



# Review Body for Nursing and Other Health Professions

Twenty-First Report on Nursing and  
Other Health Professions 2006

*Chair:* Professor Gillian Morris



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*Chair:* Professor Gillian Morris

**Presented to Parliament by the  
Prime Minister and the Secretary of State for Health**

**Presented to the Scottish Parliament by the  
First Minister and the Minister for Health and Community Care**

**Presented to the National Assembly for Wales by the  
First Minister and the Minister for Health and Social Services**

**by Command of Her Majesty  
March 2006**

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## Review Body for Nursing and Other Health Professions

The Review Body for Nursing and Other Health Professions (NOHPRB) is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the First Minister and the Minister for Health and Community Care of the Scottish Parliament and the First Minister and the Minister for Health and Social Services of the National Assembly for Wales on the remuneration of the following staff groups employed in the National Health Service:

- (i) Nurses, Midwives and Health Visitors;
- (ii) The Allied Health Professions;
- (iii) The Health Care Science Professions;
- (iv) Pharmacists, Optometrists, Applied Psychologists and Psychotherapists;
- (v) Clinical Support workers and technicians supporting these groups

In reaching its recommendations, the Review Body is to have regard to the following considerations:

the need to recruit, retain and motivate suitably able and qualified staff;

regional/local variations in labour markets and their effects on the recruitment and retention of staff;

the Health Departments' output targets for the delivery of services, as set out by the Government;

the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits;

the Government's inflation target;

the principle of equal pay for work of equal value in the NHS.

The Review Body may also be asked to consider other specific issues.

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, staff and professional representatives and others.

The Review Body should take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability.

Reports and recommendations should be submitted jointly to the Secretary of State for Health, the First Minister and the Minister for Health and Community Care of the Scottish Parliament and the First Minister and the Minister for Health and Social Services of the National Assembly for Wales and the Prime Minister.

Members of the Review Body are:

Professor Gillian Morris (*Chair*)  
Mrs Lucinda Bolton  
Professor Richard Disney  
Ms Wilma MacPherson, CBE  
Professor Alan Manning  
Professor Pauline Weetman  
Ms Sharon Whitlam

The secretariat is provided by the Office of Manpower Economics.

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## Summary of Recommendations and Main Conclusions

We are pleased to present our recommendations on the pay of nursing staff and staff in other health professions from 1 April 2006. The key issues and recommendations are summarised below.

- This year's review has taken place against the backdrop of implementation of the new pay system for the NHS, Agenda for Change. The implementation process was still ongoing, and consequently we decided to focus on the level of across-the-board pay award for all our remit groups. The main parties agreed with this approach.
- The Department of Health and the Staff Side sought a one-year award. The National Assembly for Wales and NHS Employers expressed a preference for a multi-year award. **We consider that the award should be for one year only.**
- We have carefully reviewed all the evidence we have received. In arriving at our recommendations we have examined data on recruitment and retention, morale and motivation, funding, the Government's inflation target, and other relevant economic indicators. We have also had regard to the principle of equal pay for work of equal value and legal obligations on the NHS, including anti-discrimination legislation. Lack of evidence prevented us giving detailed consideration to the Health Departments' output targets.
- We do not consider that it is necessary this year to amend the existing position of the pay structure of our remit group relative to the external market. We have sought to maintain this position as far as we judge affordability constraints permit. **We therefore recommend an increase in the Agenda for Change pay rates of 2.5 per cent from 1 April 2006.**
- The parties did not seek changes to the structure or levels of High Cost Area Supplements, although the staff bodies asked us to raise the cash maxima in line with our recommended percentage uplift to the pay scales. **We recommend that the existing minimum and maximum High Cost Area Supplements for Inner London, Outer London and the Fringe be increased by 2.5 per cent from 1 April 2006.**
- We were asked to consider national recruitment and retention premia (RRPs) for pharmacists, cytology screeners, occupational therapists, radiographers and orthoptists by the individual staff bodies representing those groups. We do not recommend any RRP this year, but note that local employers may pay local RRP under the Agenda for Change Agreement where specified criteria are met. We have asked our secretariat to discuss with the parties the data to be provided to support the case for a national RRP in future years.
- We conclude from our work this year that we require more comprehensive and up-to-date data on the earnings of our remit group, including their distribution within the new pay structure. **We recommend that the Health Departments ensure that in 2006 and in every year thereafter a comprehensive survey is conducted to identify the earnings of our remit groups and their location within the pay bands. These consistent surveys should also give breakdowns by gender and age, and should be timed so that they take account of the effects of basic pay uplifts from April each year, and enable results to be publicly available in the autumn to inform our annual reviews.**

- We would be assisted by additional data in the areas of recruitment and retention; morale and motivation; and affordability. We have asked our secretariat to discuss with the appropriate bodies whether this data can be provided to us for our next review.

PROFESSOR GILLIAN MORRIS (*Chair*)  
LUCINDA BOLTON  
RICHARD DISNEY  
WILMA MACPHERSON  
ALAN MANNING  
PAULINE WEETMAN  
SHARON WHITLAM

OFFICE OF MANPOWER ECONOMICS

*20 February 2006*

# Chapter 1: Background to our Report

## Introduction

- 1.1 This is our twenty-first report on the remuneration of nurses, midwives, health visitors and professions allied to medicine<sup>1</sup>. As part of the Agenda for Change agreement of January 2003 our remit has now been expanded to include those staff classified as allied health professions not previously covered by our remit, as well as healthcare scientists, pharmacists, optometrists, applied psychologists and psychotherapists, family therapists, operating department practitioners and clinical support workers and technicians engaged in supporting these groups. Our title was also changed at this time to reflect the new composition of our remit group. A full list of staff groups covered by our remit is in Appendix A. As these staff are now covered by the same pay structure, and we have not been asked by the parties to make any changes to that structure, we have chosen to produce a single report this year. During this review we have been served by a secretariat provided by the *Office of Manpower Economics*. We are grateful to our officials for their help and support.
- 1.2 We have followed the broad structure of our most recent reports. In this chapter we set out our approach this year, the context in which we have carried out our review and the sources of the evidence we have received. In the later chapters we set out the statistical evidence at our disposal, the evidence from the parties and our comments and recommendations where appropriate (also summarised on pages iv and v). Chapters 2 to 7 analyse the evidence we have received in relation to the key considerations we are required to take account of under our terms of reference. Chapter 8 reviews the evidence from the parties on how they believe we should structure our recommendations in the light of the evidence they have submitted.
- 1.3 We believe it important to remind the parties of the principles which we and our predecessors have traditionally applied in reaching our recommendations. Firstly, we work independently to agreed terms of reference. Secondly, we base our recommendations on very careful consideration of all the evidence. Finally, we consider that our recommendations form a coherent package and believe they should be implemented in full.
- 1.4 Our recommendations in 2002<sup>2</sup> were implemented in full. In 2003 the parties agreed a three-year settlement to enable their focus to remain on implementing Agenda for Change (see paragraphs 1.5 – 1.12 below). Consequently our recommendations in 2003<sup>3</sup> were limited to endorsing this agreement. During the period of the three-year settlement, and at the request of the parties, we concentrated upon monitoring the introduction of Agenda for Change at twelve Early Implementer sites. However, throughout this period our secretariat also maintained contact with the parties and discussed matters of relevance to our remit group as they arose.

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<sup>1</sup> Throughout this report we have used the term 'our remit group' to denote all the groups in our current remit.

<sup>2</sup> Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine (NAPRB) Nineteenth Report on Nursing Staff, Midwives and Health Visitors 2002 Cm 5345, and Professions Allied to Medicine 2002 Cm 5346

<sup>3</sup> Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine (NAPRB) Twentieth Report on Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine 2003 Cm 5716



## The Context for Our Review This Year – Agenda for Change

- 1.5 **Agenda for Change** is the pay system agreed between the UK Health Departments, NHS Confederation, Unions and Professional Bodies to modernise the NHS pay system. It was rolled out on a national basis from 1 December 2004. Based on the principle of equal pay for work of equal value, and underpinned by a tailored job evaluation scheme, it is intended to be simpler and more flexible than the system it replaced. Under Agenda for Change, annual leave, working hours and the method of calculating remuneration for work undertaken outside normal working hours are all harmonised. It also provides for enhancements in the form of additional pay for staff in high cost areas (high cost area supplements) and additional pay for those in posts where recruitment and retention of staff is difficult (recruitment and retention premia).
- 1.6 The Knowledge and Skills Framework (KSF) is key to the success of Agenda for Change and provides a means of recognising the skills and knowledge that a person needs to apply to be effective in a particular NHS post. The Framework ensures that staff have clear and consistent objectives which will help them to develop or update the knowledge and skills appropriate to their job. All staff will receive an annual appraisal and development review that identifies development needs and describes how learning will be supported. There are two identified points in each pay band known as gateways. Pay progression at these gateways is linked to the demonstration of knowledge and skills set out in the applicable elements of the KSF outline for the post. The first gateway is no later than twelve months after appointment to the pay band; the position of the second depends upon the pay band in question.
- 1.7 In 2002 we made our final recommendations covering the previous Whitley pay system. Following the conclusion of ballots in which Staff Side organisations received a mandate for moving forward with the piloting of Agenda for Change, we were asked by the parties jointly in June 2003 to endorse a three-year pay deal designed to underpin the transition to the new pay system, along with the testing of Agenda for Change at twelve Early Implementer (EI) sites in England. Our twentieth report endorsed this approach.
- 1.8 The twelve Trusts selected to become EI sites had been engaged in piloting Agenda for Change since June 2003. Health Boards in Scotland had opted to undertake a paper exercise and Local Health Boards in Wales were to await the outcome of the EI exercise before proceeding. During this period our role, as agreed with the parties, was to monitor the issues; commission research; and continue our programme of visits to Trusts to assess the impact of Agenda for Change. Two visits programmes were undertaken, the first to all EIs in early 2004, with selected Trusts identified for a follow up visit later in the year.
- 1.9 Our findings from the initial visits programme<sup>4</sup> were generally positive, although we did highlight some issues of concern. Key issues were;
- affordability in relation to other budgetary pressures on Trusts, such as the consultant and GP contracts;
  - the impact of releasing staff involved in implementing Agenda for Change along with people to sit on the matching panels, both in terms of maintaining service delivery and the financial impact of providing backfill;

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<sup>4</sup> Review Body for Nursing and Other Health Professions: Report on the key lessons from the Early Implementers of Agenda for Change in England 2003, May 2004

- the amount of available central support for training job matchers and assessors; and
  - the system for remunerating unsocial hours working, and whether it provided sufficient incentives for staff to cover shifts at short notice.
- 1.10 Staff bodies were also concerned about the proposed system for remunerating unsocial hours working, and so they welcomed the Department of Health's decision in Summer 2004 to review the system of unsocial hours payments, decoupling these from the main Agenda for Change pay system. They also welcomed the decision to put back the date for national roll-out of the new pay system from 1 October 2004 to 1 December 2004. The new NHS Staff Council subsequently approved the revised Agenda for Change agreement on 23 November 2004, following successful ballots by UNISON and Amicus.
- 1.11 The follow up visits to the EIs, carried out in Autumn 2004, provided us with a further snapshot of progress with Agenda for Change. Concerns continued to be expressed about the adequacy of funding, with Trusts feeling that the cost implications had not been accurately predicted. Concerns were also raised about the continuing lack of national job profiles for some staff groups and the ability of some Trusts to implement the Knowledge and Skills Framework effectively.
- 1.12 Informal discussions we had held with the parties, as well as our visits programme undertaken in Summer 2005, highlighted delays in implementing Agenda for Change. At 30 September 2005, the deadline set for completion of the assimilation process, only 87 per cent of Trusts in England had met the deadline, with Wales and Scotland further behind. This has had a direct impact upon the evidence available to inform this review.

### **Public Spending Limits**

- 1.13 The Departmental Expenditure Limits for 2005/06 until 2007/08 were set out as part of the Chancellor's 2005 Budget Statement. Assuming a GDP deflator of 2.7 per cent, the real terms increase in NHS funding in England is 7.5 per cent for 2006/07. On the same basis, the real terms increase in NHS funding in Scotland will be 5.45 per cent and in Wales it will be 4.9 per cent.

### **Consequences for this Year's Review**

- 1.14 This year the most significant issue has been progress in implementing Agenda for Change. Given that this process is not yet complete, we believe that our recommendations this year should concentrate on the level of across-the-board pay award, setting aside any issues that might relate to structural change in the pay system. We indicated that this was our intention at the start of the round and the main parties were broadly in agreement. We have, however, received some evidence in support of national recruitment and retention premia for particular groups.
- 1.15 The Health Departments and NHS Employers (NHSE) argued in favour of a simple across-the-board award as Agenda for Change was still being rolled out. They argued that the system would take time to bed down fully and transitional issues, such as they were, would be ironed out as they emerged. Consequently they felt that no changes should be made to the structure of the new pay system at this time. The National Assembly for Wales (NAW) and NHSE sought an identical level of pay uplift across all staff groups, with NAW seeking the specific inclusion of doctors and dentists. Both expressed a preference for a further multi-year settlement. Neither sought an extension to the existing national recruitment and retention premia. The Department of Health expressed a preference for a one-year award.

- 1.16 The Staff Side called on us to help provide stability through our recommendations, in particular by urging the Health Departments not to introduce further changes to the pay structure and system. They suggested that such selective interventions in the past had caused problems and would lead to uncertainty. They felt it was not possible to assess the impact of Agenda for Change until the assimilation process was complete, and therefore asked for a one-year award. They went on to say that they were not convinced of the need for a localisation of pay, because recruitment and retention strategies were already available under Agenda for Change, and were sufficient to cope with key shortages without the need to consider geographical pay differentiation. However, in their separate evidence to us, some individual staff bodies called for the awarding of national recruitment and retention premia to address particular difficulties for their membership.

### **Timing of our Report**

- 1.17 As in previous years, our work has been completed to a tight timescale. Given the complex nature of the new landscape this year we consulted with the parties over what would be a reasonable deadline for receipt of written evidence. In light of these consultations we extended the usual deadline for receipt of initial written evidence to the end of September. We received significant further evidence from the Health Departments in December 2005 and invited comments from the other main parties on that evidence.
- 1.18 We would remind parties that evidence submitted to us cannot be considered by us until it is freely available to other parties. This means that in future any organisation submitting written evidence to us must publish it on the public part of their internet site or copy it to the other parties to the process when it is forwarded to us. We would also emphasise that the timing of our report is dependent upon all parties continuing to work together to a mutually acceptable timetable.

### **Our Approach this Year**

- 1.19 We strongly support the principle underlying Agenda for Change of a modern, equality-proofed pay system for the NHS.
- 1.20 The delay in implementation of Agenda for Change is regrettable, especially as this would seem to be a significant demotivating factor amongst staff. However, given that robust management information is not yet available and we have not been asked to recommend changes to the main Agenda for Change structure, we have decided to concentrate upon a straightforward award this year to allow Agenda for Change the necessary period of stability to bed down. Where we have received evidence relating to other aspects of our remit we comment at the appropriate point in our report.

### **Evidence for the Review**

- 1.21 We have undertaken our review this year in broadly the same manner as in previous years. We have carefully assessed the evidence we have received, and have

commissioned our own research to support our deliberations. Two major pieces of work were undertaken in this respect. The first is the Workforce Survey, a regular annual survey undertaken on our behalf by *GFK NOP* to provide information on the recruitment and retention picture for our remit groups. The second is a one-off report undertaken on our behalf by *NHS Partners' Research and Information* on how we might approach that part of our new remit relating to high cost area supplements and recruitment and retention premia. Both these reports are available on our website – <http://www.ome.uk.com>

- 1.22 We have applied our judgement in determining the weight we should give to conflicting evidence, or to the differing interpretations of the data that the parties have put forward. One familiar problem we have faced is a general lack of relevant information about pay. We look forward to receiving more comprehensive evidence next year.

### **Parties Giving Evidence and Visits Made for the Twenty-First Review**

- 1.23 We received evidence from the Secretary of State for Health\*, the Health Departments\*, NHS Employers (NHSE)\*, the NHS Staff Side\*, Amicus\*, the British Orthoptic Society (BOS), the Chartered Society of Physiotherapy (CSP)\*, the Federation of Clinical Scientists (FCS), the Royal College of Midwives (RCM)\*, the Royal College of Nursing (RCN)\*, the Society of Radiographers (SoR)\*, the Transport and General Workers Union (T&G), and UNISON\*. We are grateful to the parties for the evidence they have given us, much of which included results from external research commissioned by the parties themselves.
- 1.24 Distinct from the earlier programme of visits we made to the Early Implementers, during 2005 we also visited a number of Trusts and Health Boards across Great Britain to talk to managers, staff representatives, and a wide variety of staff groups to hear their views about those issues we should take into account when formulating our proposals this year. These discussions were wide ranging and touched upon such issues as Agenda for Change, the financial situation, recruitment and retention, morale and motivation and training and development.
- 1.25 We tried to make our visits as representative as possible, and last year we visited organisations providing mental health, acute, community care and ambulance services. We tried to meet as many staff from the newly-included remit groups as possible. Visits are an essential part of the review process and afford us a valuable reality-check of what life is like for our remit groups 'on the ground'. We wish again to thank all those involved in organising our visits, and to thank staff for finding the time to tell us their views so frankly.

### **Composition of the Workforce**

- 1.26 Our remit covers a large group of staff in a wide range of occupations. Statistics on the composition of our remit group are given in tables 1.1 and 1.2 below. The tables give percentages in employment in Great Britain, by gender and age. Data on ethnicity are not collected on a consistent national basis and so do not allow a Great Britain comparison to be made.

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\* denotes also gave oral evidence.

1.27 Table 1.1 shows the composition of all the broad non-medical staff groups within our remit by gender. With the exception of ambulance staff, it is clear that employees in these non-medical staff groups are mainly female. For example, nearly 90 per cent of nursing, midwifery and health visiting staff are female. This compares to a split of 46 per cent female and 54 per cent male in the workforce for the whole economy<sup>5</sup>.

**Table 1.1: Percentage of Directly Employed NHS Non-medical Staff by Gender (GB) (Headcount)**

	Male	Female
Nursing, Midwifery & Health Visiting	11.2	88.8
Scientific, Therapeutic & Technical	22.3	77.7
<i>Of which Allied Health Professions</i>	12.8	87.2
Ambulance Staff	70.5	29.5
Healthcare Assistants & Support (Ancillary)	25.6	74.4
<b>Total Specified Staff</b>	<b>17.5</b>	<b>82.5</b>

*Note: Data on the gender of bank staff are not collected.*

*Sources: NHS Health and Social Care Information Centre, Non-medical Workforce Census September 2004; ISD Scotland; and Key Health Statistics for Wales.*

**Table 1.2: Percentage of Directly Employed NHS Non-medical Staff and Employees in the Whole Economy by Age (GB) (Headcount)**

	Under 20	20-29	30-39	40-49	50-59	Over 60
Nursing, Midwifery & Health Visiting	0.3	14.0	29.3	33.6	19.7	3.2
Scientific, Therapeutic & Technical	0.5	22.1	28.2	27.8	18.2	3.1
<i>Of which Allied Health Professions</i>	0.1	23.5	28.9	27.6	17.1	2.7
Ambulance Staff	0.1	15.7	35.3	29.2	16.7	3.0
Healthcare Assistants & Support (Ancillary)	2.8	12.3	20.4	28.8	27.4	8.2
<b>Total Specified Staff</b>	<b>0.8</b>	<b>15.5</b>	<b>27.7</b>	<b>31.4</b>	<b>20.6</b>	<b>4.0</b>
	<b>Under 50</b>			<b>Over 50</b>		
Employees in the Whole Economy	73.9			26.1		

*Note: Age data are not collected for nursing bank staff.*

*Sources: NHS Health and Social Care Information Centre, Non-medical Workforce Census September 2004; ISD Scotland; Key Health Statistics for Wales; and Office for National Statistics January 2006.*

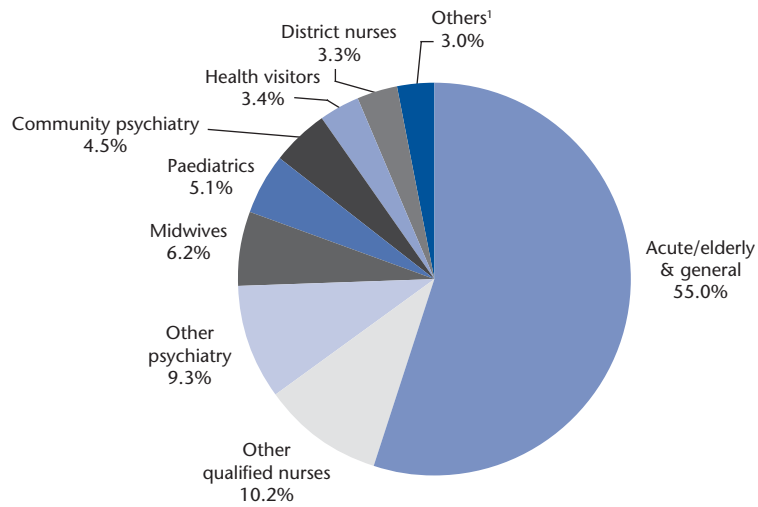
1.27 Table 1.2 shows the percentage directly employed in non-medical staff groups by age. Healthcare assistants have the largest proportion of employees aged 50 and over at 35.6 per cent. This compares to 26.1 per cent of employees in the whole economy aged 50 and over<sup>6</sup>.

1.28 The composition of the remit group in England, Scotland and Wales by main occupation and work area are shown in Figures 1.1 to 1.6. Data are not collected on a consistent national basis and so do not allow a Great Britain comparison to be made. Latest available data are for September 2004.

<sup>5</sup> Labour market statistics, January 2006. All those in employment aged 16 and over.

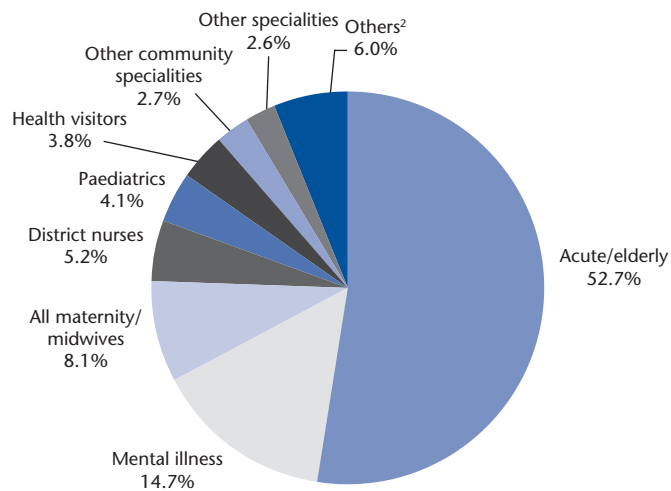
<sup>6</sup> Labour market statistics, January 2006. All those in employment aged 50 and over. These were the latest data available at the time of writing.

**Figure 1.1: Proportion of qualified nursing staff in England by speciality (WTE), September 2004**



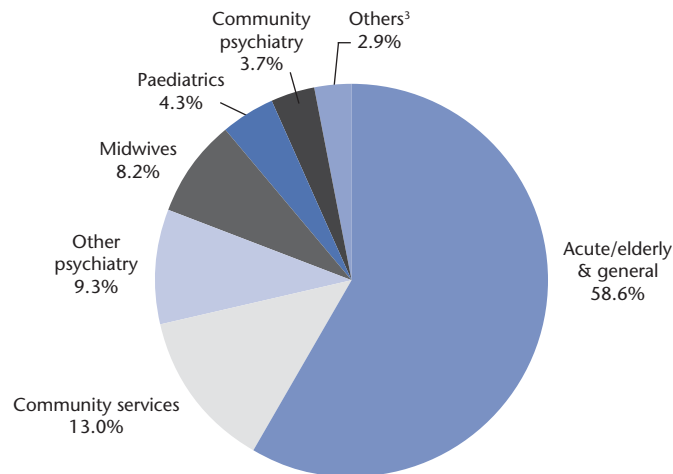
<sup>1</sup>Others includes learning disabilities and qualified school nurses (each comprising less than 2.5 per cent)  
 Source: NHS Health and Social Care Information Centre, Non-medical Workforce Census September 2004

**Figure 1.2: Proportion of qualified nursing staff in Scotland by speciality (WTE), September 2004**



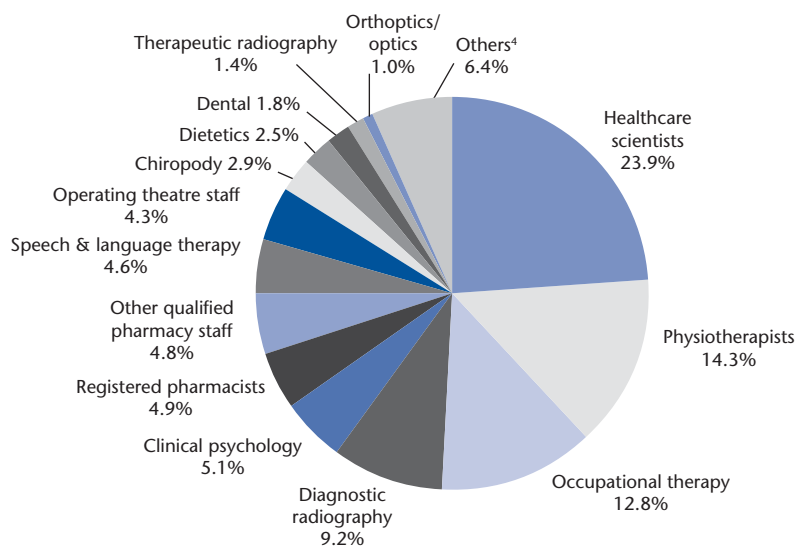
<sup>2</sup>Others includes learning disabilities, community psychiatry and clinic/school nurses (each comprising less than 2.5 per cent)  
 Source: ISD Scotland

**Figure 1.3: Proportion of qualified nursing staff in Wales by speciality (WTE), September 2004**



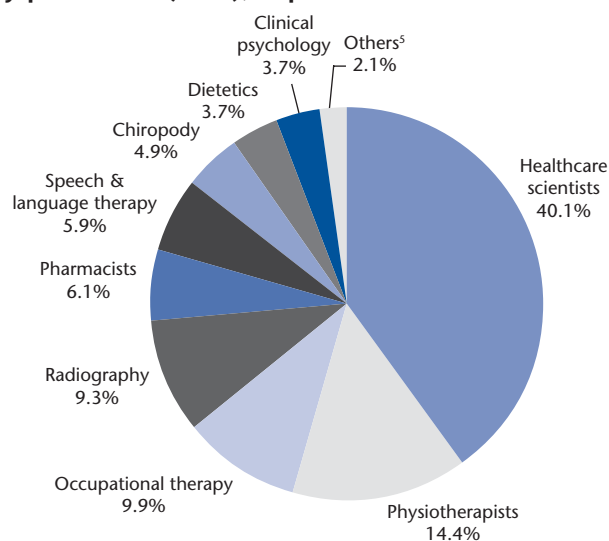
<sup>3</sup>Others includes learning disabilities, school nurses and Education staff (each comprising less than 2.5 per cent)  
 Source: Key Health Statistics for Wales

**Figure 1.4: Proportion of qualified AHP and ST&T staff in England by profession (WTE), September 2004**



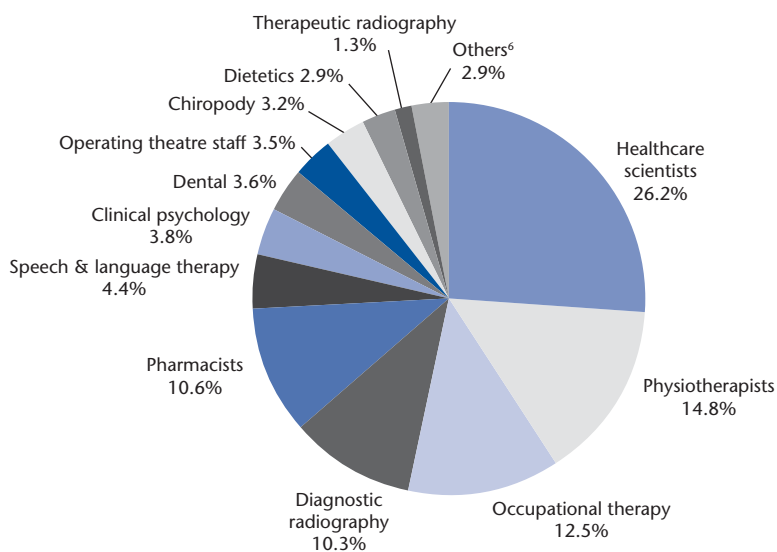
<sup>4</sup>Others includes art/music/drama therapy, multi-therapies, psychotherapy and pre-registration pharmacy trainees (each comprising less than one per cent) and other unspecified professions (4.5 per cent)  
 Source: NHS Health and Social Care Information Centre, non-medical Workforce Census September 2004

**Figure 1.5: Proportion of qualified AHP and ST&T staff in Scotland by profession (WTE), September 2004**



<sup>5</sup>Others includes orthoptists, sonographers, art/music/drama therapy and orthotists (each comprising less than one per cent)  
Source: ISD Scotland

**Figure 1.6: Proportion of qualified AHP and ST&T staff in Wales by profession (WTE), September 2004**



<sup>6</sup>Others includes orthoptics, art/music/drama therapy, multi-therapies and psychotherapy (each comprising less than one per cent) and other unspecified professions (1.6 per cent)  
Source: Key Health Statistics for Wales



## Chapter 2: Equal Pay and Related Areas

### Introduction

- 2.1 Our remit places two specific requirements on us in respect of equal pay and related areas. First, there is a *general* requirement that in reaching our recommendations we should take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief, and disability. Secondly, there is a *specific* requirement to have regard to the principle of equal pay for work of equal value in the NHS. This chapter sets out the evidence we have received in respect of these areas. In the commentary we respond to this evidence, setting out our own assessment of these requirements, and an indication of how we intend to proceed in future to ensure that they are met.

### Evidence from the Parties

#### *The Health Departments*

- 2.2 The **Department of Health** said that Agenda for Change provided a number of benefits to our remit groups, including fair pay based on the principle of equal pay for work of equal value. The new pay system was based on the concept of job evaluation, which meant that pay would be determined on the basis of the skills needed for a post. The job evaluation system had been developed especially for NHS staff. It would ensure staff received equal pay for work of equal value by determining the correct pay band for each post, and so the correct basic pay. National roll-out of the new system was not yet complete and it would not be appropriate to propose changes to the structure at this time.
- 2.3 More generally, it drew our attention to the results of the National NHS Staff Survey 2004 which showed that 73 per cent of NHS staff believed that their employer was committed to equal opportunities, up from 69 per cent a year earlier. In addition, whilst it claimed that other surveys showed employees' feelings of fairness and trust had diminished in the private sector, 61 per cent of NHS staff felt that their employer acted fairly with regard to career progression or promotion, regardless of ethnicity, gender, religion, sexual orientation, disability or age.

#### *NHS Employers (NHSE)*

- 2.4 **NHSE** pointed out that the NHS job evaluation scheme had been extensively tested and its operation reviewed by independent experts. A review of the Early Implementer sites, which the Agenda for Change partners had undertaken, concluded that the scheme was robust, fair, equality proofed and fit for purpose.
- 2.5 They highlighted the requirement in our remit to take into account the principle of equal pay when making our recommendations. They argued that this meant that, in order to maintain the integrity of the pay bands and to ensure equal pay, there was a direct linkage between the pay awards for remit staff and for staff outside the remit. They asked us to take this into account when considering the financial impact of our recommendations.

## *Staff Bodies*

- 2.6 Evidence from the **Staff Side** also drew attention to the principles of equal pay underpinning Agenda for Change, and to the consequent amendment to our terms of reference. It said that until assimilation of staff to the new system was complete it was not possible to monitor whether equal pay had become embedded in the pay system, but that such monitoring, once undertaken, should be shared and be easily available to both sides. It said we should also note that there was a parallel pay determination process for staff outside our remit conducted in the Pay Negotiating Council, and that we should have regard to deliberations in that forum in respect of a pay claim for 2006.
- 2.7 Of the individual staff bodies that commented on this issue, **Amicus** expressed confidence that, provided it was fairly and consistently applied, the NHS job evaluation scheme would make a significant step towards achieving equal pay for work of equal value. Initial assessments supported this conclusion, and Amicus intended to continue to monitor the situation. However, it was concerned that the deadlines that had been set for implementing the new pay system had under-estimated the scale of the task in hand and carried the danger that employers may cut corners in order to meet the targets set, in turn undermining the prospects of achieving equal pay for work of equal value.
- 2.8 Monitoring for consistency of outcome would be an important next stage in the process. The national monitoring system based on computer assisted job evaluation would provide useful data across job families, bands and factors. However, Amicus intended to augment these data with its own surveys so that a qualitative assessment could be made on whether equal value was being achieved. Additionally, it proposed that we should undertake an equal pay audit of Agenda for Change outcomes as it had concerns about the degree to which 'subjective' factors might shape outcomes across some NHS employers, the evidence it had seen suggesting 'abuses' of the job evaluation scheme, and inadequate funding to implement Agenda for Change. At the same time, fragmentation resulting from organisational changes within the NHS could seriously compromise the national pay system and reintroduce inequalities.
- 2.9 The issue of funding was also taken up by the **CSP**. It was concerned that the financial situation in many Trusts would mean that the implementation of the new pay system would not be fully funded. Physiotherapy staff had raised concerns that job matching had been 'shoe-horned' to fit existing budgets, rather than posts being banded on their merits in line with ensuring equal pay for work of equal value. It sought assurances that full funding would be provided. CSP also noted the importance of monitoring the equal value outcomes from Agenda for Change. Such monitoring should be comprehensive and cover factors such as race and disability, in addition to gender. It said that anecdotally, some employers were reluctant to share this information with staff representatives.
- 2.10 The **T&G** raised particular concerns about the implementation of Agenda for Change, as it said that a range of NHS Trusts were attempting to use the job matching exercise to depress the pay of ambulance staff, especially ambulance technicians. It argued that such a strategy would undermine the equal pay basis of the new structure. It also expressed concern about a gender pay gap among ambulance staff, with median male full-time employees earning some 27 per cent more than female full-time staff. It believed that this should be analysed and appropriate action taken to close the gap during the implementation of the new pay system. Finally, the T&G said that careful consideration should be given to ensuring equality of treatment for all NHS staff in the same geographical area, in the application and value of supplements designed to reflect the higher cost of living in certain locations.

