



NHS Pay Review Body

Twenty-Fifth Report 2011

Chair: Professor Gillian Morris



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**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
March 2011**

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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 Minister 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
- Professor David Blackaby
- Dame Denise Holt
- Mr Graham Jagger
- Professor Alan Manning
- Mr Ian McKay
- Mrs Maureen Scott

The secretariat is provided by the Office of Manpower Economics.

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Summary of Recommendations and Main Conclusions

Our remit for 2011/12 is set in the context of the public sector pay policies of the UK Government and Devolved Administrations which announced a two-year pay freeze, except for public sector workers earning £21,000 or less. The UK Government and Devolved Administrations informed us that they would not submit evidence or seek recommendations for public sector workers paid above £21,000 but would provide information on recruitment, retention and other aspects of the workforce. The Secretary of State for Health and the Devolved Administrations also recognised our role set out in the Agenda for Change (AfC) Agreement and agreed to provide evidence, as necessary, on high cost area supplements and recruitment and retention premia.

We understand the exceptional economic circumstances surrounding the UK Government's public sector pay policy, whilst noting that the UK Government policy for 2011/12 constrains our role to make recommendations for all staff paid under AfC as set out in our terms of reference. Any constraints placed upon our role limit our ability to assess the full range of evidence on pay and related matters and potentially undermine the parties' confidence in an independent Review Body process. During the period of the pay freeze our role is limited and therefore we urge the Health Departments to plan their strategies so that, at the end of the pay freeze, they can implement any changes that may be necessary to ensure the AfC pay structure continues effectively to support recruitment, retention and motivation of staff.

We received evidence from the parties in late 2010 covering AfC staff earning £21,000 or less and renewed applications from the parties for national recruitment and retention premia for pharmacists and building craft workers.

AfC Staff Earning £21,000 or Less

We acknowledge that the imposition of a limit of £21,000 and the decision to seek or commit to an increase of £250 were matters of judgment for the UK Government and Devolved Administrations rather than being specifically linked to economic and labour market circumstances. We have carefully assessed the evidence using the definitions in the Chief Secretary to the Treasury's remit letter and the four areas that letter stated we might want to consider. The first was the level of pay progression provided to the workforce. We recognise that NHS pay is a significant cost pressure for employers. However, it remains our view that incremental progression is a separate issue from basic pay. The second area was the affordability of any increase and we note the Health Departments' evidence that an increase of £250 is all that can be afforded. We also note the significant pressures on costs combined with rising demand for services, continued service development, NHS reforms and the need to find substantial efficiency savings. The third area was the potential for payments to be more generous for those on the lowest earnings but this was not widely supported in the evidence we received and we are not persuaded that there is evidence to justify it. We also conclude that a single uniform uplift is the least disruptive to the pay structure for those earning £21,000 or less. The fourth area was how best to avoid "leapfrogging" of those earning just under £21,000 with those earning just over £21,000. Our recommendation this year does not require this to be considered although the compression of the pay structure would leave little headroom should this approach be repeated in 2012/13.

In addition to the specific considerations set out in this year's remit, we make our recommendation in line with our standing terms of reference. Our assessment remains that the recruitment position for our remit group continues to be healthy and the retention position remains stable. NHS non-medical workforce numbers have been on an upward trend and vacancy rates continue to improve. We note that inflation measures have increased during the latter part of 2010 and early 2011. We sympathise with the Staff Side's concerns that high inflation rates could squeeze living standards and that the lower paid could be more vulnerable

but note that this will impact on all workers across the economy and in the public sector not just those working in the NHS.

Our overall assessment is that there is no recruitment and retention evidence to justify an increase above the single uniform uplift of £250 proposed by the Health Departments. **We recommend an uplift of £250 to Agenda for Change spine points 1 to 15 from 1 April 2011.** This uplift compresses the pay structure and there could be consequences for recruitment, retention and promotion pathways which we ask the parties to bear in mind in presenting future evidence.

High Cost Area Supplements (HCAS) and National Recruitment and Retention Premia (RRP)

We received no proposals or evidence on existing high cost area supplements or proposals for supplements for new areas and therefore we make no recommendations on these. We received two applications for national RRP: from Unite in respect of pharmacists and from UCATT in respect of building craft workers.

In considering the parties' applications for national RRP, we reiterate our approach based on our interpretation of the AfC Agreement and our consistent emphasis that the parties seeking pay differentiation will need to provide robust evidence to support their case.

For pharmacists, this is the fifth successive year in which we have considered a proposal for a new national RRP. Though our recommendation in 2009 for a new national RRP was rejected, our concerns about the shortage of pharmacists have been acted upon through increasing the number of pre-registration trainee pharmacists and promulgating advice on alternative methods of retaining junior pharmacists in the NHS. Vacancy rates in Bands 6 and 7 are generally falling and there is no consistent geographical pattern of vacancies across the UK. **We therefore do not recommend a national RRP for pharmacists in Bands 6 and 7, although we will continue to monitor the position.**

For building craft workers, we note the continuing limitations on specific data but from that available there continue to be few indications of national or widespread recruitment and retention problems. **We again conclude that there is no substantive evidence to support UCATT's case for a national RRP for building craft workers.**

General Workforce Issues

We are grateful to the parties for information which enables us to keep in touch with general workforce issues affecting our remit group as a whole over the period of the UK Government's and Devolved Administrations' pay freeze. While the overall recruitment position is healthy and retention stable, we consider it essential that the Health Departments and employers maintain recruitment of high quality staff and retain staff in whose training and development significant investment has been made. We note that the overall position masks a series of specialist areas experiencing shortages of staff which we intend to monitor carefully. NHS staff surveys have shown slight improvements in the main indicators related to staff motivation and morale although they have yet to capture recent major changes in the NHS.

In relation to workforce planning we note the establishment of the Centre for Workforce Intelligence and look forward to its first reports later in 2011. We consider it important that wider NHS reforms planned for England are not allowed to fragment the way in which information on workforce requirements is gathered at a local level. We ask the Health Departments to keep us informed of education and training developments as the reforms are implemented. We welcome the NHS Staff Council's review of the Knowledge and Skills Framework and we hope that revised and simplified guidance with its less prescriptive approach and greater local flexibility will support organisations in delivering appraisals based on the KSF.

We also welcome developments in collection of workforce data and we make specific requests for further improvements.

PROFESSOR GILLIAN MORRIS (*Chair*)

MR PHILIP ASHMORE

PROFESSOR DAVID BLACKABY

DAME DENISE HOLT

MR GRAHAM JAGGER

PROFESSOR ALAN MANNING

MR IAN MCKAY

MRS MAUREEN SCOTT

11 March 2011

Chapter 1 – Introduction and Background

Introduction

- 1.1 Our remit for 2011/12 is set in the context of the public sector pay policies of the UK Government and the Devolved Administrations. In June 2010, the UK Government announced a two-year public sector pay freeze from 2011/12, except for workers earning £21,000 or less. The Devolved Administrations informed us (between September and November 2010) that they were adopting a similar approach. The pay freeze is part of the UK Government's financial plans set out in the budget (June 2010) and followed up in the spending review for the years up to 2014/15 (published in October 2010).
- 1.2 The remit for our 2011/12 round was further clarified in letters from the Chief Secretary to the Treasury, the Secretary of State for Health, and the Devolved Administrations which stated that our recommendations were sought for NHS Agenda for Change (AfC) staff earning £21,000 or less. These letters also stated that evidence would be provided, as necessary, on high cost area supplements (HCAS) and recruitment and retention premia (RRP). This report, therefore, assesses the evidence relevant to that remit, makes recommendations for those earning £21,000 or less and considers specific pay proposals from the parties.

The Parties' Three-Year Pay Agreement 2008/11

- 1.3 This report makes recommendations for 2011/12 and follows the parties' three-year pay agreement¹ which ran from April 2008 to March 2011. The final year of that agreement, 2010/11, provided an increase in the AfC pay scale of 2.25%, a flat rate pay increase of £420 for the lowest 13 points of the pay scale and some changes to Pay Band 5. The agreement also provided for further talks on proposals to reduce the number of incremental pay points (starting with Pay Bands 6 and 7) that are affordable within the context of future pay awards. The agreement allowed us to seek a remit from the Secretary of State for Health to review the pay increases contained in the agreement for 2009/10 and/or 2010/11 provided that specified criteria were met – *“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”*. We wrote to the parties in December 2008² and again in December 2009³ and on neither occasion did we decide that these criteria were met.

The Scope for our Twenty-Fifth Report

- 1.4 The context for this report was initially set in May 2010 by the Coalition Government's *Our Programme for Government*⁴ and the emergency budget⁵ on 22 June 2010. Detailed UK Government spending plans were published in the *Spending Review 2010*⁶ on 20

¹ Details of the three-year pay agreement are available from NHS Employers' website: http://www.nhsemployers.org/PayAndContracts/AnnualPayReview/PreviousPayRounds/2008-09PayRound/Pages/PayReview-08_09AwardV2.aspx

² NHSPRB (2009), *Twenty-Fourth Report*, TSO (Cm 7646), Appendix B.

³ NHSPRB (2009), *Consideration of Whether to Seek a Remit to Review the Pay Increase Agreed by the Parties for 2010/11* – 10 December 2009. Published at: <http://www.publications.parliament.uk/pa/cm200910/cmhansrd/cm100106/wmstext/100106m0001.htm#10010646000032>

⁴ *The Coalition: Our Programme for Government* (May 2010). Published at: <http://webarchive.nationalarchives.gov.uk/20100526084809/http://programmeforgovernment.hmg.gov.uk>

⁵ HM Treasury (June 2010), *Budget 2010*, TSO (HC61).

⁶ HM Treasury (October 2010), *Spending Review 2010*. Published at: http://cdn.hm-treasury.gov.uk/sr2010_completereport.pdf

October 2010. We explore the Health Departments' spending plans further in Chapter 3 as part of our affordability considerations.

- 1.5 For public sector pay, the UK Government announced in the budget "a two-year pay freeze for public sector workforces, except for workers earning less than £21,000 a year who will receive an increase of at least £250 per year in these years".
- 1.6 On 26 July 2010, the Chief Secretary to the Treasury wrote to Review Body Chairs clarifying the UK Government's approach to public sector pay in England. He stated that for those earning a full-time equivalent of £21,000 or less the UK Government *would seek increases* (our italics) of at least £250 per year. The Chief Secretary to the Treasury confirmed that the UK Government would not submit evidence or seek recommendations on pay uplifts for public sector workers earning above £21,000 but would provide information on recruitment, retention and other aspects of the workforce and may ask Review Bodies to consider specific issues within their terms of reference.
- 1.7 The Chief Secretary to the Treasury looked to the Pay Review Bodies to provide recommendations on uplifts for workers earning £21,000 or less, defined as basic salary for full-time equivalents not including specified payments (such as overtime, London Weighting, recruitment and retention premia or other allowances). In considering the size of the uplift for those earning £21,000 or less the Chief Secretary to the Treasury said that Review Bodies may want to consider the level of pay progression, affordability, the potential for payments to be more generous for those on the lowest earnings, and how best to avoid "leapfrogging" of those earning just under £21,000 with those earning just over that figure.
- 1.8 On 19 August 2010, the Secretary of State for Health reaffirmed the overall remit in a letter to the Review Body Chair. He also recognised the role of the Review Body set out in the Agenda for Change Agreement and agreed to provide evidence, as necessary, on high cost areas supplements and recruitment and retention premia. The Secretary of State added that it was for each of the Devolved Administrations to decide on their approach to this round.
- 1.9 The Welsh Assembly Government confirmed the same approach for NHS staff in Wales on 29 September 2010. The Minister for Health, Social Services and Public Safety, Northern Ireland confirmed on 4 October 2010 that the pay freeze would apply to Health and Social Care staff and recognised that there would be an increase of at least £250 for those earning £21,000 or less subject to the Review Body process. On 22 November 2010, the Deputy First Minister and Cabinet Secretary for Health and Wellbeing in the Scottish Government also confirmed the same overall approach to public sector pay. She stated that all staff earning less than £21,000 should receive a minimum annual pay increase of £250 and added a commitment to introduce a Scottish Living Wage (at the rate of £7.15 per hour at the time of this report) across all bodies under direct Ministerial control. These remit letters are reproduced at Appendix A.
- 1.10 There are differences between the UK Government's announcement in the budget, the terms of the Chief Secretary to the Treasury's letter and those of the Secretary of State for Health and the Devolved Administrations respectively. The first difference lies in the nature of the undertaking given. The budget, and the remit letters from Scotland and Northern Ireland, provide that staff within the remit will receive an increase of at least £250 per year. By contrast, the letters from the Chief Secretary to the Treasury, the Secretary of State and the Welsh Assembly Government commit the Governments only to seeking an increase of £250 per year. The second difference lies in the scope of the remit group. The budget, and the Scottish Government in part, refer to those earning less than £21,000; the Chief Secretary to the Treasury, Secretary of State, Wales

and Northern Ireland refer to those earning £21,000 or less. As there are currently no full-time equivalent staff employed under AfC whose basic pay is precisely £21,000 this does not present a practical difficulty for us this year. In this report we refer to the group covered by our remit as those earning £21,000 or less.

- 1.11 We understand the exceptional economic circumstances surrounding the UK Government's approach to public sector pay, whilst noting that the UK Government's policy for 2011/12 constrains our role to make recommendations on the remuneration of all staff paid under AfC and employed in the NHS as set out in our standing terms of reference. This follows the limited role accorded to us under the three-year pay agreement concluded by the parties in 2008. The Chief Secretary to the Treasury's letter of 26 July 2010 sets out the UK Government's recognition that the Review Bodies bring an independent and expert view that is valued by the UK Government and those representing public sector staff. The Staff Side also commented that the Pay Review Body system provides recommendations which are evidence-based, transparent and independent. Any constraints placed upon our role limit our ability to assess the full range of evidence on pay and related matters and potentially undermine the parties' confidence in an independent Review Body process. During the period that our role is limited, we will continue to monitor the position of our remit group as a whole in accordance with our standing terms of reference to enable us to return on an informed basis to a full review process following the pay freeze. We also urge the Health Departments to plan their strategies so that, at the end of the pay freeze, they can implement any changes that may be necessary to ensure the AfC pay structure continues effectively to support recruitment, retention and motivation of staff.
- 1.12 For this report, we focus on the key aspects of our remit for 2011/12 as determined by the remit letters. In Chapter 2, we set out information on the recruitment, retention and earnings of our remit group. In Chapter 3, we turn to the central remit issue and assess the parties' evidence presented for AfC staff earning £21,000 or less, including labour market and economic indicators, the composition and numbers of those staff groups earning £21,000 or less, affordability and recruitment and retention. Specific cases for recruitment and retention premia are examined in Chapter 4. We conclude in Chapter 5 by reporting on general workforce issues.

Parties Giving Evidence for our Twenty-Fifth Report

- 1.13 The timetable for this round was revised to accommodate the UK Government's spending review announced in October 2010. Our original deadline for receiving written evidence was extended from 23 September 2010 to 10 November 2010. The NHS Employers, Joint Staff Side and individual unions submitted evidence to meet the revised deadline and the Department of Health and Devolved Administrations submitted evidence on 25 November 2010. The parties were asked to copy their evidence to other parties and to publish evidence on their websites.
- 1.14 We are concerned that the Health Departments were unable to submit their written evidence by our extended deadline. We accepted the initial delay as a result of the spending review in October 2010 and the additional complications this presented the Devolved Administrations in compiling their evidence. However, we can only plan effectively and act in a timely manner in the presentation of our reports if the Health Departments meet our deadlines for evidence.

1.15 We received written evidence from the following organisations:

Government departments

Department of Health (DH), England;
Department of Health and Social Services (DHSS), Wales;
Department of Health, Social Services and Public Safety (DHSSPS), Northern Ireland;
Scottish Government Health Directorates (SGHD);

Bodies representing NHS staff

Joint Staff Side⁷;
British and Irish Orthoptic Society (BIOS);
Chartered Society of Physiotherapy (CSP);
Royal College of Midwives (RCM);
Royal College of Nursing (RCN);
Society of Radiographers (SoR);
UNISON;
Unite the Union;
Union of Construction, Allied Trades and Technicians (UCATT);

Employers' bodies

NHS Employers.

1.16 On 25 January and 1 February 2011, we held oral evidence sessions with the following parties: the Secretary of State for Health and the four health departments and HM Treasury; the Joint Staff Side; NHS Employers; Unite; and UCATT. We also held 11 Review Body meetings during 2010 and 2011 to consider the evidence and wider information on the labour market and economy. We are grateful to all the parties for their submission of written and oral evidence.

Review Body Visits in 2010

1.17 We supplement the parties' evidence by visiting NHS trusts, health boards and the Devolved Administrations. Our visit programme aims to cover a range of NHS organisations including trusts providing acute, mental health, community care and ambulance services. These visits are essential to our review process as they allow members of the remit group to tell us first hand their views on pay and related matters. We wish to thank all those staff who participated in or organised our visits.

1.18 Between May and August 2010 we visited the following NHS organisations:

England

- Norfolk and Waveney Mental Health Foundation Trust;
- Royal Free Hampstead NHS Trust;
- Salford Royal NHS Foundation Trust;
- South Central Ambulance Service;

Scotland

- NHS Greater Glasgow and Clyde Health Board;

⁷ The Joint Staff Side comprises: British Association of Occupational Therapists; British Dietetic Association; British Orthoptic Society; Chartered Society of Physiotherapists; Federation of Clinical Scientists; GMB; Royal College of Midwives; Royal College of Nursing; Society of Chiropractors and Podiatrists; Society of Radiographers; UCATT; Unison; and Unite.

Wales

- Department of Health and Social Services (DHSS), Cardiff;
- Cwm Taf Health Board;

Northern Ireland

- Department of Health, Social Services and Public Safety, Belfast;
- South Eastern Health and Social Care Trust.

Other Developments

- 1.19 We note other developments which have provided a background to this report but which could have a greater bearing on our remits for future pay rounds. We ask the parties to assess the implications of these developments and to keep us informed in the documentation they submit to us.
- 1.20 In July 2010, the UK Government published the White Paper *Equity and Excellence: Liberating the NHS*⁸ on the future of the NHS in England. Following consultation on the White Paper, the intended NHS reforms were set out in the *Health and Social Care Bill*⁹ presented to Parliament on 19 January 2011. These reforms could have significant implications for the configuration and deployment of the NHS workforce and their employment arrangements.
- 1.21 The *Independent Public Service Pensions Commission*, led by Lord Hutton, was commissioned by the Chancellor in June 2010 to report on public sector pensions in time for the March 2011 budget. The Commission published an interim report¹⁰ on 7 October 2010 highlighting its progress in considering long-term structural reform options and savings within the current spending review period. In his response to the Commission's interim report the Chancellor announced in the *Spending Review 2010*¹¹ the UK Government's intention to implement progressive changes to the level of employee pension contributions equivalent to three percentage points on average leading to substantial savings by 2014/15. The potential for changes to pension contributions and pension provision could have consequences for NHS recruitment and retention which we will keep under review.
- 1.22 Finally, our standing terms of reference require us to take account of legal obligations on the NHS including anti-discrimination legislation. The parties confirmed in oral evidence that there were no specific issues for consideration under the remit for 2011/12. Following the passage of the *Equality Act 2010*¹² we would ask the parties in future to address in their written evidence whether there are any matters in this area which they wish to bring to our attention or to confirm that there are no such matters.

⁸ Department of Health (July 2010), *Equity and Excellence: Liberating the NHS*, TSO (Cm 7881). Published at: <http://www.dh.gov.uk/en/Publichealth/LiberatingtheNHS/index.htm>

⁹ Published at: <http://services.parliament.uk/bills/2010-11/healthandsocialcare.html>

¹⁰ Independent Public Service Pensions Commission (7 October 2010), *Interim Report*. Published at: http://www.hm-treasury.gov.uk/d/hutton_pensionsinterim_071010.pdf

¹¹ HM Treasury (October 2010), *Spending Review 2010*.

¹² Published at: <http://www.legislation.gov.uk/ukpga/2010/15/contents>

Chapter 2 – Recruitment, Retention and Earnings of Our Remit Group

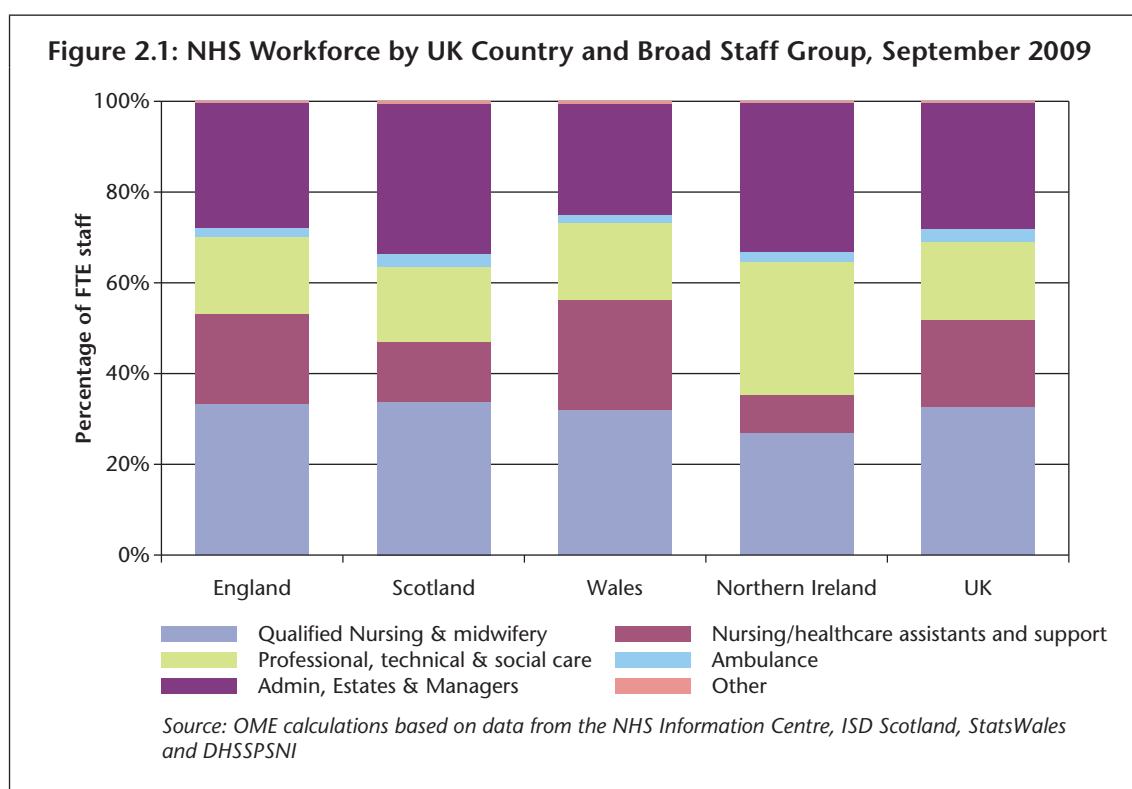
Introduction

2.1 This chapter provides summary information on: the size and composition of the NHS non-medical workforce in each country; recent changes in the size of the workforce; vacancies and turnover; and earnings. Data relate to full-time equivalent (FTE) staff except where specified.

Composition of Our Remit Group

2.2 Figure 2.1 shows the composition of our remit group in each country and in the UK as a whole as at September 2009¹. Detailed categories of staff in each country have been aggregated into broad staff groups, to enable cross-UK comparisons to be made²:

- Qualified nursing and midwifery staff was the largest group, at 33% of the total UK non-medical workforce, followed by administration, estates and management (28%); and
- As health and social care are integrated in Northern Ireland, there are proportionally more professional, technical and social care staff in this country compared with others (29%, compared with a UK average of 17%).

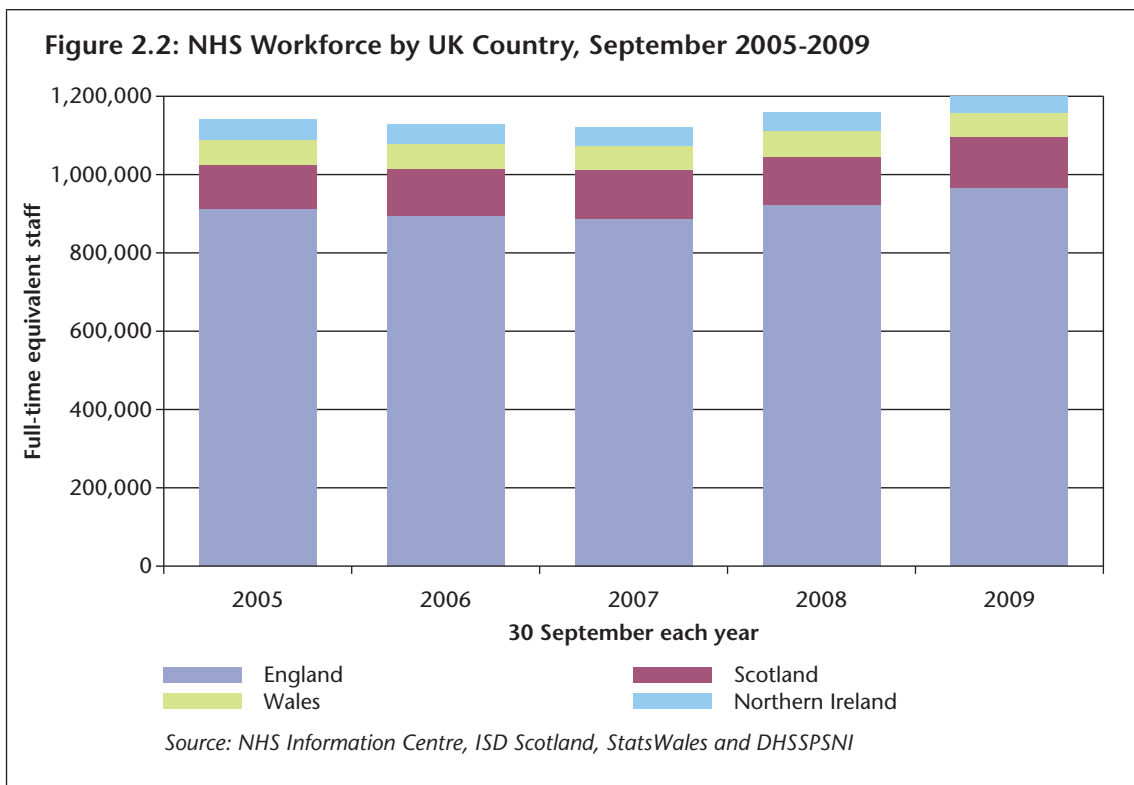


¹ The most recent date for which UK-wide data were available at the time of writing.

² Appendix C provides information on which categories of staff in each country have been allocated to broad staff groups. These comparisons should be treated with caution: some ancillary staff in England and Wales are categorised in the census as HCAs and support staff, but have job roles that fit better in the broad group "administration, estates and management".

2.3 Figure 2.2 and Table 2.1 show recent changes in the non-medical NHS workforce:

- The FTE non-medical NHS workforce increased by 4.4% between September 2008 and September 2009, to stand at a record high in all four UK countries, and a total of 1.21 million FTE (1.47 million headcount);
- The non-medical workforce in England increased by 5.0% between 2008 and 2009, compared with 2.2% in Scotland, 1.9% in Wales, and 1.3% in Northern Ireland; at UK level, and within each country, there were increases in FTE staff for all main staff groups³. The largest increase was observed for administrative, estates and management staff, up 7.3% between 2008 and 2009; and
- Staff in England comprised 80% of the UK total; Scotland, 10%; Wales, 6%; and Northern Ireland, 4%.



³ Except for "other" staff, which represented just 4,030 (0.3%) of non-medical NHS staff in September 2009.

