



Health Services Safety
Investigations Body

Investigation report

Workforce and patient safety: temporary staff - integration into healthcare providers

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NHS staff, Patient safety themes

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A note of acknowledgement

We would like to thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements in patient safety.

About this report

This is one of several investigations that HSSIB is carrying out to explore the theme of [workforce and patient safety](#). This stream of work is looking at how working conditions in the NHS can be optimised to support patient safety.

This report is intended for healthcare organisations, policymakers and the public to help improve patient safety in relation to the integration of temporary clinical staff into healthcare providers' teams. This is a legacy investigation completed by the Health Services Safety Investigations Body (HSSIB) under The NHS England (Healthcare Safety Investigation Branch) Directions 2022.

The investigation recognises that temporary staff are used across the healthcare system. The evidence from this investigation was gathered predominantly from secondary healthcare providers and where evidence was obtained from other healthcare providers such as from General Practice, this is indicated in the report.

Executive summary

Background

The NHS regularly uses temporary staff to fill gaps in its workforce, including clinical staff such as doctors, nurses, allied health professionals and healthcare assistants. This investigation explored the challenges of integrating temporary clinical staff (bank only staff, agency staff and locum doctors) into healthcare providers. Integration is important because temporary staff coming into a new healthcare setting may be unfamiliar with its systems, processes and patient groups, which can pose a risk to patient safety.

HSSIB analysed serious incident reports provided by acute and mental health NHS trusts which detailed patient safety incidents where temporary staff had been involved. This identified risks to patient safety. To explore the risks further, the investigation carried out site visits and engaged with NHS trusts, providers of bank staff, agencies that supply staff to the NHS, substantive (permanent) NHS staff, bank and agency staff, and a range of national stakeholders.

This is one of several investigations that HSSIB is carrying out to explore the theme of workforce and patient safety. This stream of work is looking at how working conditions in the NHS can be optimised to support patient safety. Visit the HSSIB website for more information about the work being undertaken within the [workforce and patient safety theme](#).

Findings

- Temporary workers are being discriminated against by some staff, organisations, and national bodies because of their working status, and in some cases because of their ethnicity. This can affect the support they receive and their ability to ask questions, which can in turn impact on patient safety.
- Some temporary workers feel unable to raise concerns about patient safety with the organisation in which they are working because they fear they will lose future opportunities to work in that organisation. Staff from ethnic minority backgrounds face known barriers to speaking up because of their ethnicity; their status as temporary workers adds an additional challenge to raising patient safety concerns.
- Where temporary workers are needed to fill gaps in the workforce, these gaps are advertised with limited information about the knowledge and skills required of the worker to help maintain safe care. This makes identification of suitably trained and qualified workers challenging.
- The knowledge, skills, and levels of experience of temporary workers may be unknown to their place of deployment. This affects an organisation's ability to deploy workers in ways that make best use of their abilities, and can create patient safety risks when workers are placed in situations they are not confident to manage.
- Temporary workers are often redeployed to different areas of an organisation to meet the fluctuating demands on that organisation. This redeployment may also not take into account the abilities of the worker or the impact on patient safety.
- Local inductions to a new place of work for temporary workers are not always effective in preparing the worker to provide safe care in that particular environment.
- Temporary staff do not always have the necessary access to electronic clinical systems which can mean they are unable to access vital patient information, record details of patient care or request tests.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/036:

HSSIB recommends that the National Guardian's Office, working with relevant stakeholders, identify the barriers that prevent temporary staff from speaking up and develops mechanisms to address those barriers. This will build on their work to explore barriers for other staff groups and enable all workers to contribute to patient safety improvements without fear of reprisal.

HSSIB makes the following safety observations

Safety observation O/2024/028:

National bodies can support patient safety by developing credentialing systems which enable staff to verify their competencies when moving between NHS organisations.

Safety observation O/2024/029:

Organisations that provide temporary staff to the NHS can improve patient safety by including information about the NHS England Learn from Patient Safety Events service to temporary staff as part of their onboarding process. This is to enable temporary staff to record patient safety risks if they do not have access to a healthcare provider's reporting system.

Local-level learning

Healthcare providers can use the findings from this investigation as prompts to help them consider how to integrate temporary staff into their workforce.

- How do you enable temporary workers to feed back on their experiences of working in your organisation, to understand the organisational culture in relation to this group?
- How do you ensure that temporary staff know how to speak up and that they feel safe to raise concerns?
- How do you ensure that you are clearly advertising the skills required of a temporary worker to fill a rota gap?
- How do you ensure that the skills and experience of temporary workers are taken into account when redeployments are being considered?

- How do you work with providers of temporary staff to understand the skills and experience of temporary workers so they can be used most effectively?
- How do you ensure that temporary workers can access electronic systems and physical environments that are vital to providing safe care?
- How do you ensure that inductions are carried out and that the time needed to complete local inductions is factored into the workload of staff?
- Do you have a dedicated and accountable professional lead for ensuring that local inductions are carried out?

1. Background and context

1.1 Introduction

1.1.1 This investigation report is part of a wider programme of work being carried out by HSSIB on the theme of workforce and patient safety. The investigation focused on temporary clinical healthcare staff who work in the NHS in England and sought to identify the challenges this cohort of staff experience that may impair their ability to deliver safe patient care. While temporary staff are present throughout the NHS, including in non-clinical roles, the scope of this investigation was limited to clinical staff only (that is, those with a direct role in the care and treatment of patients).

1.1.2 The investigation analysed 30 serious incident reports (investigation reports by local trusts into patient safety incidents) that were conducted between May 2022 and May 2023, where temporary staff had been involved in the incident. More details about how the analysis was carried out can be found in the appendix. This analysis identified that the safety of patients may be put at risk where temporary staff have not been appropriately integrated into healthcare providers and local clinical teams (for example, a ward). This investigation specifically considers the role of induction and orientation for temporary staff.

