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Journal of Organizational Effectiveness: People and Performance

The Impact of Temporary Staff on Permanent Staff in Accident and Emergency Departments

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The Impact of Temporary Staff on Permanent Staff in Accident and Emergency Departments*

Abstract:

Purpose: The aim of this paper is to address a gap in the recent literature on employment of temporary workers by exploring the impact of temporary workers on the perceptions, attitudes and behaviour of permanent staff with particular reference to their implications for patient safety and service quality in hospital Accident and Emergency Departments. The analysis is set in the context of the job demands – resources theory.

Design/methodology/approach: The research was undertaken using a case study approach with semi-structured interviews in two London hospitals. Participants included staff from the HR director level, clinical managers and permanent staff who all had an influence in the hiring and management of temporary staff in some way. Transcripts were analysed thematically using an adopted framework approach.

Findings: The results indicate that the effect of temporary staff on permanent staff depended on the quality of the 'resource'. There was a 'hierarchy of preference' for temporary staff based on their familiarity with the context. Those unfamiliar with the department served as a distraction to permanent staff due to the need to 'manage' them in various ways. While this was rarely perceived to affect patient safety, it could have an impact on service quality by causing delays and interruptions. In line with previous research, use of temporary staff also affected perceptions of fairness and the commitment of some permanent staff.

Practical Implications: A model developing an approach for improved practice when managing temporary staff was developed to minimise the risks to patient safety and service quality and improve permanent staff morale.

Social Implications: The review highlights the difficulties that a limited amount of temporary staff integration can have on permanent staff and patient care, indicating that consideration must be placed on how temporary staff are inducted and clarifying expectations of roles for both temporary and permanent staff.

Originality/value: This paper studies the under-researched impact of temporary staff, and, distinctively, staff employed on a single shift, on the behaviour and attitudes of permanent staff. It highlights the need to consider carefully the qualitative nature of 'resources' in the job demands – resources theory.

Keywords: Temporary staff, Permanent staff, patient safety and service quality, psychological contract, management, demands, resources.

Paper type: Qualitative case study research

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Introduction:

There is an extensive body of research on the employment of temporary staff. This has explored a range of issues including why organizations hire temporary staff, why people choose to become temporary staff (Hopp, Minten and Toporova, 2016), and how the experience of temporary employment affects individual wellbeing, particularly where the associated job insecurity is a potential source of stress (De Cuyper, Piccoli and Fontinha, 2018). There is also a body of work addressing the role of temporary agencies and how working with an agency can lead to multiple and potentially competing commitments (Chambel, Sobral, Espada and Curral, 2015). However, there is far less research, particularly recent research, exploring the impact of temporary staff on the attitudes and behaviour of permanent staff. It is this gap in the research literature that the present study seeks to address. We do this by reporting a qualitative study of the use of temporary staff in the Accident and Emergency (A&E) Departments of two large hospitals.

The paper is structured as follows. First, we outline the relevant problems and challenges facing A&E departments, as well as their distinctive requirements for temporary staff. We follow this with a brief review of relevant research on temporary employees and on the relationship between permanent and temporary employees. The job demands – resources theory (Bakker and Demerouti, 2017) is used as an analytic framework within which to assess the impact of temporary staff on permanent staff. After describing the research context, the data are presented followed by a discussion of the findings and their implications for theory and practice.

Staff Shortages and Use of Temporary Staff in Healthcare

For the past decade, shortages of staff in the National Health Service (NHS) have never been far from the headlines. The pressures on staff caused by these shortages exacerbate the problem by causing stress and leading to increased absence and labour turnover. Indeed, the Nursing and Midwifery Council (2018) reported that for the first time for many years, between March 2016 and March 2017 the number of registered nurses and midwives fell. While the shortage of staff can affect all healthcare specialties, Accident and Emergency (A&E) Departments are invariably singled out as a particular problem. Research has shown that 18 per cent of nursing posts in A&E lack permanent staff (Royal College of Nursing,

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2017). The government and NHS England claim that there are more doctors and nurses than ever and in particular an increase since 2010. While there is evidence to support this claim, the most relevant statistic is the ratio of clinical staff to patients. On this basis, the number of doctors per 100 patients has increased from 1.93 in 2010 to 1.99 in 2016 while for nurses the ratio has dropped from 6.04 in 2010 to 5.77 in 2016. As NIESR (2017) noted, it is a question of demand and supply and "put simply, there are not enough doctors and nurses to go around". With the statutory obligation of the NHS to provide safe healthcare to the public, there is a need to provide a safe staff to patient ratio on a continuous basis; and with increasing evidence of the consequence of reduced staffing for patient safety and service quality (Aiken et al, 2014), the need to fill staff shortages in healthcare remains a high priority.

A standard response has been to hire temporary staff to cover the shortfall. However, this has led to concerns about costs and patient safety. A report by the Health Services Journal (2015) noted that the costs of hiring temporary staff were estimated to have increased from 3.5 per cent of staffing costs in 2004 to 7.2 per cent in 2015. However, these figures are estimates that are influenced by the extent to which Trusts use their own 'bank' staff. The National Institute for Health and Care Excellence undertook a major review of the problems of employing temporary staff and recommended guidelines for safe staffing levels that would be likely to increase staff requirements in A&E and Critical Care Departments. This report was suppressed and never officially published but was leaked in the Health Services Journal in January 2016. NHS Improvement (to where responsibility for safe staffing levels had been moved from NICE) subsequently published 'agency rules' imposing an NHS approved framework agreement for the use of temporary agency staff including fixed maximum rates. These could only be breached if patient safety was at risk. The NIESR (2017) review revealed that this had helped to reduce the costs of agency staff but in the context of continuing staff shortages was dealing with the symptom rather than the causes of the underlying problem. The requirement to use temporary staff in NHS Trusts will therefore continue for the foreseeable future.

