Planning ward nursing – legacy or design?

A follow-up report

Prepared for the Auditor General for Scotland

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Part 1. Setting the scene

NHS boards and the SEHD have made progress in addressing the recommendations made in Audit Scotland's baseline report.

1. Nurses and midwives are the largest staff group in the health service. There were 55,469 whole time equivalent (WTE) nurses and midwives as at 30 September 2005, representing 43 per cent of the workforce of the NHS in Scotland.[1] Eighty-four per cent were employed in hospitals and £1.34 billion was spent on nurses and midwives in the hospital sector in 2005/06. This represented 45 per cent of staff costs in that sector.[2] The size and skills of the nursing workforce mean that it has a crucial role to play in delivering high-quality, efficient healthcare.

2. To carry out this role, the nursing workforce needs to be effectively planned. Audit Scotland carried out a baseline study of ward nurse planning in 2002. The aim of the baseline report was to analyse how ward-level nursing workforce planning was being carried out in the NHS in Scotland and to examine the impact it had at ward level. The study was undertaken at a time when there were concerns about nursing recruitment and retention, and uncertainty about the impact of policies such as the European Working Time Directive and changes in junior doctors' hours on the demand for nurses, the supply of nurses and the roles they perform.

3. The report concluded that:[3]

- the information available on nurse deployment, costs and service quality, required by nurse managers to effectively plan the nursing workforce, varied at trust and ward level
- there was unexplained variation in the number and costs of nurses at ward level
- improvements were needed in workforce planning
- quality of care measures needed to be developed.

4. The baseline report included a range of recommendations about:

- workforce and workload planning, including the methods used to calculate ward nurse establishments
- improving information on the quality of nursing care
- recruitment and retention
- the use of bank and agency nursing.

5. The baseline report also included commitments to review progress against these recommendations and review the impact of the Scottish Executive's work on nursing recruitment, retention and workforce planning and development.

6. Since the report was published, the context for ward nursing workforce planning has evolved rapidly. Trusts and NHS boards have been brought together so responsibility for addressing recommendations aimed at trusts now rests with the unified health boards. Agenda for Change has been introduced, changing nursing pay, terms and conditions, professional development and, potentially, the way the nursing workforce is used in the NHS in Scotland.[4] New contracts for consultants and for General Medical Services and changes in the way junior doctors are trained have been introduced. The Kerr Report and the response of the Scottish Executive Health Department (SEHD) set out changes in the way health care will be delivered in the future.[5 6] These developments will affect the demand for, and skills required of nursing staff.

7. Given these developments, we assess progress on the broad themes covered by the recommendations made in the baseline report, rather than assessing each recommendation individually. We also consider developments in wider workforce planning where relevant to the development of nursing workforce planning.

Key messages

- NHS boards and the SEHD have made progress in addressing the recommendations made in Audit Scotland's baseline report. This has laid the foundations for better ward nursing workload and workforce planning in the future.
- Work is underway to improve the information available on the nursing workforce, nursing workload and the quality of nursing care. Further work is required before this information can become a routine part of workforce planning.

1 ISD Workforce Statistics. There were 56,369 nursing and midwifery WTEs as at 31 March 2006 but no data are currently available in the ISD Workforce Statistics on the number of nurses in hospital specialties on that date.
2 *Scottish Health Service Costs 2005/06,* ISD, 2006.
3 *Planning ward nursing – legacy or design?,* Audit Scotland, 2002.
4 http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingPay/AgendaForChange/fs/en
5 *Building a health service fit for the future.* The 'Kerr Report', Scottish Executive, 2005.
6 *Delivering for Health,* Scottish Executive, 2005.

- Most boards have not met national recommendations on building additional time into nurse staffing requirements to cover annual leave, sickness absence, study leave, maternity leave and protected time for senior nursing staff with team leadership responsibilities.

- The SEHD, NHS boards and NHS Education for Scotland (NES) have implemented a wide range of recruitment and retention programmes, including work to enhance the roles and skills of existing nursing staff. Vacancy rates changed little across Scotland as a whole between March 2002 and March 2006 and long-term vacancy rates remained low. Vacancy rates vary among specialties and NHS board areas.

- Between 2001/02 and 2005/06, the use of agency nurses fell by 17 per cent, although expenditure changed little. The use of bank nursing has increased by 73 per cent and expenditure has increased by 121 per cent over the same period. This is partly due to measures taken to promote nurse banks by improving the management and terms and conditions of bank nurses. NHS boards need to keep the growth of bank nursing under review.

About the study

8. The scoping phase of the current study revealed that several strands of work had begun to address the recommendations in the baseline report. The scoping phase also showed that the work was ongoing and that it would be too early to undertake a full assessment of its impact. Therefore, the aim of this report is to identify progress and outstanding issues in the work being undertaken, taking account of the changing environment in which nursing workforce planning is taking place.

9. We used a variety of methods and sources of information in the study:

- Analysis of workforce statistics published by the Information Services Division (ISD) of National Services Scotland (NSS).

- Interviews with directors of nursing in the 14 area NHS boards and the Golden Jubilee National Hospital, regional nursing workload advisers, regional workforce development directors and the SEHD officials with responsibility for nurse workforce planning and quality indicators.

- Document review:

- regional and board workforce plans, focusing in particular on the nursing sections of the plans

- minutes of the meetings of the Nursing and Midwifery Workload and Workforce Planning Project (NMWWPP)

- minutes of the Expert Advisory/ Action Group (EAAG) and Adult Acute subgroup of the NMWWPP

- updates submitted by boards to the SEHD on progress made in implementing the recommendations contained in the NMWWPP and Nationally Coordinated Nurse Bank Arrangements (NCNBA) reports.

10. We did not look in detail at the midwifery workforce, the State Hospital or community nursing because these areas were not included in the baseline report.

Part 2. Planning the ward nursing workforce

Key messages

- Several streams of work addressing the recommendations in the baseline report have laid the foundations for the future development of ward nursing workforce planning.
- Most boards are not achieving recommended predictable absence allowances or protected time for nursing staff with team leadership responsibilities.
- Since the baseline report, the SEHD has taken steps to improve the information available on the nursing workforce and to develop the use of tools for measuring nursing workload. Further work is required before these tools can be used routinely.
- Boards are monitoring the quality of nursing care in a variety of ways but there is no national system for routinely compiling data on an agreed set of quality indicators.
- The SEHD needs to clarify whether the action points set out in the NMWWPP to develop nursing workforce and workload planning are recommendations to, or mandatory requirements of, the NHS in Scotland.

11. In this chapter we look at the development of nursing workforce planning and the information required to inform workforce planning. In the baseline report most of the recommendations made by Audit Scotland were about planning nursing at ward level but we also made recommendations about nursing workforce planning at trust and board level and about the wider development of workforce planning. Therefore, in this chapter we consider:

- developments in workforce planning for the wider NHS workforce
- developments in nursing workforce planning
- measures to develop workforce planning skills
- allowances in nursing establishments to cover predictable absences and time out for nurses with team leadership responsibilities
- information to support nursing workforce planning
- challenges to the development of nursing workforce planning.

Several streams of work have laid the foundations for the development of workforce planning

12. Ward nurse planning needs to be embedded in higher level planning that takes account of the demand for and supply of nursing staff at board, region and national level. In addition, the numbers of nurses required and the skills they need are affected by changes in the demand for and supply of other staff groups. This is reflected in the work

undertaken to develop workforce planning since the baseline report in 2002. The SEHD has published a number of documents on workforce planning.[7 8 9] The National Workforce Unit was established in 2002 to oversee the work programme set out in *Working for Health*.[10] The National Health Service Reform (Scotland) Act passed in 2004 placed on boards a statutory obligation to put in place arrangements for workforce planning. Most recently, the *National Workforce Planning Framework*[11] provided a template for developing workforce plans and set out a number of key actions and timetables for producing local, regional and national workforce plans. Regional plans were produced by January 2006 and local plans were produced by boards in April 2006. Updated regional plans have been produced and a national plan was produced in December 2006.

13. The SEHD issued guidance on the development of boards' and regions' workforce plans.[12] The guidance requires boards to consider the main factors affecting the development of the workforce and sets out the information required to quantify their effects on workforce demand and supply. The guidance also encourages boards to plan the workforce on the basis of the multi-professional teams needed to provide services, rather than the size and skill mix of particular staff groups.

14. We assessed each of the plans against the guidance and examined the data and projections specific to the nursing workforce.

15. The plans address the key themes in the guidance from the Scottish Executive but the level of compliance with the data requirements set out in the guidance is variable. In these first plans there is limited detail on the methods used to calculate workforce projections. The guidance recognised that the first workforce plans would reflect current levels of expertise and data and that the plans will develop further in the future.

16. Regional workforce planning arrangements have been established within each of the three regions: north, south-east and west.[13] Regional workforce directors have been appointed in each region and regional workforce planning groups have been set up comprising representatives from boards and dedicated regional workforce planning staff. The regional workforce planning groups are responsible for producing the regional workforce plans. They work with boards to support workforce planning and development, in particular where regional approaches help to integrate workforce development and planning of services at board level.

A number of actions have been taken to develop nursing workforce planning

17. In 2004, the SEHD published the NMWWPP report which described how boards were:

- examining nursing workload
- planning the nursing workforce
- measuring the quality of care at an operational level.[14]

18. The project report included 20 action points which addressed the areas covered by the recommendations in our baseline report. The action points were about:[15]

- using bank and agency nursing
- developing data and tools for workload and workforce planning that take account of patient dependency
- educating and training staff in workload and workforce planning skills
- developing flexible working to improve recruitment and retention and enhance patient care
- incorporating protected time for managerial duties and predictable absence allowances into nursing establishments

7 *Planning Together – Final Report of the Scottish Integrated Workforce Planning Group and Response by SEHD*, Scottish Executive, January 2002.
8 *Working for Health – the Workforce Development Action Plan for NHSScotland*, Scottish Executive, 2002.
9 *The Scottish Health Workforce Plan – Baseline 2004*, Scottish Executive Health Department, 2004.
10 *Working for Health – the Workforce Development Action Plan for NHSScotland*, Scottish Executive, 2002.
11 *National Workforce Planning Framework*, Scottish Executive, 2005.
12 *National Workforce Planning Framework 2005 – Guidance*, NHS HDL(2005)52, SEHD, November 2005.
13 North region includes Tayside, Grampian, Highland, Orkney, Shetland, Western Isles. South-east region includes Lothian, Borders and Fife. West region includes Greater Glasgow and Clyde, Lanarkshire, Dumfries and Galloway, Ayrshire and Arran, Forth Valley.
14 The project also assessed the information management and technology systems being used to collate and analyse workforce data.
15 *Nursing & Midwifery Workload & Workforce Planning Project*, SEHD, 2004.

Exhibit 1

Developing the skills for planning the nursing workforce

Following an assessment of the training needs of the workforce involved in nursing workforce planning, NHS Grampian, in collaboration with the Robert Gordon University, has developed a short course for healthcare professionals in workload planning and workforce management.

It is designed for nursing and non-nursing staff in a variety of roles with responsibility for workload planning and workforce management. The course is delivered online. Course content includes skill mix, workforce analysis, workload measurement tools, workload planning, staff utilisation and multi-professional working.

All 80 places available in the first year of running the course have been taken up by staff from across Scotland, funded by the SEHD.

NHS Grampian has developed the course as part of a programme of work to improve ward nurse planning. This includes comparing ward nurse staffing levels in Grampian to those in hospitals in England and Wales using data compiled by the Healthcare Commission in 2005. NHS Grampian has also piloted the use of Telford methods to review nurse staffing levels in relation to nursing workload.[16]

Sources: NHS Grampian; SEHD

- assessing progress in developing comparative workload and workforce planning indicators in national performance assessment arrangements
- developing action plans to take these issues forward.

19. The action points were accepted by the Minister for Health and Community Care.[17] In October 2005, all boards submitted action plans that set out how they intended to address the action points. Boards provide updates to the Project Steering Group on the progress they have made in implementing these plans.[18] The SEHD has funded a programme manager post to coordinate this work and three regional nursing workload advisers for two years from the start of 2006 to support boards in taking this work forward.

20. We discuss progress on these action points in the following paragraphs.

Boards are developing the staff and skills to carry out nursing workforce planning but progress among boards is variable

21. The NMWWPP report stated that directors of nursing should lead an education and training needs analysis. This should identify the education and training requirements of staff contributing to workforce planning locally in relation to calculating the required numbers and skills of the nursing workforce, budget control and resource allocation. Boards are developing these skills in the nursing workforce but progress is variable. Eight of the 15 boards had carried out an assessment by September 2006.[19] The other boards were at varying stages of assessing training needs or putting in place training in the skills required. Boards have developed a variety of approaches to meet the training needs identified (Exhibit 1).

22. Boards and regional workforce planning groups also require dedicated workforce planning staff with specialist skills to estimate the numbers and skill mix of different staff groups needed at board and regional level to meet service requirements. Audit Scotland's baseline report found that a minority of trusts had dedicated workforce planning staff. All boards now have such staff in place, in line with the recommendations made in the baseline report.

