NHS Pay Review Body

Twenty-Fourth Report 2009

Chair: Professor Gillian Morris

Cm 7646

£19.15

NHS Pay Review Body

Twenty-Fourth Report 2009

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 Cabinet Secretary for Health and Wellbeing

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

Presented to the Northern Ireland Assembly by the First Minister,
Deputy First Minister and the Minister for Health, Social Services
& Public Safety

by Command of Her Majesty
July 2009

Cm 7646 £19.15

ISBN: 9780101764629

NHS Pay Review Body

The NHS Pay Review Body (NHSPRB) is independent. Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing in Scotland, the First Minister and the Minister for Health and Social Services in the National Assembly for Wales, and the First Minister, Deputy First Minster and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive, on the remuneration of all staff paid under Agenda for Change (AfC) and employed in the National Health Service (NHS)*.

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 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 overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

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, Trades Unions, representatives of NHS employers 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 Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing in Scotland, the First Minister and the Minister for Health and Social Services of the National Assembly for Wales, and the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive.

* References to the NHS should be read as including all staff on AfC in personal and social care service organisations in Northern Ireland.

Members of the Review Body are:

Professor Gillian Morris (Chair)
Mr Philip Ashmore
Mrs Lucinda Bolton
Professor Richard Disney
Mr John Galbraith
Professor Alan Manning
Mr Ian McKay
Ms Sharon Whitlam

The secretariat is provided by the Office of Manpower Economics.

Contents

Summary of Recommendations and Main Conclusions

Since we last reported in April 2008, the parties reached an agreement on a three-year pay deal. We are content that the pay uplift of 2.75 per cent in 2008/09, as recommended in our Twenty-Third Report, was implemented in full, and we agreed to continue to gather evidence throughout the period of the parties' agreement. We received and analysed evidence from the parties in the autumn of 2008 and concluded that we would not seek a remit from the Secretary of State to review the pay settlement contained in the agreement between the parties for 2009/10, but that we would undertake a further review in the autumn of 2009 to consider whether to seek a remit from the Secretary of State to review the agreed pay settlement for 2010/11. We also received new applications for national recruitment and retention premia (RRPs) for midwives and building craft workers but concluded that we should not request a remit in relation to these applications on this occasion. A copy of our conclusions can be found at Appendix B to this Report.

We are pleased to present our recommendations on matters arising from our Twenty-Third Report and other matters relevant to our remit. We have carefully reviewed all the evidence we have received, and in arriving at our recommendations we have had regard to the considerations set out in our standing terms of reference detailed on page iii. The key issues and recommendations are summarised below.

National recruitment and retention premia

We have sought to clarify with the parties our role in awarding new national RRPs. We agree with the parties that the term 'national' in the context of the provisions of the Agenda for Change (AfC) Handbook means UK-wide. We also continue to hold the view, set out in paragraph 4.19 of our Twenty-First Report, that we may recommend national RRPs with local differentiation to reflect geographical variation in the underlying problem. The parties did not dispute this interpretation of the AfC Agreement prior to or following our Twenty-First Report and the Department of Health, NHS Employers and Unite have confirmed, in their evidence for this Report, that they share it.

We do not agree with the view of the Department of Health that, for a new national RRP to be recommended, we would have to be satisfied that there are problems across all employers in the UK. This argument is inconsistent with the express provision in AfC for guidance to employers on the appropriate level of payment where the underlying problem is considered to vary across the country.

We do not agree with the view of the Department of Health and the Health Departments for the Devolved Administrations that there must be clear and robust evidence of a recruitment and retention difficulty across all four countries in the UK. The AfC Handbook refers in paragraph 5.3 to 'national recruitment and retention pressures', which, interpreting 'national' to mean UK, means recruitment and retention pressures in the UK. The requirement that these pressures should exist in all four countries is nowhere mentioned in the Agreement or the Handbook. **We have concluded, therefore, that in considering whether a UK-wide RRP is justified the evidence should be assessed on a UK-wide basis.**

Local recruitment and retention premia

There is little hard evidence on the usage of local RRPs in England; it is clear that more work is needed in this area to provide a reliable picture. We therefore ask that the parties work with our secretariat to determine what future research can be conducted, and that the Department of Health and the NHS Information Centre work together to examine whether the Electronic Staff Record HR system has the potential to record data on the usage of local RRPs on a

consistent and accurate basis. We also request that the Department of Health and NHS Employers share with us their guidance to Trusts on the application of local RRPs when it becomes available.

National recruitment and retention premium for pharmacists

In our last Report, we asked the parties to address the problem relating to the retention of pharmacists before the next Review Body round and to reach a workable solution. We asked the parties to report back to us on progress, with a view to us considering the making of a formal recommendation this year if we believed insufficient progress had been made.

The parties reported that they had met to discuss proposals and consider research undertaken on behalf of the pharmacists' working group. There appears to be a consensus among the parties that the difficulties in recruiting and retaining pharmacists are concentrated in bands 6 and 7, but in our view progress in agreeing a workable solution has been too slow.

The lack of urgency in agreeing a solution to the shortage of pharmacists in the NHS carries considerable risks, including further detriment to service delivery and staff morale. We consider that action needs to be taken in the short term to address the problem of recruitment and retention of pharmacists in the NHS, and that a national RRP is the appropriate mechanism. This approach allows the parties time to consider longer-term strategies to address the problem. We consider that the action should be primarily focused at the lower end of the pay structure for pharmacists, to provide a financial incentive for pre-registration pharmacists to remain in the NHS. We are also concerned to address the retention rate of pharmacists in the early years of their NHS careers.

We recommend a short-term national RRP for pharmacists of £5,000 at the lowest point of band 6, decreasing in stages to £500 at the sixth point of band 7. This should be implemented from 1 October 2009, and remain in place for a fixed term of 2½ years until 31 March 2012. Detailed payscales are set out in paragraph 3.77. We envisage that we will undertake a review of this national RRP in spring 2011, such that a decision can be taken as to whether it should or should not be renewed (or renewed in a modified form) after 31 March 2012.

Collection and analysis of data

It is our view that the availability of robust, timely data on our remit group is critical to our ability to make informed, evidence-based decisions on pay and other matters. We note in Chapter 2 the progress the parties have made in providing us with better data, but we consider that gaps still exist, in particular for those data relating to staff whose pay was formerly determined by the Pay Negotiating Council. Given that staff in our remit group are employed under a single set of terms and conditions of service covering all four UK countries, it is vital that we have access to data that are comparable on a UK basis. The Report specifies our requirements in this area.

We welcome the information we have received on workforce planning from the Health Departments. Having access to accurate and timely information on the conclusions of workforce planning exercises is essential for us to fulfil our function. Specifically, we would like to be kept informed of forecast shortages or surpluses of particular categories of staff within our remit group, the Health Departments' strategies for addressing them, and the effectiveness of those strategies in helping to predict and manage shortages and surpluses of individual groups.

We consider the measurement of morale and motivation of staff to be essential in our considerations and we value the data we receive from surveys of staff. However, as the questions posed to staff differ between countries, comparisons are difficult to draw. It would be helpful if the Health Departments, in consultation with other parties and our secretariat, could consider adopting a set of common 'core' questions for use in future surveys. We also urge the Staff Side to consider commissioning its own survey to gather data on staff morale to support our review of the parties' pay agreement later this year.

We repeat our request for information on how the Health Departments are progressing in developing evidence regarding the extent to which staff productivity contributes to the achievement of efficiency savings, and ask the Health Departments to collect evidence on how workload is changing from year to year.

Knowledge and Skills Framework

We are disappointed at the slow progress made by the parties in implementing the Knowledge and Skills Framework (KSF). We urge all parties to continue to give implementation of the KSF the highest priority, and report back to us on progress in the evidence for the next round.

PROFESSOR GILLIAN MORRIS *(Chair)*
MR PHILIP ASHMORE
MRS LUCINDA BOLTON
PROFESSOR RICHARD DISNEY
MR JOHN GALBRAITH
PROFESSOR ALAN MANNING
MR IAN MCKAY
MS SHARON WHITLAM

OFFICE OF MANPOWER ECONOMICS

7 April 2009

Chapter 1 – Introduction and Background

Introduction

1.1 Since we last reported in April 2008, the parties reached an agreement on a three-year pay deal[1]. The full text of the parties' agreement appears at Annex A of Appendix B to this Report. We are content that the pay uplift of 2.75 per cent in 2008/09, as recommended in our Twenty-Third Report, was implemented in full. However, we were not consulted on the pay settlement for 2009/10 or 2010/11 or on the terms under which the settlements for these two years could be reviewed, nor were we consulted on any other aspects of the agreement between the parties. Nevertheless, we agreed to undertake the work requested by the parties which is specified below.

The parties' three-year pay agreement

1.2 The Department of Health, the Scottish Government, the Welsh Assembly Government, the Northern Ireland Executive, NHS Employers and the Staff Side of the NHS Staff Council wrote to us on 27 August 2008 outlining the role the parties had agreed we would play during the period of the three-year pay agreement (2008/09, 2009/10 and 2010/11). In this letter, they advised that the negotiating parties had agreed that we would continue to play an important role during the period of the three-year agreement as set out below:

"The NHSPRB will continue to gather evidence throughout the period of this agreement. In the event that the NHSPRB receive and identify new evidence of a significant and material change in recruitment and retention and wider economic and labour market conditions, they may request a remit from the Secretary of State to review the increases set out in this agreement for 2009/10 and/or 2010/11."

1.3 We received and analysed evidence from the parties in the autumn of 2008 and concluded that we would not seek a remit from the Secretary of State to review the pay settlement contained in the agreement between the parties for 2009/10. We stated that we would undertake a further review of all the available evidence and information in the autumn of 2009 to consider whether to seek a remit from the Secretary of State to review the pay settlement contained in the agreement between the parties for 2010/11. A copy of our conclusions can be found at Appendix B, and it is also available on the OME website[2].

The scope of the Twenty-Fourth Report

1.4 The letter from the parties of 27 August 2008 referred to in paragraph 1.2 above specifically stated that:

"The parties will endeavour to provide you with information and/or evidence as identified in your 23rd report on a range of issues, covering High Cost Area Supplements (HCAS), recruitment and retention for pharmacists, efficiency savings targets and staff contribution, recruitment and retention and workforce planning, KSF implementation and benefits realisation, quality of staff and applicants and finally on morale and motivation in Scotland, Wales and Northern Ireland."

1.5 Our Twenty-Fourth Report therefore covers issues relating to these areas. We have also included discussion of some broader matters relevant to our remit, in particular of data relating to our remit group and recruitment and retention premia.

---

[1] Unite rejected a three-year settlement following a ballot of its membership.

[2] www.ome.uk.com

Parties giving evidence for the Twenty-Fourth Review

1.6 We received written and oral evidence from the following organisations:

- The four UK Health Departments and HM Treasury;
- NHS Employers;
- The NHS Staff Side (Joint Staff Side)[3];
- British Orthoptic Society;
- Chartered Society of Physiotherapy;
- Community and District Nursing Association;
- GMB;
- Royal College of Midwives;
- Royal College of Nursing;
- Society of Radiographers;
- UCATT;
- UNISON; and
- Unite

1.7 We are grateful to the parties for the evidence they have given us. The submissions made by the individual staff organisations echoed the points raised in the joint Staff Side evidence, but also raised a number of specific concerns in relation to their members.

1.8 We have briefly summarised the parties' written evidence in the relevant chapters. The detailed submissions are available from the parties whose website addresses are listed in Appendix D.

Visits made for the Twenty-Fourth Review

1.9 During summer 2008 we visited seven Trusts and Health Boards across the UK to talk to managers, staff representatives and a wide variety of staff groups. These discussions were wide-ranging and touched upon such issues as the three-year pay agreement, recruitment and retention, morale and motivation, the Knowledge and Skills Framework and training and development.

1.10 We have tried to make our visit programme as representative as possible and last year we visited organisations providing acute, mental health, community care and ambulance services. Visits are an essential part of the review process and afford us a valuable reality-check of what life is like for our remit group 'on the ground'. We wish to thank again all those involved in organising our visits, and those staff who found the time to come and tell us their views so frankly.

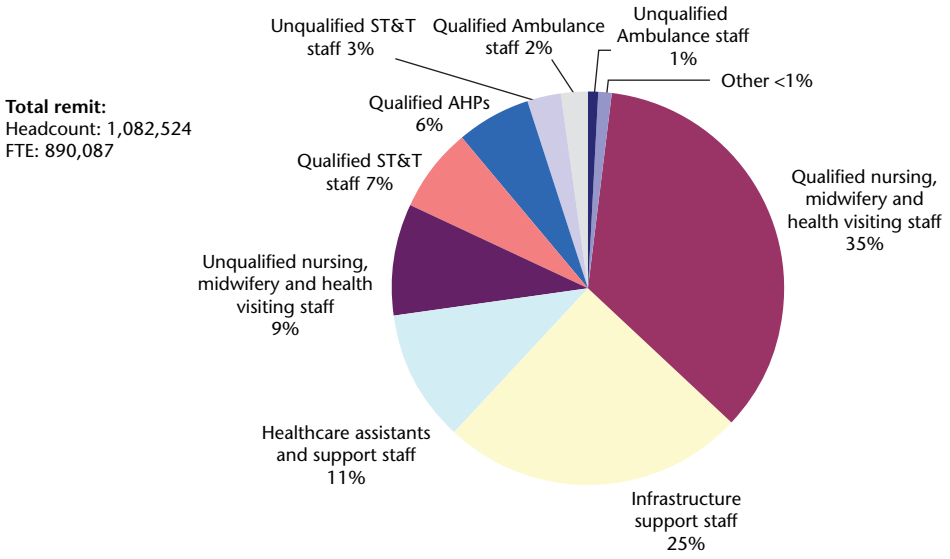
[3] The joint Staff Side evidence represents the views of the following staff side organisations: UNISON, Unite, GMB, UCATT, RCM, RCN, CSP, SoR, British Association of Occupational Therapists, SCP, Community and District Nursing Association, British Dietetic Association, Federation of Clinical Scientists and the British and Irish Orthoptic Society.

The composition of the workforce

1.11 Our remit covers around 1.3 million staff in the UK (over 1.1 million on a full-time equivalent (FTE) basis), employed in a wide range of occupations. The compositions of our remit group in England, Scotland, Wales and Northern Ireland are shown in Figures 1.1 – 1.4[4]. Data are not collected on a consistent basis in all countries, which makes UK-wide comparisons difficult to draw; we discuss this further in Chapter 2.

1.12 The largest staff groups within our remit are nursing staff (qualified and unqualified) and infrastructure support staff; these two staff groups comprise over 70 per cent of the total.

Figure 1.1: The Composition of the NHSPRB Remit Group in England by Main Staff Group (FTE), September 2007

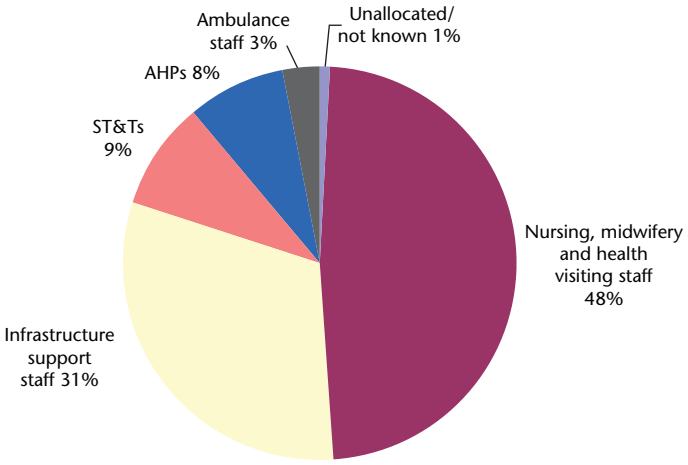


Source: NHS Information Centre, Non-Medical Workforce Census September 2007
Note: "Other" staff includes nurse learners and staff with unknown post description

[4] Percentages may not sum to 100 per cent due to rounding.

Figure 1.2: The Composition of the NHSPRB Remit Group in Scotland by Main Staff Group (FTE), September 2008

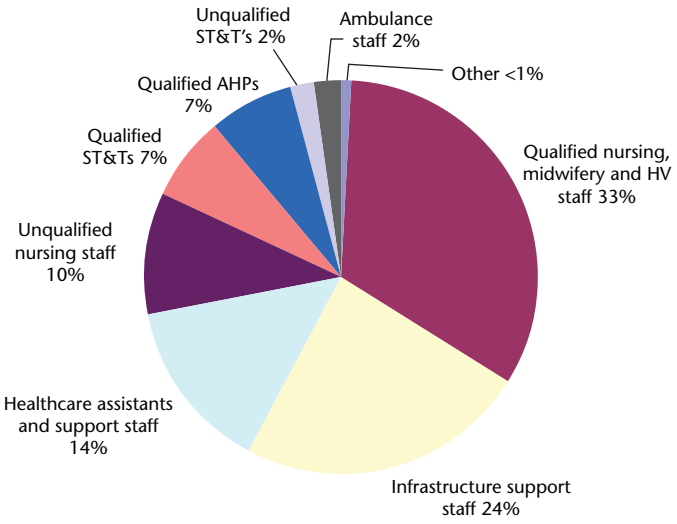
Total remit:
Headcount: 144,716
FTE: 120,287



Source: ISD Scotland, NHS Scotland Workforce Statistics 2008
Notes: 1. Data on nursing staff, AHPs, ST&Ts and ambulance staff include unqualified staff and healthcare assistants as they are not separated in the collection of such data
2. Unallocated/not known includes staff with unknown post description and/or payscale

Figure 1.3: The Composition of the NHSPRB Remit Group in Wales by Main Staff Group (FTE), September 2007

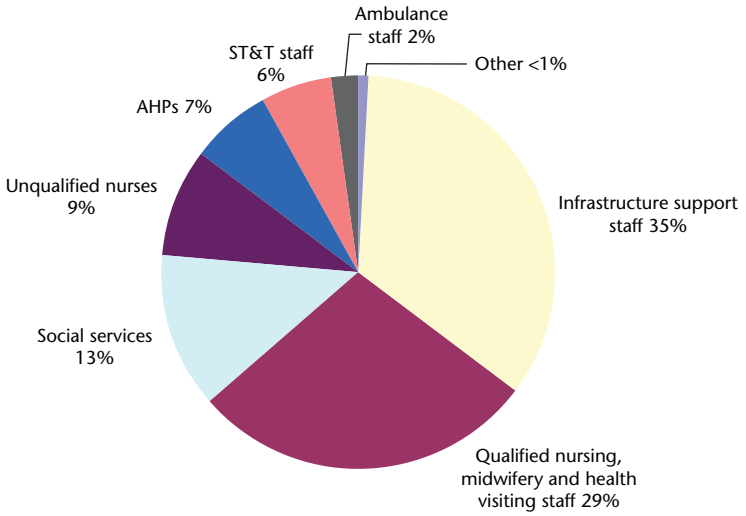
Total remit:
Headcount: 98,990
FTE: 65,099



Source: Welsh Assembly Government, Staff Directly Employed by the NHS, 30 September 2007
Notes: 1. Ambulance data include unqualified staff
2."Other" staff includes staff on general payments and those with no staff group specified

Figure 1.4: The Composition of the NHSPRB Remit Group in Northern Ireland by Main Staff Group (FTE), March 2008

Total remit:
Headcount: 56,503
FTE: 48,233



Source: Department of Health, Social Services and Public Safety, Northern Ireland
Notes: 1. Data on AHPs and ST&Ts include unqualified staff
2. Healthcare assistants are included in the data for individual professions
3. "Other" staff include those classified as generic by DHSSPSNI

Chapter 2 – Recruitment, Retention and Workforce Planning

Introduction

2.1 In our Twenty-Third Report, we asked the parties, and the Health Departments and NHS Employers in particular, to consider what evidence they could provide to demonstrate how the NHS's longer-term recruitment and retention needs for all groups of staff had been taken into account in workforce planning, and also urged the parties to provide evidence on the quality of staff and applicants. In this chapter we review the evidence from the parties on these matters, and we also review the Health Departments' statistical releases on the health workforce, including realised or imminent improvements in the quality and timeliness of data.

Data Relating to our Remit Group

Background

2.2 In our Twenty-Third Report, as part of our analysis of the recruitment and retention position for our remit group, we stated our concerns about certain aspects of the underlying data, particularly with respect to vacancies, and to those data relating to staff in our remit group whose pay was previously determined by the Pay Negotiating Council (PNC)[5]. We also highlighted the Department of Health's response to us regarding the feasibility of providing more timely data[6].

2.3 In this section, we outline the improvements made to workforce statistics since our last review, and identify the scope for further improvement.

Former PNC staff

2.4 We noted in our Twenty-Third Report that there was very little detailed workforce data on the staff in our remit group which previously came under the old PNC, in contrast to other staff groups for which data are collected and reported on at a greater level of detail below broad staff groupings. We stated that the broad categories under which data were presented were insufficient for our needs, and we asked that the Health Departments work with other parties to ensure better data in time for our next review.

2.5 The level of detail in which data on the former PNC group are collected varies between countries, and even varies between different data sources in the same country, as the table below shows.

[5] Previously two different mechanisms existed for determining the pay uplift for staff covered by the AfC pay spines: our Review Body (the Review Body for Nursing and Other Health Professions), which covered non-medical clinical staff and their support workers; and the PNC which covered all other staff on AfC terms and conditions. The parties agreed that this dual system had proved unsatisfactory because of the requirement for the pay uplift outcomes to be the same in order to maintain the integrity of the AfC pay structure. On 26 July 2007 the Secretary of State wrote to our Chair notifying her that the parties had agreed to extend the coverage of our remit to include the staff groups covered by the PNC and to change the Review Body's name to reflect the wider remit group.

[6] NHSPRB (2008) *Twenty-Third Report*, TSO (Cm 7337), Appendix F

Table 2.1: Level of detail in workforce statistics for former PNC staff by UK country[7]

Country	Categories of former PNC staff groups
England	**Census, turnover, earnings** – 4 categories: • Administrative & clerical, covering 183,400 FTE staff • Maintenance & works (10,100) • Managers (24,900) • Senior managers (10,100) **Vacancies** – 1 category: • Administrative & estates, covering 228,000 FTE staff **Healthcare Commission staff surveys** – 4 categories: • Administrative & clerical • Central functions/corporate services • Maintenance & ancillary • General managers
Scotland	**Census** – 6 categories: • Central functions, covering 14,400 FTE staff • Support to clinical staff (8,100) • General services (3,500) • Hotel services (8,300) • Maintenance & estates (1,900) • Sterile services (600) **Vacancies, turnover** – no data collected on former PNC staff
Wales	**Census** – 4 categories: • Administrative & clerical, covering 12,000 FTE staff • Maintenance & works (1,200) • Managers (1,500) • Senior managers (1,300) **Vacancies** – 1 category: • Administrative & estates (16,000)
Northern Ireland	The Department of Health, Social Services and Public Safety in Northern Ireland produces the most detailed data relating to former PNC staff. **Census, vacancies** – 3 high-level categories, within which 29 job roles can be identified: • Administrative & clerical, within which 5 job roles: clerical & administrative; medical secretary; personal secretary; manager; senior manager • Ancillary & general, within which 10 job roles: catering services; domestic services; laundry services/sewing room; driver; porter/orderly; facilities; security/caretaker/warden; telephonist; care assistant; other • Works & maintenance, within which 14 job roles: estates officer; planner estimator; painter; joiner; fitter/engineer; plumber; electrician; upholsterer; builder; boilerman; multi-skilled support; multi-skilled supervisor; groundsman/gardener; labourer **Turnover** – published for the three high-level categories only

[7] The number of staff in each category is derived from workforce census data available in February 2009.

Vacancy statistics

2.6 Our Twenty-Third Report in March 2008 outlined the Staff Side's concerns relating to the inadequacies of the vacancy data: nil returns from Trusts, usage of bank and agency staff, vacancy freezes, and collection of data solely on long-term vacancies meant that these data were an underestimate of the true extent of vacancies. Moreover the data were not sufficiently detailed, in the Staff Side's view, to highlight recruitment difficulties affecting specific bands and specialties within wider staff groups. We shared some of the Staff Side's concerns, although we emphasised that we did not consider it to be our role to comment on the appropriate level of establishment.

2.7 The Department of Health, in its response in 2007 referred to in paragraph 2.2 above, said it was in discussion with a range of stakeholders to improve the timeliness and coverage of vacancy data to improve the ongoing vacancy survey. At the time of our Twenty-Third Report, the following work was in its early stages:

- discussion with NHS Employers as to whether it would be possible to obtain data on vacancies from the NHS Jobs website;
- examination of the methodology used in Scotland to gather data on 'on-the-day' vacancy rates in addition to information on longer-term vacancies; and
- discussion with the NHS Information Centre (IC) on the potential for data from the Electronic Staff Records (ESR) HR system to give proxy information on both vacancy numbers and the length of vacancies.

