NHS Professionals

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Medical locum expenditure: treating the disease, not the symptoms

1 Contents

2

Chief executive's foreword

Throughout 2011/12 it became increasingly clear from feedback from our Client Board and in-house client relationship teams, that cost and quality issues associated with medical workforce expenditure were a source of growing concern to Trust leadership teams.

> QIPP plans to reduce spend on agency (non-NHS staff) to 2008/09 levels of at least £1.4bn by 2013/14. This equates to an efficiency saving of approximately £500m against a 2008/9 baseline or £800m applied against the total spend in 2009/10 of £2.2bn.[1]

We know from many years' experience managing flexible workforce solutions for Trusts throughout England, which includes running large banks of nurses and care support workers, that insight and planning drive up quality and bring down cost.

We wanted to see whether some of our highly successful models could be applied to managing locum doctor supply, and as a starting point convened a round table of senior NHS managers and clinicians chaired by The King's Fund chief executive, Professor Chris Ham. The findings of this illuminating event are outlined in this report and will shortly be supplemented by a second diagnostic and recommendations report based on an in-depth research project commissioned by NHS East Midlands to review locum doctor usage.

I am proud that NHS Professionals continues to lead the way in providing valuable insight to the wider service, and remains at the forefront of understanding and managing the supply of temporary doctors and nursing staff.

Stephen Dangerfield
Chief executive, NHS Professionals

[1] Managing the Flexible Workforce: Department of Health webinar 28 February 2011; http://www.nhsemployers.org/SiteCollectionDocuments/Flexible workforce presentation DH.ppt

3

Executive summary

The reported rising cost of locum doctors' fees has driven the narrative around their usage to such an extent that one might assume the solution to reducing spend lies solely in managing the often criticised agencies.

However, a recent round table convened by NHS Professionals has revealed a more complex picture. Attended by senior managers and clinicians from a wide range of NHS organisations, and chaired by The King's Fund chief executive, Professor Chris Ham, delegates reported a series of complex reasons for rising locum spend that go to the very heart of national NHS workforce planning and will not be fixed by procurement frameworks alone.

On the face of it there appears to be a curious anomaly. Many Trusts are taking proactive steps to manage their temporary nursing workforce and are seeing substantially reduced agency spend. Yet the cost of locum doctors remains stubbornly high on Trusts' balance books and, while it is recognised there is much good practice, many Trusts are at risk of tackling only part of the problem.

As the Chair noted, Trusts appear to be addressing only the part of the problem that is readily visible, while nine-tenths of the demand and expenditure 'iceberg' remains concealed from view.

This paper examines what lurks beneath the waterline. It is clear that until we engage with the underlying causes of high levels of locum spend, Trusts' efforts to achieve the cost reductions demanded of them may fall short of expectations.

As QIPP (Quality, Innovation, Productivity and Prevention) targets to reduce temporary staffing costs by £300m by 2014 loom, the next few months are critical for Trusts that, as delegates suggested, need to recognise, assess and set solutions for a flexible locum doctor workforce that meets the demands of the NHS today and in the future. And, in addressing locum management, Trusts can be reassured that they have the policies and processes in place to maintain high standards of patient safety and care.

4

Findings at a glance

- Are Trusts as powerless to reduce spend on locum doctors as many claim? No, the solution lies in demand management.
- Lack of data from one central source within the Trust was identified as an overwhelming reason why Trusts fail to manage locum doctor spend.
- In extreme cases, Trusts may not even know how many locums they have working for them.
- Participants agreed it was vital to know where the gaps are.
- Management information and authorisation controls can deliver 15% savings, with improved invoice accuracy delivering another 4 – 5%.
- Workforce planning should be driven by service demand rather than the current workforce profile. Too few Trusts have a medical workforce strategy that is fully integrated with the business planning process.
- Building a long-term relationship with locums, rather than regarding them as a commodity, will improve continuity of care and reduce agency costs.
- One of the underlying difficulties is the disconnect between workforce planning and medical education.
- Trusts must be wary of failing to comply with the Agency Worker Regulations and Part Time Work Regulations.
- HR and staffing functions cannot own this agenda: it is the responsibility of the Board and senior management team.
- Doctor revalidation, due to come into force in December 2012, should provide Trusts with greater reassurance that the locums they employ are of acceptable quality.
- Trusts should be more robust in challenging poor agency behaviours.
- It is generally agreed that procurement teams should lead negotiations with agencies.
- There has been a widespread failure to share good practice between Trusts and SHAs, and internally, between nurse banks and the people booking medical locums.
- The key to sustained reduction in locum spend is effective medical workforce strategy and planning by the executive team.