1.2 Background

The NHS workforce

1.2.1 The NHS has a shortfall of staff which has been recognised to impede patient safety (NHS Providers, 2022). Many of the gaps in staffing left by the shortfall are filled using temporary staff, with 'an estimated four in five registered nurse vacancies and seven in eight doctor vacancies ... being filled by temporary staff' (Nuffield Trust, 2022).

1.2.2 Clinical staff may be employed directly by the NHS or work under various contractual arrangements. Staff who have a permanent contract with an NHS trust are known as substantive staff. This investigation focused on three specific types of temporary staff: bank only staff, agency staff and locum doctors. These are described below.

Bank staff

1.2.3 Bank staff are flexible workers who can be contracted directly by a provider or through an outsourced organisation to take on shifts which are available due to planned or unplanned gaps in rotas. Some substantive staff work extra shifts as bank staff. Other bank staff do not hold substantive posts and take on available shifts on an ad hoc basis in line with their individual choices – these are known as bank only staff.

1.2.4 Trusts will often have a local bank of staff they can offer shifts to and there are also regional or collaborative banks which can be drawn upon to fill rota gaps. In this investigation report the term bank staff is used to refer to non-doctor clinical staff, such as nurses or healthcare assistants.

Agency staff

1.2.5 In this investigation report the term agency staff is used to refer to non-doctor clinical staff who are contracted through an agency, such as agency nurses or healthcare assistants.

1.2.6 NHS healthcare providers may use agencies to secure temporary staff to cover gaps in rotas. The Nursing and Midwifery Council told the investigation that approximately 5% of Nursing and Midwifery Council registrants work for an agency, equivalent to around 16,000 staff. The use of agencies in the NHS is monitored by NHS England, which collects data on the number of shifts undertaken by agency staff and the associated costs. Data provided by NHS England indicated that the shifts completed by agency staff in 2023 cost £3.4bn, which was approximately 2.3% of the overall workforce budget.

1.2.7 There are attempts at a national level to reduce the spend on agency staff (NHS England, 2023a). However, it has been recognised that while shortfalls in staffing exist in the NHS 'they will continue to be largely covered by use of temporary staffing, including a mixture of bank and agency' staff (NHS England, 2023b).

1.2.8 Many agencies provide staff to the NHS and each healthcare provider will have individual arrangements with the agencies they use. Temporary staff may work for a number of agencies and may work just one shift at a particular provider, or for a set number of shifts over a period of time, depending on the needs of the provider and choice of the staff member.

1.2.9 NHS England has mandated that trusts use only agencies which are governed by an authorised framework agreement (NHS England, 2023a). At the time of drafting this report, two such framework agreements had been approved by NHS England for use in the provision of clinical staff. These framework agreements provide a level of assurance by stipulating certain requirements which the agency must adhere to. The organisations that designed and manage these frameworks are known as the framework operators. These organisations undertake audits of elements of their framework in order to provide assurance that agencies are meeting the required standards.

1.2.10 Some agencies operate 'off-framework' which means that they are not signed up to a framework agreement but still offer staff to the NHS. While the use of framework agencies is mandated the NHS England 'Agency rules' do allow the use of such agencies 'on exceptional patient safety grounds only' and subject to executive sign-off (NHS England, 2023a). Trusts that use an off-framework agency must follow strict reporting requirements, reporting to both their integrated care board (the NHS body responsible for planning and arranging for the provision of healthcare services within their geographical area) and to NHS England.

1.2.11 In England, NHS providers are regulated by the Care Quality Commission. However agencies that supply workers to these providers are not regulated by the Care Quality Commission. The Employment Agency Standards Inspectorate is the recruitment sector regulator and ensures the rights of workers are maintained and that minimum legal standards are complied with. These minimum legal standards include ensuring the work seeker has the right qualifications, experience and training to carry out the role they are being placed into.

Locum doctors

1.2.12 A locum doctor or 'doctor in locum tenens' is defined as 'one who is standing in for an absent doctor, or temporarily covering a vacancy, in an established post or position' (NHS Executive, 1997). Locums may have a contract directly with a healthcare provider, or work through a locum agency.

1.2.13 The most recent data available from the General Medical Council shows that in 2017 there were 43,346 licensed doctors working as locums, which equated to 18.3% of the total doctor workforce (General Medical Council, 2018). This data includes 'locum only' doctors (those who work only as locums) and those who undertake locum work while also maintaining a full-time or part-time contract within the NHS.

1.2.14 NHS England has recognised that there are challenges for those working as locums in relation to 'continuing professional development, appraisal, revalidation [meeting the necessary requirements to remain a registered doctor], and governance' (NHS England, 2018). Guidance has been issued in recognition of this, entitled 'Supporting locums and doctors in short term placements: a practical guide for doctors in these roles' (NHS England, 2018).

The National Guardian's Office

1.2.15 The National Guardian's Office was set up in response to recommendations made by The Freedom to Speak Up Review (Francis, 2015) and provides support, training and leadership to more than 1,000 Freedom to Speak Up Guardians across England. The Freedom to Speak Up Guardians are primarily in independent and NHS healthcare providers as well as national organisations. They 'operate independently, impartially and objectively, whilst working in partnership with individuals and groups throughout their organisation, including their senior leadership team.' (National Guardian's Office, 2018). Their role is to:

- 'Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement' (National Guardian's Office, 2018).

To achieve this they ensure that:

- 'Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement' (National Guardian's Office, 2018).