Temporary staff are widely used across all sectors of the economy in the UK and more particularly in a number of European countries and have been the focus of considerable academic research (De Cuyper et al, 2008). However, there are reasons to believe that their use in A&E poses a set of distinctive challenges. For example, temporary staff are likely to find themselves thrown into unfamiliar teams where they may be required to make urgent decisions that could affect the life and future well-being of patients. They should, of course,

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be carefully supervised but in extremely busy departments they can find that they are left to use their own initiative. Not all temporary staff will be well equipped to accept this responsibility and as a result, there is potentially increased risk to patients. In an Audit Commission report (2001) discussing how to maximise the potential of temporary staff, it was emphasised that no matter how qualified a temporary member of staff may be, they will be unlikely to perform at their best in an unfamiliar setting as time can be wasted asking where equipment is, and adjusting to subtle differences and nuances between wards, departments and different hospitals. Limited knowledge of hospital environments can be rectified by the provision of staff induction, including a guide around the working area, an introduction to policy and practices and to key members of ward staff who they may be working alongside. This responsibility can fall on already busy staff members, who may not have the time to provide the quality of induction necessary with potential implications for the quality of patient care that temporary staff can provide. Permanent staff find themselves having a responsibility to ensure safe working among temporary staff; however, when dealing with staff who are unfamiliar with A&E work this can be time-consuming and can detract from their own urgent work. This in turn can affect the quality of patient care.

Most attention has focussed on the temporary staff and how to address staff shortages while paying less attention to the implications for permanent staff in A&E Departments. But there are potentially major albeit not well understood challenges for permanent staff when temporary staff are required. The aim of this paper is therefore to explore the use of temporary staff in A&E departments focusing on their impact on permanent staff and how this affects patient safety and service quality. We set this in the context of research on temporary employment and within the conceptual framework for the job demands – resources model (Bakker and Demerouti, 2007).

Research on Temporary Staff

Two dominant models have been used to explain why organizations hire temporary staff. The first concerns the advantages of flexibility (Atkinson, 1984: Cappelli, 2000) and the desire to balance variations in demand for labour with the desire for efficient use of labour. This results in recommendations to have a core of highly valued employees combined with a range of more peripheral workers including temporary staff. Lepak and Snell (1999) have set out criteria for determining whether staff should be viewed as core or peripheral, depending on their distinctive value to the organization. There are more prosaic reasons for hiring temporary staff such as cover for sickness, holidays, maternity/paternity leave and during the time taken to select replacement staff for others who have left. The second model

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3 focuses on institutional arrangements and in particular legislation concerning temporary
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5 employment (Damiani, Pompei and Ricci, 2014). For example, in some European countries,
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7 with Spain as a prime example, it is very difficult to fire permanent staff and therefore
8 extensive use of temporary staff provides a source of flexibility. However, neither model is
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10 fully able to account for the circumstances of healthcare in the UK where the problem, as
11 noted above, is mainly one of a chronic gap between the demand and supply of staff.
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14 Research exploring why people engage in temporary work reveals a range of motives (de
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16 Jong et al, 2009). Most studies reveal that about a third of people prefer to have temporary
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18 work primarily because it suits their domestic or educational needs, and the ability to
19 combine work and non-work roles. Others use temporary work as a stepping stone to
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21 permanent employment (Hopp, Minten and Toporova, 2016), perhaps by demonstrating their
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23 value to a potential employer and still others, for example actors, may engage in temporary
24 work between their main employment. Alternatively, temporary work can provide individuals
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26 with the opportunity to gain experience with different tasks and jobs (De Cuyper et al., 2010).
27 Although for some, temporary employment is a personal preference, for a sizeable
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29 proportion of temporary workers it is the only type of employment contract they are able to
30 obtain, especially in countries with restrictive employment legislation that reduces the
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32 propensity for employees to hire permanent staff (Green and Livanos, 2015). The reasons
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34 for opting for temporary work are likely to affect the motivation to perform effectively,
35 especially when working under pressure in bust A&E departments.
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38 Research exploring the attitudes and experiences of temporary staff consistently reveals that
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40 temporary work is associated with higher job insecurity; but, contrary to expectations, it is
41 not invariably associated with lower wellbeing. Indeed, one major European study revealed
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43 that temporary workers reported higher wellbeing than permanent staff (Guest, Isaksson and
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45 De Witte, 2010). We should not therefore assume that the experience of temporary work is
46 associated with more negative attitudes or poorer wellbeing. There are a number of possible
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48 reasons for this including the role of a narrower and more transactional psychological
49 contract limiting, among temporary workers, the pressure, stress and obligations often
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51 experienced by permanent employees. The risk is that the 'deal' that minimises stress for
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53 temporary workers ends up loading more pressure on the permanent staff.
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56 In many settings where temporary workers are used they are typically employed for a period
57 of time that can often extend to months or years. This contrasts with the experience of most
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59 temporary staff in A&E Departments who are often employed for a single shift. This means
60 that they may not be familiar with the work setting yet they need to demonstrate immediate

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competence. It can make it difficult for them to perform effectively and it places particular emphasis on the need for permanent staff to provide information, guidance and support while often working under intense pressure. This raises the question of how permanent cope in these circumstances and what effect this has on patient outcomes.

The Impact of Temporary Staff on Permanent Staff

There is a limited and generally rather dated body of research exploring the impact of temporary workers on permanent staff. An underlying assumption in the employment of temporary staff is that they should help to alleviate the workload of permanent staff. As a result, this should enhance the satisfaction and commitment of permanent staff. However the early studies reported by Geary (1992) and Pearce (1993) found that employment of temporary staff resulted in poorer interpersonal relations within teams and reduced commitment. One explanation is that the introduction of temporary staff into teams alters the work dynamics, requires paying attention to the learning and coordination of temporary staff and thereby damages the psychological contract (Rousseau, 1995). As Geary (1992) and Smith (1994) noted, permanent staff are often expected to take responsibility for socialization, training and supervision of temporary staff (often without increased financial reward) and may be held responsible for mistakes they make. This can cause concern among permanent staff and George (2003) found that trust in the organisational could be reduced. These concerns are likely to be particularly acute in the context of A&E departments, notably in the case of temporary staff engaged on a single shift who may not be familiar with the work environment.

Davis-Blake, Broschak and George (2003), using a large cross-organization sample, confirmed the negative effect of using temporary staff on commitment and on management-employee relations among permanent staff. Kraimer et al., (2005) reported that employees with lower levels of job security were also more likely to attribute the use of temporary staff to efforts by their organisation to reduce costs through internal changes and as a threat to their roles, altering the exchange relationship; this in turn was associated with fewer obligations for permanent staff to perform well.