Table 2.1: Change in NHS non-medical workforce by UK country and broad staff group, September 2008 – September 2009

“Broad” staff group	England	Scotland	Wales	Northern Ireland	UK
Qualified nursing & midwifery	2.2%	1.4% ⁴	1.7%	1.2%	2.1%
Nursing / healthcare assistants and support	3.8%	0.7%	2.8%	2.0%	3.4%
Professional, technical & social care	6.1%	6.4%	3.3%	2.3%	5.7%
Ambulance	5.9%	4.1%	0.3%	0.9%	5.2%
Admin, estates & managers	8.7%	3.9%	0.6%	0.6%	7.3%
Other	1.9%	-60.3%	5.1%	-20.1%	-16.9%
Total	5.0%	2.2%	1.9%	1.3%	4.4%

Source: NHS Information Centre, ISD Scotland, StatsWales, DHSSPSNI

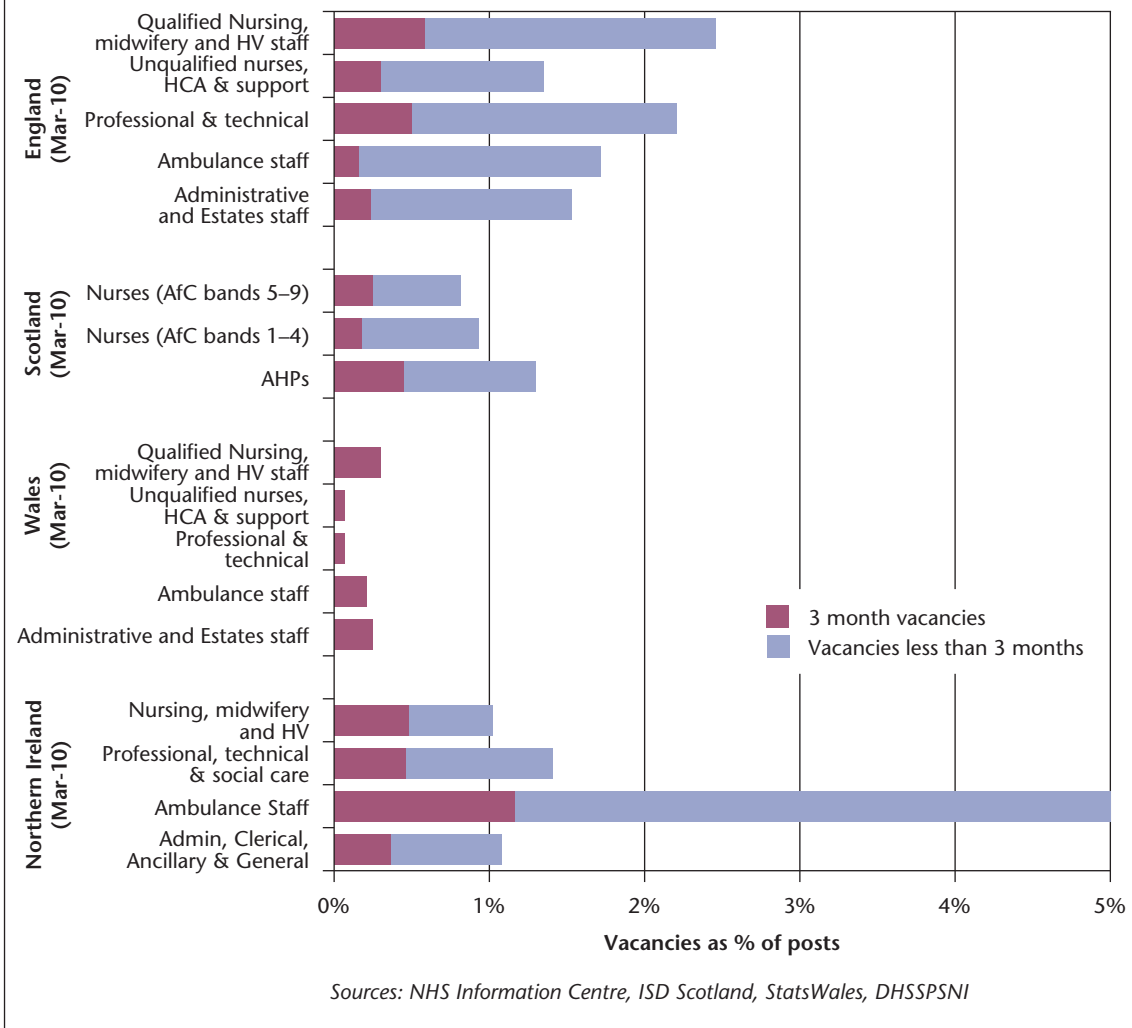
- 2.4 Between September 2009 and September 2010, the size of our remit group in Scotland decreased by 0.8% (974 FTE posts); in Northern Ireland, the size of our remit group decreased by 1.1% (580 FTE posts) between September 2009 and December 2010.
- 2.5 Though not directly comparable with the annual workforce census, new data produced each month by the NHS Information Centre show that the non-medical workforce in England increased by 1.1% (10,505 FTE) between September 2009 and November 2010.

Vacancies and Turnover

- 2.6 Figure 2.3 shows the latest vacancy rates by main staff group. Three-month and total vacancy rates decreased slightly in England and Scotland for all main staff groups. Vacancy rates in Wales and Northern Ireland showed small changes, increasing for some staff groups, and decreasing for others.

⁴ Data in Scotland do not provide for identification of qualified and unqualified staff; consequently nursing staff in Scotland on Bands 5 and above are assumed to be qualified, and staff in Bands 1-4 are assumed to be nursing and healthcare assistants and support staff, with unbanded staff allocated pro-rata.

Figure 2.3: Three-month and total vacancies in 2010 by main staff group and UK country



- 2.7 The leaving rate⁵ for qualified nurses in England was 8.0% in the 12 months to November 2010, compared with 6.5% in the 12 months to September 2008⁶. The leaving rate for NHS staff (including medical and dental staff) in Scotland was 6.5% in the 12 months to March 2010, compared with 6.8% the year before. The leaving rate for nursing and midwifery staff in Scotland was 5.5% in the year to March 2010. In Northern Ireland, the leaving rate for nursing and midwifery staff was 4.5% in the 12 months to March 2010, compared with 5.6% a year earlier.
- 2.8 We discuss recruitment and retention issues for specific staff groups in Chapter 5.

⁵ Staff leaving the NHS in one country, as a percentage of the average staff in post that year.

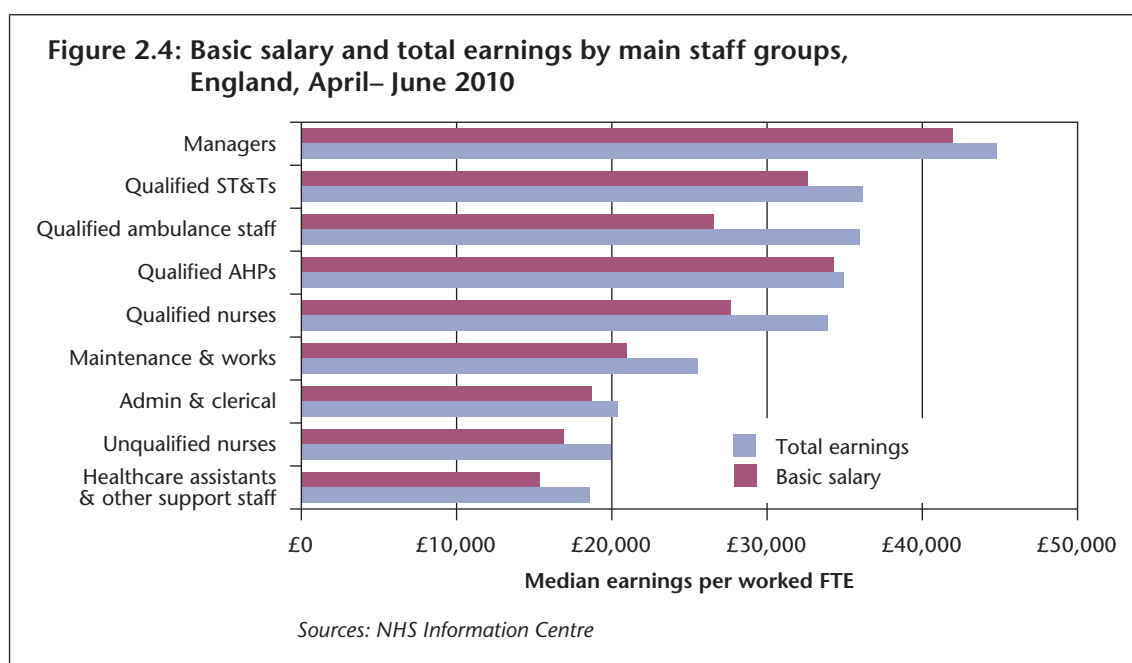
⁶ Data for 2009 are not available.

Earnings of Our Remit Group

Median Earnings in England⁷

2.9 Figure 2.4 shows the median basic salary⁸ and total earnings⁹ per 'worked full-time equivalent'¹⁰ by staff group in the second quarter of 2010:

- Managers had the highest basic salary and total earnings per worked FTE, at £41,800 and £44,700 respectively. The median total earnings of the next highest earning group, qualified scientific, therapeutic and technical staff (ST&Ts) were £8,600 lower, at £36,100;
- Qualified ambulance staff, qualified allied health professionals (AHPs) and qualified nurses also had median total earnings in excess of £30,000; and
- Median total earnings were well in excess of basic salary for qualified ambulance staff, qualified nurses, and maintenance and works staff.



⁷ Source: NHS Information Centre. The data are obtained from the Electronic Staff Record HR system (ESR), which is used by all NHS organisations except for two Foundation Trusts. Earnings data are therefore based on nearly all NHS staff in England.

⁸ Basic salary is an individual's Agenda for Change spine point.

⁹ Total earnings include: hours-related pay, such as on-call, shift working and overtime; location payments such as location allowances and other local payments; recruitment and retention premia; and 'other' payments such as occupational absence and protected pay.

¹⁰ Earnings per worked FTE is a notional figure showing how much would be paid, on average, if all staff worked full-time. It is calculated by taking the sum of earnings for a staff group, and dividing by the number of paid hours worked. Unpaid hours are not recorded on ESR.

2.10 Table 2.2 shows recent changes in median total earnings and basic salary per worked FTE¹¹. Comparing April-June 2010 with the same period in 2009:

- Qualified ST&Ts had the largest increase in median basic salary (5.5%), with administrative and clerical staff recording the lowest increase (2.2%); and
- Administrative and clerical staff had the largest increase in median total earnings (3.6%), followed by healthcare assistants (HCAs) and support staff (3.4%). Median total earnings were unchanged for maintenance & works staff.

Table 2.2: Changes in median basic salary and total earnings in England by main staff group, 2008-2010

	Change in median basic salary		Change in median total earnings	
	2008 Q2 – 2009 Q2	2009 Q2 – 2010 Q2	2008 Q2 – 2009 Q2	2009 Q2 – 2010 Q2
Qualified nurses	5.5%	2.6%	6.5%	2.4%
Unqualified nurses	5.2%	3.1%	6.6%	2.6%
HCAs & other support staff	8.1%	3.4%	6.6%	3.4%
Qualified AHPs	5.0%	2.4%	4.9%	1.2%
Qualified ST&Ts	5.5%	5.5%	5.4%	2.3%
Qualified ambulance staff	5.5%	n/a ¹²	7.4%	n/a ¹²
Managers	9.9%	n/a ¹³	6.3%	n/a ¹³
Admin & clerical	5.2%	2.2%	5.4%	3.6%
Maintenance & works	6.8%	2.5%	2.8%	0.0%

Source: NHS Information Centre

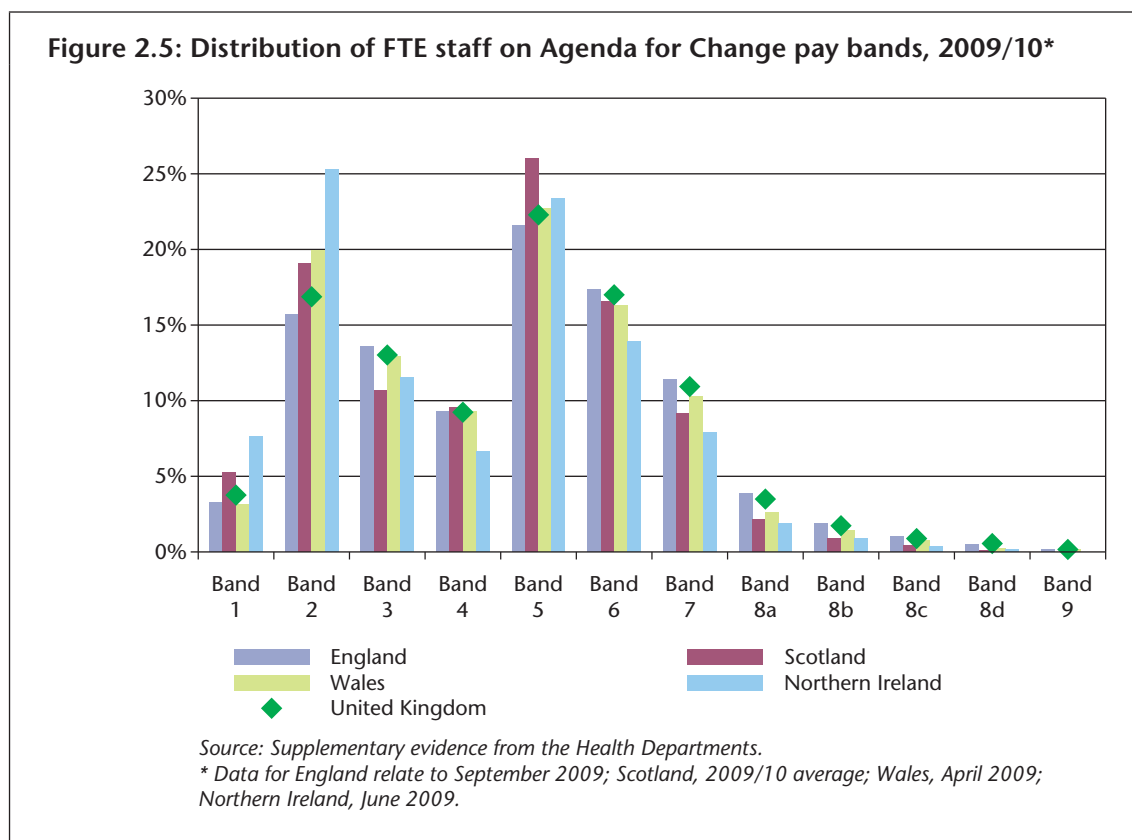
¹¹Note that between 2008Q2 and 2009Q2, two separate pay increases were paid to staff paid on Agenda for Change pay rates. The uplift of 2.75% in the first year of the three-year deal was paid in Q3 2008, backdated to 1 April 2008. Therefore it does not appear in 2008Q2 earnings figures. The April 2009 uplift of 2.4% was paid on time.

¹²Prior to 2010 Q2, data for ambulance staff were divided into "London" and "outside London". From 2010 Q2 onwards, data have been combined, causing a discontinuity.

¹³Data for 2010 onwards exclude senior managers, and are not comparable with earlier years.

Distribution of Staff on Agenda for Change Bands

2.11 The distribution of our remit group across the Agenda for Change (AfC) pay structure is shown in Figure 2.5. The pattern is similar for each UK country, with peaks at Bands 2 and 5, reflecting the main entry bands for professionally qualified clinical staff, and clinical support workers, respectively.

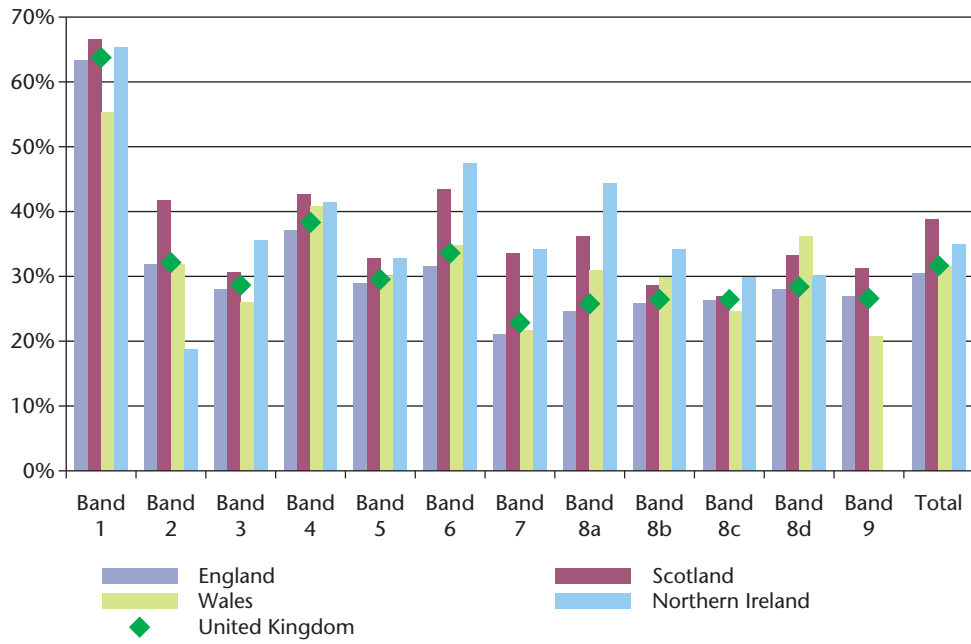


2.12 Figure 2.6 shows the percentage of staff at the top of each AfC pay band, for each UK country. Typically 25% to 35% of staff were at the top of each band (with Band 1 a notable outlier¹⁴); the overall percentage of staff at the top of their AfC pay bands in the UK was 32%. England and Wales tended to have lower percentages of staff at the top of pay bands than was the case in Scotland and Northern Ireland.

2.13 Data provided by the Department of Health show that in England, a slightly higher proportion of males than females were at the top of their pay band in September 2009; however, in Bands 1 to 3 the reverse was the case (Figure 2.7).

¹⁴Band 1 of AfC contains only three spine points, the fewest of all bands.

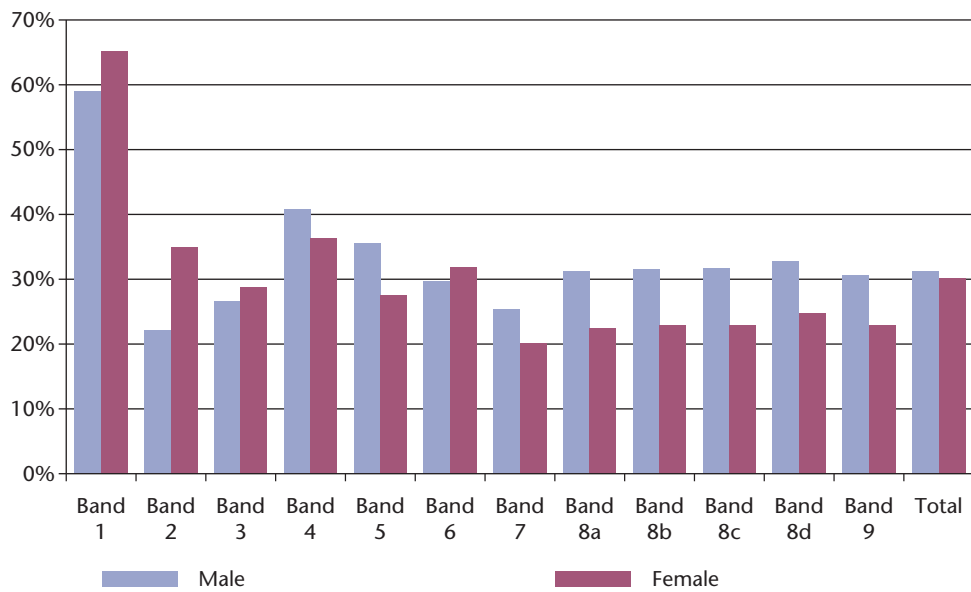
Figure 2.6: Percentage of staff at the top of pay bands by UK country, 2009/10*



Source: Supplementary evidence from the Health Departments.

* Data for England relate to September 2009; Scotland, 2009/10 average; Wales, April 2009; Northern Ireland, June 2009.

Figure 2.7: Percentage of FTE staff at the top of pay bands in England by gender, September 2009



Source: Department of Health

Relative Earnings of the NHSPRB Remit Group

2.14 We have used data from the *Annual Survey of Hours and Earnings (ASHE)* to track changes in median gross weekly pay¹⁵ for our remit group, compared with other employees, as shown in Table 2.3:

- In April 2010, median pay for our remit group as a whole exceeded that in the wider economy and in the private sector, but was less than in the public sector as a whole;
- The increase in median pay of our remit group between 2009 and 2010 exceeded that in the whole economy and the public and private sectors;
- Median pay for former NOHPRB staff¹⁶ was greater than that for former PNC staff¹⁷; and
- NHS nurses' and midwives' median pay was more than that for 'associate professional and technical occupations'¹⁸.

Table 2.3: Median gross weekly pay for full-time employees at adult rates, April 2008-2010

NHSPRB remit group:	Median gross weekly pay (£)			Increase (%)	
	April 2008	April 2009	April 2010	2008-09	2009-10
All NHSPRB employees	496	514	530	3.7	3.1
Former NOHPRB	526	549	562	4.3	2.4
Former PNC	388	409	421	5.2	3.2
NHS nurses & midwives	560	590	599	5.2	1.5
Wider economy¹⁹:					
All employees	479	489	499	2.0	2.1
Public sector	523	538	554	3.0	3.0
Private sector	460	464	473	0.9	2.0
Professional occupations ²⁰	681	697	704	2.2	1.1
Associate professional and technical occupations ²¹	540	551	563	2.1	2.0
Administrative & secretarial occupations	359	374	382	4.1	2.2

Source: ONS (*Annual Survey of Hours and Earnings*)

¹⁵Gross weekly (as at April 2010), rather than annual (the year to March 2010) pay is used, as it represents a more up-to-date indicator.

¹⁶The remit group for the Review Body on Nursing and Other Health Professions included: nurses; AHPs; healthcare scientists; other healthcare professions; and clinical support workers and technicians.

¹⁷Staff formerly covered by the Pay Negotiating Council included all other staff paid under AfC, including: administrative and clerical; maintenance and works; ancillary; and management.

¹⁸Under the Standard Occupational Classification (SOC) codes, nurses and midwives are contained within major group 3: 'associate professional and technical occupations'.

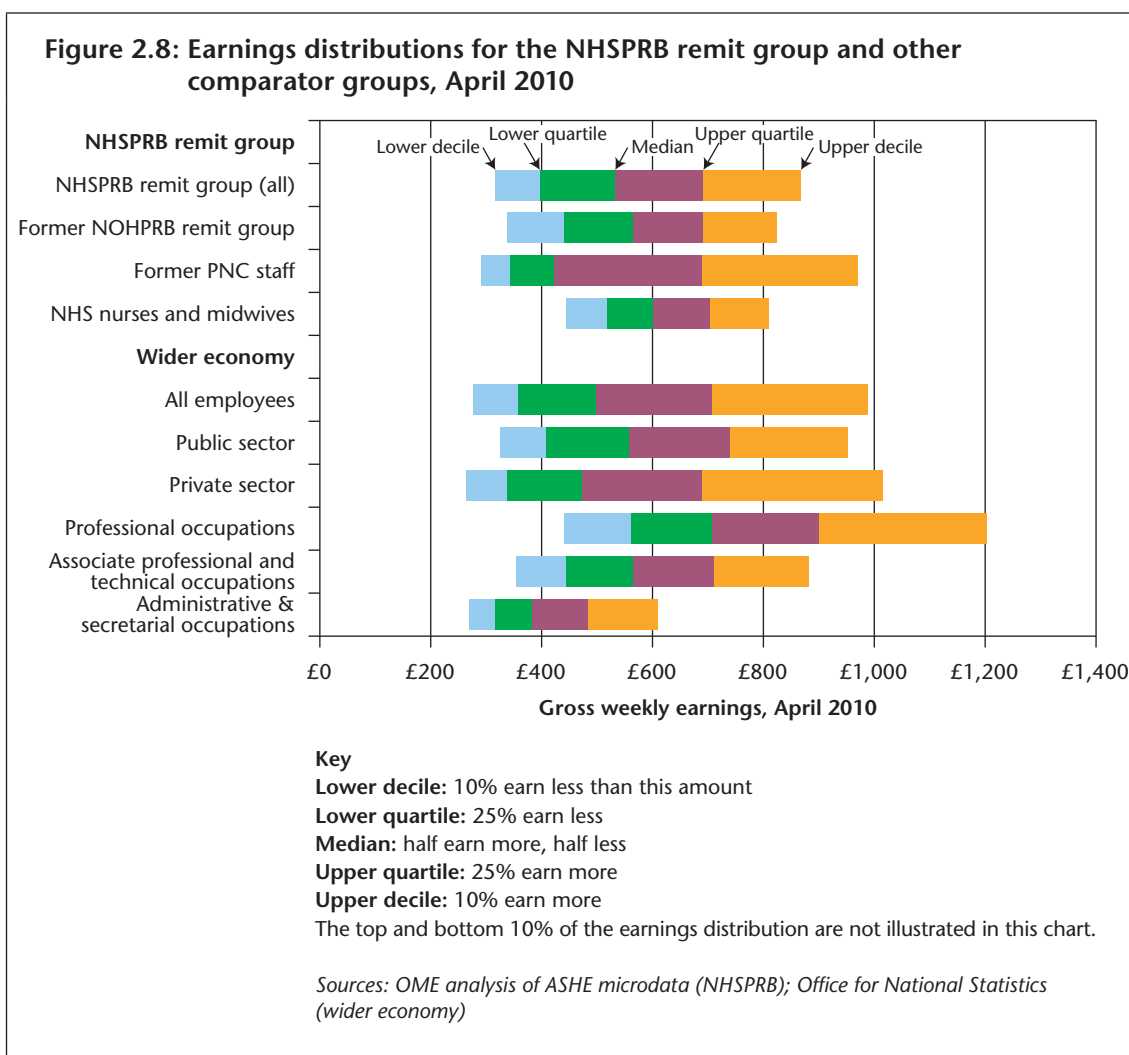
¹⁹With the exception of 'private sector', all categories include NHSPRB staff.

²⁰For example teachers, solicitors, accountants, doctors and some AHPs and ST&Ts.

²¹For example nurses, police officers and some AHPs and ST&Ts.

2.15 Figure 2.8 shows the distribution of earnings of the NHSPRB remit group in April 2010, alongside equivalent information for other employees:

- The earnings distribution for the NHSPRB remit group is more compressed than that for all employees. The middle 50% of staff are contained in a much narrower range of earnings;
- The lower decile and quartile earnings for the NHSPRB remit group are higher than for all employees (implying fewer “low” earners); conversely, the upper quartile and decile are at a lower level (implying fewer “high” earners); and
- The distribution of NHSPRB earnings is slightly narrower than that for the wider public sector.



2.16 Figure 2.9 and Table 2.4 show growth in median gross weekly pay for our remit group and other employees since 2000. Care must be taken in interpreting these figures as the skill profile and composition of the workforce may have changed over time.

- Median pay for our remit group increased by 49% over a 10-year period, compared with 39% for all employees. Median pay for our remit group also increased relative to the private and public sectors (Figure 2.9).
- The upper decile for our remit group increased by more than the median between 2000 and 2010; this was also the case for all employees, and the public and private sectors (Table 2.4).