2. Patient safety incidents and harm

The following anonymised vignettes, based on serious incident reports provided to the investigation by NHS trusts, demonstrate the patient safety impacts of a lack of integration of temporary staff into teams. The vignettes illustrate common themes found in the serious incident reports reviewed by the investigation.

2.1 Vignettes

Jack

2.1.1 Jack had been receiving mental health care and his care had recently been transferred from child to adult mental health services. He had been detained under Section 2 of the Mental Health Act and was working towards discharge. This had led to increased anxiety and some thoughts of self-harm.

2.1.2 One evening Jack telephoned his father and told him that he had ingested batteries, in an act of self-harm. Jack's father contacted the ward and the ward staff talked to Jack; he was taken to the local emergency department (ED) for assessment and treatment.

2.1.3 Jack was escorted to the ED by a member of agency staff from the mental health ward. Limited handover had been given about what the role of the escorting staff member was, whether they were just escorting the patient, or were expected to maintain continuous observation (the clinical intervention of continuously engaging with and observing a patient to reduce their risk of self-harm).

2.1.4 While ED staff were deciding whether Jack needed to have surgery, the escorting staff member went to use the toilet, leaving Jack alone. While they were absent Jack absconded from the hospital and was later found near a railway track. Jack was returned to the ED by the police and received treatment for the battery ingestion.

2.1.5 The incident was initially not recorded on the mental health trust's incident reporting system as the agency staff member did not have access to the system. It was recorded by a substantive member of staff who was not present at the time of the incident.

Enzo

2.1.6 Enzo, who was 88 years old, was admitted to the acute hospital via the ED following a fall at home. Enzo had not sustained any injury from the fall but was found to have a urinary tract infection. His past medical history included recurrent falls and dementia.

2.1.7 Enzo remained in hospital, receiving treatment for his urinary tract infection while plans were made with the local authority in relation to a package of care. His discharge was delayed due to him developing pneumonia.

2.1.8 Enzo got up from his bed in the early hours of the morning to use the toilet and fell to the floor. A nearby staff member immediately came to his aid and a doctor was called to attend. Enzo suffered a broken hip which required surgery. During this time the ward was being staffed, in part, by temporary staff.

2.1.9 The local investigation identified that the nightlights on the ward had been turned off, limiting visibility in the area where Enzo had his fall. The local investigation found that the requirement to keep nightlights on was not included in temporary staff induction. Similarly, the local investigation found that following his fall, Enzo's risk assessment was not updated, again due to temporary staff's lack of knowledge of this policy because it was not included in their induction.

Mary

2.1.10 Mary, who was 86 years old, suffered a traumatic haemothorax (blood inside the chest cavity) when she lost consciousness and fell at home. She was taken to the ED and had a chest X-ray before being moved to the same day emergency care unit for older people.

2.1.11 The local investigation found that there were delays in a CT scan of her chest being completed, which meant that this was outstanding when her health deteriorated and she died, 2 days after admission. One factor that contributed to the delay was that access restrictions meant the locum doctor in the same day emergency care unit was not able to use the electronic system to request a CT scan.

3. The investigation

The investigation analysed the serious incident reports (see 1.1.2) and identified issues relating to the induction and orientation of temporary staff. The investigation's examination of the induction and orientation of temporary staff identified factors that contributed to the safety of patients when receiving care from temporary staff. These factors are explored under the following headings:

- Processes for allocating temporary staff to teams.
- Processes for staff induction and orientation on arrival in the clinical areas.
- Organisational cultures and attitudes in relation to temporary staff.

3.1 Processes for allocating temporary staff to teams

3.1.1 The investigation explored the process by which temporary staff are deployed within NHS trusts and how patient safety is considered in their deployment. These elements are explored through the consideration of rota gaps and the redeployment of staff.

Rota gaps

3.1.2 Through engagement with trusts, the investigation learned that most trusts used a tiered approach to advertising available shifts, to encourage these to be filled firstly by substantive and then bank staff before being offered to agencies. Several trusts told the investigation that the main reason for this approach was to minimise costs, because it is more expensive to hire staff through an agency.

3.1.3 Agencies told the investigation that when shifts were made available to them, aside from the date and time, commonly the only information provided was the type of staff being sought (for example nurse or health care assistant), and the name of the ward. They explained that

they would usually know the type of ward from their experience with the provider, but that additional information about the skills being sought was not provided and this affected their ability to identify appropriate staff.

3.1.4 Similarly, temporary staff managers in trusts told the investigation that they would be informed of a staffing gap which needed to be filled but not the experience that was required. They may be told “I need an RMN [registered mental health nurse], rather than I need an RMN with experience in XYZ”. The investigation was told that this lack of information meant that identifying the correct person, whether bank or agency, to fill a rota gap was challenging.

3.1.5 Nationally it has been recognised that ‘having the right numbers of nursing staff, with the right skills, in the right place, at the right time improves health outcomes, the quality of care delivered, and patient safety’ (Royal College of Nursing, 2021).

3.1.6 Similarly, the Nursing and Midwifery Council has recognised that the delivery of safe care relies on safe staffing, which is about ‘skill mix as well as numbers’ (Nursing and Midwifery Council, 2016). Studies have also shown that the way temporary staff are ‘recruited, employed and used by organisations, may result in a higher risk of harm to patients’ (Ferguson et al, 2021).

3.1.7 Trust staff told the investigation that they had no information about the skill set of a temporary staff member prior to their arrival and this meant that the allocation could only be done on the basis of their role rather than their skills or experience. Agencies told the investigation that CVs of temporary staff were provided when they were put forward to work at a trust but that this information was not commonly available to ward staff. This led to temporary staff “not being used to their full capacity”.