2.8 Since our Twenty-Third Report, the vacancy survey in England has been expanded to include collection of data on 'on-the-day' (total) vacancies in addition to data on posts vacant for three months or more. In Scotland and Northern Ireland, collection of data on total vacancies is well-established; Wales is now the only UK country which does not collect data relating to 'on-the-day' vacancies in the NHS.

2.9 In Scotland since 2007, the vacancy survey has been conducted in September rather than March, to align with the annual workforce census. Vacancy data in Scotland are limited to nursing staff and allied health professionals (AHPs), broken down by Agenda for Change bands (AfC) 1 – 4 and 5 – 9.

Other workforce data

2.10 Since our Twenty-Third Report, usage of the ESR system by Trusts in England has increased, and is now used in all but two Trusts.

2.11 The Department of Health, in its response in 2007 referred to in paragraph 2.2 above, explained that there was potential to use the ESR system to provide a monthly monitoring report to supplement the annual workforce census and provide trend analysis. To date, this potential has not yet been realised; the IC has informed our secretariat that the target date for this new reporting system is September 2009.

2.12 Since July 2007, the IC has been using data from the ESR Data Warehouse to produce quarterly estimates of average earnings for our remit group. The sample size has increased since this time and now covers nearly 100 per cent of NHS Trusts in the latest release (July – September 2008), which suggests that these data can now be considered to be robust.

2.13 In Scotland since 2007, workforce data in all NHS Boards have been captured using the Scottish Workforce Information Standard System, a workforce information system which links human resources, payroll, finance and other systems.

Evidence from the Parties

The Health Departments

2.14 The **Department of Health** provided an overview of the level of detail available from its various data collections (summarised in Table 2.1 above), and confirmed that information below the broad staff groupings of administrative and clerical, maintenance and works, and managers remained more limited than that available for nurses and other healthcare professional groups.

2.15 The Department of Health explained that the ESR Data Warehouse had the capacity to record specific job roles, but that data had not been entered by Trusts on a consistent basis and could not therefore be used. Inconsistent data entry would be resolved as users became more familiar with the ESR system over time: the Department was seeking to improve this in its work with the IC.

2.16 Whilst it would be possible to take steps to increase the level of detail in statistical outputs relating to former PNC staff, this would require significant resource investment to accomplish and the Department of Health was expected to deliver significant cost savings. The Department would consider this with the IC.

2.17 The Department intended to explore what detailed data could be made available from professional bodies and/or unions, and planned to discuss with the IC whether anything further could be done with data not based on the ESR system.

2.18 The **Scottish Government Health Directorates (SGHD)** told us that, since 2007, the way in which data on former PNC staff groupings were collected in Scotland had changed. Whereas, previously, data were gathered on staff grouping broken down by Whitley grade, now staff groupings were broken down into various functions as well as by AfC pay band to give a more detailed picture of their function within the service.

2.19 The **Welsh Assembly Government (WAG)** explained that data relating to former PNC staff could not be broken down by specific job, but within the main staff groupings data could be broken down by broad area of work, e.g. central functions, clinical support.

2.20 The **Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI)** provided data detailing high-level staff groupings broken down by AfC band, and it also publishes workforce statistics for former PNC staff by job role as outlined in Table 2.1 above.

NHS Employers (NHSE)

2.21 **NHSE** stated that it was the responsibility of the Department of Health to commission workforce data from the IC and therefore it was for the Department of Health to look at how to improve data collection on former PNC staff groups.

Staff Bodies

2.22 The **Staff Side** repeated the concerns it had raised in 2007 about the inadequacies of the vacancy data upon which the Department of Health relied. The Staff Side told us that these were compiled on the basis of returns from NHS Trusts and where a return was not received it was not counted and this had the effect of distorting the percentage vacancy rate figure. The Staff Side also said that Trusts/Boards with the highest vacancy rates were less likely to return their survey statistics as they tended to have relatively higher workloads.

2.23 The Staff Side stated that a vacancy was defined by the Department of Health as "an empty position which had been vacant for three months or more and which employers were actively trying to fill", which meant that if a Trust was not 'actively' recruiting there were technically no vacancies.

2.24 **UCATT** told us that it had been unable to obtain detailed data from the IC on vacancies and turnover rates for building craft workers: data were only available at the aggregated level of administrative and estates, and maintenance and works staff respectively.

Our Comment

2.25 It is our view that the availability of robust, timely data on our remit group is critical to our ability to make informed, evidence-based decisions on pay and other matters. The amended scope of our remit during the parties' three-year pay agreement allows us the opportunity to take stock of the progress that has been made in this area, and come to a view as to how we think work should proceed. We review the available data relating to local recruitment and retention premia in Chapter 3.

2.26 Given that staff in our remit group are employed under a single set of terms and conditions of service covering all four UK countries, it is vital that we have access to data that are comparable on a UK basis.

2.27 The provision of robust data on the earnings of our remit group in England is the first of many benefits we expect from the ESR system: we are grateful to the IC and the Department of Health for their work in this area, and we look forward to having regular statistics on staffing numbers and turnover in the near future, as well as further improvements in the range and detail of outputs from the ESR system.

2.28 Whilst we welcome the progress the Health Departments have made, there are a number of areas where we consider there is scope for further improvement.

2.29 We stated in our Twenty-Third Report that the level of detail of the workforce data for former PNC staff was insufficient for our needs. This remains our view, and **we urge the Health Departments in England, Scotland and Wales to take steps to further disaggregate these data.** Each country should follow a common framework for classifying job roles: the Northern Ireland model (see Table 2.1) appears to provide an appropriate starting point, although a greater degree of specificity in the administrative and clerical category would be welcomed, to include job roles such as clinical coders, finance and human resources.

2.30 We continue to share the Staff Side's reservations regarding the Health Departments' vacancy surveys. It is not clear from these surveys the extent to which recruitment freezes, usage of temporary staff, unpaid overtime and other coping mechanisms mask the true extent of vacancies. We cannot be the arbiters of the accuracy or otherwise of the vacancy surveys, and to that end **we ask that all parties work together to agree what changes, if any, should be made to the methodology for collecting and presenting vacancy statistics.**

2.31 Data on 'on-the-day' vacancies have been collected in Scotland and Northern Ireland for some time. We appreciate that data are now being collected in England on a consistent basis, though it is too early to draw firm conclusions from this first snapshot. The data do, however, provide a helpful context within which to analyse three-month vacancy rates. **It would be helpful in future for these data to be collected in Wales, in such a way that outputs are comparable with those produced in other countries.**

2.32 **The vacancy survey in Scotland should be extended to cover all staff groups at the earliest opportunity.**

2.33 We are disappointed that no data on turnover in the NHS are produced in Scotland and Wales. Whilst we accept that turnover is natural in any organisation, it is helpful to identify whether it is high or increasing for certain staff groups. **We therefore urge the Health Departments in Scotland and Wales to collect data on staff turnover, identifying separately staff leaving the NHS altogether, and staff moving between NHS organisations**.

2.34 We acknowledge that there is likely to be a lag between implementing measures to provide better data, and the provision of robust and quality-assured statistical outputs. **We ask that the parties keep our secretariat informed of progress. The Health Departments should report back to us at the time of our next review on the feasibility of complying with our recommendations, and provide an estimated timetable for delivery.**

Workforce Planning

2.35 In our Twenty-Third Report, we asked the parties, and the Health Departments and NHS Employers in particular, to consider what evidence they could provide for future reviews to demonstrate how the NHS's longer-term recruitment and retention needs for all groups of staff had been taken into account in workforce planning.

Evidence from the Parties

The Health Departments

2.36 The **Department of Health** told us that workforce planning was a matter for local NHS organisations which were supported nationally by bodies such as the Workforce Review Team (WRT), a dedicated group of workforce planners who provide objective modelling, analysis and evidence-based guidance to enable planning decisions to be made in an informed way across the NHS workforce.

2.37 The **Department of Health** explained that *A High Quality Workforce*[8] outlined details of the new devolved workforce planning system which would be based on greater clarity of accountability, roles and responsibilities, and that new professional advisory boards would be established to give clinicians a voice in workforce planning education and training strategy to ensure that more flexible workforce deployment, education and training standards were embedded in workforce development plans over the long term.

2.38 The Department told us that a Centre of Excellence for workforce planning would be set up in 2009 to provide objective analysis, advice and support for the NHS. The Centre would perform horizon scanning and analysis of long-term workforce requirements, and would work with the NHS to ensure that this was incorporated into current workforce planning and education and training commissioning. The Centre would also have a capability and capacity building function to ensure local NHS organisations could produce high quality workforce planning.

2.39 The Department stated that the new system would ensure that high quality staff were employed in the right areas to deliver the services patients need, and, combined with more flexible career structures, would reduce shortages of staff in key service areas, and reduce the need to pay premium rates for shortage staff groups. The introduction of more flexible career structures would enable staff to move more readily between clinical, management, academic and research career pathways, creating greater flexibility in workforce planning and enhancing career opportunities.

2.40 The **WAG** advised us that *Designed to Work*[9], the workforce and people management strategy for NHS Wales, would ensure that workforce planning was undertaken on a health economy basis and would focus on whole workforce planning fully integrated with financial and service plans at a local and health economy level. It told us that most organisations had strengthened their workforce planning functions to ensure they were able to meet the demands and challenges of the new system.

2.41 The WAG also told us about the new Integrated Workforce Planning System that was being implemented. As part of this the Workforce Development Unit would gather information about NHS Wales's workforce, population and labour market, as well as UK, EU and global issues affecting the workforce. The WAG told us that this information would be used to provide advice to the Advisory Group for Workforce Development made up of representatives from the service, education and professional bodies who would in turn advise the Assembly's Education and Commissioning Board.

2.42 The WAG considered that its data confirmed that the recruitment and retention position remained strong throughout Wales but work was still needed in some organisations to reduce the reliance on bank, agency and locum staff. Such staff were mainly used in nursing, and in specialist areas such as accident and emergency, and intensive therapy units in particular.

2.43 The **DHSSPSNI** told us that recruitment and retention issues were monitored through the workforce planning mechanism which consisted of a programme of comprehensive regional workforce reviews across the main professions and a number of supporting groups in the Health and Social Care sector.

2.44 The **SGHD** provided no evidence relating to workforce planning.

---

[8] Department of Health (2008) *A High Quality Workforce: NHS Next Stage Review*

[9] Welsh Assembly Government (2006) *Designed to Work: A Workforce Strategy to Deliver Designed for Life*

NHS Employers

2.45 **NHSE** told us that whilst there was evidence of some problems with certain professional groups of staff, these shortages were not directly related to levels of pay. NHSE also told us that consultations with employers reported that remuneration was not necessarily a key factor in shortages of certain occupations but that there were other aspects such as workforce supply, for pharmacists in particular, and increased activity to meet the demands of national policy such as the 18-week Referral to Treatment target.

2.46 NHSE told us that it had sought information from employing organisations on recruitment and retention, and feedback suggested that employers considered that the recruitment and retention position was generally stable, helped by the continued minimal rate of staff turnover in most areas, and did not require any further national action.

2.47 NHSE told us that it carried out a short consultation in March 2008 to ascertain which occupations employers were experiencing difficulty in recruiting to and requested information relating to alternative approaches that had been implemented. The results showed regional variations in a number of occupations with national trends being reported in areas such as theatre nursing and pharmacy. NHSE advised us that these specialties had subsequently been included on the Migration Advisory Committee's list of shortage occupations[10] to support employers in recruiting these professionals, but with the proviso that their inclusion on the list be reviewed by March 2009.

Staff Bodies

2.48 The **Staff Side** said that recruitment continued to be low in the NHS and statistics suggested recruitment freezes. At the same time, demand for staff was increasing to support reforms such as the *Next Stage Review* in England. The Staff Side foresaw a cycle of boom and bust in the labour market, most likely in the community and primary care sectors where, in the Staff Side's view, there had been a failure to grow or train the workforce necessary to support reforms. The failure to implement the Knowledge and Skills Framework (KSF) effectively and therefore get good succession planning in place was contributing to a continued lack of effective workforce planning, particularly in England.

Our Comment

2.49 We welcome the information we have received and note the changes in the processes of workforce planning in England. There has been a wide variety in the level of detail in the evidence submitted to us, and an absence of evidence from Scotland in this area. We note that the provision for processes of workforce planning lie beyond our remit. However, having accurate and timely information on the conclusions of workforce planning exercises is essential for us to fulfil our function.

2.50 **Once again, we ask that the Health Departments provide better information on workforce planning, such that we may take a view on the longer-term recruitment and retention picture. Specifically, we would like to be kept informed of forecast shortages or surpluses of particular categories of staff within our remit group, the Health Departments' strategies for addressing them, and the effectiveness of those strategies in helping to predict and manage shortages and surpluses of individual categories of staff.**

[10] Migration Advisory Committee (September 2008) *Skilled, Shortage, Sensible: The Recommended Shortage Occupation Lists for the UK and Scotland*

Quality of Staff and Applicants

2.51 In our Twenty-Third Report, we expressed concern that we had received no evidence on the quality of staff, nor the quality of applicants and asked the parties to provide us with such evidence for our next review.

Evidence from the Parties

The Health Departments

2.52 The **Department of Health** told us that it did not routinely collect comprehensive data on the qualifications held by applicants for jobs within our remit group as this was the responsibility of individual employers. The Department advised us that in time, the ESR system may hold more reliable and better completed information around qualifications that could contribute to the evidence it provided on the quality of staff.

2.53 The Department noted that the NHS funded large numbers of pre-registration courses for staff groups within our remit. Strategic Health Authorities (SHAs) commissioned local Higher Education Institutions (HEIs) to deliver pre-registration courses and held those HEIs to account for the quality of the courses and the resultant graduates.

2.54 The Department was exploring with Universities and Colleges Admissions Service (UCAS) whether it could provide more information about the qualifications of candidates who applied for pre-registration training and would keep us informed about the outcome of these discussions.

2.55 The Department stated that since the publication in 2000 of *The NHS Plan*, the Government had increased the numbers of clinical staff. In addition, it had encouraged a higher level of academic entry as nursing and related careers such as midwifery and health visiting became increasingly challenging and the opportunities for high-level clinical involvement improved.

2.56 The Department told us that there had been a shift in nursing careers from vocational to professional. Midwifery had recently become an all-graduate profession on registration, and the Nursing and Midwifery Council had recently proposed that the minimum academic award for pre-registration nursing programmes would be a degree. More qualified nurses were of graduate calibre – in recent years the number of nursing degree places had increased from 297 in 1997 to 4,062 in 2007/08.

2.57 Data from the Nursing and Midwifery Admissions Service showed that between 2003 and 2007 the number of applications relative to the number of successful applicants for nursing and midwifery pre-registration programmes rose from 4.4 to 4.6, suggesting increased demand for places. The Department of Health said it was working with UCAS to ensure that the statistics on nursing and midwifery admissions continued to be collected, now that the Nursing and Midwifery Admissions Service had ceased to operate.

2.58 The Department explained that *A High Quality Workforce*, published in June 2008, underpinned the workforce contribution to the vision in the *Next Stage Review*, in which a range of actions were identified to refocus education commissioning on quality. In particular, the Department told us that it would support education commissioners in SHAs to be clearer about the outputs they required; work in strategic partnerships with HEIs and service providers to promote quality and innovation; promote the use of feedback from trainees, employers, patients and the public in the design and delivery of education and training; and ensure effective quality assurance systems with minimum duplication and burden on the NHS or higher education sector.

2.59 As part of the Government's commitment to increasing knowledge and skills for all, the Department of Health told us that it would work with trade unions, Skills for Health[11] and other key partners to double the investment in apprenticeships by 2012/13. Apprenticeships would be available both to new and existing staff and the Department of Health considered that this would enhance investment in the substantial minority of staff who had basic qualifications (equivalent to NVQ level 1) and had not attracted the level of training enjoyed by the more highly qualified groups in the NHS.

2.60 The Department noted that the quality of staff was dictated not just by the quality of the applicant but also by the support and training they received once in the NHS, for example clinical staff maintained their clinical standards as required by their regulatory bodies.

2.61 **The DHSSPSNI** told us that it had not been possible to provide the Review Body with information on the quality of staff and applicants as data on staff qualifications had not historically been captured in Northern Ireland.

2.62 The **SGHD** and the **WAG** provided no evidence on this matter.

NHS Employers

2.63 **NHSE** said that, like the Department of Health, it did not collect any information on the qualifications held by applicants for posts and that this was the responsibility of individual employers.

Staff Bodies

2.64 We received no evidence from staff bodies on the quality of staff and applicants.

Our Comment

2.65 It remains our view that the quality, as well as the number, of staff and applicants, is crucial to delivering effective and efficient healthcare. We are grateful to the Department of Health for its evidence on staff qualifications, and agree that the quality of staff depends on a number of factors, including procedures for appointing staff, access to training and staff development, and appraisals. It is important that the quality of staff, and measures for ensuring that there are sufficient staff of the appropriate quality, are taken into account in workforce planning.

[11] The Sector Skills Council for the health sector, part of the Skills for Business network of 25 employer-led Sector Skills Councils.

Chapter 3 – High Cost Area Supplements and Recruitment and Retention Premia

Introduction

3.1 In this chapter, we review the evidence on recruitment and retention premia (RRPs) and high cost area supplements (HCAS).

3.2 The Agenda for Change (AfC) agreement contains provisions governing the operation of recruitment and retention premia 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. Where it is agreed that an RRP is necessary for a particular group the level of payment should be specified or, where the underlying problem is considered to vary across the country, guidance should be given to employers on the appropriate level of payment. In making such recommendations we are required to seek evidence or advice from NHS Employers (NHSE), staff organisations and other stakeholders. In addition, the parties have agreed under AfC that some posts will automatically attract RRPs. Separately there is scope for local employers and staff bodies to agree on the need for an RRP to address local recruitment and retention problems.

3.3 We are required, under our general remit, to have regard to regional/local variations in labour markets and their effects on the recruitment and retention of staff. In addition, AfC provides for a system of high cost area supplements 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 the lowest.

National Recruitment and Retention Premia

3.4 Under the parties' three-year pay agreement, existing national RRPs were increased by 2.75 per cent from April 2008, and will be uplifted by 2.4 per cent from April 2009.

3.5 In the autumn of 2008, we received new applications for national RRPs for midwives and building craft workers. We wrote to the parties on 16 December 2008 outlining our analysis of the evidence presented to us and our conclusions. A copy of our conclusions is reproduced in Appendix B, and is also available on the OME website[12].

3.6 We comment later in this chapter on the specific matter of a national RRP for qualified pharmacists; in this section we discuss process issues in respect of national RRPs in general.

Evidence from the Parties

The Health Departments

3.7 The **Department of Health** told us that all parties accepted that periodic reviews of nationally determined RRPs were required as part of the AfC agreement. The responsibility for this lay with the NHS Staff Council. The Department confirmed that it would ask the NHS Staff Council to conduct a review of nationally determined RRPs in 2009.

[12] www.ome.uk.com

3.8 We asked the Department of Health to clarify what geographical area a national RRP covered. The Department responded that in its view the term "national" applied to all four countries covered by the AfC Final Agreement. Any RRP below UK level was a local award and was a matter for local decision-making. For a national RRP to be recommended, the Department considered that we would have to be satisfied, supported by clear and robust evidence, that there were problems across all employers in the four UK countries to meet the requirements set out in Section 5 and Annex R of the AfC Handbook[13]. The Department believed that, if there was evidence of areas in the UK where a national RRP would not be appropriate, then by definition the problem was not national and required a local solution in line with Section 5 and Annex J of the AfC Handbook.

3.9 The Department confirmed that it was content with paragraph 4.19 of our Twenty-First Report[14]. This reads as follows:

*"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 for our respective remit groups (with local differentiation as necessary to reflect geographical variation in the underlying problem)."*

3.10 The Department said that, as set out in paragraph 4.19, these "recruitment and retention pressures" could vary, hence the facility for "local differentiation". However, to create either class of national RRP set out in paragraph 4.19 we would have to be satisfied there was sufficient UK-wide evidence of a recruitment and retention problem across all four countries that merited all employers across the UK paying a recruitment and retention premium. We could then go on either to specify an amount for each geographical area according to the extent of the problem in that area or provide "guidance... to employers on the appropriate level of payment"[15]. Either way, the Department considered that the application of a national RRP would place an obligation on each country to implement an RRP whether specified by us or taking account of our guidance.

3.11 The **Devolved Administrations** agreed that the introduction of any national RRP or national RRP with local differentiation should apply on a UK basis and should be fully supported by robust and clear evidence of a recruitment and retention difficulty across all four countries of the UK.

3.12 The **Scottish Government Health Directorates (SGHD)** considered AfC to be a UK-wide agreement and that, under the terms of the agreement, national RRPs were UK-wide.

3.13 The **Welsh Assembly Government (WAG)** told us that its understanding was that a national RRP could only be UK-wide, but said that there was no reason why all parts of one country could not implement a local RRP in all NHS organisations in that country.

3.14 The **Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI)** told us that it did not consider that under the AfC agreement a national RRP could be made on a single country basis. The DHSSPSNI noted that the national RRP for maintenance craft workers was not supported by evidence of recruitment difficulties for these staff in Northern Ireland, but Health and Social Care (HSC) employers were required under the AfC agreement to pay the premium on the basis that it was a national agreement, applying equally to all four countries.

---

[13] NHS Staff Council (2007) *NHS Terms and Conditions of Service Handbook*

[14] NHSPRB (2006) *Twenty-First Report*, TSO (Cm 6752), paragraph 4.19

[15] NHS Staff Council (2007) *NHS Terms and Conditions of Service Handbook*, Annex R

3.15 We asked the **Devolved Administrations** for their views on the possible consequences, should an RRP be recommended for England only. The SGHD considered that it was likely that such a move would create some pressure in Scotland to adopt a similar RRP and such approaches would be difficult to resist. The SGHD told us it would not be in favour of us recommending a national RRP for England only. The WAG did not give a view on the possible consequences. The DHSSPSNI told us that if we were to recommend a national RRP for England only this would have the potential to cause some recruitment difficulties in Northern Ireland, but these would not be on the scale of the difficulties that could arise elsewhere.

NHS Employers

3.16 **NHSE** told us that its understanding of the AfC provisions was that national RRPs should be regarded as UK-wide. NHSE stated that there was no provision in the agreement for us to make a recommendation for a country-specific local RRP. NHSE said that, provided it had first been established that there was sufficient evidence to justify the need for a national RRP across all of the UK, it was possible for differential rates to be recommended for different parts of the UK to reflect different market conditions. NHSE emphasised that any rates of national RRP would need to be justified by robust evidence.

3.17 NHSE considered that recommending an RRP for England only would adversely impact on employers in border areas in the Devolved Administrations.

Staff Bodies

3.18 The **Staff Side** told us that AfC was a UK-wide agreement and that therefore national RRPs were UK-wide. **Unite** also confirmed its belief that within the AfC agreement national premia should be implemented on a UK-wide basis. In Unite's view, implementing a national RRP in England only could create recruitment and retention difficulties in Scotland, Wales and Northern Ireland, with England 'pulling in' staff from neighbouring areas. Unite also referred to our conclusion in paragraph 4.19 of our Twenty-First Report (see paragraph 3.9 above).

Our Comment

3.19 We have previously stressed the importance of regular and robust reviews of national RRPs, and **we therefore welcome the proposed review in 2009 of nationally determined RRPs by the NHS Staff Council and we ask the Department of Health to submit the findings of this review to our secretariat.**

3.20 We agree with the parties that the term "national" in the context of the provisions of the AfC Final Agreement relating to RRPs means UK-wide. We also continue to hold the view, set out in paragraph 4.19 of our Twenty-First Report and paragraph 3.9 above, that we may recommend national RRPs with local differentiation as necessary to reflect geographical variation in the underlying problem. The parties did not dispute this interpretation of the AfC Agreement prior to or following our Twenty-First Report and the Department of Health, NHSE and Unite have confirmed, in their evidence for this Report, that they share it.

3.21 We do not agree with the view of the Department of Health that, for a new national RRP to be recommended, we would have to be satisfied that there are problems across all employers in the UK. The argument that there must be problems across all employers is inconsistent with the express provision in AfC for guidance to employers on the appropriate level of payment where the underlying problem is considered to vary across the country.

3.22 Nor do we agree with the view of the Department of Health and the Health Departments for the Devolved Administrations that there must be clear and robust evidence of a recruitment and retention difficulty across all four countries in the UK. The AfC Handbook refers in paragraph 5.3 to "national recruitment and retention pressures"[16], which, interpreting "national" to mean UK, means recruitment and retention pressures in the UK. The requirement that these pressures should exist in all four countries is nowhere mentioned in the Agreement or the Handbook. **We have concluded, therefore, that in considering whether a UK-wide RRP is justified the evidence should be assessed on a UK-wide basis.**

National Recruitment and Retention Premium for Pharmacists

3.23 In our Twenty-Third report we considered Unite's claim for a new national RRP for pharmacists[17]. We were unable to support the proposal put forward by Unite but commented that we believed that there was a problem with the retention of newly-qualified pharmacists reaching their third year of service, and we recommended that the parties address the problem of the retention of pharmacists before the next Review Body round and reach a workable solution. We suggested an alternative approach for consideration by the parties based on the concept of a retention bonus, payable to newly-qualified pharmacists who remain in the NHS for five years. We asked the parties to report back to us on progress, with a view to us considering a formal recommendation if we believed insufficient progress had been made.