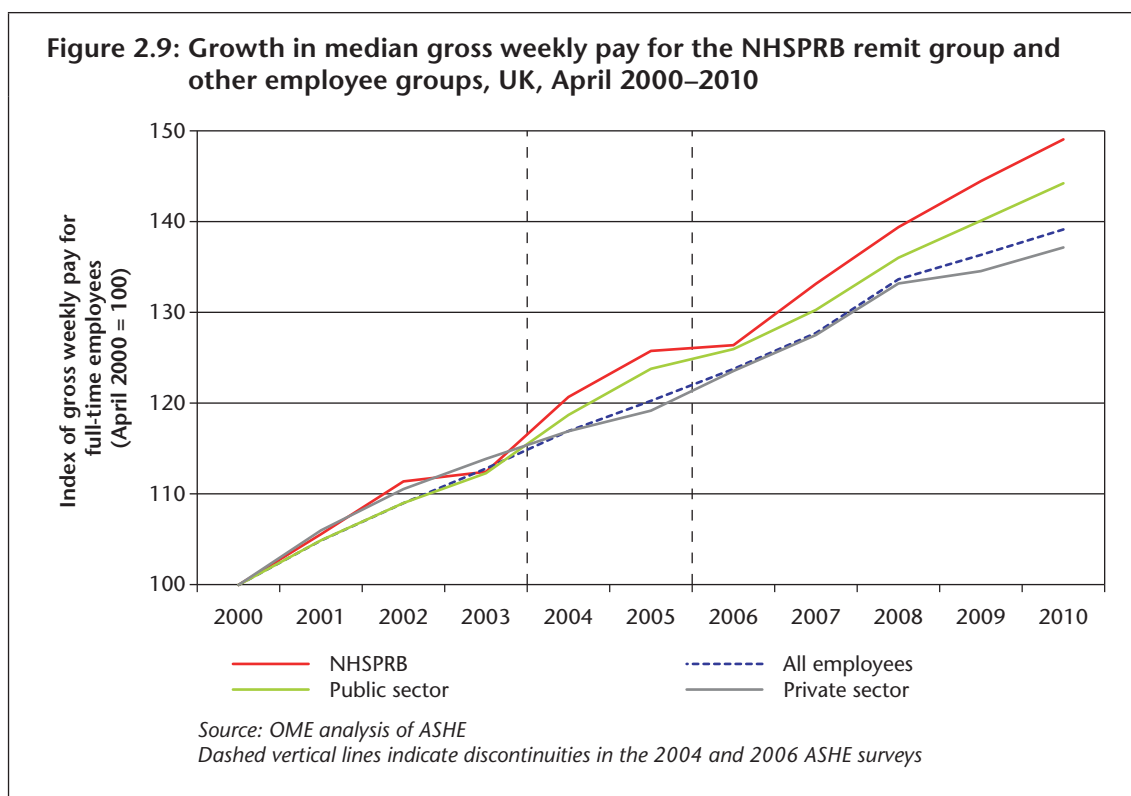


Table 2.4: Growth in gross weekly pay percentiles for full-time employees between 2000 and 2010

	Growth between April 2000 and April 2010				
	10th percentile	25th percentile	Median	75th percentile	90th percentile
NHSPRB	49%	50%	49%	52%	66%
All employees	41%	38%	39%	41%	44%
Public sector	46%	47%	44%	46%	53%
Private sector	38%	35%	37%	38%	42%

Source: OME analysis of ASHE

Chapter 3 – Agenda for Change Staff Earning £21,000 or Less

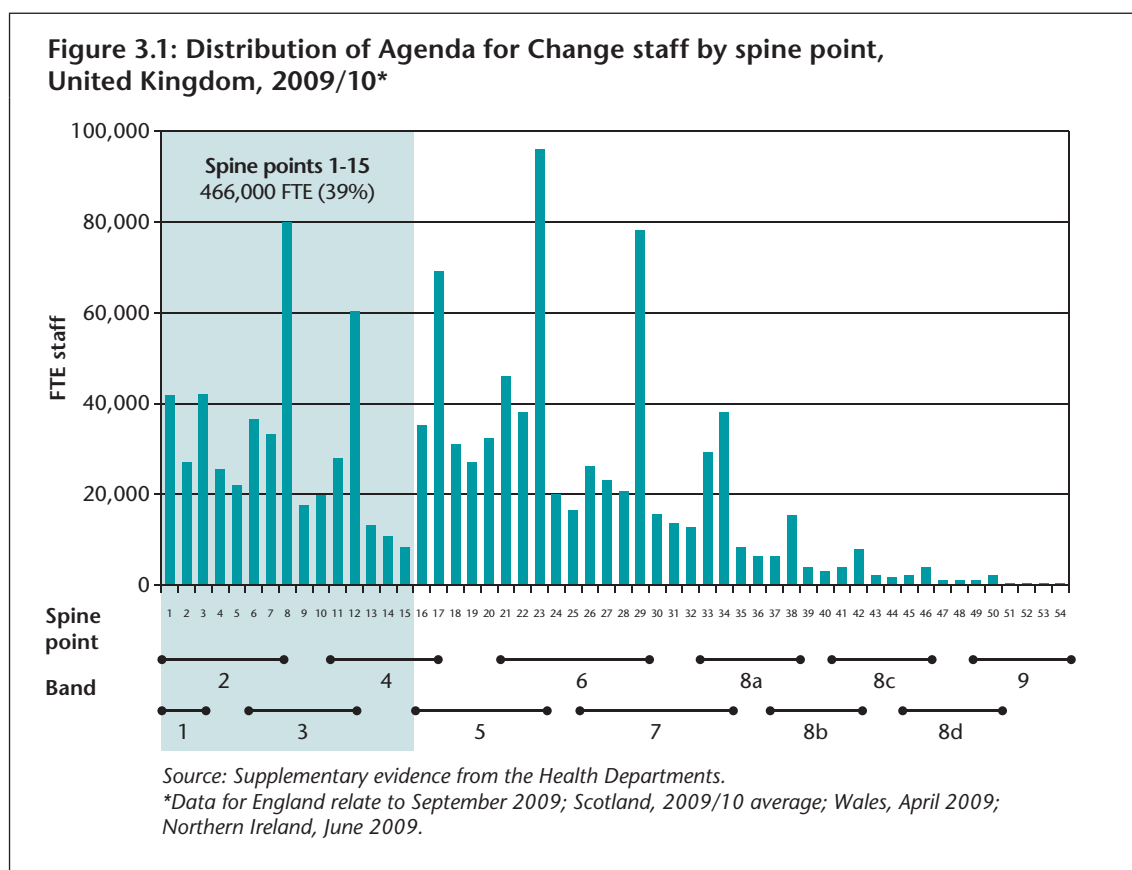
Introduction

3.1 This chapter examines the evidence presented under our specific remit for 2011/12 to consider pay increases for Agenda for Change staff earning £21,000 or less. The UK Government’s public sector pay policy, and those of each of the Devolved Administrations, sought our recommendations in relation to those earning a full-time equivalent salary of £21,000 or less. We start by explaining the composition of this group. We then review the evidence for this group under the headings of the economy, inflation, labour market and earnings; funds available to the Health Departments; and recruitment and retention. This review of the evidence is followed by our comments and recommendations.

AfC Staff Earning £21,000 or Less

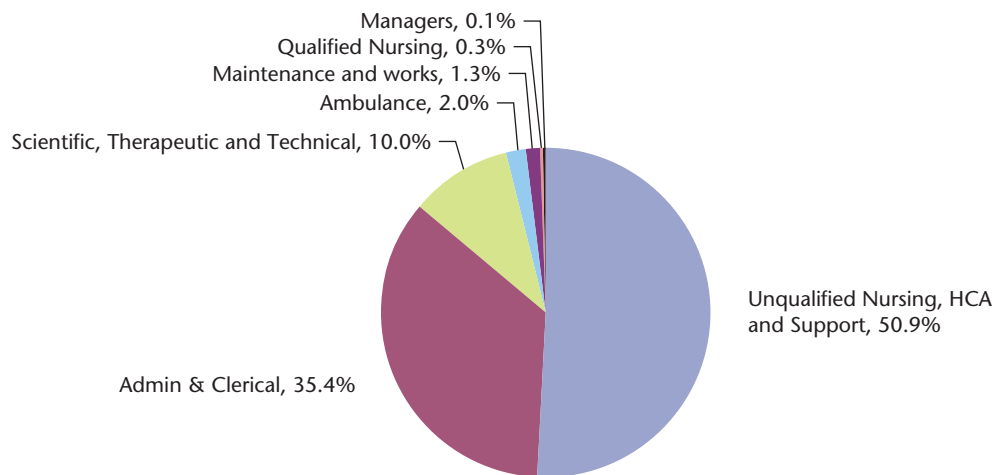
3.2 The Chief Secretary to the Treasury’s letter of 26 July 2010 and those from the Devolved Administrations looked to us to provide recommendations on uplifts for workers earning £21,000 or less, as set out in paragraphs 3.60 and 3.61. For NHS employees employed under AfC terms and conditions, the limit is spine point 15 (currently £20,554). Spine point 16 (currently £21,176) is the first point above the limit, equivalent to the bottom point of Band 5 (the starting salary for qualified nurses and many other professionally qualified clinical staff), and the penultimate point of Band 4.

3.3 The distribution of our remit group by AfC spine point is shown in Figure 3.1, with the shaded area indicating the number of staff in our remit group paid at or below spine point 15. In 2009/10, the most recent year for which data for the UK are available, approximately 466,000 FTE staff (39% of the remit group) were paid at or below spine point 15.



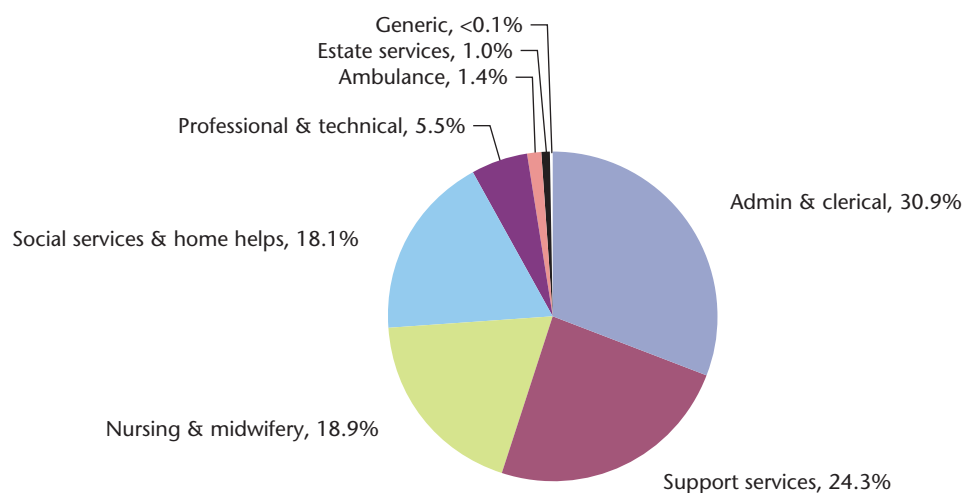
3.4 Figure 3.2 shows that in England, of those staff paid at or below spine point 15 in September 2009, over half (50.9%) were unqualified nurses, healthcare assistants (HCAs) or support workers, with administrative and clerical staff the next largest group (35.4%). The Department of Health told us that specific job roles within these totals included, amongst others: healthcare assistants; porters; clerical workers; receptionists; and medical secretaries. In Northern Ireland, as health and social care are integrated, in addition to these groups some social services staff – primarily home helps – are paid at or below spine point 15 (Figure 3.3). We would find it helpful for our next review to have similar data from Scotland and Wales.

Figure 3.2: Composition of FTE staff paid at or below AfC spine point 15 in England, September 2009



Source: Department of Health

Figure 3.3: Composition of FTE staff paid at or below AfC spine point 15 in Northern Ireland, June 2010



Source: DHSSPSNI

Economy, Inflation, Labour Market and Earnings

- 3.5 Later in this chapter we summarise the parties' evidence on the labour market, inflation and earnings at the time of submission of their evidence in November 2010. This section sets out the economic and fiscal background and reviews the trends in economic indicators and forecasts as at March 2011.
- 3.6 The current pay round is being carried out against a backdrop of exceptional circumstances in the UK economy and in the UK Government's finances. The economic recession, one of the longest and deepest since the Second World War, and the associated financial crisis that has unfolded over the past three years have pushed the UK's public finances from an apparently sustainable path to one which, in the absence of the appropriate fiscal response, would have been unsustainable, with high levels of annual borrowing and rising debt¹.
- 3.7 The UK Government's response in the emergency budget in June 2010 and in the spending review in October 2010 sets out an accelerated programme to reduce the structural deficit over the course of the Parliament. A greater proportion of this planned fiscal consolidation is expected to come from a reduction in public spending rather than from increases in taxation².
- 3.8 The Institute of Fiscal Studies in its Green Budget in February 2011 commented that the biggest domestic policy challenge for the UK Government over the next few years will be to ensure that the public finances are returned to a sustainable footing in a way that minimises the fall in households' living standards arising from higher taxes, lower welfare payments and cuts to spending on public services. It concludes that the five years from April 2011 are set to be the tightest five-year period for public spending since at least the Second World War³.

Economic Growth

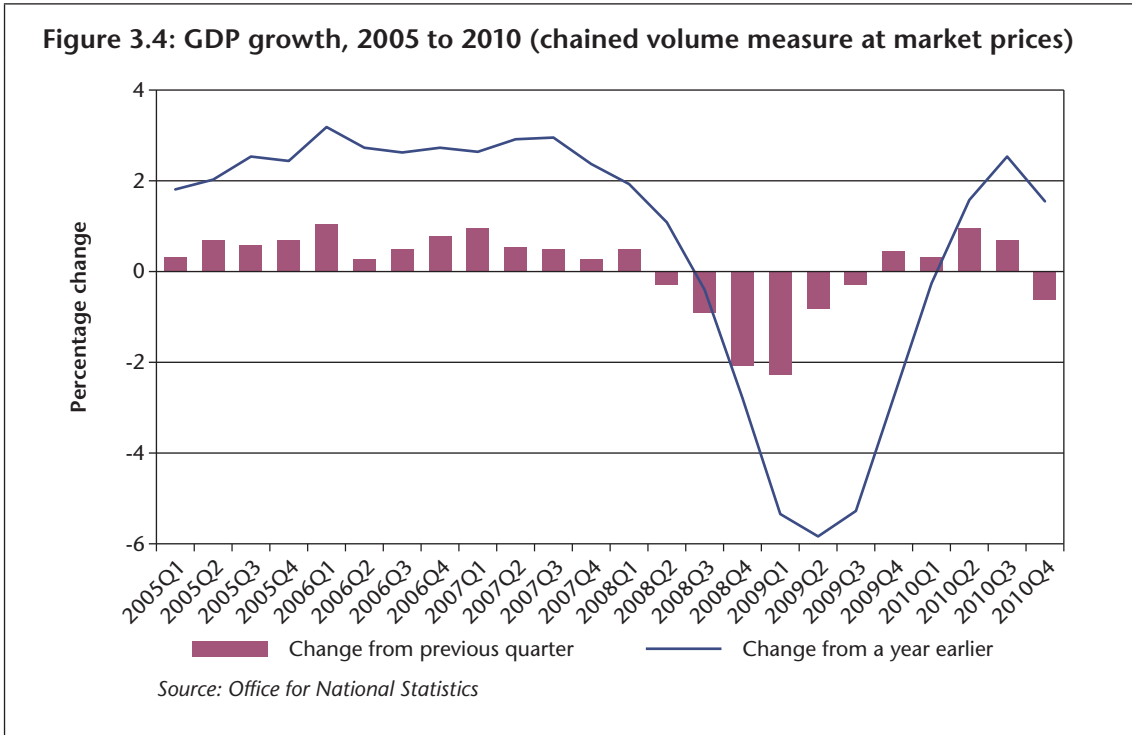
- 3.9 The UK economy moved out of recession in the final quarter of 2009 with GDP growth of 2.1% in the first three quarters of 2010. This higher than forecast GDP growth was driven in large part by the construction sector with significant growth also in the manufacturing, business services and finance sectors. However, in the fourth quarter of 2010 GDP contracted by 0.6% and ended the year still 4.6% below its peak in the first quarter of 2008. The contraction in GDP was primarily attributed to the bad weather in December 2010 although without this the Office for National Statistics estimated that GDP would still have shown a slight fall.
- 3.10 The Office for Budget Responsibility (OBR) published its economic and fiscal outlook on 29 November 2010. The OBR's central forecast was that the economy would continue to recover from the recession but at a slower pace than in the recoveries of the 1970s, 1980s and 1990s. It added that this relatively sluggish medium-term outlook reflected the gradual normalisation of credit conditions, efforts to reduce private sector indebtedness and the impact of the UK Government's fiscal consolidation. Over the medium-term, the OBR forecast GDP growth would slow down by 2014 and 2015 as the working population grows less quickly. It continued to expect a rebalancing toward business investment and net trade, with private consumption growth more subdued

¹ Crawford, R., Emmerson, C. and Tetlow, G. *The New Fiscal Framework: An Assessment*, in The IFS Green Budget (February 2011) Institute of Fiscal Studies.

² Crawford, R. Institute of Fiscal Studies, *Where Did The Axe Fall?* (Presentation October 2010 on the spending review).

³ Institute for Fiscal Studies, Press Release (2 February 2010), *Tax Rises and Spending Cuts Will Hurt But Little Room for Budget Easing*.

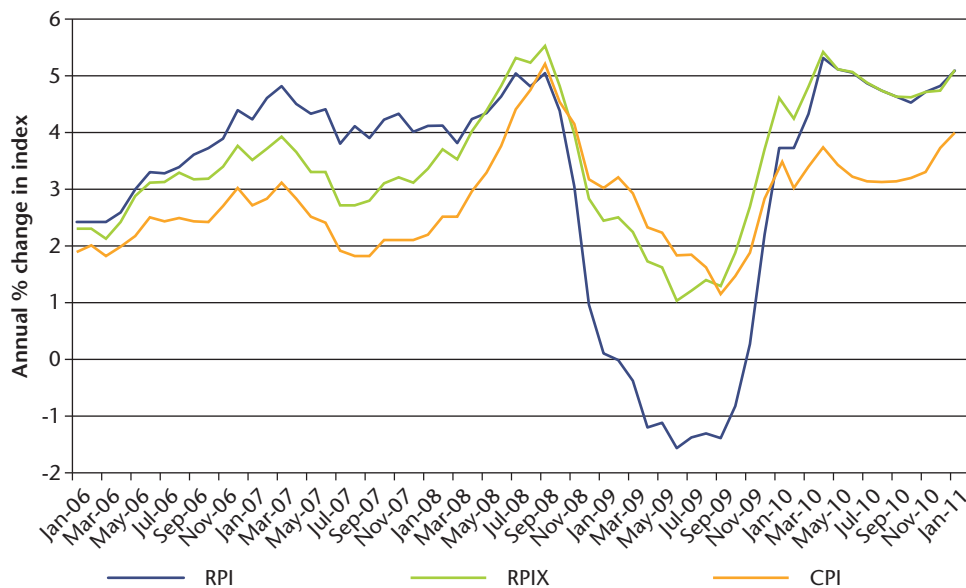
than in recent years. In November 2010, the OBR forecast GDP growth of 2.1% in 2011 and 2.9% in 2013. The Bank of England predicted growth of 2.4% in 2011 and annual growth of 2.8% in 2013. In January 2011, the HM Treasury average of independent forecasts estimated GDP growth of 2.0% in 2011 and 2.4% in 2013.



Inflation

3.11 As shown in Figure 3.5, at January 2011 inflation was rising with CPI inflation reaching 4.0% and RPI inflation 5.1%. Inflation had increased due to significant price rises for food, petrol, car insurance, rail and air fares and the increase in VAT to 20%. The target set by the UK Government for the Monetary Policy Committee (MPC) is to maintain inflation (measured by the CPI) at 2%. The Governor of the Bank of England wrote to the Chancellor in January 2011 to explain why inflation had moved away from its target. The letter said that the current high rate of inflation was a result of the rise in VAT, the fall in sterling and increases in commodity prices, particularly energy prices. The letter said that, excluding these factors, prices would probably have increased at a rate well below the 2% inflation target.

Figure 3.5: Increases in consumer price indices, 2006 to 2011



Source: Office for National Statistics

- 3.12 In February 2011, the Bank of England⁴ stated that CPI inflation is likely to be between 4% and 5% over the next year and to remain above the 2% target through 2012 reflecting increases in commodity and import prices. Further ahead, the Bank expected inflation to fall back as those effects diminished and downward pressure from spare capacity persisted. However, both the timing and extent of that decline in inflation were uncertain.
- 3.13 Other forecasts⁵ suggested that CPI inflation would stay around 3% for much of 2011 and would not fall back below 2% until 2012 when the VAT rise was a year old. RPI inflation was forecast to be over 4% for most of 2011 then falling back closer to 3% in the first half of 2012. Utility and food prices were expected to provide upward pressure on all inflation measures throughout 2011.

Labour Market

- 3.14 The recent picture on employment has been mixed. Employment reached a low point of 28.84 million in the three months to March 2010 but then rose to 29.19 million in the three months to September 2010 (Figure 3.6). Employment then fell back slightly to 29.12 million in the three months to December 2010 but was still 218,000 higher than a year previously.
- 3.15 The OBR expects total employment to rise from 29.0 million in 2010 to 30.1 million in 2015, an increase of 3.5%. This increase comprises a rise in private sector employment of around 1.5 million, partially offset by a fall in general government employment⁶ of just over 400,000 between 2010/11 and 2015/16.

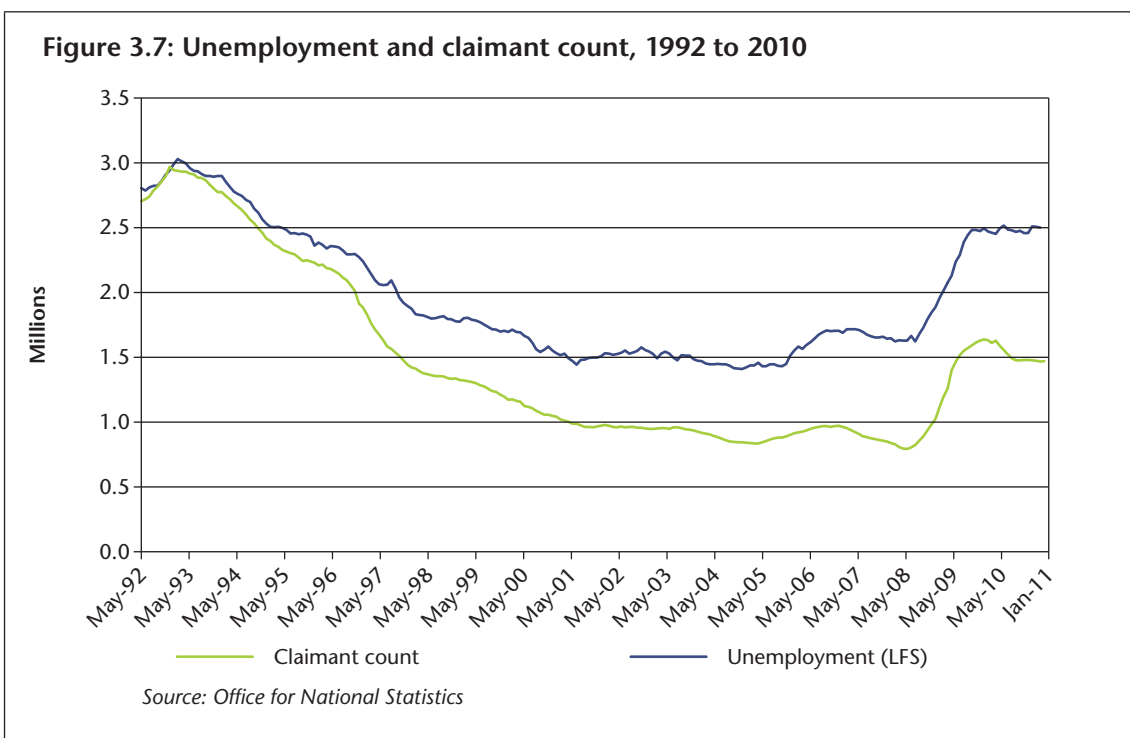
⁴ Bank of England (February 2011), *Inflation Report*.

⁵ Office for Budget Responsibility (November 2010), *Economic and Fiscal Outlook*, TSO (Cm 7979), and HM Treasury (February 2011), *Forecasts for the UK Economy: A Comparison of Independent Forecasts*.

⁶ Public sector employment including central and local government but excluding public sector corporations. Further details at: <http://www.statistics.gov.uk/pdfdir/pse0610.pdf>

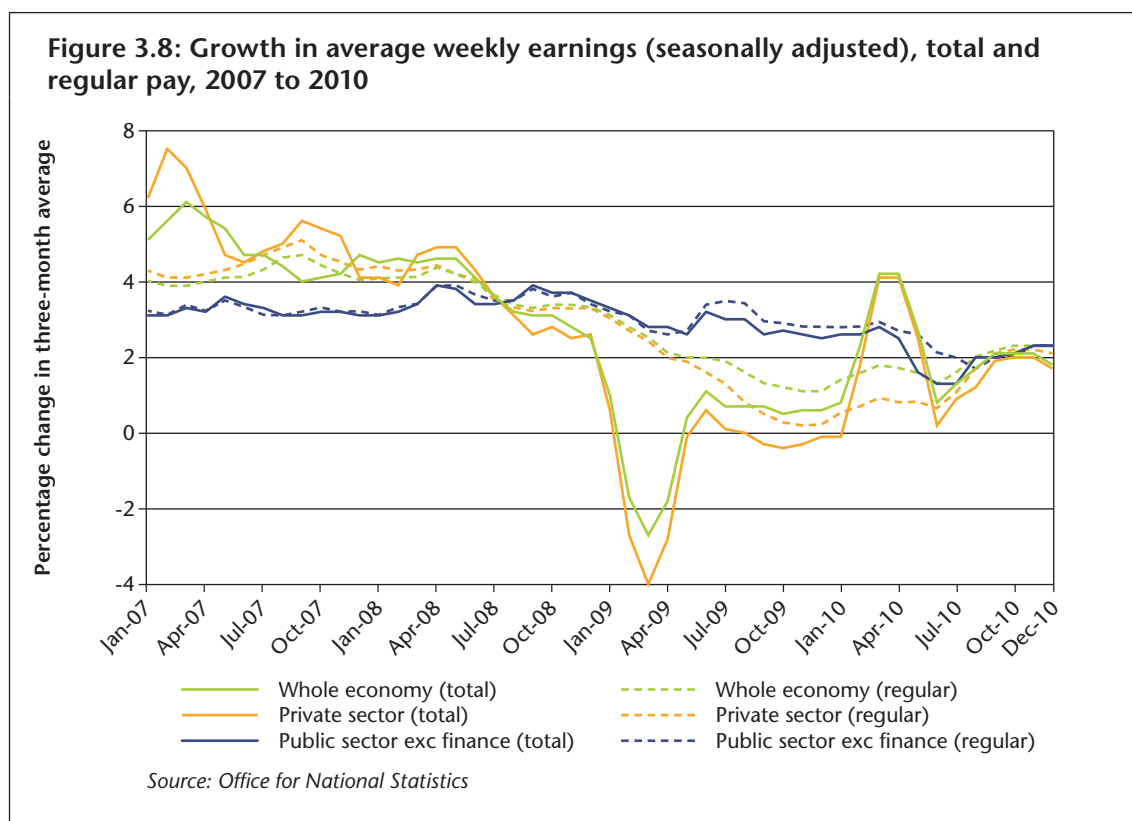


- 3.16 The level of unemployment measured by the Labour Force Survey rose by 44,000 in the three months to December 2010 and by 40,000 in the year to December 2010 to reach 2.49 million (7.9%). The claimant count was at 1.46 million in January 2011, up 2,400 on the month and down 157,100 on the year (Figure 3.7). The claimant count rate was 4.5% in January 2011, down 0.5 percentage points on the year.
- 3.17 The OBR forecast at November 2010 expects the ILO unemployment rate to rise slightly as economic growth slows in 2011, peaking at 8.1% before falling back again from 2012. The claimant count is also expected to rise over the near term.



Average Earnings Growth and Pay Settlements

3.18 Whole economy average weekly earnings⁷ (including bonuses) grew by 1.8% in the three months to December 2010 (Figure 3.8). Over the same period, private sector average earnings grew by 1.7% and public sector average earnings grew by 2.4%, with the latter including the nationalised banks (excluding them, public sector average earnings growth was 2.3%). The OBR forecasts whole economy average earnings growth to rise gradually from 1.9% in 2011 to 4.4% by 2014 as productivity recovers.



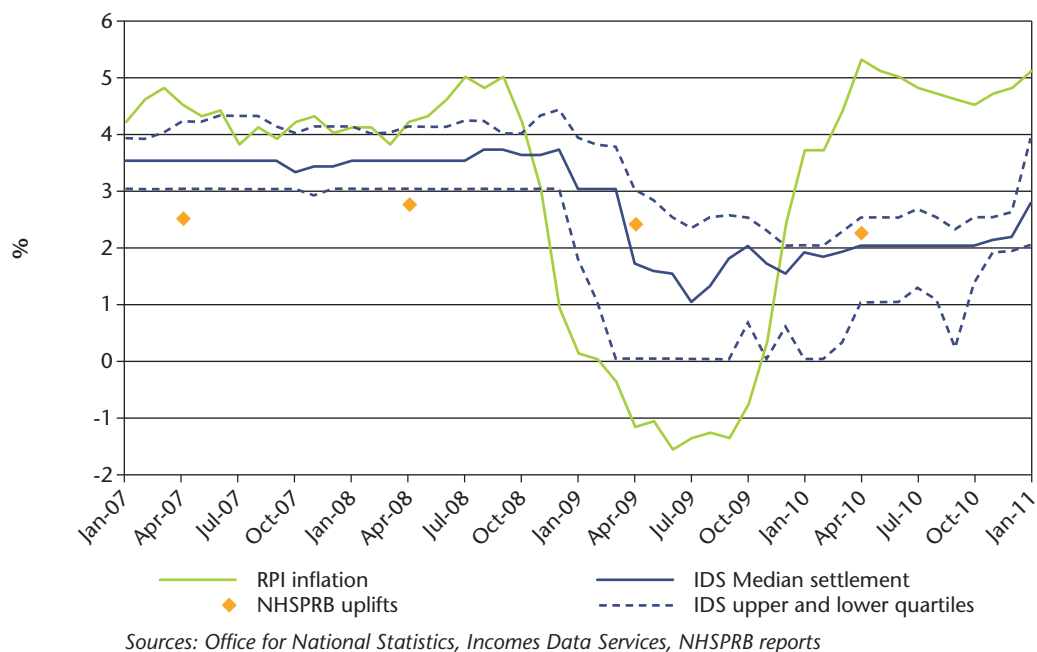
3.19 The median pay settlement showed an increase at the start of 2011 to 2.8% in the three months to January 2011, according to Incomes Data Services (IDS), having been stable at around 2% through 2010, but remains significantly below the rate of inflation (Figure 3.9). The median, however, disguises the fluctuating proportion of pay freezes which, according to IDS, reached nearly half of all pay settlements in autumn 2009 but fell to below one in five in the second half of 2010. An increasing proportion of these pay freezes were in the public sector in 2010 whereas in 2009 pay freezes were overwhelmingly a private sector trend. IDS data⁸ indicate that 35% of private sector pay reviews were freezes in 2009 compared to 20% in 2010. In contrast, 8% of public sector pay reviews were freezes in 2009 compared to 43% in 2010.