23. Further work is required to develop the skills of these staff. This work has started. The *Skills for Health* initiative developing the workforce planning competency framework sets out the skills

16 Telford-based tools for workforce planning are a way of formalising professional judgements on appropriate staffing levels into formulae for calculating nursing establishments. See *Selecting and Applying Methods for Estimating the Size and Mix of Nursing Teams*, Hurst K, April 2002.
17 *Response to the Nursing & Midwifery Workload & Workforce Planning Project*, Scottish Executive, 2004.
18 The latest updates were requested by SEHD in early November 2006.
19 Fife, Forth Valley, Golden Jubilee National Hospital, Grampian, Greater Glasgow and Clyde, Lanarkshire, Lothian, Western Isles.

required by operational and strategic workforce planners.[20] The SEHD has funded three senior workforce planners, one from each region, to participate in a new Postgraduate Certificate in Strategic Workforce Planning designed to develop these skills, delivered by Thames Valley University. The three participants are evaluating the course and, as part of the programme, exploring ways of developing a learning network for other dedicated workforce planning staff in boards in Scotland.

Not all boards are achieving recommended predictable absence allowances or protected time for nursing staff with team leadership responsibilities

24. Nurse staffing establishments should contain sufficient staff to allow for predictable absences such as periods of annual leave, sickness absence, study leave and maternity leave. These are called predictable absence allowances (PAAs). Establishments that include insufficient PAAs put pressure on existing staff; put pressure on budgets if overtime or temporary staffing needs to be arranged; and can affect the quality of care.

25. The baseline report found that PAAs varied widely among trusts. The report recommended that allowances be reviewed, agreed and incorporated into nursing establishments. This was taken forward in the NMWWPP report, which recommended that PAAs should be a minimum of 21 per cent. The report also recommended that nurse establishments should incorporate 7.5 hours per week protected time for nurses with team leadership responsibilities to focus on leadership, managerial, education and clinical governance aspects of their role.

26. Boards have made variable progress in developing and implementing plans to achieve the 21 per cent recommendation on PAAs. Four of the 15 boards we interviewed said that the recommendation was already in place.[21] Other boards were at varying stages of reviewing current allowances and analysing the implications of achieving the 21 per cent.

27. Some boards expressed concerns about the appropriateness of the recommendations regarding PAAs and protected time. A standard figure of 21 per cent may not reflect local circumstances. The recommended 21 per cent includes four per cent for sickness absence, reflecting the Efficient Government target for all NHS staff, one per cent for maternity leave and 13.5 per cent for annual leave.[22] In practice, sickness absence amongst nursing staff is higher than four per cent in all boards (Exhibit 2).

28. Boards have expressed concerns that 21 per cent will not allow enough time for the training required to help the nursing workforce meet the requirements of *Delivering for Health*.[23] In addition, extra leave and other entitlements arising from Agenda for Change need to be factored into nursing establishments, estimated to be the equivalent of a 1.2 per cent reduction in nursing workforce capacity.[24] The precise effect will vary by board according to the age and experience of the nursing workforce and will not be known until the agreement has been fully implemented. Additional annual leave allowances arising from Agenda for Change should be factored into establishments over and above the 21 per cent.

29. Protected time for nursing staff with team leadership responsibilities, such as senior charge nurses (SCNs), differs among boards. Only two boards demonstrated that they had implemented the 7.5 hours recommended for all eligible staff.[25] The remaining boards are at various stages in moving towards meeting the recommendation, such as having protected time in place for some staff and implementing protected time within PAAs as establishments are reviewed. The extent to which protected time is monitored differs among boards, and some are currently reviewing the protected time available to eligible staff.

30. Boards raised a number of issues in relation to achieving the recommended level of protected time, including:

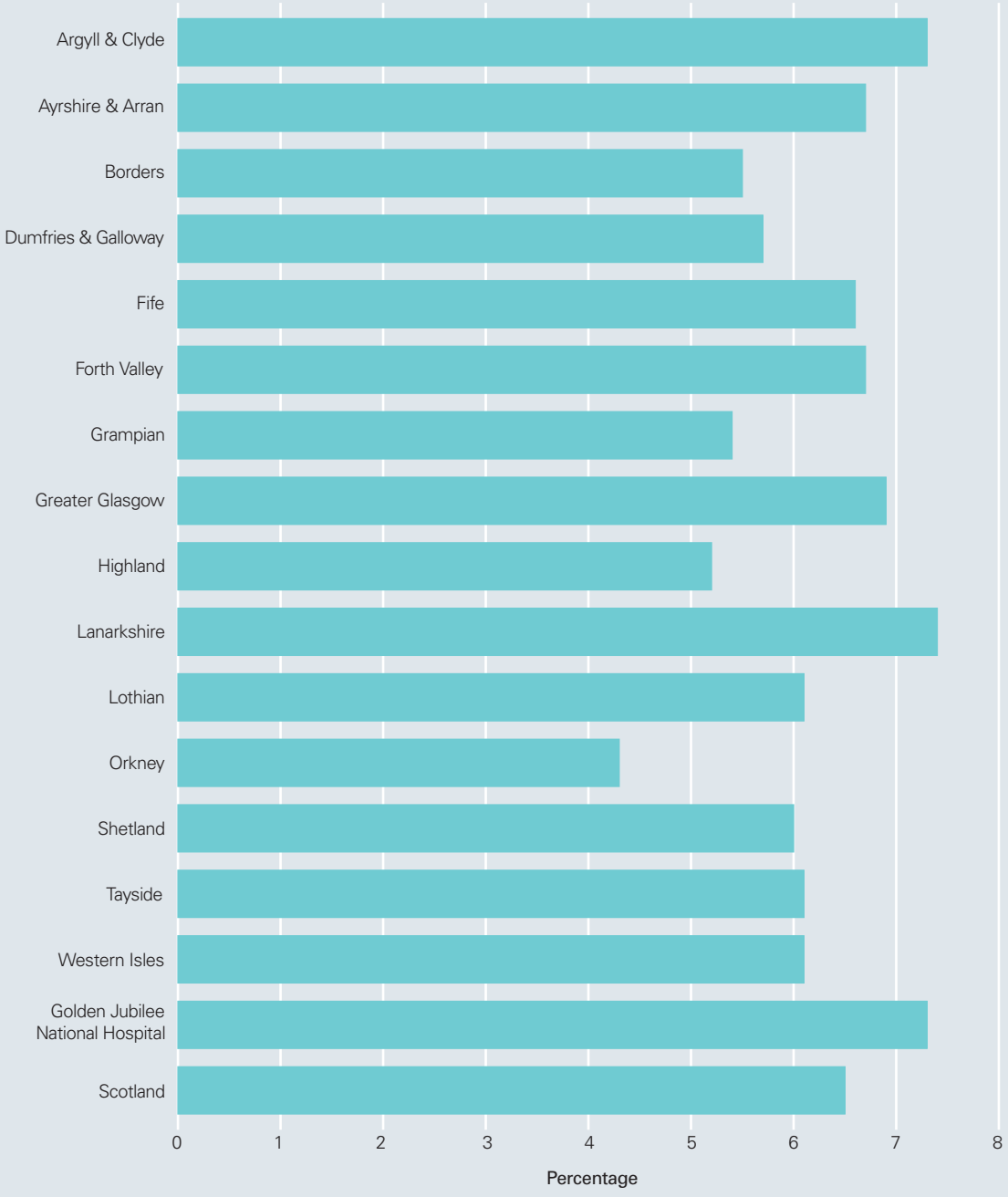
- the difficulty of demonstrating protected time in the absence of formal monitoring of whether and how it is allocated and used
- workload pressures that can prevent protected time being taken, even when it has been allocated
- whether it is always appropriate to have 7.5 hours protected time per week in teams of different sizes or in different clinical areas.

20 Skills for Health is the UK-wide body set up to define and support development of the skills required in the healthcare sector. It has a National Director for Scotland to facilitate access to the information and services it provides. http://www.skillsforhealth.org.uk/
21 Dumfries and Galloway, Golden Jubilee National Hospital, Orkney and Shetland.
22 *Efficient Government: Achievement of Time Releasing Savings Targets,* NHS HDL (2005) 51, SEHD.
23 *Delivering for Health,* SEHD, 2005.
24 *National Workforce Planning Framework,* p63, Scottish Executive, 2005.
25 Dumfries and Galloway and Golden Jubilee National Hospital.

Exhibit 2

Nursing and midwifery sickness absence by board, April 2005 to March 2006

Sickness absence rates are higher than 4% in every board.



Source: Audit Scotland analysis of data supplied by ISD

31. The balance of managerial and clinical duties carried out by SCNs is one of the issues currently being considered in a SEHD review. The review aims to identify a modern SCN role that will enable front-line clinical leaders to maximise their contribution to delivering safe and effective care. A supporting toolkit and guidance, which will describe the clinical, coordination and management functions of SCNs, will be piloted across NHSScotland in early 2007. The review is due to report in August 2007.

Since the baseline report, steps have been taken to improve the information available on the nursing workforce

32. The baseline report recommended that ISD, boards and operating divisions should work together to improve information on the nursing workforce, workload and the quality of nursing care. This information is required to better understand the relationships between the number and skills of nurses, their activity and nursing quality. This understanding is vital when reviewing and calculating nursing establishments.

33. At a national level, the Scottish Workforce Information Standard System (SWISS) is being developed to increase the range and quality of information available on the size and structure of the current workforce.[26] The aim of the project is to create a national system providing accurate and consistent information on the NHS workforce to meet the workforce planning needs of the NHS in Scotland.[27]

34. The first stage of the project involves creating a national database of workforce information. This is now being used to capture workforce information and provides some of the data in the latest ISD workforce statistics. The target date to establish the full capability of the system is June 2007.[28] This capability will enable boards to analyse the NHS workforce by service area rather than staff group. Such analyses are required to underpin the approach to workforce planning set out in the SEHD's planning guidance.

35. The second stage will involve creating a single functional human resources (HR) information system that links HR, payroll and other systems (including finance). The initial agreement for the system has been approved by the Capital Investment Group of the SEHD and the outline business case is currently being developed.

36. One of the recommendations made in our baseline report was that boards should work with trusts to develop a minimum set of management information on the nursing workforce at ward and trust level. The report recommended that information should cover nursing establishments and staff in post, full-time and part-time staff, vacancy and turnover rates, time out for sickness, maternity and study leave, costs of nursing staff, including bank and agency costs, and quality of nursing care.

37. We found that every board now collects data on most or all of the indicators recommended. However, information in some areas such as patient dependency and quality is not routinely collected in each board area.

38. In addition to operational information on the existing workforce, workforce planning also needs data at a national level on flows into and out of the nursing workforce. In early 2006, the SEHD established a group to review the data required to support nursing workforce planning and to develop indicators that will allow accurate national comparisons of workload and workforce planning data.[29] The remit of the group is to address differences in definitions and quality of data available from different sources and to address areas where workforce data are limited, such as the care homes sector and retirement patterns in the nursing workforce. The group's remit is also to consider gaps in information identified in a review of the nursing labour market.[30] The planned completion date for the group's work was the end of 2006.

The NHS in Scotland has made substantial progress in developing the tools for measuring nursing workload at ward level. Further work is required before these tools can be used routinely

39. The baseline report recommended that workforce planning should be used to calculate nursing establishments. The subsequent NMWWPP report demonstrated that there was little consistency in the approaches being used to analyse workload and plan the nursing workforce across Scotland. It recommended developing nationally agreed tools for measuring nursing workload. The use of national tools will help the NHS in Scotland to make meaningful comparisons of workforce data between boards,

26 http://www.show.scot.nhs.uk/swiss/
27 SWISS will also meet legal and operational requirements for workforce monitoring.
28 Information on nursing skills and competencies will be held in the eKSF system established under Agenda for Change.
29 Workforce Data and Intelligence Subgroup.
30 *Past trends, future imperfect? A review of the UK nursing labour market in 2004/05*, Buchan J and Seccombe I, 2005.

make more informed decisions about ward nursing establishments and potentially support more efficient use of nursing staff.

40. Four subgroups are taking forward work in adult acute care, paediatrics and neonatal nursing, primary care, and mental health and learning disabilities. A Telford group has recently been established. Work in the other groups began in 2005 and involves:

- identifying potential tools
- evaluating them against agreed criteria
- selecting a subset of tools to pilot within Scotland
- piloting in a sample of boards
- comparing results to assess the validity of the tools and how practical they are to use in the clinical setting.

41. This work has proved more complex than anticipated and the groups are at different stages. The difficulties faced, in particular the availability of appropriate tools in each area of work, have differed between groups. The groups were due to make their recommendations regarding the most appropriate tools to use and the further work required to develop them in December 2006.[31]

42. Following the recommendations, NHS boards will need to train staff to use the tools. They will also need to estimate the nurse staffing implications of using the tools and of the recommendations arising from them. These issues are due to be addressed in the implementation phase of the project beginning in early 2007, with the tools available for planning ward nursing from April 2007. Boards will need to carefully plan and manage the potential staffing and financial implications of using the tools.