5 State of play

Severe national economic pressures persist, with the NHS facing a target of reducing expenditure on temporary staff by £300m by April 2014 as part of the Quality, Innovation, Productivity and Prevention work programmes. This makes it imperative that medical locum expenditure, which remains by far the largest area of uncontrolled expenditure per capita in Trusts' temporary worker costs, is addressed as a matter of urgency.[1]

In addition to the high – and rising – level of costs, figures show wide variations between Trusts, reflecting marked inconsistencies and lack of transparency in how they monitor expenditure and medical staff attendance. Alarmist coverage in the press has highlighted 'exorbitant' pay rates for locums and fears about dangerous gaps in medical cover.[2]

The dual objective for Trusts must be to maintain and improve patient care while managing a workforce that reflects the changes within the NHS and commissioning arrangements. This necessitates having greater workforce flexibility and interrogates when, why and which type of locums should be used.

[1] NHS Employers and Department of Health National Workforce Programme

[2] Daily Mail, 18th March, 2012: 'Agency doctors being paid 'footballers' wages' of up to £20,000 a week to cover NHS staff shortages', Tamara Cohen

Read more: http://www.dailymail.co.uk/news/article-2116654/NHS-spends-hundreds-millions-agency-doctors-staff-shortages-caused-European-rules.html

Daily Telegraph, 25 March 2012: 'Agencies make millions from £120-an-hour doctors', Jason Lewis.
http://www.telegraph.co.uk/health/healthnews/9164697/Agencies-make-millions-from-120-an-hour-doctors.html

6

Measuring the problem

At the heart of the debate lies a fundamental question: Are Trusts as powerless in reducing spend on locum doctors as many might claim to be? It was argued that the answer is no, and the solution lies in demand management. However, it's far harder to tackle demand through better workforce planning than it is to see agencies reduce their hourly rate by £10, despite the fact that greater savings could be made by addressing the root of the problem.

A further concern for the round table participants was that Trusts are working to tackle this problem without insight into their current usage. Lack of data from one central source within the Trust was identified as an overwhelming reason why Trusts' attempts to get a grip on the problem might fail at the outset. Without access to consistent management information, Trusts are unable to understand the patterns of demand for locum doctors and manage shift fill more cost-effectively.

Some Trusts still lack an answer to the most basic question of all: Why do they need locums? Is it to cover holidays or to plug longer-term gaps in the workforce? In extreme cases, Trusts may not even know how many locums they have working for them, which clearly makes demand management impossible.

Jonathan Parsons, associate medical director at Leeds Teaching Hospitals NHS Trust, agreed: 'We simply don't know why we need locums. Part of my work with e-rostering is suggesting locums are not actually filling gaps, they are filling historical gaps.'

For Andrew Milner, programme lead, NHS Employers, all the issues under discussion led back to lack of data: 'For specialties it's sometimes hard to use framework agencies, but for me it's about going a step back and asking, why do we need these locums in the first place?'

Mr Parsons added: 'We need information and a managed system would help with that. We need to understand where the gaps are coming from.'

It is the lack of data and management information to build upon the foundation for a tailored flexible workforce strategy which has left many Trusts at the mercy of some agencies, according to Neil Baigent, category lead - health, professional services directorate at Government Procurement Service. 'As soon as a Trust goes to some, not all, agencies with a requirement to fill a vacancy at the last minute, those agencies know that you are at your most vulnerable to ensure continuity of patient care. Some agencies make best use of this vulnerability by encouraging the Trust to pay a higher premium for that locum doctor or accepting reduced safeguarding and employment checks. It comes down to challenging the culture, improving the lack of data and examining alternative ways to use substantive staff more flexibly – that's what we need to address. The lack of data is allowing this to perpetuate.'

Claire Rix, organisational development consultant at NHS Professionals, acknowledged there was a tendency to blame expenditure on the agencies 'because it's easier than tackling the more challenging issues of managing demand'. She added that there is a case to be made for 'spending to save' and outlined a typical Friday night scenario where Trusts are turning to agencies as an emergency measure because they do not have adequately inducted doctors of their own.

Mr Baigent agreed: 'NHS trusts need to look internally at both their flexible workforce and procurement strategies for locum doctors before looking at the commercial service providers they go to, including agencies.'

A single operating model, which includes a single set of policies and procedures on issues such as timesheet authorisation and invoice validation, can deliver significant savings. Jenny Hargrave, head of workforce strategy at NHS Professionals, has found that: 'Management information and authorisation controls can deliver 15% savings, with improved invoice accuracy delivering another 4 -5% within a two-year period.'

