NHS Pay Review Body - Market Facing Pay

Written Evidence from the Health Department for England – April 2012

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Executive summary

Market Facing Pay Remit

1. The Government has asked the NHS Pay Review Body (NHSPRB) to review how the pay of Agenda for Change (AfC) staff could be made more appropriate to local labour markets. This document sets out the DH's initial evidence to the NHS Pay Review Body (NHS PRB) to support that process.

2. In summary, the DH view is that there is a prima facie case for the introduction of more Market Facing Pay for AfC staff. NHS allocation processes and the tariffs for Payment by Results (PBR) that are used to fund most clinical services already take account of geographical variations of staffing costs. Current rates of pay in the NHS do vary geographically, but significantly less so than the pay of comparable staff in the private sector. The introduction of more sensitive Market Facing Pay would therefore enable more efficient and effective use of NHS funds.

3. Moreover, the DH believes that Market Facing Pay could be achieved fairly, simply, safely and effectively through modest changes to the existing AfC pay framework with the addition of a number of new High Cost Area Supplements (HCAS) zones (with the geography and value of these zones informed by staff Market Forces Factors (sMFFs)), whilst retaining the scope for existing employer flexibilities such as Recruitment and Retention Premia (RRPs) to deal with local and staff group specific issues.

4. The evidence and reasoning behind this view is set out in the rest of this document and summarised below.

The Case for Market Facing Pay

5. There is considerable geographical variation in pay in the private sector. This variation reflects cost of living differences across areas and differences in the attractiveness of these areas as places to work. Employers will often seek to attract and retain staff to high cost, or low amenity areas, by offering higher pay.

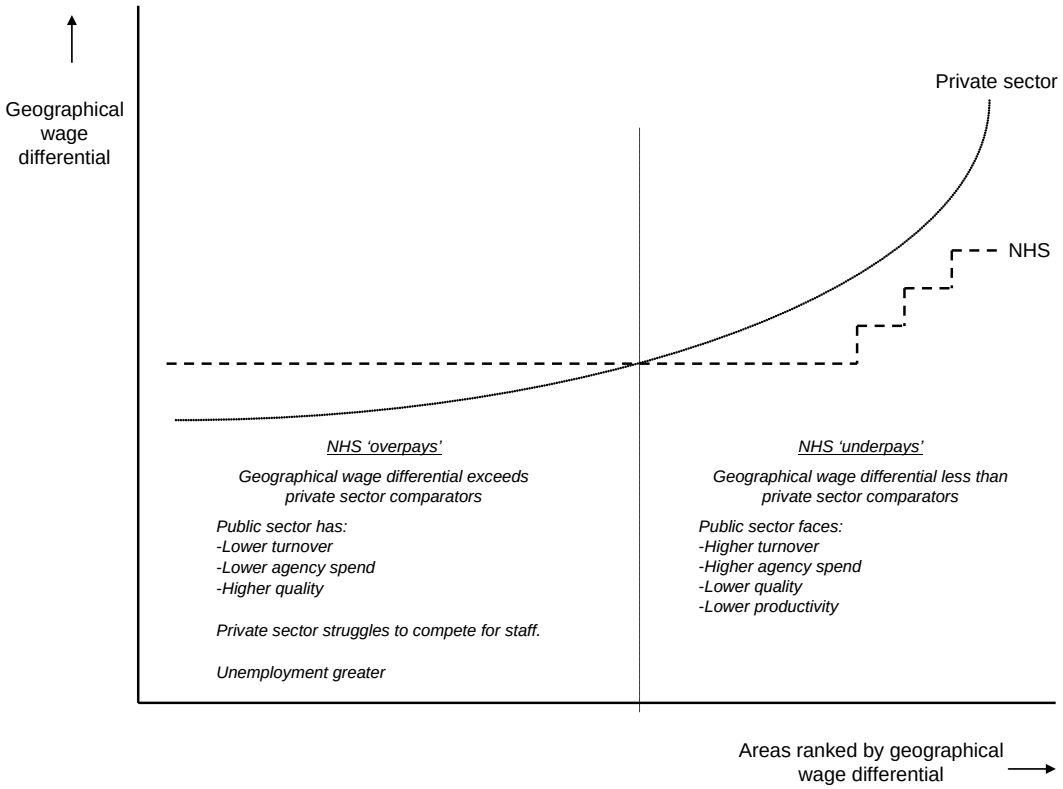
6. In the NHS, and the public sector more widely, there is much less geographical variation in pay than in the private sector. For some staff groups this is not justified by market conditions. This can have the following impacts:

    - In areas where the geographical pay differential the NHS offers is low, compared to the local market, it creates recruitment and retention difficulties that can manifest in higher agency spend, grade drift, higher turnover and recruitment costs, greater vacancies, lower productivity and lower quality.

- In areas where the geographical pay differential the NHS offers is high, compared to the local market, there are fewer such difficulties creating potential variations in quality.

- Furthermore, where the NHS pay premium is relatively high there is the potential for private sector enterprise to be crowded out with adverse impact on the prospects for local economic growth. Figure 1.1 illustrates this situation.

Figure 1.1: Stylised representation of the impact of national public sector pay structures



7. Improved alignment between the geographical variation in NHS pay and that of the private sector could help address these issues. Of course there are many questions about *how* Market Facing Pay could be implemented; these questions are addressed in the evidence and summarised below.

Should there be a centralised approach?

8. Within the AfC framework are a multitude of contractual mechanisms that could support either a decentralised or centralised approach to Market Facing Pay implementation or something in between. Neither extreme model appears to offer an ideal solution to the implementation of Market Facing Pay.

9. The DH believes that it would be unrealistic to expect a completely centralised system to reflect the infinite variety of local circumstances across multiple staff groups. Local issues are most appropriately dealt with through local flexibilities.