Boards are monitoring quality of nursing care in a variety of ways but challenges remain in working towards a national system of quality indicators

43. The baseline report found that the availability of information on quality indicators varied across Scotland. Partly in response to this finding, the SEHD commissioned a pilot project hosted by NHS Quality Improvement Scotland (NHS QIS) exploring the potential to agree and develop indicators of the quality of nursing care.[32] The project report highlighted a number of issues that needed to be resolved before valid and reliable indicators of the quality of nursing care could be developed nationally. These included conceptual issues, such as the complexity of establishing the relationships between nursing care inputs and health outcomes, and practical issues, such as the resources required to develop indicators and gather good quality data. The NHS QIS report made a number of recommendations about developing nursing quality indicators.

44. The SEHD has now decided to take this work forward on a national basis in collaboration with directors of nursing, NHS QIS and ISD. The range of indicators was due to be decided by the end of 2006 and the process for collecting the information will be piloted in February 2007. This programme of work has been integrated into the review of the role of the SCN. Clinical quality indicators will form a key component of the toolkit to enable these clinical leaders and their staff to gather information to support improvements in clinical care and the overall performance of the team.

45. A variety of methods for measuring the quality of nursing care is in use across Scotland. Boards are not yet collecting data in a consistent way on an agreed set of indicators that would provide comparable data on nursing quality for all boards.

46. There has been limited progress since the baseline report in developing nursing quality indicators. However, this will be taken forward in the SCN review. The SEHD needs to ensure a high priority is attached to this work in the future and monitor progress.

Comparative analysis of workforce information at ward level remains difficult

47. The baseline report recommended that boards, operating divisions and the SEHD should use comparative nursing workforce indicators as part of the workforce planning process.

48. Boards collate and consider comparative information at ward level for operational management purposes and when reviewing ward nurse establishments but it is not yet possible to routinely compare ward-level workforce information between areas. Analyses have been carried out by some boards using, for example, benchmarking data available for England and Wales. Regional nursing workload advisers are also planning to develop comparative analysis of ward-level nursing workforce statistics in the future.

31 We have been advised that the workload tools being developed will include 21 per cent for predictable absence allowance.
32 *The impact of nursing on patient clinical outcomes: developing quality indicators to improve care*, NHS Quality Improvement Scotland, November 2005.

49. No national system exists for compiling comparative nursing workforce indicators at ward level. The SEHD compiled comparative data on the nursing workforce at board level as part of the annual review process for 2005/06. Data have been compiled on the following indicators of the nursing workforce:

- growth of the nursing workforce 2000 to 2005
- turnover and turnover rates as a proportion of staff in post in 2004/05
- change in the turnover rate between 2000/01 and 2004/05
- vacancies and vacancy rates (for total and over three-month vacancies) as a proportion of establishment at 2005
- change in vacancy rates 2001 to 2005
- the proportions of the nursing workforce aged over 50 and over 60 for registered and non-registered nurses 2001 to 2005.

50. Data for each board were presented alongside the national average for each measure and issued to each board.

51. Comparative analysis is constrained by the consistency of the information available and by differences among boards in the type of services and case mix of patients within specialties and wards. Smaller boards find this particularly problematic because of the very varied caseloads they have within the same wards.

52. Such analysis is also made difficult by uncertainty about how to interpret comparative information. The value of comparative analysis depends on how well the relationships between nursing inputs, workload and the quality of nursing care are understood. This has been hampered by the lack of good information in these three areas. The SEHD and the NHS in Scotland are developing this information, which will support both workforce planning and research on the relationships between staffing levels, workload and quality of nursing care to inform valid comparative analysis of the nursing workforce.

There are several challenges ahead for the development of nursing workforce planning

53. In interviews with directors of nursing, the risk most frequently mentioned was Agenda for Change. Fourteen out of 15 boards raised issues in relation to Agenda for Change. These included the time and cost involved in implementing the agreement, the impact on morale if nurses' pay bands do not match their expectations, increases in annual leave entitlements and the potential effect of changes in the way nurses are paid for sickness absence.

54. Boards are still in the process of implementing Agenda for Change. By the end of December 2006, nearly all nursing posts had been matched against new pay bands and approximately 70 per cent of nursing staff had been assimilated on to the new bands. Some posts were still going through the job evaluation process to identify the appropriate band.

55. Other risks identified were the impacts of pay modernisation on the demand for nursing, mentioned by eight boards, service redesign mentioned by five, Modernising Medical Careers mentioned by four, and the implications of using the workload measurement tools by three.

56. Another risk is the relative priority attached to the development of ward nursing workforce planning. We have found variable progress on some of the recommendations of the NMWWPP, despite the priority attached to them by the Minister for Health and Community Care.[33] Boards have not always provided full information in their updates on progress to the Project Steering Group. In addition, nursing workforce planning is not routinely addressed in the annual review process, although particular problems that boards are facing in relation to aspects of the nursing workforce, such as high levels of agency nursing, are discussed.

57. The SEHD needs to clarify whether the action points set out in the NMWWPP to develop nursing workforce and workload planning are recommendations to, or mandatory requirements of, the NHS in Scotland. It also needs to clarify the timescales for their implementation.

33 *Response to the Nursing & Midwifery Workload & Workforce Planning Project*, SEHD, 2004.

Recommendations

- All boards should ensure that staff involved in workforce planning have their training needs assessed and met.
- All boards should ensure that as part of their nursing workforce planning they incorporate appropriate PAAs reflecting local circumstances.
- The SEHD should keep under review the recommendations on protected time and predictable absence allowances to ensure they are appropriate in light of the results of the senior charge nurse review, trends in predictable absence and the impact of Agenda for Change.
- Following the recommendations of the working groups on workload measurement, boards should assess and plan for the training and cost implications of using workload measurement tools.
- The SEHD should ensure that a high priority is attached to developing nursing quality indicators in the future and put in place strategies to monitor progress.
- The SEHD should support analysis and research of the relationships between nurse staffing, workload and quality of care to inform future workforce planning.
- The SEHD should clarify to boards the status of the NMWWPP action points and the timescales for their implementation.

Part 3. Recruitment and retention

Key messages

- Nursing staff in hospital specialties increased by 1,475 WTEs (3.3 per cent) between September 2002 and September 2005, most rapidly in acute specialties.
- Vacancy rates changed little across Scotland as a whole between March 2002 and March 2006 and long-term vacancy rates remained low. Vacancy rates vary among specialties and board areas.
- Boards and the SEHD have implemented a wide range of approaches to improve recruitment and retention although there are still difficulties in some boards and some clinical areas, such as intensive therapy nursing, theatre nursing and care of the elderly.

58. Two of the issues addressed in the baseline report were recruitment and retention. The report examined differences between planned staff numbers and actual staff in post at ward level and recommended that trusts review reasons for the differences observed.

59. In this report we have looked at trends in staff in post and vacancy rates since the baseline report. ISD normally publishes data on nursing staff in post by board and specialty every six months at 31 March and 30 September. Because the introduction of Agenda for Change is not yet complete, there is a temporary loss of detail in this information. ISD has published information on overall staff in post and vacancy figures by board at 31 March 2006 but data on hospital nursing staff in post were only available up to September 2005 at the time this report was prepared.

60. ISD estimates vacancy rates as vacancies counted on the workforce census date as a proportion of nursing establishments. It presents data on total vacancies and vacancies of three months or more. All vacancies potentially cause difficulties for ward staffing but the causes of short-term and longer-term vacancies differ so it is important to distinguish between the two. Longer-term vacancies indicate recruitment difficulties arising from ongoing shortages of staff whereas short-term vacancies may represent temporary delays in filling posts.

61. Vacancy rate data need to be treated with caution. Their value as an indicator of need for additional nurses depends on whether the nursing establishments have been accurately calculated. Establishments also need to reflect new ways of delivering services. For example, as more services are provided in the community, boards need to review establishments to make sure they continue to meet the changing volume and case mix of patients treated in hospital.

Nursing staff numbers increased between 2002 and 2006. There were variations among boards and specialties in the rates of increase

62. The number of all nursing and midwifery staff increased by six per cent between September 2002 and March 2006, from 53,197 to 56,369 WTEs. Nursing and midwifery staff in hospitals increased by 3.3 per cent between September 2002 and September 2005, from 45,264 to 46,739 WTEs. These increases were seen in most boards, but there were variations among boards and among specialties in the scale and direction of the changes (Exhibit 3, overleaf).[34]

63. Nursing staff increased most rapidly in acute specialties, which saw a 10.5 per cent increase in nursing staff between September 2002 and September 2005, from 21,982 to 24,301 WTEs. Trends in mental illness, learning disabilities and care of the elderly show the effect of moving services out of hospital settings into the community.

Vacancy rates changed little between 2002 and 2006 in Scotland as a whole but varied by board and specialty

64. Total vacancy rates in the nursing and midwifery workforce fluctuated between 3.6 per cent and 4.2 per cent between March 2002 and March 2006. They peaked at 4.2 per cent (2,445 vacancies) at March 2005 before falling back to 3.6 per cent (2,083 vacancies) at March 2006 (Exhibit 4, page 17).

65. Exhibit 5 (page 18) shows vacancy rates for posts vacant for three months or more. Rates in Scotland as a whole fluctuated around one per cent for most of the period, rising to 1.6 per cent in March 2005 before falling back to 0.7 per cent in March 2006. This is a fifth of total vacancies across Scotland. There were differences in trends among boards over the period as a whole and substantial reductions in some boards in 2005/06, for example, Greater Glasgow and Lothian.

66. Specialty-level vacancy rates differ among boards. In March 2005, for example, total vacancy rates in general acute nursing ranged from zero per cent to 10.8 per cent. There were similar variations in the other main hospital specialties. Exhibit 6 (page 19) presents these data for March 2005.

67. Exhibit 6 also shows that the vacancy rates at specialty level were highest in general acute nursing and care of the elderly. The latest data available at sub-specialty level (March 2003) show that there are particular pressures in some sub-specialties, for example, intensive therapy and theatres. Our interviews confirmed that vacancy rates remain high in these areas.

68. The changes in the way workforce and vacancy data are compiled by ISD, and the temporary loss of detail in workforce data described earlier, have created gaps in the information that the SEHD and boards need to monitor and manage the nursing workforce. It is important that these gaps are filled when the national database is fully established and operational (paragraph 34).

69. Boards highlighted several factors influencing vacancy rates. These included:

- shortages of specialist nursing skills in particular clinical areas
- shortages in supply of staff due to the demands of the work in some specialties
- retention problems caused by the age structure of the nursing workforce in some boards
- problems with recruitment in care of the elderly due to the structure of care provision with several small hospitals distributed across the board area
- reductions in recruitment to manage financial pressures
- recruitment difficulties due to the remoteness of some boards
- recruitment difficulties due to the high cost of living in particular board areas.

70. The range of factors cited by boards indicates the need for a variety of responses to reduce vacancy rates.

Boards and the SEHD have implemented a wide range of approaches to promote recruitment and retention although difficulties remain in some areas