Despite some indications that temporary staff may increase rather than alleviate the workload of permanent staff, most studies have not explicitly considered this issue. An exception is the study by Banergee, Tolbert and DiCiccio (2012), utilising a sample of 200 small firms in the 2004 UK Workplace Employment Relations Survey, who found that use of temporary staff was not associated with any change in levels of work overload among permanent staff. However, it is not clear how closely the respondents worked with the

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temporary staff in their workplace. They did find evidence of an association between use of temporary staff and higher job insecurity which mediated a link to lower job satisfaction and commitment. Finally, Wilkin, De Jong and Rubino (2018) found some evidence that in blended teams there was less interaction and indications of less effectiveness unless there was a particularly impressive team leader.

The balance of the evidence suggests that temporary workers have a negative impact on permanent staff leading to reductions in their job satisfaction, commitment, trust and job security. There is also some indication that they may also have a negative impact on performance. These findings might therefore be expected to extend into healthcare settings. However most of the research is based on surveys and provides little understanding about the dynamics of working with temporary staff; nor does it provide insight into the temporariness of the temporary staff. Some have months and even years of tenure in the research settings. This is very different from single shift temporary assignments in highly pressured work settings. Additionally, little attention has been paid to the type of temporary staff and their degree of familiarity with the work setting. Finally, the research lacks a clear theoretical perspective to address the consequences for permanent staff of using temporary staff.

In this study, we use the analytic framework of the job demands – resources model (Bakker and Demerouti, 2017). This proposes that for employee wellbeing and effective performance there should be a balance between the demands of the job, reflected, for example in this context in a heavy workload and the emotional demands of dealing with seriously ill patients, and the resources, such as social support, feedback and, in this context, sufficient staff. The specific question we explore in this study is whether the provision of temporary staff offers an effective 'resource' to enable permanent staff to achieve a satisfactory balance between demands and resources and therefore to perform effectively. We address this issue and explore the dynamics of the relations between temporary and permanent staff with a qualitative study in the context of two A&E departments of major hospitals.

Methodology

Research Aims

The broad aims of the study were to explore the use of temporary staff and their impact on the behaviour and attitudes of permanent staff and on the risks to patient safety and service quality in busy hospital A&E departments.

Research settings:

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Two hospitals were chosen as case study sites for this research, as they used different approaches to temporary staff recruitment, while experiencing similar staff shortage challenges. A&E departments nationally are experiencing staff shortages resulting in a frequent need to use temporary staff. The nature of the work in A & E departments requires a high speed of response to patient needs and the ability to work under high levels of pressure involving the capacity to make on-the-spot decisions. The ability of temporary staff to contribute effectively, and the implications for both permanent staff and patient safety and service quality will depend to a considerable extent on their relevant experience and the ability to integrate them swiftly into the work of the department.

Two London Hospitals were used in the study. Hospital A is a major NHS Foundation Trust and teaching hospital providing comprehensive local and specialist services. The hospital uses NHS Professionals (NHSP) for the provision of bank and agency nurses, administrative and clerical cover and care support. NHSP also had control over the doctor/locum level of service provision however this was only for doctors who already worked in the hospital and who were willing to cover additional shifts. If there were no appropriate NHSP staff available to cover a specific shift (in terms of both speciality and staff level), then in accordance with hospital instructions the shift would be covered through temporary staff employed via approved agencies that the hospital has asked NHSP to contact. Hospital B is also a major NHS Foundation Trust and teaching hospital in London, providing a full range of services for local residents as well as specialist services. In comparison to Hospital A, Hospital B uses its own internal bank staff for the provision of any necessary temporary staff cover. Permanent staff in the Trust are all eligible to apply to join the staff bank if they would like to undertake extra shifts in addition to their substantive employment. The hospital has also introduced a range of schemes to encourage staff to join the internal staff bank to reduce the need to resort to expensive agency staff. Those not employed substantively in the Trust are able to apply to the staff bank through the hospital's vacancy recruitment advertisements. Agency staff should only be used if no internal bank staff are available, and all agencies must comply with the London Procurement Programme Framework agreements.

Research Design and Research Participants:

A qualitative approach to data collection was used in the research allowing for an in-depth investigation and study into the use of temporary staff in A&E and reacting to aspects of behaviours, actions and attitudes (and the interactions between the three) that more quantitative methods of investigation cannot achieve (Pope and Mays, 1995). The study used a case study research design complemented by interviews to test for generalisations

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within the data. Yin, (2003) highlighted that case studies were the preferred research strategy when 'how' or 'why' research questions are being posed, and they can also be valuable for investigating real life situations in detail, providing an in-depth understanding of the phenomena under investigation (Lewis, 2003). Semi-structured interviews were used, allowing for open-ended questions to encourage the opinion of participants to be explored, and to elicit views or any additional concerns regarding the use and management of temporary staff that had not previously been anticipated by the researcher. All interviews were digitally recorded with the consent of the participants and were transcribed verbatim.

Three different levels of staff were included in the study, all involved in some way in the management of temporary staff or who worked alongside them. Executive level managers who were primarily associated with workforce issues were interviewed to provide insights into hospital policies with regards to general staffing issues and temporary staff use. Clinical Managers at departmental level were interviewed to understand more 'local' issues concerning the hiring and use of temporary staff. Finally, permanent staff who worked alongside temporary staff on a daily basis, sometimes supervising their work, were included in the study to provide a more 'operational' understanding of the implications of working with temporary staff. In Hospital A interviews were conducted with the Associate Director for Workforce Resourcing, the onsite NHSP representative, the CEO of NHSP, the Clinical Director of the A&E department, the A&E Administrative Service Manager and six permanent staff of different staff levels (7 male and 4 female participants). In Hospital B, interviews were undertaken with the HR Manager, the Internal Bank Temporary Staffing Manager, the A&E Clinical Lead, the A&E Matron and 3 permanent staff of varying levels of seniority (4 male and 4 female staff). (See Table 1 for site and participant descriptions)

Interview topics with all levels of staff included the reasons for the hiring and use of temporary staff, how temporary staff should be managed, the methods adopted by the hospitals to hire temporary staff, their integration and any actual or perceived risks to patient safety and service quality (including any implications for permanent staff) and how these risks could be best managed. The emphasis placed on these topics varied according to the level of staff being interviewed. The research received the required ethical approval.