## Our Comment

- 2.11 This is our first report since the changes to our remit in July 2003 and it provides an opportunity for us to set out our understanding as regards them, and to give an indication to the parties of how we have addressed these parts of our remit this year and will do so in future years. In doing so, we believe it important first to make some observations regarding the practicalities surrounding the requirements on us for ensuring equal pay for work of equal value under the Agenda for Change agreement.
- 2.12 One of the objectives that the parties set for Agenda for Change was that any new NHS pay structure should provide equal pay for work of equal value. As a consequence, the pay structure that has emerged puts jobs of equal weight in the same pay bands so that, for example, nursing staff, AHPs, administrative staff, and technicians, may all now find themselves covered by the same pay band. For this reason, a change to the pay of one group not mirrored in the pay of other groups in the same band might give rise to equal value claims unless it could be shown that the variation in pay between the groups was due to a material factor that was not the difference in sex.
- 2.13 To reinforce the objective of ensuring equal pay, in July 2003 the Minister of State wrote to both NHS Review Bodies<sup>7</sup> proposing changes to their remits that would, *inter alia*, require them to have regard to equal value considerations. The then NOHPRB chairman accepted these changes on behalf of the Review Body. The Agenda for Change agreement subsequently fleshed out these proposals by specifying that:
- The Review Bodies objectively justify any recommendations that are likely to result in different levels of pay for staff groups with comparable job weights, whether the staff groups in question are within the same Review Body remit or in different Review Body remits; and
  - The two NHS Review Body Chairs may consult each other where the evidence suggests there is a need to address equal pay considerations affecting staff groups in different remits.
- 2.14 We fully understand and appreciate the need to justify objectively any awards we might recommend that would result in different pay rates for jobs of equal weight for groups that are *within* our remit. However, we do foresee difficulties in meeting the requirements set out in Agenda for Change as regards the interface with the pay of staff groups *outside* our remit. These are, first, that there is no reference in Agenda for Change to any mechanism to enable us to take account of negotiations affecting non-review body groups (e.g. ancillary and clerical staff) carried out by the Pay Negotiating Council (PNC). Secondly, we do not understand how the proposed interface with the Doctors' and Dentists' Review Body (DDRB) can operate in practice given that the DDRB groups have not been job evaluated, are not covered by the new NHS pay system, and have not as yet agreed the relevant amendment to the Review Body's remit.
- 2.15 We have raised these concerns with the parties in oral evidence sessions but they provided little by way of clarification. The staff bodies and employers reiterated the views expressed in their written evidence that we should have regard to the implications of our recommendations for non-remit staff. However, the Departments admitted that, at least in respect of non-remit staff covered by the new pay system, pay negotiations were likely to commence only after we had submitted our recommendations.

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<sup>7</sup> That is, the Review Body for Nursing and Other Health Professions and the Doctors' and Dentists' Review Body.

- 2.16 In the circumstances, and until clarification on these points is available, we have proceeded as we have in the past, basing our recommendations solely on the evidence we have received in respect of our remit groups. In the meantime, we would urge the parties to set out the specific processes by which they consider we may take account of potential equal pay concerns in connection with the non-remit staff groups.
- 2.17 We now turn to how we have addressed our remit this year, and plan to do so in future.
- 2.18 It is clear from legal advice we have received that the responsibility for equality proofing pay lies with NHS employers and not with the Review Body. It is important, however, that we set out clearly in our reports our reasoning in the event that we propose differential awards<sup>8</sup>. It is also important that we ask the parties to provide evidence drawing attention to any equality concerns they may have, and identifying the equality issues arising from recommendations that they ask to us to make. This has been our approach this year both in respect of the written and oral evidence we have sought from the parties.
- 2.19 We have concluded from the evidence we have received that no action is required from us this year under this element of our remit. All the parties are agreed on the importance of monitoring the impact of the new pay system with regard to its equal pay objectives. This will be extremely important, especially as some of the staff bodies have expressed concerns about aspects of the implementation process. We are pleased, therefore, that the parties have put in place nationally the necessary mechanisms for such an exercise and we look forward to receiving regular updates from the parties on the emerging conclusions. Given the wide nature of our remit, we would ask them to ensure that the data collected go beyond gender considerations alone, to look at other areas of potential discrimination such as race, age, and disability.
- 2.20 In this regard, some of the staff bodies have suggested that we undertake our own monitoring exercise, or carry out an equal pay audit. For a number of reasons, but most notably the nature of our *locus* in the process, we believe these actions are best left to the parties. We do note, however, the view put to us by NHS Employers that Agenda for Change is concerned with consistency, not uniformity. That is, that employers have the flexibility to define roles, whilst avoiding the grade drift that arose under the old pay system. Clearly, as new profiles with new responsibilities are developed individual employers would be well advised to audit their structures to ensure that equal pay for work of equal value has not been compromised.
- 2.21 Finally, individual staff bodies have raised concerns with us about what they believe are inappropriate pay bandings for some staff groups. We must stress that disagreements arising from the operation of the job evaluation system, job matching, and allocation to pay bands, are matters for the parties to address through the existing structures and procedures.
- 2.22 In future years the approach we have set out above in paragraph 2.18 will be an automatic part of the general review process. In addition, parties seeking to justify pay differentiation in respect of specific remit staff groups will need to provide robust evidence to support their case, and will also need to address the following points:
- Why they consider that pay differentiation for the particular group is necessary;

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<sup>8</sup> Differential awards may take two forms: *geographical* differentiation to address differences in the cost of living or labour markets across the country, and *occupational* differentiation aimed at addressing local or national labour market problems affecting specific staff groups. The two forms are not mutually exclusive, and both are covered here.

- Why they consider their objective(s) cannot be achieved by a route other than pay differentiation; and
- Why they consider the level of any differentiation they propose, rather than a lesser amount, is appropriate to meet their objective(s).

2.23 For our part, we will make a thorough assessment of the evidence presented to us on differentiation and its implications for equal pay. When making differential awards, the evidence we have relied on and the reasons for the conclusions we have drawn will be spelt out fully in our reports.

## Chapter 3: Recruitment and Retention

### Introduction

3.1 In this chapter we review:

- the key results of this year's Workforce Survey carried out by the OME (the results are reviewed further in Appendix F). Full results appear on our website at <http://www.ome.uk.com>;
- vacancies in the NHS, including the Department of Health vacancy survey;
- evidence from the Parties.

As there is clearly a strong link between some aspects of recruitment and retention and issues affecting motivation and morale, there is some overlap between the evidence covered in this chapter and that in chapter 5.

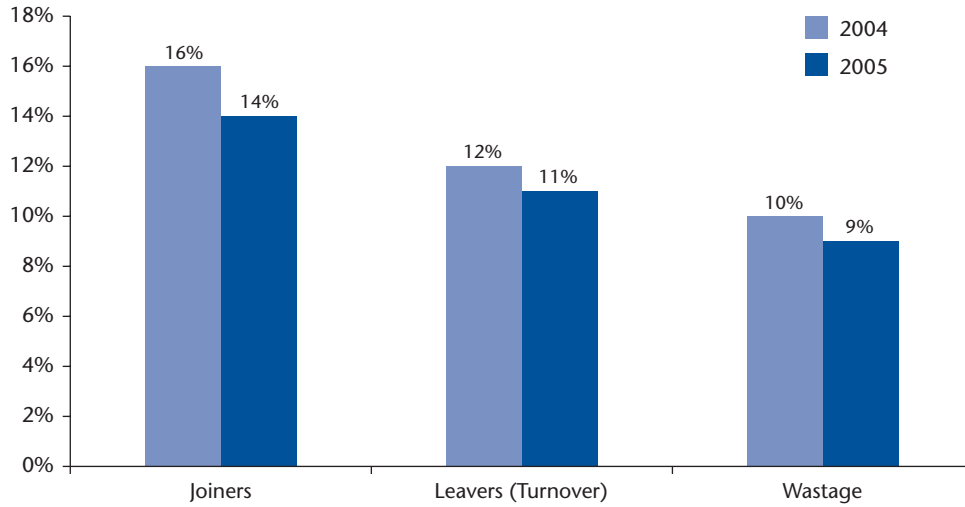
### OME 2005 Workforce Survey

- 3.2 Again this year OME has carried out a Workforce Survey covering Trusts and Health Boards in Great Britain. Some summary tables are reproduced in Appendix F and summary results are included in this chapter. Full results appear on our website at <http://www.ome.uk.com>. The survey covers recruitment and retention issues as reported by managers in Trusts or Health Boards in Great Britain, and turnover rates, that is the number of leavers as a proportion of staff in post. There are differences in the period of coverage and turnover categories between England and Wales, on the one hand, and Scotland on the other. The Scottish data show staff movements over the year to 30 September 2004 (rather than to 31 March 2005) and additionally include staff movements between NHS employers. For these reasons turnover data for England and Wales are presented separately from those for Scotland where indicated in the report.
- 3.3 Turnover information in England and Wales is looked at in terms of results for the sample as a whole collected in 2005 and a matched sample comparing 2005 with 2004. The matched sample results take into account any changes in the composition of the sample, so that like Trusts are compared with like Trusts in the two years. For the reasons above, it is not possible to include Scottish data in the matched analysis.

#### *a) Nursing staff, midwives and health visitors*

- 3.4 For the 2005 sample as a whole, nursing staff joining Trusts in the year to 31 March 2005 represented 13 per cent of staff in post in England and Wales. In Scotland total nursing staff joining Health Boards in the year to 30 September 2004 was 12 per cent of staff in post. The turnover rate in England and Wales (that is, the number of leavers as a proportion of staff in post) was 11 per cent. The wastage rate (that is, leavers excluding transfers to other NHS Trusts as a proportion of staff in post) was nine per cent. In Scotland the turnover rate was 11 per cent.
- 3.5 Figure 3.1 shows joiners, leavers and wastage for the matched sample for England and Wales. Total nursing staff joining Trusts as a proportion of staff in post at year end was around 14 per cent in 2005, compared with about 16 per cent in 2004. Both turnover and wastage fell in 2005 (turnover: from 12 per cent in 2004 to 11 per cent in 2005, and wastage: from 10 per cent in 2004 to 9 per cent in 2005). The main reason for the fall in turnover between 2004 and 2005 is an overall fall in the proportion of staff leaving for "other reasons" (including redundancy, career break, personal reasons etc.).

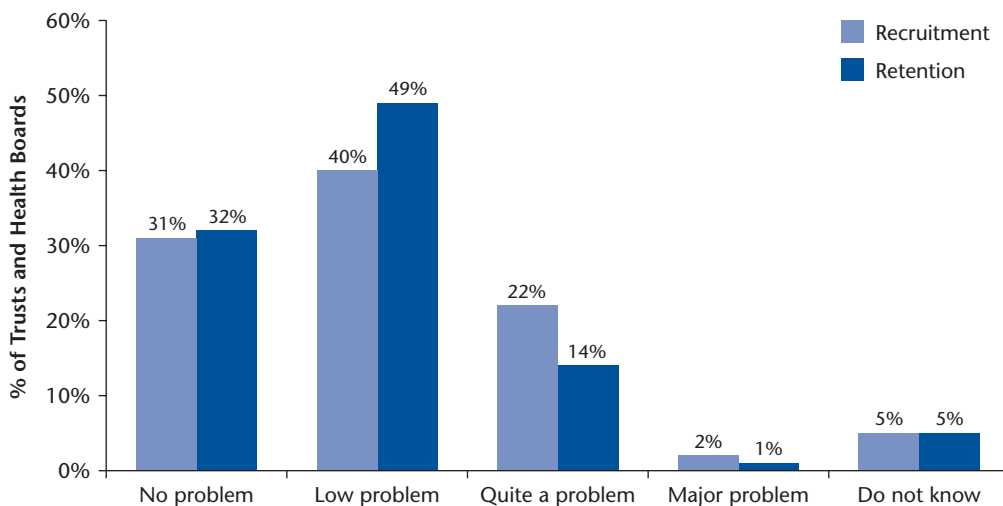
**Figure 3.1: Joiners, leavers and wastage in NHS Trusts in the year to 31st March as a proportion of staff in post for England and Wales only: total nursing staff**



Source: 2005 Workforce Survey

3.6 We also used our survey to obtain the views of managers about the recruitment and retention problems in their Trust or Health Board<sup>9</sup>. As shown in Figure 3.2, while the majority of employers had either 'no problem' or a 'low problem' with recruiting or retaining nursing staff, nearly one in four answered that they either had 'quite a problem' or a 'major problem' with recruitment. Fifteen per cent of employers recorded that they had either 'quite a problem' or a 'major problem' with retention.

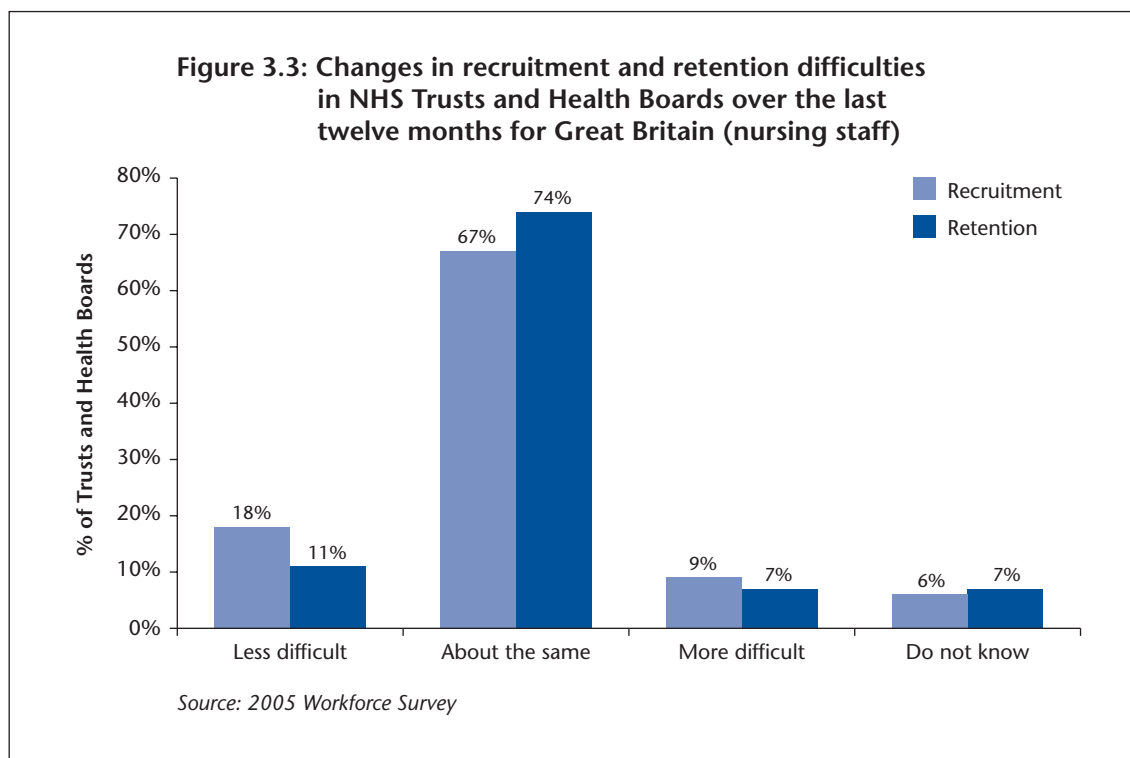
**Figure 3.2: Distribution of the extent to which NHS Trusts and Health Boards had recruitment and retention difficulties for Great Britain: total nursing staff**



Source: 2005 Workforce Survey

<sup>9</sup> Results are presented on an aggregate basis for Trusts and Health Boards and do not, unless otherwise indicated, necessarily mean that a majority of Trusts and Health Boards, for example, indicated a specified view.

3.7 As shown in Figure 3.3, on balance recruitment and retention appeared to be marginally improving, with nearly a fifth of employers reporting that recruitment was 'less difficult' in 2005 than in 2004 and about a tenth reporting that retention was less difficult. However, within these Great Britain figures, there is a different picture in Scotland. Twenty-four per cent of Scottish Health Boards reported that recruitment had got 'more difficult' in the last 12 months (compared to 7.6 per cent of English Trusts and 11.1 per cent of Welsh Trusts) and only eight per cent said recruitment was 'less difficult'.

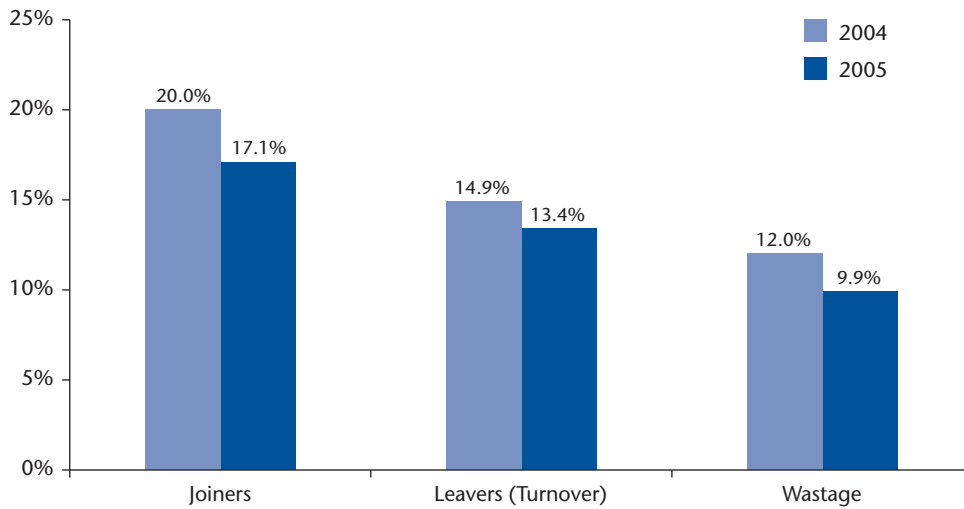


#### b) Allied Health Professionals (AHPs)

- 3.8 The category of AHP staff includes staff employed as physiotherapists, radiographers, music, art and drama therapists, occupational therapists, orthoptists, chiropodists, dieticians, and related grades in the NHS, except learners of any type.
- 3.9 For the 2005 sample as a whole, AHPs joining Trusts in England and Wales in the year to 31 March 2005 represented 17 per cent of staff in post. In Scotland total AHP staff joining Health Boards in the year to 30 September 2004 was 15 per cent of staff in post. The turnover rate was 13 per cent. The wastage rate was 10 per cent. In Scotland the turnover rate was 12 per cent for all AHP staff in post.
- 3.10 Total AHP staff joining Trusts in England and Wales as a proportion of staff in post fell from 20 per cent of staff in post in 2004 to 17 per cent of staff in post in 2005 (Figure 3.4). Turnover fell from about 15 per cent in 2004 to 13 per cent in 2005, while wastage also fell by two percentage points from 12 per cent in 2004 to ten per cent in 2005. The main reason for the reduced turnover in 2005 was fewer staff leaving for "other reasons" (including redundancy, career break, personal reasons etc).



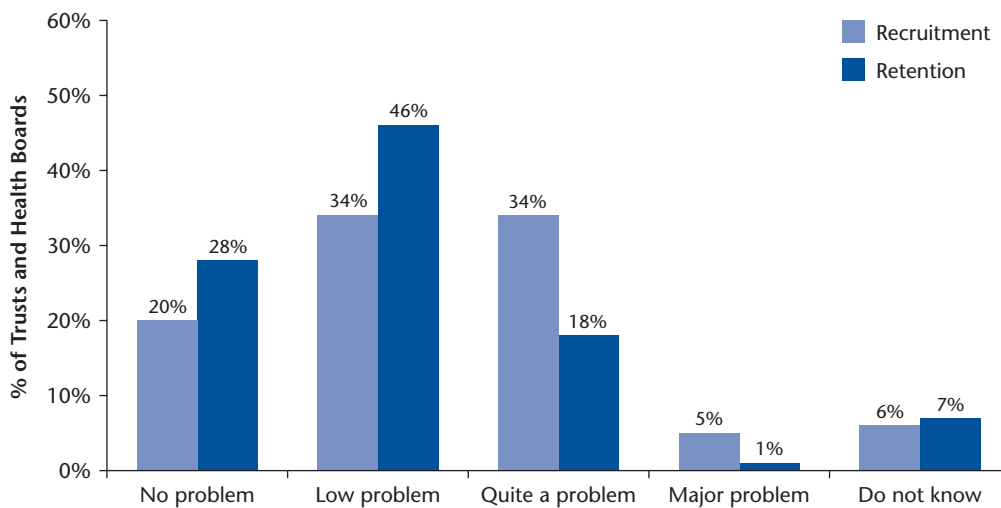
**Figure 3.4: Joiners, leavers and wastage in NHS Trusts in the year to 31st March as a proportion of staff in post for England and Wales only: total AHP staff**



Source: 2005 Workforce Survey

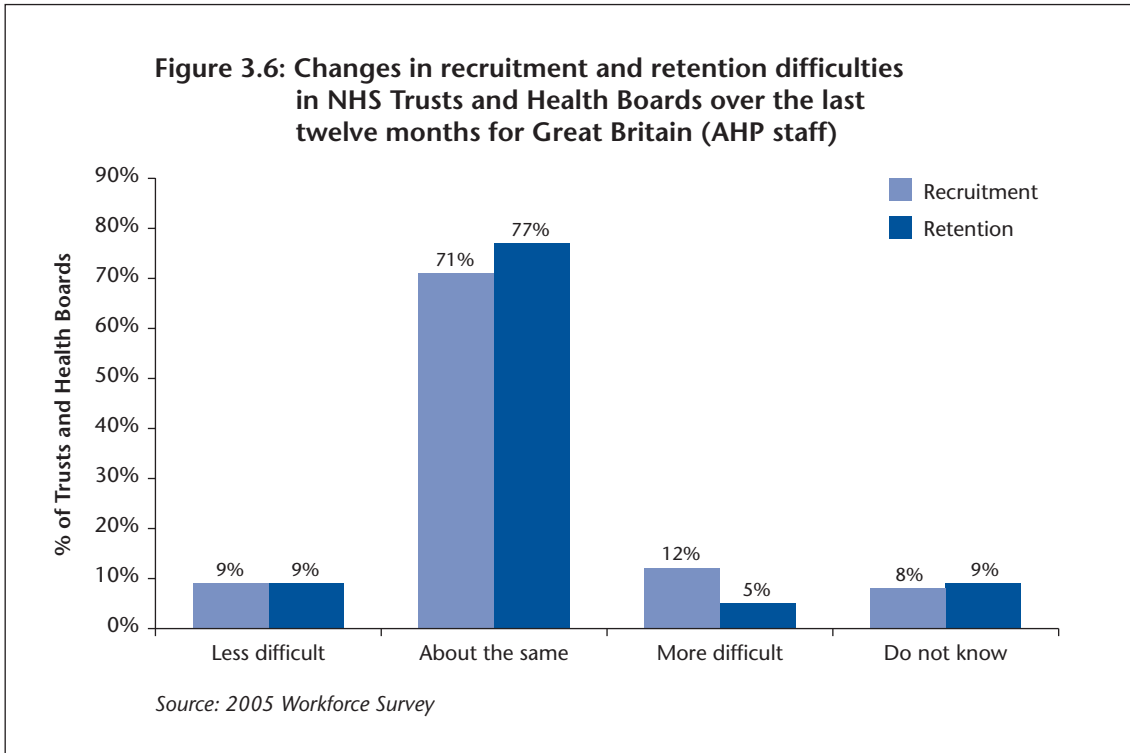
3.11 Trusts and Health Boards were asked about the extent to which they had problems either recruiting or retaining their AHP staff. As shown in Figure 3.5 below, 34 per cent said they had 'quite a problem' recruiting AHP staff, while five per cent had a 'major problem' in doing so. One fifth of employers had 'no problem' recruiting such staff.

**Figure 3.5: Distribution of the extent to which NHS Trusts and Health Boards had recruitment and retention difficulties for Great Britain: total AHP staff**



Source: 2005 Workforce Survey

3.12 The recruitment situation for AHP staff appears to have worsened slightly since last year (Figure 3.6). Twelve per cent thought recruitment had become 'more difficult' than last year, while only nine per cent said it had got 'less difficult'. Seventy-one per cent thought recruitment difficulties remained 'about the same' as last year. In contrast retention problems appear to have improved a little since last year. While nine per cent felt that retention was 'less difficult' than last year, five per cent felt it had got 'more difficult', although three-quarters of employers said that retention difficulties were 'about the same' as last year.



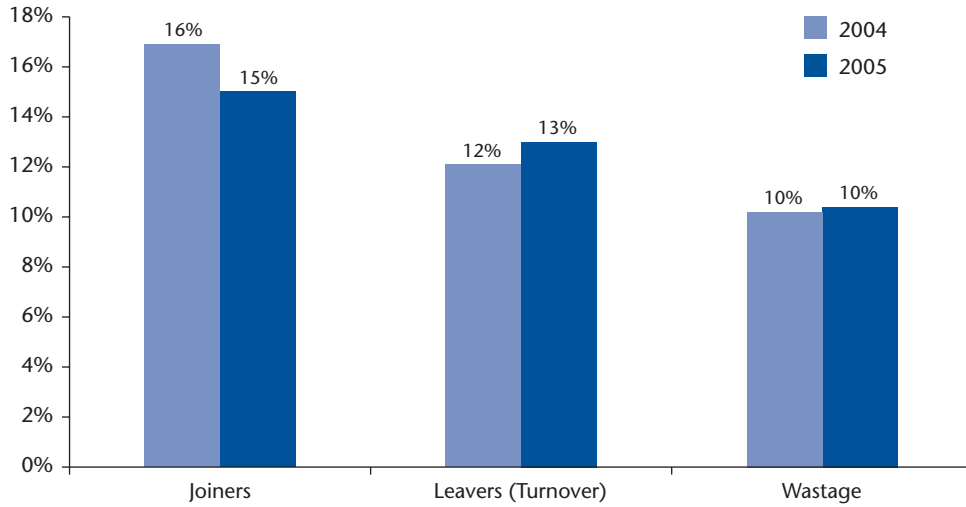
*c) Other Scientific, Technical and Therapeutic (ST&T) staff*

3.13 The category of ST&T staff includes staff employed in speech and language therapy, multi-therapies, pharmacy, clinical psychology, psychotherapy, dental, medical physics, pathology, physiological measurement, operating theatres and in other scientific, technical and therapeutic areas.

3.14 For the 2005 sample as a whole, ST&T staff joining Trusts in England and Wales in the year to 31 March 2005 represented about 15 per cent of staff in post. In Scotland ST&T staff joining Health Boards in the year to 30 September 2004 represented 10 per cent of staff in post. In England and Wales the turnover rate was 13 per cent. The wastage rate was 10 per cent. In Scotland the turnover rate was 8 per cent.

3.15 Total ST&T staff joining Trusts in England and Wales as a proportion of staff in post fell from 17 per cent of staff in post in 2004 to 15 per cent of staff in post in 2005 (Figure 3.7). Turnover rose by a percentage point to 13 per cent in 2005, while wastage remained about the same as in 2004 at 10 per cent.

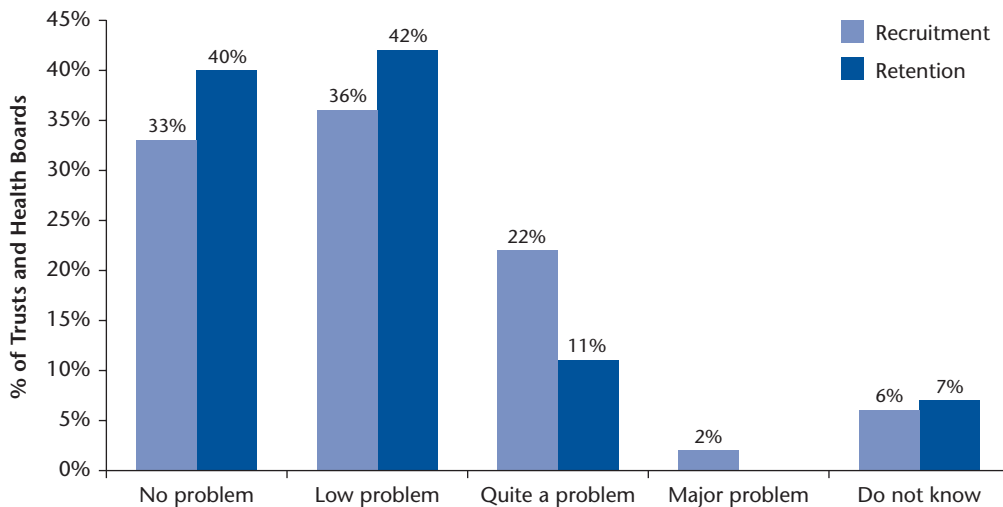
**Figure 3.7: Joiners, leavers and wastage in NHS Trusts in the year to 31st March as a proportion of staff in post for England and Wales only: total ST&T staff**



Source: 2005 Workforce Survey

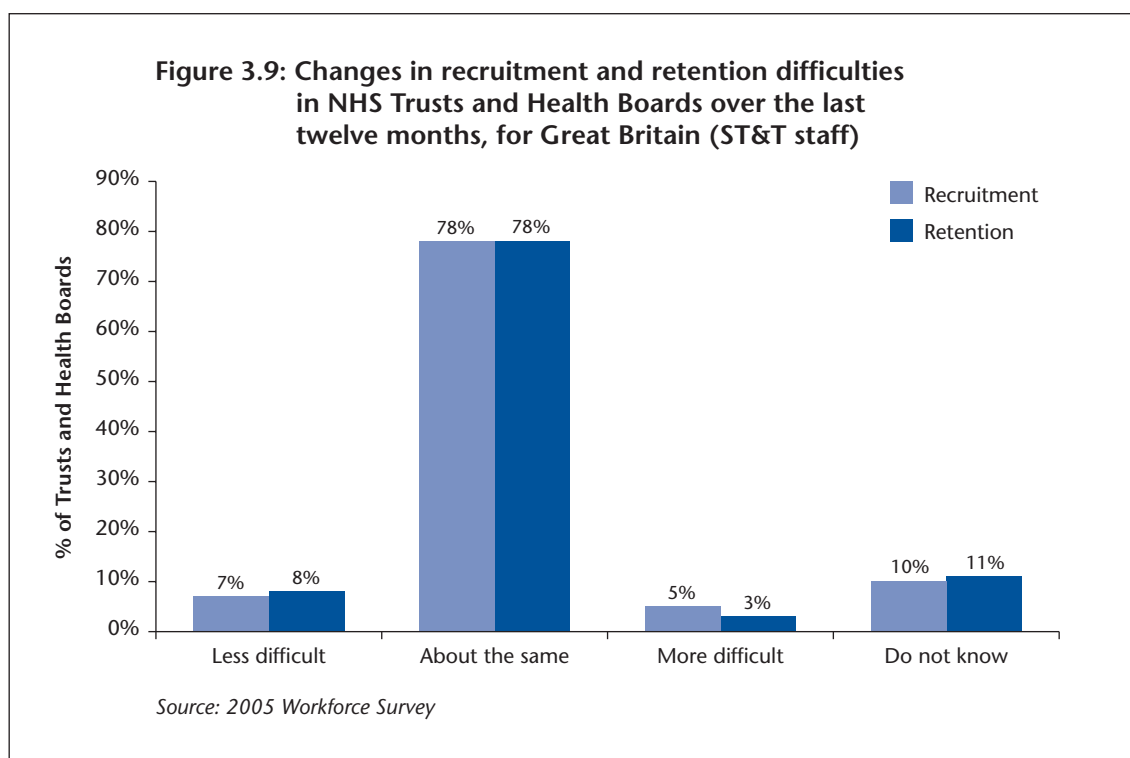
3.16 Trusts and Health Boards were asked about the extent to which they had problems either recruiting or retaining their ST&T staff. As shown in Figure 3.8, nearly a quarter of employers answered that they had 'quite a problem' or a 'major problem' with recruitment, while just over a third had a 'low problem' and a third felt they had 'no problem'. Retention of ST&T staff appeared to be less of an issue than recruitment. Over 80 per cent of employers felt they had 'no problem' or a 'low problem' with retention. Just 11 per cent recorded they had 'quite a problem' and none reported that they had a 'major problem'. Compared with nurses and AHPs, fewer employers appeared to have difficulty retaining ST&T staff.

**Figure 3.8: Distribution of the extent to which NHS Trusts and Health Boards had recruitment and retention difficulties for Great Britain: total ST&T staff**



Source: 2005 Workforce Survey

3.17 Over three quarters (78 per cent) of employers felt that the recruitment and retention situation for ST&T staff was 'about the same' as last year, which can be seen in Figure 3.9 below. While on balance the situation for both recruitment and retention appeared to be improving for ST&T staff, this was only marginal and a high proportion of 'do not know' replies may have also biased the results.

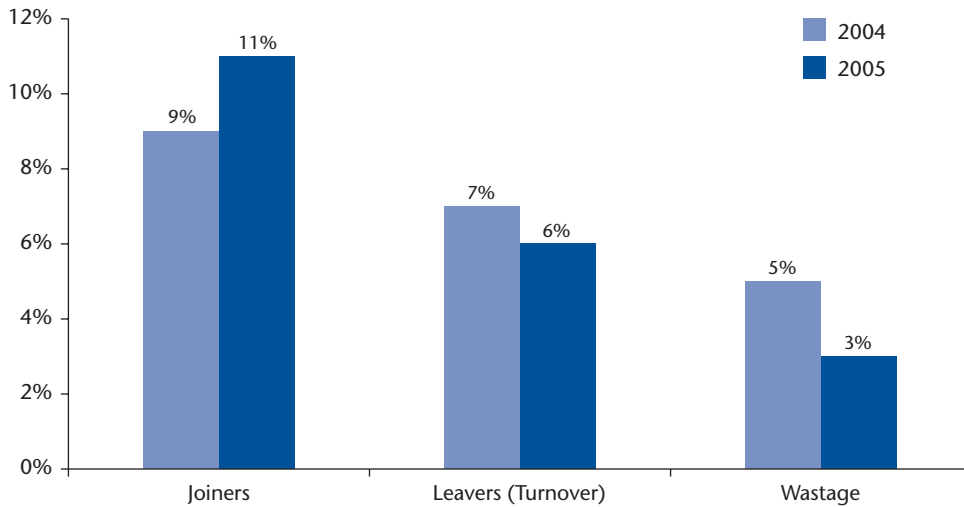


#### d) Ambulance staff

3.18 For the 2005 sample as a whole, ambulance staff joining Trusts in England and Wales in the year to 31 March 2005 represented about 11 per cent of staff in post. In Scotland ambulance staff joining Health Boards in the year to 30 September 2004 represented 12.5 per cent of staff in post. In England and Wales the turnover rate for ambulance staff was about five per cent. The wastage rate was 3.5 per cent. In Scotland the turnover rate was about 11 per cent for all ambulance staff.

3.19 Total ambulance staff joining Trusts in England and Wales as a proportion of staff in post increased from nine per cent of staff in post in 2004 to 10.5 per cent of staff in post in 2005. Turnover fell by over a percentage point to about 5.75 per cent in 2005 and wastage fell by two percentage points to three per cent (Figure 3.10).