3.1.8 In addition, trusts told the investigation that while a certain skill level could be expected of registered staff, such as nurses, there was a lack of “trust” between providers in relation to the training of clinical skills. There was also no system which enabled temporary staff to demonstrate verifiable competencies over and above core skills across different organisations. This meant that incoming temporary staff would usually not be allowed to carry out interventions, such as siting a cannula (a thin tube inserted into a vein to enable administration of medications and fluids), until their skills had been assessed by a member of the team. The need to assess skills placed an extra burden on the ward staff and, the investigation learned, often led to temporary staff being allocated to a clearly defined task rather than wider duties.

3.1.9 For example, the investigation was told that in a mental health setting temporary staff were commonly allocated to undertake continuous observation, as this was considered to be a clearly defined task which was not complex. However, the investigation heard of many instances where temporary staff carried out this role for many hours at a time. HSSIB has

explored the task of continuous observation and noted the importance of supporting staff who undertake this task, including the need for regular rotation and adequate breaks ([Health Services Safety Investigations Body, 2024](#)).

3.1.10 Studies have identified that locum doctors too were often allocated what were considered to be 'low-risk/low skill routine procedures' (Ferguson et al, 2021). Agencies and national organisations told the investigation that when temporary staff were seen to be doing less than their substantive colleagues it caused frustration and added to the cultural challenges between the groups (see 3.3).

3.1.11 The investigation explored initiatives such as e-rostering and the digital staff passport, which were respectively developed to enable the more efficient use of staff and to 'enable staff to more easily move from one NHS employer to another' (NHS England, 2021). While e-rostering systems have the functionality to record skills, this function is not always used for substantive staff, and while some providers did include temporary staff on their system, this was not the norm.

3.1.12 The digital staff passport is currently being developed to hold a staff member's personal, employment, core skills and occupational health information for substantive staff who are moved temporarily, and postgraduate doctors on rotation. NHS England told the investigation that there were plans to further develop the digital staff passport to include bank workers and that while including agency workers was technically possible, there were no plans to do so. It was explained that there were challenges around including experience or skills over and above core skills (which include fire safety, moving and handling and safeguarding) as these would need to be independently verifiable. The investigation explored the use of credentialing systems used by other industries, as detailed below.

Case study 1

The investigation engaged with a UK Fire and Rescue Service to see how similar challenges are managed and identified in that setting. The investigation learned that the fire and rescue service used an electronic system to identify rota and skills gaps across multiple locations, based on information entered by individual fire stations at the start of a shift. Their 'resource management system' then identified the skill sets missing due to rota gaps and matched them against appropriately trained staff who could be redeployed from other stations to cover the gap. The system used codes to represent skills-based attributes, commonly referred to as 'tags', to identify the right person with the right skills

to cover the rota gap. In this case there was assurance of the skills as all staff were within the same fire and rescue service and so there was consistency of training and skills recording.

Case study 2

The investigation engaged with the Rail Safety and Standards Board and learned that in the rail industry there is an authority to work system called Sentinel. It consists of an identity card with a QR code, which can be scanned using an associated app to see a log of training and competencies, which have been completed through an authorised training provider. Checks are made at the start of every shift, as competencies can change, and the identity cards are also used to manage access to work sites.

3.1.13 Credentialing systems are in use or being developed in the NHS in some areas, such as sterile services (NHS England, 2024). One system which has been launched is the Royal College of Obstetricians and Gynaecologists certificate of eligibility for short-term locums, which is designed to enable verifiable competencies for temporary clinical staff. This became a 'pre-requisite' for employment of short-term locums for middle grade rotas (2 weeks or less) in England from February 2023. It relies on locum doctors compiling evidence which is submitted and then assessed. The evidence includes mandatory clinical skills which have been 'signed off' by an individual with appropriate experience (Royal College of Obstetricians and Gynaecologists, 2022). This system was developed as part of guidance on the engagement of short-term locums in maternity following a number of reports from coroners highlighting the need for support and supervision of obstetric locums (doctors specialising in care during pregnancy and childbirth).

3.1.14 Work has been ongoing for many years in the area of passports and credentialing for clinical staff. Initiatives such as digital badges (Health Education England, 2024) have been developed but these are relevant specifically to qualifications earned rather than recognition of skills. Similarly the digital staff passport currently in use relates to core skills only, as discussed above. The need for a system to capture skills and competencies, as well as its importance to patient safety, is reflected by the development of the Royal College of Obstetricians and Gynaecologists' system.

HSSIB makes the following safety observation

Safety observation O/2024/028:

National bodies can support patient safety by developing credentialing systems which enable staff to verify their competencies when moving between NHS organisations.

Redeployment of staff

3.1.15 The investigation was told by trusts, agencies and bank providers that while staff may be booked to work a shift on a particular ward or department, it was common for staff to be redeployed to cover emerging rota gaps. The investigation was told that such moves could occur at the start of a shift or during a shift and that substantive and/or temporary staff could be moved. Trusts told the investigation that they would more commonly move temporary staff as while substantial staff's contracts enable such moves, they were often unhappy to move from their usual place of work and some may "refuse" to move. The investigation was told that temporary staff may also not want to move because they would be expecting to work in a particular ward or environment. Refusal to move was said to be a common reason for complaints to be made by trusts to agencies and for those staff members not being offered further work.

3.1.16 The investigation was told by both agencies and trusts that temporary staff were seen as moveable, regardless of whether they had been booked for a shift on a particular ward or not. Agencies told the investigation that multiple moves within a shift could also occur, with examples given of up to "eight moves" in the course of one shift. The agencies explained that this was challenging for the worker as such moves could occur without notice, the worker may be moved to an area they are less familiar with, and their skill set may not match the requirements of the ward.