3.24 The parties have subsequently met on four occasions, discussing our suggested approach alongside a number of other proposals. The parties were concerned that a retention bonus could be outside the scope of AfC, and raised a number of practical issues relating to the implementation of such a solution. On 24 February 2009, we were given a joint statement of the progress the parties had made since our recommendations in 2008. This was signed by the Health Departments, NHS Employers and Unite.

3.25 Research has been undertaken on behalf of the parties, including a survey of Strategic Health Authority (SHA) Workforce Directors on matters relating to the recruitment and retention of pharmacists, and analysis by the Workforce Review Team of the recruitment and retention of pharmacists at AfC bands 6 and 7 employed by NHS organisations in England. We discuss this research below, as well as the evidence on vacancies from regular data collections.

Pharmacy vacancy surveys (see Table 3.1 below)

Data from the Health Departments' vacancy surveys

3.26 Data on vacancies for qualified pharmacists are available from the vacancy surveys conducted annually in England, Wales and Northern Ireland. Official data on vacancies for qualified pharmacists in Scotland are not available.

3.27 In England in March 2008, the three-month vacancy rate[18] for registered pharmacists was 1.0 per cent, 0.4 percentage points lower than in March 2007 and the sixth successive year in which the observed vacancy rate had fallen. The vacancy rate in March 2008 ranged from 0.4 per cent in the West Midlands SHA to 2.3 per cent in the

[16] NHS Staff Council (2007) *NHS Terms and Conditions of Service Handbook*, paragraph 5.3

[17] NHSPRB (2008) *Twenty-Third Report*, TSO (Cm 7337) paragraphs 3.37-3.43

[18] Posts which were vacant on the date of the survey, which had been vacant for three months or more, and to which NHS organisations were actively recruiting.

North East SHA, and had increased in three of the ten SHAs between March 2007 and March 2008.

3.28 The total vacancy rate[19] for registered pharmacists in England, collected for the first time in March 2008, was 4.3 per cent, and ranged from 2.7 per cent in the London and West Midlands SHAs to 7.3 per cent in the North East SHA.

3.29 In Wales in March 2008, the three-month vacancy rate for registered pharmacists was 1.9 per cent, an increase of 0.8 percentage points since the previous March.

3.30 The three-month vacancy rate for qualified pharmacists in Northern Ireland was 3.8 per cent in September 2008, while the total vacancy rate was 1.0 per cent.

Pharmacy Establishment and Vacancy Survey

3.31 As in 2007, the OME funded the 2008 National NHS Pharmacy Establishment and Vacancy Survey (PEVS), conducted in May 2008 by the NHS Pharmacy Education and Development Committee (NHSPEDC)[20]. This survey, unlike those conducted by the Health Departments, allows analysis of vacancy rates by AfC pay bands, and for the first time in 2008 the survey collected data on three-month vacancies, and data from Primary Care Trusts (PCTs) in England and Local Health Boards (LHBs) in Wales and Northern Ireland in addition to the data previously collected[21]. The 2008 survey achieved a 100 per cent response rate from NHS Trusts and PCTs/LHBs in all three countries surveyed. Scotland did not take part in the survey. This was explained as being due to outstanding AfC banding issues.

3.32 The main findings of the 2008 survey were:

- the total vacancy rate for qualified pharmacists in England, Wales and Northern Ireland was 13.2 per cent, with more than three-fifths of these vacant posts being vacant for three months or more;
- more than one in five (22.2 per cent) of band 6 posts were vacant, and more than one in seven (14.8 per cent) had been vacant for three months or more; and
- 16.9 per cent of band 7 qualified pharmacist posts were vacant, with 10.1 per cent vacant for three months or more.

3.33 Compared with the 2007 PEVS[22], the total vacancy rate for band 6 pharmacists in England increased, but the rate decreased for band 7 vacancies. In 7 out of 10 SHAs, the vacancy rate for band 6 pharmacists increased; the vacancy rate at band 7 increased in 5 SHAs. In Wales, the vacancy rate decreased for both bands. As Northern Ireland did not take part in the 2007 PEVS, no comparison of vacancy rates in Northern Ireland between 2007 and 2008 can be made.

3.34 Table 3.1 below shows three-month and total vacancy rates by UK region, from both official sources and the NHSPEDC study. In each region, vacancy rates from official data are substantially lower than those recorded by the PEVS.

---

[19] All posts which were vacant on the date of the survey, to which NHS organisations were actively recruiting. This includes three-month vacancies.

[20] NHSPEDC (2008) *National NHS Pharmacy Establishment and Vacancy Survey 2008.* This report can be obtained from the NHSPEDC website www.nhspedc.nhs.uk

[21] Previously data from the PEVS were limited to total (on-the-day) vacancies, from acute and mental health Trusts only.

[22] The results of the 2007 PEVS were summarised in NHSPRB (2008) Twenty-Third Report, TSO (Cm 7337), paragraph 3.18 and Table 3.1.

3.35 The principal reason for the discrepancies between the results of the two surveys is the differing definitions of a 'vacancy'. In the PEVS, a vacancy is defined as a post in the staffing establishment which is not permanently occupied. This includes those posts currently occupied by locums. By contrast, official surveys conducted by the Health Departments record only those vacant posts to which NHS organisations are actively recruiting[23]. The reference date of the surveys also differs: the PEVS relates to 31 May 2008, while the official statistics relate to vacancies as at 31 March 2008 in England and Wales, and September 2008 in Northern Ireland.

[23] But excludes posts currently filled by locum and agency staff to which NHS organisations are not actively recruiting.

Table 3.1: Staffing establishments and vacancy rates for qualified pharmacists by UK country and region

	Pharmacy Establishment & Vacancy Survey, May 2008[23]													Official statistics[24]	
	Staffing establishment				**Total** vacancy rate (% posts not permanently occupied)										
	Band 6	Band 7	Bands 8a-9	Total	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	**Total** vacancy rate for all bands	**3-month** vacancy rate for all bands	**Total** vacancy rate	**3-month** vacancy rate
North East	62	84	215	361	20.0%	28.5%	12.5%	11.3%	5.7%	0.0%	0.0%	16.4%	9.8%	7.3%	2.3%
North West	192	203	606	1,001	31.7%	20.2%	6.3%	7.7%	5.2%	9.4%	0.0%	14.2%	8.8%	4.5%	0.7%
Yorkshire & Humber	112	137	449	698	19.0%	15.1%	6.8%	12.3%	5.0%	-3.9%	0.0%	10.7%	9.4%	5.2%	1.7%
East Midlands	79	127	243	448	17.5%	12.3%	11.0%	7.0%	1.9%	14.4%	0.0%	11.2%	6.3%	4.0%	1.6%
West Midlands	101	113	378	592	25.9%	17.0%	6.9%	2.5%	5.7%	-1.5%	0.0%	10.9%	8.3%	2.7%	0.4%
East of England	115	138	326	579	31.5%	12.5%	18.0%	14.2%	11.3%	6.5%	9.1%	17.4%	10.7%	5.8%	0.7%
London	359	377	833	1,569	19.8%	17.8%	13.8%	11.5%	9.7%	2.3%	4.3%	14.8%	6.7%	2.7%	0.7%
South East Coast	81	97	232	410	26.5%	18.0%	11.4%	8.8%	0.0%	0.0%	0.0%	14.3%	8.2%	4.6%	0.8%
South Central	88	109	262	459	9.8%	24.8%	16.2%	8.1%	14.4%	1.1%	-3.4%	14.7%	7.4%	4.4%	1.0%
South West	99	120	276	494	30.8%	19.4%	8.4%	1.2%	-4.2%	0.0%	0.0%	13.4%	10.2%	5.1%	0.9%
England	1,288	1,505	3,820	6,613	23.5%	18.1%	10.6%	9.0%	6.7%	3.3%	1.9%	13.9%	8.3%	4.3%	1.0%
Scotland[25]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Wales	57	87	355	499	0.0%	5.9%	5.5%	6.5%	2.2%	-8.3%	0.0%	4.3%	2.6%	n/a	1.9%
Northern Ireland	80	148	126	354	17.4%	11.3%	14.1%	8.7%	0.0%	0.0%	–	12.3%	9.6%	3.8%	1.0%
UK (exc. Scotland)	**1,426**	**1,739**	**4,301**	**7,466**	**22.2%**	**16.9%**	**10.2%**	**8.8%**	**6.0%**	**2.8%**	**1.9%**	**13.2%**	**8.0%**	**4.3%[26]**	**1.1%[26]**

n/a Not available

– No established posts in this band

[24] Vacancies are defined as posts not permanently occupied: this includes those posts occupied by locums on 31 May 2008. If an NHS organisation is unable to recruit into a particular post in its staffing establishment, it may use flexibilities to recruit into a differently banded post; this explains why occasionally the data show staffing levels higher than the staffing establishment, i.e. *negative* vacancy rates.

[25] Vacancies are defined as posts to which NHS organisations are actively recruiting. Sources: NHS Information Centre (England), March 2008; StatsWales, March 2008; DHSSPSNI, September 2008.

[26] Scotland did not take part in the PEVS. This was explained as being due to outstanding AfC banding issues. No official data are collected on vacancies for pharmacists; the vacancy survey in Scotland is limited to nursing and AHP staff.

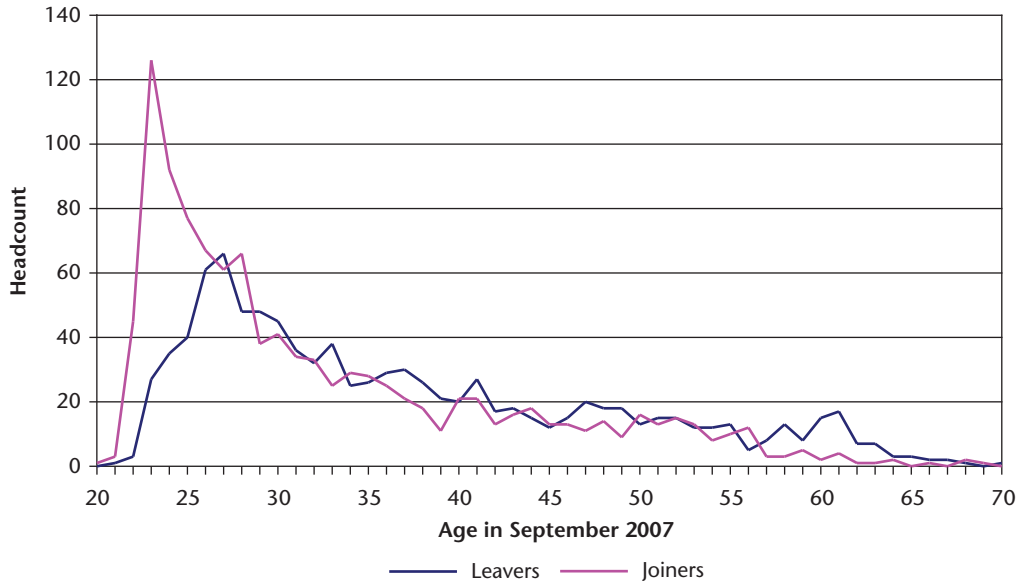
[27] OME calculations based on a weighted average of total vacancy rates (England and Northern Ireland only) and three-month vacancy rates (England, Wales and NI).

Turnover of qualified pharmacists (see Figure 3.2 below)

3.36 We noted in our previous report that there appeared to be a problem in retaining qualified pharmacists who had been employed in the NHS in England for three or more years: this apparently remains the case, as shown by the peak in qualified pharmacists leaving the NHS in England between the ages of 26 to 30.

3.37 Further data from the NHS Information Centre (IC) shows that the leaving rate for qualified pharmacists in England between the 2006 and 2007 census collections was 15.2 per cent, a decrease on the figure of 16.5 per cent for 2005-2006 but greater than the leaving rate for qualified Scientific, Therapeutic and Technical (ST&T) staff as a whole, which stood at 8.6 per cent in the period September 2006 – September 2007.

Figure 3.2: Estimated headcount of qualified NHS pharmacist joiners and leavers between the 2006 and 2007 censuses (England)



Source: The NHS Information Centre

Survey of SHA Workforce Directors

3.38 The Department of Health sent a questionnaire to the ten SHA Workforce Directors in December 2008, and responses were received from all SHAs by 30 January 2009. This questionnaire asked SHAs for their views relating to the recruitment and retention situation for pharmacists in their SHA. The Department considered that the survey of SHA Workforce Directors was a useful adjunct to the parties' work, but care was needed in drawing wider conclusions given the number of unknowns relating to the robustness of the data collection exercise. The survey and subsequent analysis had been conducted relatively quickly and the Department of Health stated that it had helped the parties agree that there were recruitment and retention difficulties in England but that these varied from SHA to SHA.

3.39 Both the Department of Health and Unite produced a summary of the survey results. We have considered these, and undertaken our own analysis of the responses, the key points of which are outlined below.

3.40 Responses from all ten SHAs suggested that there were difficulties both with recruitment and retention of pharmacists, noting particular problems in bands 6 and 7, with most stating that these difficulties were SHA-wide. Most replies referred to the pay difference between the NHS and the community sector, and some noted that morale was low, as senior pharmacists had to cover for vacancies in bands 6 and 7.

3.41 The results of the survey indicated that six of the SHAs had undertaken work to examine the destinations of pharmacists leaving bands 6 and 7. Many left on an internal promotion within their Trust, while others moved to different Trusts, PCTs, community pharmacy posts or to become locums. Three SHAs had undertaken work to determine the reasons that pharmacists in bands 6 and 7 left the hospital service, citing attractive pay in the community sector, lack of flexible working options, on-call requirements and other reasons. Some respondents noted that a substantial proportion of staff left the NHS for the community sector or locum work after completing pre-registration training.

3.42 None of the respondents considered that the supply of pharmacists was sufficient to meet the combined needs of local NHS organisations and community pharmacy. Many noted that an increase in pre-registration training places would increase supply in the medium term. However, a number of replies commented that new initiatives, such as the *Next Stage Review* and the pharmacy White Paper[28], would increase demand for pharmacists and it was not clear to what extent any increase in supply would meet both current shortfalls and this increased demand.

3.43 There were examples of Trusts using local RRPs, but most Trusts relied on other initiatives including, amongst others, financially supporting attainment of the Postgraduate Diploma (a prerequisite for progressing to band 7), flexible working, access to training and development schemes, grade drift and sharing posts with community pharmacy.

3.44 In all, seven respondents considered that we should make recommendations to address the issue of recruitment and retention of pharmacists in bands 6 and 7. Though some suggestions were outside our remit, many suggested financial incentives such as a national RRP, the ability to place pharmacists in bands 6 and 7 further up the scale, and help paying off student loan debt.

3.45 There were mixed feelings regarding the use of RRPs: some respondents considered that local RRPs would destabilise the internal NHS market, so preferred regional or national solutions; some took the view that a national RRP for pharmacists in the NHS would lead to a commensurate increase in salaries in the community sector, leading to increased costs with no benefit to the NHS.

Workforce Review Team (WRT) report

3.46 The WRT issued a survey to the workforce leads of the ten SHAs in England, which was further distributed to chief pharmacists in NHS Trusts. Eight out of ten SHAs provided responses to the WRT in February 2009 which represented input from 127 Trusts. The WRT noted that the short timescales allowed for this study had made it difficult to chase non-responders and therefore the findings should be considered with the restrictions of a limited sample size; short timescales had also made it difficult to have direct contact with chief pharmacists to validate survey findings.

3.47 Many of the key points from the WRT report echoed those from the survey of SHA Workforce Directors outlined above; below we note the WRT's additional findings.

[28] Department of Health (2008) *Pharmacy in England: Building on Strengths, Delivering the Future*, TSO (Cm 7341)

3.48 All SHAs reported difficulties in recruiting and retaining pharmacists in bands 6 and 7. The attractions of a higher salary in the community sector with less unsocial hours were cited as possible reasons. The reported salary gap between first level community pharmacy posts and first level NHS entry posts stood at about £10,000[29]. The WRT said that it had not requested data on the destinations of pre-registration pharmacists on qualification, and noted concerns raised by SHAs that increasing student debt could make the community sector more attractive to pre-registration pharmacists.

3.49 The WRT found that 71 per cent of responders to the survey used one or more recruitment and retention initiatives, including: payment of diploma fees (the most popular approach); free accommodation during the pre-registration year and subsequent 6 – 12 months; protected study leave entitlement; payment of professional fees; upgrade to band 7 post; three year contracts and other schemes. There was limited evidence of the use of local RRPs.

3.50 The WRT survey indicated that high levels of vacancies were impacting on service provision, with a prioritisation of core activities and reduced availability for non-core work. On-call duties and the need for band 8 pharmacists to cover for lower graded staff led to staff frustration and poor morale, while in some organisations high vacancy levels meant that implementation of national initiatives was slow.

3.51 The WRT concluded that recruitment and retention initiatives were required, and that these should incorporate the full spectrum of supported training and development of pharmacists in bands 6 and 7. It also concluded that the use of a national RRP may reduce the salary differential with the community sector, although it could simply increase the entry salary in this sector. The WRT considered that further analysis was required to understand the career choices of pre-registration pharmacists.

Evidence from the Parties

The Health Departments

3.52 The **Department of Health** said it was working with the other Health Departments, Unite and NHSE, meeting regularly to assess progress with agreed workstreams which would improve these parties' understanding of the problem of pharmacist retention. Consideration was being given to the possible solutions proposed by Unite, and guidance would be re-issued to employers on the use and application of RRPs. The Department also told us that any possible solutions involving changes to pay or conditions of service would need to be consistent with the requirements of the AfC agreement, and be ratified by the NHS Staff Council which oversees the AfC pay system including consideration of any changes that may be needed. The Department confirmed that all parties were committed to keeping us informed of progress.

3.53 The Department shared with us the results of the survey of SHA Workforce Directors, and the WRT's analysis of recruitment and retention of pharmacists in bands 6 and 7, which we discuss above. The Department drew our attention to the finding that the survey of SHA Workforce Directors had found that 30 per cent of SHAs in England did not want us to make any recommendations to address recruitment and/or retention issues.

[29] This is consistent with the findings of IDS (2007) *A Review of Remuneration of Pharmacists in the Community Retail Sector*, OME; summarised in NHSPRB (2008) *Twenty-Third Report*, TSO (Cm 7337) paragraph 3.17

3.54 In March 2009, the Department provided further evidence about the future increase in the supply of pharmacy training places. The Royal Pharmaceutical Society of Great Britain (RPSGB)[30] projected that graduates entering pre-registration pharmacy trainee places would increase by 17 per cent (358 places) between 2008 and 2010. Forward projections taking account of new schools of pharmacy and increased intakes suggested that there could be a 66 per cent growth (1,413 places) between 2008 and 2013 (see Table 3.3). The Department considered that these projections indicated that vacancy rates should reduce as more newly-qualified pharmacists came on stream.

Table 3.3: Estimate of pharmacy graduates entering pre-registration training[31]

Year	Pharmacy graduates entering pre-registration training (estimate)	Increase from 2008
2008	2,137	–
2009	2,209	72 (3%)
2010	2,495	358 (17%)
2011	3,241	1,104 (52%)
2012	3,500	1,363 (64%)
2013	3,550	1,413 (66%)

Source: RPSGB

3.55 The **SGHD** told us that a series of meetings had taken place at UK level (in which Scotland was represented) to discuss recruitment and retention issues around pharmacists. The SGHD stressed that any recommendations made as a result of these meetings would be considered in a Scottish context, as appropriate. The SGHD explained that NHSScotland had developed a policy which allowed all Boards to apply for RRPs as they felt necessary. To date no Board in Scotland had requested an RRP for pharmacists although the SGHD confirmed that some Boards were experiencing similar difficulties to those in England in the recruitment and retention of pharmacists.

3.56 The **WAG** told us that as at 30 September 2007 there were 509 qualified pharmacists in Wales, 51 (11.2 per cent) more than the previous year. The three-month vacancy rate was 1.9 per cent as at 31 March 2008 compared with 2.5 per cent in September 2007 and the WAG would therefore not support a national RRP for pharmacists.

3.57 The **DHSSPSNI** told us that it did not support a national RRP for pharmacists as local recruitment difficulties could be addressed through a local RRP in the same way as for other staff groups. The pharmacy workforce reviews completed in Northern Ireland in 2006 indicated that, while there was a shortfall in relation to the number of pharmacists and technicians required to deliver the modernisation initiatives underway, projections had indicated that supply and demand would come into balance after 2006. The DHSSPSNI informed us that it had not as yet scheduled the next pharmacy workforce review, but confirmed that it was likely that it would review the workforce again in late 2009 or 2010. The DHSSPSNI confirmed that it was represented on the pharmacy working group.

[30] The professional and regulatory body for pharmacists in England, Scotland and Wales.

[31] These projections take into account further potential new schools of pharmacy and increased intakes in existing schools of pharmacy.

3.58 The DHSSPSNI also commented that while pharmacy in general did not experience recruitment difficulties in Northern Ireland, the hospital sector traditionally attracted fewer recruits, largely due to the lower starting salary compared to the community sector. Overall, the DHSSPSNI told us that it had no information to show that pharmacy suffered from higher turnover than other groups.

3.59 The DHSSPSNI told us that the pharmacy workforce had expanded rapidly in the past five years with a 42.6 per cent increase in the whole-time equivalent pharmacy workforce between December 2003 and December 2008. In the year ending March 2008, 8.7 per cent of pharmacy staff (36 staff) had either moved within the HSC sector or left the HSC; this included 6.4 per cent (25 staff) within this group that actually left the HSC. This compared with 8.8 per cent staff turnover in the wider Professional and Technical staff group.

NHS Employers

3.60 **NHSE** told us that it would continue to work with the Department of Health and Staff Side organisations to consider the particular issues relating to the supply of pharmacists. NHSE informed us that there had been a number of constructive meetings with Unite and the Health Departments to discuss issues around the supply, demand and retention of pharmacists. The parties were seeking a solution consistent with AfC and acceptable to the NHS Staff Council.

3.61 As noted in paragraph 2.47, a short consultation in March 2008 by NHSE showed national problems in the recruitment of pharmacists; this profession had subsequently been included on the Migration Advisory Committee's list of shortage occupations. NHSE reported that remuneration was not necessarily a key factor in the shortage but that there were other aspects such as workforce supply; NHSE considered that local RRPs were not appropriate in relation to addressing supply shortages and would lead to unhelpful competition for staff between NHS organisations.

Staff Bodies

3.62 The **Staff Side** said that pharmacists had been on the Home Office list of shortage occupations for the past five years. There was, therefore, no reason to believe that inclusion on the Migration Advisory Committee shortage list would have any greater effect.

3.63 **Unite** pointed out that there was a strong labour market for pharmacists. Recruitment and retention difficulties experienced in pharmacy varied from region to region, but underlying this was what Unite believed to be a high vacancy rate in each region, as demonstrated by the PEVS. Unite argued that because of the level of vacancy rates, regional solutions were inappropriate.

3.64 Unite did not agree with the DHSSPSNI's statement that supply and demand of pharmacists in Northern Ireland were in balance. Unite highlighted findings from the PEVS, which showed total vacancy rates for band 6 pharmacists in Northern Ireland to be 17.4 per cent at the point of the survey and a three-month vacancy rate for band 6 pharmacists of 16.2 per cent. Unite considered that supply was well short of demand, rather than in balance.

3.65 Unite initially told us in October 2008 that it was participating in discussions with NHSE and the Department of Health. Unite confirmed that there was work in progress but there was no final outcome which could be reported to us but that Unite, alongside other parties, would keep us informed of developments.

3.66 Unite subsequently told us in February 2009 that it considered that there was no scope for continuing progress with the other parties to reach a workable solution on pharmacists, as Unite was committed to a solution based on a national RRP or a comparable provision. In Unite's view, the Departments and NHSE were opposed to this as they did not accept that there was a national recruitment and retention problem in relation to pharmacists. Consequently, Unite could not realistically see how further progress could be made and a workable solution agreed.

3.67 Unite therefore sought a national RRP of £5,000 per annum for pharmacists in bands 6 and 7, with total pay capped at the maximum value of band 7. This figure was based on the midpoint of the salary differential highlighted in the 2007 Incomes Data Services review of salaries of private sector pharmacists[32], and also represented a value of approximately five increments above the minimum value of AfC band 6.

Our Comment

3.68 As set out in paragraph 3.22 above, our approach to national RRPs is to consider the evidence for the UK as a whole. This approach is particularly appropriate for groups such as pharmacists, for which there is a national labour market.