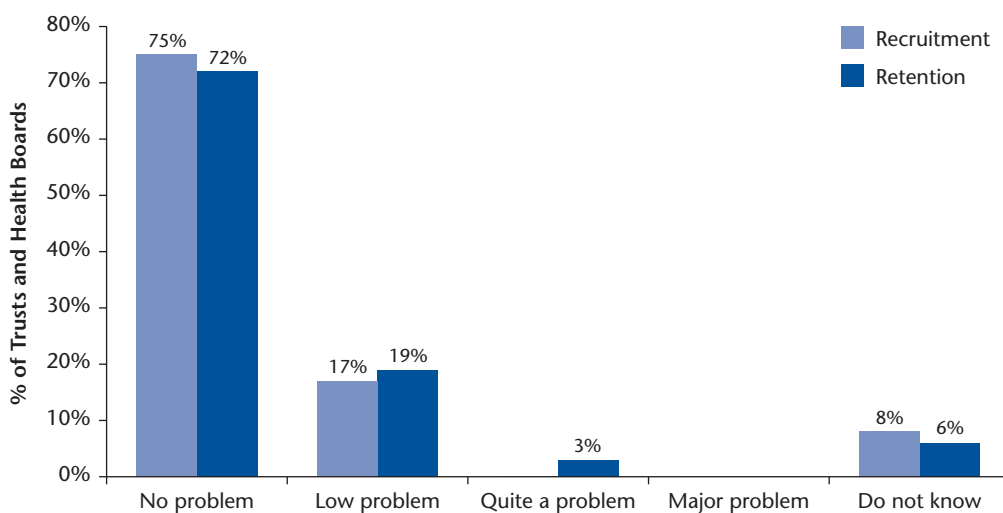
**Figure 3.10: Joiners, leavers and wastage in NHS Trusts in the year to 31st March as a proportion of staff in post for England and Wales only: total ambulance staff**



Source: 2005 Workforce Survey

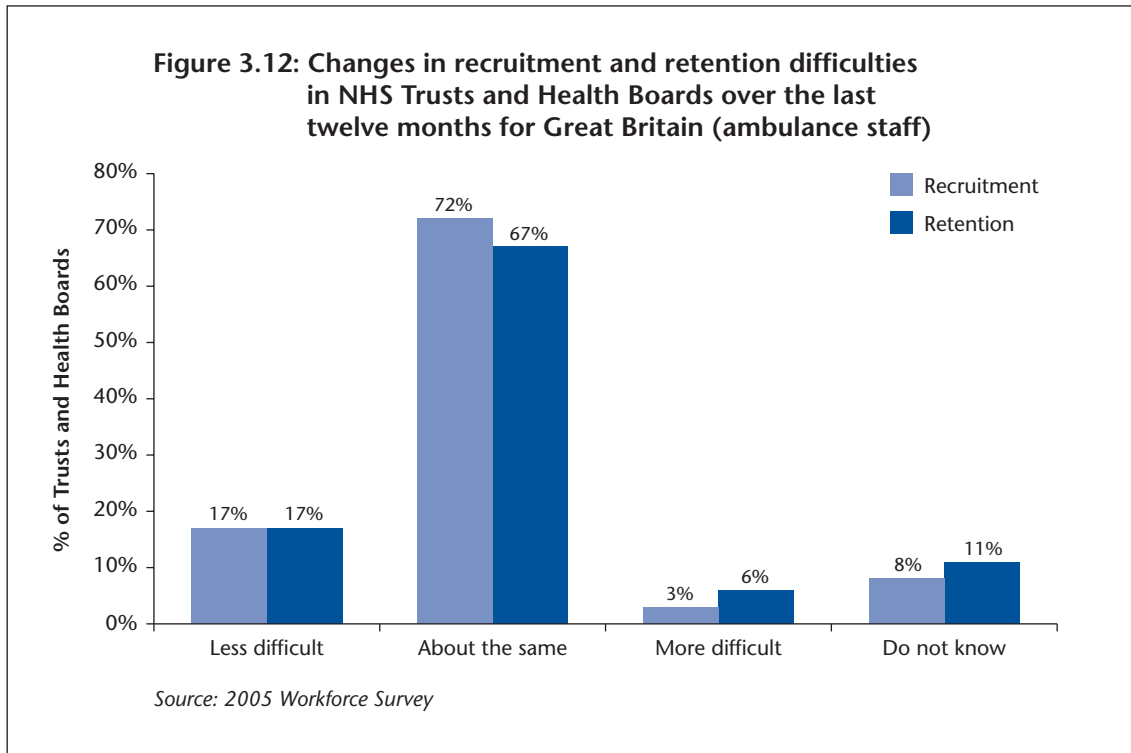
3.20 Trusts and Health Boards were asked about the extent to which they had problems either recruiting or retaining their ambulance staff. As shown in Figure 3.11, three-quarters of employers answered that they had 'no problem' with recruitment, while 17 per cent recorded that they had a 'low problem'. None had 'quite a problem' or a 'major problem'. Retention of ambulance staff appeared to be similar to recruitment. One employer reported that it had 'quite a problem' with retention.

**Figure 3.11: Distribution of the extent to which NHS Trusts and Health Boards had recruitment and retention difficulties for Great Britain: total ambulance staff**



Source: 2005 Workforce Survey

3.21 The recruitment situation appears to have improved slightly since last year (Figure 3.12). Seventeen per cent thought recruitment had become 'less difficult' than last year, while one employer said it had got 'more difficult'. Seventy-two per cent thought recruitment difficulties remained 'about the same' as last year. Retention problems appear to be similar to recruitment difficulties, although one more employer felt retention had got 'more difficult' than last year than recruitment (six per cent for retention compared to three per cent for recruitment).



## Vacancies in the NHS – The Department of Health’s Vacancy Data

### Summary

- 3.22 The three-month vacancy rates in England and Wales fell for all of the main staff groups<sup>10</sup> in March 2005 compared with the previous year. The only exception was unqualified nurses in Wales, for which the three-month vacancy rate had remained the same. However, difficulties also remained among certain key groups, particularly for three AHP professions – occupational therapy, diagnostic radiography and therapeutic radiography.
- 3.23 Scotland, in contrast to England and Wales, saw vacancy rates rise for qualified nurses<sup>11</sup> (for the fifth year) and for unqualified nurses. Scotland also experienced pockets of high vacancies among certain AHP and ST&T professions.

<sup>10</sup> Such as qualified nurses, midwives and health visitors; AHPs; and ST&Ts.

<sup>11</sup> Includes midwives and health visitors.

## *The data*

- 3.24 The Health Departments in Great Britain run vacancy surveys for England, Scotland and Wales; the latest is for 31 March 2005. Trusts and Health Boards are asked for information on vacancies which they have been actively trying to fill for three months or more. The results are expressed as a percentage of staff in post plus the actual number of three-month vacancies. Scotland provides data only for nurses and Allied Health Professions (AHPs).

## *Problems*

- 3.25 There are several reasons why the measured level of vacancies may not give an accurate impression. For example, the true level of vacancies can be underestimated if Trusts or Health Boards use short-term bank or agency staff. Vacancies can also be overestimated, for example, if they remain unfilled for a long period of time because of unusually long recruitment processes or because a vacancy is left open in order to accommodate staff temporarily not working but who are likely to return. It is therefore most useful to focus on trends rather than absolute levels.
- 3.26 Staff Side also suggested that while all professions seemed to have experienced reductions in vacancy rates, there was some evidence that fewer staff were moving to new jobs while they waited for the outcome of their job evaluations under Agenda for Change.
- 3.27 CSP was also concerned about the way in which vacancy data are compiled by the Health Departments. First, they said that because Health Departments' data only provide information on posts that had been vacant for three months or more, they do not reveal the true extent of vacancies in physiotherapy at any one time. Second, CSP argued that the data were not detailed enough and that recruitment difficulties affecting specific grades and specialities are hidden.

## *Results*

### *(a) England*

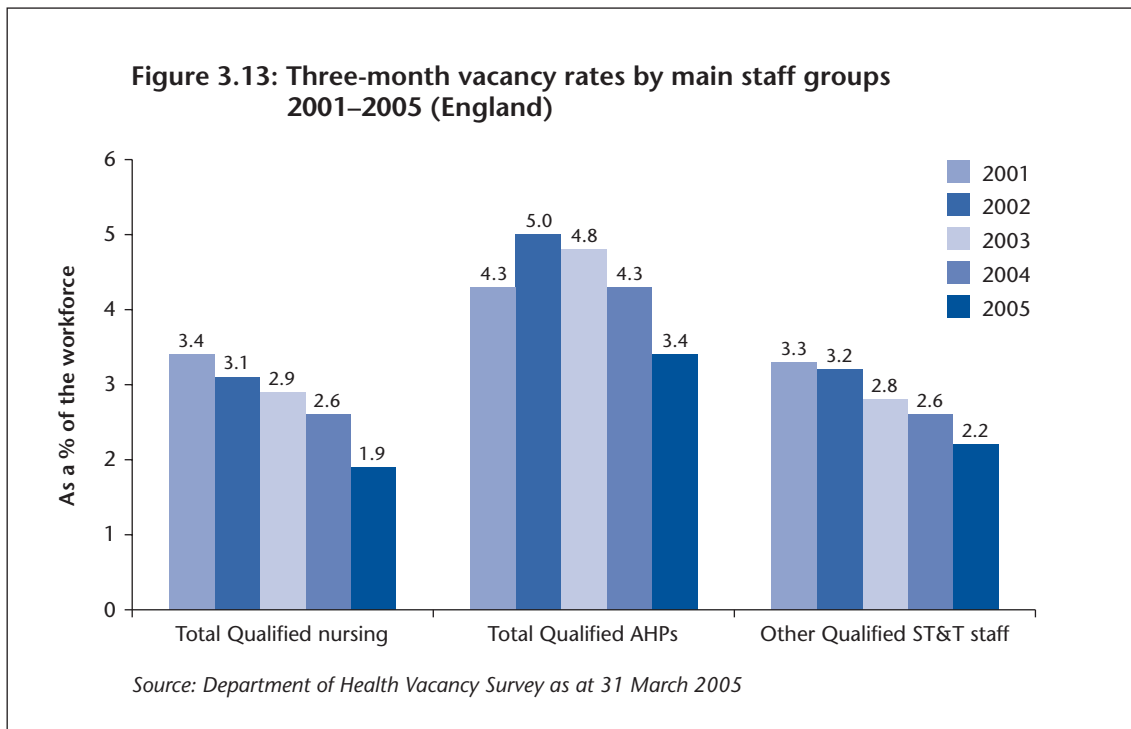
- 3.28 For qualified nurses, midwives and health visitors as a whole the vacancy rate was 1.9 per cent, a fall of 0.7 percentage points (1,700 vacancies) since March 2004. This is the fifth successive year in which vacancy rates have fallen (see Figure 3.13). For unqualified nurses<sup>12</sup>, the vacancy rate was 1.1 per cent in 2005, a fall of 0.7 percentage points on 2004. This is the first year for over three years that vacancy rates have fallen. The vacancy rate for healthcare assistants<sup>13</sup> also fell, for the second year running, from 2.1 per cent to 1.5 per cent.
- 3.29 For qualified AHPs the vacancy rate was 3.4 per cent in 2005, a fall of 0.9 percentage points (407 vacancies) compared with 2004, and also the third consecutive year the rate has fallen. Three AHP professions experienced a rise in vacancy rates: chiropody; dietetics; and art, music and drama therapy. Although rates have fallen for all but three AHP professions, difficulties remain among certain key groups. In occupational therapy, diagnostic radiography and therapeutic radiography three-month vacancy rates are relatively high compared to other NHS non-medical professions with rates at 3.9 per cent, 3.5 per cent and 6 per cent respectively, although each of these rates is lower than in 2004.

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<sup>12</sup> Defined as unqualified nursing, midwifery and health visiting staff.

<sup>13</sup> For all non-medical staff groups.

3.30 For other qualified ST&T staff the vacancy rate was 2.2 per cent, a fall of 0.4 percentage points and this is the fourth consecutive year the rate has fallen. Of the professions included in other qualified ST&T staff, only dental staff and pre-registration pharmacy trainees saw small increases in their vacancy rates.

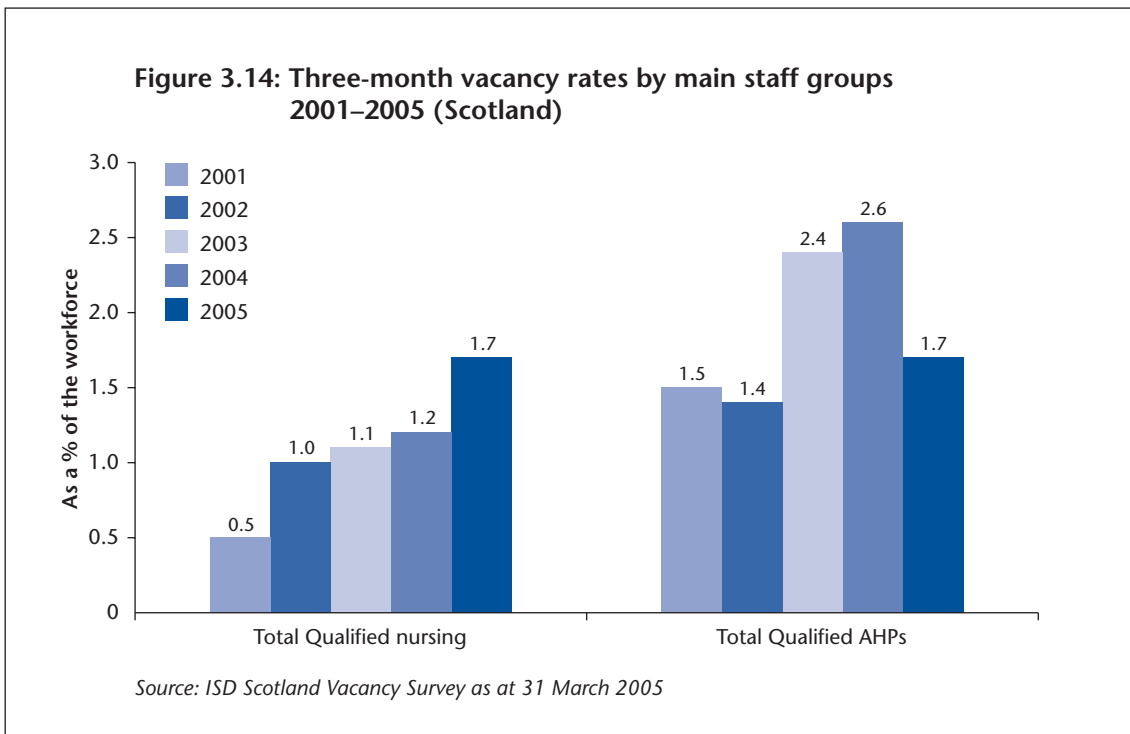


*(b) Scotland*

3.31 For qualified nurses, midwives and health visitors as a whole the vacancy rate was 1.7 per cent, an increase of 0.5 percentage points (235 vacancies). This is the fifth successive year that vacancy rates have risen (see Figure 3.14), which is the reverse of England. For unqualified nurses the vacancy rate was 1.2 per cent, a rise of 0.3 percentage points (50 vacancies) on 2004. After it had stabilised between 2003 and 2004, it resumed its upward trend.

3.32 For qualified AHPs the vacancy rate was 1.7 per cent, a fall of 0.9 percentage points (57 vacancies) compared with a year ago and the first time it had fallen for three years. Although vacancy rates have fallen for the majority of the AHP professions, difficulties, as in England, remain among certain key groups. For example not only were vacancy rates relatively high among radiographers (3.5 per cent in 2005) but they also saw an increase of 0.4 percentage points on 2004.

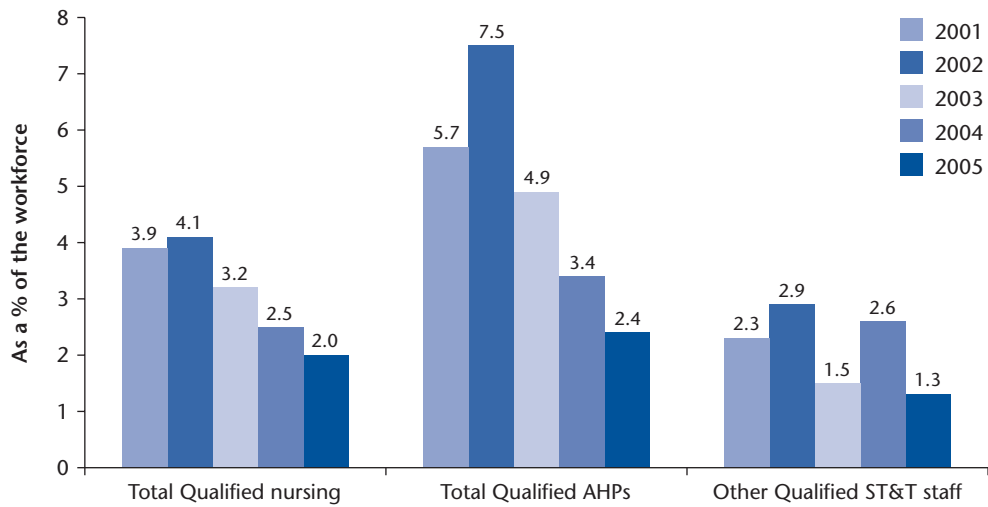




(c) Wales

- 3.33 For qualified nurses, midwives and health visitors as a whole the vacancy rate was 2.0 per cent in 2005, a decrease of 0.5 percentage points (106 vacancies) since March 2004. This is the third successive year that vacancy rates have fallen (see Figure 3.15). For unqualified nurses the vacancy rate in 2005 was 0.9 per cent, which was the same as 2004. Vacancy rates had previously risen (from 0.8 per cent) between 2003 and 2004 but had fallen by 1 percentage point between 2002 and 2003.
- 3.34 For qualified AHPs the vacancy rate was 2.4 per cent in 2005, a decrease of 1 percentage point (29 vacancies) compared with 2004 and the third successive year that vacancy rates have fallen. The vacancy rates have a tendency to be more volatile for AHPs in Wales than for England or Scotland because of the smaller numbers involved. For example, multi therapies had a vacancy rate of 30.4 per cent in 2005 yet this represented just two vacancies.
- 3.35 For other qualified ST&T staff the vacancy rate was 1.3 per cent, a fall of 1.3 percentage points (24 vacancies). This is the first year vacancies have fallen since 2003. As with AHPs, the smaller numbers involved mean that vacancy rates tend to be more volatile.

**Figure 3.15: Three-month vacancy rates by main staff groups  
2001–2005 (Wales)**



*Source: National Assembly for Wales Vacancy Survey as at 31 March 2005*

- 3.36 Although data from the Department of Health Vacancy Survey suggested falling vacancy rates in recent years, indicative of declining problems with recruitment and retention, we asked ourselves whether the vacancy rates we observed in the NHS were 'high' in an absolute sense. One way of answering this question is to compare vacancy rates in the NHS with other industries. The Office for National Statistics (ONS) provides a breakdown of vacancy rates by broad industry grouping. The average vacancy rates over the period from April 2001 to July 2005 are presented in Table 3.1. The table also contains evidence from the 2003 National Employer Skills Survey.
- 3.37 It is notable that the industry within which our remit falls, 'health and social work' has one of the highest vacancy rates, rates usually associated with industries such as hotels, restaurants and retail.

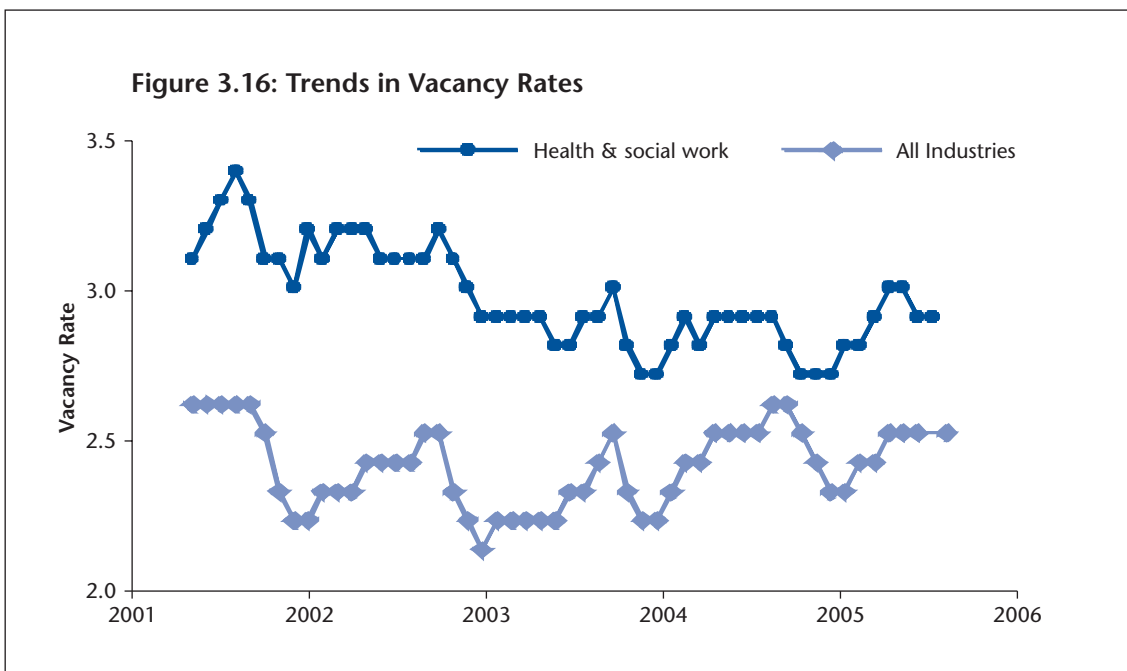
**Table 3.1: Average Vacancy Rates by Industry**

Industry	ONS Vacancy Rate (%)	NESS 2003 Vacancy Rate (%)	Fraction Hard-to-Fill
Hotels & restaurants	3.16	5.7	42.4
Transport, storage and communications	3.12	3.2	47.0
<b>Health &amp; social work</b>	<b>2.97</b>	<b>3.9</b>	<b>50.3</b>
Retail trade and repairs	2.94	3.0	33.1
Food, drink and tobacco	2.66	2.5	39.5
Financial intermediation	2.60	2.7	20.7
Other services	2.47	3.4	39.7
Real Estate & business activities	2.38	3.4	39.7
Wholesale trade	2.27	2.1	34.2
Chemicals & man-made fibres	2.03	1.8	35.8
Construction	1.87	3.6	59.2
Education	1.75	2.2	27.6
Mining & Quarrying	1.65	2.2	35.2
Other manufacturing	1.60		
Engineering & allied industries	1.53	1.4	40.4
Electricity, gas and water	1.38	2.2	11.6
Textile, leather and clothing	1.37	1.3	59.3
Base metals & metal products	1.32	1.7	49.2
Public administration	1.21	2.3	22.9

Notes:

1. ONS Data can be found at [http://www.statistics.gov.uk/downloads/theme\\_labour/latestdata.xls](http://www.statistics.gov.uk/downloads/theme_labour/latestdata.xls)
2. And NESS data in <http://www.lsc.gov.uk/NR/rdonlyres/ekts4w3fnotnxdfacwviaq6myaaadkxxdb4a3j7xbfnczytk6virmwdhumha3snqwp7spzyk4y5rnfdf/NESS2004.pdf>

3.38 Figure 3.16 presents the time series for vacancy rates in 'health and social work' and 'all industries' sectors. It shows that vacancy rates in the health and social work sector have tended to converge towards those for the whole economy in recent years. There is a fall in vacancy rates in the health and social work sector while there is no marked trend for the whole economy. However health and social work remains above average in its vacancy rates, which raises questions as to whether such vacancy rates remain a cause for concern.



- 3.39 The biggest problem with this analysis is that the industry group ‘health and social work’ is much broader than the NHS. Not all the workers within that category are within our remit or linked to it through the Pay Negotiating Council and Agenda for Change pay spines, although we estimate that just under half of the industry is in NOHPRB remit groups working in the public sector.
- 3.40 Thus, although the gap between vacancy rates in the NHS as a whole and those in the whole economy has narrowed considerably, those in the NHS in general and within our remit group in particular look high by the standards of the rest of the economy.

### Evidence from the Parties

- 3.41 Set out below is the evidence we have received from the parties in respect of recruitment and retention. Our comments follow afterwards.

#### *The Health Departments*

- 3.42 A key message contained within the evidence from the **Department of Health** was that since evidence was last submitted to the Review Body in 2001, a series of initiatives, including investment to increase student numbers, activities as part of the Improving Working Lives initiative and inter-governmental agreements to facilitate international recruitment, had led to significant increases in the size of the NHS workforce and sustained reductions in vacancy rates. Over the next year it anticipated there would be an increase in staff retiring combined with a reduction in international recruitment. However, despite these challenges the Department envisaged continued, but lower, growth due to increased output from training and stronger retention. In addition, where there were local pressures on staffing local mechanisms were being established to address them.

- 3.43 NHS Plan targets for increasing the NHS nursing workforce had been achieved early. As at September 2004 there were 301,877 full-time equivalent NHS nurses, an increase of 55,866 since 1997. Targets for increasing the number of nurses and midwives entering training had also been achieved. The number of nurses entering training had seen a 67 per cent increase between 1996/97 and 2004/05 and by the end of March 2004 over 18,500 former nurses, midwives and health visitors had returned to work since February 1999.
- 3.44 The Department said that it had ensured the NHS had the ability to attract additional capacity from outside the UK to fill gaps, including a focus on the European Union (EU). All such recruitment was underpinned by a Code of Practice, which had been updated and strengthened in 2004. It anticipated that the entry of new member states to the EU in May 2004 would also increase the number of health professionals who would come to work in the NHS.
- 3.45 The three-month vacancy rate for March 2005 showed a decline in vacancies within the NHS for each of the main staff groups compared with the previous year. The vacancy rate for qualified nursing, midwifery and health visiting staff had fallen from 2.6 per cent in March 2004 to 1.9 per cent in March 2005. The vacancy rate for qualified AHPs in the same period had fallen from 4.3 per cent to 3.4 per cent, and for qualified ST&T staff from 2.6 per cent to 2.2 per cent.
- 3.46 The Department said that therapists, healthcare scientists and other health professionals had also seen a significant growth in numbers. The number of therapists and scientists employed by the NHS had increased by 26,984 full-time equivalents since September 1997. By the end of March 2004 over 1,450 former allied health professionals and over 450 healthcare scientists had returned to work in the NHS since April 2001.
- 3.47 The paramedic workforce had also continued to grow, from 6,364 full-time equivalents in 1997 to 7,353 in 2004. The Department said that although there were generally a number of applicants for each paramedic training place, demand for ambulance services was growing and recruitment needed to keep pace with it. In particular, the growing demand for experienced paramedics to train as emergency care practitioners was leading to increasing demands on training facilities.
- 3.48 The Department acknowledged that some recruitment and retention problems did exist, for example with radiographers, and said that the UK Health Departments and NHS Employers would look at the evidence for the use of recruitment and retention premia from 2006 onwards in relation to such groups. The Department recognised the potential recruitment and retention impact the availability of affordable housing could have, especially in areas where house prices were highest, for example in London and the South East.

*The National Assembly for Wales (NAW)*

- 3.49 **NAW** said that the recruitment and retention picture in Wales was generally good. Shortages were generally specific and local, or were being addressed on a longer-term basis by increased training provision. Nurse recruitment appeared to be improving, with the number of nurses rising whilst vacancies were falling. However, it warned that specific difficulties were being experienced recruiting mental health nurses, which might need to be addressed by a regional recruitment and retention premium.

### *The Scottish Executive Health Department (SEHD)*

- 3.50 **SEHD** said that the Partnership Agreement of 2003 established recruitment targets for NHSScotland including the recruitment of an additional 12,000 nurses and midwives and 1,500 additional AHPs such as radiographers, physiotherapists, dieticians and chiropodists, by September 2007. NHSScotland was currently on target to deliver these additional staff.
- 3.51 SEHD said that the recruitment and retention position in Scotland was relatively healthy, and that any remaining pressures were believed to arise from non-pay factors. Remaining recruitment and retention issues were believed to arise from a misalignment between supply and demand and the availability of attractive posts in terms of professional content.

### *NHS Employers (NHSE)*

- 3.52 Evidence from **NHSE** was based upon information gathered from NHS employing organisations by way of a survey to which 34 per cent of Trusts had responded<sup>14</sup>. NHSE reported that recruitment and retention was generally improving or remaining stable, helped by a fall in staff turnover in most areas. However, they expressed concerns about the position in certain professional groups, in particular AHPs and nursing and midwifery.
- 3.53 National shortages had been identified within radiography, senior physiotherapy, midwifery and mental health nursing. There were also some unspecified geographical variations.
- 3.54 NHSE believed that the principal reason for difficulty in filling posts was a lack of experienced senior/specialist staff. Forty-three per cent of organisations responding to the NHSE survey indicated they had been oversubscribed with applications for vacancies, the main reason being the availability of more newly qualified applicants than available junior posts. NHSE acknowledged that international recruitment had been useful in maintaining workforce numbers, particularly of nurses, AHPs and radiographers, and that initiatives under the Improving Working Lives (IWL) banner, such as flexible working, education, training and development and childcare, had had the most significant positive effects upon retention.

### *Staff Bodies*

- 3.55 The **Staff Side** reported that the number of nursing staff, midwives and health visitors working in the NHS had grown by 74,907 between 1997 and 2005. In the period 1997 to 2004 the numbers of NHS qualified nursing/midwifery staff across the UK had increased by approximately 10 per cent in Scotland and by approximately 23 per cent in England. This growth in nursing was reported to be at all levels, with a 20 per cent increase in registered nurses, 18 per cent in nursing assistants and almost 80 per cent in staff designated as health care assistants. The numbers of health visitors, midwives and specialists were reported to have remained stable, although the number of midwives, according to the National Midwifery Council, had fallen by 942 to 32,745.

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<sup>14</sup> This survey represented the views of NHS employers in England only. All subsequent references to the NHSE survey reflect this.

- 3.56 Staff Side said that a significant contributor to the growth in the number of nurses was international recruitment, with nurses recruited outside the UK representing about 45 per cent of new entrants to the register. However, it reported that in 2005 there had been a reduction in numbers of nurses recruited from outside the UK for the first time in seven years. Staff Side believed the NHS was failing adequately to develop its non-registered workforce, which, it argued, could be an expanded pool from which to recruit trainees to qualify as registered nurses. Staff Side reported that the number of staff in the remaining health professionals group had risen by 178,157 since 1997.
- 3.57 Staff Side pointed out that at the same time as numbers had grown, services themselves had been expanded and reconfigured. The Staff Side contention was that an increase in numbers did not necessarily translate into an increase in staffing levels.
- 3.58 Staff Side highlighted that midwives had consistently suffered from higher vacancy rates than other NHS professions, reaching almost 12 per cent in some regions.
- 3.59 The ageing workforce was reported to be a growing challenge, with an increase in retirement rates being likely to have a marked impact over the next ten years.
- 3.60 Three-month vacancy rates for the main staff groups fell in March 2005, compared with the previous year. However, some areas had above average vacancy levels and in some specialist areas these were reported to have had a major impact on the ability of the NHS to meet patient needs. Areas of particular concern to the Staff Side were emergency care, mental health and midwifery.
- 3.61 There was not currently a recruitment problem for ambulance staff, although they did have a higher rate of ill-health retirement.
- 3.62 The **RCN** evidence was based on 4,975 responses to its 2005 annual survey of 9,000 members in both NHS and non-NHS healthcare. It reported that a smaller proportion (23 per cent compared to 25 per cent in 2003) of nurses working in the NHS had changed jobs in the last year, compared to 20 per cent of practice nurses and 35 per cent who were currently doing bank or agency nursing. Eleven per cent of nurses reported that they had changed employer in this period, compared to 13 per cent in 2003, 2002 and 2001. This was the first year since 1998 when the NHS turnover figure had not increased in relation to the previous year's survey. RCN suggested that this slowdown might be attributed to a reluctance to move during the transition to Agenda for Change bandings. However, it was too soon to say whether this slowdown was a temporary change or the start of a trend.
- 3.63 Typically, nurses frequently changed employer in the early stages of their career, but this, the RCN reported, had slowed in the last two years. Only 30 per cent of nurses qualified for five years or less changed jobs in 2005, which was considerably down on the 38 per cent recorded in 2003. RCN pointed out that the average age of each cohort had shifted. In 2003, 27 per cent of recent qualifiers were aged over 30. In 2005 this figure had risen to 33 per cent, leading the RCN to suggest that the older age profile might be creating a more stable workforce.
- 3.64 Job change was most often due to *pull* factors (e.g. better pay, better career prospects), but changing employers reflected *push* factors (e.g. stress, dissatisfaction with hours). This was much more likely to be the case for NHS nurses than for other nurses who changed their employer.

- 3.65 The RCN reported that 30 per cent of respondents wanted to leave their employer within the next two years, and nine per cent within six months. There was no difference in this respect between the NHS and other nursing employment. Nurses at the beginning and end of their careers were most likely to be considering moving, albeit for different reasons. In relation to nurses aged under 40, in most sectors there had been a reduction in the proportions looking to change employer in the next two years but in NHS hospitals this proportion had increased from 32 per cent to 36 per cent.
- 3.66 Twelve per cent of all nurses were intending to leave nursing in the next two years, up from 11 per cent in 2003. Most of these were aged 50+, although eight per cent of the under-40s were also looking to leave. RCN reported there had been a significant reduction in the proportion of nurses aged under 40 who planned to leave within five years (32 per cent compared to 43 per cent in 2003). The average nurse planned to retire at 59, although the expectation was itself age related.
- 3.67 Evidence on recruitment and retention from the **RCmnd.** drew heavily on survey returns from 137 Heads of Midwifery (HOMs). Of the 125 maternity units that provided details of vacancies, 74.4 per cent were experiencing some level of staffing shortage. This figure rose to 78 per cent in England and was broadly in line with last year's figures. Across the UK, vacancies represented 4.1 per cent of actual establishment. The vacancy rate for England stood at 4.9 per cent as compared with 5.8 per cent last year. London and the South East were highlighted as problem areas, with vacancy rates of 11.6 per cent and nine per cent respectively, although other regions caused the RCmnd. some concern, in particular, the West Midlands. Long-term vacancies (of three months or more) represented 59 per cent of all vacancies.
- 3.68 There had been a slight fall, from 37 per cent to 35 per cent, in the proportion of HOMs reporting an increase in job applications per maternity place year-on-year, which, RCmnd. noted, "is not much comfort in a profession that is struggling to maintain adequate staffing levels, especially in London and the South East."
- 3.69 There had been a slight reduction in the proportion of HOMs who believed that recruitment and retention were getting harder comparing 2005 with 2004, although the proportion thinking it was getting easier had also fallen. This was not welcome, especially when set against the background of Agenda for Change and Improving Working Lives roll-out. Where recruitment and retention was reportedly getting harder, the main factors were identified as heavy workloads and stress, although the number of HOMs citing these as factors was slightly down on previous years. A further improvement was that only three HOMs cited lack of family-friendly policies as a factor affecting recruitment and retention, which was substantially down on the 11 last year. RCmnd. felt this displayed the value of the Improving Working Lives initiative.
- 3.70 Although the total number of midwifery joiners was higher than in 2004 (1,518 compared to 1,477), and there had been a slight increase in newly-qualified midwives (from 868 to 881), joiners as a proportion of staff in post was lower – from 11.1 per cent last year to 8.3 per cent this year. In addition, the number of midwives leaving the profession had increased by 15 per cent compared to 2004 (1,131 compared to 981), which the RCmnd. said was disturbing given commitments that had been given to improve the supply of midwives. A comparison of the rate of leavers to joiners for 2005 and 2004 showed therefore that the increase in the number of staff leaving the NHS exceeded the increase in the number joining.