3.20 Details of individual public sector pay settlements for the second half of 2010, since the two-year public sector pay freeze was announced in June 2010, indicated that around a third were at zero. Of the remainder, most others were in the latter stages of long-term pay deals or were central government awards.

⁷ The Average Weekly Earnings (AWE) series replaced the Average Earnings Index as the headline measure of earnings growth in the economy from January 2010. The AWE was considered by the Office for National Statistics to be a more accurate and reliable measure of earnings growth.

⁸ Published at: www.idspay.co.uk

Figure 3.9: Pay settlements, 2007 to 2010 (three-month average)



Evidence from the Parties

3.21 The following summaries of the parties' evidence are based on the latest economic and labour indicators available when the parties submitted their evidence in November 2010.

The Health Departments

3.22 The **Department of Health** commented that the workforce reduction and wage restraint witnessed in the wider labour market had highlighted the relative competitiveness of the total public sector package which had remained generous in recent years. The Department provided data on employment and unemployment levels. It concluded that most labour market indicators had stabilised or started to recover through the first half of 2010 and employment had risen sharply. In November 2010 the Department commented that labour demand had not yet fully recovered, with vacancies remaining well below their pre-recession level and inflows to unemployment increasing. The OBR forecast that employment would recover modestly through the second half of 2010 and, from 2011, as GDP growth was forecast to gather momentum and demographic factors boosted the population of working age, employment was expected to rise more rapidly reaching 30 million by 2015.

3.23 The Department cited the OBR inflation forecasts for the June 2010 budget which put CPI inflation at 2.4% by Q4 2011, falling back to a little under 2% in early 2012 before settling at the 2% target over the medium-term. The Department noted that the August 2010 Bank of England Inflation Report judged that the forthcoming increase in VAT was expected to keep CPI inflation above the 2% target until the end of 2011. The Department also cited the HM Treasury's average of independent forecasters at October 2010 which expected CPI inflation to be at 2.5% by Q4 2011.

3.24 The Department noted that average earnings growth had started to recover from the record lows seen through 2009, driven by recovery in the private sector, but that whole economy earnings growth remained below its long-term average. The Department pointed to a slight rise in pay growth in the private sector and a slowdown in the public

sector. Private sector settlements had started to recover as pay freezes became less widespread than during the recession. At the June 2010 budget, the OBR expected whole economy average earnings growth to remain subdued in the near term but then to pick up progressively as productivity growth recovered.

- 3.25 The **Scottish Government Health Directorates (SGHD)** stated that the decline in Scottish output during the recession led to a sharp deterioration in the Scottish labour market which continued to weaken during the first half of 2010. The Scottish unemployment rate was 8.6%, up from 4% prior to the recession. The continued rise in unemployment in Scotland had also been associated with an increase in employment due to an inflow of people into the labour market. The SGHD added, however, that the overall level of employment in Scotland remained around 50,000 lower than 2009. Looking forward, the SGHD commented that the labour market was yet to show convincing signs of stabilisation and that low levels of employment in the medium-term implied that the weak pay growth observed over the past year could continue, leading to a reduction in real wages if earnings growth continued at a rate below inflation.
- 3.26 The **Department of Health, Social Services and Public Safety in Northern Ireland (DHSSPSNI)** told us that the global economic downturn continued to have a severe impact on the Northern Ireland labour market. The local unemployment rate was at 7.0% (June-August 2010) with the number of claimants increasing by 9.6% over the year to September 2010. Economic inactivity was a persistent feature of the Northern Ireland labour market and the level of long-term unemployment and incapacity claims were significant obstacles to reducing the level of economic inactivity.
- 3.27 The DHSSPSNI added that the announcement of public sector job cuts might have a greater adverse impact in Northern Ireland due to the local reliance on the public sector in terms of employment. The DHSSPSNI cited Croner Reward's 2010 *Cost of Living Comparisons* which indicated that consumer prices had increased more in the UK (5.7% per annum) than in Northern Ireland (5.1% per annum). Data from the 2009 *Annual Survey of Hours and Earnings* indicated that public sector earnings in Northern Ireland were below the UK average but outstripped those in the private sector.
- 3.28 The **Welsh Assembly Government (WAG)** provided no specific evidence on the economy, inflation, labour market and earnings.

NHS Employers (NHSE)

- 3.29 **NHSE** reported that NHS pay rates continued to be competitive with other sectors and the minimum NHS pay rate was well ahead of the National Minimum Wage. Employers did not consider that on labour market grounds there was a need to make adjustments to the lower levels of the national pay structure.

Staff Bodies

- 3.30 The **Staff Side** noted that while UK unemployment fell by 8,000 to 2.47 million at August 2010, the number of benefit claimants rose by 2,300 to 1.47 million. They said that employment rose by 286,000 to 29.2 million (a 0.4% increase) but job vacancies fell by 14,000 to 467,000. The Staff Side concluded that the labour market looked extremely fragile and any private sector employment growth did not look adequate to ameliorate the impacts of reduced public sector employment.
- 3.31 The Staff Side considered that RPI inflation represented the best measure of changes in prices faced by NHS staff as it included housing costs. NHS pay rises were below RPI inflation in 2008 and 2010 but above RPI inflation in 2009 and, since the three-year deal

started in April 2008, CPI inflation had been above the NHS pay rise for 21 of the 29 months that had elapsed. The Staff Side commented that since the start of 2010 both RPI and CPI inflation had outstripped the NHS pay rise and that forecasts of inflation had been revised sharply upwards.

- 3.32 The Staff Side drew on the Croner Reward March 2010 *Cost of Living Regional Comparisons* to argue that the lowest paid staff in the NHS had suffered a particularly sharp decline in living standards. The Staff Side cited comparisons showing that a family in the lowest category of wealth faced the highest percentage increase in cost of living at 6% largely driven by housing costs. It also highlighted UNISON's 2010 health member survey which showed that, generally, the lower the pay band the greater the proportion of NHS staff who felt that the value of their pay had deteriorated against the cost of living over the previous year. The Staff Side pointed to the UK Government's proposed minimum increase of £250 for those earning £21,000 or less which, in the Staff Side's view, represented a percentage increase well below the forecast RPI and CPI inflation over 2011/12, effectively meaning a drop in pay for a large proportion of the NHS workforce.
- 3.33 The Staff Side commented that average earnings growth for key NHS groups had rarely exceeded the public sector average between May 2008 and May 2010. The Staff Side cited HM Treasury forecasts of average earnings growth predicting a significant bounce back in 2010 and a rate across the whole economy of 2.7% for 2011.
- 3.34 **UNISON** provided further examples of the impact of RPI on Band 1, 3 and 5 salaries between 2007 and 2011 suggesting all had experienced a pay cut. UNISON argued that cost of living increases hit the low paid the hardest and that a £250 increase would not meet the rising cost of living for low paid NHS staff being below forecasts for RPI and CPI inflation. UNISON also analysed data from Croner Reward's annual cost of living study at March 2010 which suggested that, although all staff had suffered a deterioration in the value of their pay packets, the lowest paid staff in the NHS had suffered a particularly sharp decline. UNISON commented that the Croner Reward analysis of cost of living increases fitted with the pattern identified in its 2010 health member survey. From the survey, UNISON provided data on how inflation rates impacted on NHS Pay Bands (1-8) and provided 13 case studies to show the individual impact of economic changes.
- 3.35 **Unite** commented that all those working in the NHS should be protected from a fall in living standards and should receive a fair pay increase at least in line with inflation. Unite stated that RPI inflation was the appropriate measure of inflation to use for decisions concerning pay because it included a broader range of important items that households spend money on compared to CPI inflation. **UCATT** also commented on inflation and rapidly rising costs that disproportionately affected low paid workers.

Funds Available to the Health Departments

- 3.36 This section sets out the funds announced in the spending review and refers to a House of Commons Health Committee Report on public expenditure before setting out the evidence from the parties.

- 3.37 The UK Government's spending plans for 2011/12 to 2014/15 were published in its *Spending Review 2010*⁹ in October 2010. The UK Government stated its objective to "provide an NHS free at the point of use and available to everyone based on need not the ability to pay". The UK Government announced an above inflation increase in NHS funding every year to 2014/15 to bring NHS spending to £114 billion. The Department of Health Programme and Administrative Budget would show cumulative real growth of 1.3% by 2014/15 and overall NHS spending would increase by 0.4% in real terms by 2014/15. Alongside the funding increases, the Department of Health would be required to find savings of £20 billion by 2014/15 and the Departmental administrative budget would reduce by 33%.
- 3.38 On 14 December 2010, the House of Commons Health Committee published its report on *Public Expenditure*¹⁰ setting out the Committee's concerns about the scale of efficiency gains required in health and social care while maintaining care levels and improving the quality of services. The Committee observed that health spending was a significant proportion of UK Government spending and therefore vital to the achievement of overall spending plans. It considered that the UK Government's commitment to a real terms increase in health spending over the spending review period would not be met and that the total NHS settlement was forecast to be a real terms cut of around 0.25% following the OBR's revised forecasts for the GDP deflator.
- 3.39 The Committee stated that there was an urgent need for a credible plan to deliver efficiency gains, and early savings needed to be demonstrated to proceed at a steady pace to the £20 billion goal. The scale of the challenge was thought "enormous" and the Committee added that the NHS did not have a good record on improving productivity. It was acknowledged that the pay freeze would contribute to efficiency gains but overall savings and service improvements would depend on the efforts of NHS staff whose pay was being frozen.

Evidence from the Parties

The Health Departments

- 3.40 The **Department of Health** commented that public finances had been profoundly affected by the financial crisis. The UK had seen the deepest and longest recession since the Second World War. The overall budget deficit reached 11% of GDP in 2009/10 and therefore the UK Government had set out plans for a significant acceleration in the reduction of the structural budget deficit over the course of the Parliament.
- 3.41 The greater proportion of the UK Government's fiscal consolidation would come from a reduction in public spending rather than an increase in taxation, with savings of £81 billion required by 2014/15. The UK Government estimated that £164 billion was spent on public sector pay which represented about 50% of department spending allocations and Pay Review Body workforces made up about 45% of the total public sector paybill. The UK Government argued that managing public sector pay was central to its plans for fiscal consolidation and that pay restraint would be crucial to protect service quality in a tighter environment for spending.

⁹ HM Treasury (October 2010), *Spending Review 2010*. Available at: http://cdn.hm-treasury.gov.uk/sr2010_complereport.pdf

¹⁰House of Commons Health Committee (December 2010), *Public Expenditure: Second Report of Session 2010-11*, TSO (HC512).

3.42 The Department highlighted that the UK Government's proposals contained in evidence were inevitably shaped by wider economic and job market conditions and in particular by the vital need to reduce the deficit through spending control and pay restraint across the public sector. It added that unaffordable pay uplifts would hamper the deficit reduction programme and divert funding from frontline service delivery and could seriously affect the likelihood of the UK Government achieving its long-term aims for improving the NHS. The Department pointed to real-terms growth in NHS revenue expenditure of 5.3% per year between 2000/01 and 2010/11. Pay was a significant cost pressure, accounting for more than 40% of NHS revenue expenditure and around 60% of hospital and community health services expenditure. Between 2000/01 and 2008/09 increases in paybill prices had on average accounted for 31.4% of the cash increases in NHS revenue expenditure (see Table 3.1).

Table 3.1: Increase in revenue expenditure and proportion consumed by paybill

Year	Revenue increase (cash) (£bn)	Paybill increase (cash) (£bn)	% of revenue increase on paybill	% of revenue increase on paybill prices	% of revenue increase on paybill volume
2001/02	4.6	2.4	51.4	31.6	19.8
2002/03	4.6	2.4	51.1	25.1	26.0
2003/04	6.5	2.6	40.9	20.8	20.1
2004/05	5.0	4.5	90.6	65.1	25.4
2005/06	7.3	2.5	34.4	20.4	14.1
2006/07	4.3	1.3	30.2	42.1	-11.9
2007/08	7.9	1.3	16.3	18.5	-2.1
2008/09	4.4	2.6	59.8	27.6	32.3
Average	6.0	2.45	45.1	30.5	14.6

Source: Department of Health

3.43 The Department commented on pressures on NHS funding growth: baseline pressures, which were the first call on NHS resources, to cover existing commitments essential to the NHS, including pay; underlying demand, which had grown on average by 2.7% per annum in the last 10 years; and service development covering policy commitments to improve quality. The Department provided an indicative disposition across expenditure components for 2011/12 (see Table 3.2) showing the reduction in expenditure based on assumptions of historic pay drift at 1.6% and the application of the pay freeze and a £250 uplift for AfC pay points 1-15 – the latter was estimated to cost £950 million in 2011/12.

Table 3.2: NHS revenue since 2000/01

Year		NHS Revenue Expenditure (£bn)	Cash Growth (%)	Real growth (%)	Proportion of revenue expenditure consumed by paybill (%)
2000/01	Outturn	42.7			45.9
2001/02	Outturn	47.3	10.8	8.5	46.4
2002/03	Outturn ¹	51.9	9.8	6.6	46.8
2002/03	Outturn (rebased) ²	55.4			
2003/04	Outturn	61.9	11.7	8.8	43.6
2004/05	Outturn	66.9	8.1	5.3	47.1
2005/06	Outturn	74.2	10.9	9.1	45.9
2006/07	Outturn	78.5	5.8	2.4	45.0
2007/08	Outturn	86.4	10.1	7.2	42.4
2008/09	Outturn	90.7	5.0	2.3	43.2
2009/10	Estimated outturn	97.8	7.8	6.2	
2009/10	Estimated outturn (aligned) ³	96.0			
2010/11	Plan (aligned)	99.8	4.0	1.1	
2011/12	RDEL	102.6	2.9	0.4	
2012/13	RDEL	105.2	2.5	0.3	
2013/14	RDEL	108.2	2.8	0.1	
2014/15	RDEL	111.1	2.7	0.0	

(1) Expenditure figures from 2000/01 to 2002/03 are on a Stage 1 resource budgeting basis.

(2) Expenditure figures from 2003/04 to 2008/09 are on a Stage 2 resource budgeting basis, this means cost of capital and cost of new provisions are included in the RDEL.

(3) Expenditure figures from 2010/11 are on an aligned basis. Aligned means that cost of capital is no longer included in RDEL and new provisions are included in Annually Managed Expenditure rather than RDEL.

Source: Department of Health

- 3.44 The Department highlighted the need to make extremely challenging improvements in productivity and efficiency while focussing relentlessly on clinical quality. Work had begun on releasing up to £20 billion of efficiency savings in the spending review period to be reinvested in frontline services. The Quality, Innovation, Productivity and Prevention (QIPP) initiative was identifying how efficiencies could be driven and services redesigned.
- 3.45 The Department concluded that the funding available to the NHS was fixed and extremely tight compared with the recent past and therefore increases in pay would reduce the funds available for service developments and reduce the derived demand for staff.
- 3.46 The **SGHD** highlighted that, under its draft budget announced on 17 November 2010, NHS Boards would have around 1% additional cash funding in 2011/12 after taking account of Government priorities and commitments. The SGHD estimated that NHS Boards would need to deliver and retain a minimum of 3% efficiency savings to achieve financial balance.

- 3.47 The **WAG** told us that annual growth in the Health and Social Services revenue budget had reduced from 5.2% in 2007/08 to 2.6% in 2010/11 and that planning assumptions were for a reduction of 3% per year from 2011/12 onwards. The WAG commented that there was insufficient funding to meet the impact of previous NHS pay awards. Planning assumptions for the three years from 2011/12 will require NHS organisations to reduce their costs by 7% per annum or 19.6% over this period. Under the spending review the Assembly's budget was set to fall by around 3.1% per year with the budget in 2014/15 £1.8 billion lower in real terms than 2010/11. The cumulative real terms reduction in the Health and Social Services revenue budget will be £109 million (1.9%) in 2011/12, £234 million (4.1%) in 2012/13 and £360 million (6.3%) in 2013/14.
- 3.48 The **DHSSPSNI** informed us that formal affordability evidence could not be produced in time for our report as the Northern Ireland budget position was not clear. However, in a letter to us dated 7 March 2011 the DHSSPSNI commented that the Health and Social Care workforce enjoyed healthy levels of recruitment and retention and had benefitted from a good overall remuneration package. It added that there was a high risk that any pay increase above what was absolutely necessary to maintain the current workforce would be at the expense of staff jobs.

NHS Employers

- 3.49 **NHSE** said the spending review meant that employers in the NHS faced a very tight settlement with a severe contraction of their finances in the three years from 2011 and the need to make efficiency savings of up to £20 billion including a 45% reduction in management costs. NHSE reported growing concern that the pay freeze would not be sufficient to reduce the growth in the paybill needed. In that event, greater efficiency savings would be required resulting in possible reductions in service provision and/or workforce numbers.
- 3.50 NHSE added that the affordability of any increases in earnings dominated the thinking of employers in the NHS in England. NHSE pointed to incremental pay provisions costing around 2% of the paybill and stated that, despite the pay freeze, around 70% of employees were likely to receive uplifts averaging 3%. NHSE reported that many employers had asked about the scope for some form of negotiated suspension of incremental progression during the period of the pay freeze.

Staff Bodies

- 3.51 The **Staff Side** told us that it was acutely aware of the financial pressures facing the service, particularly the requirement to find efficiency savings over the next four years and the small real terms budget increase. The Staff Side added that, in the context of efficiency savings, many trusts had already begun to restrict access to treatments and some were actively closing or considering closing major services. The Staff Side did not consider the real terms increase for the NHS as sufficient to keep up with the costs of new drugs, the ageing population and lifestyle challenges. It commented that spending cuts in other departments and services, including social care, were likely to have an impact on the NHS as patients increasingly relied on NHS services.
- 3.52 The Staff Side made reference to Northern Ireland where, in addition to efficiency savings, the Health and Social Care paybill was to be cut by 2% in 2010/11 in order partially to accommodate a budget reduction of £113.5 million. In Scotland, the Staff Side said that despite the deferral of public sector cuts and uplifts in budgets, health boards still needed to make substantial savings and were predicting a reduction in nursing and midwifery posts of over 1,500 whole-time equivalents in 2010/11. The Staff

Side considered that Wales was particularly vulnerable to spending cuts due to the high proportion of people employed in the public sector – 27.5% of the working population.

- 3.53 **UNISON** considered that the cuts demanded of the NHS were not as a consequence of mismanagement of public funds: the NHS in England recorded a substantial surplus in 2009/10 being £1.3 billion below its resource limit; NHS Scotland was in balance in 2008/09; and NHS Wales recorded a surplus of £3.4 million in 2008/09. It concluded that the generally healthy financial position for the NHS in 2011/12 indicated that organisations would be well placed to protect the real value of NHS pay.

Recruitment and Retention

Evidence from the Parties

- 3.54 We summarise below the main conclusions of the parties in their evidence as they relate to recruitment and retention including, where identifiable, specific aspects relating to AfC staff earning £21,000 or less.

- 3.55 The **Department of Health** highlighted that:

- The recruitment and retention position was healthy both among staff earning salaries of £21,000 or less and across the NHS more generally;
- The NHS non-medical workforce had increased in headcount terms by 5% between 2008 and 2009. The NHS Workforce Census for the year ended 30 September 2009 showed that the number of support staff for doctors and nurses rose by 6% and the number of other infrastructure support staff, excluding managers, rose by 6.9% – these clearly showed increased levels of NHS employment among staff paid under AfC Bands 1-4;
- In March 2010, the three-month vacancy rate for all non-medical NHS staff was 0.5%, an improvement on the 0.6% rate for the same period in 2009. In addition, for those earning £21,000 or less vacancy rates among unqualified nurses fell from 0.4% to 0.3% and those among healthcare assistants, and support, administrative and estates fell from 0.4% to 0.2%; and
- Levels of staff motivation and satisfaction were also healthy with the numbers of staff with an “intention to leave” falling between 2008 and 2009.

- 3.56 The Devolved Administrations reported as follows:

- The **WAG** commented on workforce increases for most categories except for maintenance and works staff, and continued falls in the overall number of vacancies to September 2009;
- The **DHSSPSNI** commented on a 1.5% increase in the Health and Social Care workforce (headcount) in the period 2006 to 2010, a vacancy rate of 0.9% at March 2010 for Bands 1-4 Administration and Clerical staff, and an average of 12.2 applicants per post filled in the health sector; and
- The **SGHD** commented on a 2.3% increase in staff (headcount) at September 2009 as compared with September 2008, falling turnover rates over the last three years to 8.8%, and virtually unchanged nursing and midwifery vacancy rates.

3.57 **NHSE** commented that employers reported no particular labour market issues affecting those earning £21,000 or less and that, in general, the recruitment and retention position across the NHS had improved with turnover rates reducing as they had in each year since 2007. NHSE added that total vacancies had decreased slightly across the main AfC staff groups to 2.0% in 2010 and that applications per vacancy rose to 16, reflecting more applicants chasing each job opportunity.

3.58 The **Staff Side** commented that:

- Overall the NHS workforce showed an upward trend to September 2009 but in the three months to July 2010 NHS employment fell by 6,000;
- The total vacancy rate and the three-month vacancy rate declined in the year to March 2010 in England. However, the Staff Side urged against complacency in assessing the recruitment and retention picture in the NHS. They had doubts about the accuracy of vacancy data which might be compounded by the underreporting of vacancies and the use of recruitment freezes; and
- 68% of respondents to its Incomes Data Services' staff survey¹¹ (September 2010) reported staff shortages had frequently occurred in their working area or department over the last 12 months – staff shortages were most likely to be reported by midwives (83%) and maternity support workers (80%) followed by nurses (69%) and allied health professions (67%).

3.59 Individual staff organisations provided specific comments and data on recruitment and retention issues which can be found in the evidence on their websites (see Appendix E).

Parties' Proposals for AfC Staff Earning £21,000 or Less

3.60 In his letter of 26 July 2010, the Chief Secretary to the Treasury defined the scope of our remit to make recommendations in respect of staff earning £21,000 or less. We were advised that those earning £21,000 were defined in the following terms:

- This should be determined on the basis of basic salary of a full-time equivalent employee, pro-rated on the basis of the hours worked, using the standard number of hours per week for that organisation;
- Part-time workers with a full-time equivalent salary of less than £21,000 should receive a pro-rata increase on the basis of the number of hours worked;
- The £21,000 is based on the normal interpretation of basic salary and does not include overtime or any regular payments such as London Weighting, recruitment or retention premia or other allowances.

3.61 We were also advised that in considering our recommendations we may want to consider:

- The level of progression pay provided to the workforce;
- Affordability;
- The potential for payments to be more generous for those on the lowest earnings; and

¹¹ Incomes Data Services (September 2010), *NHS Staff Survey – A Research Report for the NHS Trade Unions*.

- How best to avoid “leapfrogging” of those earning just under £21,000 with those earning just over £21,000, potentially through the use of a taper.

Evidence from the Parties

The Health Departments

- 3.62 The **Department of Health** proposed that the 2011/12 uplift for NHS staff earning £21,000 or less should be a flat rate of £250 irrespective of an individual’s position on the AfC pay scales recognising that those not on the top of pay bands would receive increments of between 2.2% and 3.8%. The flat rate would equate to percentage increases of between 1.22% and 1.83% which the UK Government considered to be wholly appropriate in the circumstances.
- 3.63 The UK Government believed that, notwithstanding the wider financial position, considerations of recruitment and retention and evidence on motivation made £250 the correct uplift. The Department of Health added that, in the light of the over-riding imperative to reduce the deficit and the demands on the NHS, the UK Government did not consider any uplifts in addition to the flat rate £250 to be justified or affordable. The Department of Health’s proposal would cost £130 million for staff in England and would cover approximately 40% of AfC staff or around 443,000 (headcount).
- 3.64 The Department considered that the flat rate would remove any risk of “leapfrogging” as all pay points would receive the same uplift and the difference between pay points 15 (£20,554) and 16 (£21,176) was £622. The Department commented that, even with a similar flat rate uplift in April 2012, pay point 15 would still be lower than point 16. The Department said that any recalibration of the system necessary to address the proximity of the pay points may be carried out following the end of the pay freeze.
- 3.65 The **SGHD** considered that, taking into account the introduction of a Scottish “living wage” (see paragraph 3.66), the healthy recruitment and retention situation, and the constrained financial position faced by NHS Scotland, the uplift for NHS staff earning £21,000 or less should be a flat rate not exceeding £250. The SGHD estimated that 51,000 whole-time equivalent staff earned £21,000 or less and the cost of a £250 uplift would be some £17 million.
- 3.66 In addition, the Scottish Government had made a commitment to protect those staff on low incomes and announced, as part of its public sector pay policy, that no member of staff in the public sector should be earning less than the minimum “living wage” of £7.15 per hour. For AfC staff, this would mean not using point 1 on the pay scale and ensuring all staff were on at least point 2 which equated to £7.16 per hour (in 2010/11). The SGHD estimated the introduction of the “living wage” in the NHS in Scotland would cost £2 million in 2011/12 and cover some 4,500 (whole-time equivalent) staff.
- 3.67 We note the Scottish Government’s intention to introduce the Scottish “living wage” for public sector staff from 1 April 2011. This change lies outside our remit. We note, however, that the AfC structure was carefully negotiated to produce pay arrangements applicable across the UK. We therefore ask the parties to monitor any implications of this change and ask the SGHD to keep us informed of any plans to update the “living wage” and how such plans may affect staff in NHS Scotland.
- 3.68 The **WAG** told us that it would be appropriate for a flat rate increase of £250 to be awarded to NHS staff in Wales earning £21,000 or less which would cost about £8 million and cover around 26,800 staff.

- 3.69 The **DHSSPSNI** reaffirmed the Minister's remit letter recognising that there will be an increase of at least £250 for Health and Social Care staff earning £21,000 or less. Around 31,400 (whole-time equivalent) Health and Social Care staff earned £21,000 or less.

NHS Employers

- 3.70 **NHSE** saw no case on labour market grounds for any award above the minimum of £250 for those earning £21,000 or less. Employers had reported no particular labour market issues for this group and that NHS pay rates remained competitive with other sectors. NHSE were concerned about the cost of an uplift for those earning £21,000 or less which they estimated would add 0.3% to the paybill and cover around 350,000 full-time equivalent staff. They added that around 70% of staff in this group would receive pay increases as a result of pay progression ranging between 2.2% and 3.8% (between 3.7% and 5.3% when including the minimum £250 uplift). NHSE argued against differentials which might allow "leapfrogging" stating that the existing structure allowed headroom for flat rate increases over the two years of the pay freeze and that any taper with a higher uplift at the bottom would add unnecessary additional cost.

Staff Bodies

- 3.71 The **Staff Side** organisations had all opposed the policy of pay restraint which, with the rapidly rising cost of living, in effect imposed a pay cut which would damage morale and motivation. The Staff Side told us that staff on the lowest earnings had suffered most from inflation and that the recent VAT increase would only exacerbate their problems. The Staff Side commented that the award of at least £250 promised to those earning £21,000 or less was therefore an important – albeit small, below inflation – guarantee for the lowest paid NHS staff. The Staff Side added that it was vital that the long-term effects of the pay freeze were fully anticipated and analysed including the impact on recruitment and retention of the £250 award to staff earning £21,000 or less.
- 3.72 The **Royal College of Nursing** told us that support workers, and particularly health care assistants, were playing an increasingly important role in the NHS and that this overwhelmingly female workforce was among the lowest paid in the NHS. A £250 flat rate increase was seen as preferable to a pay freeze but would not make a large enough difference to living standards faced with rising inflation, VAT and changes to welfare entitlements which will affect many lower paid NHS staff. The RCN commented that the pay freeze would create internal anomalies and distortions within NHS pay bands, for example, at the end of the two-year pay freeze the pay of an employee at the top of Band 3 (such as a senior health care assistant) would be just £2,099 below that of a newly qualified staff nurse on the first point in Band 5.
- 3.73 **UNISON** recommended a sum considerably higher than £250 for those staff on the lowest NHS salaries upon whom inflation had had the most detrimental impact. UNISON proposed an 8.8% increase to bring pay point 1 in Band 1 to the Joseph Rowntree Foundation Minimum Income Standard¹² of £7.60 per hour. UNISON's proposal would also require a recalibration of pay points 2 to 7 and a £250 increase to pay points 8 to 15. UNISON commented that flat rate increases reduce the gap between low and high earnings in the NHS. UNISON also commented that an increase to pay points 1-15 would have a direct impact on staff at pay points 16 and 17 and argued that tapering should be considered in order to maintain meaningful pay differentials between pay points.