3.1.17 Agencies engaged with during the investigation said that such allocations were often done on the basis of ensuring that the correct number of staff were on a particular ward rather than matching the skills of the worker. One example given was a nurse who was experienced in ward-based care being moved to the intensive care unit, which is a very different environment requiring a different skill set.

3.1.18 The Royal College of Nursing (n.d.) has published an advice guide, 'Redeployment and unsustainable pressures', which states that 'an individual's unique experiences and skills' should be considered in relation to any redeployment, as should any 'staff limitations and competencies'. This document, although aimed mainly at substantive staff, highlights the importance of matching skills and experience to any redeployment.

3.1.19 Agencies told the investigation that staff may feel out of their depth when they are moved and feel that they are being put into a difficult position. Agencies explained that if staff refused a move it could affect whether they were offered work at the trust in future. However, if they accepted the move it could mean working outside their area of expertise, creating the potential for both a patient safety risk and action by their professional regulator.

3.2 Processes for staff induction and orientation on arrival in the clinical areas

3.2.1 The investigation was told by trusts that due to the short-term nature of their position, agency workers did not follow the usual induction processes that are in place for substantive staff, which could last several days. While bank staff usually received the standard induction, agency workers and short-term locums expected to receive an induction when they arrived for their shift.

3.2.2 Trust senior leadership teams engaged with during the investigation recognised that inductions “should” take place but acknowledged that they did not always happen; few knew how often they occurred. Reflecting this, one trust told the investigation that while an induction was mandated on its wards, it could not say “hand on heart” that it took place.

3.2.3 National documents have outlined the expectation that inductions take place, including the Royal College of Nursing (2021) workforce standards and NHS England’s ‘Supporting locums and doctors in short-term placement’ guidance (NHS England, 2018). The completion of an induction by a trust is also a requirement which forms part of the auditing process by agency framework providers (see 1.2.9), although this does not require any exploration of the content or effectiveness of the induction.

3.2.4 Studies have identified that the lack of an ‘adequate induction’ for locums impacts on their awareness of local contexts and their knowledge of local policies and procedures which are ‘relevant to providing safe and effective care’ (Ferguson and Walshe, 2019). Similarly, the Care Quality Commission (2024) found that ‘a lack of training and support can prevent agency staff from providing the high-quality care they set out to deliver’.

3.2.5 The investigation explored the induction processes in place at nine NHS trusts. These processes varied in their content and delivery, and in the expectations of what pre-deployment induction (induction provided prior to a shift) had been completed by the temporary worker. Some trusts and wards had developed induction checklists to try and ensure consistency of approach and content. However, the checklists varied between providers and individual wards which meant that it was unclear whether inductions were being completed as expected.

3.2.6 Trust ward staff who led inductions told the investigation that that there was often limited time to complete an induction as the arrival of temporary workers would coincide with the shift handover. This meant that inductions added to their workload at a busy time. Staff described inductions as taking anywhere between a few minutes to an hour, depending on the environment and the person leading the induction. Staff who led inductions told the investigation that completing inductions was seen as an additional task and not an acknowledged part of their workload.

3.2.7 The investigation was told by ward staff that there was no protected time for temporary staff inductions and the number of inductions needed would vary from shift to shift, making the task more onerous on some shifts than others. A further complication was that sometimes temporary staff arrived after a shift had already started, because they were late or had been redeployed, leaving no time to complete an induction. Agencies told the investigation about temporary staff receiving an induction while the shift handover was taking place, which meant that although they had received an induction, they had no knowledge of the patients they then had to care for.

3.2.8 The investigation engaged with staff at a membership organisation which also links locum GPs with practices requiring cover. They explained that if a practice wished to advertise their available role(s) using their platform they had to complete an online locum pack. This included information about the practice's processes and key contacts as well as detailing processes for arranging clinical investigations and referrals. The locum pack was designed as a directory which the locum could search to quickly identify the information they needed. The membership organisation told the investigation that the availability of such information was vital for GP locums as they are licensed to practice independently, without supervision.

Content of the induction

3.2.9 Healthcare providers and national stakeholders that the investigation engaged with recognised that a good induction is important to the successful placement of a temporary worker and to patient safety. However, agencies and temporary workers told the investigation that the induction felt like a "tick box" exercise. National documents produced by the Royal College of Nursing, the Royal College of Obstetricians and Gynaecologists and NHS England have outlined expectations of what a local induction should include (NHS England, 2018; Royal College of Obstetricians and Gynaecologists, 2022; Royal College of Nursing, 2021; Royal College of Nursing, n.d.). However, none of these documents are binding on providers, and apart from these indications there is no standard description of what constitutes a local induction or what it should include.

3.2.10 This lack of a standard reinforced the variability between providers and even wards. The investigation was told by an agency that when workers reported not having received an induction, it had been confirmed that an induction had taken place but may not have appeared as such as it only lasted “a couple of minutes”. At one trust visited by the investigation it was explained that the induction for temporary staff simply involved giving them a trust policy to read which related to the task they were to be allocated to; no other information was provided. At another trust an induction in the emergency department consisted of showing temporary staff the fire exits and resuscitation trolley.

3.2.11 The investigation was told by trusts that when complaints had been made about the effectiveness of temporary staff it often transpired that they had not been given any induction. This meant that they did not have the same opportunity to follow the local processes and procedures and that they were seen as ineffective without being given the tools to practise effectively. An example of this can be seen at 2.1.9.

3.2.12 The investigation was told by trust staff that because the requirements of wards and departments differed, a standard induction would not be possible and they needed to be individually tailored. However, the investigation observed that even the approach to the induction of temporary staff was different from ward to ward. This meant not only that learning across wards was limited, but that temporary staff who worked on different wards would experience different induction formats.