Data Analysis:

Thematic content analysis was used to analyse the data which included a number of stages (as described in Braun and Clarke, 2006). The first stage involved the open coding of data to identify emerging ideas across the participants and to begin to get a detailed and thorough understanding of the data. This was a highly iterative process to ensure that key

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issues had been identified. Codes were then organised into over-arching themes looking at the relationships between the codes, which were then defined, with the data being re-analysed to ensure that the date still fitted the defined themes meaningfully. This was also a highly iterative process with continuous refinement of the identified themes. The data was also charted as in Framework Analysis (Ritchie and Spencer, 1994) to map key characteristics across the various levels of staff, within and between the two case study sites. NVivo (version 9) software was used to facilitate with the initial stages of data coding. (See diagram 1 for overview of the coding and analytical process).

Results

The analysis of the data highlighted a range of key themes regarding the use and management of temporary staff and the implications of their use for both permanent staff and patient safety and service quality.

Reasons for using temporary staff:

In both hospitals managers reported that temporary staff were used as a result of recruitment difficulties leading to chronic shortages of permanent staff. Temporary staff were also used to cover for sickness absence, for holidays and for other absences, including staff training and delays in getting new staff in place due to the often protracted recruitment process. Clinical managers, especially at Hospital B discussed the need to reduce bank and agency staff as a result of cost-saving measures, but simultaneously described the 'need' to use temporary staff to ensure staff levels met patient safety needs. The cost efficiency versus safety issue was clear, but the pragmatic need to maintain staffing levels was prioritised due to the risks associated with sub-optimal staffing levels:

> *"If there was a patient issue, then the first thing they say is was there the right amount of staffing, or did they have the right skill mix and competencies" (Manager, Hospital B)*

However, some permanent staff questioned management practices with regards to temporary staff use, especially in relation to the use of temporary staff to cover long-term vacancies, in terms of their cost-effectiveness in comparison to creating a permanent position. In these cases, long-term use of temporary staff, although necessary for service delivery, contradicted cost-saving initiatives. Nevertheless, permanent staff in both hospitals accepted that temporary staff were needed to ensure that service delivery was not compromised, even though it may not always be the most desirable solution to staffing gaps. Put bluntly:

> *"We are short of staff, we need somebody" (Permanent Staff, Hospital B)*,

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Permanent staff pointed out that staff shortages were partly the result of high levels of labour turnover caused by the challenging nature of the work in the department which meant that staff were leaving the specialty. They described the A&E department as a challenging environment to work in, with the 24 hour service characterised by constant patient demand, where a 100 per cent staffing level was required because if the service was thinly spread then service delivery would be severely affected. Staff reported that for some this would not be the most attractive department to work in:

> *"The shift pattern, the antisocial nature of the specialty and the stress...I just think it's not an attractive environment." (Permanent Staff, Hospital A)*

The need to encourage staff to remain in the specialty was highlighted in one hospital where job satisfaction scores had reduced in A&E as a result of staff rota patterns. Although rota patterns were addressed aiding staff satisfaction scores, this was however offset by the need to use more temporary staff:

> *"The middle grades used to be on a one in two rota, and so we have moved them to a one in three rota, which meant that we had to deal with the gaps using temporary staff" (Clinical Manager, Hospital B).*

Policies, procedures and practices in the hiring of temporary staff.

Both hospitals had established policies, procedures and practices when hiring temporary staff; but it was not always possible to adhere to them. The hospitals were keen to encourage permanent staff to sign up for either NHSP or the internal staff bank, as these were supposed to be the first points of call for managers to contact if a shift needed to be filled. If NHSP or bank staff were unavailable, it was only then that agencies were to be contacted, and when this occurred only agencies on agreed frameworks should be used:

> *"You should be able to fill vacancies with permanent staff (overtime), if not then you should use NHSP, and then approved agencies to fill temporary positions" (Workforce Director, Hospital A).*

In both hospitals there was clear preference for both bank and agency staff who had worked previously within the department and who were known to permanent staff, facilitating speedy integration and reducing patient safety risks.

The 'hierarchy of preference' for temporary staff was also acknowledged by the clinical managers at both hospitals, especially the preference for staff previously used as temporary cover:

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> *"We've got some regular ones that we will be familiar with and what their skill set is. If we have somebody that starts and have never been here before, not known to us, that is obviously on the hierarchy what we would really want to avoid" (Clinical Manager, Hospital B).*

However, especially when waiting times in the A&E department were at unacceptable levels, then clinical managers admitted to: *"just phoning any agency I could find" (Clinical Manager, Hospital B).* Managers acknowledged that when agencies outside the framework agreement were used, not only did this increase agency spend, but there were greater risks to patient outcomes.

Permanent staff also displayed a distinct preference for temporary staff who had previously worked in the department as their skills would be known, they would have some knowledge of the processes and procedures and know the lay-out of the department. They also felt 'more comfortable' working alongside known temporary staff as they were considered to be safer, more reliable and required less supervision than more ad-hoc cover. Some permanent staff tended to keep lists of staff whom they trusted and would prioritise as they had already developed a 'working relationship' with them and had more confidence in the temporary staff's ability to provide timely, accurate and efficient patient care in a time-critical department:

> *"You have to develop a relationship with them as they become your critical friends" (Permanent staff, Hospital B).*

However, permanent staff acknowledged that when ad-hoc temporary staff hiring did occur, such staff could get a 'raw deal', and that it was the responsibility of the departmental managers to ensure that they are suitably managed to provide suitable patient care.

Temporary staff and their risks to patient safety and service quality

While there is a general perception that use of temporary staff can pose a risk to patient safety and service quality, it proved difficult to quantify this risk throughout the research. For example, departmental managers in both hospitals were unable to provide direct evidence to show this occurred, for example through patient surveys. At Hospital A, NHSP representatives discussed the need to overcome stereotypes regarding temporary staff, arguing that if managed properly and if temporary staff known to the hospital are recruited, then there would be a good likelihood of safe patient care. Similarly, the bank manager at Hospital B reported that other system factors need to be considered when discussing any use of temporary staff on patient care, noting:

> *"It would all depend on the proportion of temporary staff and how much control you have over them" (Bank Manager, Hospital B).*

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Nevertheless, clinical managers conceded that it often became more difficult to run the department when temporary staff were used, and as a result of training and qualifications being checked before they were placed on wards, it was service quality more than patient safety that was likely to be affected; for example, temporary staff may take longer to dispatch patients as a result of not understanding the finer details of the admission process.