10. The DH therefore suggests giving consideration to retaining the existing scope for local pay flexibilities and supplementing these with the introduction of some form of additional centrally agreed geographical pay differentiation to reflect broad geographical issues.

11. This dual approach of utilising both additional centralised pay differentiation and supporting the use of local flexibilities would recognise the limits of centralised approaches while continuing to allow organisations to reflect the nuance of their local situation.

12. This approach is also consistent with the aspirations in the 2010 White Paper – Equity and Excellence, Liberating the NHS which set out the Government's view that pay decisions should be led by individual healthcare employers rather than imposed by the Government. The White Paper also noted that whilst in the future all NHS employers will have the rights, as FTs have now, to determine pay for their own staff , many providers are expected to continue to use national contracts as a basis for local terms and conditions.

13. The suggested approach to Market Facing Pay therefore seeks to retain local freedoms while delivering improvements to national frameworks so that they remain fit for purpose and attractive to FTs.

How should staff group specific issues be reflected?

14. Using central mechanisms to differentiate pay by staff groups that fall within the same AfC pay band is likely to fall foul of equal pay legislation.

15. Even if this were not the case, national evidence of staff group specific problems is relatively weak and is probably insufficient to match the complexity of the recruitment and retention patterns of different staff groups across the country.

16. The DH therefore recommends that staff group specific issues should be primarily addressed through the application of existing local flexibilities such as RRPs.

What Geographical Design Is Appropriate for Market Facing Pay Measures?

17. Nevertheless, the DH considers that current pay does not adequately reflect general (as opposed to staff group specific) geographical variations in recruitment and retention. The evidence considers a range of options to address this and argues that zonal pay or the introduction of additional payment 'hotspots' appear the most promising mechanisms to make pay more sensitive to local markets for AfC staff. In practice, these two models are likely to be very similar in application.

18. In deciding the number of zones or hotspots, there is an essential trade-off between precision and simplicity. The DH favours a measured approach, at least initially, and recommends that introduction of one, or perhaps two, additional zones of geographical pay differentiation. These could then be assessed and the evidence base on Market Facing Pay further developed to permit consideration of the case for introducing further additional zones in the future.

19. In addition, we will need to consider carefully the need for special arrangements for a number of potentially 'atypical roles', particularly in relation to the new national organisations that are being set up.

20. While the vast majority of Agenda for Change (AfC) posts fit within the Market Facing Pay arrangements proposed, a small minority of roles may not fit neatly into Market Facing Pay arrangements, where for example individuals are required to work across a number of different regions.

21. Leaders and other staff in some of the new national NHS organisations will be responsible for transforming delivery and will need to attract and retain high calibre leaders and staff with the right skills and experience.

22. Some new national organisations, for example, the National Trust Development Agency, Health Education England and the NHSCB, will not be finally established until April 2013. It will be important to ensure the recruitment and retention prospects in these organisations are not adversely affected. However, the structure and roles for these new national organisation are still under development and we cannot at this very early stage accurately predict or provide the evidence (as we have provided for other NHS organisations) on the precise nature of every role, some of which may be peripatetic.

23. We invite the NHS PRB to consider how we might best ensure that the future experience of recruitment and retention of AfC staff in these particular organisations, as part of any final recommendations.

How should the Value of Geographical Pay Differentials be set?

24. The DH already uses data on private sector geographical variation in pay across the country to inform the financial allocations received by NHS commissioners and also the tariff payments to providers. This is called the Staff Market Forces Factor (sMFF), described in more detail in Annex B. The sMFF data provides an

objectively justifiable indicator of the geographical pay differentiation to offset differences in cost of living and general amenities across areas. The DH therefore believes that sMFF data offers the best prospects for informing the value of geographical pay differentiation.

25. However, the DH considers that an untempered application of sMFF data in setting the value of geographical supplements would be inappropriate. The value of supplements should reflect the need to leave some resources for use at local employer discretion to address local issues. It should also reflect national and local affordability issues allowing for the costs of any basic pay award and any possibility of transitional arrangements.

26. The DH evidence does not make proposals on the specific long or short term values of new geographical pay adjustments in this initial evidence. These values will depend on the chosen zoning option (see Chapter 3C); national and local affordability issues; pace of change decisions; and the extent to which minimum and maximum values should be applied as they are for the existing London and Fringe HCAS zones. More work will be needed to consider the appropriate value for any new geographical supplements when there is greater certainty on these factors.

Which contractual mechanism should be used to pay geographical pay differentials?

27. Bearing in mind that any change to terms and conditions would be subject to national collective bargaining, and that employers and staff are content with the current principle of using RRPs and HCASs, the DH believes that the most simple, cost-effective and safe way to introduce more Market Facing Pay would be to:

    i. Retain national collective agreements.
    ii. Retain the flexibility for individual employers to use local RRPs to address local specific recruitment and retention issues.
    iii. Retain the ability for the NHS PRB to consider the need for national RRPs, noting that these are rarely if ever likely to be more appropriate than local RRPs.
    iv. Move towards a position where national AfC pay rates are set at the minimum level necessary to ensure adequate recruitment of sufficient high quality staff in geographical areas where the sMFF is relatively low.
    v. Extend the use of HCASs where required to enable employers in areas where the sMFF is higher to recruit and retain sufficient high quality staff in most staff groups, whilst leaving local employers sufficient resource flexibility to address specific recruitment and retention needs locally using local RRPs and non-pay incentives and rewards.

28. The DH believes that this approach would offer the most cost-effective and efficient use of NHS pay bill. It would also overcome the growing problem that employers in low sMFF areas are currently resourced to take account of cheaper local labour markets but are locked into relatively expensive national contracts

for NHS staff. Failure to address this anomaly risks forcing those employers to abandon national collective agreements as unaffordable or become uncompetitive with private sector providers in their areas.

What are the implementation and transition issues?