3.2.13 The investigation observed that the ownership of inductions differed between wards and providers and this affected whether or not they took place. Some trusts had introduced the role of professional lead for inductions who was accountable for ensuring they were done. This led to more inductions being completed. The use of accountabilities to manage safety risks is in line with a safety management approach ([Health Services Safety Investigations Body, 2023](#)) and may be a way of healthcare providers managing this risk.

3.2.14 The investigation explored potential recommendations in relation to staff inductions. It noted that while a standard of core components for a local induction could be created this would not generate capacity in the system to complete inductions, which was a core problem. The investigation has therefore provided local-level learning for consideration by individual providers, which can be found above.

Access to electronic systems

3.2.15 To provide safe care to patients, healthcare workers require access to electronic systems such as patient records systems, referral systems and results systems, as well as incident reporting systems ([Health Services Safety Investigations Body, 2024](#)). However, the investigation was told that it was not uncommon for temporary staff to be unable to access such systems, as demonstrated in 2.1.5.

3.2.16 Providers told the investigation that temporary staff may not have access to many electronic systems used within a department as “everything relies on passwords” and that while “longer-term temporary staff [may] have good access” it was not seen as “worth the trust’s efforts” for shorter-term staff.

3.2.17 The problem of access to electronic systems was well known across providers and national stakeholders, with some commenting that “the safest environments for temporary staff to work in were those where paper-based notes were still used as there were no access issues”. The potential impact of such challenges is highlighted in the vignette about ‘Mary’ (see 2.1.10 to 2.1.11) where a delay in requesting a CT scan, caused by a locum doctor not having requesting rights, contributed to the incident, in which the patient died.

3.2.18 The investigation was told that temporary staff sometimes had to rely on substantive staff to access systems on their behalf and, on occasion, record actions in the notes. This was said to increase the pressure on substantive staff by adding to their workload and ‘risks resentment’ as a result. Some wards visited had ‘generic’ logins for use by temporary staff to enable them to record care provided. The availability of such logins varied not only between healthcare providers but also between individual wards within a provider.

3.2.19 One risk of this approach, highlighted to the investigation during a site visit, was that it relied on the temporary staff member including their name when recording in the notes. If they left out their name, it was impossible to show who had written the entry. The Parliamentary Health Service Ombudsman told the investigation that it had experienced this challenge when undertaking an investigation, as the nurse involved in a specific aspect of care could not be identified because they had used a shared login.

3.2.20 The investigation was also told of “break glass” logins which would allow a temporary staff member to be allocated a login, assigned to them, which lasted 24 hours. These were used as the exception rather than the rule.

3.2.21 Some agencies and trusts had put processes in place to ensure that temporary staff coming into the healthcare provider had access to the required electronic systems. For example, in one case the contract between the agency and trust required temporary staff to complete the relevant training or access requirements before they could be booked for any work. Trusts indicated that this stipulation had not affected their ability to fill rota gaps and had eliminated access problems for temporary staff.

3.2.22 Following the publication of [‘Workforce and patient safety: temporary staff – involvement in patient safety investigations’](#) (Health Services Safety Investigations Body, 2024), HSSIB was contacted by someone who volunteered at a trust. They explained that the issues around access to systems, including incident reporting and electronic patient record systems, also applied to people who volunteer at trusts. They described being one of over 1,000 volunteers at

the trust, of whom a “significant number” had direct patient contact. While volunteers are outside of the scope of this investigation, this highlights that issues around access to electronic systems are not limited to temporary staff and access needs to be considered more widely.

3.2.23 The NHS England Learn from Patient Safety Events service (LFPSE) is a system for recording patient safety events and enabling them to be analysed. It replaces the National Reporting and Learning System and the Strategic Executive Information System. LFPSE was due to be fully rolled out in autumn 2023. Local reporting systems feed into the LFPSE service, and there is also an option to record patient safety events online without the need for access to a local reporting system.

3.2.24 Although the roll-out of LFPSE has been underway for 2 years, it was not mentioned to the investigation by any healthcare provider, or by any organisation that provides temporary staff. While temporary staff are often unable to access local systems for recording patient safety events, there is an online national system which this staff group can access without the need for a login. However, lack of knowledge of this system appears to be a barrier to its effective use.

HSSIB makes the following safety observation

Safety observation O/2024/029:

Organisations that provide temporary staff to the NHS can improve patient safety by including information about the NHS England Learn from Patient Safety Events service to temporary staff as part of their onboarding process. This is to enable temporary staff to record patient safety risks if they do not have access to a healthcare provider’s reporting system.

3.2.25 The investigation was told that physical access could also be a problem for temporary staff, with staff not being provided with keys/passes and so being unable to make their way around locked wards. One trust told the investigation that they “found that there are certain bits they [temporary staff] can’t do, for example they don’t have swipe cards which means they can’t get into sluices (closed areas used to manage waste) or into one of the drug rooms”. In one extreme example, the investigation was told by a locum doctor that they were delayed in attending an emergency because it occurred in a ward requiring card access and, as a temporary staff member, they had not been given a card.

3.3 Organisational cultures and attitudes in relation to temporary staff

3.3.1 The culture of an organisation is known to influence the safety of patients and the wellbeing of staff (Lu et al, 2022). For the purposes of this report, the investigation has defined organisational culture as the values and norms of an organisation which influence beliefs about, and attitudes and behaviours towards, temporary staff.

3.3.2 The investigation engaged with national stakeholders and organisations who all agreed that elements of the NHS are currently unable to function safely without the use of temporary staff. These stakeholders told the investigation that without temporary staff, patients would likely come to harm because of workforce shortages. However, they also described that the knowledge, skills and attitudes of some temporary workers could put patient safety at risk. These concerns were shared by substantive NHS staff, both frontline and within senior management, as well as by national stakeholders.