- 3.71 RCmnd. said that the number of midwives recruited from overseas had fallen from 49 in 2004 to 39 in 2005, the 2004 figure in contrast being almost double that of 2003.
- 3.72 **UNISON** acknowledged that there had been some improvements in recruitment and retention. Overall vacancy levels had improved and turnover had declined, although it suggested that this stability may be temporary as staff may be reluctant to move until they had been assimilated onto their pay band under Agenda for Change. Wastage rates, according to the OME's 2004 Workforce Survey, had worsened slightly (9.2 per cent for registered staff and 12 per cent for non-registered) and were unacceptably high. Recorded vacancy levels, although showing a small fall, also remained a concern. The highest levels of vacancies were found in the areas of psychiatric nursing (2.8 per cent), learning disability (2.3 per cent) and health visitors (2.1 per cent). For professions allied to medicine (PAMs) the highest vacancy rates were found amongst therapeutic radiographers (six per cent) and occupational therapists (3.9 per cent); in relation to the latter, 76 per cent of employers reported recruitment and retention problems. UNISON stated that the financial problems being experienced in a substantial minority of Trusts were leading to staffing cutbacks which would exacerbate current problems and adversely affect the ability of the NHS to attract staff in the future.
- 3.73 Nurses recruited from overseas had been important in maintaining NHS numbers, but there was evidence that recruitment from this source was levelling off, with a slight drop in overseas registrants reported (14,122 in 2003/04 as compared with 11,477 in 2005). UNISON argued that better retention of overseas nurses was needed. UNISON also reported that applications for student nursing places had fallen by 20 per cent between 2002 and 2003 (the last year for which figures were available), perhaps indicating that nursing was becoming less attractive as a career. Attrition rates amongst students were high. The average age of a student nurse was 27, over half had childcare responsibilities, and an increasing proportion had debts in excess of £10,000.
- 3.74 UNISON drew attention to the increasing number of healthcare assistants being seconded to the nursing diploma programme. It considered that support staff needed to feel valued and rewarded and to have appropriate training and development opportunities, particularly where they had expanded their roles. New roles meant that the modernisation of professional regulation must follow. Devolving responsibilities and job roles, and higher education attainment, needed to be recognised.
- 3.75 UNISON argued that the proposed expansion of the nursing workforce, along with the ageing profile of the current workforce, meant that the NHS needed to position pay to attract a greater proportion of future labour market entrants. It also needed to release the potential of the non-registered workforce. Despite Agenda for Change, substantial numbers of staff were low paid compared to accepted measures, and in relation to other public sector staff. Agenda for Change did not ensure that the NHS had pay rates which allowed it to recruit and retain sufficient staff.
- 3.76 UNISON reported that there were continuing recruitment and retention problems in the non-nursing groups covered by our remit, with an average wastage rate of 10 per cent for scientific and related grades and almost 12 per cent for PAMs. Among the scientific groups, retention seemed to be more problematic than recruitment, whereas for PAMs the problem was reversed.

- 3.77 UNISON was particularly concerned about the recruitment and retention of occupational therapists, pharmacists and operating department staff. Employers reported significant problems recruiting and retaining occupational therapists. There was also a relatively high rate of loss to non-NHS employers. Vacancy rates at 3.9 per cent were amongst the highest for all NHS staff groups. Wastage rates were particularly high for these groups. UNISON argued that problems might get worse because of private sector demand for occupational therapists' skills.
- 3.78 There were continuing retention problems for both qualified and support pharmacy staff. There were also long-standing problems recruiting and retaining operating department staff.
- 3.79 **Amicus** said that the entry point for the vast majority of registered and other degree-level professions under Agenda for Change was Pay Band 5, which was right and consistent. However, it argued that this salary range compared unfavourably with starting salaries for graduates in other parts of the economy. International recruitment, it argued, had partly inflated the success of the NHS in recruiting new staff, but could not be a solution to the recruitment and retention issues facing many occupations represented by Amicus.
- 3.80 Amicus believed that Band 6 of the pay spine would become the career grade for most professions, but it was too early to assess whether this was the case. Amicus therefore proposed that OME, working on our behalf, investigate the distribution of staff in our remit across the Pay Bands.
- 3.81 The **CSP**, using data from their recruitment and retention survey, said the three-month vacancy rate for UK physiotherapy posts was 3.5 per cent.
- 3.82 CSP drew attention to its own vacancy figures which were consistently higher than the Health Departments' figures. The CSP survey had asked for information about "on the day" vacancies, as it believed that three-month vacancies data did not reveal the true picture of vacancies in physiotherapy. For this reason it felt that the Health Departments' figures did not fully reflect the picture at any one time.
- 3.83 The CSP said that difficulties in recruitment lay at Senior I level in particular but also at Senior II level in some specialities. Health Departments' vacancy data were not broken down by grade, and grades where there were no problems, such as junior grades, brought down the average vacancy rate for all posts.
- 3.84 CSP was concerned about the way in which workforce and vacancy data were collected by the Health Departments. It wanted to see more comprehensive data collection undertaken through joint working with the Department of Health, NHS Employers and OME.
- 3.85 CSP stated that the OME Workforce Survey of PAMs, covering the 12 month period to March 2004, showed that the recruitment and retention situation had worsened since the previous year. Physiotherapists were among the three professions in which managers felt they had the most difficulties recruiting and/or retaining staff.
- 3.86 The OME Workforce Survey also identified physiotherapy as having the highest wastage rate among PAMs, with 13.6 per cent of them being lost to the NHS. CSP believed this was partly because of the many career opportunities outside the NHS and felt this serious loss of trained and experienced staff ought to be addressed.

- 3.87 CSP stated that a lack of robust workforce planning data had produced a situation in which new physiotherapy graduates were struggling to find jobs because of a lack of vacant junior posts.
- 3.88 Evidence on recruitment and retention from the **SoR** drew on three surveys, an email survey of 2,000 staff, to which 800 responded, a survey of MRI radiographers and an email poll targeted at managers and industrial relations representatives.
- 3.89 SoR acknowledged that efforts had been made in the last year to address the shortfall of radiographers, with some success. However, whilst the numbers of training places had increased, and experienced radiographers had been encouraged to return, there was still an average shortage of 3.4 per cent for diagnostic radiographers and six per cent for radiotherapists. This varied between regions, with North West London having the highest shortage of radiotherapists at 22.3 per cent.
- 3.90 SoR said that the Independent Sector Treatment Centres (ISTCs) programme had identified radiography as a shortage profession to which the 'additionality' policy would apply. This policy restricted the movement of such staff into ISTCs, thereby ensuring sufficient qualified and experienced staff remained available to maintain core NHS services. However, this also meant that ISTCs were competing with the NHS for newly qualified and returning radiographers, and if they were able to offer more attractive terms and conditions radiographers would be likely to choose a career within ISTCs over one in the NHS.
- 3.91 The SoR email poll of managers and IR representatives indicated that staff were reluctant to move to a new post until they had been matched and banded in their current job under Agenda for Change, in order that they could make an informed decision about their situation and prospects. Responses to the poll varied, but there were two main themes, firstly that vacancies were evident across all grades, and secondly that posts had been frozen in anticipation of a shortfall of funds after full implementation of Agenda for Change. There was an exception in the case of radiotherapy, where efforts were continuing to improve staffing levels.
- 3.92 **FCS** said that a large proportion of senior clinical biochemists were aged over 55. An estimated 245 senior biochemists were due to retire in the next ten years. A significant fall in recruitment would severely undermine the continuation of a viable workforce. The FCS said that its Workforce Review Team Workforce Planning Recommendation for 2006/07 had identified a number of healthcare sciences groups where there was a risk that workforce supply may be insufficient to meet demand in future years.
- 3.93 **BOS** said that 22.5 per cent of orthoptists would be eligible for retirement within the next ten years. Patient workloads and staffing levels were increasing, leading to a lowering of morale. This was expected to impact upon recruitment and retention.

## **Our Comment**

- 3.94 Our assessment is that recruitment and retention trends are moving broadly in the right direction, albeit there may be problems in certain occupational and geographical areas, and with some senior positions. Similarly, a comparison of our Workforce Survey results with other sources<sup>15</sup> suggests that turnover rates are lower for our remit groups than in the economy at large although we note the suggestion by the Staff Side that recent turnover rates may have been artificially depressed by the introduction of Agenda for Change, as staff await their banding decisions. The wastage rate, that is the number of leavers less transfers to other NHS Trusts as a proportion of staff in post, has also fallen.

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<sup>15</sup> Recruitment, Retention and Turnover. Annual Survey Report 2005. CIPD.

- 3.95 Vacancy rates are also broadly favourable, and have improved for the majority of our remit groups over the last four years at least. However, as we note elsewhere, ONS vacancy data suggest rates in the NHS are above the levels prevalent in most other industry sectors. This suggests to us that the NHS faces greater problems recruiting staff than it does in retaining them.
- 3.96 We note the concerns of staff bodies that the vacancy data collected by the Health Departments may not be providing the full picture. They point to the limitations of relying on data that extend only to posts that have been vacant for three months or more. As CSP notes, these data may hide the true impact on staff that arises from having to deal with short-term vacancies on a day-to-day basis. We wonder whether it is possible to provide, in addition, data on posts that have been vacant for a shorter period. CSP also argues that because the data are not broken down by grade, the real extent of recruitment difficulties for certain grades, such as senior grades, can be hidden. We agree, and hope that the vacancy data can additionally be broken down by occupation and by pay band. Our secretariat will take this matter forward in discussion with the Health Departments.

## Chapter 4: Recruitment and Retention Premia and High Cost Area Supplements

### Recruitment and Retention Premia

#### Introduction

- 4.1 The Agenda for Change agreement contains provisions governing the operation of recruitment and retention premia (RRPs) designed to address labour market difficulties affecting specific occupational groups. The premia therefore apply to posts and not individuals. The agreement notes that such premia may be awarded on a *national* basis to particular groups on our recommendation where there are national recruitment and retention pressures<sup>16</sup>. Where it is agreed that a RRP is necessary for a particular group we should specify the level of payment or, where the underlying problem is considered to vary across the country, give guidance to employers on the appropriate level of payment. In making such recommendations we are required to seek evidence and advice from the parties and other stakeholders. In addition, the parties have agreed under Agenda for Change that some posts will automatically attract RRP.

#### Evidence from the Parties

##### *The Health Departments*

- 4.2 The thrust of the **Department of Health's** evidence was that the new pay system needed time to bed down and it was not the time to seek any changes to national recruitment and retention premia. However, working with NHS Employers, the Department would look at the evidence for the use of RRP from 2006 onwards in relation to shortage groups such as radiographers. It hoped this would enable specific issues affecting our remit groups to be identified and, where these exist, to put forward a case for targeted premia.
- 4.3 Evidence from the **National Assembly for Wales** said that RRP are centrally approved in Wales in order to maintain fairness and consistency and avoid 'leapfrogging' and escalating costs. They would be carefully monitored and would form an important part of the evidence to us in future years. The main area for concern at present was in recruiting mental health nurses; this was an 'all Wales' problem that may need addressing by a regional RRP. Although very few RRP had been requested through the Welsh process, initial indications were that premia might also be required in the South Wales M4 'corridor' to avoid the use of expensive agency nurses. RRP could be used to maintain or boost bank staff pay rates in order to attract staff from agencies. There was also concern in Wales from organisations close to the border with England that neighbouring Foundation Trusts would lead to them being disadvantaged in the local labour market.
- 4.4 The **Scottish Executive Health Department** noted the scope for various forms of RRP contained in Agenda for Change and considered that these addressed any need for regional variation within Scotland. It was not therefore currently considering any further measures on this front.

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<sup>16</sup> Separately there is scope for local employers and staff bodies to agree on the need for a RRP to address *local* recruitment and retention problems.

- 4.5 Finally, the Department of Health told us that it was looking at ways of gathering evidence to enable a move towards an 'x+y' approach, where 'x' represented the national uplift for all pay bands, and 'y' an uplift based upon specific flexibilities for any remit group or local need. The proposed formula was intended to reflect the flexibilities already contained in the new pay system. It sought our views on such an approach, whilst acknowledging that at this stage it was too early to say how it might work in practice, and proposed further discussions with us during the coming year. The Department said that it hoped to reach an agreed position with the trade unions, where at all possible.

#### *NHS Employers (NHSE)*

- 4.6 **NHSE** also argued that it would take some time before the impact of the new pay system could be fully assessed. Employers were not convinced of the need to extend the existing national RRPs. Overall, they thought that national RRPs were not always appropriate, as the most common cause of national shortages was the lack of trained and experienced staff, rather than an inability to attract them to the NHS. Problems of this nature could be addressed by changing skill mixes or promoting accelerated career development schemes. NHSE also thought that RRPs were only useful where there was widespread competition with non-NHS organisations, which was seldom the case with our remit groups. Generally, pressures should be dealt with locally, although there was a risk of pay 'leap-frogging'. For this reason, it was important that local Trusts worked together to address problems.

#### *Staff Bodies*

- 4.7 The **Staff Side** did not comment explicitly on national RRPs for new staff groups. However, it said that a number of occupations had been designated as potentially needing some sort of national premia, including midwives and pharmacists. It believed that these issues were best addressed by direct negotiation between the parties concerned, as the impact on other relativities needed to be taken into account.
- 4.8 **Amicus** noted that the equal value implications of Agenda for Change considerably reduced employers' scope to address recruitment and retention difficulties through grade drift as, it suggested, they had in the past. The Agenda for Change agreement contained scope to introduce long and short-term RRPs, the difficulty being that they could not be established in the absence of comprehensive data about the Agenda for Change outcomes for the occupations being considered.
- 4.9 It said that we had laid out excellent foundations for discussions on these issues through the report we had commissioned from NHS Partners.<sup>17</sup> However, having looked closely at the data required to formulate a claim for a RRP along the lines set out in the report, Amicus now believed that it would be very difficult to prove a case, even when patently needed, partly because of the lack of appropriate and robust data. It suggested that we set out more simply the terms on which applications should be made, and that we should consider them on the basis of the evidence the parties chose themselves to supply. This would reduce speculative approaches. It further proposed that this year we should consider the need for a national RRP for pharmacists and cytology screeners.

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<sup>17</sup> High Cost Area Supplements and Recruitment & Retention Premia: A Report for the Office of Manpower Economics. NHS Partners Research & Information, May 2005. The report is available on the OME website <http://www.ome.uk.com/>

- 4.10 With the support of evidence from the **Guild of Healthcare Pharmacists**, Amicus called for a national RRP for pharmacists targeted at pay bands 6 and 7 by adjusting the bands by a cash sum equivalent to four incremental points. Whilst such salary ranges would remain below commercial rates the adjustment would provide a greater opportunity to recruit and retain experienced pharmacists. In support of its argument it said that workforce data showed developments within the profession were likely to lead to increased demand for pharmacists, that the workforce appeared to be moving to more part-time working, that around a third of junior posts were either unfilled or covered by locums, and that turnover of the profession in the NHS was high. Other factors included the need to increase staffing levels as a result of the reduction in working hours included in Agenda for Change, at a time when vacancy rates were significantly above other professions, and when pay rates in the private sector were higher than in the NHS.
- 4.11 In its evidence **UNISON** asked us to consider whether there should be a national RRP for occupational therapists, given high vacancy rates and reports from employers of significant recruitment and retention problems. It thought that the position could worsen because of growth in the external market for occupational therapy staff arising from increasing private sector demand for these groups. It also noted that pay levels did not match the new responsibilities being undertaken, and were too low relative to staff in comparable local authority roles.
- 4.12 In later clarification, UNISON said that, whilst accepting the results of the job evaluation exercise, it was concerned that a disparity in pay banding and progression had emerged between physiotherapy and occupational therapy, which might discourage pre-registration students from choosing an occupational therapy over a physiotherapy course (they share the same entry requirements), or new occupational therapy graduates from choosing a career within the NHS as opposed to a career with an external provider.
- 4.13 It also suggested to us that occupational therapists would meet the criteria governing local recruitment and retention premia<sup>18</sup>, but doubted that individual NHS employers would prioritise the application of the relevant provisions of the handbook. It therefore asked us to include a strong recommendation that NHS organisations apply these provisions to occupational therapy posts.
- 4.14 The **SoR** endorsed the proposal from the Staff Side to begin discussions with shortage professions to consider national RRPs. In its view, work should begin as soon as possible, and it would also welcome an early dialogue with us. However, on the basis of its evidence on recruitment, retention and morale, and as an interim measure, the SoR suggested that a national RRP equivalent to 10 per cent of salary be made to radiography staff to maintain current staffing levels. This figure was not based on any formula, but represented recognition of reduced hourly earnings arising from the increase in radiographers' basic hours, along with a payment designed to improve retention.
- 4.15 The evidence from the **BOS** argued that orthoptist students were choosing to move into alternative clinical courses for professions that offered higher salaries and greater career opportunities. There were indications that the recruitment scene for orthoptists was challenging. Changes in job complexity and responsibility, while they might increase morale and aid recruitment and retention, also required a pay solution over and above that recognised following the job evaluation exercise. BOS argued that there was significant evidence to support a RRP for orthoptists towards the upper range of the maximum percentage premium allowed under Agenda for Change.

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<sup>18</sup> Set out in Annex J of the Agenda for Change Terms and Conditions Handbook.

4.16 We also sought views on the Department of Health's suggested 'x+y' formula at the oral evidence sessions with the staff bodies. The Staff Side argued that similar systems had been tried before in the NHS and had not worked. It therefore asked us to explore further with the Department what it had in mind. The RCN was concerned about how groups with special needs would be identified given the lack of adequate workforce information. Amicus, CSP, SoR and UNISON could not see the benefits of the proposal given the pay flexibilities that already existed under Agenda for Change.

## Our Comment

4.17 The concept of RRP is in its early days, and there seems to us to be some confusion about the different versions of the premia set out in Agenda for Change. During the round we circulated the main parties with our interpretation of the relevant sections of the agreement. The parties did not dispute these interpretations and we believe it would be useful to set them out here for future reference:

4.18 *Nationally agreed recruitment and retention premia:* the NHS job evaluation exercise revealed a number of jobs with relatively high levels of pay in relation to job weight, which may reflect past responses to labour market pressures. Normally, evidence would be sought to justify these market-related payments. This could not be carried out in the short term and, consequently, the parties agreed 15 occupations where there was *prima facie* evidence that a premium was necessary from day one of the new pay system. In these cases it was agreed that it would be difficult to determine a national rate for the premium and that, in effect, the premium should be sufficient to ensure no reduction in the **pre-existing** rate of pay. We have no locus to add or remove groups from this list.

4.19 *Recruitment and retention premia:* may be awarded **in future** on a national or local basis where there are recruitment and retention pressures, on a long or short-term basis. We, or the Pay Negotiating Council, may recommend national recruitment and retention premia<sup>19</sup> for our respective remit groups, (with local differentiation as necessary to reflect geographical variation in the underlying problem).

4.20 The difference between these two approaches is that the former legitimises a market-related premium which existed before Agenda for Change, where assimilation would otherwise lead to justifiable differentials being reduced; whereas the latter allow the introduction of premia on top of the Agenda for Change pay rates to reflect emerging labour market pressures.

4.21 It is clear from the Agenda for Change agreement that national RRP may only be awarded to particular groups of remit staff on our recommendation. This has been confirmed in the oral evidence sessions. In making recommendations it is also clear that we must seek evidence or advice from NHS employers, staff organisations, and other stakeholders. To assist this process and to provide advice on the evidence we would need to take into account when considering applications for RRP, we commissioned NHS Partners to prepare a report for us on sources of data and their nature. This report was circulated to the parties early in 2005 and was subsequently discussed with them.

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<sup>19</sup> In addition, Annex D of the Agenda For Change Agreement makes provision for local RRP in accordance with specified criteria.



- 4.22 Evidence from the parties suggests to us that whilst the report from NHS Partners provides a sound basis for preparing a case in support of a RRP, meeting all the data requirements outlined in the report may be difficult, particularly for the staff bodies. Consequently, we have asked our secretariat to discuss with the parties how the data needs may be simplified, whilst still ensuring that we are provided with robust evidence to enable us to make considered decisions. We would hope to have this process agreed by the parties and in place for the next round. We have also asked our secretariat to canvass the views of the parties on the suggestion from Amicus that RRP requests be considered separately from the annual revalorisation exercise.
- 4.23 The Departments, NHS Employers and the Staff Side were clear that we should not make changes to the pay structure this year, or propose extending RRP beyond the groups already identified in the Agenda for Change agreement. There was a strong view that the new system be allowed to bed down. On the other hand, in evidence some individual bodies have argued for RRP to address perceived recruitment and retention problems affecting certain specific occupations.
- 4.24 We agree with the view that it is too early, before the effects of Agenda for Change can be fully assessed, to consider the introduction or extension of RRP. In any event, the evidence we have received from individual staff bodies is insufficient, in our view, to enable us to reach soundly based recommendations. We intend that the work we have set out in paragraphs 4.21 and 4.22 will assist the parties to identify and provide relevant information in future. In addition, in Chapter 2 we have set out the question areas that the parties will need to address when submitting their arguments, particularly in respect of equal value considerations. In the meantime we note the flexibility accorded to local employers to pay local RRP in accordance with the terms of Annex D of Agenda for Change.
- 4.25 As ever, it would be helpful to receive joint evidence on RRP from the parties where possible. We note that the Department of Health proposes to work with NHS Employers to look at the use of RRP in relation to shortage groups in the hope of identifying issues and, if necessary, enabling them to put forward a case for targeted premia. We await the results of this review with interest, but it would clearly carry additional value were the staff bodies involved in the exercise from the beginning. In this respect we remind the parties that in evidence to our 2002 review the NHS Confederation suggested that the parties should jointly agree on data sources even if they did not necessarily agree on their interpretation. We supported this idea at the time and it seems to us that RRP now represent an ideal opportunity to put this concept into practice. We commend this approach to the parties. Part of this work might include an evaluation of the impact of the 'golden hellos' which we understand are being trailed for radiographers in Scotland.
- 4.26 In evidence the Department of Health said it was interested in moving to an 'x+y' approach, where 'x' represented any recommended national uplift, and 'y' an element to be used flexibly to address issues affecting one particular remit group or locality. This is at an early stage in the Department's thinking and it is unable to put flesh on how it sees such a system working in practice. It has, however, proposed further discussions with us during the coming year and we look forward to meeting with it. In light of the views we have received from the other parties it will be important for the Department to show how the flexibilities it envisages under the 'x+y' formula augment those already available under Agenda for Change. It will also be important to demonstrate that labour market data is sufficiently robust to support such an approach. The Department said that it hoped to reach an agreed position with the staff bodies where at all possible. We note this intention, though we observe that in evidence to us the staff bodies showed no enthusiasm for the Department's proposal.

## Local Pay and High Cost Area Supplements

### Introduction

- 4.27 Our remit was amended in July 2003 so that, in reaching our recommendations, we should have regard to regional/local variations in labour markets and their effects on the recruitment and retention of staff. In addition, Agenda for Change replaced the pre-existing mix of London allowances and Cost of Living Supplements with a system of three levels of high cost area supplement (HCAS) covering Inner London, Outer London and the Fringe. The value of these supplements to individual staff is based on a percentage of their salary, with a minimum and maximum cash payment. The percentages, minima and maxima, depend on area, with Inner London attracting the highest supplement, and the Fringe areas of London the lowest.
- 4.28 The value of the supplements is to be reviewed annually based on our recommendations for staff within our remit groups. In addition it is open to us to make recommendations on the future geographic coverage of HCAS and on the value of such supplements. Here we set out the evidence we have received on these issues.

### Evidence from the Parties

#### *The Health Departments*

- 4.29 The **Department of Health** drew our attention to research it had commissioned from Aberdeen University to examine the effectiveness of regional pay in helping to address localised recruitment and retention issues for various staff groups<sup>20</sup>. The research suggested that there was a local labour market in England for nurses, but in the case of AHPs, including radiographers, the position was inconclusive. In particular, the research found a significant relationship between nurse vacancies at the local level and the gap between nurse and private sector wages, supporting the case for HCAS and local RRP's for this group. However, the work did not find such a relationship in the case of AHPs, although the Department offered reasons why this may be the case.
- 4.30 The Department told us it was currently considering the detail of the research in order to determine what further steps should be taken, suggesting that Agenda for Change already delivered a system capable of dealing with local variations in the labour market.
- 4.31 The local flexibilities provided by HCAS needed time to take effect, and it believed it was too early to seek any changes to the existing supplements. However, it was its intention to see a rigorous process implemented over the coming year to monitor the use of HCAS. This could then provide evidence to help determine whether changes were needed in the 2007/08 review round. It said that there was no additional funding to increase the value of HCAS in London, and any cost pressures from this source would need to be managed within existing budgets. Its preferred approach was to move towards an 'x+y' approach for pay uplifts (see paragraph 4.5 above).

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<sup>20</sup> We were provided with a copy of the report and it was circulated to the other parties for comment.

## *Staff Bodies*

- 4.32 The **Staff Side** said that beyond adjusting the maxima in line with the overall percentage uplift, there should be no fundamental change to the system of HCAS this year. However, it believed that the current system of percentage payments unfairly discriminated against lower-paid staff who faced the same higher costs as better-paid staff. It said that it would return to this matter in future years and asked us to note that it would be seeking a review of the current arrangements.
- 4.33 It noted that the report from NHS Partners had argued that consideration should be given to paying supplements in areas designated as 'high cost', according to the NHS Staff Market Forces Supplement, and which had higher vacancy levels and staff turnover. The Staff Side believed that this required further consideration as part of the overall review of Agenda for Change. In the meantime, negotiations should take place at local level under the existing provisions in those areas where there was an identifiable problem of high costs, such as some areas adjacent to London and other 'hotspots'.
- 4.34 **Amicus** supported the Staff Side view on HCAS, and on regional pay flexibilities and added that these were unlikely to be favoured by NHS staff if they undermined national salary levels established by job profiles. HCAS should be additional to national rates, and not funded by depressing the value of the basic salaries for staff in relatively lower cost areas. It proposed that the *Office of Manpower Economics* establish a salary index for remit staff to ensure their confidence that basic salaries were not being depressed, and to enable staff bodies to enter meaningful negotiations on HCAS.
- 4.35 The **T&G** argued that there should be equality of treatment for NHS staff located in the same high cost area.
- 4.36 In respect of local pay, the **Staff Side** was unconvinced about arguments for the radical localisation of pay in the NHS, arguing that the NHS needed a national pay structure to ensure equity, prevent destructive pay competition between employers, and to preserve a national health service. It believed that the degree of local pay in the private sector had been exaggerated, and that recruitment and retention strategies could be used to address key shortages without opening the 'Pandora's box' of regional pay. In subsequent discussion the individual staff bodies endorsed this view.

## **Our Comment**

- 4.37 We note that relevant paragraphs of Agenda for Change state that from the end of the three-year deal in March 2006 the value of HCAS would be reviewed annually based on our recommendations. In addition, it would be open to us to make recommendations on the future geographical coverage of HCAS and the value of such supplements.
- 4.38 However, it is clear from the evidence that the parties are not looking for major changes in either the levels or structure of HCAS this year, with the exception of the staff bodies who ask us to raise the cash maxima in line with our recommended percentage uplift to the pay scales.
- 4.39 We have considered these arguments carefully. On one level, as with RRP, there is a strong case for leaving HCAS on hold this year to allow the new pay structure fully to take effect. On the other hand, it appears to us that the recruitment and retention data for the existing high cost areas generally show a weaker picture than elsewhere in the country.

- 4.40 HCAS are, of course, a form of local pay. Their structure is based on a minimum and maximum flat-rate cash component and a percentage of pay, and this suggests to us that they are intended both as 'compensation payments' in areas of high cost, and as pay adjustments to address particular difficulties in certain geographical labour markets. In this context we were interested in the research commissioned by the Department of Health from Aberdeen University, which showed that there were local labour markets for nurses in England, albeit the position was less conclusive for AHPs. The Department told us that it was considering these findings in detail in order to establish what further steps should be taken, although it noted the existing scope provided by Agenda for Change for local pay variation.
- 4.41 We are particularly struck by the levels of variation in nurses' earnings across the country shown by the Aberdeen study, as these appear greater than could be accounted for by the then prevailing Cost of Living Supplements (COLS) payable in certain designated areas. This suggests that NHS employers in these areas were finding other means of increasing pay to address recruitment and retention problems, over and above the COLS limits. In this regard the Aberdeen study suggests to us that the geographical pay differences allowed under the new HCAS are already too low, especially in London. If this is the case, one objective of Agenda for Change – to address grade drift within the NHS – is put at risk almost from day one. Either that, or the existing levels of HCAS must be increased, perhaps substantially, to provide the level of differentiation that is required.
- 4.42 It appears, therefore, that there is a *prima facie* case for wider geographical pay variation than currently exists, certainly for nursing staff in London. We invite further evidence on this issue next year, in particular on the degrees of pay variation that would be appropriate in London and elsewhere, and how the NHS funding regime might accommodate such variation.
- 4.43 In the meantime, we feel there is no case to suggest that the relative value of the differentials provided by the HCAS should be reduced, as would be the case were they not revalorised at least in line with our basic pay recommendation.

**We recommend that the existing minimum and maximum High Cost Area Supplements for Inner London, Outer London and the Fringe be increased by 2.5 per cent. The new minima and maxima from 1 April 2006 are set out in Appendix C.**

- 4.44 We do not propose any changes either to the existing coverage of HCAS or to the percentage proportions of basic salary that currently apply.

## Chapter 5: Morale, Motivation and Training

### Introduction

5.1 Matters of morale, motivation and training are in our view fundamental by virtue of their relevance to other areas, notably to issues around staff recruitment and retention and service delivery. The evidence we received this year demonstrates the link between the quality of working life, morale and retention. Not all aspects of morale and motivation are easy to quantify, but workload, flexible working opportunities and access to training and development are amongst the more recognisable and quantifiable factors. Perceptions of the implementation and outcomes of Agenda for Change have also proved significant, although at the time of writing the process is still ongoing and the long-term consequences have yet to be seen.

### *Sources of data*

5.2 In evidence to us relating to morale and motivation there was general reliance upon the data contained within the Health Commission's 2004 National NHS Staff Survey carried out in October 2004. This covered all 572 NHS organisations in England, with a total of 60 per cent of NHS staff responding to the survey. The survey covered a range of topics, including work-life balance, appraisals, work pressure, job satisfaction and staff intention to leave jobs, and staff views towards the organisations in which they worked. It is important to note that the 2004 survey pre-dated the full national roll-out of Agenda for Change.

5.3 NOHPRB remit groups were included in the survey under the following occupational categories: nurses (qualified, unqualified, health visitors, healthcare assistants<sup>21</sup> and midwives); allied health professions (AHPs), scientific and technical staff (Sc&T); paramedics and ambulance technicians.

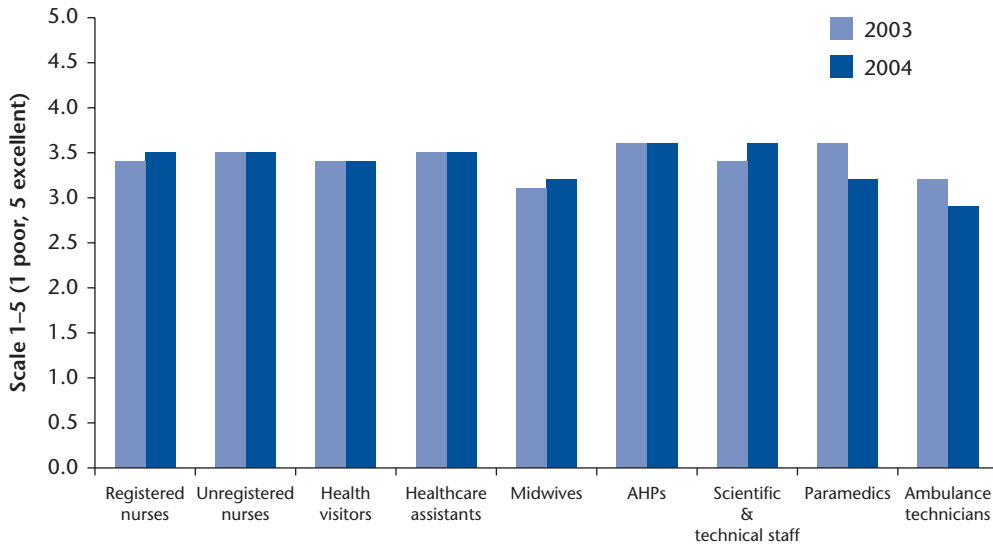
5.4 Staff were asked several questions that were used as an indication of their level of motivation and morale, such as the *quality of their work-life balance*, *job satisfaction* and the *support they felt they received from their line managers and more senior managers* within the organisation. Questions on work-life balance, job satisfaction and management were all scored between 1 and 5, with 1 representing a poor outcome to the question, 5 an excellent outcome and 3 a neutral view.

5.5 The majority of staff groups felt that their work-life balance had remained broadly the same between 2003 and 2004. There were three groups that saw a marginal improvement: registered nurses (+0.1), midwives (+0.1) and Sc&T staff (+0.2), while two staff groups felt that their work-life balance had worsened, paramedics by 0.4 and ambulance technicians by 0.3 (see Figure 5.1). Additionally all scores for all staff groups except ambulance technicians (2.9) were over 3 for 2004, indicating that staff generally agreed that their employers have a positive attitude towards helping them achieve a good work-life balance. The different outcomes may be a result of the Improving Working Lives initiative being introduced in this period with some staff groups benefiting more than others.

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<sup>21</sup> Includes auxiliary nurses.