3.69 The new data available from the PEVS point to a high UK-wide vacancy rate for pharmacists in bands 6 and 7, a position that has not changed substantially since last year. Further qualitative research, though limited to England, has reinforced the message evident from the PEVS. We note the SGHD's statement that some Boards are experiencing similar difficulties to England, though we are disappointed not to have received more detailed evidence from Scotland. Our view in our Twenty-Third Report, based on limited evidence, was that there appeared to be a problem retaining pharmacists after 3 – 5 years' service; we still have concerns about this retention problem. On the basis of the new evidence presented, we consider that there is also a significant problem in retaining qualified pharmacists in the NHS following pre-registration training, and that the higher level of pay in the community sector compared to the salary in band 6 is a contributory factor to this.

3.70 The Health Departments and NHSE told us that they do not support a national RRP for pharmacists, stating that local solutions are more appropriate. However, NHSE also told us that it did not support local RRPs, as in its view they would destabilise the internal NHS market and possibly lead to pay spirals. In our view, the combination of these two positions undermines the use of the provisions within AfC that were designed specifically to address shortages of particular groups. This seems to be borne out by the evidence from the findings of the survey of SHA Workforce Directors, the WRT report and the scoping study by Capita into the usage of RRPs by NHS organisations in England and Wales (see paragraphs 3.87 – 3.90 below).

3.71 Failure to use the scope for pay flexibility offered by AfC through RRPs may lead employers to consider strategies to recruit to hard-to-fill vacancies which may have long-term undesirable consequences. These include 'grade drift' and other *de facto* revisions to the agreed AfC job structures that could ultimately lead the NHS labour market back to the pre-AfC era of local pay differentiation. Such strategies are incompatible with a key objective of AfC which is to meet equal pay for work of equal value criteria.

[32] IDS (2007) *A Review of Remuneration of Pharmacists in the Community Retail Sector*, OME; summarised in NHSPRB (2008) *Twenty-Third Report*, TSO (Cm 7337) paragraph 3.17.

3.72 There appears to be a consensus among the parties that the difficulties in recruiting and retaining pharmacists are concentrated in bands 6 and 7; this has been an issue for a number of years[33]. In our Twenty-Third Report, we asked the parties to work together to address the problem with the retention of pharmacists before the next Review Body round and reach a workable solution, and to report back to us on progress, with a view to us considering making a formal recommendation this year if we believed that insufficient progress had been made. Although the parties have met to discuss the issue, progress has been slow, and Unite does not consider that a workable solution will be agreed. Aside from ongoing discussions around how to modernise pharmacy careers and promote local examples of best practice, and reissuing guidance to employers on the use and application of local RRPs in general, the Health Departments and NHSE take the view that it is sufficient to wait until the supply of pharmacists increases adequately to address the problem.

3.73 Table 3.3 above shows that the supply of pharmacy graduates entering pre-registration training is not projected to increase significantly until 2010; the supply of new band 6 pharmacists is not therefore expected to increase significantly until 2011 at the earliest, taking into account the requirement for a year of pre-registration training.

3.74 The lack of urgency in agreeing a solution to the shortage of pharmacists in the NHS carries substantial risks: high vacancy rates have been observed for some years, and the WRT found these to be having an adverse impact on staff morale and service delivery. From 2010, new graduates are likely to come into the labour market with more debt due to increased tuition fees (which came into effect in 2006), which is likely to increase the attraction of working in the community sector where starting salaries are higher. We also note that there is a widespread view across SHAs that we should make a recommendation that financial incentives should be introduced.

3.75 We therefore consider that action needs to be taken in the short term to address the problem of recruitment and retention of pharmacists in the NHS, and that a national RRP is the appropriate mechanism. This approach allows the parties time to consider longer-term strategies to address the problem.

3.76 We consider that short-term action should primarily be focused at the lower end of the pay structure for pharmacists, to provide a financial incentive for pre-registration pharmacy trainees to remain in the NHS on graduation. We are also concerned about the retention rate of pharmacists in the early years of their NHS careers. In our view, a financial incentive is appropriate to address these problems, with the value of the incentive tapering as individuals progress up the pay points in bands 6 and 7.

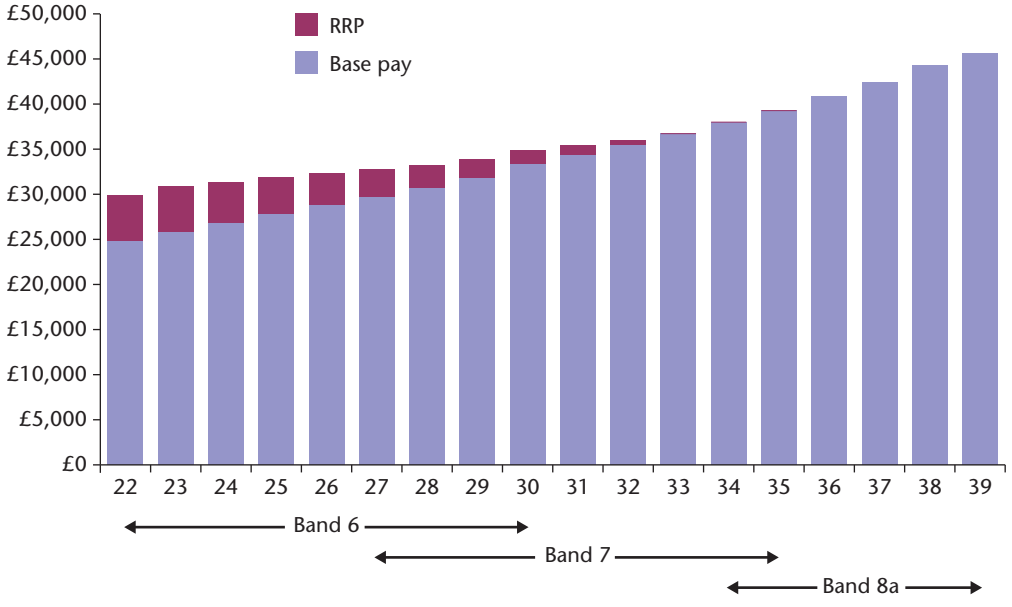
3.77 **We recommend a short-term national RRP for pharmacists of £5,000 at the lowest point of AfC band 6, decreasing in stages to £500 at the sixth point of band 7. This should be implemented from 1 October 2009, and remain in place for a fixed term of 2½ years until 31 March 2012.** Detailed payscales are set out below.

[33] Amicus first approached us in 2005 regarding a national RRP for pharmacists paid under AfC.

Table 3.4: Recommended RRP for pharmacists in bands 6 and 7 from 1 October 2009

	Band 6			Band 7			Band 8a
Pay point	Basic pay £	RRP £	**Total pay £**	Basic pay £	RRP £	**Total pay £**	Basic pay £
22	24,831	5,000	**29,831**				
23	25,829	5,000	**30,829**				
24	26,839	4,500	**31,339**				
25	27,844	4,000	**31,844**				
26	28,816	3,500	**32,316**				
27	29,789	3,000	**32,789**	29,789	3,000	**32,789**	
28	30,762	2,500	**33,262**	30,762	2,500	**33,262**	
29	31,856	2,000	**33,856**	31,856	2,000	**33,856**	
30	33,436	1,500	**34,936**	33,436	1,500	**34,936**	
31				34,410	1,000	**35,410**	
32				35,504	500	**36,004**	
33				36,719	-	**36,719**	
34				37,996	-	**37,996**	37,996
35				39,273	-	**39,273**	39,273
36							40,853
37							42,434
38							44,258
39							45,596

Figure 3.5: Basic pay and RRP for pharmacists from 1 October 2009



3.78 Employers currently paying local RRPs to pharmacists may wish to consider the relationship between these local RRPs and our recommended national RRP. Our recommendation for a national RRP should not preclude local employers from awarding additional local RRPs where necessary, subject to the guidance set out in the AfC Handbook[34], and we encourage them to continue developing non-pay benefits which are crucial in attracting and retaining pharmacists in the NHS.

3.79 We consider that our recommendation will provide value for money, in terms of increased capacity for service delivery, potential for reduced outlay on locum and agency staff, and benefiting from the investment made in training those staff who may otherwise leave the NHS.

3.80 We agree that all national RRPs should be subject to regular review, as set out in paragraph 5.10 of the AfC Handbook, to ensure that they remain appropriate. We envisage that we will undertake a review of this national RRP in spring 2011, such that a decision can be taken as to whether it should or should not be renewed (or renewed in a modified form) after 31 March 2012. We would, of course, welcome any feedback from the parties before that date.

3.81 To facilitate our review, we will require UK-wide evidence on how the RRP has affected the recruitment and retention of band 6 and 7 pharmacists in the NHS. Our detailed evidence requirements will be a matter of early discussion between the parties and our secretariat.

Local Recruitment and Retention Premia

3.82 In our Twenty-Third Report we highlighted the apparent lack of evidence on the usage and efficacy of local RRPs and whether there were problems in implementing them. We asked the Health Departments and NHSE to probe these issues in more detail, and to offer guidance to Trusts on issuing local RRPs.

3.83 The Health Departments for Scotland and Wales have informed us that no local RRPs are currently payable in these countries. Where an NHS organisation is considering paying a local RRP for a particular staff group, the case is considered by the Scottish Terms and Conditions Committee in Scotland, and the Welsh Partnership Forum Agenda for Change Implementation Sub-Group in Wales.

3.84 In Northern Ireland, where there is consensus in a Trust area that a local RRP is appropriate, a business case is submitted to the DHSSPSNI, which evaluates the business case and considers the impact that paying a premium in one Trust area would have on other Trusts across the region. One local RRP is currently payable in Northern Ireland.

3.85 There exists no comprehensive source of data on the incidence of local RRPs in England. Data are not available centrally either from the Department of Health or NHSE. Where Trusts use the Electronic Staff Record (ESR) HR System, the way in which data on pay supplements are recorded appears inconsistent. A variety of local payment types in the ESR system are aggregated in the Data Warehouse as "general" and "long-term" RRPs. It is therefore not possible to use data from the ESR Data Warehouse to determine whether Trusts are paying local RRPs.

[34] Paragraph 5.13 of the AfC Handbook states that "the combined value of any nationally awarded and any locally awarded recruitment and retention premium for a given post shall not normally exceed 30 per cent of basic salary."

3.86 With the support of the parties, our secretariat commissioned Capita Health Service Partners to conduct a scoping study into the usage of local RRPs in NHS organisations in England and Wales.

Capita survey[35]

3.87 Capita Health Service Partners conducted an email survey of Trusts in England and Wales, asking whether local RRPs were being paid, whether the Trust was considering paying local RRPs within the next 12 months, or whether the Trust was not paying or considering paying local RRPs. Of 391 Trusts contacted in England, 150 usable responses were obtained; telephone interviews were conducted with 37 of these Trusts to gather more detailed information on the payment and non-payment of local RRPs. In Wales, four out of nine Trusts responded to the email survey; a telephone interview was conducted with one of these Trusts.

3.88 There was some confusion on the part of those responding over the staff groups covered by national premia and the definition of local premia, so the findings of the survey should be treated with considerable caution.

3.89 In all, 39 per cent of Trusts responding to the email survey reported that they were paying local RRPs to staff, but these were generally paid to relatively small numbers of staff in occupations where the NHS faced competition from other employers. In telephone interviews, Trusts said they were reluctant to pay premia to larger groups of staff, as these could spread to other staff groups and to neighbouring NHS organisations.

3.90 The email survey found that 43 per cent of Trusts were neither paying nor considering paying local RRPs, with most of these Trusts stating that they were not experiencing recruitment and retention problems that justified their payment.

Evidence from the Parties

The Health Departments

3.91 The **Department of Health** told us that, to improve its understanding of the use of the local flexibilities in the AfC agreement, it had set in train work to look further at the use of local RRPs. The Department told us that some employers were unclear on the appropriate use of local RRPs, so, as part of addressing the issue of the retention of pharmacists, the Department was working with NHSE to provide further guidance on the use of local RRPs. This guidance would explain the appropriate application of local RRPs for all AfC staff groups where needed.

3.92 The **Devolved Administrations** provided information on the procedures for considering local RRPs in each country, outlined in paragraphs 3.83 – 3.84 above.

NHS Employers

3.93 **NHSE** advised us that some employers reported that there were problems with recruiting and retaining some professional groups but said that these tended to be influenced by local market factors. NHSE stressed that in the main employers had not needed to use recruitment and retention premia to address recruitment difficulties.

[35] Capita Health Service Partners (2009) *Scoping Study on the Payment of Local Recruitment and Retention Premia*, OME

3.94 NHSE also told us that employers used local RRPs where they considered it necessary to compete in local labour markets, but that local RRPs were not appropriate in relation to addressing supply shortages and would lead to unhelpful competition for staff between NHS organisations.

Our Comment

3.95 In Scotland, Wales and Northern Ireland, local RRPs are considered by a central body. It has been clarified that this process allows for local application of RRPs.

3.96 We are disappointed that the situation in England remains largely unknown. Whilst we are grateful to Capita Health Service Partners for their scoping study, it is difficult to draw firm conclusions given Trusts' apparent confusion as to the definition of "local" premia. It is clear that more work is needed in this area to obtain a reliable picture. **We therefore ask that the parties work with our secretariat to determine what future research can be conducted, and that the Department of Health and the NHS Information Centre work together to examine whether the ESR system has the potential to record data on the usage of local RRPs on a consistent and accurate basis.**

3.97 **We also request that the Department of Health and NHSE share with us their guidance to Trusts on the application of local RRPs.**

High Cost Area Supplements

3.98 As part of the three-year pay agreement, existing HCAS were increased by 2.75 per cent from April 2008, and will be increased by 2.4 per cent from April 2009. We have received no new requests for a HCAS from any of the parties.

3.99 In our Twenty-Third Report, we concluded that the evidence presented by the Staff Side for a new HCAS in South Cambridgeshire was not sufficient to justify its introduction, and stated that in the event that we were to consider on a future occasion that a new HCAS was justified, we would welcome clarification from the parties as to how the geographic boundaries applicable to such a payment should be defined.

Evidence from the Parties

The Health Departments

3.100 The **Department of Health** explained that the geographical boundaries for HCAS were based upon PCT geographical areas as set out in Annex H of the AfC Handbook[36]. The Department of Health also confirmed that it would be for us to make recommendations on the future geographic coverage of HCAS and on the value of each supplement. It confirmed that no additional funding would follow should there be a revision to the HCAS.

Staff Bodies

3.101 The **Staff Side** told us that it had discussed the outcomes of the Twenty-Third Report with the parties in South Cambridgeshire and had jointly concluded that they would not submit evidence this year in support of a HCAS, but would undertake work within the Trust and with neighbouring Trusts to further research the case, and may wish to submit evidence arising from this work to the Review Body in future years.

[36] NHS Staff Council (2007) *NHS Terms and Conditions of Service Handbook*, Annex H

Our Comment

3.102 We note that the Staff Side is undertaking further work to research the case for a new HCAS in South Cambridgeshire. In the event that such an application is received in future years for this or another PCT area, we would wish to remind the parties of the requirement to provide a robust evidence base from which we may draw our conclusions.

Chapter 4 – Morale and Motivation

Introduction

4.1 We consider matters of morale and motivation to be fundamental to our deliberations by virtue of their relevance to other areas, in particular to the recruitment and retention of staff and service delivery. The importance of the Knowledge and Skills Framework (KSF) to staff morale has been highlighted to us, as well as the importance of regular performance appraisals. In this chapter we review the evidence on the morale and motivation of our remit group, progress towards implementing the KSF, and staff contribution to efficiency savings.

NHS Staff Surveys

4.2 In our Twenty-Third Report, we noted that we had been unable, on the basis of what we had received, to give detailed consideration to the morale and motivation of our remit group in Scotland, Wales and Northern Ireland, and noted that more detailed evidence from those countries would be helpful.

4.3 In December 2008, as part of our consideration of whether we would seek a remit to review the pay increases agreed by the parties for 2009/10 and/or 2010/11, we reviewed the results of the most recent surveys of staff in England and Wales, conducted in autumn 2007. A summary of findings from a survey of staff conducted in March 2008 in the largest Health and Social Care (HSC) Trust in Northern Ireland was also submitted to us. These results are summarised, with our comments, in our letter to the parties in December 2008. This is reproduced in Appendix B to this Report, and is also available on the OME website[37].

4.4 The results of the 2008 survey of NHS staff in Scotland were published in January 2009.

Evidence from the Parties

The Health Departments

4.5 The **Department of Health**, referring to the Healthcare Commission's 2007 survey of NHS staff in England, highlighted improvement in indicators relating to: work-life balance; flexible working; work-related stress; and the number of staff working additional hours. There had been deterioration over the past 3 years in the figures relating to the intention of staff to leave the NHS, and work pressure felt by staff.

4.6 The Department considered that morale as a concept was incredibly complex and no universal measure had been agreed. For this reason the Department used the internationally recognised measure of the seven questions that made up the "job satisfaction" score as the closest indicator of the satisfaction levels of NHS staff. The Department noted that the average score for job satisfaction had increased slightly from 3.42 to 3.43 (on a scale of 1 – 5) for non-medical staff.

4.7 The **Scottish Government Health Directorates (SGHD)** highlighted the results of the 2008 NHS Staff Survey in Scotland:

- 56 per cent of staff were comfortable with the level of pressure placed on them in their job;

[37] www.ome.uk.com

- 39 per cent felt their pay was reasonable, considering their duties and responsibilities, while 62 per cent were satisfied with their total benefits package;

- 55 per cent would recommend NHSScotland as a good place to work;

- 77 per cent of staff intended to be still working within their NHS Board in 12 months time; and

- 85 per cent of staff were happy to go the extra mile when required.

4.8 The **Welsh Assembly Government (WAG)** told us that key strengths identified by the NHS Wales 2007 Staff Opinion Survey included a high level of intention to stay working for NHS Wales in 12 months' time, and that performance reviews accurately reflected performance and helped respondents to focus on improving their performance. Additionally the survey showed that, as in Scotland, a substantially higher proportion of staff were satisfied with the total benefits package than were satisfied with their level of pay, considering their duties and responsibilities.

4.9 The WAG identified several areas for improvement: there was dissatisfaction amongst respondents with communication between management and respondents and staff were quite negative about how effectively change was managed. Perception of job security was also reported as being quite low, which the WAG suggested could have been due to large levels of change: this had quite a high impact on satisfaction and engagement levels among respondents.

4.10 Following this survey the WAG told us about an *All Wales Improvement Plan*, which had been drafted to address problems with: communication and senior management; staff being treated fairly and consistently; work environment and facilities; and work life balance and conditions. The plan would determine what needed to be improved, who would be responsible, and how the success of the improvement would be measured.

4.11 The **Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI)** told us that while individual HSC organisations in Northern Ireland had undertaken comprehensive surveys of their staff, there had not been a coordinated approach to surveying staff attitudes. It advised us that plans were underway for a Northern Ireland wide survey of HSC staff in the autumn of 2009.

4.12 The DHSSPSNI provided headline results of a sample survey undertaken by the largest HSC Trust in March 2008, which the DHSSPSNI considered to be representative of the HSC workforce in Northern Ireland. The DHSSPSNI advised us that this survey found that staff were generally satisfied across service groupings, although only 34 per cent felt they were recognised for good work. One in five staff declared a wish to leave the organisation as soon as another job could be found; the single most common reason given for this was that staff felt the organisation did not value their work. 70 per cent of HSC staff felt they could cope with the demands of the job but under half felt they did not have adequate time or equipment, materials or supplies. The DHSSPSNI said that the issues raised in the staff survey that impacted on job performance and staff morale and motivation included delayed decision making, ineffective management of absenteeism, lack of facilities such as lockers and showers for staff and a need for a more proactive approach to encourage increased staff health and well-being.

4.13 The DHSSPSNI advised us that it was now using this information to improve staff working lives and to provide better care for patients and clients and that how this should be tackled was being developed. Staff focus groups had been established to consult on a range of the work-life balance arrangements highlighted in the survey and a programme of work was being developed in relation to *Improving Working Lives* and *Health and Well Being at Work*, with a Personal Contribution Framework being implemented.

NHS Employers

4.14 **NHSE** cited the results of the Healthcare Commission's 2007 survey of staff in England, which NHSE said showed that staff remained generally satisfied with their jobs despite the large amount of change taking place across the NHS. NHSE explained that this was partly due to satisfaction with the high levels of support that most staff got from their work colleagues, as well as satisfaction with the amount of responsibility they were given and the opportunities they had to use their skills.

Staff Bodies

4.15 The **British Orthoptic Society** told us that staff felt demoralised due to waiting for their AfC banding outcome, or awaiting the outcome of appeals. The **Chartered Society of Physiotherapists** provided a number of case studies indicating that morale was worsening amongst its members.

4.16 The **Royal College of Midwives** provided results of its annual survey of Heads of Midwifery (HOMs). 29 per cent of HOMs reported in 2008 that their staff were happy or very happy, compared to 40.5 per cent in the 2007 survey. 94.5 per cent of HOMs said that their unit's workload had increased in the previous 12 months, which had detrimental consequences on morale and service provision.

4.17 The **Society of Radiographers** told us that some graduates found it difficult to see how they could progress up the AfC banding structure, as there were a limited number of posts at higher grades. This negatively affected staff morale.

4.18 **UNISON** conducted a survey of its health service members in September 2008, to which over 3,300 members had responded. 77 per cent of staff reported an increase in their workload, and 73 per cent said that stress had increased over the last year. 56 per cent of respondents considered that morale in their department was low or very low; this had decreased by 7 percentage points compared to the previous survey[38]. Nearly half (49 per cent) of staff had fairly or very seriously considered leaving their current position, with the level of pay the most frequently-cited reason among those considering leaving.

4.19 A survey of speech and language therapists (SLTs) conducted by **Unite** in 2008 found that 63 per cent of SLTs felt their morale was lower than it had been the previous year, with the same percentage reporting an increase in workload.

[38] NHSPRB (2008) *Twenty-Third Report*, TSO (Cm 7337), paragraph 4.25

Our Comment

4.20 We were unable to give detailed consideration to the morale and motivation of our remit group in Scotland, Wales and Northern Ireland in our report last year and asked for more detailed evidence from those countries. We are grateful for the efforts of the parties in providing us with more information this year. We believe the measurement of morale and motivation of staff to be essential to our considerations and value the data we receive from surveys of staff. However, it is frustrating that, as the questions posed to staff differ between countries, comparisons are difficult to draw. **It would therefore be helpful if the Health Departments, in consultation with other parties and our secretariat, could consider the adoption of a set of common 'core' questions for use in future surveys.** We would find it helpful if these core questions could measure separately the level of satisfaction both with pay and with the total reward package.

4.21 Given the emphasis we placed in our Twenty-Third Report on the IDS survey of staff commissioned by the Staff Side in 2007, we were surprised that the Staff Side did not commission a further survey in 2008. **We urge the Staff Side to consider providing such evidence to support our review of the parties' pay agreement later this year.**

Agenda for Change Assimilation

Evidence from the Parties

The Health Departments

4.22 The **Department of Health** told us that it had stopped monitoring AfC implementation after March 2006 at which point assimilation in England had reached over 99 per cent, and that **NHS Employers** were not aware of any outstanding problems with regard to implementation in England.

4.23 The **SGHD** said that around 99.4 per cent of staff had been assimilated to AfC, and it expected the remaining staff to have been assimilated by April 2009. The **WAG** told us that as at September 2008, 98.6 per cent of staff had been assimilated onto AfC and 97.0 per cent had received their arrears payments. The **DHSSPSNI** told us that over 99 per cent of the workforce had been assimilated onto AfC.

Our Comment

4.24 We thank the parties for providing this update. There is anecdotal evidence, which mirrors our impressions from visits, that a substantial number of appeals against AfC banding outcomes remain outstanding. Such delays are detrimental to staff morale and impede the realisation of the expected benefits of AfC. Data on outstanding appeals should be collected and monitored centrally in the four UK countries.

4.25 We welcome the forthcoming report from the Equality and Diversity Sub-Group of the NHS Staff Council on AfC implementation, and **we request that the report be shared with us when available**.

Knowledge and Skills Framework

Introduction

4.26 In our Twenty-Third Report, we reiterated our view that the KSF is crucial to the efficient delivery of current and future services, welcomed the relaunch of the KSF, and urged the Health Departments and the Staff Side to work together to ensure that the relaunch was successful.

4.27 We also expressed concern at the low level of staff appraisals being carried out[39]. We pointed out that a properly functioning appraisal system for all staff is vital both for morale and to inform training needs, as well as ensuring a safe and appropriate service.

4.28 The National Audit Office (NAO), in its report on the implementation of AfC and the KSF[40], noted that the take-up of the KSF had been slower than expected and that the Department of Health had relaunched it in November 2007. The NAO found that between October 2007 and August – September 2008, the proportion of staff who had had a knowledge and skills review in the previous year had increased from 41 per cent to 54 per cent.