¹²Joseph Rowntree Foundation (July 2010) A Minimum Income Standard for the UK. Published at: www.jrf.org.uk/publications/minimum-income-standard-2010

- 3.74 The **Royal College of Midwives** commented that the policy for those earning £21,000 or less would narrow the carefully balanced differentials in the AfC pay scale and that it represented a 1.2% pay uplift at pay point 15 which was wildly at odds with current economic conditions. The RCM welcomed the flat rate rise but considered it would do nothing to bring people into midwifery at a time when the NHS was still many thousands of midwives short.
- 3.75 **Unite** considered that those earning £21,000 or less should receive an uplift greater than the £250 minimum suggested by the UK Government and in line with inflation increases. Unite pointed to lower income households tending to experience higher than average levels of inflation as shown by the Institute of Fiscal Studies¹³. Unite also referred to the Joseph Rowntree Foundation calculations of an acceptable standard of living.
- 3.76 The **Society of Radiographers** told us that the proposed £250 increase for those staff earning £21,000 or less was insufficient when considering the increase in VAT, travel, energy and food. The Society said that a greater pay increase would help the earnings of this important and vulnerable group of workers to keep pace with the cost of living.
- 3.77 The **Chartered Society of Physiotherapists** noted the UK Government's pay policy including for those earning £21,000 or less and commented that it should be seen in the context of the Treasury's average of independent forecasters predicting that RPI inflation will be at 3.6% and CPI inflation at 2.5% by the fourth quarter of 2011.

Our Comments and Recommendation

- 3.78 Our remit this year specifically requires us to make a recommendation on a pay uplift for full-time equivalent staff earning £21,000 or less. The context for our recommendation is the public sector pay policy adopted by the UK Government and the Devolved Administrations for a two-year pay freeze except for those earning £21,000 or less. We understand that the UK Government's and Devolved Administrations' approach was designed to offer a degree of protection to lower paid public sector workers.
- 3.79 We acknowledge that the imposition of a limit of £21,000 and the decision to seek or (in the case of Scotland and Northern Ireland) to commit to an increase of £250 were matters of judgment for the UK Government and Devolved Administrations rather than being specifically linked to economic or labour market circumstances. We also note that the Chief Secretary to the Treasury's remit letter of July 2010 said that the UK Government would seek an increase of at least £250 per year and the Health Departments, in their November 2010 evidence, did not consider any additional uplift to be justified or affordable.
- 3.80 We have carefully assessed the evidence to support a recommendation on the level of increase for those AfC staff earning £21,000 or less. In our assessment we have used the definitions of staff earning £21,000 or less set out in the Chief Secretary to the Treasury's remit letter (see paragraph 3.60). That letter also said that, in recommending on the size of the uplift for those earning £21,000 or less, we may want to consider four areas.
- 3.81 The first was the level of pay progression provided to the workforce which the Department of Health said would be between 2.2% and 3.8% (excluding a £250 increase) for those not on the top of their AfC pay bands. NHSE estimated that incremental pay provisions would deliver an average uplift of 3% for around 70% of employees. We also note that NHSE's proposal for a National Enabling Framework

¹³Institute of Fiscal Studies (March 2009) *How does inflation affect different households?*

allowing employers in England to agree locally with trade unions to freeze incremental progression in return for guarantees of no compulsory redundancies for staff on Bands 1-6 was rejected recently by the staff organisations. We recognise that NHS pay is a significant cost pressure for employers at a time of financial constraint and the requirement to achieve efficiency savings. However, it remains our view that incremental progression is a separate issue from basic pay.

- 3.82 The second area we were advised we might want to consider was the affordability of any increase. Affordability is a consideration in our standing terms of reference and we discuss it in paragraph 3.86. The third area was the potential for payments to be more generous for those on the lowest earnings but this was not widely supported in the evidence we received. The Health Departments and NHSE both supported a single uniform uplift and we were not convinced that there was evidence to justify UNISON's proposals for significant increases at the bottom pay points for the reasons given in paragraphs 3.84 to 3.86. We also conclude that a single uniform uplift is the least disruptive to the pay structure for those earning £21,000 or less although we comment later on our concerns about compressing that structure. The fourth area we were advised we might consider was how best to avoid "leapfrogging" of those earning just under £21,000 with those earning just over £21,000. Our recommendation for this year does not require this to be considered, although we note that the compression of the pay structure would leave little headroom should this approach be repeated in 2012/13.
- 3.83 In addition to the specific considerations set out in this year's remit, we make our recommendation in line with our standing terms of reference specified in the preface to this report. These require us to have regard to: the need to recruit, retain and motivate suitably able and qualified staff; regional/local variations in labour markets and their effects on recruitment and retention of staff; the funds available to the Health Departments; the Government's inflation target; the principle of equal pay for work of equal value; and 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.
- 3.84 Our assessment remains that the recruitment position for our remit group continues to be healthy and the retention position remains stable. This is broadly agreed by the parties although we acknowledge that there are specific groups that require close monitoring (see Chapter 5). There are emerging signs that the labour market will pick up with rising employment levels forecast for 2011 but unemployment is not expected to fall back until 2012. Against the background of the labour market, NHS non-medical workforce numbers have been on an upward trend in recent years with even greater increases in support staff for doctors and nurses and infrastructure support staff. Vacancy rates remain low at 0.5% or below for the majority of staff groups across the UK.
- 3.85 We note that inflation measures have increased during the latter part of 2010 and early 2011 with CPI inflation reaching 4.0% and RPI inflation 5.1%. We sympathise with the Staff Side's concerns that high inflation rates could squeeze living standards and that the lower paid could be more vulnerable to the factors driving up inflation. Squeezing of living standards will impact on all workers across the economy and in the public sector not just those working in the NHS.
- 3.86 In considering affordability and the funds available to the Health Departments, we note the Health Departments' evidence that a £250 flat rate increase is all that can be afforded. It is also clear to us that, despite increases in the Health Departments' settlements under the spending review, there are significant pressures on costs combined with rising demand for services, continued service development, a programme of wide ranging NHS reforms and the need to find substantial efficiency savings.

- 3.87 Our overall assessment is that there is no recruitment and retention evidence to justify an increase above the single uniform uplift of £250 proposed by the Health Departments. **We recommend an uplift of £250 to Agenda for Change spine points 1 to 15 from 1 April 2011.**
- 3.88 In Chapter 1 (paragraph 1.11) we urged the Health Departments to plan their strategies so that at the end of the two-year pay policy they can implement any changes that may be necessary to retain the effectiveness of the AfC pay structure. In this regard, we note that a single uniform uplift compresses the pay structure and brings the pay of those staff on pay points 1-15 closer to those on higher AfC pay bands (pay point 16 and above). This is particularly noticeable at the key entry point for qualified professionals in Band 5. Should a similar approach be adopted in 2012/13 the gap between pay points 15 and 16 would be narrowed to just £122. There are also likely to be consequences for recruitment, retention, and promotion pathways and incentives in specific occupational groups as a result of squeezing differentials. We ask the parties to bear in mind these consequences in presenting future evidence and specifically consider whether any appropriate structural adjustments should be made during or at the end of the two-year period.

Chapter 4 – High Cost Area Supplements and Recruitment and Retention Premia

Introduction

- 4.1 In this chapter we consider the evidence and information on any application from the parties for high cost area supplements (HCAS) and recruitment and retention premia (RRP) in relation to our role under the Agenda for Change (AfC) Agreement. The remit letters for 2011/12 specifically recognised our role under the AfC Agreement on HCAS and national RRP and provided for evidence to be presented as necessary on these matters.

High Cost Area Supplements

- 4.2 Our general remit requires us to have regard to regional/local variations in labour markets and their effects on the recruitment and retention of staff. 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 the area, with Inner London attracting the highest supplement and the Fringe areas of London the lowest.
- 4.3 We received no proposals or evidence for this report on existing high cost area supplements or proposals for supplements for new areas. Therefore we make no recommendations on these.

National Recruitment and Retention Premia

- 4.4 The AfC Agreement¹ 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 to 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, staff organisations and other stakeholders. In addition, the parties have agreed under AfC that some posts will automatically attract RRP. 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.
- 4.5 We received applications for a national RRP from Unite relating to pharmacists and from the Union of Construction, Allied Trades and Technicians (UCATT) relating to building craft workers. In reaching our conclusions on these applications, we have been guided by our general approach to the introduction of any new national RRP. We therefore summarise this approach and refer to other recent developments relating to national RRP before considering the case for each in detail.

¹ Department of Health (December 2004) *Agenda for Change: Final Agreement*, Section 4 (Recruitment and Retention Premia) and Annex H (Guidance on the Application of Nationally Agreed Recruitment and Retention Premia). Now in Section 5 and Annex R of NHS Staff Council *NHS Terms and Conditions of Service Handbook (Amendment Number 16)*, Pay Circular (AforC) 1/2010.

Our Approach

- 4.6 Since the AfC Agreement, we have considered a number of proposals for new national RRPs. In reaching our conclusions on these proposals, we have interpreted our role 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...may recommend national recruitment and retention premia for our...remit groups, (with local differentiation as necessary to reflect geographical variation in the underlying problem)*”².
- 4.7 We have consistently stated that parties seeking to justify pay differentiation in respect of specific remit staff groups will need to provide robust evidence to support their case, and will also need to address the following points:
- Why they consider that pay differentiation for the particular group is necessary;
 - Why they consider their objective(s) cannot be achieved by a route other than pay differentiation; and
 - Why they consider the level of any differentiation they propose, rather than a lesser amount, is appropriate to meet their objective(s)³.
- 4.8 We set out our interpretation of the provisions for national RRPs in the AfC Agreement in some detail in our Twenty-Fourth Report⁴. In summary, we agree with the parties that the term “national” in the context of the provisions of the AfC Agreement relating to RRPs means UK-wide. We do not, however, agree with the view previously presented by 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, nor do we consider that there needs to be a recruitment and retention difficulty in all four countries⁵.

The Judgment in Hartley and Others v Northumbria Healthcare NHS Foundation Trust and Others

- 4.9 In April 2009 an employment tribunal gave judgment in *Hartley and Others v Northumbria Healthcare NHS Foundation Trust and Others*⁶ (henceforth “*Hartley*”). This judgment made a number of points of relevance to the justification of pay differentiation. It also specifically required the national RRP for qualified maintenance craftspersons and technicians to be reviewed by 1 April 2011 or to cease. The *Hartley* judgment stated that “*Paragraph H13⁷...shall be reviewed by the NHS Staff Council before 1 April 2011 and if not so reviewed shall cease to have effect on that date. Further research shall be undertaken and considered for the purpose of the review. The Pay Review Body shall be consulted and the review shall be subject to any necessary consent by the Pay Review Body. Having carried out that review, the NHS Staff Council may retain paragraph*

² Review Body for Nursing and Other Health Professions (2006), *Twenty-First Report*, TSO (Cm 6752) paragraph 4.19; also cited in NHSPRB (2009), *Twenty-Fourth Report*, TSO (Cm 7646), paragraph 3.9.

³ NHSPRB (2006), *Twenty-First Report*, TSO (Cm 6752), paragraphs 2.22 – 2.23.

⁴ NHSPRB (2009), *Twenty-Fourth Report*, TSO (Cm 7646), paragraphs 3.19 – 3.22.

⁵ Letter of 26 February 2009 from Nick Adkin, Department of Health, to the Office of Manpower Economics (OME).

⁶ Reserved Judgment of the Employment Tribunal, Newcastle upon Tyne, *Ms S C Hartley and Others v Northumbria Healthcare NHS Foundation Trust, Unison and other Unions, the Secretary of State for Health, NHS Confederation (Employers) Company Ltd, and the GMB*, 2009.

⁷ Paragraph H13 of the *Agenda for Change: Final Agreement*.

H13 or it may (with effect from such date as it shall determine) replace or amend it or remove it from this agreement without replacing it”⁸.

IES Report

- 4.10 Following the *Hartley* judgment, the NHS Staff Council prepared a specification for further research on recruitment and retention premia which was sent to us for comment. We specifically requested that the research should include NHS building craft workers. The NHS Staff Council commissioned the Institute for Employment Studies (IES) in 2010 to review national recruitment and retention premia, and provided us with the IES Report⁹ which was published in December 2010.
- 4.11 IES were asked by the NHS Staff Council to investigate whether or not there was adequate, convincing evidence for:
- The continued payment of a national RRP to qualified maintenance craft operatives and technicians, and, if so, at what rate;
 - A nationally determined RRP payable to healthcare chaplains, and, if so, at what rate;
 - Locally determined RRP’s payable to the other occupations listed in Annex R of the AfC Handbook¹⁰.
- 4.12 IES were also asked to investigate whether there was evidence to support a new national RRP for building craft workers.
- 4.13 In summary, the main conclusions in the IES Report relating to specific occupational groups were that:
- The national RRP for qualified maintenance craft workers should be suspended for 2-3 years to assess the recruitment and retention effects in its absence;
 - The national RRP for chaplains should be converted to a local RRP as circumstances vary too much to operate a national policy;
 - There was no justification on recruitment, retention or pay grounds for a national RRP for building craft workers;
 - A national RRP for pharmacists was not recommended although supply and pay comparisons suggested the matter should be reviewed in 2-3 years;
 - After reviewing the occupations listed in Annex R of the Agenda for Change Handbook¹¹, no national RRP’s were recommended but the position for invoice clerks, biomedical scientists and qualified new entrant midwives should be kept under review.

⁸ Op.cit *Hartley* judgment, paragraphs 16 to 18.

⁹ Institute for Employment Studies (2010) *Review of National Recruitment and Retention Premia in the NHS 2010*.
Published at: http://www.nhsemployers.org/SiteCollectionDocuments/NHSE_RRP_final%20report_final_ap171210.pdf

¹⁰ NHS Staff Council, *NHS Terms and Conditions of Service Handbook*.

¹¹ Clinical coding officers; cytology screeners; dental nurses, technicians, therapists and hygienists; estates officers/ works officers; financial accountants; invoice clerks; biomedical scientists; payroll team leaders; pharmacists; qualified medical technical officers; qualified midwives (new entrant); and qualified perfusionists.

- 4.14 At the time of writing, the IES Report is under consideration by the NHS Staff Council. We do not consider it necessary at this stage for us to make any general comment on the methodology, conclusions and recommendations of the IES Report in relation to national RRPs. However, we have drawn on the relevant information in the IES Report as appropriate to pharmacists and building craft workers along with the specific evidence presented in the applications for national RRPs by the parties.
- 4.15 In general, we have no role in decisions on the continuation of existing national RRPs. These are matters for the NHS Staff Council. However, specifically for the national RRP for qualified maintenance craftspersons and technicians, the *Hartley* employment tribunal required that “the Pay Review Body be consulted and the review shall be subject to any necessary consent by the Pay Review Body”. At the time of this report, the NHS Staff Council is considering the review and will make its decision which may be the subject of separate correspondence between the Review Body and the NHS Staff Council.

Proposal for a National Recruitment and Retention Premium for Pharmacists

- 4.16 There have been difficulties in recruiting and retaining qualified pharmacists in Bands 6 and 7 for a number of years, which we have highlighted in successive reports. In our Twenty-Fourth Report¹² we recommended a fixed term national RRP for pharmacists in Bands 6 and 7 from 1 October 2009 to 31 March 2012. Our recommendation was rejected by the UK Government in July 2009 on the grounds that recruitment and retention varied widely across England, that the Devolved Administrations made clear a national RRP was not necessary, and that the difficulties would be best addressed by increasing supply and by using local RRPs alongside local initiatives to support training and development.
- 4.17 We reviewed the evidence later in 2009¹³. That evidence, in our opinion, reinforced and strengthened our view that a fixed term, targeted national RRP was appropriate as part of a balanced package of measures. We suggested that the UK Government and other parties might wish to reconsider the matter and that we would continue to monitor the situation and return to it for this report.
- 4.18 In 2010, Unite again presented a renewed case for the introduction of a pharmacists’ national RRP. The Health Departments and NHS Employers provided evidence on the current position. We summarise that evidence in paragraphs 4.24 to 4.39. We first examine the latest results of the Pharmacy Establishment and Vacancy Survey and the conclusions from the Institute for Employment Studies Report commissioned by the NHS Staff Council.

¹²NHSPRB (2009), *Twenty-Fourth Report*, TSO (Cm 7646), paragraph 3.77.

¹³NHSPRB Report *Consideration of Whether to Seek a Remit to Review the Pay Increase Agreed by the Parties for 2010/11* – 10 December 2009, paragraphs 103 to 111.

Pharmacy Establishment and Vacancy Survey

- 4.19 The Department of Health commissioned the 2010 National NHS Pharmacy Establishment and Vacancy Survey (PEVS), which was conducted in May 2010. This survey allows for analysis of vacancy rates by AfC band, which is not possible using the Health Departments' vacancy surveys. A 100% response rate was achieved from NHS organisations in all four UK countries.
- 4.20 Summary tables showing national-level results from the PEVS since 2006 are in Tables 4.1 and 4.2, with data by "UK region"¹⁴ in Table 4.3. The main findings of the 2010 survey are as follows:
- The total vacancy rate in Band 6 in May 2010 was 16.2%, a decrease of 8.4 percentage points (pp)¹⁵ since May 2009, and the lowest rate since data started to be gathered by Agenda for Change bands in 2006. The three-month vacancy rate in Band 6 in May 2010 was 11.6%, a decrease of 9.3pp on a year earlier;
 - The total vacancy rate in Band 7 in May 2010 was 17.6%, a decrease of 1.4pp since May 2009, but slightly higher than the May 2008 figure. The three-month vacancy rate in Band 7 in May 2010 was 11.5%, a decrease of 2.6pp on a year earlier;
 - The total vacancy rate in Band 6 decreased in nine out of 13 UK regions between 2009 and 2010, and in 2010 ranged from a low of minus 4.1% in North East SHA to a high of 26.4% in East Midlands SHA;
 - The three-month vacancy rate in Band 6 decreased in ten out of 13 UK regions between 2009 and 2010, and in 2010 was lowest in Northern Ireland (3.5%) and highest in Scotland (19.9%);
 - The total vacancy rate in Band 7 decreased in seven out of 13 UK regions between 2009 and 2010, and in 2010 ranged from a low of 10.8% in Wales to a high of 28.6% in Yorkshire & the Humber SHA; and
 - The three-month vacancy rate in Band 7 decreased in eight out of 13 UK regions between 2009 and 2010, and in 2010 was lowest in Northern Ireland (3.3%) and highest in Yorkshire & the Humber SHA (25.4%).

¹⁴For brevity, "UK region" denotes Scotland, Wales, Northern Ireland and each strategic health authority (SHA) in England.

¹⁵Data in Tables 4.1 and 4.2 have been rounded to the nearest one decimal place, as have differences in vacancy rates.

Table 4.1: Total vacancy rates for qualified pharmacists by Agenda for Change bands, 2006-2010

Year	Participating UK countries	Total vacancy rate (%)							
		Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Overall
2006 ¹⁶	England, Scotland, Wales	16.8	11.0			3.6			11.7
2007	England, Wales	17.2	18.0	8.1	6.3	5.4	2.5	4.1	12.0
2008	England, Wales, Northern Ireland	22.2	16.9	10.2	8.8	6.0	2.8	1.9	13.2
2009	All UK countries	24.7	19.0	10.0	7.3	5.6	2.2	4.6	13.7
2010	All UK countries	16.2	17.6	8.6	5.2	8.1	2.4	2.0	11.2

Source: Pharmacy Establishment and Vacancy Survey

Table 4.2: Three-month vacancy rates for qualified pharmacists by Agenda for Change bands, 2008-2010

Year	Participating UK countries	Three-month vacancy rate (%)							
		Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	Overall
2008	England, Wales, Northern Ireland	14.8	10.1	6.4	4.1	2.7	2.5	1.0	8.0
2009	All UK countries	20.9	14.1	7.2	5.1	4.3	1.4	0.9	10.5
2010	All UK countries	11.6	11.5	6.3	4.0	6.4	1.1	3.5	7.9

Source: Pharmacy Establishment and Vacancy Survey

¹⁶In 2006, data were presented for “junior” (AfC Band 6 and Whitley grades A-C), “middle” (AfC Bands 7-8b and Whitley grades D-E) and “senior” pharmacists (AfC Bands 8c-9 and Whitley grades F-H) because implementation of the Agenda for Change pay system was not complete.

Table 4.3: Staffing establishments and vacancy rates for qualified pharmacists by UK country and region

	Pharmacy Establishment and Vacancy Survey													Official Statistics ¹⁷		
	Staffing establishment 2010 (number of funded posts)			Total vacancy rate ¹⁸ 2010 (%) (posts not permanently occupied) <i>Comparison with 2009 survey</i>				3-month vacancy rate ¹⁹ 2010 (%) (posts vacant for 3 months or more) <i>Comparison with 2009 survey</i>				Total vacancy rate (%) <i>Comparison with 2009</i>	3-month vacancy rate (%) <i>Comparison with 2009</i>			
	Band 6	Band 7	Bands 8a-9 Total	Band 6 (%)	Band 7 (%)	Bands 8a-9 (%)	All bands (%)	Band 6 (%)	Band 7 (%)	Band 8a-9 (%)	All bands (%)	Band 6 (%)	Band 7 (%)	Band 8a-9 (%)	All bands (%)	
North East	54	94	252	400	-4.1 -3.1	28.1 +3	9.3 -5	11.9 -7	8.9 -2.9	19.4 +8	7.0 nc	10.2 -2	0.5 -2.8	0.0 -1.2		
North West	168	254	691	1,113	18.4 -2.0	21.6 +3	8.1 -1	12.7 -3	16.1 -2.0	13.6 nc	7.5 nc	10.2 -3	5.1 +0.2	1.5 -0.3		
Yorks & Humber	105	151	501	757	0.9 -1.5	28.6 +5	8.0 +2	11.1 nc	9.5 -5	25.4 +7	5.3 nc	9.9 +1	1.2 -2.3	0.3 -1.4		
East Midlands	82	135	282	498	26.4 +8	20.5 +1	8.3 +4	14.6 +4	9.8 -5	15.6 +1	6.5 nc	9.5 -1	3.3 -2.1	1.6 -0.1		
West Midlands	110	123	447	680	20.9 -2	21.5 +1	9.1 nc	13.2 nc	13.6 -5	15.7 -2	6.0 +1	9.0 -1	4.5 -0.1	0.7 -0.7		
East of England	103	166	382	651	18.2 -1.5	21.8 -6	10.2 -3	14.4 -6	7.6 -2.1	15.2 +2	7.5 +2	9.5 -2	5.3 -2.6	1.6 -1.0		
London	322	433	910	1,665	12.1 -1.0	12.9 -6	8.0 -3	10.1 -5	7.1 -5	6.6 -6	5.8 -2	6.3 -4	3.5 -1.7	0.8 -0.5		
South East Coast	89	121	265	475	22.4 +1	20.2 -3	7.7 -1	13.6 -1	7.3 -1.5	16.0 -3	4.9 -1	8.2 -4	4.9 -0.2	1.1 nc		
South Central	87	128	297	512	19.6 +6	15.2 -8	4.8 -5	9.9 -4	16.7 +6	12.8 -7	4.7 -2	8.8 -2	1.7 -6.3	0.7 -0.8		
South West	108	140	330	578	21.5 -1	11.0 -3	5.5 +1	9.8 nc	19.4 +6	6.9 -1	2.6 nc	6.8 +1	2.4 -3.0	0.2 -0.4		
England	1,229	1,743	4,357	7,329	15.6 -8	18.9 -2	8.0 -1	11.9 -3	11.2 -8	13.2 -1	5.9 nc	8.5 -2	3.4 -1.8	0.9 -0.7		
Wales	71	77	392	540	21.5 +1.2	10.8 -9	3.7 nc	7.1 +1	11.3 +3	5.7 -8	1.7 -1	3.6 -1	n/a	0.2 -0.8		
Scotland	139	266	555	960	25.1 -1.5	14.1 +3	4.3 nc	10.0 -2	19.9 -1.9	7.4 -4	3.3 -1	6.8 -5	n/a	n/a		
Northern Ireland	85	184	111	380	5.9 -8	13.0 -4	-1.8 -8	7.1 -6	3.5 -1.0	3.3 -1.3	4.5 -3	3.7 -1.0	2.8 -0.8	0.8 +0.5		
UK²⁰	1,523	2,270	5,415	9,208	16.2 -8	17.6 -1	7.1 -1	11.2 -3	11.6 -9	11.5 -3	5.3 nc	7.9 -3	3.4 -0.2	0.8 -0.6		

n/a Not available

nc No change (change less than 0.5 percentage points)

Sources: *Pharmacy Establishment and Vacancy Survey; NHS Information Centre; StatsWales; DHSSPSNI*¹⁷ Calculated as the number of posts to which NHS organisations are actively recruiting, divided by the sum of staff in post plus vacancies.¹⁸ Calculated as establishment minus number of staff in post, divided by establishment. This gives negative vacancy rates if staff in post exceeds establishment.¹⁹ Calculated as number of 3-month vacancies divided by establishment.²⁰ UK vacancy rates in the Official Statistics table are 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).

4.21 Though they are useful for year-on-year comparisons, averages can mask considerable variation in the results nationwide. Tables 4.4 and 4.5 show the distribution of vacancy rates, and full-time equivalent vacancies, respectively, for acute and mental health NHS organisations²¹:

- 64 organisations (35%) had a total vacancy rate in Band 6 of zero (or less²²), while 81 organisations (44%) had vacancy rates in excess of 20%. 105 organisations (57%) had no posts in Band 6 that had been vacant for three months or more;
- 75 organisations (41%) had a total vacancy rate in Band 7 of zero (or less), and 112 (61%) had no three-month vacancies; and
- Where vacancies exist, in general just one or two posts are vacant.

Table 4.4: Distribution of vacancy rates in Bands 6 and 7 in acute and mental health NHS organisations, May 2010

Vacancy rate (%)	Band 6		Band 7	
	Total	3-month	Total	3-month
	No. Trusts	No. Trusts	No. Trusts	No. Trusts
Less than 0	15	0	6	0
Exactly 0	49	105	69	112
0.1 to 9.9	11	10	35	30
10.0 to 19.9	30	19	33	30
20.0 to 29.9	26	15	30	18
30.0 to 39.9	21	11	16	14
40.0 to 49.9	12	9	9	7
50.0+	22	17	24	11
Not applicable – no established posts	67	67	31	31
Total	253	253	253	253

Source: Pharmacy Establishment and Vacancy Survey

²¹ Primary care organisations have very few Band 6 posts, and are therefore omitted from these tables.

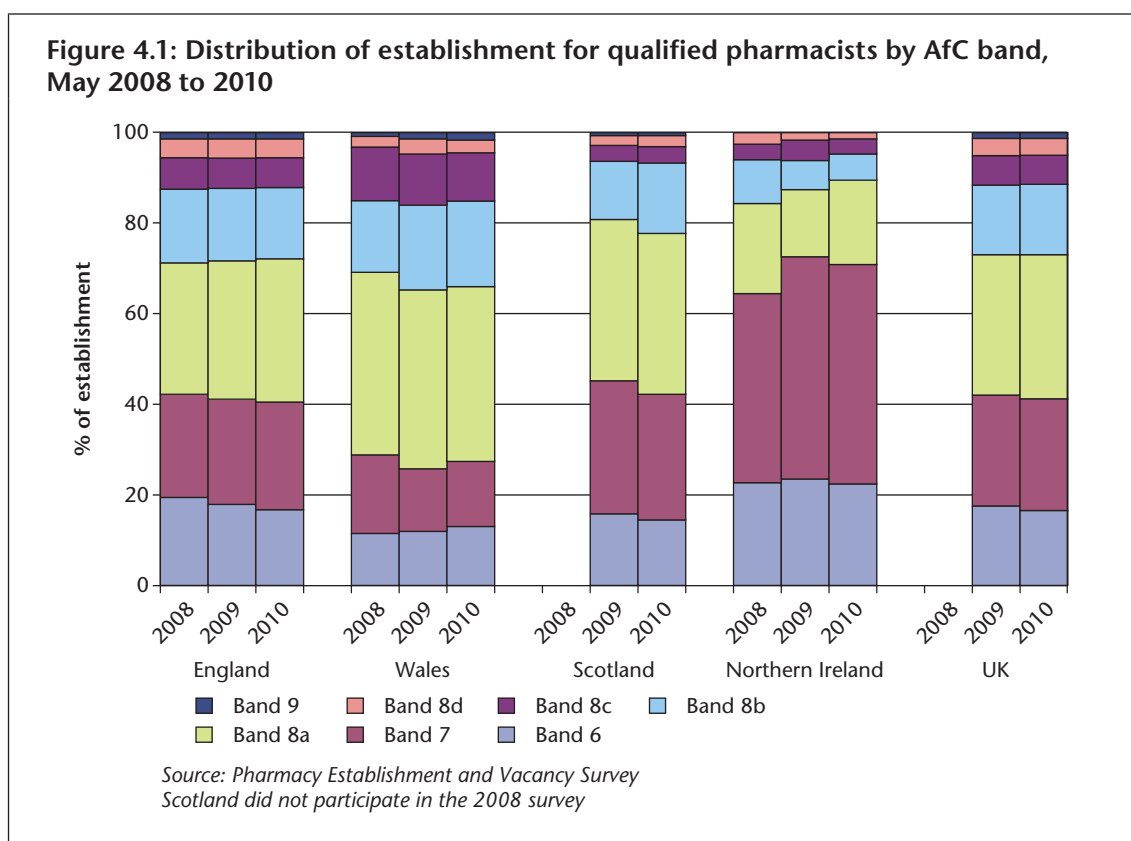
²² “Negative” vacancy rates occur when the number of staff in post in an AFC Band exceeds the funded establishment.