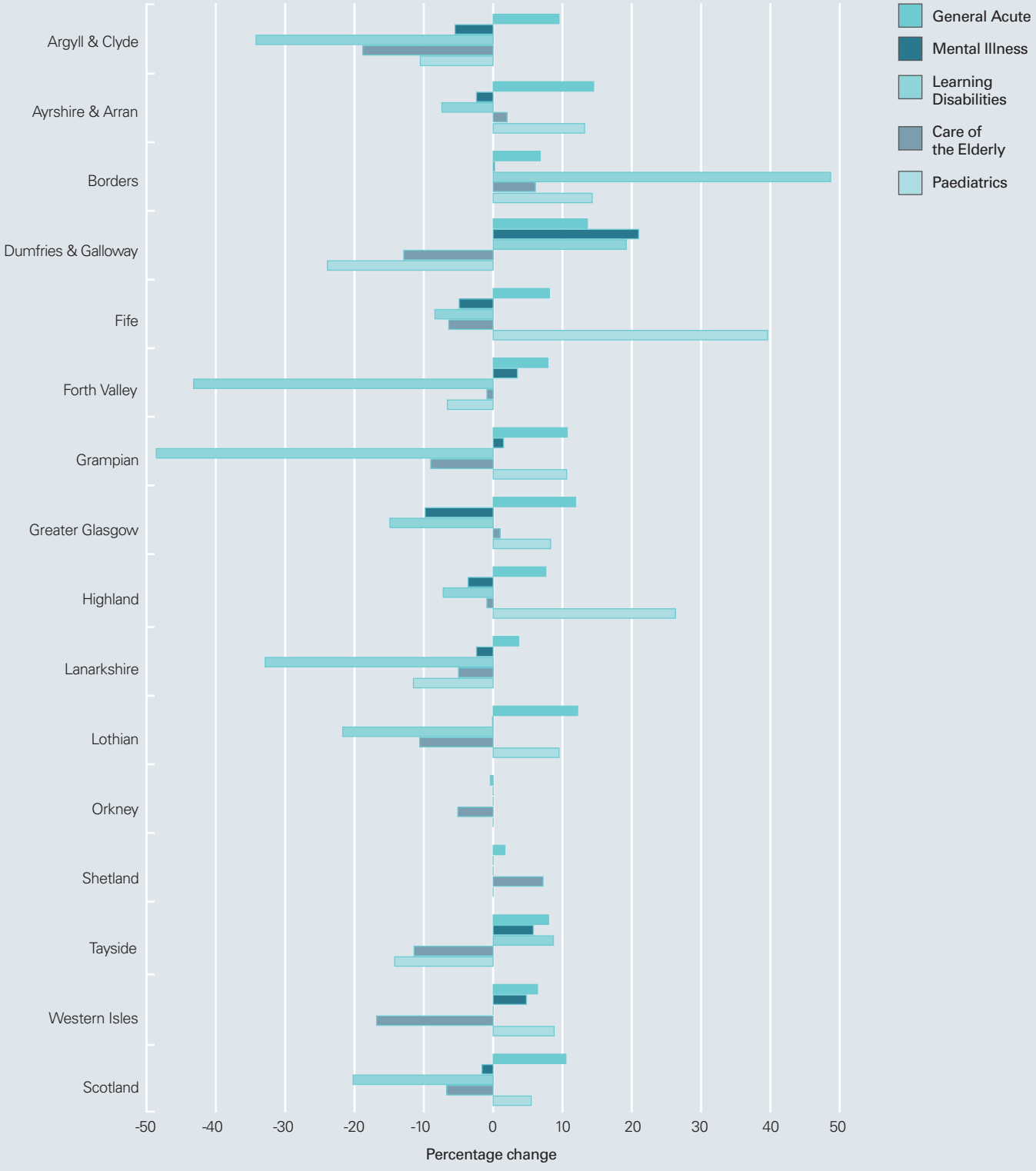
71. The SEHD, in collaboration with organisations such as NES and the Royal College of Nursing (RCN), has provided financial support to a number of initiatives to improve recruitment and retention. Exhibit 7 (page 20) summarises the main schemes.

34 The Golden Jubilee is not included in the exhibits due to discrepancies between published data and the hospital's own data and because of particular circumstances which make data for the hospital incomparable with other boards.

Exhibit 3

Change in hospital nursing and midwifery staff in post, by board and specialty, September 2002 to September 2005 for registered and non-registered nurses

Changes in staff in post vary markedly by board and specialty, with the biggest increases in Scotland as a whole in acute adult specialties.

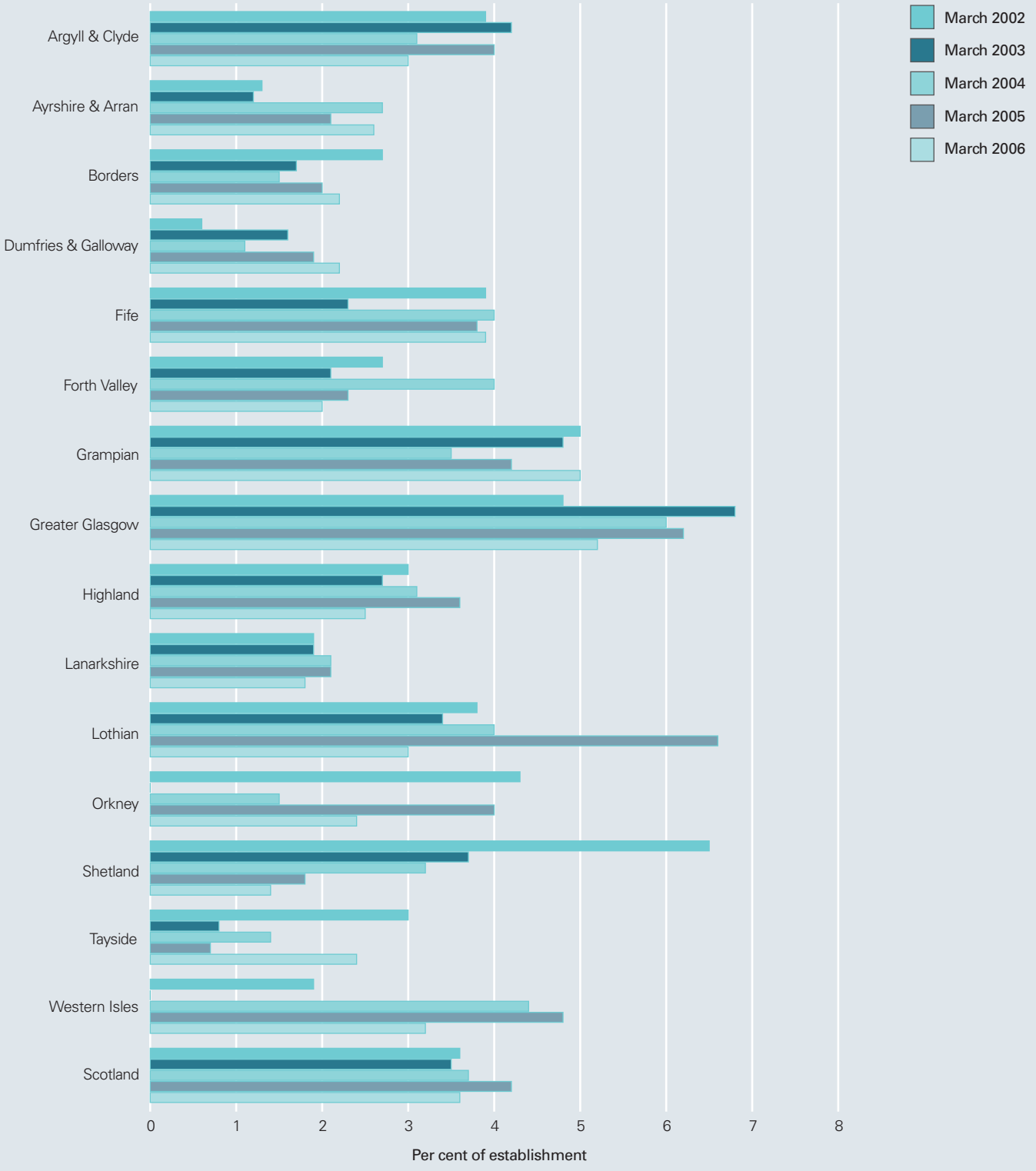


Source: Audit Scotland analysis of ISD Workforce Statistics, July 2006

Exhibit 4

Nursing and midwifery total vacancy rates by board, March 2002 to March 2006 for registered and non-registered nurses

Total vacancy rates in Scotland as a whole changed little between 2002 and 2006, but they fell in the majority of boards.



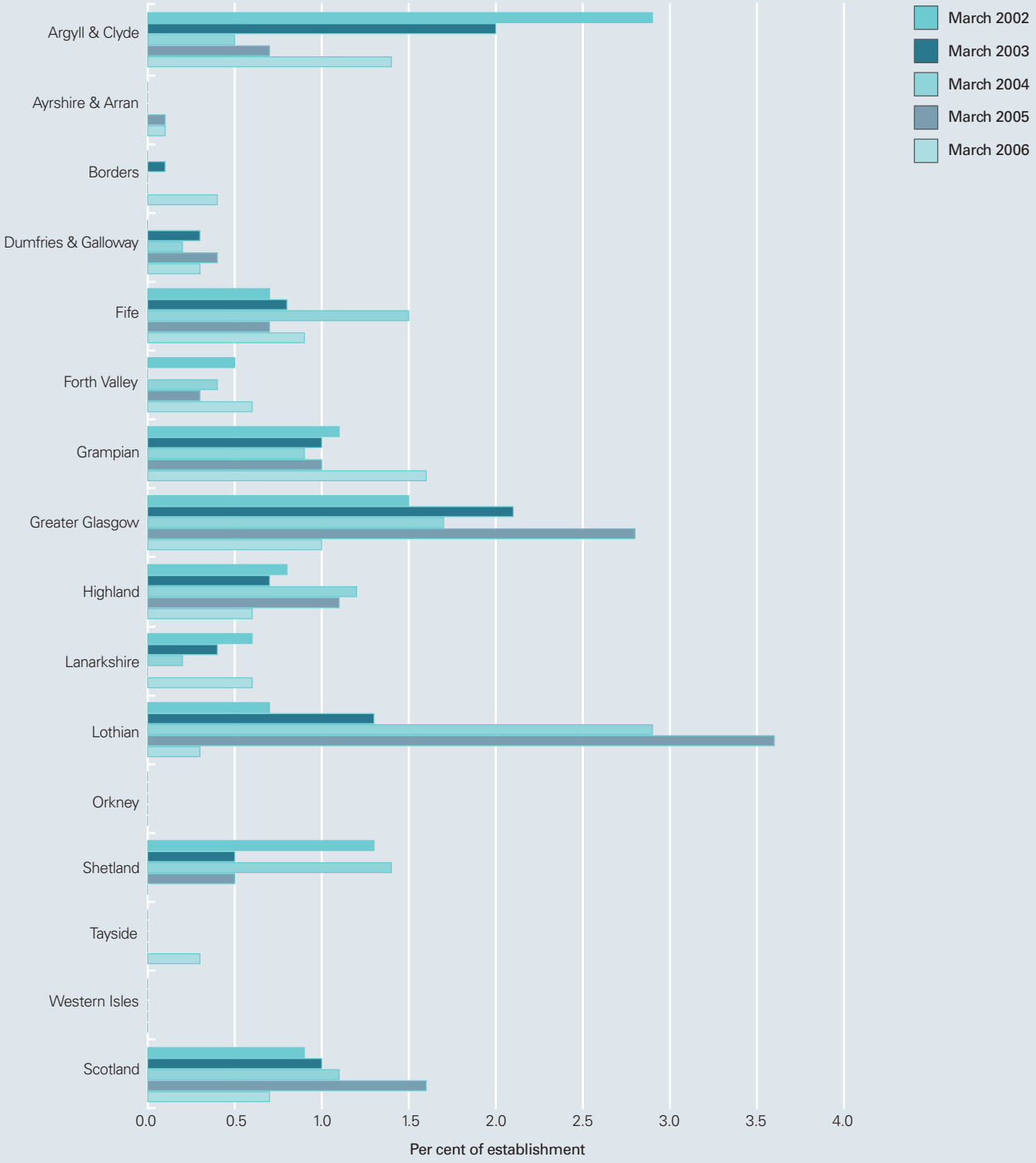
Note: Rates are calculated at 31 March for each of the years shown.

Source: ISD Workforce Statistics, July 2006

Exhibit 5

Nursing and midwifery three-month vacancy rates, March 2002 to March 2006 for registered and non-registered nurses

Longer-term vacancy rates have fallen since March 2002.



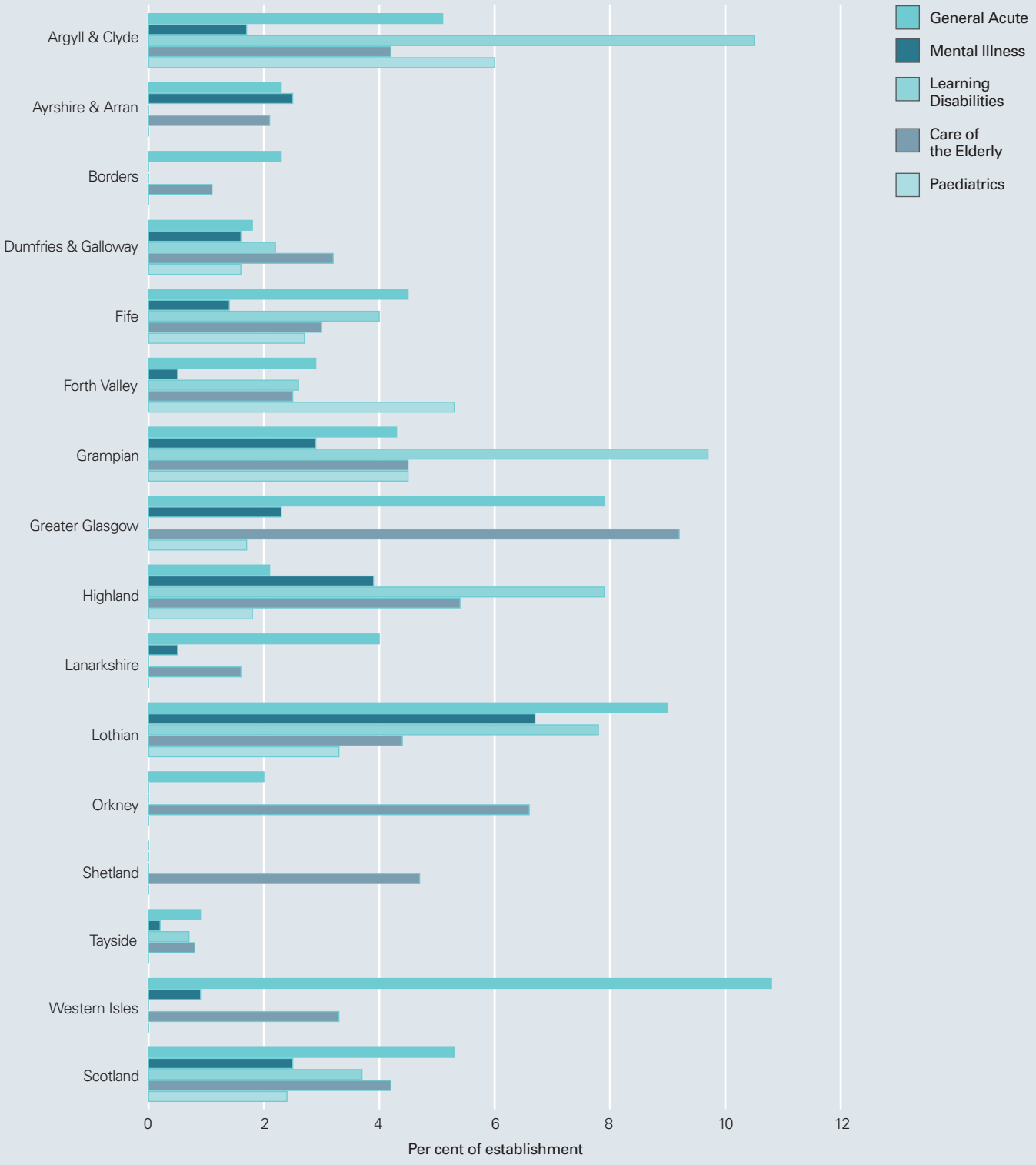
Note: Rates are calculated at 31 March for each of the years shown.