3.3.3 Temporary staff and organisations providing temporary staff acknowledged that, as with substantive staff, the mixture of knowledge, skills and attitudes among temporary workers varied. They described concerns that substantive staff in NHS organisations made generalisations that all temporary workers provided poorer care to patients. Temporary workers told the investigation that “the NHS do not like agencies” and the “culture is not good”. Similarly, one national organisation described a “long-term insidious bias” towards locum doctors.

3.3.4 During site visits the investigation heard comments suggesting these generalisations were being made across different organisations. Similarly, studies have found that temporary staff are perceived as ‘inferior’ to permanent staff in terms of quality, competency and safety and this perception impacts on their professional identity, team functioning and relationships (Ferguson et al, 2021). However, studies have also shown that there is ‘very limited’ evidence to support these perceptions (Ferguson and Walshe, 2019). Academics working in organisational behaviours told the investigation that temporary staff were also at risk of being targets of sexual harassment and abuse due to being an isolated group.

3.3.5 The investigation explored how this culture had developed and, through discussions with temporary and substantive staff and national organisations, identified factors which had contributed to the culture. Concerns shared with the investigation included were:

- The perceived pay gap – temporary staff being paid more than substantive staff was consistently reported to the investigation as being the main cause for the sometimes difficult relationship between these groups, and
- negative perceptions – the media coverage around agency costs, the national agenda of reducing the reliance on temporary staff and the perception that they “do less for more money” and were “less accountable”.

3.3.6 The investigation observed that this national narrative had led to the acceptance of othering (distancing a group based on characteristics) temporary staff as there were moves to stop their use, despite acceptance that temporary staff are necessary for the health service to function. One stakeholder commented that the terminology of 'temporary worker' was unhelpful and in fact this group were more appropriately described as "flexible workers". They explained that often people decided to work in this way to support their personal circumstances, including other responsibilities they may have such as being a carer or having young children.

3.3.7 The investigation found that the culture in relation to temporary workers had a negative impact on their ability to integrate into clinical teams. This was found to affect their ability to deliver safe and effective care and to raise concerns (see 3.3.12). It is outside of the scope of this investigation to comment on the value for money of temporary staff, but it is important to acknowledge that perceptions around pay may have an impact on the relationship between temporary and substantive staff.

3.3.8 The investigation experienced challenges in engaging with some agencies, who had concerns about how their organisations may be presented in a published report and how this may be "biased" by the way they are presented in the media. The investigation noted that this stance may be a reaction to the attitudes and behaviours towards temporary staff explored above. Other agencies openly engaged with the investigation and were supportive throughout.

Patient safety impact

3.3.9 As a result of the culture described above some temporary staff felt unwelcome, not part of the team and "disposable" while working in the NHS. They described being told "we don't need you" when having been deployed and substantive staff sticking together, not providing them with support and, on occasion, not passing on important clinical information or answering questions.

3.3.10 In his first report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Sir Robert Francis identified cultural themes among the workforce which had contributed to patient harm at the Trust. These included bullying, isolation and acceptance of poor behaviours (Francis, 2013). Similarly, there has been recognition that those in temporary roles are part of an 'outsider group' and that this can affect the support they receive (General Medical Council, 2019; Nursing and Midwifery Council, 2022). The investigation observed evidence of isolation such as temporary clinical staff being referred to as "agency" instead of their role, such as a nurse.

3.3.11 Temporary workers also described to the investigation the wider impacts of the above cultures, such as limited support after incidents ([Health Services Safety Investigations Body, 2024](#)) and a more punitive response compared to substantive staff to any concerns raised about their performance. The rationale given by substantive ward staff for this was that "It's not the same, they're bank". Trusts told the investigation that there were limited remedies available

to them when an issue had been raised about a temporary worker. They explained that in such circumstances patient safety was paramount, which meant their chosen route was to block temporary staff from working, even for minor complaints. However, trusts acknowledged that the response to issues with temporary staff was often harsher than for substantive staff.

Speaking up

3.3.12 The investigation was told by agencies that because of the culture that can exist within healthcare providers, temporary staff can feel vulnerable about raising concerns. Temporary staff told the investigation that raising concerns can lead to them being seen as a “troublemaker”, potentially resulting in them being “blacklisted” from working at the provider.

3.3.13 Agencies told the investigation that workers who are concerned about safety on a ward may ask the agency not to place them there again, rather than telling the agency about their concerns. They might only talk about their concerns after further probing by the agency. While it was acknowledged that there is a professional duty to report such concerns, staff are afraid to do so because of fear of reprisal. The ‘Reading the signals’ report (Kirkup, 2022) described similar findings.

3.3.14 The NHS Race and Health Observatory told the investigation that workers from ethnic minority backgrounds are less likely to speak up as they are more likely to experience “harsher consequences” if they do. This was also described by the National Guardian’s Office. Both organisations said that there was a high number of people from ethnic minority backgrounds employed as temporary workers, which is supported by NHS data (NHS Staff Survey, 2024), and these workers then experienced additional challenges around speaking up due to their status as temporary workers.

3.3.15 The investigation was told by some temporary staff that they had experienced discrimination on the grounds of race from both patients and other staff members. The investigation observed that some temporary staff accepted such discriminatory behaviours as the norm, saying “that is just the way it is”.

