the trusts they visited had systems to monitor the hours worked and to see whether they could reach the European Working Time Directive. You have not one of them checking whether the nurses are overworked and overtired and at the same time you have this very high incidence of inadequacy of training. That is very worrying, is it not, but it does not seem to be to you.
Mr Nicholson: I think you said I was not interested in quality. I certainly have not said that.

Q191 Mr Williams: You did. I wrote it down. I think it was in answer to Mr Dunne. You did not have concerns about quality.
Mr Nicholson: We can always do better, can we not? That is the issue that I was raising at that particular time.

Q192 Mr Williams: You passed your code of conduct in 2002 and these figures are the latest figures that were supplied by the NAO in July this year. What have you been doing since 2002?
Mr Nicholson: In terms of what we have been doing with temporary nursing staff, we have set up the PASA framework; we have a framework now which sets out to agencies what quality standards we expect from the agencies and from the staff. We have NHS Professionals which again do exactly the same thing for staff who work in NHS Professionals. We are

improving the overall management of temporary nursing staff through the code of practice and through the best practice work that the NHS employers are doing with organisations. We are reducing the amount of money that we are spending on temporary nursing staff. We are reducing the utilisation of temporary nursing staff. We are reducing the amount of money we are spending on agency staff and we are improving the position in relation to training and staff on the ward. You are saying to me it is not enough and we should do better. You are absolutely right. We should do better. All I would say on infection control is that the incidence of MRSA has come down over the last period and not gone up.

Q193 Mr Williams: That is not much consolation to a patient if they find themselves in the situation you are describing. It also has a litigation impact, does it not?
Mr Nicholson: I do not accept that just because someone has not done their mandatory training, although we hope that they would, they are necessarily not competent to clinically assess and treat patients on the ward, for the very reasons that Janice just described. Someone might be in practice doing this sort of work every day and be satisfied by their discussions with the ward sister that, at a particular moment in time, they were not to do it. We should encourage and support people to do more training but we should not assume that they are incompetent.
Mr Williams: We all understand that nurses are very hard worked and that there are enormous pressures on their time. It does seem to me that the Department has been more concerned about protecting its back in relation to the problems I have outlined than ensuring that they protect patients adequately. I do not blame the nurses for this; I blame the Department for not doing its job.

Q194 Chairman: You keep mentioning NHS Professionals but we read in paragraph 26 that they are only used in 24% of trusts. If they are so good, why are they being used so little?
Mr Nicholson: NHS Professionals had quite a troubled history. When they were first set up they did try to expand very quickly indeed and got themselves into enormous managerial and financial difficulties.

Q195 Chairman: That is the past. Are you going to meet your target of all NHS trusts using NHS Professionals by 2008?
Mr Nicholson: That as an aspiration of NHS Professionals. It is not a target for the Department.

Q196 Chairman: The answer is no, you are not going to meet that aspiration.
Mr Moss: We do not think it is necessary to. We think that 25% to 30% of the market is sufficient to have a very significant impact on improving quality and driving down cost. We want the NHS to improve and we want it to be a benchmark that trusts can gauge their in-house bank against to make sure that they are meeting the same standards as NHS Professionals. It does not mean NHS Professionals have to take on all the trusts in the country.
Chairman: Thank you very much. That concludes our hearing, ladies and gentlemen.

Supplementary memorandum submitted by the Department of Health

Question 118 (Mr Philip Dunne): *What has been the cost to the NHS of placing recruitment ads, say in the last year?*

Spending on recruitment advertising in PCTs and trusts (excluding Foundation Trusts) peaked in 2003–04 (see table below). Provisional figures for 2005–06 suggest that spending has fallen by around 45% since then.

	2002–03	*2003–04*	*2004–05*	*2005–06*
Spending on recruitment advertising in PCTs and trusts (excluding Foundation trusts)	£124.5 million	£132.2 million	£111.7 million	£73 million*

* = provisional figures, not yet fully validated.

Question 171 (Mr Richard Bacon): *Can you please supply a table showing all expenditure on temporary nursing staff in each of the last 10 years, broken down by agency nursing, bank nursing and any other sub-divisions which are used for England and Wales and how many shifts this amounted to?*

The information below applies to England as the Department of Health only holds and collects data for England.