29. Care would need to be taken when implementing Market Facing Pay to manage the trade-offs of achieving greater geographical pay differentiation while:

- Maintaining national affordability;
- Maintaining local affordability and employer stability;
- Maintaining adequate recruitment and retention in all areas of the NHS;
- Delivering adequate earnings for all staff.
- Maintaining effective industrial relations.

30. The DH would therefore wish to engage closely with Trades Unions and NHS Employers through the NHS Staff Council to ensure that the introduction of Market Facing Pay took due account of national collective agreements, employment law and equality legislation. This would include the development of an appropriate impact assessment, including consideration of any equality impact.

31. Pace of change decisions would need careful consideration to balance a faster realisation of the benefits of Market Facing Pay, against the potential risks around affordability and recruitment and retention.

32. The DH envisages a key role for NHS PRB in helping manage these issues. The trade-offs could be managed in the context of a framework where basic pay awards are constrained to generate headroom for greater pay differentiation through HCAS payments. A balance would need to be struck between the basic pay awards necessary to deliver adequate earnings for all staff and protect the lower paid, and the levels required to maximise the funds available for HCASs to ensure sufficient geographical differentiation in pay to recognise local market factors.

33. The DH proposes managing this balance incrementally, year by year, at least in the first instance, to facilitate informing this with the emerging economic environment, new data and better intelligence from the introduction of Market Facing Pay to date.

34. The DH also recommends that the NHS PRB builds on the facilities within AfC to reflect Market Facing Pay more effectively, including the review of HCASs as a key element of the annual PRB process from April 2013. This would ensure that the national pay framework remains affordable and fit for purpose, and would be consistent with the Government's high-level aspiration to move towards greater Market Facing Pay in time for 2013/14.

35. As described in Annex B, sMFFs are already reflected in both the financial allocations received by NHS commissioners and also in the tariff income

received by providers. This financial distribution promotes financial equity across the NHS and is consistent with the underpinnings of Market Facing Pay. In the longer term, this puts the NHS in a strong position for implementing Market Facing Pay. The DH would therefore not wish to amend this allocation process which is well-founded academically and well understood by the NHS.

36. However, in the shorter term the introduction of Market Facing Pay may introduce challenges for some employers. Some organisations in the new HCAS zones may face additional paybill pressures from the payment of new HCASs, especially where they have previously invested in RRPs or non-pay alternatives to address local recruitment and retention difficulties. Absorbing the additional cost of a new HCAS may be challenging for them, depending on the value of the HCAS and wider financial circumstances.

37. From the point of view of facilitating local affordability and stability, this suggests a case for limiting the pace of change to a locally manageable level. If a faster transition is sought then the DH might need to consider whether any transitional measures to ease implementation issues were justified and affordable.

How can the system be maintained over time?

38. The maintenance of DH's preferred model for moving towards greater Market Facing Pay can be split into two areas:

    - Supporting a centralised HCAS system;
    - Supporting the use of employer flexibilities to address local issues.

39. The DH has therefore reviewed the data required to support these.

40. The data needed to support a centralised HCAS system is similar to that used in this evidence:
    - Affordability intelligence;
    - Geographical pay differentials for AfC staff.
    - Staff Market Forces Factors;
    - Detailed recruitment and retention indicators.

41. This information will be needed to manage the value of HCASs, headline pay awards and the size, shape and number of HCAS zones. The DH expects these issues to be a key element of NHSPRB rounds in the future and will seek to provide whatever evidence the NHS PRB requires.

42. The DH is also committed to consider how recruitment and retention indicators can be improved. The DH evidence therefore notes some specific data issues to be mindful of and to address for the future.

43. The same information described above will also be useful for employer level consideration of flexibilities to address local issues. However, they may also benefit from the following additional data items that are most useful when they can be interpreted with the aid of specific local contextual intelligence:

- Local labour market information such as unemployment rates;
- Local earnings data;
- Information on the pay and conditions offered by key competitors;
- Cost of living data.

44. Decisions on applying local flexibilities also benefit from wider intelligence, for example exit interviews may give some indication about whether there are any underlying recruitment and retention issues among particular pay groups, and whether these are related or might be solved by additional pay or some other form of incentive or reward, including non-pay recruitment tools.

45. The DH would welcome the NHSPRB's views on any central measures that might promote the prospects for local flexibilities without adding disproportionate administrative burdens upon the NHS.

46. Overall, however, the DH considers that the evidence already available is more than sufficient to enable the introduction of Market Facing Pay.

Chapter 1

Introduction & Background

Market Facing Pay Remit

1.1 In the Autumn Statement, the Chancellor announced that the Government would ask selected independent Pay Review Bodies to consider how public sector pay could be made more responsive to local labour markets.

1.2 The Chancellor subsequently announced that within the NHS, the Government would ask the NHSPRB to consider this for AfC staff and the SSRB to consider it for Very Senior Managers.

1.3 The Chancellor wrote to the Chair of the NHSPRB on 7 December 2011 confirming that the Government believes there is a clear case for Market Facing Pay and asking the NHSPRB to consider how to make pay more market-facing in local areas for NHS AfC staff.

1.4 In taking forward this remit he asked the Review Body to take into account:

- the need to recruit, retain and motivate suitably able and qualified staff across the UK;
- the difference in total reward between the NHS workforce and those of similar skills working in the private sector by location – and the impact of these differences on local labour markets;
- how private sector employers determine wages for staff in different areas of the country;
- what the most appropriate areas or zones by which to differentiate pay levels should be;
- the affordability of any proposals in light of the fiscal position – these should not lead to any increase in the paybill in the short or long-term;
- the need to ensure that proposals are consistent with law on equal pay;
- whether and how the new approach could be delivered within national pay frameworks; and
- whether proposals should apply to existing staff, or just to new entrants.