4.29 The NAO also found that there was a perception among some managers and staff that the KSF was complex and burdensome. In the Trusts that had maximised the use of the KSF, there had been a management commitment to making the system work, and staff and managers had received adequate training and were given time to carry out the process.

Evidence from the Parties

The Health Departments

4.30 The **Department of Health** noted that research conducted by the NAO in September 2008 showed that 54 per cent of staff had received a KSF personal development review/ appraisal. The former Chair of the NHS Staff Council's KSF Group had estimated in 2008 that about 60 per cent of staff had a KSF post outline.

4.31 The Department told us that since our Twenty-Third Report was published, the KSF had been relaunched and that Skills for Health[41] had been working with the NHS Staff Council's KSF Group (a sub group of the NHS Staff Council) to align its training and development programmes by mapping competencies to the KSF.

4.32 The Department explained that a relaunch of the KSF had been necessary because there had been concern about the level of take up of the KSF. There was some indication that NHS organisations either had existing systems in place that they considered adequate for knowledge and skills development and/or considered the use of the KSF as cumbersome given the amount of work required to put staff onto the KSF. There was concern therefore that staff were not receiving the training and development that the KSF was designed to enable. Further, there was concern that ineffective use of the KSF might lead to some staff passing through AfC gateways, points at which they should demonstrate they have met the KSF requirements to access the next pay point, without the relevant knowledge and skills.

---

[39] NHSPRB (2008) *Twenty-Third Report*, TSO (Cm 7337), paragraph 4.45

[40] National Audit Office (2009) *NHS Pay Modernisation in England: Agenda for Change*, TSO, paragraph 19

[41] The Sector Skills Council for the health sector, part of the Skills for Business network of 25 employer-led Sector Skills Councils.

4.33 The Department told us that at a Social Partnership Forum (SPF) meeting in November 2008 a sub-group of the SPF was reconvened, which would be jointly chaired by the Director of Pay, Pensions and Employment Relations at NHSE and the Staff Side Chair of the Staff Council. This sub-group would consider and assess the challenges that the NHS is facing in the use of the KSF and would steer the work required in identifying the potential solutions all of which would help to inform the workplan of the NHS Staff Council's KSF Group (KSFG). The KSFG, which includes both management and staff side representation, would develop the practical arrangements to implement the solutions through appropriate NHS networks.

4.34 The Department also told us that registered clinical staff maintained their clinical standards as required by their regulatory bodies and that most recently, many of these bodies had been working with the NHS Staff Council to align training and development programmes with the KSF to ensure the increased skills of their members were recognised by NHS organisations. The Department stated that while non-clinical staff were not regulated in the same way, following publication of the *Next Stage Review*, the Department intended to work with the profession, the NHS and other stakeholders to ensure that there were fair and effective arrangements to prevent poorly performing leaders from moving on to other NHS organisations inappropriately.

4.35 The Department told us that the Healthcare Commission's surveys of NHS staff in England had found that the percentage of staff receiving an appraisal in the 12 months prior to the surveys had risen from 57 per cent in 2006 to 61 per cent in 2007, with those receiving an appraisal with a personal development plan (PDP) rising from 48 per cent to 52 per cent over the same period.

4.36 The **SGHD** described the KSF as a "key plank" of AfC which provided a structured and improved approach to development for NHS staff, linked closely to pay progression. The SGHD told us that the KSF was not being relaunched in Scotland as it was performance-managing implementation which it reported was progressing well.

4.37 The SGHD explained that the KSF was now a Health Efficiency Access and Treatment target: all Health Boards were required to ensure that each member of staff had a KSF outline and KSF PDP in place by 31 March 2009. As at 31 December 2008, 72.8 per cent of staff covered by AfC had been assigned a KSF outline and 44.2 per cent had a KSF PDP; as at 30 September 2008, 5.5 per cent of NHSScotland staff had had a KSF review.

4.38 The **WAG** told us that 36 per cent of staff had had a performance review, and subsequently said that, as at January 2009, 79 per cent of staff had an assigned approved post outline and 11 per cent had a PDP.

4.39 The **DHSSPSNI** considered that the KSF was a mandatory element of the terms and conditions of service for staff employed in HSC organisations in Northern Ireland, but despite good progress in relation to the matching and assimilation of staff onto AfC pay bands, it reported that progress on implementation of the KSF had lost focus. The DHSSPSNI advised us that this situation had not been helped by the establishment of new HSC organisations under the Review of Public Administration which had been the prime focus during the past year. As the new organisational structures took shape, and matching and assimilation activity neared completion, the focus would be concentrated on the implementation and continuing use of the KSF. The DHSSPSNI advised us that current data showed that 42 per cent of the workforce was covered by a KSF post outline.

4.40 The DHSSPSNI also told us that plans were underway to hold a relaunch of the KSF, in partnership with the staff side, later in 2008 and that this would be directed at senior staff in HSC organisations. The relaunch would also coincide with the launch of the HSC Workforce Learning Strategy in Northern Ireland.

4.41 The DHSSPSNI told us that 33 per cent of staff had received a personal development/ individual performance appraisal within the last 12 months.

NHS Employers

4.42 **NHSE** informed us that feedback from individual employers highlighted the critical role that board-level support and leadership continued to play in the successful implementation and benefits realisation of the KSF. NHSE explained that national job evaluation had taken priority over implementation of the KSF, due to a lack of capacity within NHS organisations to respond to competing priorities.

4.43 NHSE said that the relaunch of the KSF in 2007 had been aimed primarily at Chief Executives, and had been successful in raising awareness of the benefits of the KSF in addition to sharing examples of good practice in its use. NHSE advised that implementation of the KSF remained a priority and was the focus of a number of key areas of work that were being undertaken in partnership with the Department of Health and the Staff Side.

Staff Bodies

4.44 The **Staff Side** told us that it saw the KSF as the tool to manage career and pay progression in the NHS and that it was crucial to delivering current and future services effectively. The Staff Side said that the KSF would enable staff to develop the necessary skills to increase efficiency and flexibility, creating a workforce that was able to adapt to the changing context of healthcare.

4.45 The Staff Side informed us that much work had been done to re-establish the KSF partnership networks at all levels, with each of the ten SHAs having led a regional event aimed at Trust board members, to share good practice, reinforce the benefits of the KSF and kick-start the process for those organisations that had fallen behind. Whilst the Staff Side saw this progress as encouraging, it believed that there was still a long way to go before the KSF was successfully embedded and that it would continue to require sustained effort at all levels to ensure that the KSF was fully implemented throughout the NHS.

4.46 The Staff Side told us that monitoring figures for June 2008 on implementation of the KSF in England showed that, of the 45 per cent of Trusts that responded, around 67 per cent of staff were recorded as having a full KSF outline, 35 per cent were reported as having had a personal development review in the past year and 33 per cent were reported as having a PDP. September 2008 monitoring figures for Wales showed that an estimated 76 per cent of the workforce was covered by a KSF post outline. In Scotland 32 per cent of staff had an assigned KSF outline and 24 per cent had a KSF review based on their PDPs.

4.47 The Staff Side also highlighted the results of the Healthcare Commission's 2007 survey of NHS staff in England (see paragraph 4.35), and considered this to be disappointingly slow progress given that without a proper appraisal system provided by the KSF, an organisation could not assess the skills of its workforce or identify the training needs necessary to deliver its objectives.

4.48 The Staff Side told us that the success of the KSF had been patchy so far, with some employers showing reluctance to recognise the benefits of the framework. Following the relaunch of the KSF in England in 2007, the joint partners had been working through various channels to drive through the full benefits of the KSF but even in England, which was further ahead in embedding the KSF than the rest of the UK, the Staff Side considered that some employers were implementing the KSF "painfully slowly".

Our Comment

4.49 Once again, we reiterate the points made in our previous reports. We believe that the KSF is key to the success of AfC; it provides the means of recognising the skills and knowledge needed to be effective in a particular post; it ensures staff have clear and consistent objectives to help them develop; it provides for an annual appraisal and development review; and it determines the knowledge and skills required in the post before the postholder can progress through the pay gateways in each band. It is crucial to the efficient delivery of current and future services as it identifies the training and development needs of staff such that they can be equipped with the skills needed to meet the objectives of the NHS.

4.50 A properly functioning appraisal system for all staff is vital both for morale and to inform training needs, as well as ensuring a safe and appropriate service. We continue to be concerned at the low level of staff appraisals being carried out (for example, only 54 per cent of staff in England had had an appraisal in the 12 months to September 2008) and we consider that progress to date has been poor.

4.51 We welcome the renewed focus on this matter, and **we urge all parties to continue to give implementation of the KSF the highest priority, and to report back to us on progress in the evidence for the next Review Body round.**

Staff Contribution to Efficiency Savings

4.52 In our Twenty-Third Report we recommended that the Health Departments report back to us each year using a standardised and comparable format on how efficiency savings in the NHS had been measured and achieved, and how staff had contributed to the achievement of those targets.

4.53 The NAO in its report referred to in paragraph 4.28 above noted that the Department of Health expected that AfC would result in a 1.1 – 1.5 per cent year-on-year rise in productivity. The NAO reported that the Department had not carried out a specific exercise to demonstrate the productivity savings resulting from AfC, nor had Trusts attempted to measure the resulting efficiency or productivity gains. Without the means to estimate the specific impact of AfC it was not possible, in the NAO's view, to determine whether the productivity savings had been achieved.

4.54 The NAO noted that the more general measures of NHS productivity and efficiency that were available did not take account of changes in quality of services and could not easily be disaggregated to show the specific impact of AfC. As a result the NAO concluded that AfC could not yet be shown to have enhanced value for money.

Evidence from the Parties

The Health Departments

4.55 The **Department of Health** told us that as part of the 2007 Comprehensive Spending Review (CSR) settlement, it was committed to making 3 per cent year-on-year sustained and cash-releasing value for money (VfM) savings. It advised us that all other Government departments were set similarly stretching targets, which were designed to build upon the 2.5 per cent per year savings required under the 2004 Gershon efficiency review[42], which the Department had exceeded. These targets were set on the basis of detailed analysis of further VfM opportunities undertaken as part of the CSR. This equated to an annual saving of over £8 billion by 2010/11.

4.56 The approach to delivering efficiency gains was devolved to individual NHS organisations, though the Department was responsible for key central actions. It was for the NHS locally to decide exactly how to deliver efficiency gains, though these would be powerfully incentivised by fully reflecting 3 per cent efficiency gains in uplifting tariff prices. Progress towards the efficiency targets would be measured and tracked nationally using a variety of indicators, which would be supported by associated local benchmarking measures (which would not constitute local targets).

4.57 The Department said that the work being done to achieve these efficiencies was substantial and wide-ranging. All NHS staff were involved in changing the way they worked to ensure improved efficiency was used to increase investment in patient care.

4.58 The **SGHD** noted that the NHS in Scotland was expected to deliver cash-releasing savings of 2 per cent annually over the CSR period; the savings would be available for local reinvestment.

4.59 The **DHSSPSNI** told us that each HSC organisation had been told to plan on making cash-releasing efficiency savings of 3 per cent in 2009.

Our Comment

4.60 We reiterated in our Twenty-Third Report the importance of clear evidence from the Health Departments regarding the affordability of our recommendations on pay, which included the measurement of planned efficiency savings and the contribution to be made by staff productivity. We welcome the Department of Health's commitment to measuring achievement against its target of 3 per cent year-on-year efficiency savings, and look forward to an update in due course. It remains unclear how efficiency savings in Scotland, Wales and Northern Ireland are to be measured, so **we urge these countries to provide us with evidence at the time of our next review**.

4.61 We have received nothing of detail from the Health Departments regarding the extent to which staff productivity contributes to the achievement of efficiency savings, so **we repeat our request for information on how the Health Departments are progressing in developing evidence in this area**.

4.62 In our Twenty-Third Report we asked the Health Departments to consider what evidence they could provide us on workload for consideration in this round. **We are therefore disappointed that we received no evidence on this from the Health Departments, nor any explanation for this omission. We reiterate our request for more information to be collected and provided for our next round. We ask the Health Departments to keep our secretariat informed of progress in this area.**

[42] Gershon. P, *Releasing Resources to the Front Line: Independent Review of Public Sector Efficiency*, TSO

APPENDIX A

Professor Gillian Morris
Chair NHS Pay Review Body
Office of Manpower Economics
6th Floor
KingsGate House
66-74 Victoria Street
LONDON
SW1E 6SW

27 August 2008

Dear Professor Morris

ROLE FOR THE NHS PAY REVIEW BODY DURING THE PERIOD OF THE 3 YEAR DEAL (2008/9 to 2010/11)

As you will be aware a three year pay settlement was reached between UK Governments, NHS Employers and NHS Trade Unions covering all staff on 'Agenda for Change' contracts for the years 2008/09, 2009/10 and 2010/11. The settlement for the first year was that recommended by the NHS PRB in its 23rd Report.

We attach a copy of the pay circular issued with the agreement of the parties.

The negotiating parties agreed that the NHSPRB would continue to play an important role during the period of the three year deal as set out below:

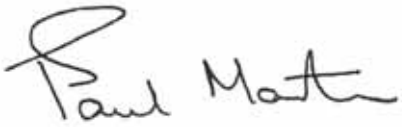
"The NHSPRB will continue to gather evidence throughout the period of this agreement. In the event that the NHSPRB receive and identify new evidence of a significant and material change in recruitment and retention and wider economic and labour market conditions, they may request a remit from the Secretary of State to review the increases set out in this agreement for 2009/10 and/or 2010/11."

We are pleased that the PRB has conducted visits during 2008 and drawn up a provisional timetable for considering evidence during the rest of this year. However, we feel it is unlikely that the parties will be in a position to submit written evidence by the currently proposed date of the 25th September 2008. We would ask you to consider a later date in consultation with ourselves. The Trade Unions have signalled that they will wish to submit information relevant to the revised remit to the PRB by 29 October 2008 and the UK Governments and NHS Employers are content to work to the same timetable.

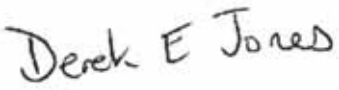
The parties will endeavour to provide you with information and/or evidence as identified in your 23rd report on a range of issues covering, High Cost Area Supplements (HCAS), recruitment and retention for pharmacists, efficiency savings targets and staff contribution, recruitment and retention and workforce planning, KSF implementation and benefits realisation, quality of staff and applicants and finally on morale and motivation in Scotland, Wales and Northern Ireland.

Yours Sincerely,

Department Of Health



Scottish Government

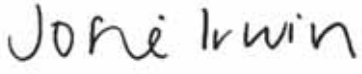


Welsh Assembly Government

Northern Ireland Executive

NHS Employers

Staff-Side Chair of the NHS Staff Council



Staff-Side Secretary of the NHS Staff Council

APPENDIX B

Consideration of whether to seek a remit to review the pay increases agreed by the parties for 2009/10 and/or 2010/11

OFFICE OF MANPOWER ECONOMICS

OFFICE OF MANPOWER ECONOMICS
6th FLOOR
KINGSGATE HOUSE
66-74 VICTORIA STREET
LONDON SW1E 6SW

Direct Telephone Line 020-7215-8387
GTN 215
Fax 020-7215-4445
Web site www.ome.uk.com

Rt Hon Alan Johnson MP, Secretary of State for Health

Michael McGimpsey MLA, Minister for Health,
Social Services and Public Safety, Northern Ireland Executive

Edwina Hart, Minister for Health and Social Services,
Welsh Assembly Government

Nicola Sturgeon MSP, Deputy First Minister and Cabinet Secretary
for Health and Wellbeing, Scottish Government

Gill Bellord, NHS Employers

Mike Jackson, Staff-Side Chair of the NHS Staff Council

16 December 2008

Role for the NHS Pay Review Body during the period of the 3 year deal (2008/9 to 2010/11)

Your letter of 27 August 2008 outlined the role that the parties had agreed we would play during the period of the three year pay settlement (2008/09, 2009/10 and 2010/11). In this letter we were advised that the parties had agreed that we would continue to play a role during the period of the three year deal, as set out below:

> *"The NHSPRB will continue to gather evidence throughout the period of this agreement. In the event that the NHSPRB receive and identify new evidence of a significant and material change in recruitment and retention and wider economic and labour market conditions, they may request a remit from the Secretary of State to review the increases set out in this agreement for 2009/10 and/or 2010/11".*

In our response of 4 September 2008 we advised that after considering all the evidence available, we would write to all parties in the week commencing 15 December 2008 indicating whether we would be requesting a remit from the Secretary of State to review the increases set out in your agreement for 2009/10 and/or 2010/11.

Our focus has been on gathering evidence and information to enable us to make a judgement about whether there is new evidence of a significant and material change in recruitment and retention and wider economic and labour market conditions since the multi-year pay settlement was announced on 7 April 2008. Our analysis is in the attached paper: Annex B to the paper summarises the evidence and information we have considered in making our assessment.

The latest available statistics indicate that the recruitment and retention situation in the NHS appears healthy, with a stable workforce and historically low vacancy rates. Based on the data available to us, there is no new evidence of a significant and material change in recruitment and retention. We have some concerns about the level of on-the-day vacancies and certain indicators of morale, and we wish to keep these under review.

It is clear from the available evidence that the wider economic and labour market situation has changed significantly. However, we do not consider that these changes have materially affected the relative position of our remit group, or that the Agenda for Change pay structure is getting out of line with the wider labour market.

We have therefore decided not to request a remit from the Secretary of State to review the pay settlement contained in the agreement between the parties for 2009/10.

In the light of the data available to us, we do not think it appropriate to take a view on the 2010/11 pay increases contained in the agreement at this time. We will undertake a further review of all the available evidence and information in autumn 2009 to consider whether to seek a remit from the Secretary of State to review the pay settlement contained in the agreement between the parties for 2010/11.

The Royal College of Midwives (RCM) has made an application for a national recruitment and retention premium (RRP) for midwives. At this stage, we do not consider that the available evidence is sufficiently strong to convince us to request a remit from the Secretary of State in relation to the RCM's application for a national RRP for midwives.

As in 2007, The Union of Construction, Allied Trades and Technicians (UCATT) has presented a case for the national RRP currently paid to maintenance craft workers to be extended to include building craft workers. As no new evidence has come to light since we expressed our views in our 23rd report, our position has not changed since that report.

We should be finalising our recommendations on the issues arising from our 23rd Report as specified in the letter of 27 August 2008 early in 2009.

Professor Gillian Morris
Chair
NHS Pay Review Body

NHS PAY REVIEW BODY

Consideration of whether to seek a remit to review the pay increases agreed by the parties for 2009/10 and/or 2010/11

1 Introduction

1.1 The Department of Health, Scottish Government, Welsh Assembly Government, Northern Ireland Executive, NHS Employers and the Staff Side of the NHS Staff Council wrote to us on 27 August 2008 outlining the role the parties had agreed we would play during the period of the three-year pay agreement (2008/09, 2009/10 and 2010/11). In this letter they advised that the negotiating parties had agreed that we would continue to play an important role during the period of the three-year agreement, as set out below:

"The NHSPRB will continue to gather evidence throughout the period of this agreement. In the event that the NHSPRB receive and identify new evidence of a significant and material change in recruitment and retention and wider economic and labour market conditions, they may request a remit from the Secretary of State to review the increases set out in this agreement for 2009/10 and/or 2010/11".

1.2 In that letter they also stated:

"The parties will endeavour to provide you with information and/or evidence as identified in your 23rd report on a range of issues, covering High Cost Area Supplements (HCAS), recruitment and retention for pharmacists, efficiency savings targets and staff contribution, recruitment and retention and workforce planning, KSF implementation and benefits realisation, quality of staff and applicants and finally on morale and motivation in Scotland, Wales and Northern Ireland."

1.3 The full text of the parties' pay agreement appears in Annex A to this paper.

1.4 The NHSPRB Chair's response of 4 September 2008 advised the parties that after considering all the evidence available, we would write to all parties in the week commencing 15 December indicating whether we would be seeking a remit from the Secretary of State to review the increases set out in the agreement for 2009/10 and/or 2010/11.

The Review Body's approach to the remit

1.5 We are content that the pay uplift of 2.75% in 2008/09, as recommended in our 23rd Report, was implemented in full. However, we were not consulted on the pay settlement for 2009/10 or 2010/11 or on the terms under which the settlements for these two years could be reviewed. Nonetheless we have agreed to undertake the work as specified in the remit at the request of the parties.

1.6 Our focus has been on gathering evidence and information to enable us to make a judgement about whether there is new evidence of a significant and material change in recruitment and retention and wider economic and labour market conditions since the multi-year pay settlement was announced on 7 April 2008.

1.7 We have received both oral and written evidence and information from the parties: the parties' written evidence and information is available from their websites (see Appendix D to this report). We have also drawn on other sources of data. Our analysis of recruitment and retention and wider economic and labour market conditions is set out below. A high-level summary of the evidence and information we have considered in making our assessment is in Annex B to this paper.

1.8 We understand from discussions with the parties that, should we wish to consider whether to make a formal recommendation on Recruitment and Retention Premia (RRPs) for staff other than pharmacists, we would need to seek a remit from the Secretary of State to do so. We have received new applications for RRPs from the RCM in respect of midwives, and from UCATT in respect of building craft workers: our views on these applications are summarised below.

1.9 We will be considering all the evidence on the issues identified in our 23rd report at a later date, and expect to report on these issues early in 2009.

2 Recruitment and retention

2.1 The lack of up-to-date NHS workforce data hampers consideration of whether there has been a significant and material change in recruitment and retention.

2.2 To aid us in future reviews of pay for our remit group, it would be helpful for the Health Departments and employers to continue to work to improve the timeliness, quality and consistency of workforce data. We would also like better information from the Health Departments on workforce planning, such that we may take a view on the longer term recruitment and retention picture. We shall explore these issues further in our report in 2009.

Staff in post

2.3 The latest workforce censuses appear to show a fairly stable workforce in each UK country, with overall increases in the number of qualified staff. We note the Staff Side's concern at the increase in the usage of staff drawn from the non-medical staff bank in England, but the increase was negligible as a proportion of the workforce as a whole, and we believe that no reliable conclusion can be drawn from such a snapshot of the workforce.

Vacancies

2.4 The Health Departments' vacancy surveys show low, and decreasing, three-month vacancy rates for nearly all staff groups in England and Wales. Three-month vacancy rates in these countries were below 1% for all staff groups in 2008, and were not materially higher in Scotland and Northern Ireland (see Table 2.1 in Annex B).

2.5 We welcome the publication of 'on-the-day' vacancy rates in England for the first time in 2008, which allows comparison with data from Scotland and Northern Ireland, and with data on vacancies in the wider economy (Chart 2.2). The data, though 'experimental' for England, appear to show that 'on-the-day' vacancy rates in the NHS are at a similar level to those in the wider economy.

2.6 The Staff Side has again told us that the official vacancy statistics understate the true position, as the data show only those vacancies which are being actively recruited to, rather than all posts which are vacant. As we have said on previous occasions, we do not consider it is our role to comment on the appropriate level of establishment. In our view, it is for employers to determine their staffing needs, informed by their own particular pressures and imperatives.

Turnover

2.7 Latest statistics from the NHS Information Centre on turnover of non-medical staff in the NHS in England (Table 2.3), though out-of-date, appear to show a fairly stable leaving rate, at a level lower than the rest of the public sector and the wider economy. Data from Northern Ireland (Table 2.4) show a similar picture. It would be helpful in future for turnover statistics to be provided for NHS staff in Scotland and Wales.

Morale and motivation

2.8 The results of the Healthcare Commission's latest survey of NHS staff in England, conducted in autumn 2007, appear to show some detrimental – but fairly small – changes in key indicators of morale and motivation of NHS staff compared to the 2006 survey results (Table 2.5). Responses to questions relating to work-life balance and job satisfaction were generally slightly more positive than negative, though we have some concerns about staff's perceptions of work pressure, with more negative responses in 2007 than in 2006. The results of the 2007 survey of NHS staff in Wales showed that levels of satisfaction appeared to be broadly similar to those in England. We look forward to receiving the results of the recent surveys of NHS staff conducted in Scotland and Northern Ireland.

3 Wider economic and labour market conditions

3.1 Economic and labour market data are published regularly– often monthly – so changes in these indicators are apparent more quickly. It is clear from examining the data that the economy and labour market have changed since April 2008, and further changes have become apparent in the period since the parties submitted their written evidence and information to us in October 2008.

Pay settlements

3.2 According to Industrial Relations Services, whole-economy median pay settlements have remained around 3.5% since late 2006, notwithstanding other changes in the economy, with lower and upper quartiles generally around 3% and 4% respectively over the same period (Chart 3.1). The basic pay award for the NHSPRB remit group in 2008 was below the median for the whole economy, but above that of the public sector.