7 Workforce planning

For all, access to this type of data was just the starting point. What many Trusts seem to fail to do, is take a planned approach to their medical workforce management, built on a solid rationale.

Workforce planning (WP) should be driven by service demand rather than the current workforce profile. Too few Trusts have a medical workforce strategy that is fully integrated with the business planning process, specialist knowledge and resource allocation to respond to staffing needs. This failure to forecast future demand reduces opportunities for collaborative work with other Trusts, which might reduce the need for agencies even further.

Most job planning processes are still based on the current consultant profile rather than the Trust's service demand. Often, information is only stored locally, there is little opportunity for analysis and monitoring and there is a heavy reliance on paper-based systems.

One East Midlands SHA Trust brought in experts to move all consultants onto new job plans based on both the Trust's business plans and on demand, rather than historical reasons such as consultants' special interests. The experts took much of the politics out of the implementation leaving management free to move forward.[3]

Failure to plan also leads to some missed opportunities. Round table participants emphasised that use of locums as a commodity, rather than building a long-term relationship with them, is missing the opportunity to improve continuity of care and reduce agency costs.

Jenny Hargrave, head of workforce strategy at NHS Professionals estimated that some 80 per cent of doctors return to the area where they trained. 'There is a mind-set that we have to pay top whack or bus someone in from Scotland.'

Helen McGill, clinical director and responsible officer for NHS Professionals, agreed that many junior doctors 'probably have loyalties to key Trusts, but we just don't capture them.'

Managing demand can also be achieved through looking at the optimum contract period for locum doctors. There is a clear link between vacancy levels within a Trust and the demand for longer-term medical locums (over four weeks). The control of longer-term locum bookings is best managed in the same way as vacancies – for example, through a vacancy control group – and the information reported back to the medical workforce planning group.

[3] East Midlands Human Resources Directors Group and Strategic Health Authority Medical Locum Review, July 2012, Claire Rix

8

Deaneries as Trust supplier

One of the underlying difficulties facing Trusts was identified by Andrew Milner as the 'disconnect' between workforce planning and medical education; several round table participants spoke of the need to align Deaneries with Trusts' workforce needs.

The Trusts found it particularly irksome when Deaneries did not inform them in good time that junior doctor training posts had not been filled, leaving the Trust to resort to agency use to fill the gap. Carolyn Apps, resourcing manager, East Kent Hospitals University NHS Foundation Trust emphasised this point, stating there were often gaps in medical workforce that could be filled by a fixed term substantive appointment, but there is rarely enough time to undertake the recruitment checks required by the time they identify need, resulting in an over reliance on agency medical locums.

Ms Apps added: 'We regularly push back to the Deaneries to say we want to fill these gaps locally with LASs[3] but we can sometimes wait until the week prior to commencement of a rotation before we're allowed to start recruiting them. It makes it so hard to take that proactive approach but would sometimes be more beneficial for the running of our services if we were allowed more flexibility.'

Bill McMillan, head of medical pay and workforce at NHS Employers, perceived medical education and Trusts' lack of input into workforce planning at national level to be at the heart of Trusts' problems: 'How many juniors do we need? What are we training doctors for?'

Where there are gaps in junior doctors' rotation, round table participants called for collaborative recruitment with other Trusts. With difficult-to-fill medical posts, could another staff group, such as assistant practitioners, pick up some or all of the work?

There are a number of areas in which Trusts can work with Deaneries to:

- identify alternative ways of covering rotation gaps;
- ensure earlier notification of rotation gaps;
- agree a performance management framework for the Deaneries;
- ensure implementation of a region-wide Medical Training Initiative to provide a possible entry route for overseas doctors wishing to work in the NHS.

These issues now fall within the remit of the newly formed Health Education England (HEE). Its chief executive, Ian Cumming, has said HEE will give commissioners the freedom required to create flexible workforces that meet their own local needs: 'We need to train people who are flexible and adaptable', and added: 'There are some parts of the country and some Trusts where I do not believe workforce planning has been taken as seriously as it should have been in terms of thinking about the consequences for themselves about the supply of the workforce in the future.'[4]

[3] LAS is Locum Appointment for Service - less formal appointment carried out by a hospital and does not count towards total time required for Certificate for Completion of Training (CCT) for entry to the GMC register

[4] Health Service Journal, 12 July, Shaun Lintern
http://www.hsj.co.uk/news/workforce/exclusive-new-workforce-chief-promises-staff-flexibility/5046859.article?blocktitle=Workforce&contentID=8810

9

Risk exposure and governance

At the heart of round table participants' concerns over employment of medical locums was the risk to patient safety by their mismanagement.