Clinical managers in both hospitals were also concerned about the implications of temporary staff on team familiarity, citing the importance of team stability and cohesiveness, once again indicating that known temporary staff were the preferred choice for A&E teams:

> *"Those we don't know can be a little more challenging...they can cause an enormous amount of stress, that's always the risk with new and unknown locums" (Clinical Manager, Hospital A).*
>
> *"I am not saying they're all bad because they're not; there are some very, very good ones. But when they're bad, they can be very bad". (Clinical manager, Hospital B).*

This unfamiliarity was perceived to compromise patient care, especially when communication and engagement with team members was disturbed and patient decisions could go unchallenged. Using bank staff was therefore a management approach used to avoid team stability challenges, but when ad-hoc staff had to be used, there was the assumption (among clinical managers) that permanent staff would supervise temporary staff, and that there was a level of tolerance amongst staff regarding their supervision and aiding team stability.

Permanent staff also acknowledged the difficulties in quantifying the risks to patient safety and service quality when using temporary staff but considered the risk to be proportional to the number of temporary staff in the department and what else was occurring in the department at any given time. They also accepted that variations in the qualities of temporary staff, rendered unfair any generalisations about their impact. However, when risks were perceived by permanent staff it was typically associated with temporary staff who were unknown, or who had not previously worked in the department:

"If they don't quite know anything, they're struggling and they just carry on with what they are doing, it can definitely have an impact on the patient …with poor communication things fall apart (Permanent staff, Hospital B).

There were concerns that some agency staff were not of the required quality:

> *I am not saying that every agency member of staff is rubbish. I'm just saying that you've got the odd one that slips through. I think it depends on where you work and who you get'. (Permanent staff, Hospital B).*

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Permanent staff also questioned the argument that temporary staff are more of a risk to patient safety as a result of their competence, since all staff must have the skills to provide baseline care. Rather, it was issues such as familiarity with the human and physical environment where patient care issues arose, more especially ad hoc temporary staff:

> *"How familiar they are with the surroundings will impact the care of patients because it just delays the whole process when they don't know where things are kept, where to find things, what to look for, what to do with the patient. When they don't know the other information relevant for patient care, then the whole delay in the process will have an impact on patient care. (Permanent staff, Hospital A)*.

In these cases, permanent staff reported having to spend more time to 'manage' temporary staff, reducing the time they themselves had to deliver patient care which in turn could affect patient safety and service quality.

Permanent staff in both hospitals discussed being able to 'trust' temporary staff in relation to meeting team goals, reliably identifying patient care issues and performing safely in. The level of trust in temporary staff was related to the frequency and regularity of their shifts:

> *"If they are regular then you are happy to have them in the team...those who a here now and again, you are not very confident in them" (Permanent Staff, Hospital A).*

Permanent staff recognised the importance of developing clear communication channels, and clarifying the expectations of temporary staff, more easily accomplished through regular temporary staff being hired and through permanent staff investing time in developing the relationship.

Impact of use of temporary staff on permanent staff

Clinical managers in both hospitals were quick to emphasise the increased supervisory demands that unknown temporary staff needed, and added that the burden did land predominantly on to permanent staff:

> *"You cannot just let them in and do the job, you have to get more involved" (Clinical Manager, Hospital B).*

Operational efficiency, increased performance and patient safety checks and providing on-the-job feedback became more onerous when more temporary staff were present. Concerns were raised about the implications for the workload of permanent staff and how this added stress affected their morale. They emphasised that using regular temporary staff meant that workload distribution could be managed appropriately reflecting any distinctive strengths of the temporary employee and thereby reducing the extra burden for permanent staff.

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Permanent staff reported that the use of temporary staff often resulted in them having to take time away from patient care, as a result of feeling they needed to monitor the duties, more particularly in the case of unknown temporary staff, to ensure they were performing to the required standard. Typically, for example, they had to provide explanations about departmental processes surrounding medical adherence, point out where equipment was stored and check that temporary staff had the necessary skills to ensure that the paperwork for patients they treated was completed correctly. This was in addition to their already busy roles:

> *"You have to take time off to explain things and it doesn't just stop at one explanation...you have to be alongside them the whole shift. It takes time away that could be better utilised looking after your own patients...it puts more time and pressure on me added to the fact that I already have so much work on my hands" (Permanent staff, Hospital A).*
>
> *"Everyone can feel they're struggling because they've got that person they're having to support' (Permanent staff, hospital B)*
>
> *"You end up having to write a few lines less in your notes than you ought to, which again is a risk" (Permanent staff, Hospital A).*

This increased workload also added to the emotional stress and pressures that permanent staff already experienced, affecting staff morale. This stress was reduced when working alongside regular temporary staff with relevant departmental knowledge and where there was already a confidence and trust in their experience and ability. Risks to service quality were also mentioned, caused by the reduction in time spent with each patient and the reduced attention to detail if permanent staff, in effect, undertook the workload of two roles.

Permanent staff did understand the need to integrate temporary staff, hoping that this would increase the likelihood of competent staff returning on a regular basis, but also acknowledged that management must be aware of their needs, especially as the extra workload often went unrewarded which had an impact on the 'deal' that staff perceived:

> *"You have to look at the needs of your permanent staff, and make sure their needs are being met...you have to make sure that they are receptive to having them (temporary staff) on board" (Permanent staff, Hospital A).*

One of the issues that was especially pertinent was the hourly pay differences between temporary agency staff and permanent staff, with permanent staff discussing feelings of resentment especially if temporary staff had an easier role in the shift.

There was evidence among some permanent staff of an unwillingness to help temporary staff, which has implications for patient care:

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"If you don't know someone particularly well, you're going to get on with your own work" (Permanent staff, Hospital A).

This was sometimes referred to in connection with the perceived commitment of temporary staff, as it was often inferred that temporary staff did not have the same level of performance and commitment in comparison to permanent staff as there was a limited necessity to take on the full level of responsibility:

"They (temporary staff) can just come and go as they like without having to take on the full weight of worrying and planning" (Staff Bank Representative, Hospital B).

"I think that there is probably a mentality of, well I am not going to be here tomorrow, so I'll just do what I can while I am here, and then I'll get out of the door as quickly as I can and when I leave it's no longer my problem". (Permanent staff, Hospital A).

"It's that lack of responsibility and the feeling of ownership to the department or the hospital, and that translates into a little bit of slackness…so that then increases the working load pressure on the person who has to pick up the pieces" (Permanent staff, hospital A).

Permanent staff understood the relationship between regularity of the temporary staff working in an A&E department and their commitment, reporting that it was only 'natural' for there to be limited vested interest in what was occurring in the department, if they were not going to return.