Earnings

Economy-wide earnings growth

3.3 Data on headline average earnings growth show that earnings in the public sector as a whole have grown more slowly than those in the private sector in recent years (Chart 3.2). However the latest data, covering the three months to the end of September, show that earnings growth in the public sector has increased since June 2008 and now exceeds that in the private sector, with headline average annual earnings growth at 3.9% and 3.1% in the public and private sectors respectively.

Earnings of the NHSPRB remit group

3.4 We are grateful to the NHS Information Centre for producing quarterly estimates of the earnings of NHS staff in England, which in the latest release covered nearly all NHS organisations (Chart 3.3). Managers had the highest median earnings, followed by qualified staff. Growth in median total earnings was 4.7% for qualified nurses between the second quarter of 2007 and the same period in 2008. We would appreciate the provision of similar and timely data from Scotland, Wales and Northern Ireland.

Relative earnings

3.5 Data from the *Annual Survey of Hours and Earnings* (ASHE) show that median earnings of our remit group have grown at a faster pace than those of the wider economy, and have exceeded the whole-economy average since 2004 (Chart 3.4). Average earnings of our remit group exceed those in the whole economy in all UK regions except London and the South East (Chart 3.5). In our view, the proposed headline pay increase for 2009/10 of 2.4%, along with assumed pay drift and amendments to the pay scales, is likely to produce an average earnings outcome in line with the economy as a whole. We have seen no evidence to suggest that the Agenda for Change pay structure agreed by the parties is getting out of line with the wider UK labour market.

Starting salaries

3.6 The bottom point of Band 5 on the Agenda for Change pay scale, currently £20,225 outside London, is considered to be the "normal" starting salary of a newly-qualified nurse. The relative positioning of the starting salary for nurses has not significantly changed in recent years (Chart 3.6).

Inflation

3.7 It is clear that, after the parties announced proposals for a three-year pay agreement for staff in our remit group, outturns for inflation were much higher than had been anticipated. CPI had been expected to peak at around 3%, but in fact increased to a 16-year high of 5.2%, before falling to 4.1% in November 2008. RPI, which had been expected to fall throughout 2008, maintained the high levels experienced since late 2006, and increased to a peak of 5% in July and September 2008, but then decreased to 3% in November 2008 (Chart 3.7).

3.8 Forecasts, though having a high degree of uncertainty, suggest that both CPI and RPI will continue to fall rapidly in the coming months: the Chancellor in his Pre-Budget Report in November 2008 forecast that RPI inflation will fall below minus 2% in the third quarter of 2009 and CPI inflation will fall to 0.5% in the fourth quarter of 2009. These new forecasts of inflation in 2009 and 2010 are considerably lower than those available when the three-year agreement was announced on 7 April.

3.9 Prices for certain non-discretionary elements of the indices, such as food and energy, have risen at rates well above the average for the indices as a whole. On the basis of this, the Staff Side has said that increases in inflation have had a disproportionate effect on our remit group. Given the average earnings of our remit group as a whole, relative to the whole economy (Charts 3.4 and 3.5), we are not persuaded by the Staff Side's argument that changes in consumer prices have had a disproportionate effect on our remit group, over and above that experienced by the wider population.

Employment and unemployment

3.10 The latest statistics show that the labour market as a whole is weakening, with the employment rate declining, the unemployment rate rising on both measures (Chart 3.8), and the number of vacancies decreasing. Forecasts suggest that unemployment will increase further over the next year. In this climate, we consider that the NHS is likely to appear more attractive as an employer, due to perceived job security, and to non-pay benefits such as pensions, flexible working and leave entitlement.

4 Our conclusions

4.1 We are grateful to the parties for submitting written and oral evidence and information to us. We have considered all the available evidence carefully in reaching a judgement on whether to seek a remit from the Secretary of State to review the pay increases agreed by the parties.

4.2 In the light of the data available to us, we do not think it appropriate to take a view on the 2010/11 pay increase contained in the agreement at this time: our conclusions below therefore relate to the 2009/10 pay period only.

4.3 The latest available statistics indicate that the recruitment and retention situation in the NHS appears healthy, with a stable workforce and historically low vacancy rates. Based on the data available to us, there is no new evidence of a significant and material change in recruitment and retention. However, we have some concerns about the level of on-the-day vacancies and certain indicators of morale, and we wish to keep these under review.

4.4 It is clear from the available evidence that the wider economic and labour market situation has changed significantly. However, we do not consider that these changes have materially affected the relative position of our remit group, or that the Agenda for Change pay structure agreed by the parties is getting out of line with the wider UK labour market.

4.5 Changes in inflation are not in themselves sufficient to compel us to seek a remit to review the pay award agreed by the parties. Our approach is not, and has never been, automatically to link pay to inflation.

4.6 In our view, the increase in the values of the Agenda for Change pay scales contained in the agreement between the parties for 2009/10 is likely to lead to an increase in average earnings that is competitive in the wider UK labour market.

4.7 **We have therefore decided not to seek a remit from the Secretary of State to review the pay settlement contained in the agreement between the parties for 2009/10.**

4.8 **We will undertake a further review of all the available evidence and information in autumn 2009 to consider whether to seek a remit from the Secretary of State to review the pay settlement contained in the agreement between the parties for 2010/11.**

Consideration of whether to seek a remit to make recommendations on National Recruitment and Retention Premia

5 National recruitment and retention premium for midwives

5.1 The Royal College of Midwives (RCM) has made an application for a national recruitment and retention premium (RRP) for midwives. The RCM has proposed that the value of such a national RRP should be £2,000 for qualified midwives in band 5, and £1,000 for those midwives banded above 5.

5.2 We have considered written and oral evidence from the RCM in support of its application, and responses from the Health Departments and NHS Employers. Written evidence from the parties is available from their websites. We have also considered evidence from other sources, summarised in Annex B.

5.3 We note that rising birth rates and Government policies will contribute to an increased demand for midwifery services, and that the average age of the midwifery workforce is increasing. We also note that the Government has recognised that there is a shortage of midwives in England. To address this, the Government aims to recruit 4,000 additional midwives by 2012, and we understand that there has been good progress to date.

5.4 As we identified in our 21st report, when recommending differential awards we must be satisfied that there is robust evidence to support the case. Specifically, in this case, the following points need to be addressed:

- why pay differentiation for midwives is necessary;
- why the recruitment and retention of midwives cannot be achieved by a route other than pay differentiation; and
- why the level of any pay differentiation proposed by the RCM, rather than a lesser amount, is appropriate.

5.5 We recognise that shortages in the midwifery workforce in England exist, but measures are already in place to address this. The issue of shortages is a matter that we will continue to monitor closely, including the impact of those measures put in place to address shortages. We would therefore welcome further evidence from the parties, including evidence on the position in Scotland, Wales and Northern Ireland.

5.6 **At this stage, we do not consider that the available evidence is sufficiently strong to convince us to request a remit from the Secretary of State in relation to the RCM's application for a national RRP for midwives.**

6 National recruitment and retention premium for building craft workers

6.1 As in 2007, The Union of Construction, Allied Trades and Technicians (UCATT) has presented a case for the national RRP currently paid to maintenance craft workers to be extended to include building craft workers. The value of the existing national RRP for maintenance craft workers is £3,130 p.a.

6.2 **As no substantive new evidence has come to light since we expressed our views in our 23rd report, our position has not changed since that report.**

APPENDIX B, ANNEX A

Full text of the three-year pay agreement reached by the parties[43, 44]

Multi Year Agreement

1. These elements taken as a package will provide a way of linking the key NHS business objectives of delivering service reconfiguration and improving patient satisfaction with improving staff satisfaction and commitment.

Pay – uplifts

2. We propose that to assist stability for employers in delivering services and provide certainty for staff the pay uplifts for each of the three years for all pay points will be:

   2008/09 2.75%

   2009/10 2.4%

   2010/11 2.25%

Pay – Other Issues

3. The following changes will be implemented from the date(s) shown below:

   2009/2010 (year 2)

   Remove the bottom point of band 1 (point 1) from the pay scales. Move the incremental date of all those on point 1 to 1st April from year 2.

   Increase the top point of band 5 (point 25) by 0.33%

   2010/11 (year 3)

   Reduce the length of band 5 from nine to eight. Re-spread the remaining points across the band. Reset incremental date of staff on the removed point to 1 April from year 3 to prevent leapfrogging. Increase the top point of band 5 (point 25) by 0.33% (repeat in year 4) as set out in the attached spreadsheet.

   A flat rate pay increase of £420 for points 1-13 (equivalent to 2.25% at point 14)

The NHS PRB will continue to gather evidence throughout the period of this agreement. In the event that the NHS PRB receive and identify new evidence of a significant and material change in recruitment and retention and wider economic and labour market conditions, they may request a remit from the Secretary of State to review the increases set out in this agreement for 2009/10 and/or 2010/11.

The remit of the Review Body will be amended to reflect this agreement.

---

[43] http://www.nhsemployers.org/pay-conditions/pay-conditions-3612.cfm

[44] Unite rejected the three-year settlement following a ballot of its membership.

Future talks

4. The parties have agreed to hold further talks within the three year period on proposals to reduce the number of incremental pay points (starting with bands 6 and 7) that are affordable within the context of future pay awards.

5. The trade unions claim for a reduction in the hours of the working week will be considered within future talks between the parties on productivity improvements within the NHS.

6. Commitment to working in partnership to continue to increase the number of apprenticeships in the NHS in line with Government policy

Non-Pay Elements

7. The following components relate to the management of

   a. Revised facilities agreement for NHS staff

   b. Work – life balance and well being statement

8. The signatories propose that this agreement would provide the NHS with known and affordable arrangements for pay during the period April 2008 to March 2011. The arrangement would apply to all staff employed by the NHS on terms and conditions agreed under the 'Agenda for Change' arrangements set out in the NHS Staff Handbook.

APPENDIX B, ANNEX B

Summary of statistical evidence

1 Introduction

1.1 This annex contains a headline summary of the statistical evidence available up to and including 16 December 2008 on recruitment and retention and wider economic and labour market conditions. It draws on written evidence and information submitted by the parties as well as data from other sources.

1.2 This annex also contains statistical evidence relevant to the Review Body's consideration of applications for Recruitment and Retention Premia for midwives and building craft workers.

1.3 This is not an exhaustive overview of the evidence and information presented to us by the parties: copies of the parties' written evidence and information can be obtained directly from their websites. A list of the parties' websites is in Appendix D.

2 Recruitment and retention

Vacancies

2.1 Table 2.1 shows three-month vacancy rates by main staff group as at March 2008 in England, Wales and Northern Ireland, as at September 2007 in Scotland, and the change since the previous survey in March 2007 for all countries. Three-month vacancy rates in England were low in 2008 and vacancy levels had decreased for all seven staff groups; vacancy rates were similarly low in Wales, but were more variable in Northern Ireland. Three-month vacancy rates in Scotland in September 2007 had increased since the March 2007 survey.

2.2 On-the-day ('total') vacancy rates (Chart 2.2) for most staff groups in March 2008 in England and Northern Ireland ranged from 1.8% to 3.5%, while the whole-economy vacancy ratio was 2.6% in the three months ending March 2008[45]. Total vacancy rates increased in Scotland between March 2007 and September 2007, while total vacancy rates fell for most staff groups in Northern Ireland between March 2007 and 2008.

[45] Seasonally adjusted. Source: ONS (series AP2Z). Vacancy ratios are vacancies expressed as a percentage of staff in post. Vacancy rates, as produced by the Health Departments, are vacancies expressed as a percentage of staff in post plus vacancies – i.e. the total number of available posts. The methods of calculation mean that, for a given number of vacancies, the ratio will always be higher than the rate.

Table 2.1: Three-month vacancy rates[46] in March 2008[47], by UK country and main staff group[48]

	ENGLAND			SCOTLAND			WALES			NORTHERN IRELAND		
	Change in no. vacancies[47]	Vacancy rate in 2008	Percentage point change[48]	Change in no. vacancies[49]	Vacancy rate in 2007	Percentage point change[50]	Change in no. vacancies[47]	Vacancy rate in 2008	Percentage point change[48]	Change in no. vacancies[47]	Vacancy rate in 2008	Percentage point change[48]
Qualified Nursing, midwifery and HV staff	-130	0.5%	0.0%	+383	1.1%	+0.6%	+9	0.5%	+0.1%	-173	0.5%	-1.2%
Unqualified nursing staff	-42	0.4%	0.0%				-30	0.2%	-0.5%	+19	1.2%	+0.4%
Qualified AHPs[51]	-135	0.5%	-0.2%	+90	1.9%	+1.0%	-15	0.8%	-0.4%	-6	1.2%	-0.3%
Qualified ST&Ts[52]	-285	0.5%	-0.5%	–	–	–	+12	0.8%	+0.3%	-22	0.7%	-0.7%
Unqualified AHP and ST&T staff	-89	0.3%	-0.3%	–	–	–	-1	0.4%	-0.1%	–	–	–
Ambulance staff	-27	0.1%	-0.1%	–	–	–	0	0.0%	0.0%	-29	1.9%	-2.9%
Admin & estates	-487	0.4%	-0.2%	–	–	–	-42	0.7%	-0.3%	-21	0.9%	0.0%

– Not available

[46] Vacancies that, as at 31 March 2008, NHS Trusts had been actively trying to fill, which had been vacant for three months or more.

[47] Scotland vacancies are as at 30 September 2007. NHS Scotland is now carrying out its vacancy survey in September of each year, to align with its workforce census.

[48] Sources: NHS Information Centre, ISD Scotland, StatsWales, DHSSPSNI.

[49] Change between March 2007 and March 2008.

[50] Percentage point change between March 2007 and March 2008.

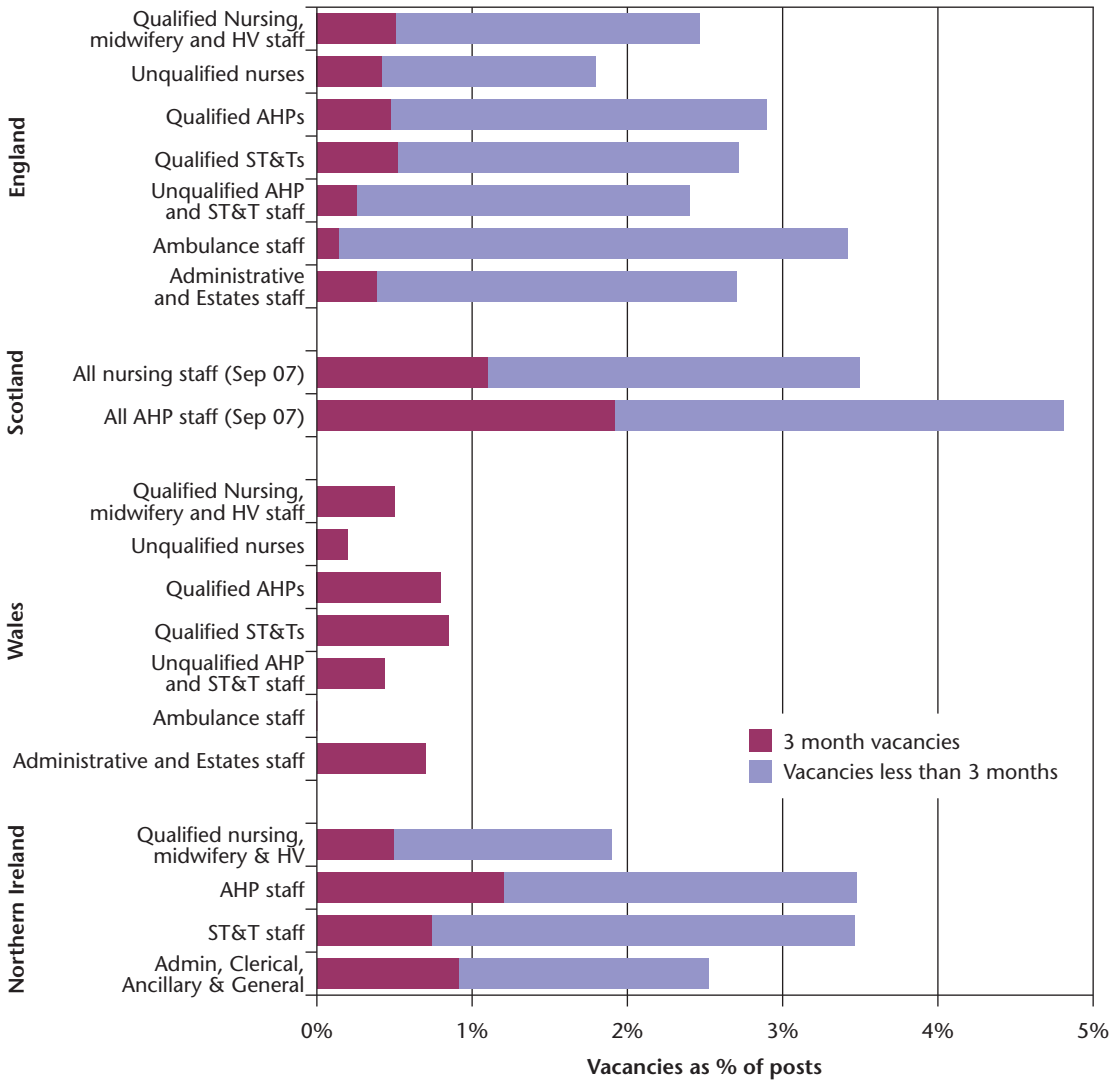
[51] Change between March 2007 and September 2007.

[52] Percentage point change between March 2007 and September 2007.

[53] Includes unqualified staff in Scotland and Northern Ireland.

[54] Includes unqualified staff in Northern Ireland.

Chart 2.2: Three-month and total vacancy rates by staff group and country, March 2008*



**Except Scotland, for which vacancy rates relate to September 2007.*
Sources: NHS Information Centre, ISD Scotland, StatsWales, DHSSPSNI.
No data are available on total vacancies for NHS staff in Wales

Turnover

2.3 Table 2.3 below shows the joining and leaving rates from the English NHS, between the censuses of September 2005 and 2006, and between 2006 and 2007. The leaving rate for qualified nurses, AHP & ST&T staff, healthcare scientists and qualified ambulance staff was less than the NHS non-medical average. Table 2.4 shows that the level of turnover[55] in Northern Ireland was below 10% for all staff groups except ancillary & general, and was lowest for works & maintenance staff. No data on turnover were submitted for NHS staff in Scotland or Wales.

[55] Not directly comparable to figures for England, as NI figures include movement between DHSS organisations

Table 2.3: Turnover of non-medical staff in England[56]

	Joining rate			Leaving rate		
	2005-06	2006-07	Change	2005-06	2006-07	Change
All non-medical Staff	**9.6%**	**9.0%**	**-0.5%**	**10.9%**	**10.1%**	**-0.8%**
Qualified nurse	8.0%	6.3%	-1.7%	8.0%	7.3%	-0.7%
Unqualified nurse	10.4%	8.9%	-1.5%	11.9%	12.1%	0.3%
Qualified AHP and ST&T	10.0%	9.6%	-0.5%	9.3%	8.6%	-0.7%
Healthcare scientist	6.0%	5.4%	-0.6%	7.2%	6.7%	-0.5%
Qualified ambulance staff	4.1%	3.8%	-0.3%	6.8%	6.4%	-0.4%
Healthcare assistant	12.5%	12.9%	0.4%	13.2%	12.3%	-0.9%
Support worker	12.5%	13.1%	0.5%	15.5%	13.0%	-2.6%
Manager & senior manager	7.5%	8.0%	0.5%	13.2%	14.6%	1.4%
Clerical & admin	9.8%	10.3%	0.5%	13.1%	12.2%	-0.9%
Maintenance & works	6.9%	7.2%	0.3%	11.0%	10.3%	-0.7%

Table 2.4: Turnover of non-medical staff in Northern Ireland[57]

Terms and Conditions group	Movers and Leavers (headcount) 2007/08	Staff in post at Sept 2007 (headcount)	Staff turnover %
Professional and Technical	598	6799	8.8
Social Services	470	6015	7.8
Nursing and Midwifery	1496	20880	7.2
Ancillary and General	936	7951	11.8
Works and Maintenance	18	551	3.3

2.4 The CBI/AXA *Absence and Labour Turnover Survey 2008* found that, in 2007, average turnover[58] in the UK economy was 14.9%, an increase of 0.2 percentage points compared to the 2006 survey. Turnover in 2007 was highest in retail (31%) and lowest in manufacturing (13%), while the overall average for the private sector was 16%, compared to 13% in the public sector.

[56] Source: NHS Information Centre

[57] Source: DHSSPSNI information to NHSPRB, October 2008

[58] Defined in this survey as the number of leavers divided by the average number employed

Morale and motivation

England

2.5 Table 2.5 overleaf presents a summary of certain key scores from the Healthcare Commission's annual survey of NHS staff in England, from 2005-2007.

- Staff's perceptions of their work-life balance were the same or slightly better in 2007 compared with 2006 for most staff groups, the exceptions being paramedics and ambulance technicians, whose average scores were lower in the 2007 survey.

- Average scores for job satisfaction were lower for some staff groups in the 2007 survey compared to 2006, with many staff feeling their work was not valued by their Trust.

- Staff's perceptions of their work pressure increased for some staff groups between 2006 and 2007, with midwives and health visitors reporting the highest feelings of work pressure.

- A new question in the 2007 survey asked staff to indicate their satisfaction with their level of pay: 46% of staff expressed dissatisfaction.

Scotland

2.6 No new data are available on morale and motivation indicators for staff in NHS Scotland; results of a survey conducted in autumn 2008 are scheduled to be released in early 2009.

Wales

2.7 Results of a survey of NHS staff in Wales, conducted in autumn 2007, showed that staff levels of satisfaction were broadly similar to those of staff in England. A minority of staff (38%) in NHS Wales, and within this 32% of registered nurses, agreed that their pay was reasonable, given their duties and responsibilities; however 61% of staff in NHS Wales, and within this 55% of registered nurses, were satisfied with their total benefits package.

Northern Ireland

2.8 Recent data from a survey of the largest Health and Social Care Trust in Northern Ireland, conducted in March 2008, showed that staff were generally satisfied across service groupings, although a minority (34%) felt they were recognised for good work. One quarter of those who had received their AfC banding thought it was fair.

Table 2.5: Healthcare Commission National NHS Staff Survey – Results for 2005-2007 (England)

* Higher scores are better. Deterioration (lower score in 2007 compared with 2006) marked in red
** Lower scores are better. Deterioration (higher score in 2007 compared with 2006) marked in red
Difference is between 2006 and 2007 surveys.