At a very practical level, there were particular concerns among round table participants that inductions were not being properly carried out at evenings and weekends – the very times when shift-fill is often needed – because the relevant staff or systems are not available.

Trusts may also risk exposure in other areas. While Trusts have put enormous effort into ensuring compliance with the Working Time Regulations (WTR), many are inadvertently overlooking the demands of the Agency Worker Regulations (AWR) and Part Time Work Regulations (PTWR), which provide part-time workers with important employment protection rights encompassing both pay-related issues such as pension entitlement, and non-pay-related issues. While agencies may neglect these issues, compliance remains the responsibility of the Trust.

Mr Baigent also expressed concerns about the number of NHS trusts going 'off framework':

'There are currently 51 framework agencies and many more locum doctor recruitment agencies out there, which could be easily used by NHS Trusts today. However, this marketplace is not as closely regulated as other areas, for example, the Finance and IT industry. We could all leave this room now and go and set up a locum doctor agency, trading from our garden shed and supplying workers into the NHS. However, our framework agreement provides NHS Trusts with the assurance they need to help them meet their CQC, NHS Litigation Authority and NHS Protect governance requirements. Each appointed agency is of high quality, has been vetted in terms of their financial and business suitability, subjected to ongoing performance management and regularly health assured and audited by Government Procurement Service. Contractually, they continue to meet all relevant codes of practice, legislation, regulations and standards. It is therefore understandable [in the absence of close regulation] that our framework agreement be widely adopted and used by Trusts when they are looking to source locum doctors from agencies.'

Recognising the pivotal role of HR in these issues, the Chair identified what he described as an NHS-wide historic 'neglect of the HR function' and wondered if there might be a case for renewed investment in training. Others agreed that doctors are usually dealt with by the medical staffing function which may sit under HR or the medical director and is often regarded as HR's poor relation.

Ms Rix agreed: 'So many Trusts will say 'we developed our own spreadsheets, we use paper timesheets, our doctors don't need to record their attendance, job plans are held in divisions and we don't have any centralised reporting. There's a lack of spend to save.'

But HR and the staffing functions cannot own this agenda and it is the responsibility of the Board, senior management team and clinical leads to put in place strategies to drive down demand, costs and manage risk.

The Chair identified the dangers to the whole service, and the potential for wider political fallout, if the problem remained unsolved: 'If bad things happen in the NHS because use of locums is not watertight, the public would be outraged. Whose job is it to reassure the public that bad things won't happen with the use of locums?'

10 Revalidation

Doctor revalidation, due to come into force in December 2012, will provide Trusts with far greater reassurance that the locums they employ are of acceptable quality. As the Chair put it, the need for doctors to have to prove their fitness to practise, is 'the key to regulating [locum] quality'.

But Trusts must be up-to-speed with implementation. All employing organisations will have to appoint a Responsible Officer to report to the General Medical Council on doctors' fitness to practise, every five years. The cornerstone of revalidation is the annual appraisal and Trusts will need to assess how many appraisers they need to carry out annual appraisals and ensure that they are suitably trained and supported.

11 Standing up to agencies

With cost considerations and risk recriminations bearing a weight of responsibility on Trusts, delegates questioned why many had failed to stand up to the agencies and strike a better deal.

All the participants had experience of bad behaviours by agencies and felt that lack of regulation in relation to either price or quality has created a sellers' market in which unscrupulous agencies quite literally trade on the perceived 'desperation' of Trust managers to fill shifts.

Mr Baigent said: 'You've got some agencies, which, through lack of regulation, are unscrupulous and all they're interested in is profit. They're talking numbers whereas the NHS is talking care.'

There was concern that some locum doctors are happy to participate in this culture of exploiting market forces and play agencies off against one another in order to maximise earnings. Crucially, lack of data is allowing these attitudes to be perpetuated.

Ms Hargrave highlighted a widespread failure to understand the demographic of the locum workforce and queried the assumption that doctors would always 'go to the highest [agency] bidder'.

There was widespread feeling that Trusts should be far more robust in challenging bad agency behaviours and that sometimes there is a tendency to allow them to 'get the upper hand'. However, it was also pointed out that there are many Trusts that have progressed in this area, working with framework agencies that work hard to maintain their framework status and procurement terms.