1.5 The Secretary of State for Health wrote to the NHSPRB Chair on 23 December 2011. In addition to the Chancellor's remit, he asked the PRB to take account of:

- the extent to which AfC already recognises the impact of local differences in pay through recruitment and retention premia and HCASs and whether these could be used more effectively;
- the way in which the Department uses the Market Forces Factor (MFF) to reflect local labour market costs in PCT allocations and whether these might be used (or amended) to support more Market Facing Pay;

- the need to recognise the implications of Market Facing Pay for the different staff groups within AfC at a local level, including any implications for equal pay;
- the impact of any “cliff edges” in pay between different local labour markets and how these might be managed;
- what information might be needed in the future to make recommendations on local labour markets; and,
- the need to submit initial findings to Ministers by 17 July 2012 so that they can implement agreed recommendations in time for the 2013/14 pay review cycle.

1.6 This remit applies to the NHS AfC workforce in England only. As far as we are aware, other UK Health Departments in the Devolved Administrations have not provided a remit on Market Facing Pay to the NHSPRB or the SSRB.

1.7 This document provides evidence on behalf of the Government for the NHS in England. It addresses the case for Market Facing Pay, presenting material relating to both the NHS specifically and the wider economic case. It then considers how a model for delivering greater Market Facing Pay for the NHS could be designed. Finally, it considers the implementation and transitional issues involved in introducing any new system before considering how such a system could be maintained over time. It is organised into chapters as follows:

- Executive Summary
- Chapter 1 - Introduction & Background
- Chapter 2 - The Case for Market Facing Pay
- Chapter 3 – Designing the Model for Market Facing Pay:
    - 3A – How Centralised or Decentralised should the Approach to Market Facing Pay be?
    - 3B - How should Market Facing Pay measures apply across different staff groups?
    - 3C – What geographical design is appropriate for Market Facing Pay measures?
    - 3D – How should the value of geographical pay differentials be set?
    - 3E – Which contractual mechanism should be used to pay geographical pay differentials?
- Chapter 4 - Implementation and Transition Issues
- Chapter 5 – Maintaining the System over Time
- Annexes A to G

CHAPTER 2

THE CASE FOR MARKET FACING PAY

2.1 The Government has asked the NHS Pay Review Body (NHSPRB) to review how the pay of AfC staff could be made more appropriate to local labour markets. This chapter outlines the underlying rationale behind 'Market Facing Pay' before the rest of the evidence focuses on issues of implementation.

2.2 There is considerable geographical variation in pay in the private sector. This variation reflects cost of living differences across areas and differences in the attractiveness of these areas as places to work. Employers attract and retain staff to high cost, or low amenity areas, by offering higher pay.

2.3 In the NHS, and the public sector more widely, there is much less geographical variation in pay than in the private sector. For some staff groups this is not justified by market conditions. This can have the following impacts:

- In areas where the geographical pay differential the NHS offers is low, compared to the local market, it creates recruitment and retention difficulties that can manifest in higher agency spend, grade drift, higher turnover and recruitment costs, greater vacancies, lower productivity and lower quality.

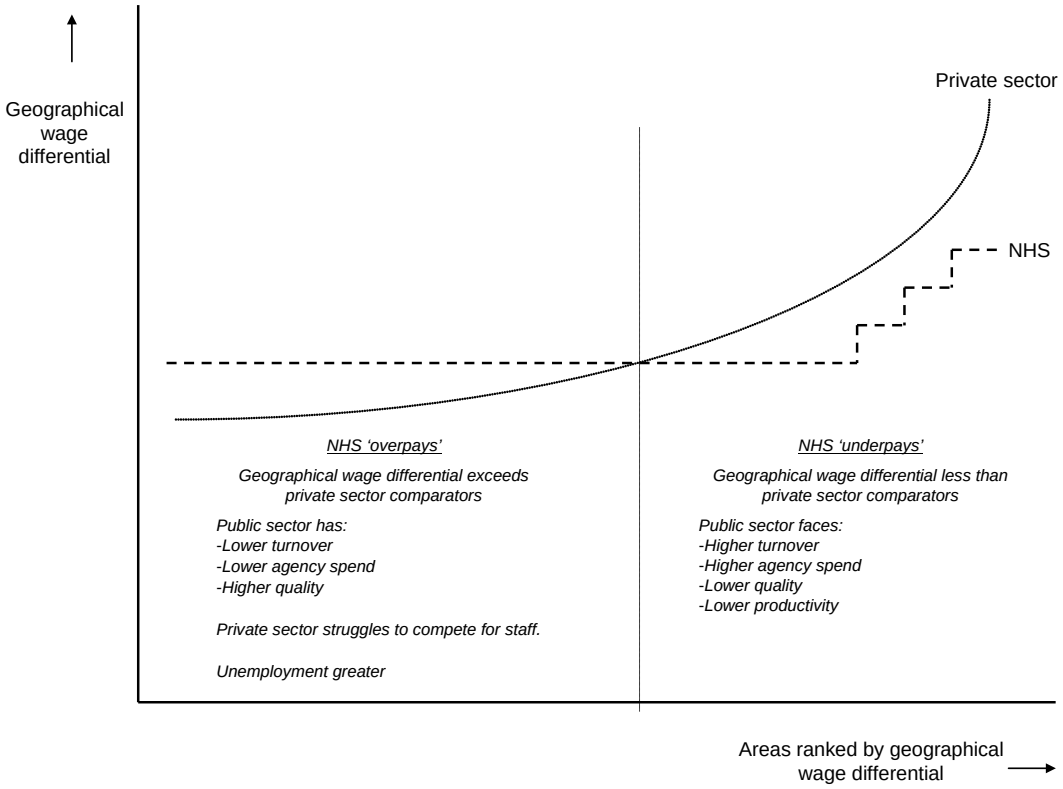
- In areas where the geographical pay differential the NHS offers is high, compared to the local market, there are fewer such difficulties creating potential variations in quality.