Registered Nurse	2005	2006	2007	Diff
Percentages				
Appraised in 12 mths *	62	60	63	3.2
Received job-relevant training *	-	84	86	2.3
Scores 1-5				
Quality of work life balance *	3.4	3.3	3.4	0.0
Staff job satisfaction *	3.5	3.4	3.4	0.0
Support from immediate managers *	3.6	3.5	3.7	0.2
Positive feeling within organisation *	3.1	3.0	2.7	-0.2
Work pressure **	3.2	3.3	3.3	0.0
Intention to leave **	2.7	2.8	2.8	0.0

Health Visitors	2005	2006	2007	Diff
Percentages				
Appraised in 12 mths *	65	65	62	-2.6
Received job-relevant training *	-	84	88	3.8
Scores 1-5				
Quality of work life balance *	3.4	3.4	3.4	0.0
Staff job satisfaction *	3.4	3.4	3.3	-0.1
Support from immediate managers *	3.4	3.4	3.4	0.1
Positive feeling within organisation *	3.0	3.0	2.7	-0.3
Work pressure **	3.5	3.6	3.6	0.0
Intention to leave **	2.6	2.8	2.9	0.1

Midwives	2005	2006	2007	Diff
Percentages				
Appraised in 12 mths *	65	62	66	4.0
Received job-relevant training *	-	88	88	0.6
Scores 1-5				
Quality of work life balance *	3.2	3.1	3.1	0.0
Staff job satisfaction *	3.4	3.3	3.3	0.0
Support from immediate managers *	3.4	3.3	3.5	0.1
Positive feeling within organisation *	3.0	2.9	2.7	-0.2
Work pressure **	3.3	3.5	3.6	0.1
Intention to leave **	2.6	2.7	2.7	0.1

Health care assistants	2005	2006	2007	Diff
Percentages				
Appraised in 12 mths *	56	54	58	4.6
Received job-relevant training *	-	75	78	3.3
Scores 1-5				
Quality of work life balance *	3.5	3.4	3.4	0.0
Staff job satisfaction *	3.5	3.4	3.4	0.0
Support from immediate managers *	3.6	3.5	3.7	0.1
Positive feeling within organisation *	3.2	3.1	2.9	-0.3
Work pressure **	2.7	2.9	3.0	0.1
Intention to leave **	2.5	2.6	2.6	0.0

AHPs	2005	2006	2007	Diff
Percentages				
Appraised in 12 mths *	71	68	70	2.1
Received job-relevant training *	-	82	83	1.2
Scores 1-5				
Quality of work life balance *	3.6	3.5	3.5	0.0
Staff job satisfaction *	3.6	3.5	3.5	0.0
Support from immediate managers *	3.7	3.6	3.7	0.1
Positive feeling within organisation *	3.1	3.0	2.8	-0.2
Work pressure **	3.2	3.3	3.3	0.0
Intention to leave **	2.6	2.7	2.7	0.0

ST&Ts	2005	2006	2007	Diff
Percentages				
Appraised in 12 mths *	59	56	61	5.1
Received job-relevant training *	-	77	76	-0.3
Scores 1-5				
Quality of work life balance *	3.6	3.4	3.5	0.1
Staff job satisfaction *	3.5	3.4	3.4	0.0
Support from immediate managers *	3.6	3.5	3.6	0.1
Positive feeling within organisation *	3.2	3.0	2.8	-0.2
Work pressure **	3.1	3.2	3.2	0.0
Intention to leave **	2.6	2.7	2.7	0.0

Paramedics	2005	2006	2007	Diff
Percentages				
Appraised in 12 mths *	52	34	37	3.1
Received job-relevant training *	-	76	69	-7.0
Scores 1-5				
Quality of work life balance *	3.0	3.1	2.7	-0.4
Staff job satisfaction *	3.1	3.2	3.0	-0.2
Support from immediate managers *	3.0	3.1	2.9	-0.2
Positive feeling within organisation *	2.5	2.8	2.0	-0.7
Work pressure **	3.2	3.3	3.3	0.1
Intention to leave **	2.6	2.6	2.8	0.1

Ambulance technicians	2005	2006	2007	Diff
Percentages				
Appraised in 12 mths *	50	42	41	-1.1
Received job-relevant training *	-	64	68	4.0
Scores 1-5				
Quality of work life balance *	2.8	2.8	2.6	-0.2
Staff job satisfaction *	3.2	3.1	3.0	-0.1
Support from immediate managers *	3.0	2.9	3.0	0.1
Positive feeling within organisation *	2.5	2.4	2.0	-0.4
Work pressure **	2.9	3.0	3.2	0.2
Intention to leave **	2.4	2.6	2.6	0.0

Admin and clerical	2005	2006	2007	Diff
Percentages				
Appraised in 12 mths *	54	51	52	1.0
Received job-relevant training *	-	59	63	4.0
Scores 1-5				
Quality of work life balance *	3.6	3.5	3.6	0.1
Staff job satisfaction *	3.5	3.5	3.5	0.0
Support from immediate managers *	3.6	3.5	3.7	0.1
Positive feeling within organisation *	3.1	3.0	2.8	-0.2
Work pressure **	3.0	3.0	3.0	-0.1
Intention to leave **	2.7	2.8	2.8	0.0

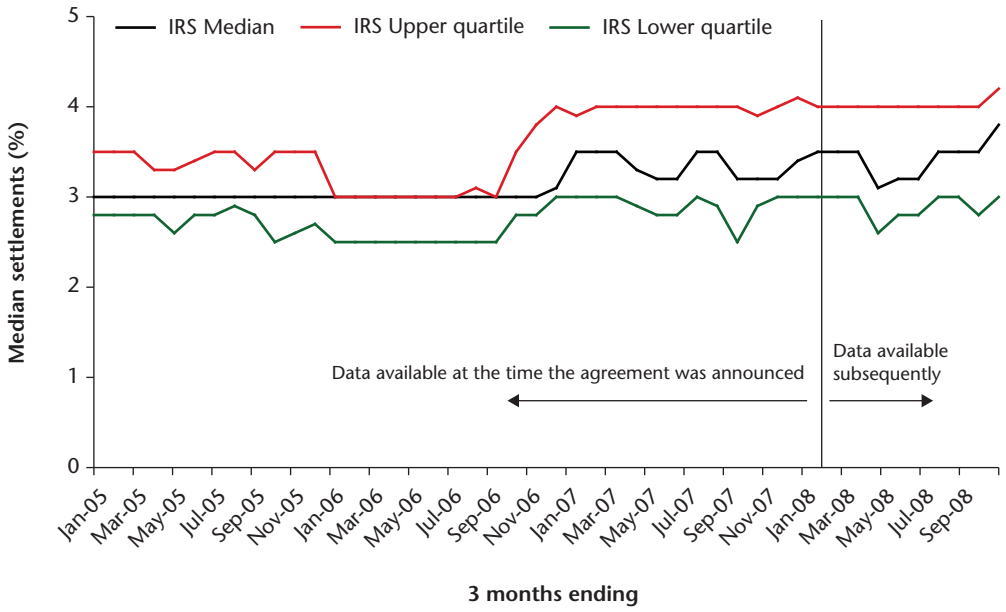
Maintenance/ancillary	2005	2006	2007	Diff
Percentages				
Appraised in 12 mths *	45	48	48	0.4
Received job-relevant training *	-	52	62	10.4
Scores 1-5				
Quality of work life balance *	3.4	3.4	3.4	0.0
Staff job satisfaction *	3.5	3.4	3.5	0.0
Support from immediate managers *	3.5	3.4	3.5	0.1
Positive feeling within organisation *	3.1	3.0	2.9	-0.2
Work pressure **	2.9	3.0	3.0	0.0
Intention to leave **	2.5	2.5	2.5	0.0

3 *Wider economic and labour market conditions*

Pay settlements

3.1 Analysis from Industrial Relations Services indicates that the median whole-economy pay settlement in the three months to October 2008 was 3.8%, compared to 3.5% in the three months to September 2008. The private sector median was 3.8%, with the public sector median (over the 12 months to October 2008) somewhat lower at 2.6%. The whole-economy median pay settlement has generally ranged from 3.1%-3.5% over the past 12 months, the lower quartile has ranged from 2.6%-3%, and the upper quartile has remained broadly stable since late 2006 (Chart 3.1).

Chart 3.1: Economy-wide settlements, 2005-2008



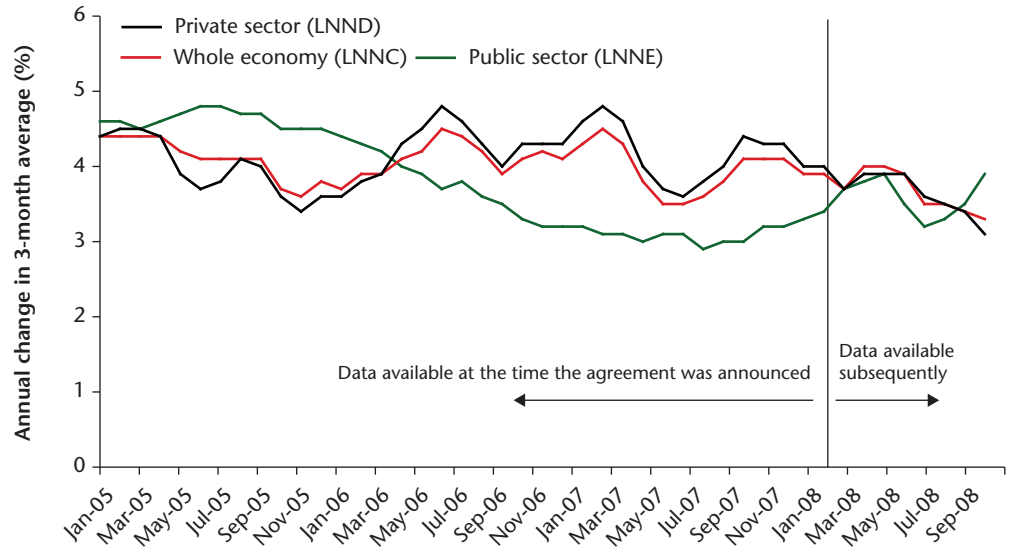
Source: Industrial Relations Services

Earnings

Economy-wide earnings growth

3.2 Chart 3.2 below shows that headline average earnings growth in the public sector currently exceeds that in the private sector, having trailed behind the private sector for a period of nearly two years. The current slowdown in earnings growth in the private sector appears to be influenced by lower growth in bonus payments and particular low growth overall in manufacturing. The headline growth in earnings in the private sector exclusive of bonuses was 3.6% in the three months ending September 2008, having declined from 3.9% in the three months to April 2008.

Chart 3.2: Growth in the Average Earnings Index including bonuses (seasonally adjusted)

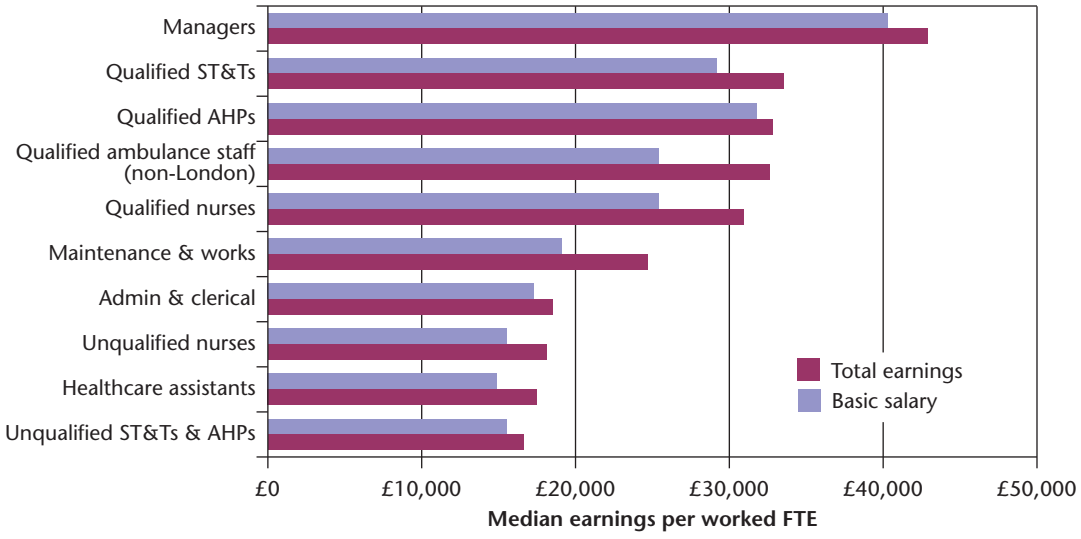


Source: ONS

Earnings of the NHSPRB remit group

3.3 Chart 3.3 shows median basic salary and total earnings per worked FTE by staff group for NHS staff in England in the second quarter of 2008. Managers had the highest basic and total earnings per worked FTE, at £40,300 and £42,900 respectively. Growth in median total earnings was 4.7% for qualified nurses between the second quarter of 2007 and the same period in 2008. The median basic salary per worked FTE for qualified nurses in the second quarter of 2008 was £25,400, with median total earnings at £30,900.

Chart 3.3: Median basic salary and total earnings of NHSPRB staff groups, April-June 2008



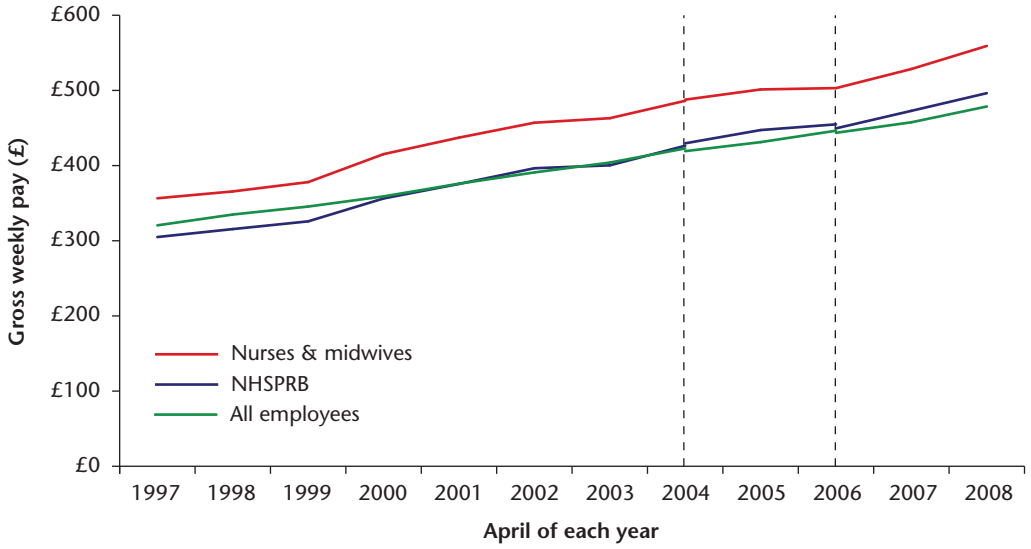
Source: NHS Information Centre

Relative earnings

3.4 Data from the Annual Survey of Hours and Earnings (ASHE) show that the median gross weekly pay of full-time employees in the NHSPRB remit group has been similar to that of all full-time employees in the wider UK economy since 1997 (Chart 3.4), while the median pay of full-time nurses and midwives has been consistently higher than the whole-economy median.

3.5 Between the 2007 and 2008 surveys, the median weekly pay of full-time employees in the NHSPRB remit group increased by 5%, compared to an increase of 4.6% for all full-time employees. Median weekly pay for nurses and midwives increased by 5.8% between the two surveys.

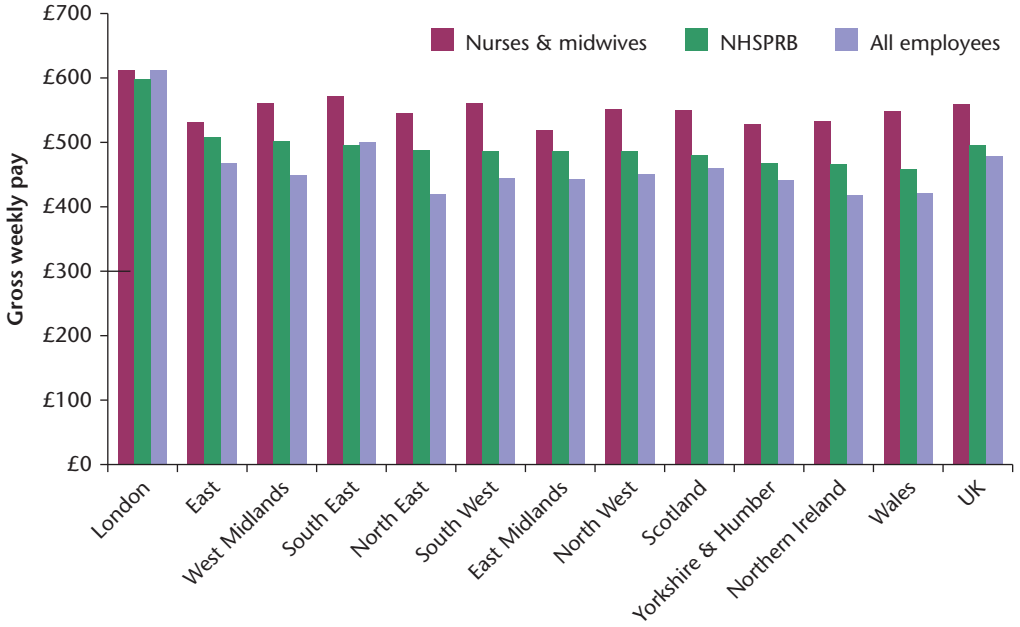
Chart 3.4: Median gross weekly pay* of full-time employees (UK), 1997–2008**



**Gross weekly pay includes basic pay, incentive pay, shift & premium payments, overrtime and "other"*
***Full-time employees on adult rates, whose pay in the survey period was unaffected by absence.*
The vertical lines indicate discontinuities in the data for 2004 and 2006.
Source: ONS (whole economy data); OME analysis of ASHE microdata (NHSPRB and nurses & midwives data)

3.6 Chart 3.5 breaks down median gross weekly pay for various employee groups by UK region, as at April 2008. The median weekly pay of the NHSPRB remit group exceeded that of the wider UK economy in all regions and countries except London (2.4% lower) and the South East (0.7% lower); weekly pay for employees in the NHSPRB remit group in other regions/countries exceeded the whole-economy average for the region/country by between 4.3% (Scotland) and 16% (North East).

Chart 3.5: Median gross weekly pay of full-time employees by UK region, April 2008



Source: ONS (whole economy data); OME analysis of ASHE microdata (NHSPRB and nurses & midwives data). Region relates to the place of work.

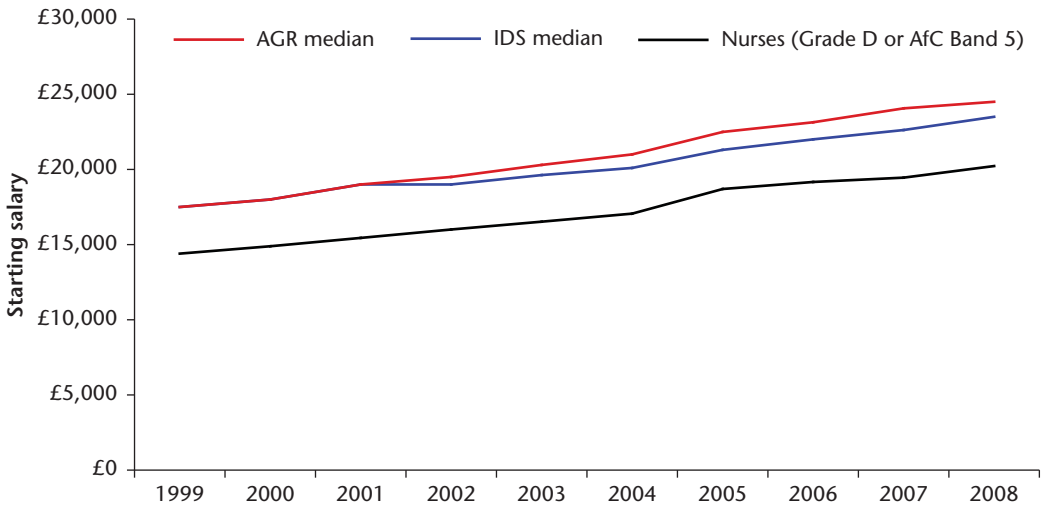
Starting salaries

3.7 Research conducted by the *Association of Graduate Recruiters* (AGR) and *Incomes Data Services* (IDS) into median graduate starting salaries is summarised in Chart 3.6 below. The gap in cash terms between the starting salary of a nurse, and the median starting salary as measured by IDS, has remained fairly steady, while the pay lead over nurses as observed by AGR has been more variable.

3.8 In 2008, the median starting salary for a nurse (band 5) was £20,225 outside London, an increase of 2.75% on the previous year. The AGR median starting salary was £24,500 (up 1.8%)[59], and the IDS median of expected graduate starting salaries was £23,500 (up 3.9%)[60]. In February 2008, IDS research showed that the median expected starting salary for graduates in the public sector was £24,295; AGR's 2008 summer review showed a public sector starting salary of £25,000.

3.9 Starting salaries for nurses in 2008 are exceeded in all UK regions by the AGR median, with the differential 10% or more in 6 of the 11 regions. Starting salaries for nurses in London, taking into account the High Cost Area Supplement of 20% of salary, trailed the AGR London median by 14.5%.

Chart 3.6: Nursing starting salaries compared to all graduates, 1999–2008



Sources: AGR Graduate Recruitment Surveys; IDS Executive Compensation Reviews

[59] AGR (2008) *Graduate Recruitment Survey Summer Review 2008*

[60] IDS (February 2008) *Executive Compensation Review* (Research File 78)

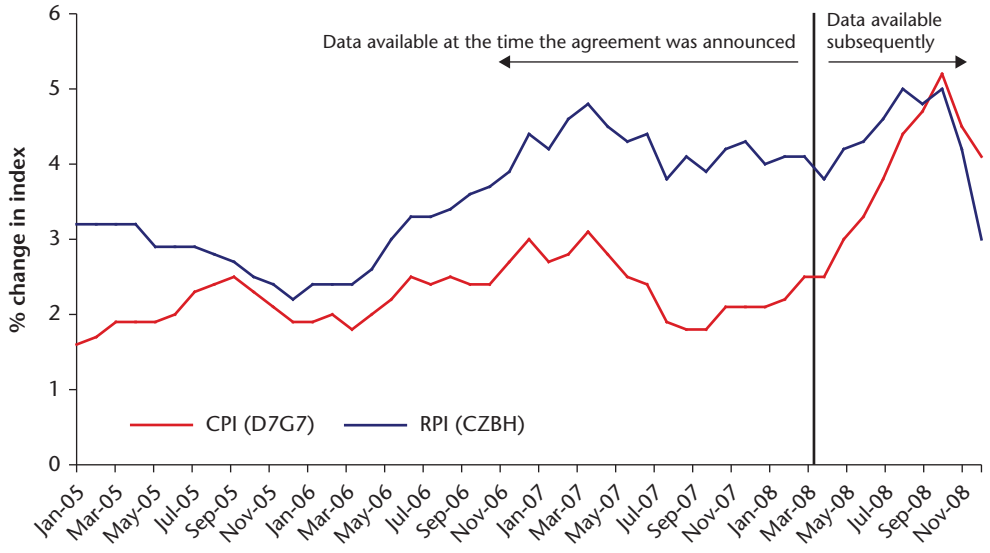
Inflation

3.10 Headline CPI inflation in February 2008 – the latest available data at the time the agreement was announced – was 2.5%, with RPI at 4.1%. Since the three-year pay agreement was announced on 7 April 2008, outturns for inflation rose sharply (Chart 3.7). Both measures have fallen steeply since September 2008, and in November 2008 CPI stood at 4.1% with RPI at 3.0%. The largest downward contribution to CPI between October and November 2008 was transport expenses, particularly fuel and lubricants; the largest downward contributions to RPI were from motoring expenditure and housing.

3.11 The largest upward pressures on CPI in the past 12 months came from *housing and household services*, within which gas prices were up 50.6% and electricity prices up 31.3%; and *food and non-alcoholic beverages*, up by 10.6%. The largest downward pressure on CPI came from *clothing and footwear* prices, which fell 7.1% in the 12 months to November 2008.

3.12 The RPI has been affected by the same upward and downward pressures noted above, but the annual increase in the index has been tempered by low and even negative growth in items relating to housing, which are not included in CPI.

Chart 3.7: Annual change in consumer price indices, 2005–2008

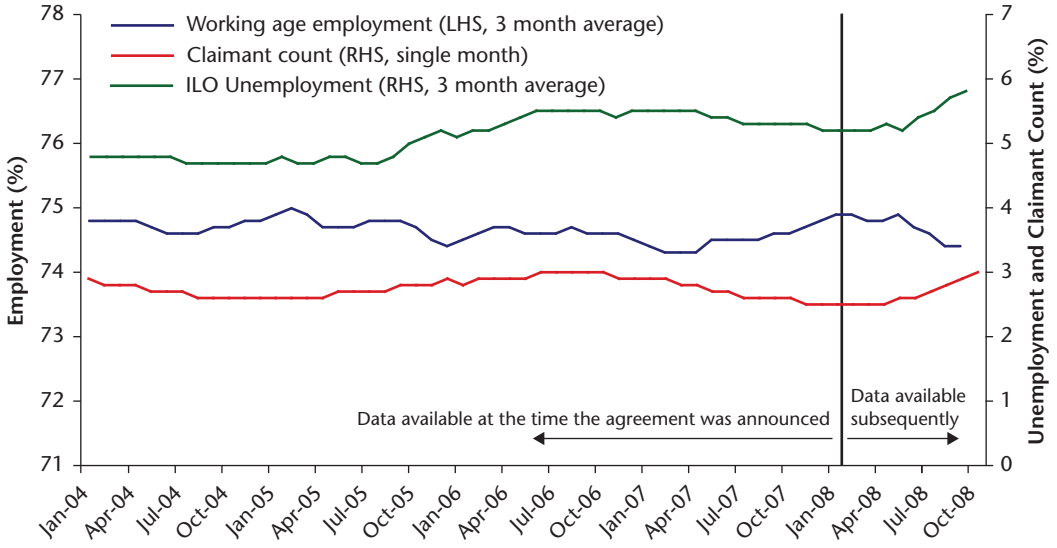


Source: ONS

Employment and unemployment

3.13 Data from the Office for National Statistics show a weakening in the labour market (Chart 3.8), with unemployment on the ILO measure rising to 1.825 million in the three months to September, an increase of 140,000 on the previous three months and up 182,000 on the year. The ILO unemployment rate increased 0.4 percentage points in the three months to September compared to the previous three months, to 5.8%, with the employment rate falling by 0.4 percentage points to 74.4%. The claimant count was 980,000 (3%) in October 2008, an increase of 36,500 compared to September 2008, and up 154,800 over the year. There were 589,000 vacancies in the three months to October 2008, down 40,000 on the previous three month period. There were 2.3 vacancies per 100 employee jobs, down 0.2 on the previous quarter. The economic inactivity rate was 20.9%, unchanged compared to the previous three months.