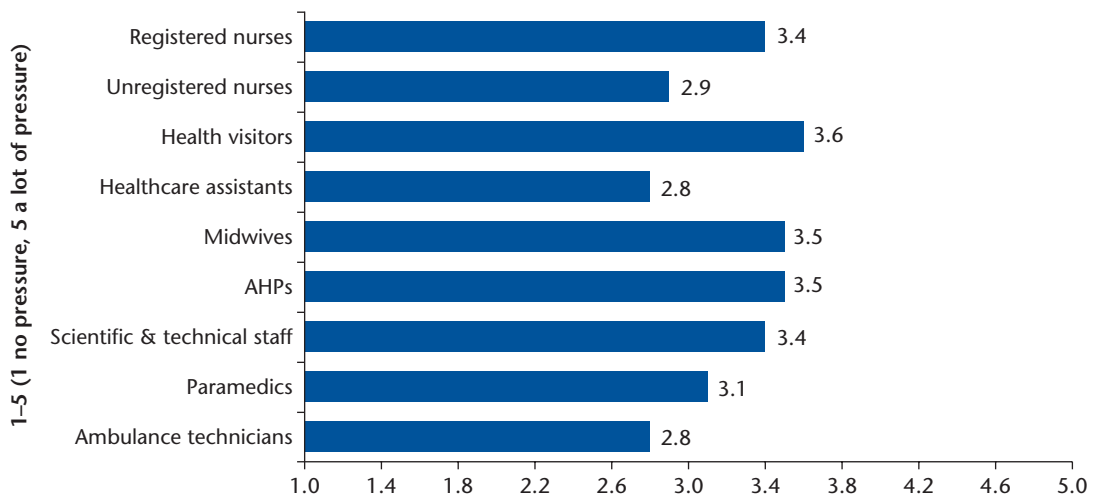
**Figure 5.1: Staff's perception of their work-life balance**



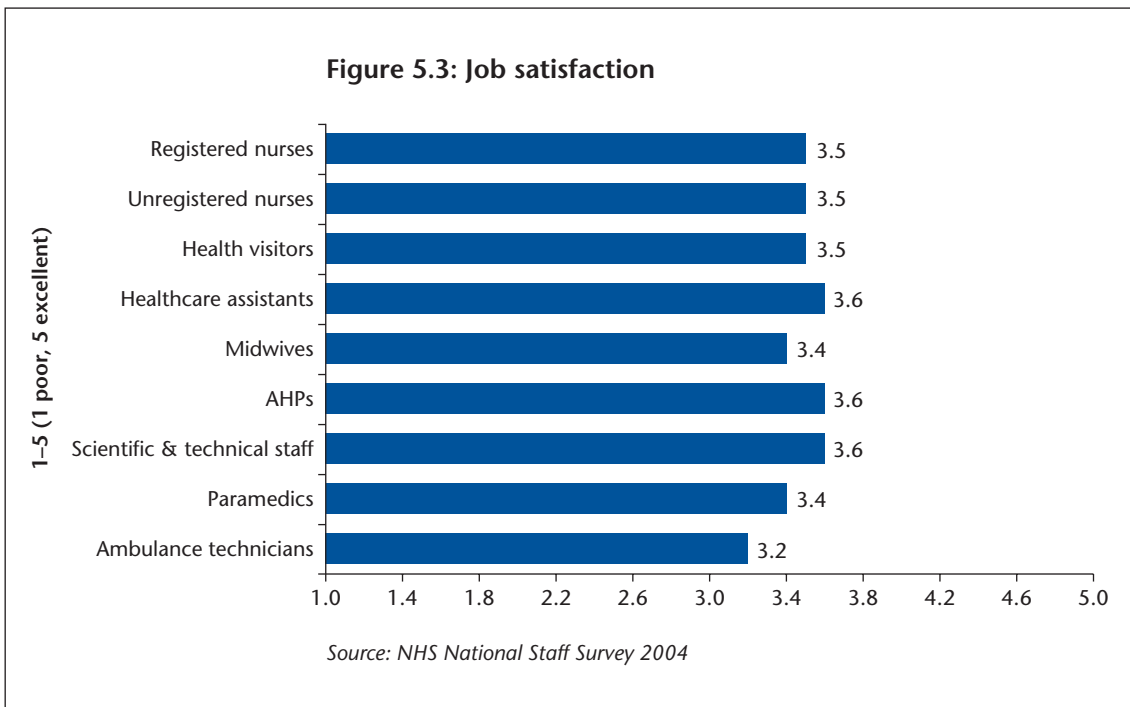
Source: NHS National Staff Survey 2004

5.6 The scores indicating the amount of work pressure felt by staff (see Figure 5.2) were more diverse than the scores for job satisfaction (see Figure 5.3). According to the Health Commission work pressure is often regarded as the best predictor of stress in the NHS and this predicts, in turn, absenteeism and poor performance. Ambulance technicians and health care assistants had the lowest amount of work pressure. Health visitors felt the most pressure at work, followed closely by midwives and AHPs.

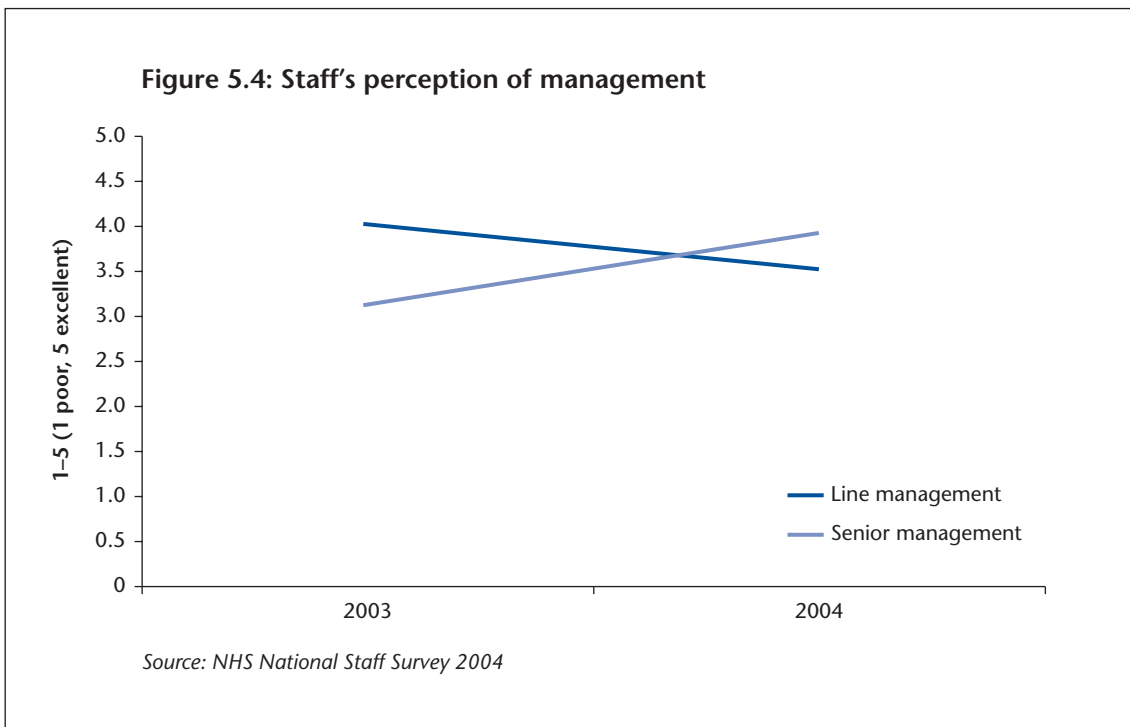
**Figure 5.2: Work Pressure**



Source: NHS National Staff Survey 2004



5.7 Staff views of line managers and senior management were unusual (see Figure 5.4). The scores in 2003 were perhaps as expected, given that line managers might be expected to score more highly due to having greater contact with staff on a day-to-day basis. However this picture was reversed in 2004. One possible explanation was that both Agenda for Change and Improving Working Lives began to emerge in 2004. It is possible that there had been improvements in the communication of key messages of these new policies to staff, which altered staff's perception of senior managers.



- 5.8 Individual staff bodies have also undertaken their own surveys. These have provided useful additional information on motivation and morale. We would be interested to see further data next year when the Agenda for Change implementation process will be complete.

## Evidence from the Parties

### *The Health Departments*

- 5.9 The **Department of Health** said it remained committed to supporting NHS staff to deliver a high quality health service to the public and that the most valuable asset of the NHS was its staff. By putting the Improving Working Lives (IWL) standard into practice it said the NHS would address many of the issues that impacted upon staff morale and motivation. The IWL standard made it clear that every member of staff was entitled to work in an organisation which could prove that it was investing in more flexible, supportive and family friendly working arrangements, which would improve diversity, tackle discrimination, harassment and bullying, and develop the skills of staff to improve patient services.
- 5.10 The IWL initiative had provided NHS Trusts with a measured framework to create a well-managed, flexible working environment through good communication and ultimately partnership between staff and managers. Substantial progress had been made towards making the NHS the employer of choice for new as well as existing staff and those who were returning to work within the NHS.
- 5.11 The Department reported significant participation in the IWL agenda, particularly from nurses at all levels, which had led to improvements in the standard of care, and it argued it was important to continue this effective partnership.
- 5.12 The Department said that the 2004 National NHS Staff Survey showed that in key areas, e.g. job satisfaction, the position was one of consolidation and in some cases improvement. The numbers of staff receiving training was up from 89 per cent in 2003 to 93 per cent in 2004, and 61 per cent of staff were reported as feeling their employer acted fairly with regard to career progression or promotion, regardless of ethnicity, gender, religion, sexual orientation, disability or age.
- 5.13 The findings of the 2004 National NHS Staff Survey also reflected improvements in HR and management practices. Staff were generally fairly satisfied, in contrast to staff in the private sector where there had been a downward trend in job satisfaction since 2001. Fifty three per cent of staff agreed or strongly agreed that if they did leave their job they would want to remain in the NHS.
- 5.14 The Department pointed out that the organisational climate was shown to be strongly related to the performance of Trusts and to innovation. A positive organisational climate was also associated with high levels of staff wellbeing and satisfaction, which were themselves indicators of performance and staff retention. The 2004 survey results showed that in the majority of organisations the general feeling was more positive than negative, and that if anything this positive feeling was increasing.



5.15 The Department said that it accepted recommendation 16 of Sir Alan Langland's report on Gateways to the Professions<sup>22</sup>. This recommends that we and other Review Bodies should monitor the impact of the new higher education funding regime on recruitment and retention in the professions and whether additional forms of support should be considered. It also recommends that we be asked to identify instances where student debt may strengthen the case for higher starting salaries. The Department proposed to liaise with us to discuss appropriate mechanisms to take this forward for NOHPRB staff groups, but in doing so pointed out that the majority of nurses and AHPs were not affected by the introduction of variable fees and the new higher education support measures as their education was commissioned directly by the NHS. It was therefore outside the scope of the Higher Education Act 2005.

### *NHS Employers (NHSE)*

5.16 **NHSE** told us that many NHS employers reported signs that the morale of their staff was improving. Progress had been made towards creating a culture of effective communication, with employers listening to staff and responding to their concerns.

5.17 NHSE reported that the IWL initiative had a positive effect upon staff morale and motivation. Flexible working in particular was cited as a positive benefit for the majority of staff with some retention gains reported as a consequence. The IWL framework was also cited as a means of achieving a healthy work-life balance for staff, with the introduction of modern employment practices such as:

- childcare provision and support for carers in the workplace;
- flexible careers;
- flexible retirement;
- improved access to training and development;
- healthy workplaces;
- staff involvement; and
- partnership working.

5.18 NHSE also reported improvements in terms of staff satisfaction as measured by the 2004 National NHS Staff Survey, with 73 per cent generally satisfied and 93 per cent having received training and development opportunities in the previous 12 months. These results would enable Trusts to make informed improvements to working conditions and practices.

### *Staff Bodies*

5.19 The **Staff Side** said that the constant change in NHS structures and ways of working, coupled with increasing demand for more and better services impacted upon staff morale and motivation.

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<sup>22</sup> The Gateways to the Professions Report, Department for Education and Skills, July 2005.

- 5.20 The Staff Side reported that the 2004 National NHS Staff Survey indicated a number of improvements in human resource and management practice. They cited as an example the proportion of staff that had received an appraisal in the previous 12 months, which had risen from 60 per cent in 2003 to 63 per cent in 2004. There had also been improvements in reported levels of team working. However, they also noted that there had been no change in the amount of work pressure felt by staff, and the proportion of staff suffering from work-related stress had dropped only slightly from 39 per cent in 2003 to 36 per cent in 2004. Fourteen per cent of staff had been attacked by patients or their relatives in 2004, and 27 per cent had been bullied, harassed or abused by patients or relatives.
- 5.21 Staff Side noted that there was no change between the 2003 and 2004 surveys in reported levels of job satisfaction. The average score of 3.5 indicated staff were generally fairly satisfied. However, there was a slight increase in satisfaction levels with the climate of the organisation, for example perceptions about communication within the organisation, and employee involvement in decision-making and patient care.
- 5.22 Staff Side said that the relative position of NHS professional staff compared to other public service professionals had improved since 1997, but that pay gaps remained with key comparators. Staff Side felt these pay gaps to be unjustifiable and said that unless closed they would, over time, damage morale and also affect the NHS's ability to recruit and retain.
- 5.23 Staff Side said that recent increases in fuel prices had been significant and current levels of mileage allowance, mainly affecting community-based staff, did not provide adequate compensation. This had allowed a sense of resentment to grow as staff felt they were subsidising the NHS for their work travel. This had an effect on morale and might also affect motivation. In consequence the Staff Side sought an interim uplift of 10 per cent in mileage allowance, with a review in six months.
- 5.24 The **RCN** submitted separate written evidence in the form of the results of their most recent annual employment survey. The survey questionnaire, to which almost 5000 nurses responded, was sent out in February 2005. This meant that the survey was conducted at a time when the majority of nurses had not been told which Agenda for Change pay band they would be on.
- 5.25 RCN reported that there had been a 15 percentage point improvement in enthusiasm levels since 1996. In addition, more nurses believed that career prospects were becoming more attractive, that nursing was a rewarding career and that they would recommend it to others.
- 5.26 Nurses' views about their own careers had not changed as much. Most improvement was seen in how nurses viewed their ability to determine the way their career develops and having a sense of knowing where their career is going, but there had been a small increase in those who said they would like to work outside nursing.
- 5.27 RCN reported that there had been a large increase in the number of nurses who felt they would have a secure job for years to come; 70 per cent as compared with under 20 per cent in 1996. RCN reported a similar reduction in fears of redundancy.

- 5.28 'Pay' engendered the most negative response. Only a small minority of nurses felt that they could not be paid more for less effort if they left nursing. The vast majority thought that they were not well paid by comparison with other professional groups, or considering the work that they did. Such views had been negative for the last decade, but had improved marginally in the last couple of years.
- 5.29 Nurses' views of their workload were also broadly negative, with only 20 per cent of respondents to the RCN survey saying that they did not feel under too much pressure, or that their workload was not too heavy. Over half of the respondents working in NHS hospitals reported heavier workloads resulting from changes in junior doctors' hours. Changes to GP contracts were reported to have increased out-of-hours working by nurses in NHS community and GP practice jobs.
- 5.30 Nurses' views of employer support for training had become more positive since 1996. However type of job was a key variable in whether nurses had a training and development plan.
- 5.31 The **RCmnd.** said that considerable pressure was being generated by the challenge of providing high quality maternity care, whilst absorbing high levels of sickness absence and maternity leave. Increases in annual leave introduced by Agenda for Change added to the pressure. This, combined with the high vacancy rates within the profession, had adverse implications for the level of care and sapped morale, and may encourage people to leave the profession.
- 5.32 **RCmnd.** also reported that staff shortages had prevented midwives from taking part in training and development activity. Such shortages had also meant senior midwives were unable to support less experienced staff and had increased stress levels.
- 5.33 The **RCmnd.** said that it was reported in 2003 that up to one-fifth of nurse and student midwives left their courses because they were unable to live on their bursary. Subsequent research carried out on the RCM's behalf showed that 800 out of 900 student midwives who had been asked considered finance to be the biggest obstacle to joining the profession. **RCmnd.** said that people who wished to enter the profession did so because they were passionate, dedicated and enthusiastic. It warned that this enthusiasm was in danger of being turned into disillusionment if this disincentive were allowed to continue and pressed for realistic and fresh resources to tackle the problem. In doing so **RCmnd.** called for an annual non-means tested bursary of £10,000 for all midwifery students.
- 5.34 **UNISON** quoted the 2004 National NHS Staff Survey, which showed some improvements in morale but it said that staff remained under severe stress and were coping with ever greater demands. It pointed out that the survey did not look directly at whether low pay was a major factor in staff leaving, and argued that a question on this issue should be included in future staff surveys and that Trusts should routinely monitor the destination of leavers.
- 5.35 **UNISON** stated that one major factor affecting the morale of staff was the continual pace of change in the NHS. It cited the 2004 CIPD survey which provided evidence that continual organisational change in the public sector had a negative effect on morale. The forthcoming reorganisation of PCTs in England was causing fear and worry for thousands of community based staff. The new financial framework, known as Payment By Results (PBR), would also have a destabilising effect as would the arrangements for patient choice. In addition, the increase in the use of the private sector as a provider would have a negative effect on morale.

- 5.36 In its evidence **Amicus** concentrated on the effect on morale of the proposals for changing the structure of PCTs in England. These were contained within the Department of Health's publication 'Creating a Patient-led NHS'<sup>23</sup>. Amicus had recently undertaken a survey of community nurse members employed by PCTs which showed examples of job freezes and redundancies. It also reported a reduction in training places for health visitors and noted that a large proportion of community nursing staff were expected to retire in the next five years. Amicus argued that this would place the future of community nursing services in jeopardy.
- 5.37 The Amicus survey also revealed reports of staff being threatened with dismissal if they spoke publicly about their concerns. This came at a time when the Department of Health was attempting to step up work to tackle bullying in the workplace, the most important non-pay factor impacting upon staff morale.
- 5.38 Amicus said it had received reports that Workforce Development Confederations, who commission training places, had received no additional funding for Agenda for Change. As a result it feared that training places would be cut. Amicus was committed, through the Knowledge and Skills Framework, to developing non-professionally qualified staff and supporting moves to provide vocational routes into the professions. It warned that such opportunities for professional development might be restricted if training was not fully funded.
- 5.39 **CSP** said that Agenda for Change had reduced motivation and morale in the short term at least. Assimilation had taken longer than predicted, leaving many members in a state of uncertainty and this, combined with concerns about sufficient funding for implementation, was causing problems with morale.
- 5.40 A further problem was the amount of time spent by managers and CSP members preparing for assimilation. Although some backfill had been provided it had only gone part of the way in covering the total amount of time taken away from patient care.
- 5.41 CSP was a firm supporter of Agenda for Change, but until such time as assimilation and appeals were complete there was a strong need to ensure morale and motivation was boosted.
- 5.42 The **SoR** cited its online poll of a random sample of radiographers working in the NHS, to which 800 had responded, as evidence that staff were working harder than ever, dealing with an increased workload in inadequately staffed departments, with consequent loss of morale. The development of the wave one Independent Sector Treatment Centre (ISTC) programme had also had an impact upon service delivery and morale. A survey of MRI radiographers conducted in May 2005 showed that the majority of respondents were not against use of ISTCs per se, but felt that in taking routine work away, they left NHS staff with the more complicated and stressful activity. Seventy per cent of respondents felt ISTCs were responsible for there being less time available for Continuing Professional Development (CPD) activity and career advancement.
- 5.43 SoR believed that the periodic review of career progression against a post outline as part of the KSF process would highlight the lack of employer support for CPD through protected study time. However, it felt evidence in this respect would only begin to materialise within the next two to three years and consideration would need to be given to a review of the effect of KSF on the numbers of its members in particular pay bands and whether this would lead to improvements in the service.

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<sup>23</sup> Creating a Patient-Led NHS - Delivering the NHS Improvement Plan, Department of Health, March 2005.

- 5.44 The **T&G**, reporting on behalf of its ambulance staff members, said that the use of temporary staff within particular Trusts was a matter of concern. The refusal to offer permanent contracts to such staff had affected morale, with attendant concerns about wider team working and career progression.
- 5.45 T&G also said it was important to ensure the opportunities available to long serving technician staff were not undermined by the opportunities afforded to external candidates by the introduction of the Paramedic Foundation Degree course. Places on such courses had become more difficult for serving staff to obtain, with consequent negative effects upon morale. T&G also gave us details of staff in one Trust having to fund their own training which, while penalising those less able to pay, contrasted with professions like teaching where golden hellos were available due to a tight labour market. T&G said that the provision of training was a key element of the development of a professional workforce and was at the heart of the Agenda for Change process. Investment in training had historically been underfunded to the detriment of staff within the ambulance service, but for Agenda for Change to be properly implemented, this funding should be forthcoming.
- 5.46 T&G also raised the financial status of Trusts as a key factor in morale and motivation terms. Implementation of Agenda for Change would be much more straightforward in Trusts without financial difficulties. The introduction of PBR and encouraged use of private providers would add further to financial uncertainty in the future.
- 5.47 The **FCS** raised concerns about the cost of training clinical scientists to the level of competence necessary for registration. Posts are funded by Workforce Development Confederations from top sliced revenue. The NHS Staff Council agreed that clinical science trainees should be placed at the appropriate point on the new NHS pay spine which should result in significant salary improvements, help to reduce drop out rates and attract the best science graduates into the NHS. FCS said that Workforce Development Confederations had indicated that this would considerably exceed their budgets and that the only two options open to them would be either to pass on increases to lead Trusts, or to reduce the number of posts receiving funding. This potential reduction in the number of training posts would coincide with a peak of year-on-year retirements of senior professionals. Accordingly, FCS called on us to recommend that funding of all training posts be protected to the new cost level.
- 5.48 The **BOS** said that patient workloads and staffing levels had increased without an equivalent increase in working accommodation. This had led to a lowering of staff morale, which in turn would affect future recruitment and retention. Insufficient numbers of support staff had also led to clinicians spending a disproportionate amount of time on non-clinical duties.
- 5.49 BOS said that there was a lack of dedicated time for CPD, clinical audit and research, and many services had reported difficulty in securing funding for training and development.

## Our comment

- 5.50 It is important to note that the available evidence for this review generally pre-dates staff assimilation to the pay bands established by Agenda for Change. When we visited Trusts and Health Boards, feedback from staff suggested that morale among some groups had declined as their expectations of the new pay system had not been met. We have no way of knowing whether this reflects a broader picture. In the circumstances it would have been extremely helpful had the results of the 2005 National NHS Staff Survey been available to inform our deliberations. It would also have been useful to have equivalent information for Scotland and Wales. Our secretariat intends to discuss with the Healthcare Commission whether it would be possible to publish the results of future surveys sooner. We hope that the Healthcare Commission will appreciate the value of earlier publication and take steps to meet this request.
- 5.51 We are pleased to note the emphasis given by the Department of Health and NHS Employers to the Improving Working Lives initiative. Flexible, family-friendly working arrangements are crucial to many members of our remit group. We look forward to receiving further evidence next year of measures taken under this initiative.
- 5.52 We also look forward to receiving further evidence relating to staff training and development. The Knowledge and Skills Framework is integral to the pay system established by Agenda for Change and, more generally, to staff morale and motivation. It is important that adequate funding is available to support training and development and that it is incorporated into Trusts' business plans.
- 5.53 We note the concerns expressed by the Staff Side about mileage allowances. The level of mileage allowance lies outside our remit. However, we observe that NHS Mileage Allowances appear to be out of line with those allowed by HM Revenue and Customs as tax-free and NIC-free levels of reimbursement. This could affect transparency and may in turn affect motivation and morale. This is a point to which the NHS Staff Council may wish to have regard.
- 5.54 Finally, we note the representations of the RCmnd. for an annual non-means tested bursary for all midwifery students. Our secretariat will be engaging in discussions with the Department of Health during the forthcoming year on how we are to take forward recommendation 16 of Sir Alan Langland's report on Gateways to the Professions. We shall consider relevant evidence when the mechanisms to take recommendation 16 forward within our remit have been clarified.

## Chapter 6: The funds available to the Health Departments

### Introduction

- 6.1 Our remit requires us to have regard to the funds available to the Health Departments in reaching our recommendations. Evidence we have received on these 'affordability' issues is reviewed in this section. As might be expected, the Health Departments and NHS Employers have submitted the bulk of the evidence on this item.
- 6.2 Our remit also requires us to have regard to the Health Departments' output targets for the delivery of services. The Department of Health said that it did not believe it was possible to quantify in any precise way the impact of our recommendations on pay in one year on the achievement of output targets in the next. Moreover, it did not consider that it would be meaningful to attempt any such quantification given the complex factors at play. In such circumstances we have been unable to give detailed consideration to this aspect of our remit, although we note the Department's general point that unnecessarily large pay increases may prejudice the delivery of service improvements.

### Evidence from the Parties

#### *The Health Departments*

- 6.3 The **Department of Health** said that pay awards for NHS staff had to be set within a framework that considered Departmental spending limits, output targets and the anticipated rate of inflation in the economy as a whole. It pointed out that currently approximately 60 per cent of a Trust's budget was spent on pay, so even very small changes had a substantial effect on the ability of Primary Care Organisations<sup>24</sup> (PCOs) to manage the substantial non-pay spending pressures that the NHS faced.
- 6.4 The Department stressed that were excessive pay awards to be agreed, there would be an inevitable impact upon the cost of patient services delivered by NHS providers. PCO commissioners would have to consider the impact of such increased costs when determining their commissioning strategies, which could result in some services being put at risk.
- 6.5 Providing some illustrations of the opportunity cost of relative pay increases, the Department said that each additional 0.1 per cent increase in NHS pay translated as the equivalent of 1,000 nurses, 525 doctors or 30,000 elective procedures.
- 6.6 The Departmental Expenditure Limits (DELs) for England showed real terms growth of 6.9 per cent in 2005/06, and 7.5 per cent in 2006/07, but these increases were not a benchmark for pay settlements. Other factors impinging on the DEL were the Government's commitment to the modernisation of the NHS, in particular the objectives set out in the NHS Plan including Public Service Agreement Targets and the impact of underlying demand pressures.
- 6.7 The Department stressed that the increase in NHS resources until 2007/08 provided a fixed funding envelope and that there would be no resources over and above this to fund any excess costs arising from pay settlements. Consequently it was crucial that pay increases were no more than necessary to meet the recruitment and retention needs of the NHS in order to ensure that resources were available to deliver growth in capacity, service improvements and pay modernisation.

<sup>24</sup> Primary Care Trusts in England, Local Health Boards in Wales and Health Boards in Scotland.

- 6.8 The Department concluded by pointing out that the 2004 Spending Review announced the need to make efficiency improvements of at least £20 billion p.a. across the public sector by 2007/08, with the aim of releasing resources to front line delivery. With tight affordability constraints it was important that resources needed for service improvement were not absorbed by pay. It asked us to recommend an increase of no more than 2.5 per cent across all pay bands.
- 6.9 In supplementary written evidence submitted in December 2005, and attached as Appendix H, the Department said it was reviewing the appropriateness and affordability of the recommended level of award contained in its original written evidence. This was in the light of what it claimed was emerging evidence that Agenda for Change was proving more expensive and more financially beneficial to staff than expected. It provided us with the figures set out in Table 6.1.

**Table 6.1: Department of Health's Comparison of Agenda for Change Cost Estimates**

Benefits for Staff in 1 <sup>st</sup> 12 Months (October 2004 to October 2005)		October 2004 Estimate		November 2005 Estimate		Difference	
		% Pay Bill	£m	% Pay Bill	£m	% Pay Bill	£m
<b>Costs impacting Earnings</b>		2.26	516	2.78	635	0.51	117
<b>Costs of extra leave and hours<sup>25</sup></b>	LOW CASE	0.62	142	1.07	244	0.45	103
	HIGH CASE	0.62	142	1.79	409	1.17	267
<b>Total benefiting Staff<sup>26</sup></b>	LOW CASE	2.88	658	3.85	879	0.97	222
	HIGH CASE	2.88	658	4.57	1044	1.69	386

Note: data collected from 28 sites (5 PCTs, 3 Ambulance Trusts, 3 Mental Health Trusts, 3 SHAs, 1 Care Trust and 13 Acute Trusts)

- 6.10 The Department calculated that the increase in earnings from Agenda for Change in the first 12 months, based on data collected from a sample of 28 Trusts, was 2.78 per cent, an excess of around £120 million or 0.51 per cent of the estimated Agenda for Change paybill of 22.8 billion in 2004/05.

<sup>25</sup> NB Agenda for Change will eventually produce a net increase in hours especially for some key allied health professions such as radiography. There is however a short term cost from harmonisation of hours as reductions are phased in faster than increases to help existing staff adjust.

<sup>26</sup> Excludes Employer NIC and Pension contributions, which are included in overall cost estimates.



- 6.11 In addition, the Department said that most staff had benefited from more leave and some from shorter hours. These benefits were originally estimated by the Department to cost 0.62 per cent of pay bill. However, on the basis of the sample data, the cost was now estimated at between 1.07 and 1.79 per cent per annum, an excess of between 0.45 per cent and 1.17 per cent of pay bill – between £103 and £267 million in cash terms. The total excess cost of Agenda for Change of between £222 million and £386 million was around 0.97 per cent to 1.69 per cent of the Agenda for Change pay bill. Of this total it estimated that 0.51 per cent would feed through into higher than expected earnings per head, and the rest into providing the necessary staff cover for extra leave and shorter hours.
- 6.12 In 2004/05 the NHS finished the year in deficit by £250 million. It was clear that a significant minority of NHS organisations were struggling to achieve financial balance and it was likely that a number would finish the year in deficit again. The Department said that these deficits would have a first call on resources in 2006/07 and therefore would impact upon the affordability of pay awards.
- 6.13 The Department stated that the pay of nurses and other health professions outside medicine amounted to one-third of all NHS costs, and that therefore one of the major factors contributing to the deficits was likely to be the additional unplanned cost of Agenda for Change. As Agenda for Change had been worth more to staff than originally envisaged the Department now asked us to consider a recommendation as close as possible to 2 per cent for 2006/07 on the grounds of greater than expected benefits to staff, affordability and the need to keep to the Chancellor's inflation target.
- 6.14 **The National Assembly for Wales (NAW)** outlined the real growth in the DELs for 2005/06 and 2006/07 as 5.5 and 4.9 per cent respectively. It advised that while NHS settlements in earlier years had funded the majority of cost increases, all Trusts had needed to make additional efficiencies of approximately 1 per cent per annum to meet local cost pressures. In 2005/06 the need to fund pay modernisation costs had meant that additional cost pressures had not been funded, resulting in a 3.31 per cent funding shortfall. This equated to approximately £95m.
- 6.15 NAW went on to say that Trusts were required to contribute to efficiency programmes as part of addressing the deficits inherited by Local Health Boards from the former Health Authorities. All Trusts reported that they had to absorb cost pressures from clinical developments. The NHS in Wales was entering the next three years with a level of resources that would challenge commissioners and providers in their efforts to make changes while maintaining service levels and quality. Financial discipline was therefore essential.
- 6.16 Against this background, NAW considered that a modest general uplift in line with the recommendation from the Department of Health was appropriate.
- 6.17 NAW subsequently endorsed the affordability comments contained within the supplementary written evidence from the Department.
- 6.18 The **Scottish Executive Health Department (SEHD)** said that a substantial and sustained injection of new resources had been invested in health services in Scotland which should allow the recruitment and retention of well trained and motivated staff. Staffing accounted for around 60 per cent of total expenditure on health in Scotland and a substantial proportion of this additional funding would go on staffing costs. Growth in the Health Department budget showed a real terms increase of 6.66 per cent in 2005/06 and 5.45 per cent in 2006/07.

- 6.19 It reiterated the view that we should not conclude that these increases were benchmarks for pay rises. Recent increases in staff pay had had a major impact on Health Boards' budgets and SEHD argued that excessive pay uplifts on top of these would have an opportunity cost on the ability of Boards to develop and extend responsive services to patients. Any rise in the pay bill would also result in fewer resources to fund other key priorities.
- 6.20 NHS Boards had been allocated revenue for 2005/06 comprising a minimum increase of 7.0 per cent with an average increase of 7.6 per cent and a maximum increase of 9.2 per cent. NHS Boards had been notified of indicative increases averaging 7.25 per cent for 2006/07 and 6.5 per cent for 2007/08. This allocation encompassed the estimated cost of assimilation of staff onto the new Agenda for Change pay bands. SEHD argued that the level of any pay award should take account of the totality of funding available to it, the ongoing commitment to the modernisation of NHSScotland, affordability, the competing demands for investment and the Government's inflation target. SEHD concluded that our recommendations should balance affordability with the continuing requirements to secure sufficient levels of recruitment and retention. It supported the Department of Health's recommendation of a general uplift of no more than 2.5 per cent.
- 6.21 SEHD subsequently endorsed the affordability comments contained within the supplementary written evidence from the Department.

#### *NHS Employers (NHSE)*

- 6.22 **NHSE** said that the 2004 Spending Review set spending plans to 2007/08 that protected the increased resources delivered in previous Spending Reviews. These plans represented an annual increase of 7.1 per cent in real terms between 2005/06 and 2007/08 – a total increase of 23 per cent in real terms over the period. However, under the system of direct funding of PCTs no money was specifically allocated within the departmental budgets to spend on annual pay increases. Therefore, any further large increases in pay would have an effect on the amount PCTs would have available to spend on additional services.
- 6.23 NHSE advised that the NHS star ratings, recently published by the Healthcare Commission, reported that almost a quarter of Trusts failed the key target on financial management to break even by the year end (2004/05). This resulted in a total overspend of almost £500 million. Twenty four per cent of PCTs failed to achieve financial balance, with one in three acute Trusts failing on this measure.
- 6.24 Chief Executives had real concerns over affordability. A recent survey conducted by the NHS Confederation revealed that 93 per cent of NHS Chief Executives did not believe that the current workforce reforms were affordable. NHSE also stated that future policy developments in the NHS might increase the financial pressure on organisations from 2005/06. Examples of such policy developments were the implementation of Payment By Results (PBR) and the new commissioning arrangements.
- 6.25 In the light of this, NHSE asked us to consider carefully the impact that any pay increase deemed unaffordable by employers would have on an already difficult financial position. It argued that such an award would lead to a deferment of developments coupled with workforce reductions and service reconfigurations. Most organisations with deficits were already working towards driving out inefficiencies and had recovery plans and cash releasing efficiency saving programmes in place.

- 6.26 NHSE said that an affordable pay settlement was necessary to ensure the current financial position in the NHS did not worsen, and that a pay uplift of 2.5 per cent in line with inflation targets was the most that could be afforded.
- 6.27 In supplementary evidence clarifying its earlier remarks NHSE said, that despite financial difficulties, employers generally realised that a pay increase broadly in line with the predicted rate of inflation was needed to support continued progress on recruitment and retention and maintenance of staff morale. It said that the affordability of pay reform was a slightly different issue. In an email dated 14 December 2005 it stated that it had chosen the figure of 2.5 per cent because at the time of its initial submission this was the upper limit of any of the rates of inflation. Inflation had subsequently fallen and was forecast to be nearer to 2 per cent in 2006. It reiterated its view that an uplift of not more than inflation was an appropriate balance between affordability and the need to recruit and retain staff.
- 6.28 Finally, NHSE said that any additional cost of a new system of unsocial hours payments, over and above the cost of the interim regime currently in operation, would need to be met from the projected level of investment for Agenda for Change in the financial year 2006/07. The Department of Health's remit to NHSE limited the potential cost of a new system, over and above the cost of the interim regime, to £75 million. This was a full year cost in 2006/07 at the relevant prices for that year.

### *Staff Bodies*

- 6.29 The **Staff Side** said that the Chief Executive's report to the NHS in May 2005<sup>27</sup> detailed how extra funding of £6.7 billion in 2004/05 had been used. Around £2 billion had been invested in pay to attract and retain more staff. Growth in the total NHS workforce had increased by an average of 3.9 per cent every year since 2000. However, at the same time the range of services was growing, waiting times and waiting lists were falling and there was evidence that demand for services was increasing. Staff Side said that the NHS could not afford not to award a substantial pay increase in 2006, if staff vital to delivering expanding health services were to be retained and recruited in increasing numbers.
- 6.30 Commenting on the supplementary written evidence from the Health Departments, the Staff Side said that a key driver for pay modernisation was the need to ensure equal pay for work of equal value in the NHS. To link the cost of introducing the new pay system with the annual pay increase, effectively off-setting the introduction of equal pay by a reduced pay increase, called into question not only the fairness of the process by which pay awards were determined, but also satisfaction with Agenda for Change itself. They also pointed out that not all staff had received increases in annual leave and the majority had either seen their working hours remain the same or increase.
- 6.31 Staff Side challenged the estimates of excess spend on Agenda for Change contained in Table 6.1. They understood that data relating to the cost of annual leave and reduced hours was not available in six of the 28 Trusts surveyed to generate the Department of Health's figures, and that there was considerable variation between the costs identified by each Trust. They also disputed that pay was a decisive figure in deficits. The rate of assimilation to Agenda for Change had been variable in England. Although the national assimilation level was high, implementation varied within and between Strategic Health Authorities. Some of those Trusts which were struggling to implement Agenda for Change, and where assimilation was low, were experiencing the worst financial difficulties. The numbers of staff enjoying the benefits of Agenda for Change in Scotland

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<sup>27</sup> National Health Service (2005) *Chief Executive's report to the NHS: Statistical supplement*, May 2005.

and Wales were very low. Staff Side suggested that the Department and others might be using Agenda for Change to deflect attention from historical deficits arising out of either inadequate management or inappropriate funding levels.