- Furthermore, where the NHS pay premium is relatively high there is the potential for private sector enterprise to be crowded out and economic growth hampered. HMT have separately submitted evidence on the overall economic case for Market Facing Pay.

2.4 Figure 2.1 illustrates this situation.

2.5 A greater alignment between the geographical variation in NHS pay and that of the private sector could help address these issues. Of course there are many questions about *how* Market Facing Pay could be implemented; these questions are addressed later in the evidence.

Figure 2.1: Stylised representation of the impact of national public sector pay structures



External Evidence

2.6 There is considerable external evidence supporting the case for Market Facing Pay. Annex C summarises a literature review of external research relevant to this area.

2.7 There is a body of work investigating the impact of geographical pay differentiation in the NHS compared to the private sector, focussed particularly on pay for doctors and nurses. This suggests that there is greater differentiation in the private sector.

2.8 For nurses, the research finds a link between the gap among NHS and private sector geographical differentials and recruitment and retention indicators such as turnover rates, vacancy rates and the use of agency staff. In particular, those areas in the NHS with lower geographical pay differentials than the private sector, tend to have greater recruitment and retention problems.

2.9 By contrast, areas in the NHS where the private sector offers lower geographical pay differentials than NHS national payscales tend to have more stable workforces and lower reliance on agency staff.

2.10 Some studies then take this further and consider the knock-on impacts on productivity and quality indicators. There are also external papers which warn about the potential consequences on private sector enterprise in areas where the public sector offers excessive geographical pay differentials.

2.11 Overall, the external evidence appears to support a prima facie case for greater geographical pay differentiation for non-medical staff.

Detailed DH Analysis

Geographical variation in NHS pay

2.12 Recent data suggests a lack of geographical variation in NHS pay compared to private sector comparators.

2.13 Annex D contains estimates, made using ESR data, of the variation in non-medical total earnings per FTE across SHAs in 2010/11. Aggregate SHA level comparisons will be skewed by staff group mix so estimates by staff groups are also provided. However, cross-SHA differences in working patterns, such as the prevalence of overtime, and skill mix within staff groups may also confound comparisons.

2.14 Annex D contains analogous estimates, made using ESR data, of variations in non-medical basic earnings across SHAs in 2010/11. This eliminates the role of working patterns, but the impact of skill mix differences within staff groups remains.

2.15 Better indicators of earnings differences that cannot be tied to staff group, skill mix, experience mix or working pattern differences may be found in the distribution of High Cost Area Supplements (HCASs) and Recruitment and Retention Premia (RRP) payments as a share of basic pay. These effectively control for many of the factors that may confound cross-SHA earnings comparisons. Tables 2.1 and 2.2 present these indicators across SHAs for 2010/11.

Table 2.1: 2010/11 Estimated Recruitment and Retention Premia Payments as a Proportion of Basic Pay by SHA and Non-Medical Staff Group

	2010/11 Estimated Total RRPs as % of Basic Earnings									
Staff Group	North East **Q30**	North West **Q31**	Yorkshire & the Humber **Q32**	East Midlands **Q33**	West Midlands **Q34**	East of England **Q35**	London **Q36**	South East Coast **Q37**	South Central **Q38**	South West **Q39**
Qualified Nursing	0.1%	0.0%	0.0%	0.2%	0.1%	0.5%	0.1%	0.9%	0.7%	0.6%
Unqualified Nursing, HCAs and Support	0.1%	0.1%	0.0%	0.0%	0.1%	0.2%	0.3%	0.2%	0.2%	0.1%
Qualified AHPs	0.0%	0.0%	0.0%	0.2%	0.0%	0.4%	0.1%	0.7%	0.5%	0.5%
Qualified Other ST&Ts	0.1%	0.1%	0.1%	0.2%	0.1%	0.2%	0.2%	0.5%	0.5%	0.2%
Unqualified AHPs	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%	0.0%
Unqualified Other ST&Ts	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.2%	0.0%	0.1%
Admin & Clerical	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%
Maintenance & Works	4.9%	6.1%	6.1%	6.5%	7.2%	6.4%	7.3%	6.2%	7.7%	8.1%
Qualified Ambulance Staff	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.2%	0.0%	0.0%
Unqualified Ambulance Staff	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Managers	0.0%	0.1%	0.2%	0.3%	0.1%	0.2%	0.2%	0.2%	0.2%	0.2%
Aggregate	**0.1%**	**0.1%**	**0.1%**	**0.2%**	**0.1%**	**0.4%**	**0.2%**	**0.6%**	**0.5%**	**0.4%**

Notes:

- Uses the 10 SHA classification rather than the new 4 SHA cluster classification.
- Based on Electronic Staff Record - Data Warehouse (ESR-DW) extracts after the application of data cleaning filters.
- Presentation excludes Special Health Authorities.

Table 2.2: 2010/11 Estimated High Cost Area Supplement Payments as a Proportion of Basic Pay by SHA and Non-Medical Staff Group