Chart 3.8: Employment, unemployment and claimant count rates, 2004–2008 (seasonally adjusted)



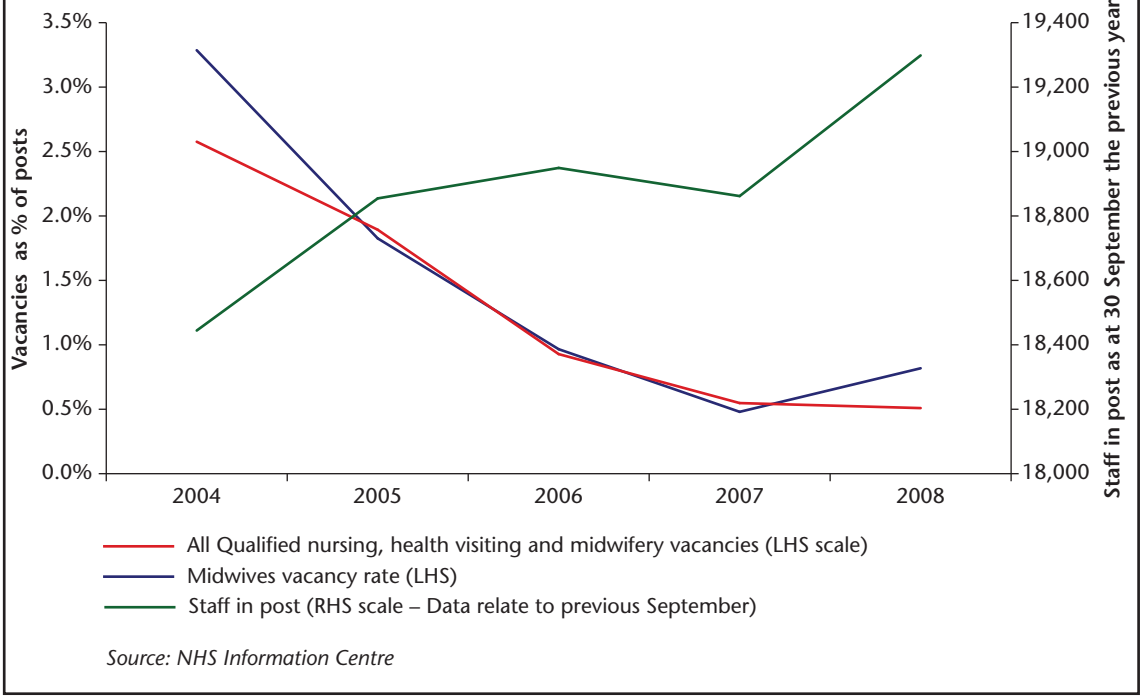
Source: ONS (series MGSU, MGSX, BCJE). The lag between the reference period and the publication date for claimant count data is shorter than that of employment and ILO unemployment data, as they come from different data collections. When the multi-year agreement was announced on 7 April the parties had access to claimant count data relating to February 2008, and employment and ILO unemployment data relating to the three months ending January 2008.

4 Recruitment and retention of midwives

4.1 Chart 4.1 shows that, between the September 2003 and September 2007 non-medical workforce censuses, the number of FTE midwives in post in England increased by 4.6%, from 18,400 to 19,300. Between March 2004 and March 2007, the three-month vacancy rate for midwives in England steadily decreased from 3.3% to 0.5%, then increased by 0.3 percentage points to 0.8% in the latest survey in March 2008.

4.2 In March 2008, the total (on-the-day) vacancy rate for midwives in England was 2.1%, compared to 2.5% for qualified nursing, health visiting and midwifery staff as a whole, 1.8% for health visitors, 2.9% for qualified AHPs, 2.7% for qualified ST&Ts, and 3.4% for qualified ambulance staff.

Chart 4.1: Three-month vacancy rates (England) as at 31 March each year, 2004–2008, and FTE midwives in post (England) as at 30 September each year, 2003–2007



Source: NHS Information Centre

4.3 An RCM survey of Heads of Midwifery[61] found that the total vacancy rate[62] for midwives was 5.2% in July 2008. 38.5% of heads of midwifery considered that the recruitment and retention of midwives was "quite a problem" or "a major problem", with 61.5% considering it was either "no problem" or "a low problem". The proportions responding in a similar manner in the previous year's survey[63] had been 17.9% and 82.1% respectively.

4.4 A summary of midwives' responses to the Healthcare Commission's annual Staff Surveys is shown in Table 2.5 of this annex. Between the 2006 and 2007 surveys, there was deterioration in average scores for perceptions of work pressure, positive feeling in the organisation, and intention to leave, while the average score increased for the extent to which midwives felt supported by their immediate managers.

[61] RCM in 2008 issued 203 questionnaires to Heads of Midwifery and received 109 returns, a response rate of 53.6%.

[62] As a percentage of staff in post plus vacancies ("WTE establishment").

[63] RCM in 2007 issued 216 questionnaires to Heads of Midwifery and received 115 returns, a response rate of 53.2%.

4.5 A report produced by the NHS Information Centre[64] showed that the average age of the midwifery workforce in England had increased since 1997, and that many midwives left the NHS prior to normal retirement age.

5 Recruitment and retention of building craft workers

5.1 Official health workforce statistics are not available in a sufficient level of granularity to identify specifically building craft workers in most UK countries[65]. It is therefore not possible to determine the number of building craft staff in post, the vacancy and turnover rates, or the change in these statistics over time.

5.2 DHSSPSNI has provided information on the number of building craft workers, presented in table 5.1 below. DHSSPSNI have said that the decrease in building staff shown from 2004 is the result of staff being re-graded as multi-skilled workers under the AfC arrangements. Multi-skilled workers are not included in these figures.

Table 5.1: Building craft workers in Northern Ireland, 1997-2008[66]

	Headcount	WTE
Sep-97	215	215
Sep-98	191	191
Sep-99	182	182
Sep-00	174	174
Sep-01	174	174
Sep-02	169	169
Sep-03	165	165.0
Sep-04	161	160.4
Sep-05	152	152.0
Sep-06	145	145.0
Sep-07	135	135.0
Sep-08	123	123.0

[64] *Focus on: Midwives* is available on request from the NHS Information Centre.

[65] In England alone, building craft workers are included in "Maintenance and Works" for staff in post, earnings and turnover statistics produced by the NHS Information Centre; "Admin & Estates" (a much larger aggregation) for statistics on vacancies; and "Maintenance and Ancillary" for the Healthcare Commission's surveys of NHS staff.

[66] Source: DHSSPSNI response to supplementary questions, November 2008.

APPENDIX C

THE DEPARTMENT OF HEALTH'S PAY METRICS

Historical figures

1. The historical pay metrics (up to and including 2007/08) have been estimated using pay bill data from NHS financial returns, NHS accounts, and Foundation Trust annual reports, together with workforce statistics from the annual NHS workforce census.

2. Figures for 2008/09 and 2009/10 are projections (see below).

3. The pay bill figures include all employees of Trusts, Primary Care Trusts, Strategic Health Authorities and Foundation Trusts in England. They do not include agency staff, contractors' employees, GPs, other GP practice staff or family dentists and their staff.

4. The pay bill figures come from the NHS financial returns and Foundation Trust annual reports. The latter do not include a breakdown by staff group, so this has been estimated using the NHS financial returns. Pay bill per full-time equivalent (FTE) employee has been calculated by dividing pay bill by the FTE number of staff.

5. Earnings and earnings per FTE figures have been estimated from the pay bill and pay bill per FTE figures using NHS accounts data together with the NHS Pension Scheme and National Insurance rates and thresholds which apply to NHS employers.

6. Note that, in years when the number of staff in higher paid staff groups has grown by more than the number in lower-paid groups, the average earnings figure for all staff has increased as a result.

7. Pay bill and pay bill per FTE figures had a step increase in 2004/05 when responsibility for the cost of pensions indexation was transferred from the Treasury to NHS employers.

Projected figures

8. Figures for 2008/09 and 2009/10 have been projected from the 2007/08 actuals.

9. The workforce FTE figures for each staff group are taken from the September 2007 NHS census (published March 2008) for 2007/08 and, for 2008/09 and 2009/10 are supply projections produced by the NHS Workforce Review Team for DDRB staff, and demand projections produced by DH for NHSPRB staff. These have been selected as the best available forecasts. Projections for medical and dental groups have been modelled individually, taking into account information on current numbers employed by the NHS, age profiles, historical retirement trends, training numbers, international recruitment, wastage, historical career trends and participation rates as appropriate.

10. Projections for 2008/09 have been calculated for each staff group by applying the general pay uplift, workforce growth, estimated earnings drift and estimated on-costs drift to the 2007/08 actuals. Projections for 2009/10 have been calculated in a similar way, based on the 2008/09 projections, but with a range of general pay uplift figures for 2009/10.

11. Earnings drift for each staff group has been estimated using a combination of analysis of historical earnings growth together with estimates of the cost of specific drivers. These drivers include recent and planned NHS pay reform and the forthcoming national increase in minimum holiday entitlement. Other drift will arise from previous changes to national pay arrangements; occupation and grade drift (skill mix change); local pay decisions; and use of other earnings, eg use of overtime, use of recruitment & retention premia and bonuses.

12. On-costs drift has been estimated using the projected earnings per FTE figures together with expected increase in employers' pension contribution rate and the published and expected national insurance rates and thresholds relevant to NHS employers.

HCHS non-medical Paybill (£million)[1]

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2]	2007/08[2,3]	2008/09[4]	2009/10
Qualified nursing	6,181m	6,699m	7,427m	8,085m	8,677m	9,923m	10,548m	10,968m	11,397m	12,189m	12,799m
Unqual & support[6]	2,162m	2,250m	2,512m	2,740m	2,946m	3,406m	3,731m	3,757m	3,888m	4,159m	4,368m
ST&Ts[7]	2,379m	2,616m	2,919m	3,199m	3,538m	4,115m	4,452m	4,785m	4,954m	5,274m	5,508m
Admin & Clerical	1,989m	2,161m	2,444m	2,724m	3,000m	3,604m	4,007m	4,199m	4,323m	4,534m	4,709m
Main. & works	231m	235m	240m	239m	237m	266m	270m	269m	283m	296m	308m
Ambulance Staff	364m	395m	433m	478m	524m	747m	890m	779m	843m	919m	993m
Managers	1,055m	1,187m	1,331m	1,571m	1,777m	2,247m	2,414m	2,341m	2,284m	2,390m	2,483m
Total remit[8]	14,388m	15,588m	17,362m	19,164m	20,825m	24,425m	26,443m	27,232m	28,182m	29,983m	31,399m

Unqual & support – unqualified nursing, HCA and support

Growth in HCHS non-medical Paybill[1]

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2]	2007/08[2,3]	2008/09[4]	2009/10
Qualified nursing	7.7%	8.4%	10.9%	8.9%	7.3%	14.4%	6.3%	4.0%	3.9%	7.0%	5.0%
Unqual & support[6]	11.8%	4.1%	11.6%	9.1%	7.5%	15.6%	9.5%	0.7%	3.5%	7.0%	5.0%
ST&Ts[7]	9.5%	10.0%	11.6%	9.6%	10.6%	16.3%	8.2%	7.5%	3.5%	6.5%	4.4%
Admin & Clerical	6.7%	8.7%	13.1%	11.4%	10.2%	20.1%	11.2%	4.8%	2.9%	4.9%	3.9%
Main. & works	0.8%	2.0%	2.2%	-0.8%	-0.5%	12.0%	1.5%	-0.4%	5.2%	4.9%	3.9%
Ambulance Staff	2.7%	8.6%	9.6%	10.2%	9.6%	42.7%	19.0%	-12.4%	8.2%	9.0%	8.1%
Managers	10.7%	12.5%	12.2%	18.0%	13.2%	26.5%	7.4%	-3.0%	-2.4%	4.7%	3.9%
Total remit[8]	8.4%	8.3%	11.4%	10.4%	8.7%	17.3%	8.3%	3.0%	3.5%	6.4%	4.7%

HCHS non-medical Paybill per FTE (£)[1]

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2]	2007/08[2,3]	2008/09[4]	2009/10
Qualified nursing	24,661	26,142	27,901	28,947	29,722	32,870	34,274	35,675	37,046	39,028	40,763
Unqual & support[6]	12,364	12,655	13,529	14,246	14,815	16,980	18,183	19,448	20,755	21,870	22,843
ST&Ts[7]	22,256	23,701	25,214	26,028	27,210	29,864	30,998	33,022	33,566	35,202	36,566
Admin & Clerical	14,527	15,192	16,258	17,132	17,473	19,659	20,919	22,583	23,574	24,725	25,683
Main. & works	18,713	19,586	20,449	20,164	20,682	23,545	24,687	25,619	27,855	29,213	30,345
Ambulance Staff	23,877	25,100	26,559	27,983	30,006	40,117	45,360	35,896	38,829	40,905	42,722
Managers	45,114	48,925	50,650	50,806	52,567	62,418	64,289	66,800	65,341	68,387	71,036
Total remit[8]	19,934	21,082	22,456	23,547	24,334	27,444	28,851	30,288	31,556	33,182	34,584

Growth in HCHS Paybill per FTE[1]

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2]	2007/08[2,3]	2008/09[4]	2009/10
Qualified nursing	6.3%	6.0%	6.7%	3.7%	2.7%	10.6%	4.3%	4.1%	3.8%	5.3%	4.4%
Unqual & support[6]	10.4%	2.4%	6.9%	5.3%	4.0%	14.6%	7.1%	7.0%	6.7%	5.4%	4.5%
ST&Ts[7]	5.9%	6.5%	6.4%	3.2%	4.5%	9.8%	3.8%	6.5%	1.6%	4.9%	3.9%
Admin & Clerical	3.6%	4.6%	7.0%	5.4%	2.0%	12.5%	6.4%	8.0%	4.4%	4.9%	3.9%
Main. & works	4.0%	4.7%	4.4%	-1.4%	2.6%	13.8%	4.9%	3.8%	8.7%	4.9%	3.9%
Ambulance Staff	0.6%	5.1%	5.8%	5.4%	7.2%	33.7%	13.1%	-20.9%	8.2%	5.3%	4.4%
Managers	3.5%	8.4%	3.5%	0.3%	3.5%	18.7%	3.0%	3.9%	-2.2%	4.7%	3.9%
Total remit[8]	6.3%	5.8%	6.5%	4.9%	3.3%	12.8%	5.1%	5.0%	4.2%	5.2%	4.2%

HCHS non-medical Earnings per FTE (£)[1]

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05[2,5]	2005/06[2]	2006/07[2]	2007/08[2,3]	2008/09[4]	2009/10
Qualified nursing	22,329	23,427	24,733	25,702	26,342	27,697	28,784	29,912	31,106	32,763	34,218
Unqual & support[6]	11,451	11,609	12,256	12,899	13,394	14,563	15,528	16,553	17,669	18,611	19,437
ST&Ts[7]	20,181	21,268	22,378	23,138	24,136	25,189	26,062	27,711	28,211	29,583	30,730
Admin & Clerical	13,327	13,795	14,588	15,376	15,665	16,738	17,745	19,104	19,959	20,930	21,741
Main. & works	16,976	17,590	18,169	17,959	18,392	19,893	20,790	21,545	23,436	24,575	25,528
Ambulance Staff	21,566	22,442	23,492	24,792	26,511	33,606	37,750	30,028	32,509	34,241	35,761
Managers	40,075	43,021	44,135	44,344	45,760	51,581	52,954	54,963	53,889	56,509	58,700
Total remit[8]	18,124	18,968	19,980	20,968	21,628	23,173	24,275	25,441	26,537	27,904	29,082

Growth in HCHS non-medical Earnings per FTE[1]

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/052,5	2005/062	2006/072	2007/082,3	2008/094	2009/104
Qualified nursing	6.1%	4.9%	5.6%	3.9%	2.5%	5.1%	3.9%	3.9%	4.0%	5.3%	4.4%
Unqual & support6	9.8%	1.4%	5.6%	5.3%	3.8%	8.7%	6.6%	6.6%	6.7%	5.3%	4.4%
ST&Ts7	5.9%	5.4%	5.2%	3.4%	4.3%	4.4%	3.5%	6.3%	1.8%	4.9%	3.9%
Admin & Clerical	4.8%	3.5%	5.7%	5.4%	1.9%	6.8%	6.0%	7.7%	4.5%	4.9%	3.9%
Main. & works	4.0%	3.6%	3.3%	-1.2%	2.4%	8.2%	4.5%	3.6%	8.8%	4.9%	3.9%
Ambulance Staff	0.2%	4.1%	4.7%	5.5%	6.9%	26.8%	12.3%	-20.5%	8.3%	5.3%	4.4%
Managers	4.1%	7.4%	2.6%	0.5%	3.2%	12.7%	2.7%	3.8%	-2.0%	4.9%	3.9%
Total remit8	6.3%	4.7%	5.3%	4.9%	3.1%	7.1%	4.8%	4.8%	4.3%	5.2%	4.2%

HCHS non-medical workforce[1]

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09[9]	2009/10[9]
Qualified nursing	250,651	256,276	266,171	279,287	291,925	301,877	307,744	307,447	307,628	312,302	313,989
Unqual & support[6]	174,874	177,796	185,687	192,370	198,868	200,615	205,207	193,208	187,349	190,195	191,222
ST&Ts[7]	106,887	110,384	115,767	122,903	130,043	137,789	143,606	144,899	147,583	149,825	150,635
Admin & Clerical	136,900	142,263	150,317	158,978	171,707	183,338	191,528	185,947	183,368	183,368	183,368
Main. & works	12,333	12,016	11,758	11,831	11,479	11,289	10,932	10,487	10,146	10,146	10,146
Ambulance Staff	15,250	15,755	16,320	17,076	17,455	18,627	19,610	21,703	21,706	22,466	23,252
Managers	23,378	24,253	26,285	30,914	33,810	36,007	37,549	35,041	34,955	34,955	34,955
Total remit[8]	721,767	739,399	773,141	813,854	855,799	889,973	916,548	899,091	893,087	903,610	907,919

Growth in HCHS non-medical workforce[1]

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09[9]	2009/10[9]
Qualified nursing	1.4%	2.2%	3.9%	4.9%	4.5%	3.4%	1.9%	-0.1%	0.1%	1.5%	0.5%
Unqual & support[6]	1.3%	1.7%	4.4%	3.6%	3.4%	0.9%	2.3%	-5.8%	-3.0%	1.5%	0.5%
ST&Ts[7]	3.4%	3.3%	4.9%	6.2%	5.8%	6.0%	4.2%	0.9%	1.9%	1.5%	0.5%
Admin & Clerical	3.0%	3.9%	5.7%	5.8%	8.0%	6.8%	4.5%	-2.9%	-1.4%	0.0%	0.0%
Main. & works	-3.0%	-2.6%	-2.1%	0.6%	-3.0%	-1.6%	-3.2%	-4.1%	-3.3%	0.0%	0.0%
Ambulance Staff	2.1%	3.3%	3.6%	4.6%	2.2%	6.7%	5.3%	10.7%	0.0%	3.5%	3.5%
Managers	7.0%	3.7%	8.4%	17.6%	9.4%	6.5%	4.3%	-6.7%	-0.2%	0.0%	0.0%
Total remit[8]	2.1%	2.4%	4.6%	5.3%	5.2%	4.0%	3.0%	-1.9%	-0.7%	1.2%	0.5%

Notes:

1. Figures for NHS Staff in England only & exclude agency
2. Includes estimates for Foundation Trusts
3. Pay bill figures taken from final NHS financial returns for 2007/08.
4. Figures in grey are projections and subject to change. Growth in 2008/09 includes hangover from staging settlement in the previous year.
5. In 2004/05 responsibility for the cost of pensions indexation shifted from HMT to NHS employers.
6. Unqualified nursing, HCA and support includes ancillary staff (e.g cleaners and porters)
7. ST&T – Scientific and Therapeutic and Technical staff. This includes AHPs, PAMs, healthcare scientists and other groups working in scientific, therapeutic and technical areas.
8. This total includes a small number of other staff (less than 0.5% of NHSPRB workforce) who do not fit into any of the above sub-groups
9. Workforce figures for 2008/09 and 2009/10 are projections and subject to change

APPENDIX D

The parties' website addresses

The Department of Health	http://www.dh.gov.uk/en/index.htm
The Scottish Government Health Directorates	http://www.scotland.gov.uk/Home
Welsh Assembly Government	http://new.wales.gov.uk/?lang=en
The Department of Health and Social Services & Public Safety in Northern Ireland	http://www.dhsspsni.gov.uk/
NHS Employers	http://www.nhsemployers.org/
NHS Staff Side (joint Staff Side)	http://www.unison.org.uk/
	http://www.rcn.org.uk
British and Irish Orthoptic Society	http://www.orthoptics.org.uk/
Chartered Society of Physiotherapy	http://www.csp.org.uk/
Community and District Nursing Association	http://www.cdna-online.org.uk/
GMB	http://www.gmb.org.uk/
Royal College of Midwives	http://www.rcm.org.uk/
Royal College of Nursing	http://www.rcn.org.uk
Society of Radiographers	http://www.sor.org/
Union of Construction, Allied Trades and Technicians	http://www.ucatt.info
UNISON	http://www.unison.org.uk/
Unite	http://www.unitetheunion.org.uk

The parties' written evidence should be available through these websites.

Appendix E

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 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
Twenty-First Report on Nursing and Other Health Professionals	Cm 6752, March 2006
Twenty-Second Report on Nursing and Other Health Professionals	Cm 7029, March 2007

NHS PAY REVIEW BODY

Twenty-Third Report, NHS Pay Review Body 2008	Cm 7337, April 2008
Decision on whether to seek a remit to review pay increases in the three year agreement – http://www.ome.uk.com/review.cfm?body=6	December 2008

Appendix F

GLOSSARY

AfC	Agenda for Change
A&E	Accident and Emergency
AGR	Association of Graduate Recruiters
AHPs	Allied Health Professionals
ASHE	Annual Survey of Hours and Earnings
CSP	Chartered Society of Physiotherapy
CSR	Comprehensive Spending Review
Department	The Department of Health
Departments	The Health Departments
DH	Department of Health
DHSSPSNI	Department of Health, Social Services & Public Safety in Northern Ireland
ESR	Electronic Staff Record
EU	European Union
FTE	Full-Time Equivalent
HEAT	Health Efficiency Access and Treatment
HEIS	Higher Education Institutes
HCAS	High Cost Area Supplements
Health Departments	The Department of Health, the Scottish Government Health Directorates, the Welsh Assembly Government and the Department of Health, Social Services and Public Safety in Northern Ireland
HMT	HM Treasury
HoMs	Heads of Midwifery
HSC	Health and Social Care
IC	NHS Information Centre
IDS	Incomes Data Services
KSF	Knowledge and Skills Framework
KSFG	Knowledge and Skills Framework Group
LHB	Local Health Board
NAO	National Audit Office
NHS	National Health Service
NHSE	NHS Employers
NHSPEDC	NHS Pharmacy Education and Development Committee
NHSPRB	NHS Pay Review Body
NOHPRB	Review Body for Nursing and Other Health Professions
NVQ	National Vocational Qualification

OME	Office of Manpower Economics
ONS	Office for National Statistics
PCT	Primary Care Trust
PDP	Personal Development Plan
PEVS	Pharmacy Establishment and Vacancy Survey
PNC	Pay Negotiating Council
RCM	The Royal College of Midwives
RCN	The Royal College of Nursing
RRP	Recruitment and Retention Premium
RPSGB	Royal Pharmaceutical Society of Great Britain
SCP	The Society of Chiropodists and Podiatrists
SGHD	The Scottish Government Health Directorates
SHA	Strategic Health Authority
SPF	Social Partnership Forum
ST&T	Scientific, Technical and Therapeutic
UCAS	Universities and Colleges Admissions Service
UCATT	Union of Construction, Allied Trades and Technicians
UK	United Kingdom
VfM	Value for Money
WAG	Welsh Assembly Government
WRT	Workforce Review Team
WTE	Whole Time Equivalent

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office
ID6106251 07/09

Printed on Paper containing 75% recycled fibre content minimum.

Published by TSO (The Stationery Office) and available from:

Online
www.tsoshop.co.uk

Mail, Telephone Fax & E-Mail
TSO
PO Box 29, Norwich, NR3 1GN
Telephone orders/General enquiries 0870 600 5522
Order through the Parliamentary Hotline Lo-Call 0845 7 023474
Fax orders: 0870 600 5533
E-mail: customer.services@tso.co.uk
Textphone: 0870 240 3701

The Parliamentary Bookshop
12 Bridge Street, Parliament Square,
London SW1A 2JX
Telephone orders/ General enquiries: 020 7219 3890
Fax orders: 020 7219 3866
Email: bookshop@parliament.uk
Internet: http://www.bookshop.parliament.uk

TSO@Blackwell and other Accredited Agents

Customers can also order publications from
TSO Ireland
16 Arthur Street, Belfast BT1 4GD
028 9023 8451 Fax 028 9023 5401

ISBN 978-0-10-176462-9

9 780101 764629