Table 4.5: Distribution of numbers of full-time equivalent vacancies in Bands 6 and 7 in acute and mental health NHS organisations, May 2010

Number of vacancies (FTE)	Band 6		Band 7	
	Total	3-month	Total	3-month
	No. Trusts	No. Trusts	No. Trusts	No. Trusts
Less than 0	15	0	6	0
Exactly 0	49	105	69	112
0.1-0.99	5	2	28	13
1.0-1.99	49	35	52	48
2.0-2.99	33	19	29	25
3.0-3.99	15	16	13	9
4.0-4.99	12	6	6	6
5.0+	8	3	19	9
Not applicable – no established posts	67	67	31	31
Total	253	253	253	253

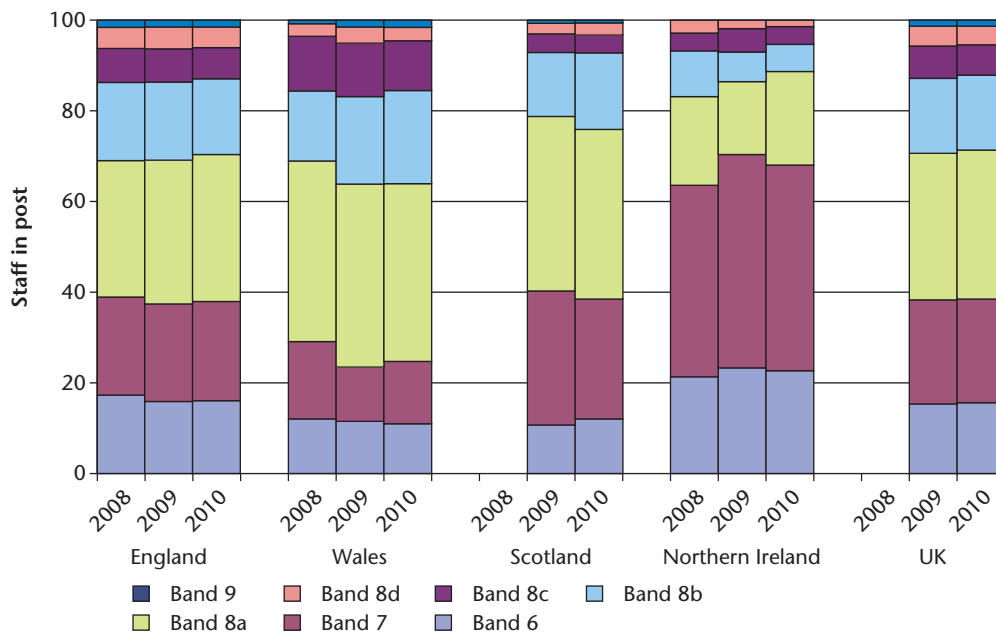
Source: Pharmacy Establishment and Vacancy Survey

4.22 Figure 4.1 shows the distribution of established posts in each band by UK country, and change since 2008. In the UK as a whole between 2009 and 2010, the proportion of established posts in Band 6 decreased, but increased in Bands 7 and 8a.



4.23 Figure 4.2 shows the percentage of staff in post in each band by UK country, and change since 2008. The percentage of staff in post in Band 6 in the UK was largely static between 2009 and 2010, while the percentages in Bands 7 and 8a increased.

Figure 4.2: Distribution of qualified pharmacists in post by AfC band, May 2008 to 2010



Source: Pharmacy Establishment and Vacancy Survey
Scotland did not participate in the 2008 survey

Evidence from the Parties

The Health Departments

4.24 The **Department of Health** continued to consider that, although there had undoubtedly been problems in some geographical areas in relation to junior pharmacists, there was not a national problem which required the solution of a national RRP. Employers had access to local RRPs as necessary and new guidance on their use was issued in November 2009. Work by the Department and Strategic Health Authorities had significantly improved the position over the last two years with three-month vacancy rates for Band 6 (11%) and Band 7 (13%) pharmacists lower in 2010 than 2009 and training places increased by 45% to 693 placements in 2010.

4.25 The Department provided further analysis of the 2010 Pharmacy Establishment and Vacancy Survey. Alongside lower vacancy rates, the Department pointed to considerable variation in vacancy rates at Band 6 and 7 across the four home nations, between SHAs in England, and between individual trusts and PCTs. The Department highlighted: the increased supply of newly-registered pharmacists and improved retention of NHS-trained pharmacists on registration; a significant rise in establishment numbers at Bands 7 and 8; and the substantial increase in training numbers across all SHAs which appeared to be relatively stable for 2011/12. In addition, the Department's own datasets suggested that the attrition rate during the pre-registration year (Band 5) remained low at around 2% and the retention rate had improved among the 2008/09 cohort. However, the Department acknowledged that planning numbers for training commissions for 2011/12 and 2012/13 might be reducing slightly in the light of financial pressures and that retention at registration might also be slightly reduced.

4.26 While the Department reiterated that variations in vacancy rates continued to argue against a national, compared to a local, RRP approach, it noted evidence that the

demand for pharmacists had increased significantly over the last five years in both the NHS and community pharmacy. The Department considered the relevant factors to be: changing demographics; developments in commissioning of public health and medicines usage services; and increases in the numbers of new community pharmacies with longer opening hours. The Department also provided information on longer-term policy strategies to allow for the more effective and efficient use of pharmacists' time and to increase training capacity in the NHS.

- 4.27 The **SGHD** told us that it had done considerable further work in reconsidering its decision not to apply a national RRP and had developed an action plan with a range of short-term measures to address recruitment and retention difficulties. The plan included collection of quarterly establishment and vacancy data which showed Band 6 vacancy levels rising in spring and summer 2010 as staff gained promotion or moved on and then falling in autumn 2010 as new graduates took up posts.
- 4.28 The SGHD reported that Band 6 vacancies in Scotland were at 24.5% in April 2010 falling back to 18.9% in July 2010. Similarly, Band 7 vacancies reached a high of 15.2% in April 2010 before falling back to 7.6% in July 2010. The SGHD noted the variability around the country, for instance at July 2010 Lothian had a Band 6 vacancy rate of 40% whereas Greater Glasgow and Clyde had a rate of 3.29%. The Cabinet Secretary and Scottish Government officials had met with Scottish Staff Side pharmacy representatives on several occasions to discuss the position. The SGHD remained of the view that, given falling vacancy levels and the variability of the position around the country, a national RRP was not the correct approach in this instance.
- 4.29 The **WAG** provided data on pharmacists' vacancies and establishments. Although the WAG commented on the continued difficulty in recruitment due to competition from the community sector, it pointed to the pharmacist vacancy rate in Wales remaining lower than in any other region or devolved administration in the UK. The rate of growth in full-time equivalent posts had decreased in 2009/10 but there had been consistent growth between 2008 and 2010.
- 4.30 The Welsh vacancy rate for Band 6 pharmacists in 2010 was 21.5%, partly as a result of complicated recruitment procedures, and for Band 7 it was 10.9%. Among pre-registration pharmacists, increasing student debt and the need to earn more money were stated as reasons for leaving the NHS and moving to community pharmacy. The WAG reported that it was reviewing the skill mix and which service delivery roles could be undertaken by different members of the pharmacy team. It was also looking at the gap in employment packages/salaries for newly qualified pharmacists between community and the managed sector with consideration being given to making a contribution to their student debt while in Bands 6 and 7 and to meet their professional registration costs.
- 4.31 The **DHSSPSNI** commented that, since the DHSSPS Minister had rejected the recommendation for a national RRP for pharmacists at Bands 6 and 7, the position had not changed and that there were no grounds for a national RRP.

NHS Employers

- 4.32 **NHSE** told us that employers considered a "one size fits all" solution would be unlikely to resolve pharmacy recruitment problems and did not represent good value for money. Employers viewed any new national payment as placing additional financial pressures on NHS organisations when NHS resources were tight and efficiency requirements increased, and a national RRP would have a direct impact on local pharmacy budgets.

IES Report

- 4.33 The NHS Staff Council provided us with the IES Report²³ which reviewed the evidence for a pharmacists' national RRP. IES stated that just under half of its 17 case study trusts reported recruitment problems, particularly due to competition with the retail sector, with its higher salary levels and better total reward package. The recruitment experience varied between trusts, but commonly there was a shortage of applicants for vacancies. Where retention problems existed, they were frequently attributed to moves to the higher-paying private sector. Staff turnover was lower at the higher end of the pay scale (Band 8a and above), and the nature of the pharmacy role within the NHS could be an effective factor in retention.
- 4.34 IES reported that the number of pharmacists had increased from 5,925 in 2005 to 6,493 in 2009, that 22% were male (compared with 19% for all non-medical staff), and that 49% were aged under 35 years (compared with 27% for all non-medical staff). IES' pay comparisons showed that a Band 6 salary in 2010 (the typical band for a newly-qualified pharmacist) was lower than the *Annual Survey of Hours and Earnings* (basic pay in 2009) and *Labour Force Survey* (average gross weekly earnings in 2010) medians for all pharmacists (regardless of seniority). IES commented that changes in the value of the top point of Band 6 had not kept pace with the change in the ASHE median for all pharmacists (2006 to 2009). The percentage increase in the number of Jobseekers' Allowance claimants identifying themselves as pharmacists between 2006 and 2009 was less than that of the economy as a whole, and low numbers of claimants per pharmacist vacancy suggested a tight labour market for pharmacists.

Staff Bodies

- 4.35 The **Staff Side** commented that evidence suggested problems with the recruitment and retention of pharmacists which would be alleviated by the payment of a recruitment and retention premium. The Staff Side supported our previous recommendation and considered it should be respected and implemented.
- 4.36 **Unite** continued to consider that the payment of a national RRP was an important step towards reducing pharmacist Band 6 and 7 vacancies and the most cost effective method compared with the costs of locums and agency staff. Unite commented that, although there had been a dip in pharmacists' vacancy levels, this should not disguise the fact that vacancy levels remained far too high. Unite considered that the dip had largely been achieved by reducing available posts and an element of "upbanding" resulting in the number of Band 6 posts reducing whereas the numbers of Band 7 and Band 8a posts had increased. Unite added that there remained a reliance on locum and agency staff suggesting it would be more cost effective to implement a national RRP to increase the number of employed staff rather than to pay large fees to agencies.
- 4.37 Unite cited the IDS survey²⁴ submitted by the Staff Side in evidence which showed that pharmacists were the second largest occupational group to work above their contracted hours, with many stating all of these hours were unpaid. The top reasons for extra hours were taking on additional duties and responsibilities, and insufficient cover for leave, sickness and maternity absence. Unite quoted from a 2010 survey of NHS Hospital Band 6 and 7 pharmacists in North East and Cumbria which found that pay was the main dissatisfaction. In May 2010, a trade publication "Chemist + Druggist" reported on its survey which found that the average salary for full-time employed community

²³Op.cit. *IES Review of National Recruitment and Retention Premia in the NHS 2010*, pages 37-39, 49-52, 58-59, 64, 69-73 and 83-84.

²⁴Incomes Data Services (September 2010), *NHS Staff Survey – A Research Report for the NHS Trade Unions*.

pharmacists was £42,806 and that two-thirds of respondents had received a pay rise of whom three-quarters reported a rise of 1 or 2%.

- 4.38 Unite responded to the IES Report by commenting that its recommendations on pharmacists should be disregarded as the full breadth of labour market and NHS data had not been properly considered. Specifically, Unite considered that IES: had not given sufficient weight to the wider range of detailed evidence available to the Review Body in making the recommendation; had not given sufficient attention to the NHS Pharmacy Education and Development Committee vacancy surveys; had identified evidence of recruitment and retention problems for pharmacists with pay levels in the NHS relatively low compared to the private sector as a key reason but had downplayed this in its summary; and had used the case studies to “trump” comprehensive national data collected over a number of years.
- 4.39 Unite also provided an overview of its April 2010 survey of its members ranging from Associate Directors of Pharmacy to Chief Pharmacists. The survey received 30 responses with 19 indicating recruitment problems for Band 6 and 7 pharmacists and 8 respondents reporting no problems. When asked about support for a national RRP for pharmacists, 20 respondents were in favour, 5 were in favour but with caveats such as funding, and 4 were against a national RRP. Unite commented that these results provided a strong indication of what was happening in pharmacy services and sat alongside the vacancy information collected by the Pharmacy Education and Development Committee.

Our Comment

- 4.40 This is the fifth successive year in which we have considered in detail a proposal to introduce a new national RRP for qualified pharmacists, and we are grateful to all the parties for their efforts in improving year-on-year the quality of the evidence base through which we reach our conclusions.
- 4.41 Though our recommendation in 2009 for a new national RRP was rejected, our concerns about the shortage of pharmacists have been acted upon in other ways by the Health Departments and NHSE, through increasing the number of pre-registration trainee pharmacists, and promulgating advice on alternative methods of retaining junior pharmacists in the NHS. The latest results from the PEVS show a decrease in vacancy rates in Bands 6 and 7 across most of the UK. As the supply of new pharmacy graduates increases, we would expect to see further improvements year-on-year.
- 4.42 We also note that there is wide variation in vacancy rates across the UK – with no consistent geographical pattern – and a significant minority of employers do not have vacancies in Bands 6 and 7. For these employers, a nationally-mandated additional payment would be an unnecessary cost at a time when the wider NHS budget is under severe pressure.
- 4.43 **We therefore do not recommend a national RRP for pharmacists in Bands 6 and 7, although we will continue to monitor the position.**
- 4.44 We would wish, however, to highlight some ongoing concerns. Some employers continue to have very high vacancy rates for junior pharmacists, which has a detrimental effect on service delivery, and the morale and workload of staff covering these vacancies. We note that registered pharmacists in the NHS and hospitals remain on the Migration Advisory Committee’s list of shortage occupations²⁵. We would encourage employers to take advantage of the facility to pay short-term local RRP’s where appropriate.

²⁵Migration Advisory Committee (2010), *Skilled, Shortage, Sensible: Third Review of the Recommended Shortage Occupation Lists for the UK and Scotland: Spring 2010*.

Proposal for a National Recruitment and Retention Premium for Building Craft Workers

4.45 We considered the case for a national RRP for building craft workers in our Twenty-Third Report²⁶ and concluded that the evidence did not support the case for such a payment. We concluded in 2009²⁷ that this remained our view. However, we agreed with UCATT that there was a lack of sufficiently detailed workforce statistics relating to this group. In November 2010, UCATT presented a renewed case for a national RRP.

Evidence from the Parties

The Health Departments

4.46 The **Department of Health** and the **Devolved Administrations** provided no specific evidence on building craft workers in the NHS, but told us that they maintained their position that a national RRP for building craft workers was not necessary.

4.47 In response to a request from us, the Department of Health provided some information on the estimated distribution of building craft workers on AfC bands, shown in Table 4.6²⁸.

Table 4.6: Distribution of full-time equivalent building craft workers by AfC band and specified job role, September 2009

Job role		AfC Band											Total	
		1	2	3	4	5	6	7	8a	8b	8c	8d		9
Building craftsperson & carpenters	No.	1	7	161	434	50	5	0	0	2	0	0	0	660
	%	0	1	24	66	8	1	0	0	0	0	0	0	100
Painter / decorator	No.	1	0	110	132	2	0	0	0	0	0	0	0	245
	%	0	0	45	54	1	0	0	0	0	0	0	0	100

Source: Department of Health

IES Report

4.48 The IES Report²⁹, commissioned by the NHS Staff Council, considered the recruitment and retention evidence for building craft workers. From the case studies based on 17 NHS trusts, there were no reported problems in recruiting building craft workers but little recruitment had been needed in the last two years. Three case study trusts paid a local RRP to building craft workers. Few retention difficulties were reported with most in-house workers having long tenure. Some employers were reducing their in-house capability as there was a move to contracting out large capital projects.

²⁶NHSPRB (2008), *Twenty-Third Report*, TSO (Cm 7337), paragraphs 3.54 – 3.55.

²⁷NHSPRB Report Consideration of *Whether to Seek a Remit to Review the Pay Increase Agreed by the Parties for 2010/11* – 10 December 2009, paragraphs 118 to 124.

²⁸The Department told us that this analysis was based on an extract from the Electronic Staff Records HR system (ESR), which had been used to estimate the proportions of staff belonging to each of the job roles and within each AfC band. These proportions were then applied to the validated September 2009 staff numbers published in the latest Information Centre Workforce Census. The Department was at the time unable to assess how accurately organisations use and maintain the job role field in ESR, for example there were instances of overlapping job role descriptions and inconsistent data entry.

²⁹Op.cit. *IES Review of National Recruitment and Retention Premia in the NHS 2010*, pages 33-34, 48-54, 58-60, 69-73, 82 and 86.

- 4.49 IES reported that the NHS Information Centre included building and maintenance craft workers within the broader maintenance and works staff group. The number of maintenance and works staff fell slightly between 2005 and 2009. It was a male-dominated staff group (91% male compared with 19% for all non-medical staff) with 57% aged 50 or over (compared with 30% for all non-medical staff). Turnover rates for maintenance and works staff were similar to the rest of the non-medical workforce and were lower than for the UK economy as a whole. The proportion of leavers aged under 60 was declining.
- 4.50 IES pay comparisons suggested that: the top point of Band 4 in 2010 (the assumed “typical” basic salary for building craft workers) was around the *Annual Survey of Hours and Earnings* (basic pay in 2009) and *Labour Force Survey* (average gross weekly earnings in 2010) medians for comparable occupations³⁰; the top of Band 4, expressed as an hourly rate, was higher than the Construction Industry Joint Council minimum rate for craft workers; in the private sector, average salaries for maintenance craft workers were higher than for building craft workers; and the increase in the value of the top point of Band 4 between 2006 and 2009 had not kept pace with the ASHE median for comparable occupations. The increase in Jobseekers’ Allowance claimants identifying themselves as building craft workers between 2006 and 2009 was more than twice that of the economy as a whole, though the rate of decrease in the number of claimants between 2009 and 2010 was greater than for the whole economy. The number of unemployed building craft workers per unfilled vacancy for that occupation was higher than for the whole economy.

Staff Bodies

- 4.51 **UCATT** urged us to recommend a national RRP for building craft workers in the NHS. It argued that there was a pay difference of at least £6,283 between average pay levels for building craft workers (from the *Annual Survey of Hours and Earnings*) in the private sector and those in the NHS (at the top of Band 3). UCATT had found that areas where NHS trusts awarded local RRP were spread across the country, not just in certain “hot spots”, which it considered demonstrated the need for a national RRP.
- 4.52 UCATT commented that the reduction in numbers of NHS building craft workers might lead to a reduced patient experience with increased outsourcing or use of contractors increasing costs and diverting funding from clinical services. UCATT added that the NHS building trades workforce was elderly and many retirements were expected in the near future. UCATT considered that many of the terms and conditions that would make up for lower NHS basic pay were now diminishing and failing to lure young workers who were often attracted to higher private sector wages.
- 4.53 UCATT pointed to the fact that NHS maintenance craft workers received a national RRP when building craft workers did not. UCATT considered that this was inequitable, illogical and divisive, had a highly de-motivating effect on its members and left the NHS as an uncompetitive employer. In addition to claims for a national RRP, UCATT argued that building craft workers should be regraded to Band 4 nationally in order to reflect their superior skills, qualifications and the high demand for their work and labour.
- 4.54 UCATT submitted further evidence in response to the IES Report raising some methodological concerns that: NHS building craft workers were “wrongly” banded under AfC (Band 3 rather than 4) but IES based its comparisons and findings on Band 4; the IES work on pay was “seriously questionable” – mean earnings were a better

³⁰The comparator occupations were, under the Standard Occupational Classifications, 5312 Bricklayers & Masons, 5315 Carpenters & joiners, and 5323 Painters & decorators.

measure than median earnings in “casualised industries” such as construction (the ASHE mean was £24,440), use of basic pay distorted comparisons as construction workers’ pay was substantially boosted by bonus payments, and Construction Industry Joint Council pay rates were minima with the vast majority well in excess of these; and the impact of an ageing workforce was not quantified by IES. UCATT also criticised the methodology used to conduct the case studies and the conclusions drawn from them.

- 4.55 UCATT expressed its disappointment that the Health Departments had not followed up on the need to gather greater detailed information on the workforce and their pay and conditions.

Our Comment

- 4.56 Our approach to considering the introduction of a national RRP has consistently emphasised the importance of robust evidence to justify any pay differentiation. **From the information available, we again conclude that there is no substantive evidence to support UCATT’s case for a national RRP for building craft workers.**
- 4.57 We note the continuing limitations on specific data for building craft workers. However, from that available there continue to be few indications of national or widespread recruitment and retention problems for building craft workers. There was information that little recruitment was needed in recent years, turnover was generally low and building craft workers tended to have long serving careers in the NHS. We note that some trusts are paying local RRPs to building craft workers and we encourage employers and unions elsewhere to consider this option where justified by robust local labour market data.
- 4.58 UCATT continued to argue that it was inequitable that qualified maintenance craft workers received a national RRP whereas no such professional recognition was given to building craft workers. In this regard, we note that the NHS Staff Council is considering the future of the national RRP for qualified maintenance craft workers from 31 March 2011.
- 4.59 In addition to the national RRP, UCATT specifically argued that building craft workers should be regraded to Pay Band 4. The job evaluation of building craft workers and their allocation to pay bands are matters for the NHS Staff Council and we understand that they will be under review. However, we would comment that data from the Department of Health show that around two-thirds of building craft workers and carpenters, and over half of painters and decorators, were on Band 4 in England.
- 4.60 In our recent reports, we have shared UCATT’s concerns about the lack of sufficiently-detailed workforce statistics relating to building craft workers and the need for more extensive research to demonstrate the need or otherwise for a national RRP. As part of the research commissioned by the NHS Staff Council on national RRPs, we strongly suggested that building craft workers be included and we note that this suggestion was taken up and the information provided. In relation to the collection of better data, we note that the Department of Health is implementing improvements in data quality in the Electronic Staff Record system, which should produce specific data for building craft workers in the future.

Chapter 5 – General Workforce Issues

Introduction

- 5.1 The Chief Secretary to the Treasury's remit letter and those from the Devolved Administrations indicated that, for those groups of workers paid above £21,000, the respective Governments would not submit evidence or seek recommendations on pay uplifts but that they would provide information about recruitment, retention and other aspects of the affected workforce as appropriate.
- 5.2 In this chapter we review background and contextual information for the workforce as a whole. We review information on:
- Trends in recruitment and retention;
 - Morale and motivation;
 - Workforce planning;
 - Training and development;
 - The Knowledge and Skills Framework (KSF); and
 - Data requirements.
- 5.3 We are grateful to the parties for providing this information which enables us to keep in touch with general workforce issues affecting our remit group as a whole over the period of the UK Government's and Devolved Administrations' pay freeze.

Trends in Recruitment and Retention

- 5.4 In Chapter 3 we summarise the evidence on recruitment and retention as far as it can be related to those earning £21,000 or less. Overall, the recruitment position is healthy and the position on retention stable. It is clearly essential that the Health Departments and employers maintain recruitment of high quality staff and retain staff in whose training and development significant investment has been made. Recruiting and retaining high quality staff will be an important factor in meeting growing demand, delivering service developments and supporting the NHS reforms in England.
- 5.5 The overall recruitment and retention position masks a series of specialist areas experiencing shortages of staff. We review the specific applications for national RRP's for pharmacists and building craft workers in Chapter 4. For the workforce as a whole, the Department of Health considered that supply and demand for non-medical staff were broadly in balance but specific imbalances existed and that a number of staff were included on the Home Office Shortage Occupation list¹ including:
- Pre-registration pharmacists working in the NHS or hospitals;
 - Registered pharmacists working in the NHS or hospitals;
 - Specialist nurses working in operating theatres;

¹ www.ukba.homeoffice.gov.uk.

- Operating department practitioners;
- Specialist nurses working in neonatal intensive care units;
- Health Professions Council (HPC) registered diagnostic radiographers;
- HPC registered therapeutic radiographers;
- Nuclear medicine technologists;
- Radiotherapy technologists;
- Speech and language therapists at AfC Bands 7+ or their independent sector equivalents; and
- HPC registered orthoptists.

5.6 The parties' evidence highlighted several shortage areas of particular concern. Further details are provided in that evidence (available on the parties' websites – see Appendix E). The healthcare workforce faces significant challenges over the next few years not least in delivering the Government's NHS reforms. We intend to monitor the position carefully for the following groups in particular who were identified in the parties' evidence:

- Health visitors – the Government has made a commitment to increase the number of Sure Start health visitors by 4,200;
- Midwives – the Royal College of Midwives estimated a shortage of 3,500 midwives in the UK with excessively high vacancy rates in London, the South East, South Central and the East of England;
- Physiotherapists – the Chartered Society of Physiotherapy commented that vacancies remained unacceptably high and staff numbers were expected to be cut due to NHS efficiency savings;
- Radiographers – the Society of Radiographers pointed to qualified radiographers being very much in demand in the UK with specific radiography specialisms continuing to feature on the Government-approved shortage occupation list and attrition rates during training programmes continuing to be a concern; and
- Orthoptists – the British and Irish Orthoptic Society highlighted the constraints of commissioning showing an increasing mismatch between service demands and the available workforce.

5.7 The Staff Side called upon us actively to benchmark labour market indicators during the pay freeze to assess the impact of both the pay policy and wider organisational changes. The Staff Side said that this should include data on morale and motivation, vacancy rates, staff turnover and intentions to leave. The Staff Side also called on us to assess and analyse the effect on recruitment and retention, particularly on staff employed just below and above the £21,000 limit. For this report, we have in fact monitored the information as it relates to our remit group as a whole. However, to discharge our remit we take account of a range of evidence and information and we do not consider that labour market indicators require specific benchmarking as the Staff Side propose. Our non-mechanistic approach enables us to draw on a wide-ranging evidence-base as we see relevant to our terms of reference. We continue to welcome the parties' efforts

to improve that evidence-base and their suggestions for further improvements. We comment later in this chapter on data requirements.

Morale and Motivation

NHS staff surveys

- 5.8 The NHS staff surveys continue to provide us with helpful evidence on the morale and motivation of staff in our remit group. The 2009 survey for England attracted approximately 160,000 responses (a response rate of 55%). The 2009 survey for Northern Ireland was the first country-wide survey of Health and Social Care staff with 6,700 staff responding (a response rate of 39%). The results of the 2010 survey for Scotland were published in January 2011². The WAG was considering the format and timing of the next all Wales NHS staff survey.
- 5.9 The main conclusions from the surveys were:
- Most relevant indicators in England either improved between 2008 and 2009 or were broadly stable;
 - Satisfaction with pay in England in 2009 had, on average, increased since 2008;
 - There were very slight improvements in average scores for work-life balance, work pressure, job satisfaction and intention to leave;
 - Ambulance staff, on average, gave less favourable responses to most questions than other staff groups;
 - Responses from staff in Northern Ireland were broadly comparable to those in England, though appraisal rates in Northern Ireland were substantially lower than England; and
 - In NHS Scotland in 2010, over 70% of employees were satisfied with the sense of achievement from their work; 56% of employees were satisfied with their job security; and the number of employees who would recommend their health board as a “good place to work” increased to 58% (from 55% in the 2008 survey).