Addressing the challenges of using temporary staff.

There are some measures that could be introduced to manage temporary staff, including having a departmental induction both to the physical geography and to key staff members which could help to mitigate any risks. Permanent staff and clinical managers reported that known temporary staff (and more specifically substantive staff undertaking a bank shift) would be preferred as they would have staff familiarity and limited time would have to be taken away from patient care to provide the departmental induction. Permanent staff explained that it was the ward's responsibility to provide local inductions, but when ad-hoc temporary staff are introduced when the A&E is already busy, these inductions would be more difficult to deliver, a point acknowledged by departmental managers:

"Whether we're compliant on that a hundred per cent is slightly different, but they are meant to get some level of local induction" (Manager, Hospital B).

Permanent staff also thought that the induction was an important time to clarify the roles expected of temporary staff when they are on shift, to determine their experience and gauge their levels of motivation and expectations so that any risks associated with their use could then be mitigated.

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One of the elements of supervision discussed by clinical managers and permanent staff in both hospitals was the delivery of performance feedback and the level of on-the-job training or support that temporary staff received. Clinical managers reported often using 'informal' forms of feedback, which, when positive *"the feedback is generally we re-book them" (Clinical Manager, Hospital B).* Attempts to manage risks when using temporary staff on shift usually resulted in general performance feedback provided throughout the shift, although it was acknowledged that this was not comprehensive, and that temporary staff were not supervised on a one-to-one basis. Permanent staff reported that the provision of feedback to temporary staff was often difficult, if not impossible in A&E due to the time it would take for it to be efficient (and the resultant time away from the provision of patient care) and as a result of the number of temporary staff used in the department. Permanent staff voiced their concerns that if the education and clinical governance needs of temporary staff were not met, then temporary staff could continue to be a risk to patient care:

> *"There is a lack of control over them...they're not part of that service improvement process. Perhaps if they had been given a chance to get that feedback, they would get better" (Permanent Staff, Hospital A).*

Discussion

The main aim of this paper has been to explore the impact of the use of temporary staff on the behaviour and attitudes of permanent staff as well as their impact on patient safety and service quality in the context of busy Accident and Emergency Departments of large hospitals in London facing chronic shortages of permanent staff. The limited amount of previous research had suggested that the reactions of permanent staff are likely to be negative. For example Geary (1992), Pearce (1993) and Wilkin De Jong and Rubino (2018) reported often poorer inter-personal relations and team-working due to the presence of temporary staff. Geary and Smith (1994) found that permanent staff complained that they were often expected to take responsibility for the socialization, training and supervision of temporary staff and may even be held responsible for the mistakes they made. In some studies, temporary staff were viewed by permanent staff as a threat to job security (Kraimer et al 2005).

Many of these negative features were reported in the present study. Some challenges are likely to be exacerbated in the hospital context because temporary staff were usually, though not always, hired for a single shift. This contrasts with other studies where they may work in an organization for some considerable time. For example, in the European study reported by

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Guest, Isaksson and De Witte (2010) the average tenure of temporary staff was over a year, giving time to settle into the work environment.

The core concern of permanent staff was that temporary staff provided a distraction that could prevent them from getting on with their work. The degree and nature of this distraction varied according to the type of temporary staff, reflecting the finding that they were perceived to vary considerably in motivation and experience. Despite the different systems for hiring temporary staff in the two hospitals, there was a consensus about the hierarchy of preference concerning type of temporary staff. Top of the list were 'local' staff who volunteered to do an extra shift and who knew the environment well, while at the other extreme were temporary workers from agencies that were not on the approved list but who were hired on occasions when all alternatives had been exhausted. It was those in the latter category who were viewed as the most problematic.

Apart from a few worrying examples, temporary staff were not perceived to be a major risk to patient safety. It was more likely that they would affect the quality of patient care. This could occur in a number of ways. First, the requirement to provide guidance, supervision and feedback could distract permanent staff from their own work, taking them away from patients and rushing activities such as writing up notes. Secondly, because they were not familiar with procedures, temporary staff might work slowly, taking a long time to process patients. Thirdly, there were a few temporary staff who viewed the shift as an opportunity to absolve themselves from responsibility and to do a minimum amount of work, leaving more for others. Despite the acknowledged problems, permanent staff preferred to have additional temporary staff rather than carry the extra load themselves. This reflects the intensity of the work in A&E departments and the need to be able to provide sufficient focus when rapid decisions affecting the health and even the life of patients was required. Without the temporary staff, the risk to patient safety and service quality was perceived as likely to be even greater.

In line with previous research findings, it was found that as well as sometimes affecting their work, the use of temporary staff could also have an impact on the attitude of permanent staff. There was some resentment that temporary staff seemed to be better paid, even though they made less contribution to the work. There was frustration about the added workload caused by the presence of temporary staff and the general assumption that they would have to take responsibility for dealing with this. While the local clinical management were considered to understand and be sympathetic to the concerns of permanent staff, more senior staff were viewed less positively. The belief of the permanent staff was that more

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effort should be given to recruiting and retaining permanent staff. Furthermore, it was considered that the flexibility offered by use of temporary staff and seemingly valued by senior management as a way to control costs was considered to be a false economy. Despite their misgivings and rather low trust in senior management, all the evidence pointed to the deep commitment to their work in the A&E department among the permanent at staff who were interviewed.

The study was informed by the job demands – resource theory (Bakker and Demerouti, 2017). The assumption is that the use of temporary staff should reduce demand and increase resources. Our findings show that in this context it is not so straightforward. Much depends on the quality of the temporary staff. When they were familiar with the work setting of an A&E department they were an asset but at the other extreme where they lacked relevant experience, then, in the words of a clinical manager, they "cause an enormous amount of stress". In effect, they changed the nature of the demand rather than reducing it because they were not an effective resource. In the context of the theory, what this study reveals is that 'resources' that may appear to be quantitatively similar can be qualitatively very different. The relationships and outcomes are therefore likely to vary and can most usefully be explained in the context of the kind of qualitative study reported here.