Staff Group	2010/11 Estimated HCAS Payments as % of Basic Earnings									
	North East Q30	North West Q31	Yorkshire & the Humber Q32	East Midlands Q33	West Midlands Q34	East of England Q35	London Q36	South East Coast Q37	South Central Q38	South West Q39
Qualified Nursing	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	15.7%	1.4%	0.7%	0.0%
Unqualified Nursing, HCAs and Support	0.0%	0.0%	0.0%	0.0%	0.0%	1.4%	21.6%	2.0%	0.5%	0.0%
Qualified AHPs	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	15.0%	1.2%	0.6%	0.0%
Qualified Other ST&Ts	0.0%	0.0%	0.0%	0.0%	0.0%	1.1%	14.1%	1.2%	0.3%	0.0%
Unqualified AHPs	0.0%	0.0%	0.0%	0.0%	0.0%	1.4%	20.7%	1.5%	0.8%	0.0%
Unqualified Other ST&Ts	0.0%	0.0%	0.0%	0.0%	0.0%	1.1%	21.2%	1.5%	0.4%	0.0%
Admin & Clerical	0.0%	0.0%	0.0%	0.0%	0.0%	1.3%	17.7%	1.5%	0.5%	0.0%
Maintenance & Works	0.0%	0.0%	0.0%	0.0%	0.0%	1.3%	19.3%	1.3%	0.3%	0.0%
Qualified Ambulance Staff	0.0%	0.0%	0.0%	0.0%	0.3%	1.3%	16.4%	1.7%	0.5%	0.0%
Unqualified Ambulance Staff	0.0%	0.0%	0.0%	0.0%	0.1%	0.9%	20.9%	2.5%	0.6%	0.0%
Managers	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	8.7%	1.0%	0.4%	0.0%
Total	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**1.2%**	**15.9%**	**1.4%**	**0.6%**	**0.0%**

Notes:
- Uses the 10 SHA classification rather than the new 4 SHA cluster classification.
- Based on Electronic Staff Record - Data Warehouse (ESR-DW) extracts after the application of data cleaning filters.
- Presentation excludes Special Health Authorities.

2.16 Tables 2.1 and 2.2, above, show typically low average RRP payments as a share of basic pay, but with a skew towards the South East excluding London which benefits from higher, average HCAS payments.

2.17 This skew may have stemmed from when the Cost of Living Supplements (COLS) were re-expressed as long-term Recruitment and Retention premia payments for areas outside London and the Fringe zones with the introduction of AfC terms and conditions in 2004.

2.18 Table 2.3 presents the same information against staff Market Forces Factor (sMFF) data by SHA to give an indication of NHS geographical pay variation against private sector comparators. sMFFs provide an objectively justifiable indicator of the geographical variation in pay that would offset differences in cost of living and general amenities across areas. A score of 1 indicates average staff costs, 1.1 indicates staff costs 10% higher than average, 0.9 indicates staff costs 10% lower than average and so on. More details on the basis of the sMFF and its role in NHS finances are provided in Annex B.

2.19 To facilitate comparison between sMFF data and HCAS / RRP payments as a share of basic pay, the latter are converted into equivalent indices and combined into an overall index. The overall index can be compared to sMFF values. The table shows that whilst SHA level sMFFs range from 0.92 to 1.18 (a 0.26 range), the index measuring the impact of HCASs / RRPs only ranges from 0.97 to 1.13 (a 0.16 range). This indicates that there is significantly less variation in pay between different geographical SHA areas than there is in relevant private sector comparators[1].

[1] Note: The HCAS / RRP indices assign a value of 1 to the average HCAS / RRP payments as a share of basic pay. Other index values are generated in relation to this to produce a measure of geographical pay variation compared to a national average.

Table 2.3: SHA Level Staff MFF Data and 2010/11 Indications of Geographical Pay Differentiation

SHA Code	SHA	Staff MFF Index	Estimated Average HCAS Payments Relative to Basic Pay		Estimated Average RRP Payments Relative to Basic Pay		Estimated Sum of Average HCAS Payments & Average RRP Payments Relative to Basic Pay	
			as %	as an index	*as %*	as an index	*as %*	as an index
Q30	North East	0.92	*0.0%*	0.97	*0.1%*	1.00	*0.1%*	0.97
Q32	Yorkshire & the Humber	0.93	*0.0%*	0.97	*0.1%*	1.00	*0.1%*	0.97
Q34	West Midlands	0.94	*0.0%*	0.97	*0.1%*	1.00	*0.1%*	0.97
Q33	East Midlands	0.94	*0.0%*	0.97	*0.2%*	1.00	*0.2%*	0.97
Q31	North West	0.94	*0.0%*	0.97	*0.1%*	1.00	*0.1%*	0.97
Q39	South West	0.95	*0.0%*	0.97	*0.4%*	1.00	*0.4%*	0.97
Q35	East of England	1.01	*1.2%*	0.98	*0.4%*	1.00	*1.5%*	0.98
Q37	South East Coast	1.05	*1.4%*	0.99	*0.6%*	1.00	*2.0%*	0.99
Q38	South Central	1.06	*0.6%*	0.98	*0.5%*	1.00	*1.0%*	0.98
Q36	London	1.18	*15.9%*	1.13	*0.2%*	1.00	*16.1%*	1.13
	Average	1.00	*2.9%*	1.00	*0.2%*	1.00	*3.1%*	1.00
	Minimum	0.92	*0.0%*	0.97	*0.1%*	0.999	*0.1%*	0.97
	Maximum	1.18	*15.9%*	1.13	*0.6%*	1.003	*16.1%*	1.13
	Range	0.26	*15.9%*	0.15	*0.5%*	0.005	*16.0%*	0.15

Notes:

- Uses the 10 SHA classification rather than the new 4 SHA cluster classification.
- SHAs ordered by staff MFF index.
- Staff MFF data produced by the Health Economics Research Unit (HERU) in 2010 using ASHE earnings data from 2007 to 2009.
- Estimated average HCAS and RRP payments as a proportion of basic payment relate to 2010/11 Electronic Staff Record - Data Warehouse extracts after the application of data cleaning filters.
- Presentation excludes Special Health Authorities.

The link between geographical pay differentiation and recruitment and retention indicators

2.20 Given the relatively modest geographical variation in non-medical pay indicated above, the external research in support of Market Facing Pay would suggest there will be a link between local recruitment and retention indicators and geographical pay patterns.