3.3.16 Trusts, national stakeholders and organisations who supply temporary staff to the NHS told the investigation that they were aware that this group may experience discrimination on the grounds of race when working in the NHS. Reflecting this, studies have identified racism towards locum doctors (Walshe et al, 2023). The 2023 NHS bank only staff survey results identified that bank workers from ethnic minority backgrounds were more likely to experience discrimination both from patients and from colleagues, (NHS Staff Survey, 2024). The NHS Race and Health Observatory told the investigation that temporary staff were seen as “other” due to not being part of the core team. This, coupled with experiencing racist behaviour, may mean they do not feel psychologically safe (feeling able to take risks without fear of negative

consequences) to ask questions or raise concerns, which in turn impacts on patient safety may impact their psychological safety to ask questions or raise concerns, impacting on patient safety.

3.3.17 The National Guardian's Office told the investigation that temporary workers were a group which had been recognised as facing barriers to speaking up. They explained that the National Guardian's Office purposely used the inclusive term 'workers' in their information as they recognised that speaking up was important not only for those directly employed by the NHS but for anyone who worked within the NHS. The National Guardian's Office said that it had developed a training module for Freedom To Speak Up Guardians in relation to equality, diversity and inclusion which would be relevant to temporary workers, and that work in progress relating to international recruitment may also be relevant to this group. However, there was currently no planned or ongoing work specifically relating to the challenges faced by this group.

3.3.18 As well as having a negative impact on their wellbeing, temporary workers' experience of discrimination and barriers to speaking up may mean they do not share patient safety concerns, and therefore mitigations to safety risks may not be put in place. The National Guardian's Office told the investigation it would be able to develop learning for Guardians, and engage with agencies to explain the role of the National Guardian's Office and how temporary staff can speak up.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/036:

HSSIB recommends that the National Guardian's Office, working with relevant stakeholders, identify the barriers that prevent temporary staff from speaking up and develops mechanisms to address those barriers. This will build on their work to explore barriers for other staff groups and enable all workers to contribute to patient safety improvements without fear of reprisal.

What works well

3.3.19 While the investigation found evidence of a negative culture in relation to temporary staff, it also heard of trusts striving to improve relationships. Initiatives included a local temporary staff survey to understand their experience, and a celebration event for bank staff. The investigation was told of bank staff being supported by trusts to develop their competencies and some wards doing appraisals with them.

3.3.20 The investigation also heard from some temporary workers that they felt integrated into teams and were viewed as part of the substantive workforce. These workers had commonly worked a number of shifts on the same ward, and this had enabled them to demonstrate their abilities to the wider team. This reflects the results of the 2022 NHS bank only staff survey results, which found that those bank staff without a 'usual' team felt less valued (NHS Staff Survey, 2023).

3.3.21 Several trusts named individual temporary workers who worked with them regularly as some of the best staff they had. On speaking with such named workers, they told the investigation they had experienced the same preconceptions on arrival at a new deployment, and that when they had shown themselves to be hardworking and diligent they had been accepted and welcomed into the team.

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5. Appendix

Investigation approach

To identify topics for investigation within the workforce and patient safety theme, the investigation reviewed intelligence from service and professional regulators, national reports, the Parliamentary Health and Social Care Select Committee, academia and research. Discussions also took place with a large number of national stakeholders to understand their emerging concerns in this area. As a result of this work four investigations were launched in June 2023 looking at temporary staff, the digital environment and skill mix and integration.

A search of the Strategic Executive Information System (StEIS) (where all serious incidents are reported) was undertaken to identify trends in incidents which have involved temporary staff. This identified 55 reports which referred to bank/agency/locum staff in their description. Trusts (25 acute trusts and 15 mental health trusts) were contacted for copies of these reports and 30 were made available, all of which followed the Serious Incident Framework. Four reports were removed from the analysis as the involvement of bank/agency/locum staff was incidental and no findings or actions related to their involvement.

The reports were coded, using inductive coding (where codes are derived from the data rather than the data being categorised into predetermined codes), by one investigator. The coding was then reviewed by another investigator to ensure, as far as possible, that there was a consistent approach. The investigators undertaking the coding had different professional backgrounds which allowed for different perspectives on the data to be considered. Any differences in the coding were discussed by the investigators before the final coding was agreed.

The investigation developed 53 codes to categorise elements of the data in the reports. Common themes were identified from the coding of the reports, spanning both acute trust and mental health trust reports.

The investigation recognises that there are limitations in the methodology used, due to the varied way in which incidents are reported in StEIS and the number of reports reviewed. However, the identified themes were verified through engagement with stakeholders at both national and healthcare provider level to triangulate the evidence.

Evidence gathering

The investigation undertook site visits at three trusts (two acute and one mental health) and engaged with a variety of staff, including ward managers and patient safety and governance teams, to explore the identified trends. The investigation also engaged with six further trusts (three mental health and three acute trusts), agencies, bank staff providers and representative organisations for both primary and secondary care. Semi-structured interviews were conducted, guided by the Systems Engineering Initiative for Patient Safety (SEIPS) framework (for more information see <https://www.hssib.org.uk/news-events-blog/the-investigators-toolkit-seips/>).

Stakeholder engagement and consultation

The investigation engaged with stakeholders to gather evidence; this also enabled checking for factual accuracy and overall sense-checking. The stakeholders contributed to the development of the safety recommendation and safety observations based on the evidence gathered.

Investigation stakeholders

National organisations	Other organisations/individuals
NHS England	Observations at two acute trusts and one mental health trust
Care Quality Commission	Discussions with three further acute trusts and three mental health trusts
Parliamentary and Health Service Ombudsman	Bank staff providers
Nursing and Midwifery Council	Employment agencies
General Medical Council	A professor and academics in health policy and management
British Medical Association	
NHS Employers	

National organisations	Other organisations/individuals
Recruitment and Employment Confederation	
Employment Agency Standards Inspectorate	
National Guardian's Office	
Royal College of Nursing	