Source: ISD Workforce Statistics, July 2006

Exhibit 6

Total vacancy rates by board and hospital specialty, 31 March 2005 for registered and non-registered nurses

In Scotland as a whole, total vacancy rates are highest in general acute nursing, which includes ITU, theatre nursing and A&E.



Source: ISD Workforce Statistics, July 2006

Exhibit 7

Recruitment, retention and nursing staff development initiatives

Programme	Description	Outcomes
Return to Practice	Developed in 2002 to attract registered nurses not currently in employment back into the service, and to provide them with training and support. Those returning to the service receive a one-off payment, refresher courses and an induction programme. Funded by the SEHD.	654 nurses returned to the service under the scheme between 2002 and 2006.[1]
One-year Job Guarantee Scheme	Since 2003 the scheme has provided all newly trained nurses who cannot find employment with a guarantee of work within the service for one year. NES and the SEHD work with boards to ensure the guarantee can be met.	106 graduates have applied since 2003, 61 in midwifery, 28 in adult acute nursing and the remainder in several specialties.[2]
Alternative routes into nursing[1]	Healthcare support workers wishing to train as nurses can study part-time on their existing contracts for a Higher National Certficate (HNC) in Healthcare, endorsed by NES. The SEHD provides £8,000 per student to the employing board to offset time spent away from clinical duties. Students successfully completing the HNC can enter directly into the second year of a nursing diploma/degree for two or three years. Students are either seconded on existing pay and conditions by their current employer who receives £8,000 per student from SEHD to offset the costs, or paid an £8,000 NHS bursary by SEHD.	Between 2003/04 and 2005/06, over 700 students have taken the HNC route into nurse training funded by SEHD. 82% of the 2003/04 intake have gone on to years two and three and 84% of the 2004/05 intake have gone on to year two of the programme.
Recruitment and retention of internationally qualified nurses (IQNs) in NHSScotland[3]	Scheme to help boards identify and support IQNs for hard-to-fill posts. The SEHD will provide funding of £5,000 per IQN to cover the costs of education and three months supernumerary supervised practice.	The scheme was announced in September 2006. The pilot recruited 24 IQNs in the east and west Regions.
Flying Start[4]	An online development programme that helps newly qualified staff make the transition from student to practitioner by building up their skills and confidence in the first year of practice.	The scheme is still in its first year.
Clinical Leadership Programme	The SEHD has funded the RCN up to the end of 2006 to provide three clinical leadership programmes for nurses with management responsibilities, either directly or via facilitators based in mainland boards trained by the RCN. The RCN has also provided 'bespoke' leadership programmes tailored to the specific needs of particular boards.	Nearly 2,000 nurses in Scotland have been through the programmes since 2001 and a further 200 were expected before the end of 2006.[5]

Sources:
1 SEHD
2 NHS Education for Scotland
3 HDL (2006) 53
4 http://www.flyingstart.scot.nhs.uk/
5 Royal College of Nursing

Exhibit 8

NHS Lothian's candidate-focused strategy is improving recruitment

NHS Lothian faces particular recruitment difficulties due to the high cost of living in Edinburgh. In certain areas, a slow recruitment process and low interview attendances exacerbated this problem.

In 2005, a six-month pilot project began in Medicine and Associated Services within NHS Lothian's University Hospitals Division. The project developed a candidate-focused approach to the recruitment process. This included: sending text/telephone reminders to candidates prior to interviews; offering candidates post-interview feedback; and providing external applicants with information on local accommodation. The project also developed exit interviews to help retention. The project measured success against several key objectives and performance indicators. The division appointed dedicated staff and created a 'retention group' to monitor progress.

The impact of this work was substantial. Vacancy rates within medical services fell while interview attendance remained consistently above the 90 per cent target. In addition, NHS Lothian believes that the candidate-focused approach helps to attract high-quality staff and aids their transition into the organisation. Work is now underway to expand the project across the board and the project was recently nominated for the 2006 Health Service Journal Awards.

Source: NHS Lothian

72. The numbers of nurses participating in the Return to Practice and One-year Job Guarantee schemes have been falling. In 2005/06, only 21 applications were received for the One-year Job Guarantee Scheme and 36 nurses had completed Return to Practice courses up to August 2006. The SEHD needs to review these initiatives to see whether they effectively meet the current requirements of the NHS in Scotland.

73. In addition to participating in national initiatives, boards have developed their own approaches to increase recruitment and retention (Exhibit 8).

74. Boards need to plan recruitment and retention in the context of the wider development of nursing skills and roles. To support this process, the SEHD has published a *Framework for Developing Nursing Roles*.[36] This supports service redesign and pay modernisation by helping the nursing workforce adapt to new ways of providing services. It also aims to support recruitment and retention by ensuring that nursing is an attractive and rewarding career. More recently, the SEHD published *Modernising nursing careers: setting the direction*, which sets out how the NHS in Scotland should take this process forward.[37] The competency frameworks developed under Skills for Health also help nurses enhance their skills and develop their roles.[38]

75. The output from nurse training courses is the main source of increases in the nursing workforce. The number of new students that the SEHD commissions through academic institutions is determined through the Student Nurse Intake Planning (SNIP) process. SNIP has evolved to become part of the wider workforce planning process. In the latest SNIP exercise, boards have supplied the SEHD with projections of their nursing workforce requirements over the next ten years. Boards are asked to build into their projections estimates of the impact of factors such as pay modernisation and service redesign. The SEHD uses these projections to estimate the number of places required to meet boards' requirements, taking into account trends in vacancies, demographic variables, the number of nurses joining and leaving the workforce, the number of nurses that do not complete the nurse training course, the number of nurses who do not go into a career in nursing after qualifying, turnover, sickness absence and the balance between full-time and part-time nursing. Proposed intakes are discussed with stakeholder groups such as the employee organisations and higher education institutions before the final recommendations are put forward for ministerial approval.

76. Intakes increased between 1995/96 and 2004/05.[39] These increases are reflected in the rise in

36 *Framework for Developing Nursing Roles*, Scottish Executive, 2005.
37 *Modernising nursing careers: setting the direction*, Scottish Executive, 2006.
38 http://www.skillsforhealth.org.uk/
39 ISD Workforce Statistics.

numbers in the nursing workforce but the latest and biggest cohorts have still to complete their training so the full impact has not yet been felt. Actual intake in 2004/05 was 3,525, including nurses entering nurse training through the HNC route.[40] The intakes recommended for 2005/06 and 2006/07 are 3,500[41] and 3,325.[42]

77. The percentage of students who do not complete nurse training, termed the attrition rate, has risen in recent years, from approximately 21 per cent in the mid-90s to 28 per cent in the student intake of 2001/02.[43] Student nurse attrition rates and trends vary by nursing category, they are highest in adult (29.8 per cent in the 2001/02 intake) and mental health (27.6 per cent), lowest in learning disabilities (19.0 per cent).

78. It is too early to assess the long-term success of the range of recruitment and retention measures introduced nationally and locally. The combined effect of recent increases in student numbers and recruitment and retention strategies, together with increased spending on healthcare, has kept overall vacancy rates quite steady, but there are still relatively high vacancy rates in some clinical and board areas.

Recommendations

- The SEHD should assess whether existing recruitment and retention schemes with low levels of uptake continue to meet the needs of the NHS in Scotland.
- The SEHD and the NHS in Scotland should review their strategies for reducing vacancies in certain specialties with persistently high vacancy rates.

40 Figures provided by SEHD, 10/08/2006.
41 *National Workforce Planning Framework*, Scottish Executive, 2005.
42 Student Nurse Intake, Press Release, Scottish Executive, December 2005.
43 ISD Workforce Statistics, 23/03/06. 2001/02 is the last cohort for which figures are available and the figures are provisional as some of the students in this intake are still completing the course.

Part 4. Management of bank and agency nursing

Key messages

- The NHS in Scotland has made progress in implementing bank and agency nursing action plans.
- Agency usage in Scotland fell by 17 per cent between 2001/02 and 2005/06, although it increased in some boards.
- Bank nursing increased by 73 per cent in Scotland between 2001/02 and 2005/06, partly as a result of the measures taken by boards and the SEHD to improve the management of bank and agency nursing.
- The combined use of bank and agency nursing to cover temporary nurse staffing needs has increased by 43 per cent. This trend needs to be monitored to ensure that the quality of care is maintained and appropriate use is made of bank and agency staff.

79. Bank nurses are NHS employees contracted to work when required, often at short notice, to cover planned or unplanned shortfalls in the number of nurses available. They are paid at NHS rates and they are recruited and trained by the employing NHS body. Agency nurses are employed on an ad hoc basis via commercial nursing agencies, for a fee paid by the NHS. This fee includes both commission for the agency and pay for the nurse at a level set by the agency.

80. Boards' use of bank and agency nursing increased between the late 1990s and publication of the baseline report in 2002. The report recommended that NHS boards should review the use of bank and agency nurses to address concerns about the cost and quality of the care provided by these staff. It recommended investigating reasons for the increasing use of bank and agency nursing staff, developing guidelines for use of bank and agency staff at ward level and monitoring compliance with the guidelines.

81. Bank nurses provide flexibility to the service in meeting short-term staffing needs. They offer flexible working arrangements for nursing staff and can be a gateway into substantive employment for staff without permanent posts. They are also a less costly way of meeting temporary staffing needs than agency nurses.

The NHS in Scotland has made progress in implementing bank and agency nursing action plans

82. The SEHD and boards have taken a number of steps to review, monitor and improve management of bank and agency nursing.

83. A report by the SEHD revealed differences between nurse banks regarding the arrangements for induction, professional development and performance appraisal of bank staff.[44] The report made

44 *Nationally Coordinated Nurse Bank Arrangements: Report and Action Plan*, Scottish Executive, 2005.

recommendations to help reduce agency use by consolidating nurse bank arrangements at board level and by improving the management and terms and conditions of bank nurses. The SEHD, in collaboration with boards, has developed an audit tool to be used annually to monitor progress in meeting these recommendations. The tool was used for the first time in October 2006 and the results are currently being analysed by the SEHD.

84. The report also recommended establishing systems for monitoring and controlling the use of non-contracted agency staff. To support reductions in the cost of agency nursing, national contracts for the supply of agency nurses have been established through the Strategic Sourcing workstream of the NSS National Procurement programme. Boards are encouraged to use nurses from regional panels of contract agencies that employ nurses on standard rates of pay.[45] Compliance with the contracts is monitored quarterly by NSS National Procurement through management information reports detailing contract and off-contract agency spend by boards. Off-contract agency spend is broken down into non-contract agencies and premium rate agencies that have substantially higher costs per hour.

85. Boards are monitoring use of bank and agency nursing. Fourteen of the 15 boards have guidelines for the use of agency nursing.[46] Most report systems for monitoring their use although concerns have been expressed by nurse bank representatives that guidelines are not always followed at ward level.[47]

86. The Chief Nursing Officer receives monitoring data on historically high users of bank and agency nursing. Funding has been provided by the SEHD to amalgamate nurse banks to improve the efficiency and effectiveness with which they operate. Ten of the 15 boards have amalgamated nurse banks with four in the process of doing so.[48] NHS Highland are assessing the appropriateness of an amalgamated bank given the geographical dispersal of its nursing workforce.