2.21 The overall index of geographical pay variation, calculated by the DH in Table 2.3 above, can be compared to sMFF values to produce a measure of the geographical pay variation gap. For example, an area with a sMFF of 1.1 and a geographical pay variation index of 1.05 should have 10% higher pay according to the sMFF methodology, but will only actually pay 5% more. This area would then have a geographical pay variation gap of -0.05 i.e. minus 5%. This is similar to the standardised spatial wage differential gaps often calculated in the external research.

2.22 Organisations in areas with negative geographical wage variation gaps would be offering geographical wage differentials less than private sector comparators ('underpaying'). Organisations in areas with positive geographical wage variation gaps would be offering geographical wage differentials greater than private sector comparators ('overpaying').

2.23 The external research suggests there would therefore be a negative relationship between geographical pay variation gaps and recruitment and retention indicators. Lower or negative geographical pay variation gaps would be associated with better recruitment and retention and vice versa. The available evidence for the NHS supports this expectation for non-medical staff.

2.24 Table 2.4 presents correlation coefficients between organisation level geographical pay variation gaps (based on September 2010 ESR data) and recruitment and retention indicators.

Table 2.4: Organisation Level Correlations Between Geographical Pay Variation Gaps and Recruitment and Retention Indicators

	Correlation Coefficient with Non-Medical Geographical Pay Variation Gap
All Staff Leaving Rate	-0.30
Qualified Nursing Leaving Rate	-0.21
Share of wage bill on agency	-0.38
Non-Medical 3 Month Vacancy Rate	-0.26
Qualified Nurse 3 Month Vacancy Rate	-0.32
Qualified AHP 3 Month Vacancy Rate	-0.15
Qualified HCS 3 Month Vacancy Rate	-0.23
Qualified other ST&T 3 Month Vacancy Rate	-0.11
Unqualified ST&T 3 Month Vacancy Rate	-0.11
Health Care Assistants 3 Month Vacancy Rate	-0.12
Admin & Clerical and Managers 3 Month Vacancy Rate	-0.15
All Ambulance Staff 3 Month Vacancy Rate	-0.52

Notes:

- Non-medical geographical pay variation gap calculated by deducting the staff Market Forces Factor Index from the DH measure of non-medical geographical pay variation index.
- Staff MFF data produced by the Health Economics Research Unit (HERU) in 2010 using ASHE earnings data from 2007 to 2009.
- DH measure of geographical pay variation estimated from September 2010 Electronic Staff Record - Data Warehouse information, after the application of data cleaning filters. It looks at High Cost Area Supplement and Recruitment and Retention Premia Payments as a proportion of Basic Pay and converts this into an index in relation to the national average.
- Leaving rates taken from the quarterly supplement to the NHS Information Centre's monthly workforce statistics publication and refer to leavers from the NHS between July 2010 and July 2011.
- Share of wage bill on agency estimated using Electronic Staff Record - Data Warehouse extracts and data on agency spend from Monitor and Trust and PCT financial returns. It refers to 2010/11.
- Three month vacancy rates taken from NHS Information Centre's last vacancy rate publication and refer to March 2010.
- Some organisations are excluded from specific correlation analyses due to a lack of data availability.
- The recruitment and retention indicators of SHAs are considered unrepresentative of NHS organisations and excluded from the analysis.

2.25 The correlations in the Table 2.4 above tend to be negative, which suggests a case for Market Facing Pay, but are typically modest. However, this is effectively only a univariate analysis considering only the role of pay. Pay is only one factor influencing recruitment and retention. Non-pay issues and specific local circumstances also play a role. In this context, strong correlations at organisation level would be unexpected.

2.26 Table 2.5 presents equivalent correlation coefficients with the data aggregated at PCT level. The organisation level correlations are presented alongside for each of comparison. The correlations are often slightly stronger at PCT level.

Table 2.5: PCT and Organisation Level Correlations Between Geographical Pay Variation Gaps and Recruitment and Retention Indicators

	Correlation Coefficient with Non-Medical Geographical Pay Variation Gap	
	PCT Level	Organisation Level
All Staff Leaving Rate	-0.37	-0.30
Qualified Nursing Leaving Rate	-0.29	-0.21
Share of wage bill on agency	-0.53	-0.38
Non-Medical 3 Month Vacancy Rate	-0.39	-0.26
Qualified Nurse 3 Month Vacancy Rate	-0.45	-0.32
Qualified AHP 3 Month Vacancy Rate	-0.26	-0.15
Qualified HCS 3 Month Vacancy Rate	-0.23	-0.23
Qualified other ST&T 3 Month Vacancy Rate	-0.13	-0.11
Unqualified ST&T 3 Month Vacancy Rate	-0.08	-0.11
Health Care Assistants 3 Month Vacancy Rate	-0.13	-0.12
Admin & Clerical and Managers 3 Month Vacancy Rate	-0.20	-0.15
All Ambulance Staff 3 Month Vacancy Rate	-0.12	-0.52

Notes:

- Non-medical geographical pay variation gap calculated by deducting the staff Market Forces Factor Index from the DH measure of non-medical geographical pay variation index.
- Staff MFF data produced by the Health Economics Research Unit (HERU) in 2010 using ASHE earnings data from 2007 to 2009.
- DH measure of geographical pay variation estimated from September 2010 Electronic Staff Record - Data Warehouse information, after the application of data cleaning filters. It looks at High Cost Area Supplement and Recruitment and Retention Premia Payments as a proportion of Basic Pay and converts this into an index in relation to the national average.
- Leaving rates taken from the quarterly supplement to the NHS Information Centre's monthly workforce statistics publication and refer to leavers from the NHS between July 2010 and July 2011.
- Share of wage bill on agency estimated using Electronic Staff Record - Data Warehouse extracts and data on agency spend from Monitor and Trust and PCT financial returns. It refers to 2010/11.
- Three month vacancy rates taken from NHS Information Centre's last vacancy rate publication and refer to March 2010.
- PCT level aggregates are unweighted averages for the constituent organisations.
- Some organisations are excluded from specific correlation analyses due to a lack of data availability.
- The recruitment and retention indicators of SHAs are considered unrepresentative of NHS organisations and excluded from the analysis.