- 6.32 Commenting on the supplementary written evidence from the Health Departments, SoR said although the Departments had said that there had been an increase in earnings and benefits for staff as a result of the introduction of Agenda for Change, this was not relevant evidence. One of the strengths of Agenda for Change had been the ability to assess jobs and to match them to earnings. The NHS Job Evaluation scheme, when properly applied, had redressed the poor reward structures of the past. Any additional earnings had therefore to be seen as just entitlement and not an additional pay award.
- 6.33 SoR also disagreed with the Department's assertion that any increase above the rate of inflation would accelerate job losses and redundancies in the NHS. This was especially true for radiographers where there was a recognised and acute shortage.
- 6.34 In conclusion, SoR said the supplementary evidence from the Department was an attempt to justify its claim that the NHS could not afford to reward staff for the work they performed and also that the failure to fully account for the cost of implementing Agenda for Change should be met from staff's own pockets.

## **Our Comment**

- 6.35 Our terms of reference require us to have regard to the funds available to the Health Departments as set out in the Government's Departmental Expenditure Limits. Consideration of the funding implications of our recommendations for 2006/07 has taken place against the background of substantial injections of new money into the NHS. The NHS budget has doubled since 1997 and Departmental Expenditure Limits now show real terms growth of 7.3 per cent each year in England over the five year period 2003/04 to 2007/08. Departmental Expenditure Limits in England will grow from £76.4 billion in 2005/06 to a projected £84.4 billion in 2006/07, representing real terms growth of 7.5 per cent. In Wales there will be real terms growth of 4.9 per cent in 2006/07; in Scotland 5.45 per cent. Despite this increased funding it is clear that there are considerable financial pressures on the service. Six-month forecast figures published by the Department of Health on 1 December 2005 indicated that around a third of NHS bodies in England were in deficit, although 37 (7 per cent of the total) accounted for two-thirds of the projected gross deficit. Despite the steps being taken by the Department and NHS organisations at all levels to bring the Service into financial balance we understand that there will be a continuing deficit rolling forward into 2006/07.
- 6.36 The extent of the contribution of the rates of pay of our remit group, as compared with other factors, to these deficits has not been shown. The Departments have emphasised to us that funding growth should not be regarded as a benchmark for pay settlements. We accept that point entirely. Equally, however, we do not consider that the pay settlement for our remit group should bear the brunt of financial difficulties that are attributable to a range of sources, although clearly it must play its part. Moreover, it is not evident to us how far we can factor into our considerations the funding problems of a minority of NHS organisations when we are considering the level of a national pay recommendation. We believe that our role is to assess the pay structure as a whole and that our consideration of affordability should therefore be focussed at national level. In this context we note in particular the evidence of NHS Employers, based upon the views of the majority of employers in England, that a pay uplift of 2.5 per cent in line with inflation was the most that could be supported.

6.37 Affordability constraints are a key element of our remit. It would assist us if more specific evidence on funding pressures could be presented for our consideration in future years in order that we can attempt to assess the impact of our recommendations. This evidence might include, for example, an analysis of the actual and potential funding pressures and how outturn projections compared with original assumptions underpinning the budget; the reasons for such variances; a breakdown of the pay bill in terms of basic pay, overtime, and progression etc; and an analysis of the impact of changes in the numbers and composition of the workforce. We appreciate that much of this information will be held at the level of individual NHS organisations but we hope that it may be possible to produce statistics on these areas in summary form. We have asked our secretariat to discuss with the Health Departments and NHS Employers in more detail what evidence might be made available to us for our next review.

## Chapter 7: Pay and Prices

### Introduction

- 7.1 In this chapter we review the evidence on pay and prices we have received and comment on the points that have been put to us. Our remit requires us to have regard to the Government's inflation target<sup>28</sup>. With different emphases the parties provide us with general macro-economic evidence on, in particular, trends in inflation, average earnings, and pay settlements, and these data are updated regularly by our secretariat. These indicators provide part of the context to our work, but they are by no means the only factors we take into account. We have also received evidence specific to the pay of our remit groups covering, in particular, relative earnings levels and movements.

### Evidence from the Parties

#### *The Health Departments*

- 7.2 The **Department of Health** said that our recommendations were forward looking and that information about the future prospects for the economy was particularly important. In this regard, the macro-economy was in a strong position, with the UK benefiting from its longest period of sustained low and stable inflation for forty years. Interest rates were also low by historical standards. Employment was at a record high, while unemployment levels were close to their lowest levels since the 1970s. The strength of the economy was not resulting in any upward pressure on private sector earnings growth.
- 7.3 In terms of inflation, the Department argued that the Consumer Prices Index (CPI) had clear strengths for pay purposes over the other indices of inflation because it took account of substitution effects as consumers reacted to the changes in the relative prices of goods and services. Consequently, it was a better measure of the amount needed to maintain living standards. However, it was important not to place too much emphasis on the inflation rate in a single month as short-term movements can reflect the influence of several different factors. For this reason we were asked to consider the underlying trends in the data. These trends showed that inflation had been controlled at low levels over the preceding 12 months – a period of stability that HM Treasury expected to continue. Although CPI was above target it was expected to return to its target level during 2006 in line with the view of the average of independent forecasts.
- 7.4 The Chancellor of the Exchequer wrote to us in November 2005 to underline this point. He drew attention to the impact of recent oil price increases on CPI, and said that the resulting upward pressure on the index would be temporary. He said that it would be important to ensure that public sector pay settlements did not contribute to inflationary pressures in the economy and, therefore, that we should base our pay recommendations on the achievement of the inflation target of 2 per cent, rather than on the recent temporary rise in CPI.
- 7.5 As regards earnings growth, the Department drew our attention to a number of measures that are in use across the public sector and which are designed to provide different information about the impact of pay decisions. The measures all had their strengths and weaknesses and they advised us to consider them all when making our recommendations. The measures we were asked to take into account were, respectively:

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<sup>28</sup> Defined as an increase in the twelve-month Consumer Prices Index (CPI) of 2 per cent.

- the Average Earnings Index, which measures the speed at which earnings are growing across the whole economy, but which may be influenced by workforce compositional effects;
- earnings growth, which provides an indication of how the pay of existing employees are affected by pay progression and revalorisation;
- the headline award, which measures the increase in base pay, excluding other elements of earnings growth; and
- paybill and paybill per head, which give indications of the funding required to implement pay awards.

7.6 The Department noted that the main data source of data on earnings growth was the Average Earnings Index (AEI). It provided data from this index that showed average earnings growth in the public sector exceeding that of the private sector in recent years. It further pointed out that the UK public health sector (including social work) had seen earnings growth of 6 per cent over the 12-month period to May 2005, which was amongst the strongest of the sectors making up the AEI. These pay increases had been awarded in return for contract and workforce reform, which were being driven through the NHS.

7.7 It said that, based on productivity trends, the Government considered that whole economy average earnings growth in the range 4.5 per cent to 4.75 per cent was consistent with the inflation target over the medium term. It believed that over the same timescale, whilst public sector earnings growth should be broadly in line with the sustainable level of earnings growth for the economy as a whole, this might not be the appropriate level for all sectors. For example, depending on the recruitment and retention needs of the sector and the prevailing labour market conditions, earnings growth above or below these levels may be appropriate.

7.8 It later provided us with a table setting out the percentage growth in our remit group's paybill, paybill per head, and average earnings (reproduced below), starting in 2001/02 with projections to 2006/07 based on example awards of 0, 2.0, and 2.5 per cent. It drew our attention to the projected level of earnings growth, noting that it estimated that in 2006/07 average earnings for our remit group would rise by 2.6% above any increase in basic rates we might recommend.

**Table 7.1: Actual and projected percentage growth in NOHPRB paybill, paybill per head, and average earnings, 2001/02 to 2006/07**

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2006/07	2006/07
Basic Award	3.7%	3.6%	3.225%	3.225%	3.225%	(0%)	(2.0%)	(2.5%)
Paybill <sup>29</sup>	11.1	9.1	8.2	9.6	9.2	5.8	7.9	8.4
Paybill/Head <sup>30</sup>	6.6	4.2	3.6	5.1	5.9	2.6	4.6	5.1
Earnings/Head <sup>31</sup>	5.1	4.3	2.8	5.1	5.9	2.6	4.6	5.1

Source: Department of Health

Note: Shaded areas are estimates

7.9 It attributed recent pay drift in part to the effects of incremental progression and provided us with worked examples showing the combined effects over five years of incremental rises and basic awards on the pay of some hypothetical examples of staff groups. The examples were based on the progression of people starting on their grade minimum in 2001. It suggested that the basic pay of staff in these cases would have risen by around a third in five years.

#### *NHS Employers (NHSE)*

7.10 **NHSE** provided us with a range of general economic data covering GDP growth, retail sales, the labour market, and house prices. In the circumstances, they suggested that pay increases in other sectors of the economy were unlikely to rise. They noted that evidence from the latest *IDS Report* (September 2005) showed that the median pay settlement level had remained steady at just over 3 per cent, with no difference between the public and private sector medians. Around two-thirds of public sector staff were covered by multi-year pay arrangements, which were providing basic increases in the range 2.5 per cent to 3 per cent per year.

7.11 As regards earnings, the AEI showed that the overall rate of increase in the whole economy had been falling, but the public sector rate remained ahead of that of the private sector. They argued that this was the result of two factors: extra payments and new salary structures to address problems recruiting and retaining key workers; and the additional money arising from pay modernisation. In the NHS, for example, the growth in average earnings was not just due to recent basic pay uplifts, but also to access to higher incremental ranges in the new pay structure, which will continue to raise average earnings until the new system reaches maturity.

7.12 As regards inflation, NHSE said it was important to consider current and future inflation levels. They noted the recent increase in CPI, which they also attributed mainly to the effect of crude oil prices. On the other hand, the Retail Prices Index (RPI) had been falling because of the downward pressures from the housing components that are excluded from CPI. The Retail Prices Index excluding mortgage interest payments (RPIX) had also fallen. Looking ahead, RPI was expected to fall towards 2 per cent, stabilising at around this rate for much of 2006.

<sup>29</sup> 'Paybill' includes staff salaries, allowances, overtime payments, bonuses, ERNIC, employers' pensions contributions.

<sup>30</sup> 'Paybill per head' is paybill divided by the number of WTE employees.

<sup>31</sup> 'Earnings per head' is paybill excluding on-costs (e.g. ERNIC and employers' pensions contributions), divided by the number of WTE employees.



- 7.13 In conclusion, NHSE argued that there was evidence of a slowdown in the economy. The rate of increase in average earnings was declining, pay settlements were stable, and inflation was forecast to fall.

#### *Staff Bodies*

- 7.14 The evidence from the **Staff Side** asked us to take into consideration a climate of increasing economic uncertainty, including the impact of rising petrol prices. It noted the recent data that showed RPI falling, pay settlements running at around 3 per cent, and the labour market fairly static sustaining both high levels of employment and low unemployment, but emphasised some uncertainty in the economic outlook overall. As regards the Chancellor's letter and note on CPI, the Staff Side commented that an award based on this index would lead to reductions in real pay as CPI excludes the effects of costs such as council tax, mortgage interest payments, and other housing costs.
- 7.15 Evidence from the **RCmnd.** also reviewed the existing macro-economic data, noting that whilst the Government prefers to focus on CPI, most pay negotiators refer to RPI as the main indicator of price movements. This measure was predicted to have 'peaked' at 3.1 per cent in 2005, and was expected to fall to 2.5 per cent by June 2006. Meanwhile, vacancy rates had risen, unemployment had fallen, and employers were experiencing a 'skills gap' particularly in the public sector.
- 7.16 Various staff bodies have raised the issue of pay comparability, drawing adverse comparisons between the pay of remit staff and that of specific groups, e.g. police and teachers, or, in more general terms, with graduate entrants or the low paid. They call for a substantial, above inflation increase in part to address the pay gaps they have identified.

#### **Evidence on Pay and Prices**

- 7.17 As background to our analysis we have looked, not only at levels and trends in the macro-economic measures, such as inflation and earnings, but also at relative pay levels and movements specific to our remit groups.

#### *Labour Market*

- 7.18 Latest data on the UK labour market show some continued weakening in the indicators over the latter months of 2005. Data for the three months to November showed both the employment level and rate lower than in the period to August. Additionally, whilst still historically at low levels, unemployment levels have also risen, whilst the number and ratio of vacancies to jobs have been on a downward trend through 2005.

#### *Inflation, Settlements and Earnings*

- 7.19 The macro-economic figures that the parties provided when their evidence was submitted in the autumn have subsequently been updated by the ONS. The latest macro-economic data on inflation, average earnings and settlements available at the time we reached our recommendations were as follows.

**Table 7.2: Latest data on inflation, average earnings, and pay settlements**

Inflation measures <sup>32</sup>		
	Percentage change on the month a year ago – December 2005	Percentage change on the quarter a year ago – Quarter to December 2005
CPI	2.0%	2.1%
RPI	2.2%	2.4%
RPIX	2.0%	2.3%

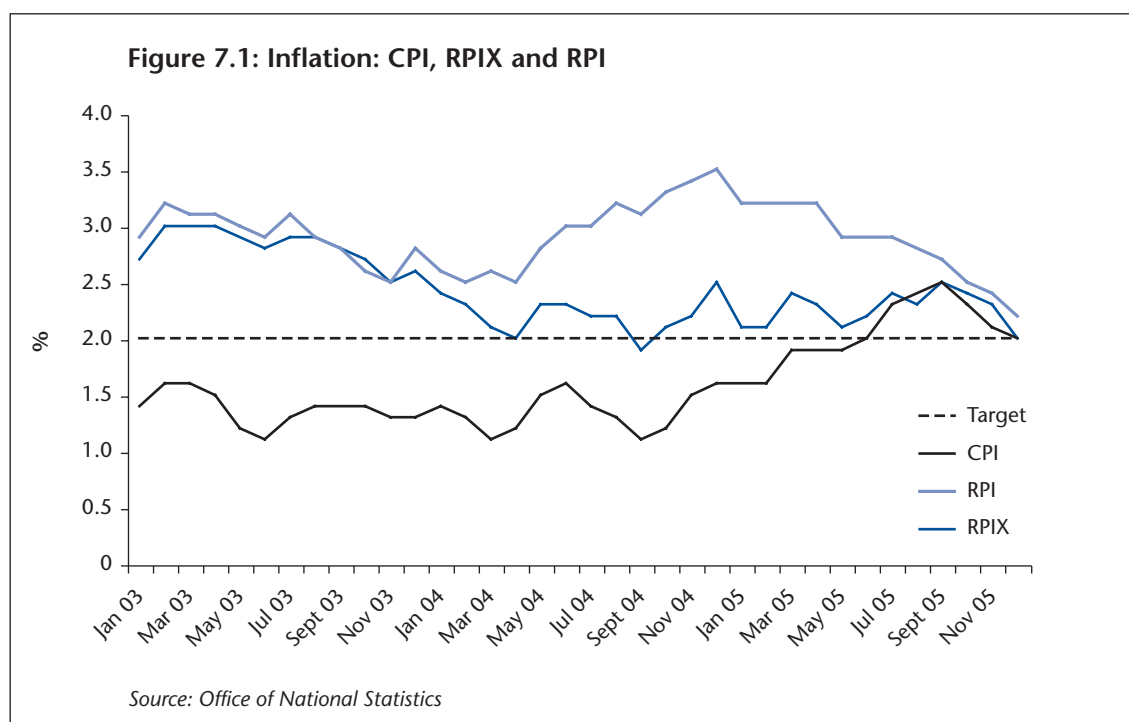
  

Average Earnings <sup>33</sup> – November 2005	
Whole Economy	3.4%
Private Sector	3.3%
Public Sector	4.1%

Settlements <sup>34</sup> – November 2005	
Median	3.0%
Lower quartile	2.5%
Upper quartile	3.5%

7.20 Inflation on all three main measures has been converging towards 2 per cent on the latest figures, a rate of decline over the period somewhat faster than forecasters had initially expected. Most recently, strong downward pressures have come from petrol prices, airfares, and, particularly in the case of RPI, housing costs. We agree with the point made by the Department that single month inflation figures can give a misleading impression and we therefore prefer to use a three month rolling average which suggests slightly higher figures for inflation.



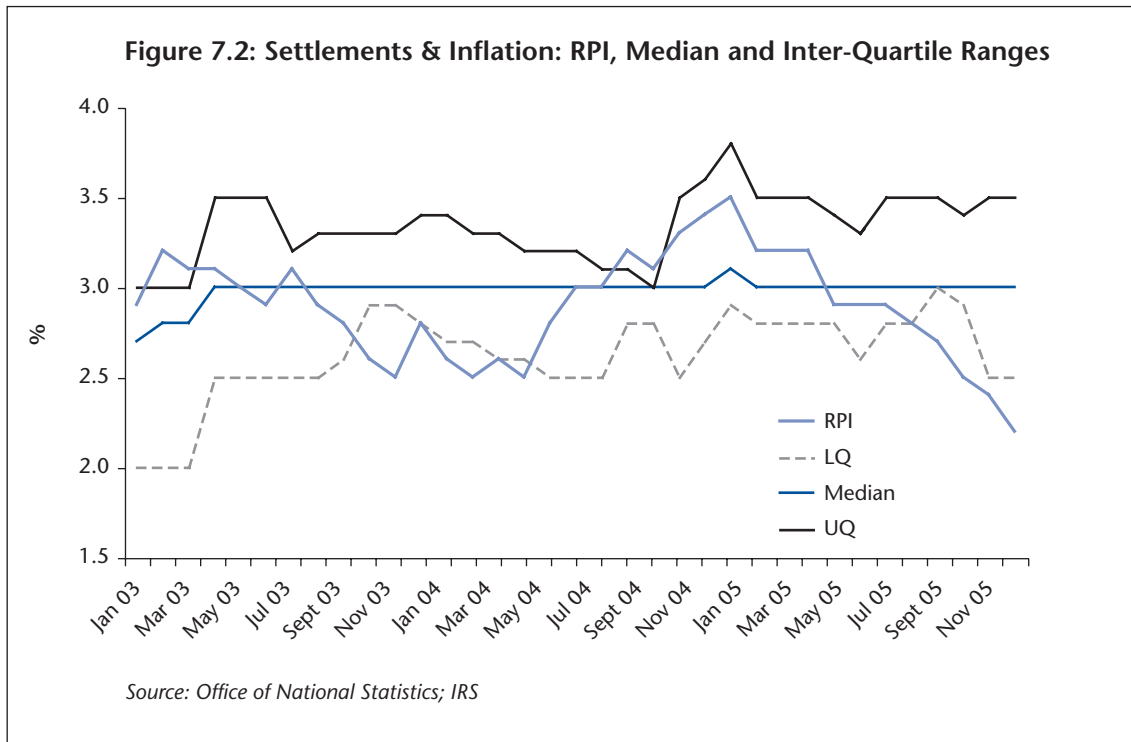
<sup>32</sup> Consumer Prices Index (CPI), Retail Prices Index (RPI), and Retail Prices Index (excluding mortgage interest payments) (RPIX). Source: Office for National Statistics.

<sup>33</sup> "Headline" rate of increase in the Average Earnings Index (AEI), three-month average including bonus effects. Source: Office for National Statistics.

<sup>34</sup> Three-month median of settlements, and upper and lower quartiles. Source: Industrial Relations Services.

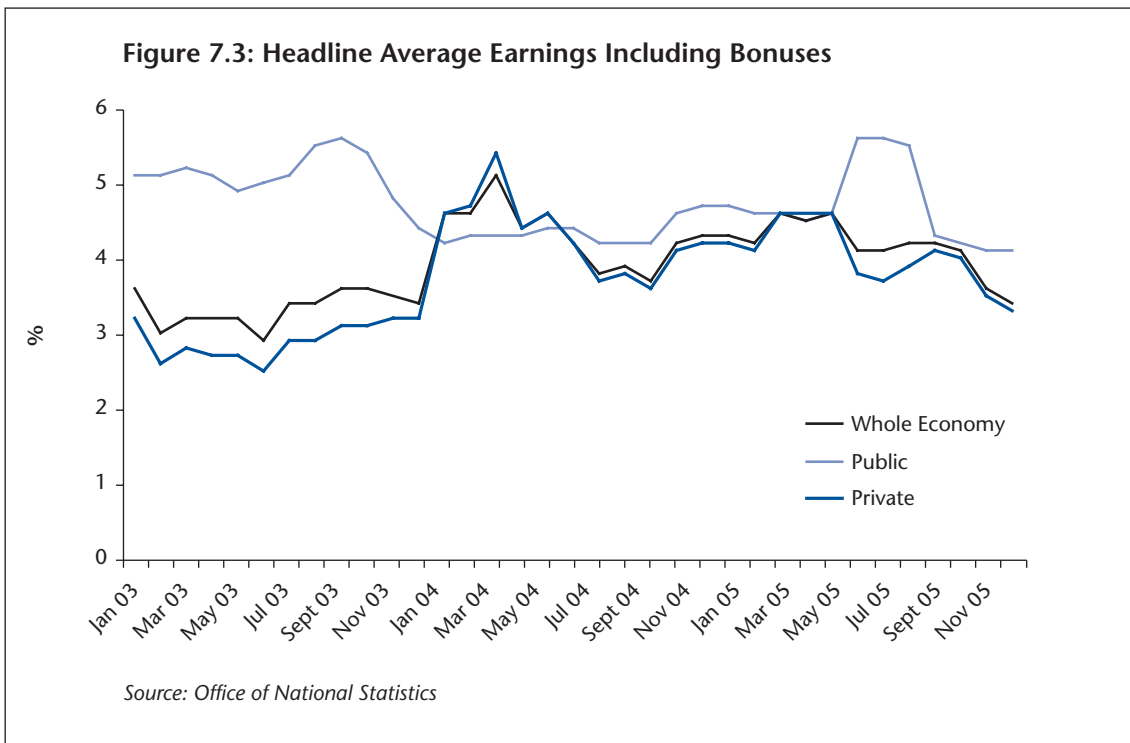
7.21 Forecasters expect little change in these rates through 2006, with HM Treasury's averages of independent forecasts<sup>35</sup> for the fourth quarter of the year at 1.9 per cent (CPI), 2.3 per cent (RPI) and 2.2 per cent (RPIX).

7.22 We note that, according to data from *Industrial Relations Services*, in recent years the median of pay settlements has remained steady at 3 per cent, despite marked variations in the level of RPI, the inflation measure that commentators feel has most influence with pay bargainers.



7.23 There is some indication that the lower quartile of pay awards has fallen recently. In addition, there is considerable variation in settlement levels across the economy, ranging from pay freezes in some sectors to awards over 8 per cent in others. This variation clearly reflects the differing economic circumstances affecting different employers.

<sup>35</sup> Forecasts for the UK Economy. HM Treasury. January 2006.



7.24 In respect of average earnings growth, the headline rate<sup>36</sup> for the whole economy rose in the first few months of 2005 reflecting high bonuses in the private sector. Since then the headline rate of increase has been falling. This appears to reflect lower bonuses in the private services sector than a year ago, as average earnings growth for this sector was 2.9 per cent for the three months to November, compared to 4.4 per cent in the same period of 2004. Overall, the effect is that in the latter part of last year public sector earnings growth was ahead of the private sector.

7.25 Looking ahead, HM Treasury's average of independent forecasts puts earnings growth at 4.3 per cent for 2006. There may be some pick up in private sector earnings growth during the early months of this year as a result of bonus payments.

7.26 The difference between average earnings movements and settlements is known as pay drift. At present, for the whole economy this difference stands at around half a percentage point, slightly below this for the private sector, and just over one per cent in the public sector. Historically, pay drift in the economy is positive and lies between one and two percentage points.

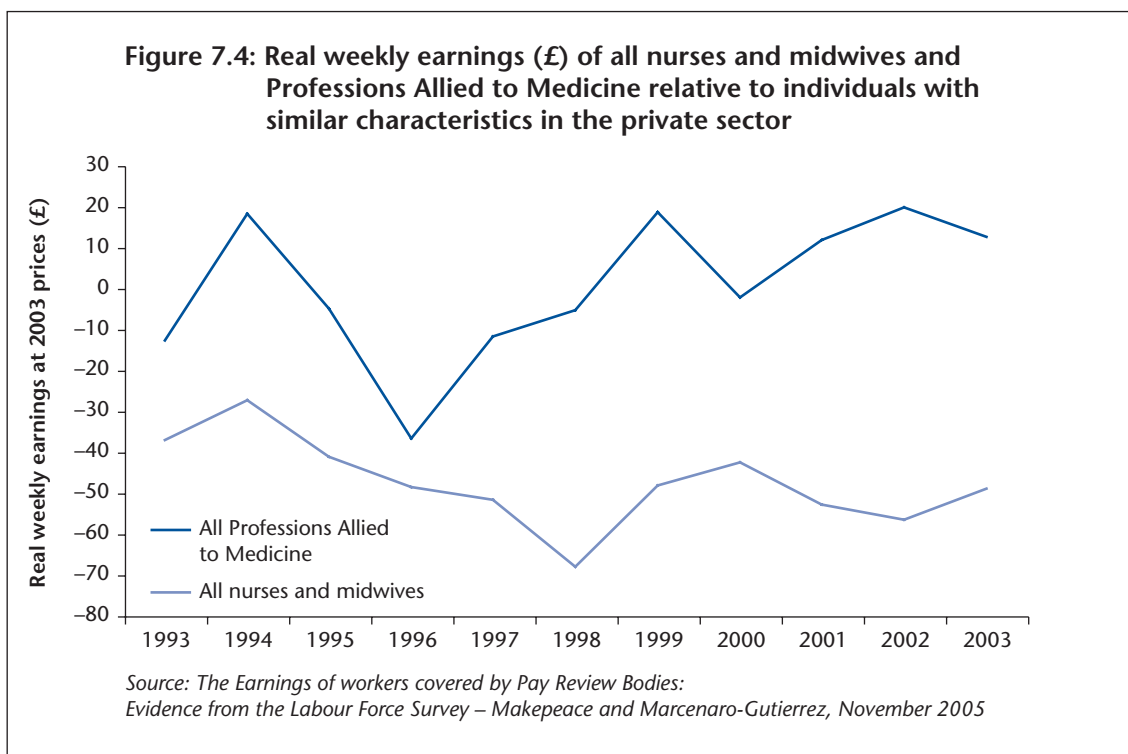
### Comparative Earnings Levels

7.27 On our visits the staff we meet often draw attention to comparisons between their own pay and that of occupations such as the police, school teachers, and local authority workers, and these views are reflected in evidence from the staff bodies.

7.28 The basis for choosing these comparisons is not always clear to us, and the earnings data provided to support such arguments are not generally very helpful. A considerable problem is ensuring the data enable 'like for like' comparisons to be made; that is, that when comparing the average earnings of two groups we are clear that the data are "controlled" for differing employee attributes such as their location, gender, education

<sup>36</sup> AEI. Three-month average, seasonally adjusted, including bonuses.

and the sector in which they work. Such analyses are possible using micro-data from the Annual Survey of Hours and Earnings (ASHE) and the Labour Force Survey (LFS). Our secretariat has commissioned some preliminary work using LFS data to look at the earnings of nurses and midwives and PAMs compared to individuals in the private sector sharing the same attributes. Unfortunately, we have so far only been able to take this analysis to 2003, but we will be looking to extend it over the coming year. We would welcome the views of the parties on how to use this and other types of analysis to provide a more systematic picture of the relative pay of our remit groups.<sup>37</sup>



7.29 On the face of it, Figure 7.4 suggests that in 2003, the real average earnings of the PAM groups were a little higher than private sector equivalents, whilst those of nursing and midwifery staff were somewhat lower. Care must be taken in interpreting such pay gaps since they may merely reflect the relative value that employees attribute to other aspects of their work (e.g. scope for flexible working, interesting work, or the existence of a comparatively generous occupational pension scheme). It is also important to note that these figures do not include the effects of higher than average pay awards for remit staff over the last three years, or the impact of assimilation to the new pay structure. These are likely to have improved the relative position of remit staff.

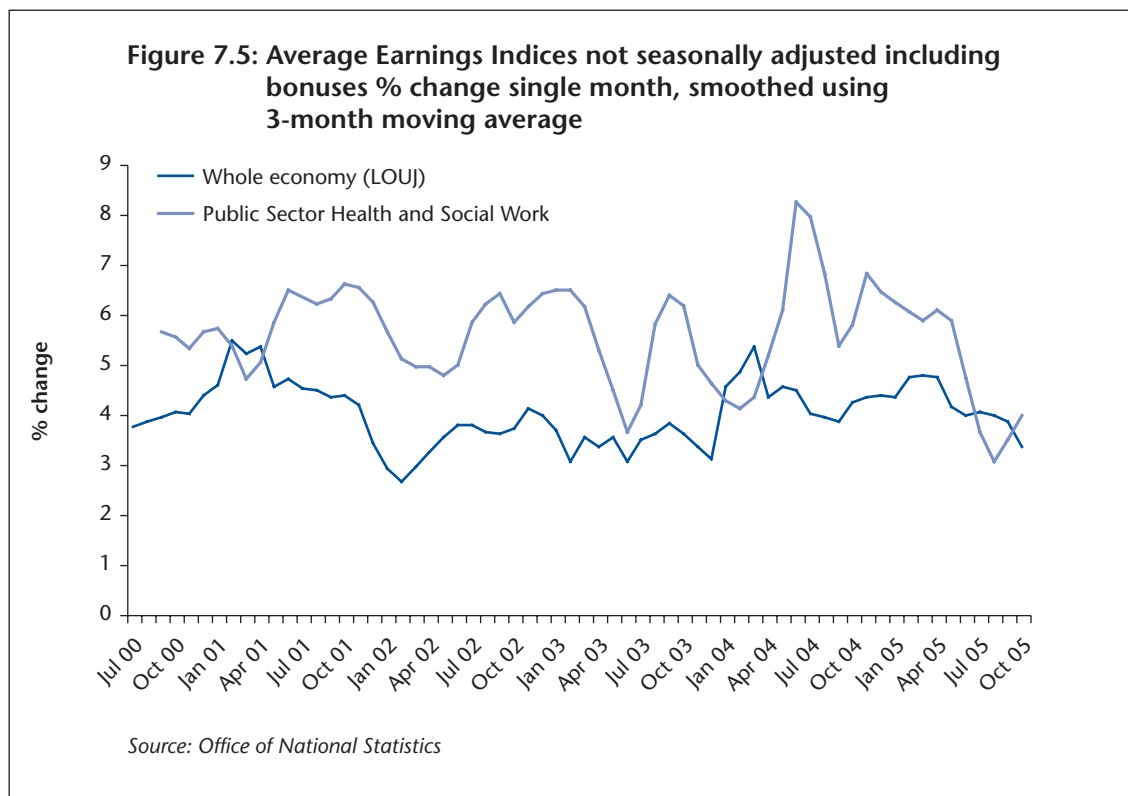
7.30 In looking at data such as that in Figure 7.4 it is more useful to focus on the movements in relative earnings rather than actual levels. In this context the chart suggests that 1998 was a low point in the relative earnings position of nurses and midwives, and this should be borne in mind when considering earnings movements over time.

### Comparative Earnings Movements

7.31 Whilst comparative pay data on levels are of interest, pay movements and trends are also important, and we have carried out some analysis of data in this area.

<sup>37</sup> The analysis so far is available under the research page our website, [www.ome.uk.com](http://www.ome.uk.com), entitled The Earnings of Workers Covered by Pay Review Bodies: Evidence from the Labour Force Survey.

7.32 Disaggregated data from the Average Earnings Index<sup>38</sup> give movements in the earnings of public sector workers in the health and social work sectors. These show increases in recent years somewhat above that for the wider economy. It is important to note, however, that besides our remit groups the disaggregated data also include social workers and doctors and dentists. Indeed, the 'spike' in the index for June 2004 reflects a settlement for hospital consultants, which included several months of back pay.