Agency usage in Scotland fell between 2002 and 2006 while bank use increased

87. The actions taken to promote bank nursing and reduce agency nursing have begun to have an effect. Agency nursing measured in WTEs fell between 2001/02 and 2005/06 (Exhibit 9). Expenditure on agency nursing increased slightly over the period as a whole, although it fell from a peak of nearly £30 million in 2003/04 to £26.5 million in 2005/06. Adjusting for the health services pay index shows that the slight increase in agency spend over the period as a whole represents a reduction in real terms.[49] Spending on agency nursing represented less than two per cent of total nursing spending in 2005/06.

88. Exhibit 9 also shows that bank usage and spend have increased between 2001/02 and 2005/06. Bank spend increased by 121 per cent in Scotland as a whole, and bank usage by 73 per cent. The size of the increase in the use of bank nurses means that overall, the use of bank and agency nurses to cover temporary staffing needs, measured in WTEs, has increased by 43 per cent. Combined spending on bank and agency nursing represented approximately 5.5 per cent of total nursing spend in 2005/06.

89. There are variations in the use of bank and agency nursing among boards. To account for differences in the size of the nursing workforce between boards, we have expressed bank and agency nurse WTEs and expenditure as proportions of total nursing WTEs and expenditure in each board.

90. Agency spend as a proportion of total nursing spend in Scotland fell from two per cent to 1.6 per cent between 2001/02 and 2005/06 (Exhibit 10, page 26). There were substantial reductions in Grampian, Greater Glasgow, Lanarkshire, Tayside and, since 2003/04, Lothian. There were increases in Borders, Fife and Forth Valley, areas where we were informed that there was limited availability of contract agency nurses.[50]

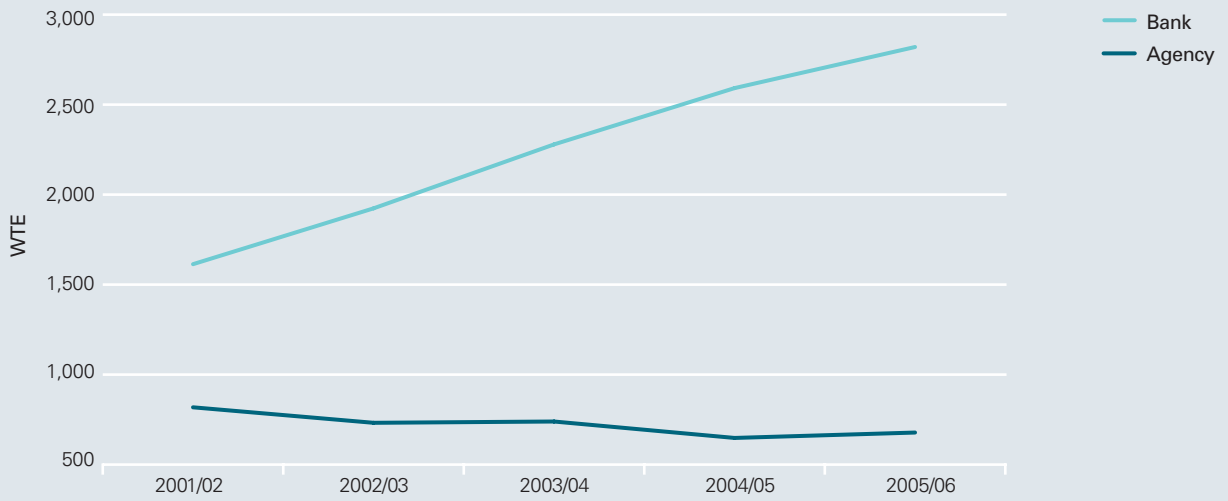
91. Agency usage expressed as a percentage of WTE fell from 1.6 per cent to 1.1 per cent between 2001/02 and 2005/06 in Scotland as a whole (Exhibit 11, page 27). The overall trend was dominated by relatively large reductions in the bigger boards: Grampian, Greater Glasgow, Lanarkshire, Lothian and Tayside. In the other mainland boards, use of agency nursing increased, although in some boards the increases were relatively small.

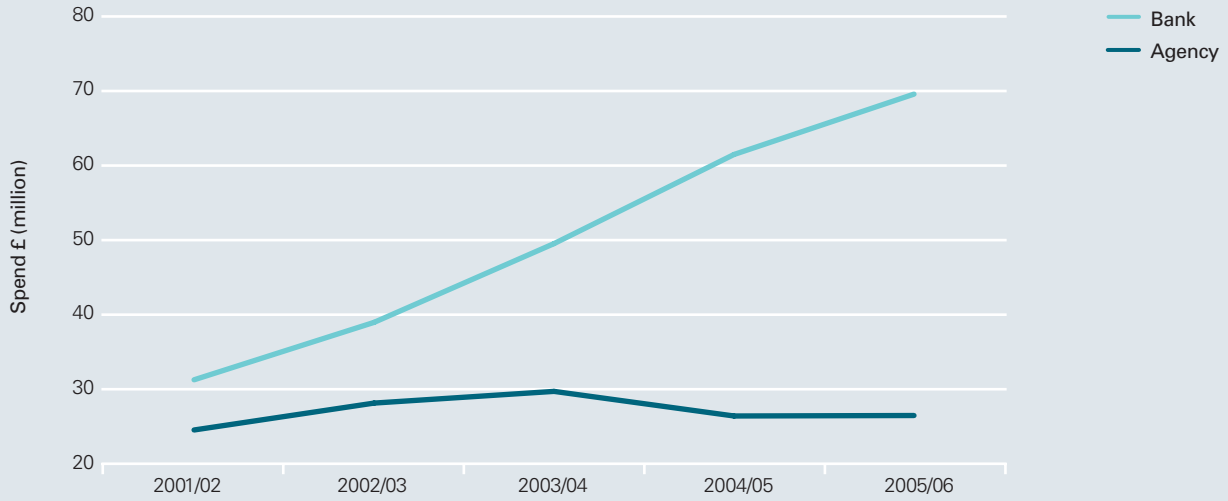
45 *Background Methodology and Results of Nationally Coordinated Nurse Bank Arrangements Project*, NHS Scotland, 2006.
46 NHS Western Isles do not have guidelines, but they make very little use of agency nursing and did not do so at all in 2005/06.
47 Notes of NHS board nurse bank representatives networking meeting, 23 March 2006.
48 Ten boards have amalgamated banks: Ayrshire and Arran, Borders, Fife, Forth Valley, Greater Glasgow and Clyde, Lanarkshire, Lothian, Orkney, Shetland and Western Isles. Western Isles stated that the status of their bank was under review due to operational problems. Four boards are in the process of developing amalgamated banks: Dumfries and Galloway, Grampian, Tayside and Golden Jubilee National Hospital.
49 The pay index for 2005/06 is not yet available with which to estimate the reduction in real terms for the period as a whole.
50 NHS Forth Valley informed us that they were previously unable to benefit from national contract agency rates due to the geographical location of the contract agencies but that this has now been resolved.

Exhibit 9

Bank and agency nursing (whole time equivalent (WTE) and expenditure), Scotland, 2001/02 to 2005/06 for registered and non-registered nurses

In Scotland as a whole, the use of bank nurses has risen by significantly more than the use of agency nurses has fallen, increasing the combined use of bank and agency nursing.





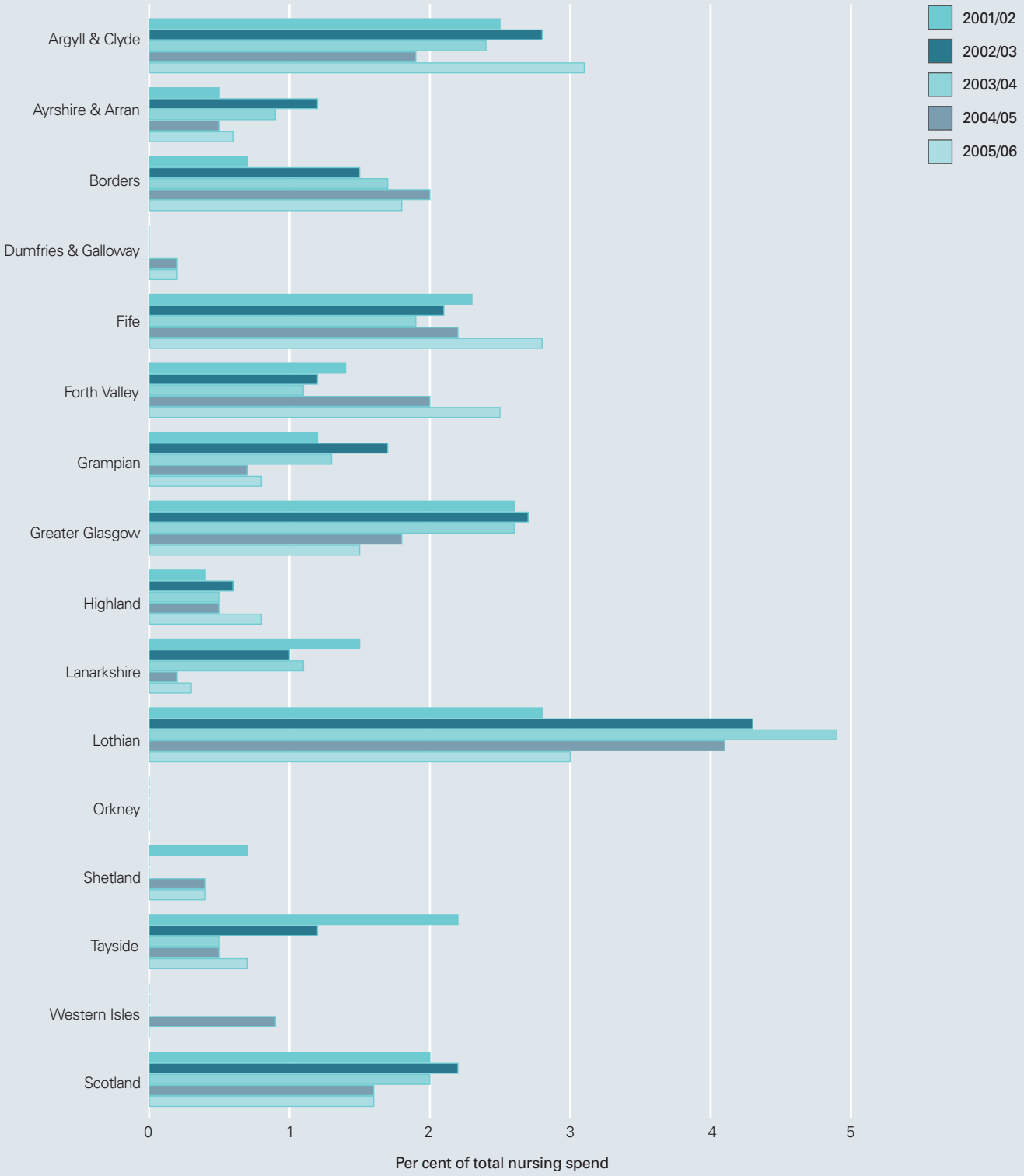
Note: Figures are not adjusted for NHS pay inflation.

Source: ISD Workforce Statistics, July 2006

Exhibit 10

Trends in agency spend as a proportion of total nursing spend, 2001/02 to 2005/06

Agency nurse spending has fallen as a proportion of total spending across Scotland, although it has risen in some boards.