The Health Departments

- 5.10 The **Department of Health** provided us with analyses of the NHS staff survey separately for staff earning £21,000 or less and staff earning over £21,000. For both groups, the Department highlighted that the score for job satisfaction was regarded as one of the key indicators of staff motivation and morale and that this had remained consistently high, had increased between 2008 and 2009, and was at its highest level in the last five years. However, the Department noted that the job satisfaction score for ambulance staff earning over £21,000 had fallen between 2008 and 2009. The Department also told us that it strongly believed that the general NHS reward package remained highly competitive and was a valuable retention and recruitment tool.
- 5.11 The **SGHD** provided evidence on a range of activities designed to improve employee experience, morale and motivation. The SGHD pointed to the results of the 2008 staff survey which suggested that staff continued to be satisfied with the overall benefits

² Published at: <http://www.scotland.gov.uk/News/Releases/2011/01/31102556>

package (increasing from 58% to 62%). The **DHSSPSNI** provided further details of its 2009 staff survey covering three themes – the resources to deliver, the support to do a good job, and a worthwhile job and the chance to develop.

Staff Bodies

- 5.12 The **Staff Side** drew on its IDS NHS staff survey which they considered that, across a variety of measures, built up a worrying picture of low levels of morale and motivation among the NHS workforce. They said that the survey found that over half (55%) of all respondents reported that their morale or motivation had either become worse or a lot worse compared to the previous year. The Staff Side added that staff reported that morale, stress, workload and unfilled posts had all been negatively affected as a result of restructuring in their organisation.
- 5.13 The Staff Side reported that two-thirds of respondents to the IDS survey said that the 2010 pay award was either low or very low and 56% stated that they were worse off in terms of their pay compared with 12 months previously. Just over half of respondents said that they were dependent on additional payments such as overtime, unsocial hours or on-call payments to sustain their standard of living. Only one-third of respondents said their current pay band or grade was appropriate given their role and responsibilities while around the same proportion said it was inappropriate.
- 5.14 The Staff Side commented that, in the context of restructuring, pay freezes and uncertainties over pensions, it was more important than ever that organisations paid attention to employee engagement and partnership working. The IDS survey indicated that just over a quarter of respondents were aware of policies in the workplace to promote employee engagement. In terms of policies/initiatives that helped improve staff morale and motivation, two-thirds of respondents stated that they valued opportunities for training and development within their trust or organisation most highly followed by staff involvement and childcare provision.
- 5.15 The staff organisations also summarised the results from their own staff surveys of their members. There are indications from the staff organisations' surveys that the pay freeze and developments in the NHS could impact significantly on levels of NHS staff morale and motivation. The evidence is available from the staff organisations' websites (see Appendix E).

Our Comment

- 5.16 We note that generally the current round of NHS staff surveys have shown slight improvements in the main indicators related to staff motivation and morale. However, these survey results relate largely to 2009 and therefore have yet to capture the major changes announced in 2010 including the pay freeze imposed by the UK Government and Devolved Administrations together with compression of the pay structure, NHS reforms and proposed changes to public sector pensions. In particular, we note that the value of NHS pensions is an important part of the total remuneration package offered by the NHS. We noted in Chapter 1 that the *Independent Public Service Pensions Commission*³, led by Lord Hutton, is considering long-term structural reform options and that the Chancellor⁴ announced the Government's intention to implement progressive changes to the level of employee pension contributions equivalent to three percentage points on average.

³ Independent Public Service Pensions Commission (7 October 2010) *Interim Report*. Available at: http://www.hm-treasury.gov.uk/d/hutton_pensionsinterim_071010.pdf

⁴ HM Treasury (October 2010) *Spending Review 2010*.

- 5.17 We observe that these changes have yet to work their way through the system and that there might be consequential impacts on morale and motivation and recruitment and retention when they do. We will continue to monitor the results of the NHS staff surveys as a measure of morale and motivation. The staff surveys and those conducted by the staff organisations add considerably to our evidence-base and we value the efforts of the parties to conduct and develop these surveys. It is therefore disappointing that, in the 2010 survey in Scotland, the views of staff toward their pay and benefits were not sought, contrary to the practice in previous years, and in other countries.

Workforce Planning

- 5.18 In our Twenty-Fourth Report⁵ we again asked that the Health Departments provide better information on workforce planning so that we might take a view on the longer-term recruitment and retention picture. We specifically asked 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.

Information from the Parties

The Health Departments

- 5.19 The **Department of Health** told us that workforce planning in England for non-medical staff worked to a medium-term time horizon, typically around five years. The Department had pursued a policy of self sufficiency for the non-medical workforce so that specific staff groups had been targeted for increased commissions over the past few years. The increased number of training commissions had been a factor in the growth of the non-medical workforce. Since 2000, the Department reported a significant increase in the NHS workforce of 26% including 64,000 (22%) more qualified nurses.
- 5.20 In January 2010, the Department of Health set up the Centre for Workforce Intelligence (CfWI) in England to better understand the future demand for non-medical staff and to develop supply strategies to meet this demand. The CfWI has a broad remit to provide long-term and strategic scenario planning for the health and social care workforce in order to build strong leadership and capability in workforce planning. The CfWI will produce its first report on the non-medical workforce in autumn 2011 analysing the short-term output from training and comparing its supply forecasts with estimated levels of demand. The CfWI will then model longer-term demand.
- 5.21 The **SGHD** told us that future demand for NHS staff groups was estimated by NHS Boards in their workforce plans and workforce demand projections. Following agreement with the Cabinet Secretary for Health and Wellbeing the current workforce demand projection process was to be reviewed. This was intended to ensure the process was fully integrated within boards and to take account of potential impacts of work underway including future service needs and drivers, Midwifery 2020, and reshaping the medical workforce.
- 5.22 The **WAG** told us that its Five Year Service, Workforce and Financial Strategic Framework identified workforce modernisation as a key area for achievement. The workforce would be rebalanced with a shift from hospital to community and primary care including a performance target working towards a 10% increase in the proportion of staff

⁵ NHSPRB (2009) *Twenty-Fourth Report*, TSO (Cm 7646), paragraphs 2.49 to 2.50.

providing services in a community setting. The Framework required all organisations to demonstrate changes to the skill mix across all grades and bands which maximised the use of flexibilities under the provisions of Agenda for Change and medical contracts. Growth in staff in Bands 1-4 of 3% per annum was planned between 2010 and 2013.

- 5.23 The **DHSSPSNI** reported that the methodology for future workforce reviews had been altered recently with more onus placed on trusts to undertake organisational-level workforce planning, integrating financial, service development and workforce planning streams. The DHSSPSNI considered that this would help better inform the regional workforce planning process.

Staff Bodies

- 5.24 The **Staff Side** commented that national workforce planning was vital in order to deal with the huge pressures on the NHS from an ageing workforce and a reversal in the trend for overseas nurses to seek employment in the UK. The Staff Side added its serious concerns about the White Paper's proposals to delegate workforce planning to local organisations.
- 5.25 The **Royal College of Nursing** provided a detailed assessment of the labour market *Sustaining the Long View – the UK Nursing Labour Market Review 2010*. The RCN commented on a tighter labour market from fewer registrations of nurses, increasing numbers leaving through retirement and migration abroad, a reduction in nurses entering the UK and a reduction in commissioned training places in universities. Against this background, the RCN continued to express concern about the lack of integrated nursing workforce planning.
- 5.26 The **Society of Radiographers** commented that there was no clear forecast of the numbers of radiographic workers required in the UK over the next ten years. The Society argued that if the NHS did not accurately predict future workforce requirements it would fail to meet a number of its policy objectives.

Our Comment

- 5.27 Although we have previously noted that provision for processes of workforce planning lie beyond our remit, they naturally have a relationship to the outputs of workforce planning exercises. We therefore note with interest the establishment of the CfWI in England, and look forward to receiving its first report on the non-medical workforce in the autumn of this year. We consider it important that wider NHS reforms planned for England – including the abolition of Strategic Health Authorities – are not allowed to fragment the way in which information on workforce requirements is gathered at a local level, leading to imbalances between demand and supply. Individual employers, it could be argued, may be likely to take a short-term view of their own requirements, especially when their own financial plans are typically of between one and three years in length; we encourage employers to engage effectively with the CfWI to ensure that longer-term training commissions are set at an appropriate level.

Training and Development

- 5.28 In addition to workforce planning, one area of NHS reform that will be important to the supply of healthcare professionals and other staff will be securing effective training and development. The UK Government published a consultation on Developing the

Healthcare Workforce⁶ in December 2010. The Department of Health proposed that it would have progressively less direct involvement in planning and development of the healthcare workforce. Local skills networks of employers would take on many of the workforce functions carried out by Strategic Health Authorities and the responsibilities for planning and developing the workforce will apply to all providers of NHS-funded care. An autonomous statutory board would be created – Health Education England – to support providers in planning, education and training and to focus on workforce issues that need to be managed nationally. Overall, the consultation aims to identify the right balance between strategic national oversight and greater freedom for local education commissioning. It also noted the need for analytical capability through such organisations as the Centre for Workforce Intelligence.

- 5.29 We ask the Health Departments to keep us informed of education and training developments as the reforms are implemented. In our view, the devolving of planning functions to local organisations carries some risks to the protection of the level of activity and investment in the required education and training of staff. It will be crucial to delivering the NHS reforms that staff are adequately trained and kept up to date with the latest developments. In previous periods of financial constraint, employers across the economy have tended to reduce their commitment to and resources for training and development. We strongly urge that employers manage these risks effectively to ensure the appropriate levels of relevant training and education continue to be delivered.

Knowledge and Skills Framework

Information from the Parties

The Health Departments

- 5.30 The **Department of Health** told us that both the National Audit Office and the Public Accounts Committee had highlighted, and made recommendations on, the need to improve the use of KSF in the NHS. The Department, through NHS Employers and in partnership with NHS staff organisations, had reviewed and simplified the guidance for using KSF.
- 5.31 The Department and NHS Employers also commissioned an independent review of KSF's structure by the Institute for Employment Studies. The NHS Staff Council had broadly accepted the recommendations including:
- The need for a stronger link between KSF and staff appraisals;
 - Simplification to allow greater flexibility and to meet local needs; and
 - The need for better support for NHS organisations in delivering KSF at local levels.
- 5.32 IES subsequently worked with relevant stakeholders to develop and agree the redesign and simplification of KSF while maintaining its core aims and principles. The NHS Staff Council endorsed IES' core conclusion that KSF guidance needed to be simplified to serve as a practical guide for managers and staff. The Department reported that NHS Employers had now given the flexibility to retain the original approach or to use a new simplified approach in which: the language of core dimensions is simplified; six core dimensions are retained; optional dimensions on leadership and management

⁶ Department of Health (20 December 2010), *Liberating the NHS: Developing the Healthcare Workforce*. Published at: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_122590

are included; the use of specific dimensions and post outlines are optional; and new guidance and model documents have been developed to enable an effective appraisal/development review process. The Department was rolling out a communication strategy to support effective implementation of the improved KSF.

- 5.33 The **SGHD** reported that its target to ensure that all substantive staff have a Personal Development Plan (PDP) by 31 March 2009 had been achieved and was a key milestone towards full implementation of KSF. By March 2011, at least 80% of AfC staff are required to have development reviews and PDPs completed and recorded using the on-line tool which supports KSF.
- 5.34 The **DHSSPSNI** told us that, while KSF was not mandatory in Northern Ireland, organisations were continuing to implement the framework in line with the national agreement. It noted that progress varied, ranging from 45% to 99% coverage for KSF outlines and 8% to 71% of staff with a completed Personal Development Review.

NHS Employers

- 5.35 **NHSE** referred to the independent review of KSF and that the national parties had agreed new, more flexible guidance which allowed employers greater flexibility on application of the appraisal and KSF process.

Staff Bodies

- 5.36 **UNISON** commented that the NHS Staff Survey in England showed that 69% of staff had had an appraisal or KSF development review in 2009 compared to 64% in 2008 and 61% in 2007. It added that 60% of those having an appraisal had agreed a Personal Development Plan but only half of these said they had received the training, learning or development identified in the plan. UNISON considered that there remained considerable work in Wales to ensure KSF was fully embedded, that Scotland had linked implementation to performance targets for NHS Boards, and Northern Ireland continued to make steady progress but that some employers were not giving KSF sufficient commitment or resources to achieve full implementation. UNISON hoped that the simplified KSF guidance would accelerate what was currently slow progress so that the benefits of KSF could be properly realised.

Our Comment

- 5.37 We have commented extensively on our concerns regarding progress implementing the Knowledge and Skills Framework in our Twenty-Third Report⁷ and Twenty-Fourth Report⁸. KSF is an integral part of the Agenda for Change structure. It is crucial to the efficient delivery of current and future services and we have urged the Health Departments and the Staff Side to give KSF the highest priority. We have also expressed considerable concern at the low level of staff appraisals being carried out and, although the latest data show some increases, the level needs to be significantly higher to ensure KSF plays its intended role in the Agenda for Change structure. We reiterate how important a properly functioning appraisal system is to staff morale and to inform training needs, as well as ensuring a safe service where professionalism is appropriately recognised.
- 5.38 We welcome the NHS Staff Council's further review of the implementation of KSF and the Department of Health's, NHS Employers' and NHS staff organisations' efforts to review and simplify the KSF guidance. The review endorsed our views from recent years

⁷ NHSPRB (2008), *Twenty-Third Report*, TSO (Cm 7337), paragraph 4.46.

⁸ NHSPRB (2009), *Twenty-Fourth Report*, TSO (Cm 7646), paragraph 4.49 to 4.51.

that there needed to be a stronger link between KSF and staff appraisals. We hope that the revised and simplified guidance with its less prescriptive approach and greater local flexibility will support organisations in delivering appraisals based on the KSF. We look forward to further feedback on progress in future evidence from the parties.

- 5.39 We are concerned that in its written evidence DHSSPSNI did not consider KSF as mandatory in Northern Ireland. We do not share this view and we urge that every effort is made to ensure its effective and widespread implementation.

Data Relating to Our Remit Group

- 5.40 We noted in our Twenty-Fourth Report 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, and we set out a number of recommendations to the Health Departments to further improve the workforce data produced in each country.

- 5.41 Since our Report was published in July 2009, there have been a number of developments, including:

- In England from July 2010, the publication of experimental⁹, provisional monthly NHS workforce and turnover statistics using the Electronic Staff Record (ESR) system, although this is not comparable with the current annual workforce census because of different collection methods;
- Annual publication of turnover statistics for NHS staff in Scotland;
- Plans to move away from an annual vacancy survey in England, with the intention of extracting vacancy data from a redesigned NHS Jobs website;
- Usage of the “job role” and “area of work” fields in the ESR system to make progress towards further disaggregating workforce data in England for those staff formerly covered by the Pay Negotiating Council;
- Plans in the longer-term to use the ESR system to calculate pay metrics in England at a lower level of detail than is the present practice (see Appendix D for the latest available pay metrics from the Department of Health);
- Further research into how local and national recruitment and retention premia are recorded on the ESR system; and
- Consideration of additional questions on motivation for the National NHS Staff Survey in England (which the Staff Survey Improvement Board decided not to include) and staff satisfaction with the total benefits package (which were included for local use rather than among the national core questions).

⁹ Statistics that are in the testing phase and are not yet fully developed.

Our Comment

- 5.42 We welcome the recent and expected future developments in workforce data outlined above, and encourage the Health Departments and the NHS Information Centre to maintain their efforts in improving the data relating to our remit group. We are pleased that the ESR system is being used in England to increase the range, detail and timeliness of workforce statistics, but we note that one outcome of the Health and Social Care Bill – that healthcare in England will in future be delivered by “any willing provider” – risks undermining these improvements in workforce data, should social enterprises and other providers not use the ESR system.
- 5.43 We have noted previously¹⁰ that it would be helpful to have workforce data on a consistent basis for all four UK countries. Whilst we would still find this desirable, we appreciate that each UK country has developed its own data collection and reporting arrangements that it considers to be appropriate. We would, however, still find it helpful if vacancy statistics in Scotland were collected for all staff groups; if turnover data could be provided from Wales; and if data on the earnings of our remit group could be provided from Wales, Scotland and Northern Ireland.
- 5.44 We note that the Department plans to review its methodology for compiling pay metrics and pay drift for our remit group. We would welcome the opportunity to discuss with the Department which factors are appropriate to include in any calculation of pay drift.

¹⁰NHSPRB (2009), *Twenty-Fourth Report*, TSO (Cm 7646), paragraph 2.26.

APPENDIX A – REMIT LETTERS



HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

TO: Chairs of the Pay Review Bodies

26 July 2010

Dear Alasdair, Ron, Gillian, Jerry, Anne and Bill

PUBLIC SECTOR PAY 2011-12

We met in June to discuss the Government's approach to public sector pay in the context of the fiscal consolidation. The Emergency Budget announced a two year pay freeze from 2011-12 for public sector workforces, except for those earning a full-time equivalent of £21,000 or less, where the Government will seek increases of at least £250 per year. I am writing now to set out how the Government proposes working with the Review Bodies in relation to the 2011-12 pay round.

2. As I explained when we met, the Government recognises that the Review Bodies bring an independent and expert view that is valued by the Government and those representing public sector staff. With regard to public sector workforces in England, for the 2011-12 pay round, the implications of the Budget announcement from the Government's perspective are that:

- for those groups of workers paid above £21,000, the Government will not submit evidence or seek recommendations on pay uplifts. It will, however, provide information about recruitment, retention and other aspects of the affected workforces as appropriate. The Government may ask the Review Bodies to consider specific issues, other than a general pay uplift, that lie within their terms of reference; and
- for those groups of workers paid £21,000 or less, we will look to the Pay Review Bodies to provide recommendations on uplifts – and I have provided



further guidance on the Chancellor's announcement in the Annex to this note. The Government will submit evidence for these groups in the autumn in the usual way, covering the usual factors and in line with the pay policy announced in the Emergency Budget.

3. Because of the varied positions of the Review Body remit groups, officials will discuss in more detail with the Review Body secretariats, and where appropriate with the Devolved Administrations, before the relevant Secretary of State writes to you about your remit, if any, for 2011-12. It may well be that there is no need for a formal report from the Review Body in this round.

4. There is a question of whether there might be a wider role for the Review Bodies, after the Spending Review, recognising that this must be consistent with their independent status and their terms of reference. I suggest that officials explore your views on any potential further remit, after the Spending Review, in advance of a formal proposition.

5. Finally, I would like to express my gratitude for the valuable contribution the Review Bodies continue to make in delivering robust, evidence-based pay outcomes for public sector workers. I look forward to continued dialogue with you in the future.

DANNY ALEXANDER

Annex to letter: Treatment of employees earning £21,000 or less

Definition of employees earning £21,000 or less

- This should be determined on the basis of basic salary of a full-time equivalent employee, pro-rated on the basis of the hours worked, using the standard number of hours per week for that organisation.
- Part-time workers with an FTE salary of less than £21,000 should receive a pro-rata increase on the basis of the number of hours worked.
- The £21,000 is based on the normal interpretation of basic salary and does not include overtime or any regular payments such as London weighting, recruitment or retention premia or other allowances.

Size of increase

It is for the Review Bodies to recommend on the size of the uplift for those earning £21,000 or less, though the Government will seek an uplift of at least £250. When considering their recommendations, Review Bodies may want to consider:

- the level of progression pay provided to the workforce;
- affordability;
- the potential for payments to be more generous for those on the lowest earnings; and
- how best to avoid 'leapfrogging' of those earning just under £21,000 with those earning just over £21,000, potentially through the use of a taper.

*From the Rt Hon Andrew Lansley CBE MP
Secretary of State for Health*



POC1_534271

Professor Gillian Morris
Chair NHS Pay Review Body
6th Floor Kingsgate House
66-74 Victoria Street
London SW1E 6SW

*Richmond House
79 Whitehall
London
SW1A 2NS*

*Tel: 020 7210 3000
mb-sofs@dhs.gov.uk*

19 AUG 2010

Dear Gillian,

It was very good to meet you, and Ron Amy, on 22 July 2010. I found our discussion very helpful and was grateful to you both for raising a number of issues on which you needed clarity for the NHS Pay Review Body during the pay freeze.

I am pleased that the Chief Secretary to the Treasury, Danny Alexander, has now written to you and the other Pay Review Body Chairs on 26 July 2010 to clarify many of these matters and set out the Government's approach to public sector pay in England in 2011/12.

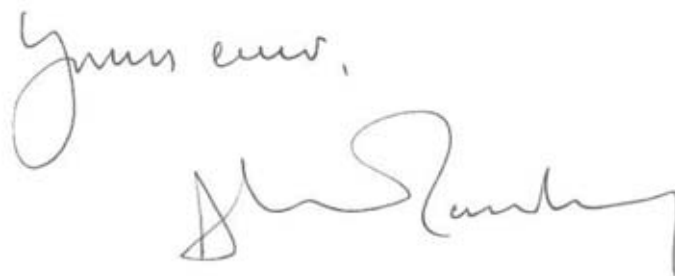
I am aware that the NHSPRB makes recommendations for the whole of the United Kingdom. It is for each of the devolved administrations to make their own decision on their approach to this year's Review Body round and to communicate this to you. My officials have been closely in touch, and remain closely in touch, with their counterparts in the other countries and will do all they can to support you in handling the consequences of any different approaches taken by each country.

I also wanted to explain that we will be unable to meet your original timetable for the receipt of evidence by 23 September 2010. As you will understand, we are currently in a very challenging spending review cycle and this will not be completed until 20 October 2010. As during the last Spending Review under the previous Government, this delay will impact on your timetable. With regard to England, we will do all we can to ensure that the evidence and information you require is with the Review Body as soon after that date as is possible, and by mid-November at the latest. I have also asked my officials to work closely with your secretariat to minimise the practical effect of this on your overall timetable. Recognising the role for the NHSPRB set out in the Agenda for Change Agreement, we will provide evidence, as necessary, on high cost area supplements and recruitment and retention premia.

AG 1808

Finally, I want to emphasise the value that I and the Government place on the independent and expert view of the Review Body. Thank you for your work. I look forward to receiving your report in due course.

I am copying this letter to Nicola Sturgeon, Edwina Hart, Michael McGimpsey and representatives of the staff side and NHS Employers.

Yours ever,


ANDREW LANSLEY CBE

Prof Gillian Morris
Chair, NHS Pay Review Body
Kingsgate House
66-74 Victoria St
London
SW1E 6SW



Llywodraeth Cynulliad Cymru
Welsh Assembly Government

29 September 2010

Dear Gill

Role of the NHS Pay Review Body in 2010/11

You asked for further clarification on the Assembly Government's stance on the pay freeze in relation to the pay of NHS staff in Wales for 2011/12 and whether we will meet the Review Body timetable for submission of evidence and information.

The Emergency Budget announced a two year pay freeze from 2011/12 for public sector workforces, except for those earning a full-time equivalent of £21,000 or less, where the Coalition Government will seek increases of at least £250 per year.

I am writing, as per your request for further information, to set out how the Assembly Government proposes working with the Review Body in relation to the 2011/12 pay round.

With regard to the pay of NHS staff on Agenda for Change pay rates in Wales for 2011/12, the implications of the Budget announcement from the Assembly Government's perspective are that:

- for those groups of workers paid above £21,000, the Assembly Government will not submit evidence or seek recommendations on pay uplifts. It will, however, provide information about recruitment, retention and other aspects of the affected workforce as appropriate
- for those groups of workers paid £21,000 or less, we will look to the NHS Pay Review Body to provide recommendations on uplifts as defined in the Annex to the Chief Secretary to the Treasury's letter of 26 July.

Recognising the role for the Review Body set out in the Agenda for Change Agreement, we will provide evidence, as necessary, on high cost area supplements and recruitment and retention premia.

We will do all we can to ensure that the evidence and information you require is with the Review Body by the 10 November.

I trust that this clarifies our position.

I am copying this letter to the Secretary of State for Health and the respective Ministers in the devolved administrations and representatives of the staff side and NHS Employers.

Yours sincerely

D G Patrick

Head of Employment Policy

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Michael McGimpsey MLA



Department of
**Health, Social Services
and Public Safety**

www.dhsspsni.gov.uk

AN tOIR
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

ADWYRSION
Poustic, Resyðnter Heisin
an Fowk Siccar

Professor Gillian Morris
Chair
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Our Ref: SUB/943/2010

4th October 2010

Dear Professor Morris,

In his recent letter to you the Rt Hon Andrew Lansley CBE, Secretary of State for Health outlined his position in relation to providing evidence to the NHS Pay Review Body in the 2011/12 pay round; this is in light of the two year pay freeze. He also indicated that each of the Devolved Administrations would be writing to you separately confirming their own approach.

I can confirm that the two-year pay freeze for public sector workers announced in the emergency budget on 22 June will apply in the 2011/2012 and 2012/2013 years to Health and Social Care staff groups governed by the NHS Pay Review Body. We recognise that there will be an increase of at least £250 for HSC staff earning £21,000 or less subject to the Review Body process in the usual way. Northern Ireland will be providing written evidence to the NHS Pay Review Body to enable you to undertake your role in 2011/12. We will however have some difficulty in meeting the deadline for submitting evidence as our final position on funding will not be clarified until mid to late October at the earliest. I will however ask my officials to liaise with your Secretariat on this issue to ensure that evidence is provided at the earliest opportunity thus ensuring minimum disruption to your timetable.

I would also like to express my appreciation for the valuable contribution that the NHS PRB make in reaching appropriate pay rates for health and social care staff.

Yours Sincerely,

Michael McGimpsey MLA
Minister for Health Social Services and Public Safety

Working for a Healthier People



HEALTHIER PEOPLE

Deputy First Minister & Cabinet Secretary for
Health and Wellbeing
Nicola Sturgeon MSP

T: 0845 774 1741
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Professor Gillian Morris
Chair, NHS Pay Review Body
6th Floor Kingsgate House
66-74 Victoria Street
LONDON
SW1E 6SW

27 November 2010

Dear Gillian

Further to my letter of 21 October 2010, I can now outline our approach to this year's NHS Pay Review Body (NHSPRB) round and submit the evidence we have prepared in support of that process.

As you know, setting a remit for the NHSPRB process in Scotland for 2011-12 has been delayed by the timetable of the Spending Review. The Scottish Government has now considered the implications of the settlement for Scotland and has set a public sector pay policy for 2011/12 which was announced by the Cabinet Secretary for Finance and Sustainable Growth on 17 November.

The key features of Scotland's public sector pay policy for 2011-12 are as follows:

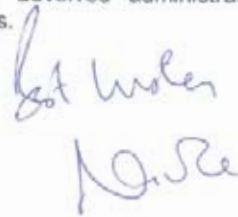
- Pay will be frozen (zero percent basic award) for all public sector staff for 2011-12 except those earning £21,000 and below.
- The Scottish Government recognises the importance of maintaining, as far as possible, some limited pay increases for lower paid staff within the public sector. The pay policy therefore allows for two specific measures to allow bodies to target some increases at this group of staff.
- The policy includes a commitment to introduce a Scottish Living Wage, currently set at £7.15 per hour across all bodies under direct Ministerial control. Organisations will therefore be required to introduce minimum pay rates of at least £7.15 per hour in line with this policy commitment.
- In addition, the policy makes a commitment that all staff earning less than £21,000 should receive a minimum annual pay increase of £250.

In terms of the remit for the NHSPRB this year, therefore, we will:

- submit evidence on recruitment, retention and other issues which affect all groups of workers covered by the NHSPRB although we will not seek recommendations on pay for staff paid over £21,000.
- submit evidence for those workers currently paid £21,000 or less, and seek recommendations from the Pay Review Body on uplifts within the parameters of the Scottish Government public sector pay policy outlined above which closely reflects the parameters included in the Annex to the Chief Secretary to the Treasury's letter of 26 July.

The evidence enclosed with this letter has been prepared in line with these parameters and in recognising the role for the NHSPRB set out in the Agenda for Change agreement, also includes evidence on recruitment and retention premia.

Copies of this letter and accompanying evidence have been sent to the Secretary of State for Health and the respective Ministers in the devolved administrations as well as representatives of the staff side and NHS Employers.

A handwritten signature in blue ink, appearing to read 'Nicola Sturgeon', is positioned above the printed name.