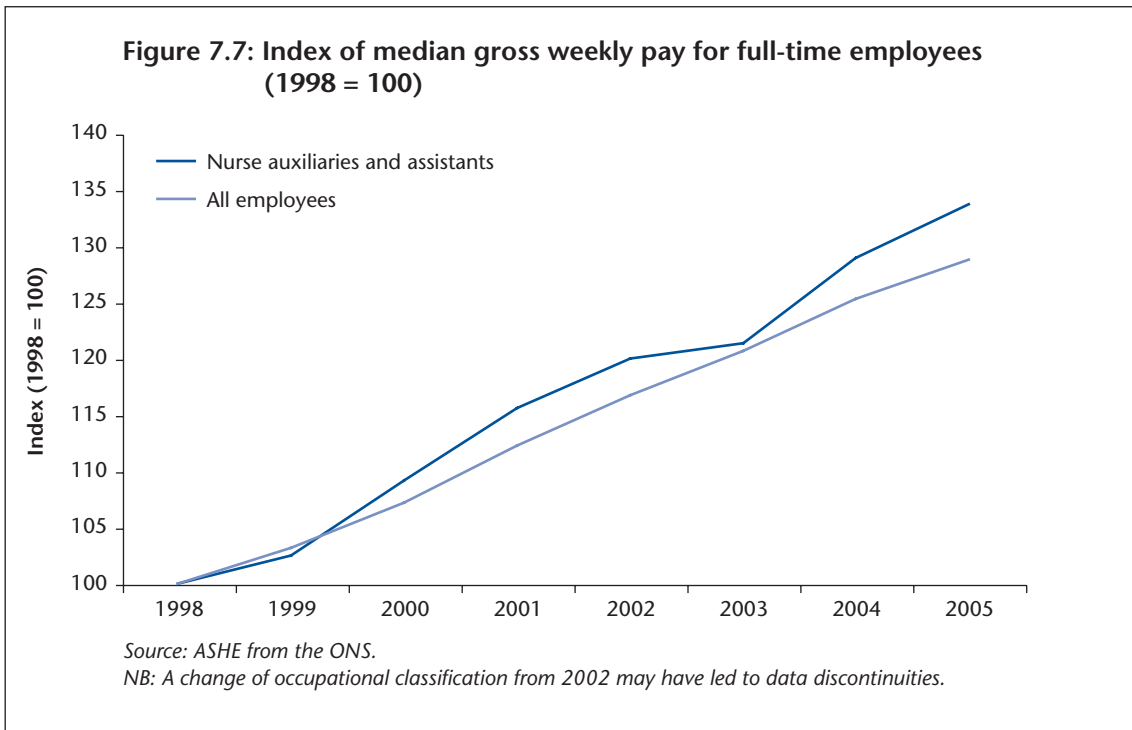
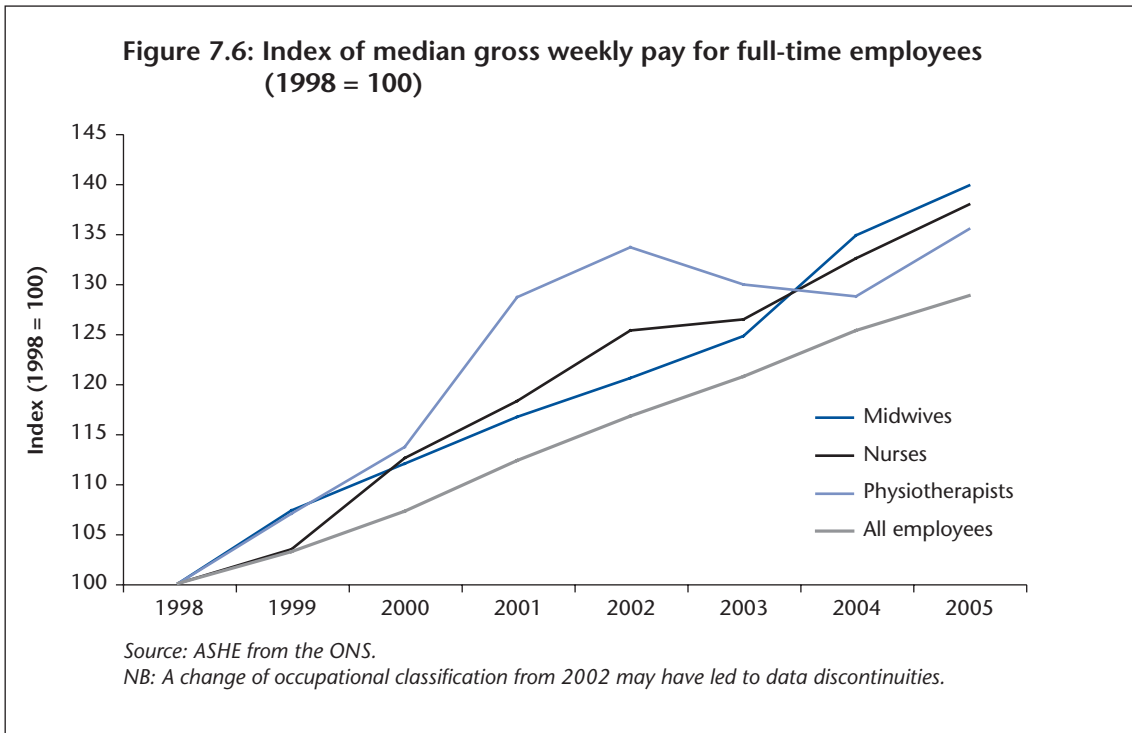
7.33 The most comprehensive earnings data for our remit groups are contained in the biennial survey carried out by the Department of Health. Data from the last three surveys (2000, 2002 and 2004) show that the average earnings of qualified nurses and midwives rose at an annualised rate of 4 per cent between 2000 and 2004. For qualified PAMs the rate was 4.2 per cent, and for scientific and professional staff the rate was 4.3 per cent. The equivalent whole economy figure using ASHE data is 4.0 per cent.

7.34 The Department of Health's latest survey data relate to 2004 and, of course, exclude the effects of the new pay system. Other data on earnings are available from the ASHE and the LFS and these enable us to examine data to April 2005.

7.35 We note that the *Office for National Statistics (ONS)* considers that ASHE is the most appropriate source for annual changes in earnings, and for data on the earnings of full-time employees. In terms of earnings movements, the increase in median gross weekly pay for full-time 'qualified' nursing staff comparing April 2005 with April 2004 was 4.1 per cent, as against 2.8 per cent for all full-time employees. Since 1998, the earliest date for which ASHE data are currently available, qualified nurses' median earnings have risen, on average, by 4.7 per cent per year, or 37.8 per cent cumulatively, compared with 3.7 and 28.8 per cent respectively for all full-time employees.

<sup>38</sup> Only available not seasonally adjusted.

7.36 Cumulative growth in the median gross weekly pay of full-time 'unqualified' nurses has exceeded that of all full-time employees in each year since 1999. Since 1998 median earnings for unqualified staff have risen by an average of 4.2 per cent per year, or 33.7 per cent in total.



7.37 Whilst ASHE is a valuable source, the published figures do not allow us to identify *public sector* nursing staff alone, and we have asked our secretariat to work with ONS to address this point. There is also unexplained volatility in the earnings movements of the other health professions. This is evident from the data we reproduce above in respect of physiotherapists. This might be due to sample size issues and could point to a potential problem in using ASHE data to assess the relative earnings of some of our smaller staff groups. Also, as we note above, at present we are only able to take ASHE data back to 1998 and that year was a low point in the relative position of many of our remit staff (see also paragraph 7.30). We hope in future to be able to take our analysis back further.

## Our Comment

- 7.38 Macro-economic data on inflation, settlements and earnings provide important context to our deliberations. The data suggest a low and stable inflationary environment over the coming twelve months, and a similarly stable profile for pay settlements. Average earnings growth has been slowing, largely on the back of lower bonuses in the private sector. Although there may be some increase in the early months of 2006, a softer labour market does not suggest that pay pressures in the economy are likely to build in the near future.
- 7.39 We have considered the views of the Chancellor of the Exchequer that we should base our recommendations on the achievement of the 2 per cent inflation target, rather than a temporary rise in CPI. We would stress that our recommendations are not, automatically or otherwise, linked to any economic index. Rather, they are based on our judgement of the respective merits of all the evidence we receive, of which inflation is only a part. For this reason, we see no need to choose between the various indices to identify the most appropriate for measuring the inflation rate faced by our remit groups, and have considered them all.
- 7.40 We have looked at the data on relative pay levels and movements. Pay comparability is not formally part of our remit. However, it is clear that we must take it into account as it impinges on issues such as recruitment, retention, motivation, and local pay, which are firmly part of our remit. This is not a simple task: as we have stated in past reports, there is little agreement amongst the parties on fundamental issues such as the comparators to be used, the start date upon which to base movements data, and the degree to which non-pay movements should be included in the analysis.
- 7.41 In the background section above we set out some trend data comparing the earnings growth of our remit groups with that of the wider economy. The different data sources all have strengths and weaknesses. The best source of data on our groups, the Department of Health earnings survey, only takes us to 2004. The different data also give us different results on the rate of change in nurses' earnings (taking this group as a proxy for our remit area).
- 7.42 We make our judgements on the evidence available to us, and it is clear to us that there are serious deficiencies in the data we have available on the remuneration of our remit groups. There are some data available in outside sources such as the ASHE and LFS, and we indicate above some uses to which this data can be put, particularly in tracking general movements in pay. We have noted that these sources come with some caveats, and it is difficult to identify the specific pay figures for our remit staff. However, we would encourage the parties to seek to provide more sophisticated analysis on relative earnings levels and movements than has generally been the case in the past, building on our own preliminary analyses.



- 7.43 Our analysis based on existing data leads us to the view that we and the parties must be provided with up-to-date and comprehensive data on the earnings of nurses and other health professionals, including their distribution within the new pay structure, to augment that already available in the general surveys. We believe that the Health Departments, working within the health community as necessary, are best placed to collect, analyse, and distribute this information.

**We recommend that the Health Departments ensure that in 2006 and in every year thereafter, a comprehensive survey is conducted to identify the earnings of our remit groups, and their location within the pay bands. These consistent surveys should also give breakdowns by gender and age, and should be timed so that they take account of the effects of basic pay uplifts from April each year, and enable results to be publicly available in the Autumn to inform our annual reviews.**

- 7.44 In their evidence Departments also raised the issue of pay drift, asking us to bear in mind the increases in earnings of remit staff over and above any uplift to basic rates that we recommend. They estimated that pay drift in 2006/07 would increase pay by 2.6 per cent. This is considerably higher than the drift normally associated with these groups. Calculating the level of pay drift from published data is not easy as, for example, ASHE data shows some volatility in earnings figures year on year. However, average pay drift for remit staff has averaged around 1 per cent in recent years. In the latest year for which we have data, 2005, it appeared to be 0.85 per cent for qualified nursing staff.
- 7.45 We are unclear about the cause of the difference in the Department's estimate for 2005/06 and 2006/07 and the historical level of pay drift for our remit groups. The rise in drift in 2005/06 is no doubt due in part to the assimilation to the new pay system, but we do not understand why the projected drift is unchanged in 2006/07, as by then assimilation should have been completed. We accept, as the Department told us, that some of the one-off costs of assimilation will be incurred in 2006/07 and that the opening up of the possibility of further incremental progression for many staff may lead to higher pay drift, but we have no way of knowing the relative magnitude of these effects. We believe that we could only consider these matters adequately if the Department shared with the Review Body its pay modelling and in particular its modelling of how the new pay structure increases pay drift.
- 7.46 Whatever the precise arithmetic of the estimated pay drift we have to consider whether to take it into account in recommending an uplift to basic pay as the Department has urged us to do. As we have said, we do not know how these estimates have been derived but three factors must be important. These are the one-off costs of assimilation to the new pay structure; incremental progression; and overtime, shift and unsocial hours payments. Our views on the extent we should take these factors into account are as follows. First, the new pay system is in part designed to address concerns about equal pay for work of equal value. The costs associated with equality-proofing NHS pay should not, in our opinion, influence decisions about a basic pay uplift. The same argument applies to other assimilation costs that arise from the recent decisions of the parties as to the appropriate placing of staff in the new grading structure, and which are, of course, offset to some extent by the zero assimilation cost for those staff on pay protection.

- 7.47 Second, we understand that the new pay structure has 'opened up' the scope for further incremental progression for some staff previously at the top of their pay ranges, and this clearly contributes to the higher than normal drift estimated by the Department of Health. However, we have noted observations from the parties that the purpose of the incremental pay system is to recognise the additional experience and knowledge of staff who progress up their pay band. The Knowledge and Skills Framework applicable to Agenda for Change explicitly links progression to skills and knowledge. It is not clear to us why, in that case, the additional pay that accrues to employees in recognition of their experience and knowledge should influence pay recommendations aimed at positioning the pay structure as a whole at an appropriate level in relation to the wider labour market. This confuses two totally different features of the NHS pay system. The result of following the Department's suggestion over time would be a decline in the relative position of the NHS pay structure against the external market, with adverse implications for recruitment and retention most notably at the starting rate for newly-qualified staff and for staff at the top of the pay band applicable to their post. Such an approach inevitably leads to the need for periodic 'catch-up' awards, which introduce unnecessary volatility into the structure and seek to address the damage to recruitment and retention after it has already been done.
- 7.48 For these reasons we do not agree that we should take the effect of incremental progression on earnings into account when deciding on our recommended level of uplift. We note that incremental progression is not automatic and that staff must pass through assessed gateways at the bottom and near the top of each pay band. However, if the Department feels that there are insufficient controls on pay progression, and has continued concerns about the cost implications of Agenda for Change, it should negotiate an alternative process with the staff bodies rather than asking us to restrain the level of basic uplift to the structure as a whole.
- 7.49 Finally, premia for overtime, shift, or unsocial hours working are compensatory payments to reflect extra or abnormal working hours. In our view it would not be appropriate to offset changes to earnings from these sources against recommended uplifts in basic rates of pay.
- 7.50 As we have received no evidence that factors other than the three discussed above are leading to higher than average levels of pay drift, we do not believe that we should take account of the estimated pay drift in making our recommendation on the uplift for basic pay this year.

## Chapter 8: Level and Structure of 2006-2007 Pay Recommendations

### Introduction

- 8.1 The evidence reviewed in the earlier chapters sets the broad context within which we consider our pay recommendations. In this chapter we outline the evidence we have received from the parties concerning the overall level of our basic pay award, the desirability of targeted action in particular pay bands and whether parties would like to see a one-year or a longer-term pay deal. Issues around geographical and occupational pay differentiation are dealt with in Chapter 4.

### Evidence from the Parties

#### *The Health Departments*

- 8.2 The **Department of Health** said that pay awards for NHS staff must be set within a framework that considers Departmental spending limits, output targets and the anticipated inflation in the economy as a whole. It also pointed out that around 60 per cent of a Trust's budget is spent on pay, of which around half was spent on our remit group.
- 8.3 It argued that recruitment and retention among remit groups were improving, vacancy rates were falling, and staff surveys showed that motivation and morale were moving in the right direction. Alongside this our remit group had received an above inflation rise of 10 per cent overall over the past three years, whilst Agenda for Change was estimated to be worth on average an extra 2.3 per cent in earnings for the period October 2005 to October 2006. In addition, finance throughout the Service was becoming tight.
- 8.4 Consequently, the Department initially proposed in its written evidence an award of no more than 2.5 per cent across all pay bands. However, at the oral evidence session (and subsequently confirmed in supplementary written evidence), it revised its view on the appropriate level of the uplift for our remit group. It argued that a better understanding of the position on earnings growth arising from Agenda for Change meant the actual increase in the first 12 months was 2.8 per cent, some 0.5 per cent higher than the original estimate. This would feed through into higher than expected earnings growth per head. In addition, non-pay benefits, such as increased leave entitlement and shorter hours, originally estimated to cost 0.6 per cent of the pay bill, were now estimated to cost between 1.1 per cent and 1.8 per cent per annum. The total excess cost was therefore now between £220 million and £390 million, or between 1 per cent and 1.7 per cent of the Agenda for Change pay bill.
- 8.5 In November 2005 the Chancellor of the Exchequer wrote to us proposing that we should base our pay recommendations on the achievement of the inflation target of 2 per cent.
- 8.6 In the light of these developments the Department of Health now recommended that the pay uplift for 2006/07 should be as close as possible to 2 per cent.

- 8.7 In terms of the structure of our award, the Department of Health said that Agenda for Change was in the process of being rolled out nationally. It would take time for the system to bed down and for transitional issues to be ironed out as they emerged. The new pay system provided opportunities for pay progression and enhancements to basic pay. Pay protection would remain in force until March 2011 and work was underway to harmonise unsocial hours. For these reasons, the Department believed that no changes should be made to the structure of the new pay system at this time. It sought a one-year, rather than a longer-term, pay deal to allow Agenda for Change to bed down and its impact to be monitored.
- 8.8 The **National Assembly for Wales (NAW)** said that Welsh employers had been surveyed about their wishes for the 2006/07 pay round and there was a high degree of agreement on two issues. Firstly, they wanted a longer-term settlement of two or three years. Secondly, they would prefer an identical level of pay uplift across all groups, including doctors and dentists, which was seen to be important from a fairness and morale perspective.
- 8.9 NAW subsequently concurred with the Department of Health recommendation for a modest pay uplift as close to 2 per cent as possible.
- 8.10 The **Scottish Executive Health Department** said that recent increases in staff pay had had a major impact on Health Boards' budgets and any further rise in the paybill would result in fewer resources to fund other key priorities. It also subsequently concurred with the position on pay uplifts outlined in the Department of Health supplementary evidence, that the pay uplift for our remit groups should be as close as possible to 2 per cent.

#### *NHS Employers (NHSE)*

- 8.11 **NHSE** said that responses to its questionnaire indicated a majority view that a pay award in excess of 2.5 per cent (in line with inflation forecasts) would be deemed unaffordable. However, a minority of respondents indicated that no pay award would be affordable and that any pay increase would cause significant problems given the current funding deficits. In later evidence it stated that the figure of 2.5 per cent had been selected because at the time of its initial submission this was the upper limit of any of the rates of inflation. It pointed out that inflation had subsequently fallen and recommended an uplift of not more than inflation.
- 8.12 The common view from employers was that there should be the same level of pay award for all NHS staff as they felt equity of treatment was particularly important in valuing all parts of the workforce. There should also be greater convergence between the medical and non-medical pay systems.
- 8.13 NHSE looked favourably on a multi-year award. Provided it was at an affordable level, they felt it would help create a climate of stability, which would assist service and financial planning, and remove the element of doubt from staff and their representatives about the level of forthcoming awards.

#### *Staff Bodies*

- 8.14 **Staff Side** recognised that there had been a significant improvement in real pay for NHS staff since 1997, and further increases would be achieved through implementation of Agenda for Change, but argued that these gains needed to be consolidated in the 2006 award. It sought a substantial, above inflation, increase to assist recruitment and retention and to close gaps with other public sector comparators.

- 8.15 In response to the Chancellor's letter that we should base our pay recommendations on the CPI inflation rate of two per cent, Staff Side said that such an award would effectively mean staff suffering a real terms pay cut because CPI excludes such costs as council tax, mortgage interest and other housing costs.
- 8.16 Finally, the Staff Side said it was not yet possible to assess the full impact of Agenda for Change given that assimilation was not yet complete and that this was a strong reason for a one-year pay award this year.
- 8.17 The **RCmnd.** noted that long-term pay agreements were of value when the increases on offer were above inflation.
- 8.18 **UNISON** recommended a significant pay increase and/or a flat rate increase for staff whose earnings are lowest.
- 8.19 **Amicus** opposed a long-term award because of the uncertainty surrounding Agenda for Change and the proposed service changes. It therefore sought a one-year award amounting to a substantial increase across the salary ranges (bands), which it defined as being above the cost of living and resting comfortably in the upper quartile of salary increases for the second quarter of 2006.
- 8.20 **CSP** suggested a substantial one-year pay award as going some way to acknowledging the additional effort of its members and their commitment to the future of the NHS during a period of reduced motivation and morale while Agenda for Change was being implemented.
- 8.21 The **SoR** endorsed the Staff Side's preference for a one-year pay deal, especially when it remained unclear what impact implementation of Agenda for Change would have on the pay of its members.
- 8.22 **T&G** argued we should ensure that the pay rise awarded for 2006/07 tackled the gap between ambulance staff and staff in other emergency services and recognised the growing responsibilities, skills and professionalism of ambulance staff.

### **Our Comment**

- 8.23 We are grateful to the parties for setting out their preferred options regarding the level and structure of this year's award. This has helped us to simplify the nature of our review, and to establish the parameters within which to consider the other evidence we have received. At one end, the Departments have asked for a recommendation as close to 2 per cent as possible, at the other Amicus has asked for an award comfortably within the upper quartile of settlements generally, which we judge to be above 3.5 per cent on present data. The proposals of the other parties appear to fall within this range.
- 8.24 We also note general agreement that there should be no changes to the structure of the pay system this year, along with the view of the Department of Health and the Staff Side that we should recommend an award for one year only.

## *Summary and Conclusions*

- 8.25 Our role is to make recommendations that are fair to all stakeholders, taking into account all the circumstances and in line with our terms of reference. We have therefore carefully considered the points put to us in evidence and summarised here and in Chapters 2 to 7.
- 8.26 In summary, the **Health Departments'** case is that the indicators on recruitment, retention and morale have improved and continue to move in the right direction; that there are pressures on affordability within the service; inflation is low; and that on average staff are receiving earnings growth from the introduction of the new pay system higher than originally expected. In these circumstances they are seeking an award close to 2 per cent. **NHS Employers** considered affordability pressures were of particular concern; the majority view of its members was that an award in line with inflation (initially represented as up to 2.5 per cent), was an appropriate balance between affordability and the need to recruit and retain staff. The **staff bodies** argued for a substantial, above inflation award to assist recruitment and retention, and to close the pay gap with comparator occupations.
- 8.27 We have reviewed the evidence on equal pay and related equality issues in Chapter 2. No issues requiring action were raised with us. We have noted the additional requirements placed on us by Agenda for Change, and have outlined the process by which we will address them in future.
- 8.28 Recruitment and retention evidence is considered in Chapter 3. We conclude that trends in the NHS are moving in the right direction. Wastage rates from the service have fallen. Labour turnover rates are typically lower than elsewhere in the economy. Vacancy rates are also broadly favourable, and have improved for most of our remit groups. However, there appear to be problems with staff retention at senior levels, which are having knock-on effects on the ability to take on and train staff in more junior positions. Overall, though, we conclude that there is no recruitment and retention evidence to suggest that the pay structure of our remit group in general is incorrectly positioned relative to the wider labour market.
- 8.29 We have considered the evidence on recruitment and retention premia in Chapter 4. We do not believe that sufficiently robust cases have been made for action this year, and agree with the main parties that the new pay system should be allowed to bed down first before introducing changes of this nature. We look forward to receiving more comprehensive evidence in future, and strongly urge the parties as far as possible to work together to provide it.
- 8.30 On high cost area supplements, also reviewed in Chapter 4, we believe the desire of the parties for stability in the pay structure points this year to our increasing the minimum and maximum payments in line with our basic uplift. We invite the parties to provide further evidence on local labour market difficulties for our next review.
- 8.31 The Department of Health also sought our views on an 'x+y' approach to future pay recommendations, representing a combination of a national uplift and flexibility to address specific local or occupational labour market problems. This is still at an early stage in the Department's thinking and we are unable to comment on the proposal as it stands, although we note that NHS Employers and the staff bodies consider that there are already sufficient flexibilities within Agenda for Change to deal with specific recruitment and retention issues.

- 8.32 Chapter 5 outlines the evidence on motivation and morale. The evidence generally predates the roll-out of Agenda for Change, and this poses a major difficulty for us this year. The data point to some improvement in staff morale up to December 2004 on many measures. However, events since then, such as unmet expectations from the new pay system and fears that training and development needs may not be fully funded, may have combined to lower morale in recent months. A clearer picture of the position in England will emerge from the results of the 2005 National NHS Staff Survey, which we hope will be available to inform our next review.
- 8.33 We note the evidence on the funds available to the NHS or 'affordability', which is covered in Chapter 6. From the point of view of the Departments and employers affordability is clearly a key issue. There has been a number of pressures on the resources available to the NHS this year and some individual employers have serious deficits. We have given substantial weight to affordability in reaching our recommendation.
- 8.34 Finally, Chapter 7 outlines the economic evidence on pay and prices. The macro-economic situation is currently one of stability with low levels of inflation and no sign of emerging pay pressures. We do not anticipate that this situation will change during the next financial year. We have considered the evidence on the relative earnings of our remit groups, and on pay drift. The data come from a number of sources and can be volatile, out of date or inconsistent, making it difficult to discern a clear trend.
- 8.35 We have noted the Department of Health's evidence on earnings growth, and on pay drift which it estimates at 2.6 per cent for 2006/07. We have discussed this issue in Chapter 7 where we have noted that this figure is some way above the historical level of drift for our remit groups. We have received no robust evidence from the Department as to how it has arrived at its estimate. That being so, we have not been able to attach any weight to the Department's evidence on pay drift. If we are to take account of pay drift in future reviews the Department must provide a clearer explanation of how its estimates of drift are derived, and why they should be taken into account in setting basic pay levels.
- 8.36 We have had to balance a range of competing evidence, in which affordability and the market position of the pay structure of our remit group appear to us to be major factors. Our assessment is as follows. We are not tied to an economic index, and the inflation target is only one piece of evidence that we consider; inflation rates, pay settlements and average earnings levels and movements are also important macro-economic indicators. On affordability, we accept that there are strong pressures on the Service and that a small proportion of Trusts face severe financial difficulty. We note the evidence from NHS Employers that NHS employers in England would deem an award in excess of 2.5 per cent unaffordable. For the reasons explained in paragraph 6.2 we have been unable to give detailed consideration to the Health Departments' output targets for the delivery of services, although we note the general point that unnecessarily large pay increases may prejudice service improvements.
- 8.37 We believe that recruitment and retention have improved, but note that vacancy rates within the Service remain typically higher than in the economy generally. Motivation and morale was showing signs of improvement by the end of 2004, but there have been major developments since that time which have contributed to a climate of challenge and uncertainty and we consider it important to ensure that morale and motivation are not adversely affected in such a climate. Finally, Agenda for Change may result in atypical levels of pay drift for some workers in the short term, but the evidence does not yet allow us reliably to judge either its extent or its causes. For the reasons stated in paragraph 8.35 above we have not taken this into account.

8.38 We do not believe that the balance of evidence suggests it is necessary to amend in either direction the existing position of the pay structure of our remit group relative to the external market, but affordability is a consideration to which we must have regard. Consequently we have sought to maintain the relative market position of the pay structure as far as we judge affordability constraints allow. In this, we have had regard to the view expressed by NHS Employers as to the level of award the majority of employers in England, as budget holders, believe affordable, noting that we received no evidence to suggest a differentiated award should apply in Scotland or Wales.

**We recommend an increase in the Agenda for Change pay rates of 2.5 per cent from 1 April 2006. The recommended new rates<sup>39</sup> are set out in Appendix B.**

- 8.39 We have examined the implications for equal pay and related equality issues. We see no equal pay implications arising from the nature of the increase we propose.
- 8.40 In view of the evidence from the parties that there should be no changes to the pay structure beyond our recommended uplift we are not making any recommendations to this effect. It follows that we are making no recommendations that would alter the basic pay differentials within the pay structure that have recently been agreed by the parties.
- 8.41 Finally, it is the strong view of the Department of Health and the Staff Side that we should recommend for one year only. We agree with this and consequently, our recommendations cover the pay year 2006/07. We would like to make clear, however, that we have no objection to recommending for longer periods in future if that is supported by the evidence before us.

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<sup>39</sup> This is the first year that we have recommended an award based on the Agenda for Change pay scales. Our secretariat has discussed with the parties an appropriate base pay rate from which to apply our recommendations. The recommended rates from 1 April 2006 have been calculated as follows: we have taken the rates applicable at October 2004 as our base as this date reflects the intended national roll-out of the new pay system. We have applied the 3.225 per cent increase agreed by the parties as the 1 April 2005 uplift to the base, and further applied our recommended uplift from 1 April 2006. The resulting figures have been rounded up to the nearest pound.



## APPENDIX A

### COVERAGE OF THE NURSING AND OTHER HEALTH PROFESSIONS REVIEW BODY (NOHPRB)

#### i) Nurses, Midwives and Health Visitors

#### ii) Allied health professional groups

Art Therapists

Drama Therapists

Music Therapists

Chiropodists/Podiatrists

Dieticians

Occupational Therapists

Orthoptists

Orthotists

Prosthetists

Physiotherapists

Radiographers

Speech and Language Therapists

Ambulance Paramedics

#### iii) The professions in healthcare science

##### *Engineering and the physical sciences:*

Clinical Engineers

Medical Physicists

Medical Physics Technologists

Nuclear Medicine Technologists

Critical Care Technologists

Radiotherapy Technologists

Rehabilitation Engineers

Clinical Measurement Technicians

Vascular Technologists

Medical Illustrators

Renal Dialysis Technologists

Technologists in Equipment Management

##### *Physiological sciences:*

Audiological Scientists

Hearing Therapists

Audiological Technicians

Cardiology Physiologists

Cardiographers

Clinical Perfusionists

Gastroenterology Technicians  
Neurophysiologists  
Respiratory Physiologists

*Life Sciences:*

Biomedical Scientists  
Cytology Screeners  
Medical Laboratory Assistants  
Phlebotomists  
Clinical Biochemists  
Clinical Cytogeneticists  
Molecular Geneticists  
Cytogenetics and Molecular Genetics Assistants  
Clinical Embryologists  
Clinical Microbiologists  
Clinical Scientists (in haematology)  
Clinical Scientists (in immunology and histocompatibility)  
Post-mortem Technicians  
Quality Assurance Scientists

**iv) Other healthcare professions**

Healthcare Pharmacists, Hospital Optometrists, Clinical Psychologists, Adult and Child Psychotherapists;  
Family therapists with a minimum training requirement of at least three years to diploma level or equivalent in family therapy;  
Operating Department Practitioners

**v) Clinical support workers and technicians**

Clinical support workers and technicians who directly support the work of the professions outlined above:-

Nursing Auxiliaries, Health Care Assistants and Maternity Assistants (supporting Nurses, Midwives and Health Visitors);  
Assistant Psychologists and Child Psychotherapists (supporting Clinical Psychologists and Child Psychotherapists);  
Dental Nurses, Hygienists, Therapists and Technicians;  
Medical Laboratory Assistants, Assistant Technical Officers, Senior Assistant Technical Officers (supporting Healthcare Scientists);  
Operating Department Assistants (supporting Operating Department Practitioners);  
Pharmacy Technicians and Assistants;  
AHP Helpers, AHP Assistants and Technical Instructors, Speech and Language Therapist Assistants and Ambulance Technicians.

## APPENDIX B

### RECOMMENDED NATIONAL SALARY SCALES FROM 1 APRIL 2006<sup>40</sup>

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1	11,782	11,782*										
2	12,177	12,177	12,346*									
3	12,514	12,514										
4	12,853	12,853	12,853*									
5		13,247										
6		13,642	13,473*									
7		14,037	14,037	14,262*								
8		14,543	14,543									
9		15,107	15,107	15,107*								
10			15,446									
11			15,897	15,671*								
12			16,405	16,405								
13			16,799	16,799	16,799*							
14				17,419	17,475*							
15				18,039	18,039*							
16				18,602								
17				19,166	19,166							
18				19,730	19,730	20,012*						
19					20,294							
20					20,970	20,970*						
21					21,646							
22					22,266	21,985*						
23					22,886	22,886						
24					23,789	23,789	23,338*					
25					24,803	24,803	24,803*					
26						25,818						
27						26,720	26,269*					
28						27,622	27,622					
29						28,524	28,524					
30						29,538	29,538					
31						31,004	31,004					
32						31,906	31,906*					
33						32,921	32,921*					
34						34,048	34,048*					
35						35,232	35,232					
36						36,416	36,416	36,416*				
37							37,881	37,881*				
38							39,346	39,346*				
39							41,038	41,038				
40							42,278	42,278	42,278*			
41								44,420	44,420*			
42								46,900	46,900*			
43								49,381	49,381			
44								50,733	50,733	50,733*		
45								52,988	52,988*			
46								55,469	55,469*			
47								59,189	59,189			
48								60,880	60,880	60,880*		
49									63,417	63,417*		
50									66,517	66,517*		
51									69,899	69,899		
52									73,281	73,281		
53										76,798		
54										80,485		
55										84,349		
56										88,397		

\*Pay rates in italic are special transitional points which apply only during assimilation to the new system. They are shown here for convenience.

<sup>40</sup> This is the first year that we have recommended an award based on the Agenda for Change pay scales. Our secretariat has discussed with the parties an appropriate base pay rate from which to apply our recommendations. The recommended rates from 1 April 2006 have been calculated as follows: we have taken the rates applicable at October 2004 as our base as this date reflects the intended national roll-out of the new pay system. We have applied the 3.225 per cent increase agreed by the parties as the 1 April 2005 uplift to the base, and further applied our recommended uplift from 1 April 2006. The resulting figures have been rounded up to the nearest pound.

## APPENDIX C

### RECOMMENDED LEVELS OF HIGH COST AREA SUPPLEMENTS

Area	Current level (1 April 2005)	Recommended level (1 April 2006)
Inner London	20% of basic salary, subject to a minimum payment of £3,300 and a maximum payment of £5,500	20% of basic salary, subject to a minimum payment of £3,383 and a maximum payment of £5,638
Outer London	15% of basic salary, subject to a minimum payment of £2,750 and a maximum payment of £3,850	15% of basic salary, subject to a minimum payment of £2,819 and a maximum payment of £3,946
Fringe zone	5% of basic salary, subject to a minimum payment of £825 and a maximum payment of £1,430	5% of basic salary, subject to a minimum payment of £846 and a maximum payment of £1,466

## APPENDIX D

## FULL TIME EQUIVALENT STAFF NUMBERS AT SEPTEMBER 2004

## Nursing, midwifery and health visiting staff

	ENGLAND		WALES		SCOTLAND		GREAT BRITAIN	
	Number	%	Number	%	Number	%	Number	%
Qualified staff	301,877	75.4	20,272	74.0	38,907	70.9	361,056	74.8
Unqualified staff <sup>(a)</sup>	98,413	24.6	7,134 <sup>(b)</sup>	26.0	15,946	29.1	121,494	25.2
Total	400,290	100.0	27,406	100.0	54,853	100.0	482,550	100.0

## Allied Health Professionals (AHPs) and Scientific Therapeutic &amp; Technical (ST&amp;T) staff

	ENGLAND		WALES		SCOTLAND		GREAT BRITAIN	
	Number	%	Number	%	Number	%	Number	%
Qualified AHP staff <sup>(c)</sup>	48,338	35.1	3,366	35.8	6,117	35.5	57,820	35.2
Qualified ST&T staff <sup>(d)</sup>	60,246	43.7	3,972	42.3	7,731	44.9	71,949	43.8
Unqualified AHP and ST&T staff	29,204	21.2	2,055	21.9	3,389	19.7	34,654	21.1
Total	137,788	100.0	9,393	100.0	17,237	100.0	164,423	100.0

## Ambulance staff

	ENGLAND		WALES		SCOTLAND		GREAT BRITAIN	
	Number	%	Number	%	Number	%	Number	%
Ambulance Paramedics	7,353	39.5	665	49.4	1,023	37.5	9,040	39.8
Other Qualified staff	9,234	49.6	525	39.0	982	36.0	10,741	47.3
Trainee Ambulance personnel	2,039	10.9	157	11.7	722	26.5	2,918	12.9
Total	18,626	100.0	1,347	100.0	2,727	100.0	22,699	100.0

Sources: Health and Social Care Information Centre - non-medical workforce census;

NHS Directorate of the National Assembly for Wales;

Scottish Executive Health Department

- (a) Includes nursing assistants/auxiliaries and nursery nurses  
 (b) Includes nursing assistants/auxiliaries and nursery nurses. Also includes nurse learners, as they are not specifically identified in the Welsh figures.  
 (c) Includes qualified AHP workers in the following professions: Physiotherapists, Radiographers, Music, Art and Drama Therapists, Occupational Therapists, Orthoptists, Chiroprodists, Dietitians  
 (d) Includes qualified ST&T workers in the following professions: Speech and language therapy, Multi-therapies, Pharmacy, Clinical psychology, Psychotherapy, Dental, Medical physics, Pathology, Physiological measurement, Operating theatres and in other qualified scientific, technical and therapeutic areas

## APPENDIX E

### Breakdown of estimated<sup>(a)</sup> 2005/06 paybill<sup>(b)</sup> for Great Britain

#### PAYBILL FOR NURSING STAFF, MIDWIVES AND HEALTH VISITORS

	Cost	
	Cash	As a percentage of paybill <sup>(c)(d)</sup>
	£ million	%
Pay <sup>(e)</sup>	13,515	98.2
London allowance	252	1.8
Sub-total <sup>(c)(d)</sup>	13,767	100.0
Employers' on-costs <sup>(f)</sup>	1,651	–
Agency staff costs	569	–
<b>Total<sup>(c)</sup></b>	<b>15,987</b>	<b>–</b>

#### PAYBILL FOR ALLIED HEALTH PROFESSIONS

	Cost	
	Cash	As a percentage of paybill <sup>(c)(d)</sup>
	£ million	%
Pay <sup>(e)</sup>	2,011	98.3
London allowance	35	1.7
Sub-total <sup>(c)(d)</sup>	2,046	100.0
Employers' on-costs <sup>(f)</sup>	250	–
Agency staff costs	144	–
<b>Total<sup>(c)</sup></b>	<b>2,440</b>	<b>–</b>

## PAYBILL FOR SCIENTIFIC, TECHNICAL, PROFESSIONAL AND THERAPEUTIC STAFF

	Cost	
	Cash	As a percentage of paybill <sup>(c)(d)</sup>
	£ million	%
Pay <sup>(e)</sup>	2,807	98.3
London allowance	48	1.7
Sub-total <sup>(c)(d)</sup>	2,855	100.0
Employers' on-costs <sup>(f)</sup>	345	–
Agency staff costs	152	–
<b>Total<sup>(c)</sup></b>	<b>3,352</b>	<b>–</b>

## PAYBILL FOR AMBULANCE STAFF

	Cost	
	Cash	As a percentage of paybill <sup>(c)(d)</sup>
	£ million	%
Pay <sup>(e)</sup>	786	98.6
London allowance	11	1.4
Sub-total <sup>(c)(d)</sup>	797	100.0
Employers' on-costs <sup>(f)</sup>	100	–
Agency staff costs	0	–
<b>Total<sup>(c)</sup></b>	<b>897</b>	<b>–</b>

Source: Health Departments

- (a) Estimates are based on uplifted 2004/05 provisional accounts figures from the Health Departments and estimated staff numbers at 30 Sept 2004, and are subject to revision. The split into pay, London allowance, employers' costs and agency costs is based on the proportional split from the Health Departments' 1997 FIS10 exercise.
- (b) Excludes students on Project 2000 courses, and senior nurses and senior midwives.
- (c) Totals may not equal the sum of components because of rounding, and percentages have been calculated from unrounded figures.
- (d) Excluding employers' national insurance contributions and superannuation, agency staff, students on Project 2000 courses and senior nurses and senior midwives.
- (e) Includes basic pay, overtime, special duty payments, pay-related and non pay-related allowances, none of which are separately identifiable.
- (f) Employers' national insurance contributions and superannuation.