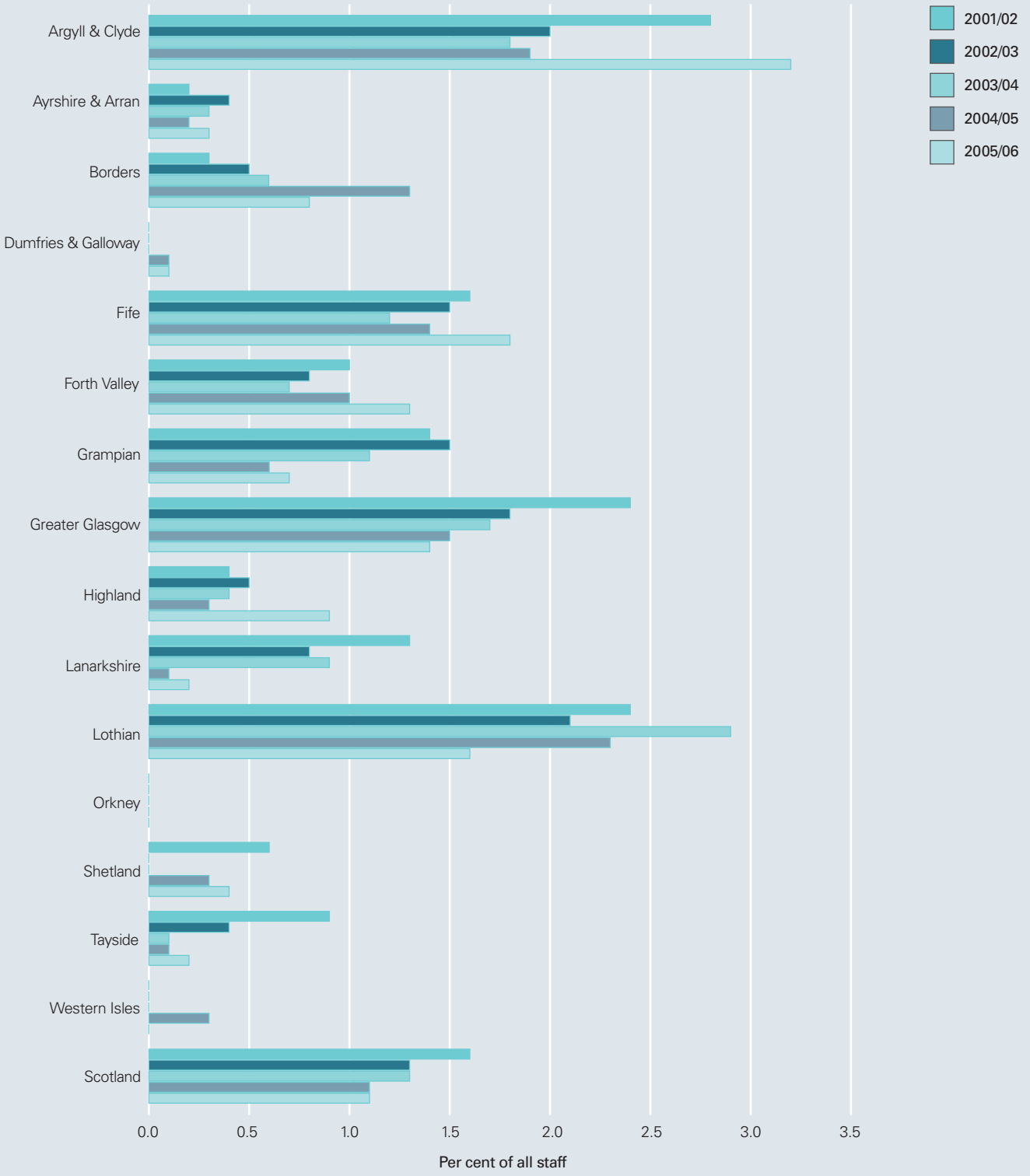


Source: Audit Scotland analysis of ISD Workforce Statistics, July 2006

Exhibit 11

Trends in use of agency nursing as a percentage of total nursing and midwifery whole time equivalents (WTEs) by board, 2001/02 to 2005/06

Agency nurse use has fallen as a percentage of total WTEs across Scotland, although it has risen in several boards.



Source: Audit Scotland analysis of ISD Workforce Statistics, July 2006

92. Bank spend as a percentage of total nursing spend in Scotland increased from 2.6 per cent in 2001/02 to 4.1 per cent in 2005/06. There were increases in all boards except Borders and Orkney (Exhibit 12).

93. Bank use as a proportion of all nursing WTEs rose from 3.1 per cent to 4.7 per cent in Scotland as a whole between 2001/02 and 2005/06 (Exhibit 13, page 30). The proportion varied between just over two per cent in Tayside and just over six per cent in Forth Valley, Lanarkshire and Lothian.

There are continued pressures on agency nursing spend

94. Boards continue to face pressures on agency spend. Use of agency nursing across Scotland as a whole increased by 30 WTEs (five per cent) in 2005/06. Exhibits 10 and 11 (page 26 and 27) showed that in terms of WTEs and/or spend, some boards increased agency use over the period 2001/02 to 2005/06. In addition, off-contract agency spend as a proportion of total agency nurse spending increased through 2005 and up to June 2006, with spending on premium nursing agencies changing little at around 50 per cent of the total. Overall, the percentage of all agency spend on nursing supplied by contract agencies was 37 per cent in the first quarter of 2006/07, down from 45 per cent in the first quarter of 2005 and 48 per cent in the second half of 2005.[51]

95. In response to these pressures, the SEHD has recently instructed boards to end the use of non-contracted suppliers of agency nursing staff.[52] Recent estimates by the SEHD in response to a parliamentary question suggested that this might generate potential savings of just over £5 million.[53] Data are not yet available on the impact this has had, but we have been informed by the National Procurement programme that the effect on the use of off-contract agency nursing has been considerable.

Use of agency nurses has fallen but the combined use of bank and agency nurses to meet temporary staffing needs has continued to increase

96. An increasing proportion of temporary nurse staffing needs are met by bank nurses. Agency spend as a percentage of bank and agency nursing spend has fallen in nine boards (Exhibit 14, page 31). The proportions and the scale of the reductions differ markedly among boards.

97. The growth in bank spending and, in some boards, the move away from agency nursing reflects measures taken to increase the availability and improve the management of bank staff. In Greater Glasgow, for example, there is a city-wide nurse bank supported by one information technology (IT) system covering all areas of the city. This is complemented by a robust process for authorising bank and agency deployment. In Lothian, investment in and improved management of an amalgamated nurse bank have reduced the use of agency nursing. A key element of this has been the introduction of a single authorisation process across NHS Lothian for supplementary staffing. The impact of the bank has been reinforced by measures to address the high underlying vacancy rates that contributed to the previously high use of agency nursing staff (Exhibit 8, page 21). Lothian's experience underlines the importance of integrating different aspects of nursing workforce planning.

98. The biggest percentage reduction in agency spend has been achieved in NHS Lanarkshire. Exhibit 15 (page 32) describes the approach taken there to reduce agency nursing as part of an integrated approach to managing demand for bank and agency nursing staff.

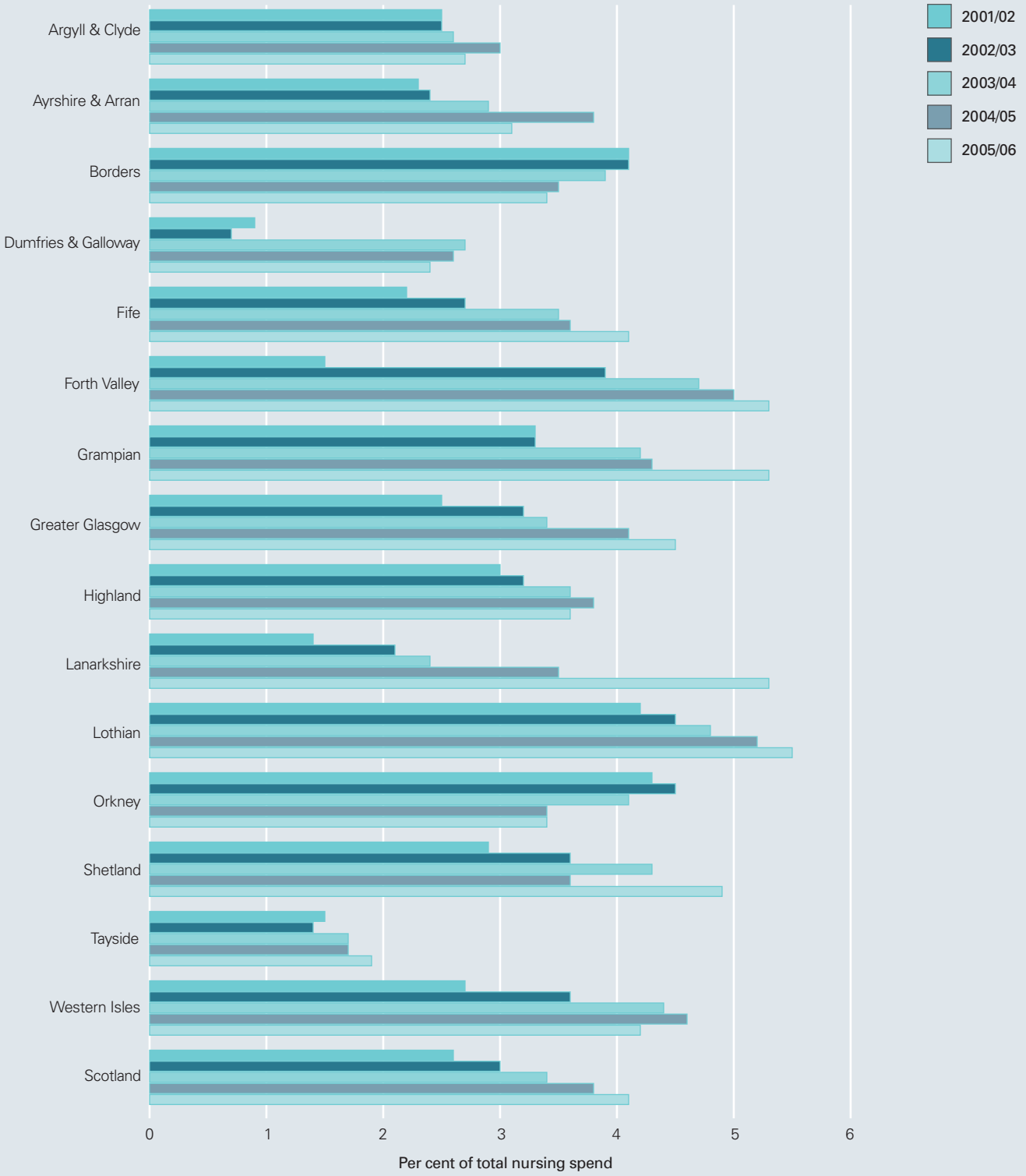
99. The continued pressures on agency nursing and the growth in bank and agency nursing combined, also reflect pressures faced by boards on the demand for and supply of nursing staff. Demand pressures include the requirement to meet waiting time targets. Supply pressures include the impact of Agenda for Change, which has increased annual leave allowances. Nursing staff began to move on to Agenda for Change contracts in October 2005. As the full impact is felt, boards will need to manage increased leave allowances carefully to offset their potential impact on the use of bank and agency nursing. Other supply pressures include sickness absence and recruitment and retention difficulties discussed earlier.

51 Data supplied by NSS National Procurement programme, October 2006.
52 *National Procurement: Use of National Contracts for Agency Labour Purchase; and Review of Procurement in Scotland*, HDL (2006) 39, SEHD, July 2006.
53 Scottish Parliament Written Answers, S2W-27748, 29 August 2006.

Exhibit 12

Trends in spending on bank nurses as a percentage of total nurse spending by board, 2001/02 to 2005/06, registered and non-registered nurses

Spending on bank nursing has risen as a percentage of total nurse spending in nearly all boards.

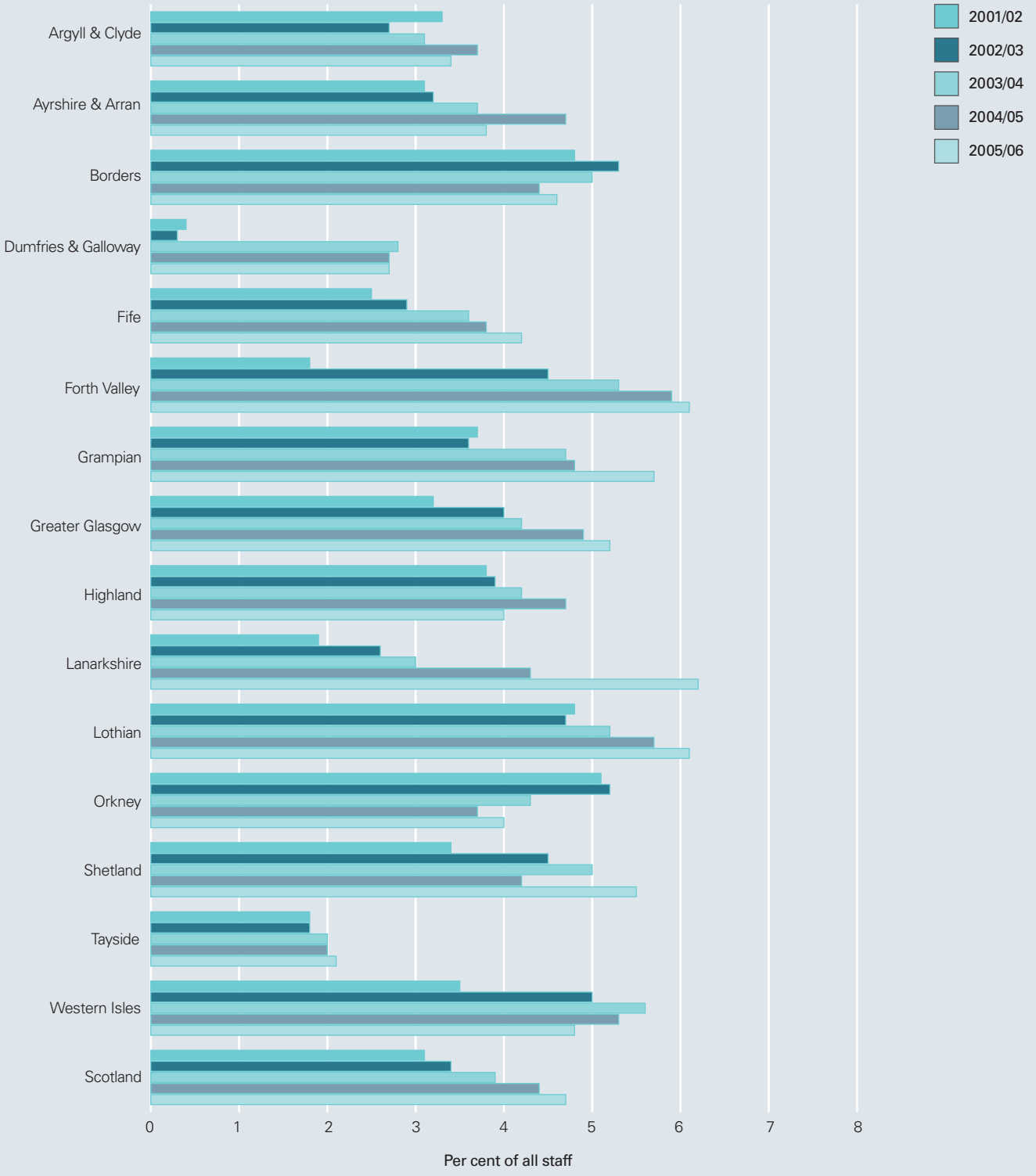


Source: Audit Scotland analysis of ISD Workforce Statistics, July 2006

Exhibit 13

Trends in use of bank nursing as a percentage of total nursing whole time equivalents (WTEs) by board, 2001/02 to 2005/06, registered and non-registered nurses

Bank nurse use as a percentage of WTEs has risen in nearly all boards.