Bill McMillan at NHS Employers believes that doctor revalidation will assist Trusts in managing the agency relationship. 'There will be a higher demand for better exit reports, feedback process, and evaluation and so on. Systems will be in place which will make information more accessible, specific and relevant.'

But the frustrating aspect for many delegates was the fact that very simple management approaches could make a difference to the power balance.

Although daunting at first, the HR department, backed by the Board in East Kent, undertook a major review of their agencies checking compliance procedures, and formalising key processes around placement and invoicing. The process has whittled down the number of agencies they work with who, in return, demonstrated greater loyalty and provided better rates as they have fewer agencies to compete with for business.

Ms Apps, resourcing manager, East Kent Hospitals University NHS Foundation Trust, explained how her Trust had taken steps to address this: 'We have done an awful lot of work in developing our own locum framework. **At one point we were just spiralling out of control and the expenditure was ridiculous, so about eighteen months ago we put in place our own framework and we don't go off that framework.**

'We are probably a bit ahead of the game; our spend is significantly smaller than a lot of other Trusts out there, particularly for our size. But we did that purely by enforcing frameworks and using very few locum agencies. And it is about being brave enough to say I know we need to fill a gap but with the cost limit we have, the agencies will have no choice but to provide a doctor within the cost that we have agreed. And it is not an easy thing to do, it won't happen overnight, but every Trust has to be brave to enforce this and abide by the fee structure and the governance rules.'

It was generally agreed that procurement teams should lead the negotiations with the individual agencies to drive down rates, and that the various Trust staffing management teams, including staff bank and medical staffing, could and should work with procurement hubs more productively.

12

Service reconfiguration

Perhaps the most far-reaching discussion at the round table was the proposition that reconfiguration of services might be necessary in order to achieve the essential reductions in locum expenditure.

Mr Parsons flagged up the mistaken assumption that locum fill was always the right answer. 'If there is a gap in the service, we fill it with a locum rather than considering alternatives – are there other options or other staff to fill the gap? This is what we should look at.' Others commented that it should also be asked what the risk would be if the assignment were not covered.

In addition, there is an identified need for far greater cross-organisational collaboration - what Mr Parsons identified as 'sharing training, protocols and staff'.

There are a number of approaches that Trusts could explore either individually or in collaboration with others:

- move to a trained doctor-delivered service as part of a multi-professional team;
- implement new and advanced roles within nursing and for AHPs;
- change skill mixes within teams through, for example, the development of physician assistant roles;
- introduce new technology to facilitate changes to traditional working practices – for example, new technology allows radiologists to review images remotely or even at home, reducing demands for on-site out-of-hours radiologist cover;
- change service delivery through innovations such as Hospital at Night teams.

13

Capturing best practice and shared learning

Many Trusts have used a variety of management and operational techniques to reduce the use of nursing agency staff with considerable success, in particular, to target the 'distress purchases' for last-minute shift-fill which force many Trusts to turn to high-cost, off-framework agencies – the dreaded '6 o'clock call on a Friday night'.

Round table participants said there had been a widespread failure to share good practice between Trusts and SHAs, or internally, between nurse banks and the people booking medical locums. As Ms Rix, organisational development consultant at NHS Professionals, put it: 'We need to share best practice and innovation, and what works – not what might work.'

Taking learnings from the management of temporary nursing staff, many of these strategies can be applied to reducing demand for medical locums:

- negotiation of bulk agency rates across Trusts and SHAs;
- escalation and authorisation policies regulating the use of locum agencies and discouraging all use of off-framework agencies;
- IT systems and infrastructure such as e-rostering to support the sharing of intelligence on bank and agency usage;
- filling vacancies most appropriately, such as adoption of a core-periphery model, whereby a more flexible contract is applied, allowing for peaks and troughs in demand while providing worker continuity.

14

Conclusion

With demand and costs ever rising, there is clearly a need for Trusts to grapple with the issue of better demand and supply management of locum doctors. Half-hearted attempts will only result in half-hearted results. What is required, is a systemic review of all systems, processes and relationships around locum doctor use. Managing the agency relationship is just one aspect - tackling demand and addressing system redesign are critical to taking spiralling locum costs in hand. **The key to sustained reduction in locum spend is effective medical workforce strategy and planning that is owned by the whole organisation and led by the executive team.**

In delivering this, Trusts need to build more productive and collaborative partnerships with agencies, locums, Deaneries and each other to get more value. They also need to have clear forecast and management mechanisms to ensure the appointment of a locum doctor is justifiable on all levels.

However, it's not just about relationships. Without data to provide clear management information, Trusts are effectively blind to their needs both now and in the future.

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