Developing an approach to improved practice

Ideally, there would not be a need for temporary staff and A&Es would have shifts with a full complement of permanent staff, however as this research has indicated that as temporary staff are relied upon in A&E, and this will be the case for the foreseeable future, a model of best practice needs to be developed to ensure that both temporary and permanent staff are managed effectively to ensure the highest level of patient safety and service quality can be achieved. Thus, building on the findings from this research and relevant literature, outlined is an approach to improved practice focussing on different levels of management:

Macro level managers: The role that managers at the macro level may usefully have includes: maintaining patient safety and service quality as a higher policy priority than contracting costs, and reflecting this in staffing policies; ensuring the policies and practices for the use of temporary staff that hospitals have in place reflect the current need for adequate staffing levels and that they are correctly implemented at all management levels and providing further incentives to encourage permanent members of staff who wish to undertake occasional temporary shifts to sign up with staff banks.

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Meso level managers: The role that managers at this level might usefully have include: attempting to hire preferred temporary staff where possible, ideally A&E staff who worked for the bank, followed by bank staff who worked in the hospital, and then preferred agency staff; managers may have limited time to develop psychological contracts with ad-hoc staff, but expectations for both sides should be agreed to avoid contract breaches; if ad-hoc temporary staff are used measures should be introduced to properly induct staff to the department ensuring optimal behaviours (a checklist of key points to be included maybe important if time is rushed); being aware of the effects of temporary staff on permanent staff to maintain a positive psychological contract with them.

Micro level managers: Permanent staff had little influence in the hiring decisions of temporary staff, but 'managed' them on a day-to-day basis. Thus their roles include: inducting temporary staff and providing on-the-job supervision, and communicating any problems with temporary staff to clinical managers to reduce the possibility of lower quality temporary staff being recruited again.

<u>Study limitations and opportunities for future research</u>

There are some limitations to the present research. There are conceptual difficulties in defining temporary staff in healthcare, highlighted throughout the interviews when participants often had to be prompted to define what 'type' of temporary staff they were referring to. For example, they could include staff from the A&E department who had volunteered to do an extra shift. The breadth of type of temporary staff made it difficult to offer general findings about the impact they could have for patient safety and service quality and on permanent staff. The case study design was used because of the nature of the research questions, and the need to study complex, real-life research environments. Ideally a case study of this type would also have included quantitative data such as staff levels, number of vacant shifts, and data regarding the hours and costs of temporary staff use that would have helped contextualise the issues further. Attempts were made to access this information, but due to the sensitive nature to the topic amidst the climate of cost saving, access to the information was not permitted. Ideally, temporary staff would also have been included in the research to gain their perspectives, and once again attempts were made to include their views, but due to data protection issues from both hospitals, staff banks and agencies, contact had to go through various gate keepers even though the study had ethical clearance, and recruitment attempts were unsuccessful.

Future research on this topic should therefore incorporate temporary staff, something omitted in several previous studies. The use of temporary staff in hospitals is not limited to

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A&E departments, and other departments also need to ensure they have safe patient care, even if they may not have the need for the same type of rapid response. However, the need for continuity of care presents new challenges for the use of temporary staff. Other departments could therefore be investigated to identify whether the risks perceived were distinctive A&E phenomena, whether the preference for specific categories of temporary staff is the same, and if policies are more successfully implemented.

Conclusions

The impact temporary staff can have on permanent staff in healthcare has been largely neglected in previous research. The present study nevertheless confirms the findings of limited previous research in reporting a generally negative impact on permanent staff. However, this finding is qualified because it depends to an important extent on the type of temporary staff that are hired; in terms of the job demands – resource theory, it depends on the quality of the 'resource'. In hospital A&E departments, in addition to the implication of their use on permanent staff, the use of less suitable temporary staff can increase the risk to patient safety and more particularly service quality. This paper presents some recommendations to address these problems and also outlines further research that might usefully address the topic.

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	Hospital A	Hospital B
Description of hospital	- NHS Foundation Trust and teaching hospital in London providing local and specialist services - Uses NHS Professionals (NHSP) for the provision of bank and agency nurses, administrative and clerical cover care and support. - If no NHSP staff are available the shift will be covered by an approved NHSP agency.	- NHS Foundation Trust and teaching hospital in London providing local and specialist services. - Uses its own internal bank staff for the provision of any necessary temporary staff cover. - Permanent staff in the Trust are eligible to apply for the staff bank. - Those not employed by the Trust are able to apply to the staff bank through hospital recruitment. - Agency staff are only used if no permanent staff are available.
Number of management staff interviewed at the macro level	- Associate director for workforce - NHSP CEO - NHSP on-site representative	- HR Manager - Internal Bank Temporary Staffing Manager
Number of management staff interviewed at the meso level	- Clinical Director of A&E - A&E Administrative service manager	- A&E Clinical Lead - A&E Matron
Number of permanent staff interviewed at the micro level	- 6 permanent staff of range of staff nursing levels	- 3 permanent staff of various levels of seniority

Table 1: Description of research sites and research participants

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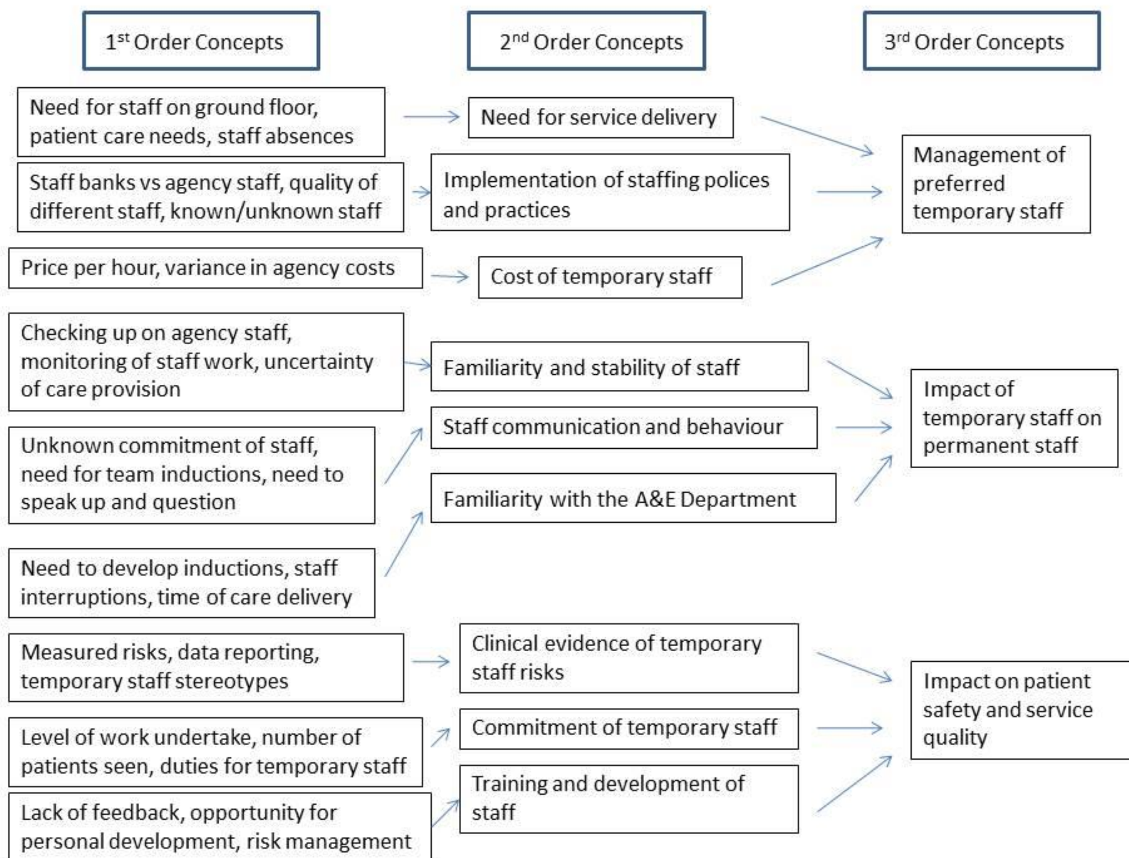
Diagram 1: Thematic codes and order concepts