The following figures are estimates. The footnotes for each table explain the assumptions made in arriving at the figures.

Table 1

ALL TEMPORARY NURSING STAFF (AGENCY AND BANK)

Year	*Estimated spend on temporary nursing staff*	*Estimated number of temporary staff shifts*
1995–96	£492 million	5.5 million
1996–97	£529 million	5.7 million
1997–98	£609 million	6.4 million
1998–99	£687 million	6.9 million
1999–2000	£795 million	7.7 million
2000–01	£913 million	8.7 million
2001–02	£1,093 million	10 million
2002–03	£1,269 million	11.4 million
2003–04	£1,245 million	11.1 million
2004–05	£1,098 million	9.6 million

1.1 Spend on temporary nursing staff is based on recorded agency spend and *estimated* bank staff spend (see tables below).

1.2 This table is simply presenting the combined results of the tables in sections 2 and 3.

Table 2

AGENCY NURSING STAFF

Year	*Non-NHS (agency) spend on nursing*	*Estimated Agency shifts*
1995–96	£167 million	1.5 million
1996–97	£191 million	1.6 million
1997–98	£216 million	1.8 million
1998–99	£272 million	2.2 million
1999–2000	£362 million	2.9 million
2000–01	£435 million	3.4 million
2001–02	£554 million	4.2 million
2002–03	£590 million	4.4 million
2003–04	£525 million	3.8 million
2004–05	£413 million	2.9 million

2.1 Estimated agency shifts are calculated from financial returns data—trust financial returns (TFR), PCT financial returns (PFR) and HA/SHA financial returns (HFR)—which provide spend on non-NHS (agency) nursing salaries and wages.

2.2 Trust (TFR) spend in 2004–05 has been uplifted by 4% to account for the estimated spend by ten trusts who received foundation trust status and did not report to the TFR in 2004–05. This is based on the proportion of the TFR non-NHS spend on nursing spent by these trusts in 2003–04.

2.3 The number of shifts is estimated using the average agency hourly cost specified in the NAO report (£19.11 per hour in 2005).

2.4 The hourly rate for earlier years is estimated by deflating the 2005 figure using the GDP deflator (http://www.hm-treasury.gov.uk/economic_data_and_tools/gdp_deflators/data_gdpfig.cfm)

2.5 Dividing the non-NHS spend on nursing by the hourly rate gives an estimated number of hours. This is then divided by 7.5 to estimate the number of shifts (assuming five shifts per week and a 37.5 hour week).

Table 3

BANK NURSING STAFF

Year	*FTE bank staff*	*Estimated spend on bank staff*	*Estimated number of bank shifts*
1995–96	15,546	£325 million	4 million
1996–97	15,610	£337 million	4 million
1997–98	17,654	£393 million	4.6 million
1998–99	18,204	£415 million	4.7 million
1999–2000	18,642	£434 million	4.8 million
2000–01	20,262	£478 million	5.3 million
2001–02	22,286	£538 million	5.8 million
2002–03	27,268	£679 million	7 million
2003–04	28,084	£720 million	7.3 million
2004–05	26,000	£685 million	6.8 million

3.1 Estimated spend on bank nursing staff and estimated number of bank shifts are calculated using data from the Information Centre's non-medical workforce census.

3.2 These data are presented in the second column of the table above.

3.3 Census data are presented as number of full time equivalents (fte).

3.4 Estimated spend on bank nursing staff is calculated using the average bank hourly cost specified in the NAO report (£13.73 per hour in 2005).

3.5 The hourly rate for earlier years is estimated by deflating the 2005 figure using the GDP deflator (http://www.hm-treasury.gov.uk/economic_data_and_tools/gdp_deflators/data_gdp_fig.cfm)

3.6 The estimated total spend is estimated by multiplying the fte figure by 52 weeks of 37.5 hours at this hourly rate.

3.7 The number of bank shifts is estimated by multiplying the fte figure by 52 weeks and five shifts per week.

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