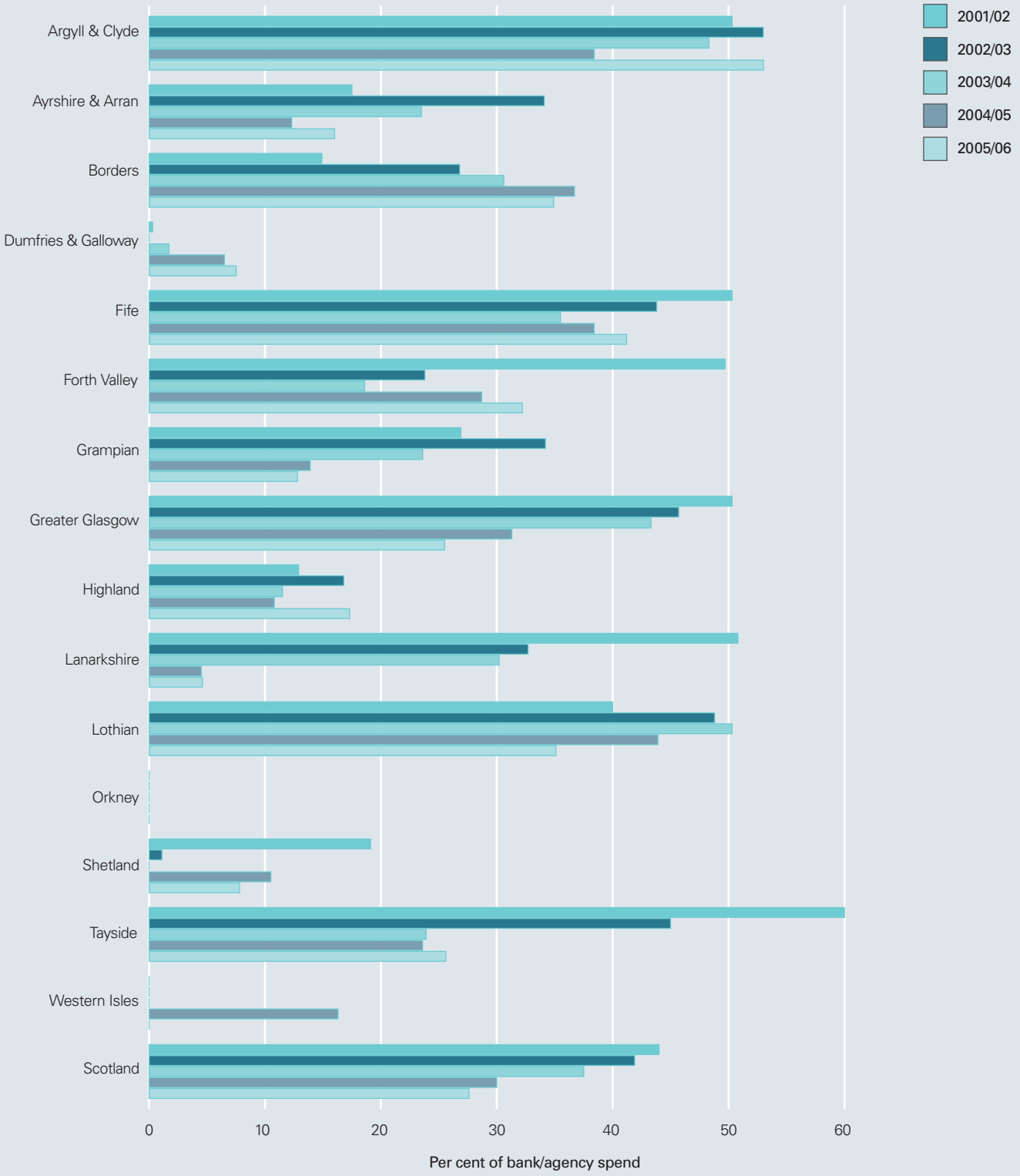


Source: Audit Scotland analysis of ISD Workforce Statistics, July 2006

Exhibit 14

Agency nurse spend as a proportion of all spend on bank and agency nursing staff by board, 2001/02 to 2005/06, registered and non-registered nurses

Agency spend as a percentage of bank and agency nursing spend has fallen in most boards.



Source: Audit Scotland analysis of ISD Workforce Statistics, July 2006

Exhibit 15

NHS Lanarkshire is reducing its reliance on agency nursing staff

Spending on agency nursing staff in NHS Lanarkshire fell by more than 75 per cent between 2001/02 and 2005/06 and is now one of the lowest of any of the mainland boards in Scotland.

The development of NHS Lanarkshire's unified nurse bank – BankAide – is enabling the board to reduce reliance on agency staff by ensuring a supply of bank nurses to meet temporary nurse staffing needs.

More than 1,000 new members have joined BankAide since 2004 and NHS Lanarkshire now has more than 3,000 members on the nurse bank. There are guidelines on the use of temporary nursing staff supported by an electronic request system that speeds up the process of arranging bank nurse cover. In 2005/06, 90 per cent of all requests for cover for nursing shifts were met by bank staff.

Funding from the SEHD to support the nurse bank has been used, in part, to support ongoing professional development of bank nurses.

The nurse bank is being used as a route into nursing employment in NHS Lanarkshire. The bank is working with Scottish Enterprise Lanarkshire, Job Centre Plus and Cumbernauld College to provide a clinical support worker training course. The project won a Scottish Training Award in 2005.

Source: ISD Scotland Workforce Statistics, BankAide Annual Report 2005/06 and NHS Lanarkshire

100. Overall, the shift away from agency nursing and the growth of bank nursing as a way of meeting temporary staffing needs is consistent with the SEHD recommendations and has been helped by the various measures taken to promote nurse banks. However, the increase in the combined use of bank and agency nurses has been substantial. This trend should be regularly reviewed to ensure that bank nurses are not used as a substitute for effective workforce planning and that the quality of nursing care provided by bank staff is maintained.

Recommendations

- Boards should keep the growth of bank nursing under review to ensure the quality of care is maintained and to achieve an appropriate balance between the use of bank nursing and substantive posts.
- Boards should assess the factors increasing the combined use of bank and agency nursing and develop strategies for managing any underlying demand and supply pressures that remain unresolved.
- Boards' strategies for managing the growth in demand for nursing staff to cover temporary staffing needs should be integrated with recruitment and retention strategies and establishment setting, including the development of PAAs and protected time for nurses with overall team leadership responsibility.

Part 5. Summary of progress and recommendations

The following table summarises progress made since the baseline report and makes recommendations regarding further work required. We have commented on the broad themes covered by the recommendations made in the baseline report, rather than commenting on each recommendation individually. Overall, the SEHD and the NHS in Scotland, working with organisations such as the RCN, have laid the foundations for the future development of ward nursing workforce planning, although work still needs to be carried out to make further progress.

Recommendations	Progress since the baseline report	Recommendations
Workforce planning	• Dedicated workforce planning staff are in place in each board. Workforce planning has been strengthened at board and regional level. • Information on many of the ward-level indicators recommended in the baseline report is being used to manage the nursing workforce. • Methods and processes for reviewing nursing establishments still differ among boards but the SEHD has promoted greater consistency through the recommendations made in the NMWWPP report. • Progress on implementing the recommendations in the NMWWPP report differs among boards. • Substantial work has been undertaken to develop workload measurement tools to support ward nurse planning but further work is required before they can be used routinely in nursing workforce planning.	• All boards should ensure that staff involved in workforce planning have their training needs assessed and met. • All boards should ensure that as part of their nursing workforce planning they incorporate appropriate PAAs reflecting local circumstances. • Following the recommendations of the working groups on workload measurement, boards should assess and plan for the training and cost implications of using workload measurement tools. • The SEHD should clarify whether the NMWWPP action points are recommendations to, or mandatory requirements of, the NHS in Scotland and what the timescales are for their implementation. • The SEHD should keep under review the recommendations on protected time and predictable absence allowances, to ensure they are appropriate in light of the results of the senior charge nurse review trends in predictable absence and the impact of Agenda for Change.
Recruitment and retention	• The SEHD, boards and NES have implemented a wide range of recruitment and retention programmes, including work to enhance the roles and skills of existing nursing staff. • Total vacancy rates changed little between 2001/02 and 2005/06 but fell between 2004/05 and 2005/06. Vacancy rates are low for posts vacant for over three months. • Total vacancies remain relatively high in some clinical and board areas.	• The SEHD should assess whether existing recruitment and retention schemes with low levels of uptake continue to meet the needs of the NHS in Scotland. • The SEHD and the NHS in Scotland should review their strategies for reducing vacancies in certain specialties with persistently high vacancy rates.

Recommendations	Progress since the baseline report	Recommendations
Bank and agency nursing	• The SEHD and boards have made progress in monitoring the use of bank and agency nursing, amalgamating nurse banks and drawing up guidelines for the use of bank and agency nursing. • The use of agency nursing has fallen since 2002. Spending on agency nursing has fallen since its peak in 2004 and has fallen over the period as a whole after adjusting for NHS pay inflation. • Use of and expenditure on bank nursing have increased substantially, partly reflecting the aim of shifting the balance away from using agency nursing to meet temporary nurse staffing needs. • Boards continue to face pressures to increase the use of temporary nursing.	• NHS boards should keep the growth of bank nursing under review to ensure the quality of care is maintained and to ensure an appropriate balance between the use of bank nursing and substantive posts. • NHS boards should assess the factors increasing the combined use of bank and agency nursing and develop strategies for managing any underlying demand and supply pressures that remain unresolved. • Boards' strategies for managing the growth in demand for nursing staff to cover temporary staffing needs should be integrated with recruitment and retention strategies and establishment setting, including the development of PAAs and protected time for senior nurse managers.
Quality indicators	• A variety of methods for measuring the quality of nursing care are in use across Scotland but limited progress has been made in developing a system for measuring quality in a consistent way on an agreed set of indicators. • An SEHD-commissioned pilot project hosted by NHS QIS highlighted a number of issues that needed to be resolved before valid and reliable indicators of the quality of nursing care could be developed nationally. • The decision has now been taken to develop a set of nursing quality indicators on a national basis, linked to the review of the role of the SCN due to report in April 2007.	• The SEHD should ensure that a high priority is attached to developing quality indicators in the future and put in place strategies to monitor progress.
Information	• Substantial work has been undertaken to improve information on the current nursing workforce and nursing workload. • Further work is required before this information can be used routinely in nursing workforce planning.	• The SEHD should support analysis and research of the relationships between nurse staffing, workload and quality of care to inform future workforce planning.

Appendix 1. Project advisory group membership

Karen Lockhart	Nursing Officer – Education & Regulation, SEHD
Wendy Wilkinson	Head of National Workforce Unit, SEHD
Eileen Moir	Director of Nursing, NHS Borders and Chair of Nursing Directors' Group
Irene Barkby	Programme Manager, Nursing and Midwifery Workload and Workforce Planning Project and the Nationally Coordinated Nurse Bank Arrangements Project (previously Acute Divisional Nurse Director, NHS Lanarkshire)
Pat Dawson	Head of Policy and Communications, Royal College of Nursing, latterly Jill Cox, Director, Royal College of Nursing
Jan Warner	Director of Performance Assessment and Practice Development, NHS Quality Improvement Scotland
Jim Buchan	Professor, Queen Margaret University College, Edinburgh

Planning ward nursing – legacy or design?

A follow-up report

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Audit Scotland
110 George Street
Edinburgh EH2 4LH

Telephone
0845 146 1010
Fax
0845 146 1009

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