NICOLA STURGEON

APPENDIX B

Recommended Agenda for Change Pay Scales with effect from 1 April 2011

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1	13,903	13,903										
2	14,258	14,258										
3	14,614	14,614										
4		15,029										
5		15,444										
6		15,860	15,860									
7		16,395	16,395									
8		17,003	17,003									
9			17,368									
10			17,854									
11			18,402	18,402								
12			18,827	18,827								
13				19,500								
14				20,183								
15				20,804								
16				21,176	21,176							
17				21,798	21,798							
18					22,676*							
19					23,589*							
20					24,554							
21					25,528*	25,528*						
22					26,556*	26,556*						
23					27,625*	27,625*						
24						28,470						
25						29,464						
26						30,460	30,460					
27						31,454	31,454					
28						32,573	32,573					
29						34,189	34,189					
30							35,184					
31							36,303					
32							37,545					
33							38,851	38,851				
34							40,157	40,157				
35							41,772					
36							43,388					
37							45,254	45,254				
38							46,621	46,621				
39								48,983				
40								51,718				
41								54,454	54,454			
42								55,945	55,945			
43									58,431			
44									61,167			
45									65,270	65,270		
46									67,134	67,134		
47										69,932		
48										73,351		
49										77,079	77,079	
50										80,810	80,810	
51											84,688	
52											88,753	
53											93,014	
54											97,478	

* As part of the parties' 2008-2011 negotiated pay agreement, the top point of Band 5 (spine point 23) is due to increase by 0.33% in April 2011, with consequential adjustments to spine points 18, 19, 21, and 22. These changes have been reflected in the above pay scales but are subject to confirmation in the next AfC pay circular.

APPENDIX C

Composition of Our Remit Group

C1 Figures C1 to C4 show the latest data on the composition of our remit group in each UK country. Owing to differences in the categorisation of staff, and the timeliness of data, information is presented separately for each country. Data relate to full-time equivalent (FTE) staff except where specified.

Figure C1: Composition of the NHS Non-Medical Workforce in England, September 2009

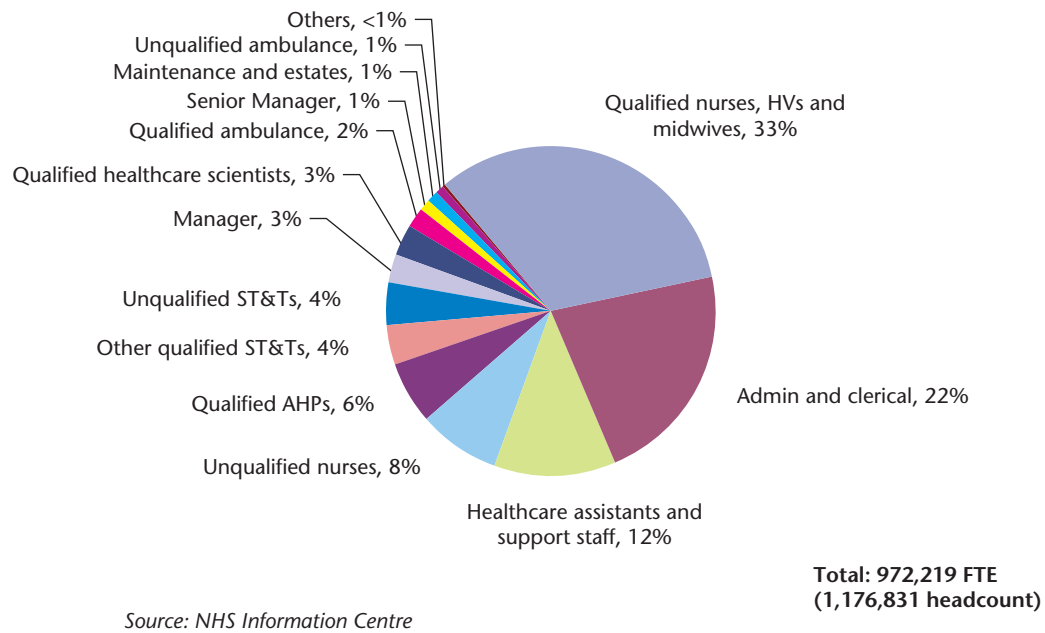


Figure C2: Composition of the NHS Non-Medical Workforce in Scotland, September 2010

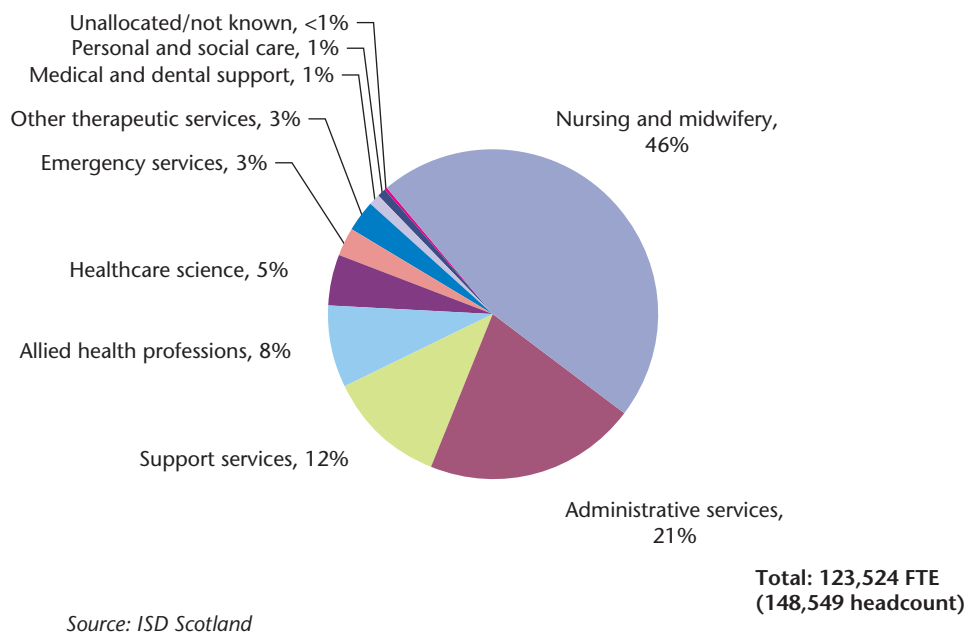


Figure C3: Composition of the NHS Non-Medical Workforce in Wales, September 2009

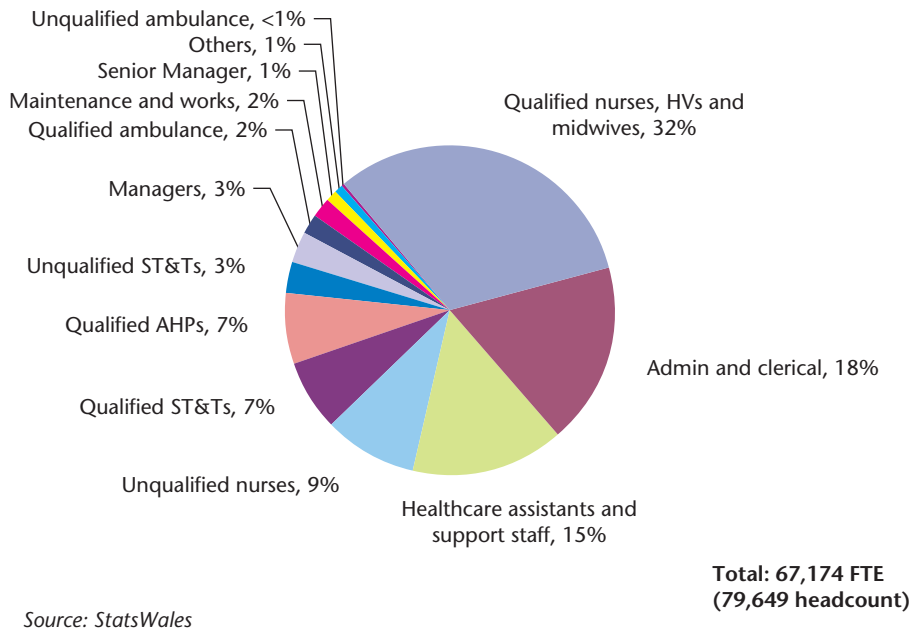
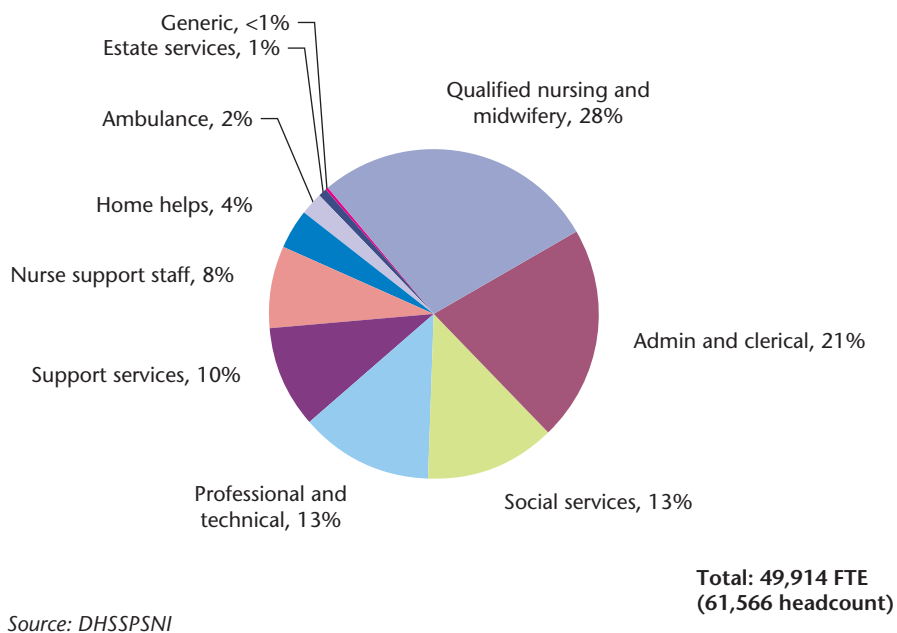


Figure C4: Composition of the HSC Non-Medical Workforce in Northern Ireland, December 2010



C2 Tables C1 to C7 show the composition of our remit group in each country and in the UK as a whole as at September 2009¹. Detailed categories of staff in each country have been aggregated into broad staff groups, to enable cross-UK comparisons to be made.

C3 Staff categories used in each administration’s annual workforce census have been grouped together by our secretariat. We have had to be mindful of the differences between the four datasets, and even these broad staff groups contain inconsistencies: some ancillary staff in England and Wales are categorised in the census as HCAs and support staff, but have job roles that fit better in the broad group “administration, estates and management”.

¹ The most recent date for which UK-wide data were available at the time of writing.

NHS Full-Time Equivalent Non-Medical Workforce as at 30 September 2009

Table C1: Qualified nurses & midwives

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Qualified nurses, HVs and midwives	322,425	Nurses & midwives bands 5-9 ²	42,738	Qualified nurses, HVs and midwives	21,790	Qualified nursing & midwifery	13,863	400,816

Table C2: Nursing and healthcare assistants and support staff

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Unqualified nurses	80,397	Nurses & midwives bands 1-4 ²	15,691	Unqualified nurses	6,352	Nurse support staff	4,103	
HcAs and support staff	113,957			HcAs and support staff	9,920			
	194,355		15,691		16,272		4,103	230,420

Table C3: Professional, technical and social care

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Qualified AHPs	61,865	Medical & dental support	1,667	Qualified AHPs	4,591	Professional & technical	6,201	
Qualified healthcare scientists	29,779	AHPs	9,579	Qualified ST&Ts	4,774	Social services	6,578	
Other qualified ST&Ts	36,687	Other therapeutic services	3,326	Unqualified ST&Ts	1,838	Home helps	2,035	
Unqualified ST&Ts	36,232	Personal & social care	763					
		Healthcare science	5,594					
	164,563		20,930		11,202		14,814	211,505

² Data in Scotland do not provide for identification of qualified and unqualified staff; consequently nursing staff in Scotland on Bands 5 and above are assumed to be qualified, and staff in Bands 1-4 are assumed to be unqualified, with unbanded staff allocated pro-rata.

Table C4: Ambulance

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Qualified ambulance	17,214	Emergency services	3,704	Qualified ambulance	1,396	Ambulance	1,027	
Unqualified ambulance	7,260			Unqualified ambulance	7			
	24,475		3,704		1,403		1,027	30,608

Table C5: Administration, estates and management

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Admin & clerical	210,501	Administrative services	26,107	Clerical and admin	12,214	Admin & clerical	10,886	
Maintenance & estates Manager	10,401 29,924	Support services	14,761	Maintenance & works Managers	1,174	Estates services	657	
Senior Manager	12,585			Senior managers	970	Support services	5,029	
	263,411		40,868		16,151		16,572	336,944

Table C6: Other

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Others	2,991	Unallocated / not known	567	Others	356	Generic	116	4,030

Table C7: Total NHS non-medical workforce

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
	972,220		124,498		67,174		50,494	1,214,324

Source: NHS Information Centre, ISD Scotland, StatsWales, DHSSPSNI

APPENDIX D

The Department of Health's Pay Metrics

Historical figures

The historical pay metrics (up to and including 2008/09) have been estimated using pay bill data from NHS Financial Returns, NHS Accounts and Foundation Trust Annual Reports. Figures for 2009/10 onwards are projections.

Workforce statistics up to and including 2009/10 are from the annual NHS Workforce Census.

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.

The pay bill data from the Foundation Trust Annual Reports does not include a breakdown of costs by staff group; this breakdown has been estimated using historic NHS Financial Returns.

Earnings per FTE figures have been derived from the pay bill per FTE figures using the NHS Pension Scheme and National Insurance rates and thresholds that apply to NHS employers.

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.

Projected figures

Pay bill figures for 2009/10 and 2010/11 have been projected based on the 2008/09 actuals.

The workforce FTE figures for each staff group for 2009/10 are from the September 2009 NHS Census (published March 2010). The workforce FTE figures for 2010/11 are demand projections.

Pay bill projections for 2009/10 and 2010/11 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 2008/09 baseline.

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. Other drift will arise from changes to national pay arrangements; changes in skill mix, changes in distribution over bands/incremental points; local pay decisions; and changes in additional earnings e.g. overtime, use of recruitment & retention premia and bonuses.

On-costs drift has been estimated taking into account the expected increases in the national insurance thresholds relevant to NHS employers.

Table D1: HCHS Paybill (£million)¹

	2001/02	2002/03	2003/04	2004/05 ²	2005/06 ²	2006/07 ²	2007/08 ²	2008/09 ²	2009/10 ^{2,3}	2010/11 ⁴
Qualified Nursing	7,427	8,085	8,677	9,923	10,548	10,968	11,421	12,148	12,849	13,542
Unqualified Nursing, HCA and Support ⁶	2,512	2,740	2,946	3,406	3,731	3,757	3,890	4,062	4,494	4,674
ST&Ts ⁷	2,919	3,199	3,538	4,115	4,452	4,785	4,956	5,326	5,688	6,103
Admin & Clerical	2,444	2,724	3,000	3,604	4,007	4,199	4,376	4,839	5,291	5,489
Maintenance & works	240	239	237	266	270	269	283	294	308	310
Ambulance Staff	433	478	524	747	890	779	844	925	970	1,034
Managers	1,331	1,571	1,777	2,247	2,414	2,341	2,285	2,428	2,747	2,706
Total remit⁸	17,362	19,164	20,825	24,425	26,443	27,232	28,266	30,173	32,510	34,028

Table D2: Growth in HCHS Paybill¹

	2001/02	2002/03	2003/04	2004/05 ²	2005/06 ²	2006/07 ²	2007/08 ²	2008/09 ²	2009/10 ^{2,3}	2010/11 ⁴
Qualified Nursing	10.9%	8.9%	7.3%	14.4%	6.3%	4.0%	4.1%	6.4%	5.8%	5.4%
Unqualified Nursing, HCA and Support ⁶	11.6%	9.1%	7.5%	15.6%	9.5%	0.7%	3.5%	4.4%	10.6%	4.0%
ST&Ts ⁷	11.6%	9.6%	10.6%	16.3%	8.2%	7.5%	3.6%	7.5%	6.8%	7.3%
Admin & Clerical	13.1%	11.4%	10.2%	20.1%	11.2%	4.8%	4.2%	10.6%	9.3%	3.8%
Maintenance & works	2.2%	-0.8%	-0.5%	12.0%	1.5%	-0.4%	5.3%	4.0%	4.9%	0.5%
Ambulance Staff	9.6%	10.2%	9.6%	42.7%	19.0%	-12.4%	8.3%	9.6%	4.9%	6.6%
Managers	12.2%	18.0%	13.2%	26.5%	7.4%	-3.0%	-2.4%	6.3%	13.1%	-1.5%
Total remit⁸	11.4%	10.4%	8.7%	17.3%	8.3%	3.0%	3.8%	6.7%	7.7%	4.7%

Table D3: HCHS Paybill per FTE (£)^{1,9}

	2001/02	2002/03	2003/04	2004/05 ²	2005/06 ²	2006/07 ²	2007/08 ²	2008/09 ²	2009/10 ^{2,3}	2010/11 ⁴
Qualified Nursing	27,901	28,947	29,722	32,870	34,274	35,675	37,126	38,515	39,853	41,550
Unqualified Nursing, HCA and Support ⁶	13,529	14,246	14,815	16,980	18,183	19,448	20,766	21,388	22,806	23,791
ST&Ts ⁷	25,214	26,028	27,210	29,864	30,998	33,022	33,580	34,326	34,567	36,028
Admin & Clerical	16,258	17,132	17,473	19,659	20,919	22,583	23,862	24,913	25,134	26,203
Maintenance & works	20,449	20,164	20,682	23,545	24,687	25,619	27,870	29,126	29,661	30,915
Ambulance Staff	26,559	27,983	30,006	40,117	45,360	35,896	38,876	40,012	39,648	41,333
Managers	50,650	50,806	52,567	62,418	64,289	66,800	65,368	63,998	64,622	67,319
Total remit⁸	22,456	23,547	24,334	27,444	28,851	30,288	31,650	32,577	33,439	34,834

Table D4: Growth in HCHS Paybill per FTE^{1,9}

	2001/02	2002/03	2003/04	2004/05 ²	2005/06 ²	2006/07 ²	2007/08 ²	2008/09 ²	2009/10 ^{2,3}	2010/11 ⁴
Qualified Nursing	6.7%	3.7%	2.7%	10.6%	4.3%	4.1%	4.1%	3.7%	3.5%	4.3%
Unqualified Nursing, HCA and Support ⁶	6.9%	5.3%	4.0%	14.6%	7.1%	7.0%	6.8%	3.0%	6.6%	4.3%
ST&Ts ⁷	6.4%	3.2%	4.5%	9.8%	3.8%	6.5%	1.7%	2.2%	0.7%	4.2%
Admin & Clerical	7.0%	5.4%	2.0%	12.5%	6.4%	8.0%	5.7%	4.4%	0.9%	4.3%
Maintenance & works	4.4%	-1.4%	2.6%	13.8%	4.9%	3.8%	8.8%	4.5%	1.8%	4.2%
Ambulance Staff	5.8%	5.4%	7.2%	33.7%	13.1%	-20.9%	8.3%	2.9%	-0.9%	4.3%
Managers	3.5%	0.3%	3.5%	18.7%	3.0%	3.9%	-2.1%	-2.1%	1.0%	4.2%
Total remit⁸	6.5%	4.9%	3.3%	12.8%	5.1%	5.0%	4.5%	2.9%	2.6%	4.2%

Table D5: HCHS Earnings per FTE (£)^{1,9}

	2001/02	2002/03	2003/04	2004/05 ²	2005/06 ²	2006/07 ²	2007/08 ²	2008/09 ²	2009/10 ^{2,3}	2010/11 ⁴
Qualified Nursing	24,733	25,702	26,342	27,697	28,784	29,863	31,150	32,335	33,378	34,777
Unqualified Nursing, HCA and Support ⁶	12,256	12,899	13,394	14,563	15,528	16,532	17,670	18,211	19,367	20,178
ST&Ts ⁷	22,378	23,138	24,136	25,189	26,062	27,666	28,204	28,854	29,000	30,204
Admin & Clerical	14,588	15,376	15,665	16,738	17,745	19,077	20,186	21,082	21,233	22,114
Maintenance & works	18,169	17,959	18,392	19,893	20,790	21,512	23,432	24,503	24,905	25,939
Ambulance Staff	23,492	24,792	26,511	33,606	37,750	29,976	32,524	33,499	33,132	34,520
Managers	44,135	44,344	45,760	51,581	52,954	54,848	53,858	52,985	53,354	55,509
Total remit⁸	19,980	20,968	21,628	23,173	24,275	25,400	26,597	27,406	28,067	29,215

Table D6: Growth in HCHS Earnings per FTE^{1,9}

	2001/02	2002/03	2003/04	2004/05 ²	2005/06 ²	2006/07 ²	2007/08 ²	2008/09 ²	2009/10 ^{2,3}	2010/11 ⁴
Qualified Nursing	5.6%	3.9%	2.5%	5.1%	3.9%	3.8%	4.3%	3.8%	3.2%	4.2%
Unqualified Nursing, HCA and Support ⁶	5.6%	5.3%	3.8%	8.7%	6.6%	6.5%	6.9%	3.1%	6.3%	4.2%
ST&Ts ⁷	5.2%	3.4%	4.3%	4.4%	3.5%	6.2%	1.9%	2.3%	0.5%	4.1%
Admin & Clerical	5.7%	5.4%	1.9%	6.8%	6.0%	7.5%	5.8%	4.4%	0.7%	4.1%
Maintenance & works	3.3%	-1.2%	2.4%	8.2%	4.5%	3.5%	8.9%	4.6%	1.6%	4.1%
Ambulance Staff	4.7%	5.5%	6.9%	26.8%	12.3%	-20.6%	8.5%	3.0%	-1.1%	4.2%
Managers	2.6%	0.5%	3.2%	12.7%	2.7%	3.6%	-1.8%	-1.6%	0.7%	4.0%
Total remit⁸	5.3%	4.9%	3.1%	7.1%	4.8%	4.6%	4.7%	3.0%	2.4%	4.1%

Table D7: HCHS Workforce (FTE)¹

	2001/02	2002/03	2003/04	2004/05 ²	2005/06 ²	2006/07 ²	2007/08 ²	2008/09 ²	2009/10 ^{2,3}	2010/11 ⁴
Qualified Nursing	266,171	279,287	291,925	301,877	307,744	307,447	307,628	315,410	322,425	325,931
Unqualified Nursing, HCA and Support ⁶	185,687	192,370	198,868	200,615	205,207	193,208	187,349	189,936	197,035	196,477
ST&Ts ⁷	115,767	122,903	130,043	137,789	143,606	144,899	147,583	155,174	164,563	169,392
Admin & Clerical	150,317	158,978	171,707	183,338	191,528	185,947	183,368	194,236	210,501	209,492
Maintenance & works	11,758	11,831	11,479	11,289	10,932	10,487	10,146	10,100	10,401	10,028
Ambulance Staff	16,320	17,076	17,455	18,627	19,610	21,703	21,706	23,109	24,475	25,025
Managers	26,285	30,914	33,810	36,007	37,549	35,041	34,955	37,937	42,509	40,198
Total remit⁸	773,141	813,854	855,799	889,973	916,548	899,091	893,087	926,210	972,220	976,853

Table D8: Growth in HCHS Workforce (FTE)¹

	2001/02	2002/03	2003/04	2004/05 ²	2005/06 ²	2006/07 ²	2007/08 ²	2008/09 ²	2009/10 ^{2,3}	2010/11 ⁴
Qualified Nursing	3.9%	4.9%	4.5%	3.4%	1.9%	-0.1%	0.1%	2.5%	2.2%	1.1%
Unqualified Nursing, HCA and Support ⁶	4.4%	3.6%	3.4%	0.9%	2.3%	-5.8%	-3.0%	1.4%	3.7%	-0.3%
ST&Ts ⁷	4.9%	6.2%	5.8%	6.0%	4.2%	0.9%	1.9%	5.1%	6.1%	2.9%
Admin & Clerical	5.7%	5.8%	8.0%	6.8%	4.5%	-2.9%	-1.4%	5.9%	8.4%	-0.5%
Maintenance & works	-2.1%	0.6%	-3.0%	-1.6%	-3.2%	-4.1%	-3.3%	-0.5%	3.0%	-3.6%
Ambulance Staff	3.6%	4.6%	2.2%	6.7%	5.3%	10.7%	0.0%	6.5%	5.9%	2.2%
Managers	8.4%	17.6%	9.4%	6.5%	4.3%	-6.7%	-0.2%	8.5%	12.1%	-5.4%
Total remit⁸	4.6%	5.3%	5.2%	4.0%	3.0%	-1.9%	-0.7%	3.7%	5.0%	0.5%

Notes:

1. Figures are for NHS staff in England only, and exclude Agency staff.
2. Includes estimates for the breakdown of the payroll by staff group for Foundation Trusts (all years from 2004/05 onwards).
3. Pay bill figures from 2009/10 NHS Financial Returns and Foundation Trusts Consolidated Accounts.
4. Shaded figures are projections and therefore subject to change.
5. In 2004/05, responsibility for NHS Pensions Indexation shifted from HMT to NHS employers.
6. Unqualified Nursing, HCA and Support includes Ancillary staff (e.g. Cleaners and Porters).
7. Scientific, Therapeutic and Technical staff (ST&T) includes Allied Health Professionals and Healthcare Scientists.
8. This total includes a small number of 'Other' staff which do not fall into any of the above staff groups (0.03% of NHSPRB workforce in 2009/10).
9. The workforce numbers are taken from published data which represents a snapshot as at 30th September for each given year. It must be noted that the profile of workforce growth during each year may affect the average earnings and payroll per FTE. We are investigating how we can adjust for this in the future.

APPENDIX E

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://wales.gov.uk/?skip=1&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/
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/

The parties' written evidence should be available through these websites

APPENDIX F

Previous Reports of The Review Body

Nursing Staff, Midwives and Health Visitors

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

Professions Allied to Medicine

First Report on Professions Allied to Medicine	Cmnd. 9257, June 1984
Second Report on Professions Allied to Medicine	Cmnd. 9528, June 1985
Third Report on Professions Allied to Medicine	Cmnd. 9783, May 1986
Fourth Report on Professions Allied to Medicine	Cm 130, April 1987
Fifth Report on Professions Allied to Medicine	Cm 361, April 1988
Sixth Report on Professions Allied to Medicine	Cm 578, February 1989
Seventh Report on Professions Allied to Medicine	Cm 935, February 1990
Eighth Report on Professions Allied to Medicine	Cm 1411, January 1991
Ninth Report on Professions Allied to Medicine	Cm 1812, February 1992
Tenth Report on Professions Allied to Medicine	Cm 2149, February 1993
Eleventh Report on Professions Allied to Medicine	Cm 2463, February 1994
Twelfth Report on Professions Allied to Medicine	Cm 2763, February 1995
Thirteenth Report on Professions Allied to Medicine	Cm 3093, February 1996
Fourteenth Report on Professions Allied to Medicine	Cm 3539, February 1997
Fifteenth Report on Professions Allied to Medicine	Cm 3833, January 1998
Sixteenth Report on Professions Allied to Medicine	Cm 4241, February 1999
Seventeenth Report on Professions Allied to Medicine	Cm 4564, January 2000
Eighteenth Report on Professions Allied to Medicine	Cm 4992, December 2000
Nineteenth Report on Professions Allied to Medicine	Cm 5346, December 2001

Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine

Twentieth Report on Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine	Cm 5716, August 2003
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
Twenty-Fourth Report, NHS Pay Review Body 2009	Cm 7646, July 2009
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 2009

APPENDIX G

Glossary

AfC	Agenda for Change
AHPs	Allied Health Professionals
ASHE	Annual Survey of Hours and Earnings
AWE	Average Weekly Earnings
BIOS	British and Irish Orthoptic Society
CfWI	Centre for Workforce Intelligence
CPI	Consumer Prices Index
CSP	Chartered Society of Physiotherapy
Department	The Department of Health
Departments	The Health Departments
DH	Department of Health
DHSS	Department of Health and Social Services
DHSSPSNI	Department of Health, Social Services & Public Safety in Northern Ireland
ESR	Electronic Staff Record
FTE	Full-Time Equivalent
GDP	Gross Domestic Product
HCA	Healthcare Assistant
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
HPC	Health Professions Council
HSC	Health and Social Care
IC	NHS Information Centre
IDS	Incomes Data Services
IES	Institute for Employment Studies
ILO	International Labour Organisation
ISD	Information Services Division (ISD Scotland)
KSF	Knowledge and Skills Framework
MPC	Monetary Policy Committee
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
OBR	Office for Budget Responsibility
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
QIPP	Quality, Innovation, Productivity and Prevention
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RDEL	Resource Departmental Expenditure Limit
RPI	Retail Prices Index
RRP	Recruitment and Retention Premium
SGHD	The Scottish Government Health Directorates
SHA	Strategic Health Authority
SOC	Standard Occupational Classification
SoR	Society of Radiographers
ST&T	Scientific, Technical and Therapeutic
UCATT	Union of Construction, Allied Trades and Technicians
UK	United Kingdom
WAG	Welsh Assembly Government
WTE	Whole-Time Equivalent



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