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	Hospital A	**Hospital B**
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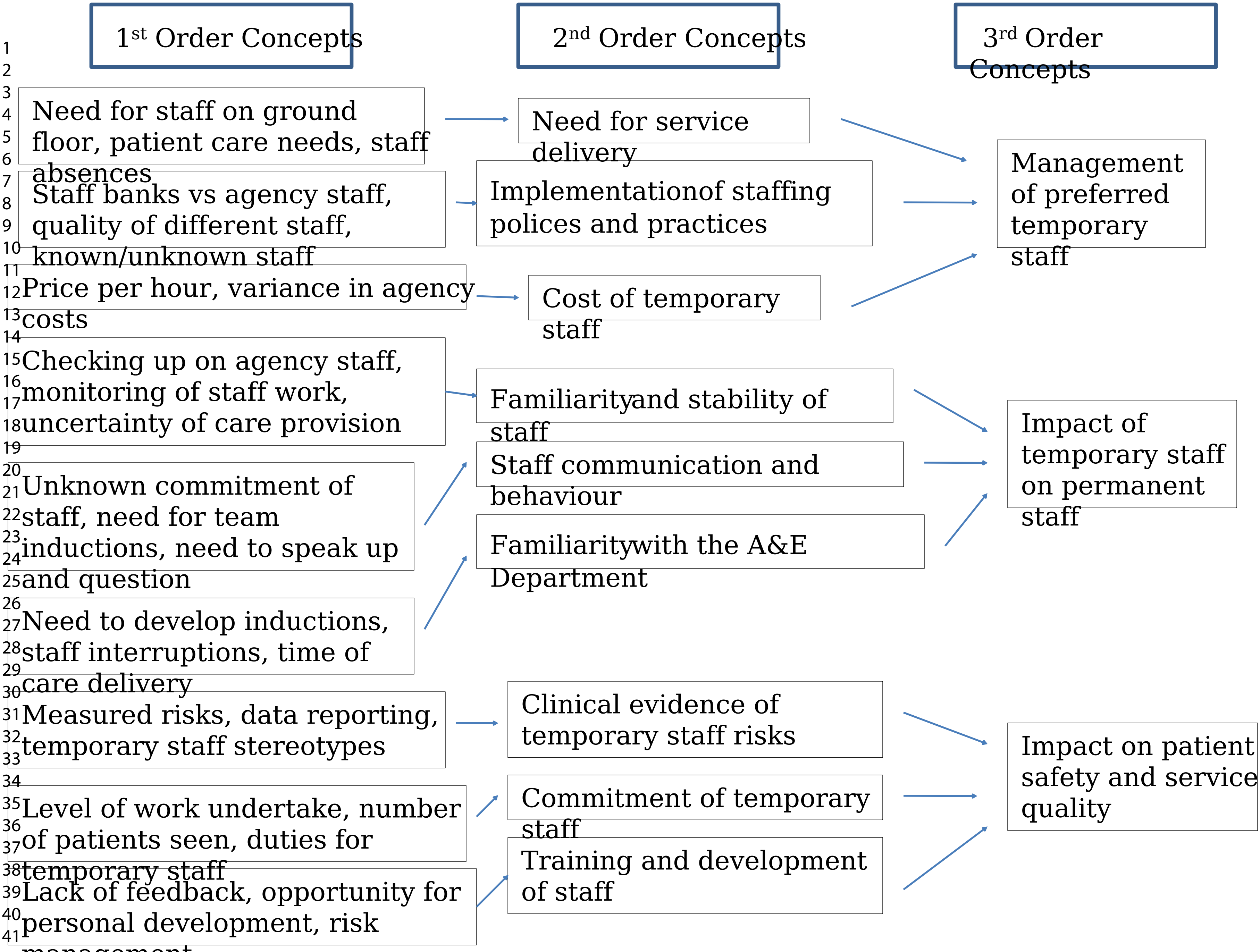
1st Order Concepts
2nd Order Concepts
3rd Order Concepts
Need for staff on ground floor, patient care needs, staff absences
Need for service delivery
Staff banks vs agency staff, quality of different staff, known/unknown staff
Implementationof staffing polices and practices
Management of preferred temporary staff
Price per hour, variance in agency costs
Cost of temporary staff
Checking up on agency staff, monitoring of staff work, uncertainty of care provision
Familiarityand stability of staff
Impact of temporary staff on permanent staff
Unknown commitment of staff, need for team inductions, need to speak up and question
Staff communication and behaviour
Need to develop inductions, staff interruptions, time of care delivery
Familiaritywith the A&E Department
Measured risks, data reporting, temporary staff stereotypes
Clinical evidence of temporary staff risks
Impact on patient safety and service quality
Level of work undertake, number of patients seen, duties for temporary staff
Commitment of temporary staff
Lack of feedback, opportunity for personal development, risk management
Training and development of staff