## APPENDIX F

### WORKFORCE SURVEY, 2005

#### Introduction

1. Again this year OME has carried out a workforce survey covering Trusts in Great Britain. For more information, please see Chapter 3 paragraph 3.2 to 3.21 or for the full results please see our website at <http://www.ome.uk.com>

#### 1. Box 1: 2005 Workforce Survey

##### Recruitment

Staff joining Trusts as a proportion of staff in post (for sample as a whole)

Main staff group	England and Wales	Scotland
	(in the year to 31 March 2005)	(in the year to 30 September 2004)
Nurses	13.5%	12.2%
AHPs	17.3%	14.6%
ST&T	14.9%	10.1%
Ambulance	11.1%	12.5%

Staff joining Trusts as a proportion of staff in post in the year to 31 March (Matched sample)

Main staff group	England and Wales only	
	2004	2005
Nurses	15.5%	13.9%
AHPs	20.0%	17.1%
ST&T	16.9%	15.0%
Ambulance	9.1%	10.5%

##### Retention

Turnover rates and wastage (sample as a whole)

Main staff group	England and Wales		Scotland	
	(in the year to 31 March 2005)		(in the year to 30 September 2004)	
	Turnover	Wastage	Turnover	Wastage
Nurses	11.5%	9.1%	11.2%	–
AHPs	13.4%	10.1%	12.0%	–
ST&T	12.8%	10.2%	8.4%	–
Ambulance	5.4%	3.5%	11.3%	–

– not available

Turnover rates and wastage in the year to 31 March (Matched sample)

	England and Wales only			
	Turnover		Wastage	
	2004	2005	2004	2005
Nurses	12.0%	11.3%	10.0%	9.0%
AHPs	14.6%	13.6%	11.6%	9.6%
ST&T	12.1%	13.0%	10.2%	10.4%
Ambulance	6.9%	5.7%	5.0%	3.0%

Turnover rates and wastage in the year to 31 March, by selected occupational groups (Matched sample)

	England and Wales only			
	Turnover		Wastage	
	2004	2005	2004	2005
Midwives	10.9%	8.1%	9.0%	6.4%
Health Visitors	12.0%	10.3%	10.3%	8.9%
District Nurses	10.6%	10.3%	8.5%	8.1%
Other general 1st and 2nd level registered	11.5%	11.1%	9.1%	8.2%
Nurse consultants, managers, school nurses	10.9%	9.3%	8.3%	6.9%
Nurse auxiliaries and assistants	13.5%	12.5%	12.1%	11.3%
Dietetics	16.2%	16.1%	11.0%	9.0%
Occupational therapy	18.2%	17.4%	13.6%	12.0%
Physiotherapy	16.9%	15.8%	13.7%	11.9%
Diagnostic radiography	10.6%	8.9%	8.5%	5.8%
Therapeutic radiography	10.1%	14.0%	8.3%	11.9%



90 **Table 1**

Summary of joiners in the year to 31 March: WTE and as a percentage of staff in post<sup>(a)</sup> by country, region and London Weighting Zone  
All nursing staff

	Joiners in the year to 31 March												Staff in post at 31 March	
	Newly qualified <sup>(b)</sup>		Transfers from within NHS		Re-entrants		Other		Don't know		Total joining		2004 WTE	2005 WTE
	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 WTE	2005 WTE
Total	1.2	1.5	2.9	3.3	0.5	0.4	4.1	4.3	6.3	4.5	15.5	13.9	146,772	155,886
<b>By country/region</b>														
Wales	0.2	2.6	0.6	1.4	0.1	0.2	0.4	1.7	10.2	5.8	11.5	11.7	12,934	13,378
England	1.3	1.3	3.1	3.5	0.6	0.5	4.5	4.5	5.9	4.4	15.9	14.1	133,838	142,508
– North East	1.5	1.7	3.3	4.4	1.0	0.5	4.8	3.4	1.6	0.9	12.3	10.9	9,733	9,939
– North West	1.8	1.3	4.8	4.1	0.4	0.4	4.6	3.6	0.9	1.4	12.5	10.9	17,071	18,254
– Yorkshire and the Humber	1.5	1.7	2.4	2.7	0.5	0.2	4.0	2.5	5.4	5.3	13.8	12.4	13,072	15,612
– East Midlands	1.3	0.7	5.6	5.0	1.1	1.1	3.7	2.2	5.3	6.5	17.0	15.6	12,842	13,420
– West Midlands	1.1	0.8	1.7	2.8	0.1	0.1	2.9	5.5	10.7	5.0	16.6	14.3	25,123	26,391
– East	0.6	1.4	1.9	2.3	0.4	0.3	2.4	5.0	13.6	11.1	18.9	20.1	8,684	9,654
– London	1.3	1.7	3.3	4.3	1.0	0.8	6.9	6.8	4.2	3.4	20.0	17.0	22,193	24,101
– South East	1.2	1.5	2.2	2.8	0.5	0.5	5.6	5.1	4.6	2.7	14.1	12.6	20,000	19,725
– South West	1.2	1.7	2.9	1.7	0.1	0.1	3.3	2.3	9.4	7.9	16.9	13.6	5,120	5,413
<b>By London Weighting Zone</b>														
Inner London	1.2	1.9	3.6	3.3	1.1	0.9	8.1	7.7	3.9	3.3	22.6	17.1	13,038	14,889
Outer London	1.5	1.3	2.9	5.8	0.9	0.7	5.2	5.4	5.1	3.9	16.5	17.2	9,306	9,381
London Fringe zone	0.5	0.6	2.1	5.3	0.3	0.1	3.7	4.4	5.1	4.8	11.7	15.3	3,697	2,589
Rest of Great Britain	1.2	1.4	2.8	3.0	0.4	0.4	3.6	3.8	6.7	4.6	14.8	13.3	120,731	129,028

(a) All figures have been rounded independently, and percentages have been calculated from unrounded figures

(b) For nursing auxiliaries and assistants, an entrant direct from full-time or part-time education

\* Indicates that less than 0.5 but greater than 0

– Indicates 0

**Table 2**

Leavers in the year to 31 March: WTE and as a percentage of staff in post<sup>(a)</sup> by country, region and London Weighting Zone  
All nursing staff

Leavers in the year to 31 March																
	Retirement		Transfers to other NHS units		To non-NHS employment <sup>(b)</sup>		Other		Don't know		Total leaving		Wastage rate <sup>(c)</sup>		Staff in post at 31 March	
	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 WTE	2005 WTE
Total	1.1	1.1	2.1	2.3	0.8	0.9	3.3	3.0	4.3	4.1	12	11.3	10.0	9.0	146,772	155,886
<i>By country/region</i>																
Wales	0.4	0.7	1.1	1.2	0.4	0.5	0.8	0.5	5.7	5.8	8.3	8.6	7.2	7.4	12,934	13,378
England	1.2	1.1	2.2	2.4	0.9	0.9	3.6	3.2	4.2	4.0	12.4	11.6	10.2	9.2	133,838	142,508
– North East	1.0	1.1	2.6	3.2	1.4	1.2	1.9	2.3	1.6	1.8	8.5	9.6	5.9	6.4	9,733	9,939
– North West	1.4	1.3	2.8	2.6	1.1	1.0	2.6	2.3	2.0	2.3	9.9	9.6	7.1	7.0	17,071	18,254
– Yorkshire and the Humber	1.1	1.1	2.1	3.2	1.6	0.6	3.3	3.1	4.3	3.3	12.4	11.4	10.2	8.1	13,072	15,612
– East Midlands	1.1	1.2	2.6	2.1	0.7	0.9	2.4	1.5	4.6	6.1	11.3	11.8	8.8	9.8	12,842	13,420
– West Midlands	1.4	0.8	1.1	1.9	0.3	0.6	5.5	3.4	4.1	4.6	12.3	11.4	11.3	9.5	25,123	26,391
– East	0.6	0.5	2.0	2.5	0.5	0.4	1.1	2.6	9.5	6.5	13.7	12.4	11.7	9.9	8,684	9,654
– London	1.2	1.3	2.0	2.4	0.7	1.3	5.4	4.5	3.9	4.1	15.5	13.7	13.5	11.3	22,193	24,101
– South East	1.0	1.3	2.9	2.0	1.4	1.0	2.9	4.5	5.0	3.0	13.3	11.8	10.4	9.8	20,000	19,725
– South West	1.5	1.1	1.9	1.6	0.5	0.7	2.8	2.4	5.4	5.2	12.1	10.9	10.2	9.4	5,120	5,413
<i>By London Weighting Zone</i>																
Inner London	0.9	1.0	1.5	2.2	0.4	1.4	6.9	4.6	3.5	3.7	16.5	12.9	15.0	10.6	13,038	14,889
Outer London	1.4	1.9	2.7	2.7	1.1	1.2	3.3	4.3	4.8	5.0	14.4	15.1	11.6	12.4	9,306	9,381
London Fringe zone	1.7	2.1	6.3	2.6	0.9	2.4	3.7	5.4	7.1	2.9	19.8	15.4	13.5	12.8	3,697	2,589
Rest of Great Britain	1.1	1.0	1.9	2.2	0.9	0.7	2.9	2.7	4.3	4.1	11.1	10.8	9.2	8.5	120,731	129,028

(a) All figures have been rounded independently, and percentages have been calculated from unrounded figures

(b) Leavers who take up appointments in the non-NHS health-care sector, including private hospitals and clinics, residential and nursing homes, health-related education, etc.

(c) Total leaving excluding transfers to other NHS units as a percentage of staff in post

\* Indicates that less than 0.5 but greater than 0

– Indicates 0

Table 3

Summary of joiners in the year to 31 March: WTE and as a percentage of staff in post<sup>(a)</sup> by country, region and London Weighting Zone  
All AHP staff

	Joiners in the year to 31 March												Staff in post at 31 March	
	Newly qualified		Transfers from within NHS		Re-entrants		Other		Don't know		Total joining		2004 WTE	2005 WTE
	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 WTE	2005 WTE
Total	2.4	2.5	3.6	4.3	0.6	0.4	4.1	4.4	8.7	5.5	20.0	17.1	17,654	19,827
<i>By country/region</i>														
Wales	1.6	3.5	1.9	2.5	0.2	0.4	0.1	2.2	11.9	5.4	15.8	14.0	1,561	1,652
England	2.5	2.4	3.8	4.4	0.7	0.4	4.5	4.6	8.4	5.5	20.4	17.4	16,093	18,174
– North East	5.8	4.5	4.3	6.2	0.6	1.1	5.0	3.8	1.4	1.1	17.1	16.7	1,022	1,138
– North West	3.5	3.5	7.8	5.2	0.7	0.3	5.0	2.3	1.8	3.5	18.7	14.8	2,338	2,468
– Yorkshire and the Humber	4.9	3.6	3.7	3.7	0.4	0.2	3.4	3.8	3.1	3.6	15.5	14.9	1,764	2,217
– East Midlands	3.0	2.6	4.5	5.3	0.9	0.8	3.5	1.9	7.2	5.6	19.2	16.2	1,721	1,823
– West Midlands	1.3	1.1	1.9	3.7	0.1	0.2	2.9	6.0	12.5	6.0	19.5	17.1	2,641	3,109
– East	0.8	0.8	0.4	1.1	0.1	–	1.8	2.8	19.0	13.6	22.1	18.2	1,326	1,573
– London	1.2	1.9	4.1	6.5	1.6	0.8	7.8	9.9	11.1	3.7	28.6	22.9	2,497	2,693
– South East	1.7	2.1	2.5	3.4	0.7	0.3	5.2	4.2	9.0	5.8	19.1	15.9	2,100	2,375
– South West	2.6	2.4	4.1	4.6	0.7	0.4	3.7	2.2	9.0	11.7	20.2	21.2	686	779
<i>By London Weighting Zone</i>														
Inner London	1.4	2.7	5.1	5.3	1.7	1.1	8.6	11.7	11.7	3.1	31.2	23.8	1,464	1,565
Outer London	0.9	0.8	2.7	7.2	1.6	0.5	6.7	6.5	10.4	6.8	25.0	21.8	1,033	1,282
London Fringe zone	0.8	2.8	3.3	4.2	0.2	0.3	2.7	7.3	10.5	2.3	17.5	16.9	473	436
Rest of Great Britain	2.7	2.6	3.5	3.9	0.5	0.4	3.5	3.4	8.2	5.8	18.6	16.1	14,684	16,544

(a) All figures have been rounded independently, and percentages have been calculated from unrounded figures

\* Indicates that less than 0.5 but greater than 0

– Indicates 0

**Table 4**

Leavers in the year to 31 March: WTE and as a percentage of staff in post<sup>(a)</sup> by country, region and London Weighting Zone  
All AHP staff

Leavers in the year to 31 March																
	Retirement		Transfers to other NHS units		To non-NHS employment <sup>(b)</sup>		Other		Don't know		Total leaving		Wastage rate <sup>(c)</sup>		Staff in post at 31 March	
	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 WTE	2005 WTE
Total	1.2	0.9	2.9	3.5	1.3	1.3	4.3	3.1	4.9	4.5	14.9	13.4	12.0	9.9	17,654	19,827
<i>By country/region</i>																
Wales	0.3	0.5	1.2	1.7	0.8	0.7	0.8	1.2	4.2	4.6	7.4	8.7	6.2	7.0	1,561	1,652
England	1.3	0.9	3.1	3.7	1.4	1.4	4.6	3.3	4.9	4.5	15.6	13.8	12.5	10.1	16,093	18,174
– North East	0.4	0.7	4.0	4.5	2.3	1.5	2.5	2.5	1.3	1.2	10.6	10.4	6.6	5.8	1,022	1,138
– North West	1.2	0.9	4.0	4.2	1.7	1.2	4.4	2.9	2.2	2.3	13.5	11.4	9.4	7.3	2,338	2,468
– Yorkshire and the Humber	0.7	1.3	3.6	4.3	2.4	2.0	3.1	3.4	3.0	2.8	12.7	13.8	9.1	9.4	1,764	2,217
– East Midlands	1.0	0.8	3.3	3.0	1.4	2.0	2.1	1.5	6.5	5.9	14.2	13.2	10.9	10.2	1,721	1,823
– West Midlands	3.1	1.3	2.1	4.3	0.5	0.8	6.1	2.8	3.4	4.3	15.2	13.5	13.1	9.1	2,641	3,109
– East	0.6	0.3	1.7	1.2	0.7	1.8	1.5	1.6	11.1	8.9	15.6	13.9	13.9	12.7	1,326	1,573
– London	0.7	0.7	3.6	4.7	1.9	1.8	8.2	5.3	6.2	5.4	23.0	17.9	19.4	13.2	2,497	2,693
– South East	1.3	1.2	2.7	2.9	0.9	0.9	4.0	4.8	6.5	4.6	15.4	14.4	12.7	11.5	2,100	2,375
– South West	1.0	1.0	2.1	2.6	0.4	0.9	7.0	4.0	5.3	5.6	15.8	14.0	13.8	11.4	686	779
<i>By London Weighting Zone</i>																
Inner London	0.7	0.8	2.9	4.3	2.3	1.9	10.6	6.6	5.3	5.5	24.7	19.1	21.8	14.8	1,464	1,565
Outer London	0.7	0.5	4.6	4.5	1.3	1.4	4.8	3.0	7.6	6.7	20.7	16.2	16.1	11.7	1,033	1,282
London Fringe zone	1.7	2.0	5.5	3.1	2.0	3.9	4.9	2.2	8.7	5.5	22.7	16.8	17.2	13.6	473	436
Rest of Great Britain	1.2	0.9	2.7	3.4	1.2	1.2	3.6	2.8	4.5	4.2	13.2	12.6	10.5	9.2	14,684	16,544

(a) All figures have been rounded independently, and percentages have been calculated from unrounded figures

(b) Leavers who take up appointments in the non-NHS health-care sector, including private hospitals and clinics, residential and nursing homes, health-related education, etc.

(c) Total leaving excluding transfers to other NHS units as a percentage of staff in post

\* Indicates that less than 0.5 but greater than 0

– Indicates 0

Table 5

Summary of joiners in the year to 31 March: WTE and as a percentage of staff in post<sup>(a)</sup> by country, region and London Weighting Zone  
All other scientific, therapeutic and technical staff

	Joiners in the year to 31 March												Staff in post at 31 March	
	Newly qualified		Transfers from within NHS		Re-entrants		Other		Don't know		Total joining		2004 WTE	2005 WTE
	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 WTE	2005 WTE
Total	0.7	0.7	2.9	3.3	0.5	0.4	4.6	5.4	7.9	5.2	16.9	15.0	25,095	26,822
<i>By country/region</i>														
Wales	0.4	0.6	1.4	3.2	*	0.1	1.1	3.8	11.2	4.8	14.2	12.6	2,100	2,154
England	0.7	0.7	3.0	3.3	0.5	0.4	5.0	5.6	7.6	5.2	17.2	15.2	22,995	24,669
– North East	2.3	1.1	4.6	4.3	0.5	0.3	4.3	5.1	1.4	1.4	13.1	12.2	1,236	1,285
– North West	1.3	1.2	6.6	4.8	1.0	0.4	4.5	3.6	3.1	2.6	16.6	12.6	2,614	2,760
– Yorkshire and the Humber	1.8	1.2	2.0	2.4	0.2	0.1	5.0	4.8	5.8	3.2	14.8	11.7	2,681	2,934
– East Midlands	0.6	0.1	1.7	2.1	0.5	1.0	4.0	1.5	8.9	7.6	15.7	12.3	2,044	2,333
– West Midlands	0.2	0.3	2.4	3.4	0.1	0.1	3.1	6.0	11.2	5.8	17.0	15.7	4,290	4,462
– East	0.4	0.3	0.9	1.5	*	0.1	3.5	4.4	13.5	11.9	18.4	18.1	1,666	1,973
– London	0.6	1.1	3.9	5.1	1.5	1.0	7.9	9.1	8.5	3.9	24.8	20.2	3,768	4,526
– South East	0.2	0.6	1.7	2.8	0.4	0.1	5.7	6.9	5.3	4.1	13.3	14.5	3,572	3,130
– South West	0.2	0.3	3.7	1.5	0.4	0.3	5.3	4.0	7.7	9.9	17.4	16.1	1,125	1,266
<i>By London Weighting Zone</i>														
Inner London	0.6	1.4	4.0	4.6	1.4	1.1	9.0	10.1	8.9	3.7	26.4	20.8	2,391	3,054
Outer London	0.7	0.6	3.7	5.9	1.7	0.6	6.0	7.1	8.2	4.6	22.1	18.7	1,411	1,506
London Fringe zone	1.0	0.8	4.1	4.6	–	–	6.4	2.2	6.3	8.4	17.9	15.9	382	493
Rest of Great Britain	0.7	0.6	2.7	3.0	0.3	0.3	4.0	4.7	7.8	5.4	15.5	13.9	20,911	21,768

(a) All figures have been rounded independently, and percentages have been calculated from unrounded figures

Columns may not add to the total joining/leaving, as some Trusts were unable to provide detailed breakdowns

\* Indicates that less than 0.5 but greater than 0

– Indicates 0

**Table 6**

Leavers in the year to 31 March: WTE and as a percentage of staff in post<sup>(a)</sup> by country, region and London Weighting Zone  
**All other scientific, therapeutic and technical staff**

Leavers in the year to 31 March																
	Retirement		Transfers to other NHS units		To non-NHS employment <sup>(b)</sup>		Other		Don't know		Total leaving		Wastage rate <sup>(c)</sup>		Staff in post at 31 March	
	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 %	2005 %	2004 WTE	2005 WTE
Total	0.7	1.6	1.9	2.5	1.1	1.2	4.0	3.6	3.9	4.1	12.1	13.0	10.2	10.4	25,095	26,822
<i>By country/region</i>																
Wales	0.4	0.4	0.7	1.9	1.8	1.2	2.2	1.8	4.2	3.8	9.4	9.0	8.7	7.1	2,100	2,154
England	0.7	1.7	2.1	2.6	1.1	1.2	4.2	3.7	3.8	4.1	12.4	13.3	10.3	10.7	22,995	24,669
– North East	1.1	1.2	3.0	3.8	2.1	1.1	2.7	3.8	1.2	2.0	10.1	11.8	7.0	8.0	1,236	1,285
– North West	1.1	1.1	3.1	3.3	1.5	1.1	4.5	2.9	1.5	3.0	11.7	11.5	8.6	8.1	2,614	2,760
– Yorkshire and the Humber	0.9	1.7	1.8	1.9	1.7	2.0	5.1	3.8	2.1	2.4	11.6	11.9	9.8	10.0	2,681	2,934
– East Midlands	0.4	1.0	1.4	2.0	1.1	0.9	1.5	1.0	4.9	6.4	9.2	11.3	7.8	9.3	2,044	2,333
– West Midlands	0.6	5.2	1.2	2.0	0.3	0.8	7.0	4.7	3.2	3.7	12.3	16.4	11.1	14.3	4,290	4,462
– East	0.5	0.2	0.8	4.6	0.3	0.5	1.3	1.5	7.2	6.7	10.2	13.5	9.4	8.9	1,666	1,973
– London	0.5	0.6	3.8	3.4	1.1	1.3	5.5	5.0	4.5	5.0	18.7	15.3	14.8	11.9	3,768	4,526
– South East	0.8	1.0	1.6	1.5	1.5	1.9	2.2	4.9	4.9	3.1	10.9	12.5	9.3	10.9	3,572	3,130
– South West	1.3	0.7	1.2	1.0	0.5	0.4	2.5	2.6	5.5	4.9	11.1	9.6	9.9	8.6	1,125	1,266
<i>By London Weighting Zone</i>																
Inner London	0.4	0.7	4.4	3.3	0.6	1.6	6.3	5.1	4.2	5.0	20.3	15.7	15.9	12.4	2,391	3,054
Outer London	0.7	0.5	2.8	3.6	1.8	0.5	4.0	4.8	5.2	5.2	15.8	14.5	13.0	10.9	1,411	1,506
London Fringe zone	2.1	1.8	4.3	2.5	1.7	1.6	3.2	2.1	6.4	6.3	17.8	14.3	13.5	11.8	382	493
Rest of Great Britain	0.7	1.8	1.6	2.4	1.1	1.2	3.7	3.3	3.7	3.8	10.8	12.4	9.3	10.1	20,911	21,768

(a) All figures have been rounded independently, and percentages have been calculated from unrounded figures

(b) Leavers who take up appointments in the non-NHS health-care sector, including private hospitals and clinics, residential and nursing homes, health-related education, etc.

(c) Total leaving excluding transfers to other NHS units as a percentage of staff in post

\* Columns may not add to the total joining/leaving, as some Trusts were unable to provide detailed breakdowns

– Indicates that less than 0.5 but greater than 0

– Indicates 0

## APPENDIX G

### PREVIOUS REPORTS OF THE REVIEW BODY

#### NURSING STAFF, MIDWIVES AND HEALTH VISITORS

First Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9258, June 1984
Second Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9529, June 1985
Third Report on Nursing Staff, Midwives and Health Visitors	Cmnd. 9782, May 1986
Fourth Report on Nursing Staff, Midwives and Health Visitors	Cm. 129, April 1987
Fifth Report on Nursing Staff, Midwives and Health Visitors	Cm. 360, April 1988
Sixth Report on Nursing Staff, Midwives and Health Visitors	Cm. 577, February 1989
Supplement to Sixth Report on Nursing Staff, Midwives and Health Visitors: Nursing and Midwifery Educational Staff	Cm. 737, July 1989
Seventh Report on Nursing Staff, Midwives and Health Visitors	Cm. 934, February 1990
First Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives	Cm. 1165, August 1990
Second Supplement to Seventh Report on Nursing Staff, Midwives and Health Visitors: Senior Nurses and Midwives	Cm. 1386, December 1990
Eighth Report on Nursing Staff, Midwives and Health Visitors	Cm. 1410, January 1991
Ninth Report on Nursing Staff, Midwives and Health Visitors	Cm. 1811, February 1992
Report on Senior Nurses and Midwives	Cm. 1862, March 1992
Tenth Report on Nursing Staff, Midwives and Health Visitors	Cm. 2148, February 1993
Eleventh Report on Nursing Staff, Midwives and Health Visitors	Cm. 2462, February 1994
Twelfth Report on Nursing Staff, Midwives and Health Visitors	Cm. 2762, February 1995
Thirteenth Report on Nursing Staff, Midwives and Health Visitors	Cm. 3092, February 1996
Fourteenth Report on Nursing Staff, Midwives and Health Visitors	Cm. 3538, February 1997
Fifteenth Report on Nursing Staff, Midwives and Health Visitors	Cm. 3832, January 1998
Sixteenth Report on Nursing Staff, Midwives and Health Visitors	Cm. 4240, February 1999
Seventeenth Report on Nursing Staff, Midwives and Health Visitors	Cm. 4563, January 2000
Eighteenth Report on Nursing Staff, Midwives and Health Visitors	Cm. 4991, December 2000
Nineteenth Report on Nursing Staff, Midwives and Health Visitors	Cm. 5345, December 2001

#### PROFESSIONS ALLIED TO MEDICINE

First Report on Professions Allied to Medicine	Cmnd. 9257, June 1984
Second Report on Professions Allied to Medicine	Cmnd. 9528, June 1985
Third Report on Professions Allied to Medicine	Cmnd. 9783, May 1986
Fourth Report on Professions Allied to Medicine	Cm. 130, April 1987
Fifth Report on Professions Allied to Medicine	Cm. 361, April 1988
Sixth Report on Professions Allied to Medicine	Cm. 578, February 1989
Seventh Report on Professions Allied to Medicine	Cm. 935, February 1990

Eighth Report on Professions Allied to Medicine	Cm. 1411, January 1991
Ninth Report on Professions Allied to Medicine	Cm. 1812, February 1992
Tenth Report on Professions Allied to Medicine	Cm. 2149, February 1993
Eleventh Report on Professions Allied to Medicine	Cm. 2463, February 1994
Twelfth Report on Professions Allied to Medicine	Cm. 2763, February 1995
Thirteenth Report on Professions Allied to Medicine	Cm. 3093, February 1996
Fourteenth Report on Professions Allied to Medicine	Cm. 3539, February 1997
Fifteenth Report on Professions Allied to Medicine	Cm. 3833, January 1998
Sixteenth Report on Professions Allied to Medicine	Cm. 4241, February 1999
Seventeenth Report on Professions Allied to Medicine	Cm. 4564, January 2000
Eighteenth Report on Professions Allied to Medicine	Cm. 4992, December 2000
Nineteenth Report on Professions Allied to Medicine	Cm. 5346, December 2001

### **NURSING STAFF, MIDWIVES, HEALTH VISITORS AND PROFESSIONS ALLIED TO MEDICINE**

Twentieth Report on Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine	Cm. 5716, August 2003
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## APPENDIX H

*From the Rt Hon Patricia Hewitt MP  
Secretary of State for Health*



*Richmond House  
79 Whitehall  
London  
SW1A 2NS*

*Tel: 020 7210 3000*

IMC 40515

Professor Gillian Morris  
Chair of Nurses and Other Health Professions Pay Review Body  
Office of Manpower Economics  
7<sup>th</sup> Floor Oxford House  
76 Oxford Street  
London  
W1D 1BS

19<sup>th</sup> December 2005

*Dear Professor Morris,*

I would like to thank you once again for giving me the opportunity to speak to the Review Body on the 6<sup>th</sup> December. As promised at the session I am writing to confirm our position and to provide you with the additional data used during my presentation.

First, let me confirm our continuing commitment to all those nurses and other health professions in your remit group. Agenda for Change, supported by the NHS job evaluation scheme, promises fair pay for all non-medical staff based on the principle of equal pay for work of equal value.

Secondly, I would point to the many positives in our evidence. For example, we have over 78,000 more nurses since 1997, vacancy rates down 2.6% from March 2004 and according to the NHS Staff survey improving staff morale.

In our written evidence we recommended an award of "no more than 2.5%" based upon an above inflation rise of 10% over the past 3 years and implementing Agenda for Change, which we estimated was worth on average an extra 2.3% in earnings for the period October 2004 to October 2005.

In supplementary written evidence, we said that we were reviewing the appropriateness and affordability of this in the light of emerging evidence that Agenda for Change was proving more beneficial to staff than expected, but also more expensive. I presented further information on this at the oral evidence session and as promised, I attach a table with the details on these costs.

We now estimate that on a comparable basis the increase in earnings from Agenda for Change in the first 12 months were actually 2.8%, an excess of around £120 million or 0.5% of the estimated Agenda for Change pay bill of £22.8 billion in 2004-05.

In addition, most staff have benefitted from more leave, and some have benefitted from shorter hours. These benefits were originally estimated to cost 0.6 % of pay bill, but are now estimated to cost somewhere between 1.1% and 1.8% per annum, an excess of between 0.5% and 1.2% of pay bill - £100 million and £270 million in cash.

This gives a total excess cost on Agenda for Change of between £220 million and £390 million, around 1% and 1.7% of the Agenda for Change pay bill. Of this total 0.5% will feed through into higher than expected earnings per head, and the rest into hiring more staff to replace extra leave and shorter hours.

In 2004/5, around 170 NHS organisations finished the year with a combined deficit of £760m. Overall, the NHS finished the year in deficit by £250m. Unfortunately, it has become clear that a significant minority of NHS organisations are continuing to struggle to achieve financial balance this year and it is likely that a number will again finish the year in deficit. These deficits will be the first call on resources next year and therefore will impact on the affordability of pay awards. The issue of deficits is a real problem and one that we would ask you to take into account in your recommendations.

The pay of nurses and other health professions outside medicine amounts to around one third of NHS costs, consequently, one of the major factors contributing to deficits is likely to be the additional, unplanned cost of Agenda for Change. As a result, several trusts have imposed recruitment freezes and some are threatening redundancies.

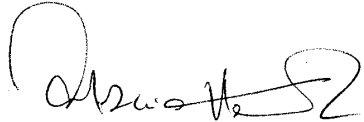
As the Chancellor made clear in his letter to all Review Body Chairs on the 23<sup>rd</sup> November, there is concern that the recent short term increase in inflation, caused mainly by oil price rises, could become locked-in if employers respond with higher wage rises. In his Pre Budget Report on the 5<sup>th</sup> November the Chancellor re-iterated that the UK is on course to meet its inflation target of 2%.

Against this background, I considered carefully what is reasonable for staff and what part pay should play in bringing the NHS back into financial balance. Our proposal of "no more than 2.5%" was based upon the planned costs of Agenda for Change, which in themselves represented a significant pay increase for staff. We now know that Agenda for Change has been worth more to staff than this.



I would therefore ask you on the grounds of last year's outturn, affordability, and the need to keep to the Chancellors inflation target to consider a recommendation as close as possible to 2% for 2006/07.

*Yours sincerely,*



**PATRICIA HEWITT**



## APPENDIX I

### GLOSSARY

<b>AEI</b>	Average Earnings Index
<b>AHPs</b>	Allied Health Professions
<b>ASHE</b>	Annual Survey of Hours and Earnings
<b>BOS</b>	British Orthoptic Society
<b>CPD</b>	Continuing Professional Development
<b>CPI</b>	Consumer Prices Index
<b>CSP</b>	The Chartered Society of Physiotherapy
<b>DDRB</b>	The Doctors' and Dentists' Review Body
<b>DELs</b>	Departmental Expenditure Limits
<b>Department</b>	The Department of Health
<b>EI sites</b>	Early Implementer sites (for Agenda for Change)
<b>EU</b>	European Union
<b>FCS</b>	The Federation of Clinical Scientists
<b>FTE</b>	Full Time Equivalent
<b>GDP</b>	Gross Domestic Product
<b>HC</b>	Headcount
<b>HCA</b>	High Cost Areas
<b>HCAS</b>	High Cost Area Supplements
<b>Health Departments</b>	The Department of Health, the Scottish Executive Health Department and the National Assembly for Wales
<b>HOMs</b>	Heads of Midwifery
<b>ISTCs</b>	Independent Sector Treatment Centres
<b>IWL</b>	Improving Working Lives
<b>KSF</b>	Knowledge and Skills Framework
<b>NAW</b>	The National Assembly for Wales
<b>NESS</b>	National Employer Skills Survey
<b>NHS</b>	National Health Service
<b>NHSE</b>	NHS Employers
<b>NOHPRB</b>	Nursing and Other Health Professions Review Body
<b>PAMs</b>	Professions Allied to Medicine
<b>PBR</b>	Payment By Results

<b>PCO</b>	Primary Care Organisation
<b>PCT</b>	Primary Care Trust
<b>PNC</b>	Pay Negotiating Council
<b>ONS</b>	The Office for National Statistics
<b>RCM</b>	The Royal College of Midwives
<b>RCN</b>	The Royal College of Nurses
<b>RPI</b>	Retail Prices Index
<b>RPIX</b>	Retail Prices Index (excluding Mortgage Interest Payments)
<b>RRP</b>	Recruitment and Retention Premia
<b>Sc&amp;T</b>	Scientific and Technical staff
<b>SEHD</b>	The Scottish Executive Health Department
<b>SoR</b>	The Society of Radiographers
<b>ST&amp;T</b>	Scientific, Technical and Therapeutic professions
<b>T&amp;G</b>	The Transport and General Workers Union
<b>WTE</b>	Whole Time Equivalent



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