2.27 The underlying impact of geographical pay variation gaps on recruitment and retention become much clearer when considered at a less granular level such as by SHA or by geographical pay variation gap quintile. This level of aggregation helps drown out the noise of non-pay and local factors and shows more clearly the broad role of pay variation.

2.28 Table 2.6 presents recruitment and retention indicators averaged by geographical pay variation gap quintiles. Table 2.7 presents recruitment and retention indicators and geographical pay variation gaps by SHA. These tables show a clearer relationship between more negative geographical pay variation gaps and recruitment and retention problems and vice versa.

Table 2.6: Recruitment and Retention Indicators by Geographical Pay Variation Gap Quintiles

	Average by Geographical Pay Variation Gap Quintile 1=most 'underpayed', 5=most 'overpayed'				
	1	**2**	**3**	**4**	**5**
All Staff Leaving Rate	14.5%	9.4%	9.6%	8.8%	8.7%
Qualified Nursing Leaving Rate	13.6%	10.6%	10.1%	8.5%	8.4%
Share of wage bill on agency	8.4%	6.0%	4.3%	3.9%	3.5%
Non-Medical 3 Month Vacancy Rate	1.0%	0.4%	0.3%	0.2%	0.2%
Qualified Nurse 3 Month Vacancy Rate	1.4%	0.7%	0.4%	0.2%	0.2%
Qualified AHP 3 Month Vacancy Rate	1.1%	0.5%	0.4%	0.5%	0.2%
Qualified HCS 3 Month Vacancy Rate	0.3%	0.5%	0.1%	0.1%	0.1%
Qualified other ST&T 3 Month Vacancy Rate	0.8%	0.6%	0.9%	0.1%	0.3%
Unqualified ST&T 3 Month Vacancy Rate	0.9%	0.2%	0.3%	0.0%	0.0%
Health Care Assistants 3 Month Vacancy Rate	0.5%	0.3%	0.1%	0.2%	0.1%
Admin & Clerical and Managers 3 Month Vacancy Rate	0.7%	0.1%	0.2%	0.1%	0.1%
All Ambulance Staff 3 Month Vacancy Rate	0.0%	0.0%	0.0%	0.0%	0.0%

Notes:

- Non-medical geographical pay variation gap calculated by deducting the staff Market Forces Factor Index from the DH measure of non-medical geographical pay variation index.
- Staff MFF data produced by the Health Economics Research Unit (HERU) in 2010 using ASHE earnings data from 2007 to 2009.
- DH measure of geographical pay variation estimated from September 2010 Electronic Staff Record - Data Warehouse information, after the application of data cleaning filters. It looks at High Cost Area Supplement and Recruitment and Retention Premia Payments as a proportion of Basic Pay and converts this into an index in relation to the national average.
- Leaving rates taken from the quarterly supplement to the NHS Information Centre's monthly workforce statistics publication and refer to leavers from the NHS between July 2010 and July 2011.
- Share of wage bill on agency estimated using Electronic Staff Record - Data Warehouse extracts and data on agency spend from Monitor and Trust and PCT financial returns. It refers to 2010/11.
- Three month vacancy rates taken from NHS Information Centre's last vacancy rate publication and refer to March 2010.
- Quintile aggregates are unweighted averages for the constituent organisations.
- Some organisations are excluded from specific correlation analyses due to a lack of data availability.
- The recruitment and retention indicators of SHAs are considered unrepresentative of NHS organisations and excluded from the analysis.

Table 2.7: Estimated Pay Differentials and Recruitment and Retention Indicators by SHAs

	SHA									
	North East Q30	Yorkshire & the Humber Q32	East Midlands Q33	West Midlands Q34	North West Q31	South West Q39	East of England Q35	London Q36	South East Coast Q37	South Central Q38
sMFF Allocation Score	0.92	0.93	0.94	0.94	0.94	0.95	1.01	1.18	1.05	1.06
DH Measure of Geographical Pay Variation	0.97	0.97	0.97	0.97	0.97	0.97	0.98	1.13	0.99	0.98
DH Measure of Gap in Geographical Pay Variation	0.05	0.04	0.03	0.03	0.03	0.02	- 0.03	- 0.05	- 0.06	- 0.08
All Staff Leaving Rate	9.2%	9.3%	10.9%	8.7%	8.6%	9.6%	9.3%	14.6%	10.0%	10.9%
Qualified Nursing Leaving Rate	5.9%	8.4%	11.1%	8.9%	8.9%	12.5%	10.6%	12.9%	9.1%	11.4%
Share of wage bill on agency	3.2%	3.4%	4.0%	5.0%	3.6%	3.1%	6.3%	9.7%	4.8%	4.9%
Non-Medical 3 Month Vacancy Rate	0.0%	0.4%	0.3%	0.2%	0.3%	0.1%	0.3%	1.0%	0.5%	0.8%
Qualified Nurse 3 Month Vacancy Rate	0.0%	0.4%	0.3%	0.3%	0.3%	0.1%	0.5%	1.5%	0.6%	1.2%
Qualified AHP 3 Month Vacancy Rate	0.0%	0.5%	0.2%	0.2%	0.8%	0.1%	0.4%	1.2%	0.5%	0.6%
Qualified HCS 3 Month Vacancy Rate	0.0%	0.1%	0.0%	0.2%	0.1%	0.0%	0.3%	0.4%	0.5%	0.3%
Qualified other ST&T 3 Month Vacancy Rate	0.0%	0.4%	0.5%	0.2%	0.8%	0.0%	1.0%	0.7%	0.8%	0.7%
Unqualified ST&T 3 Month Vacancy Rate	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	1.2%	0.0%	0.0%
Health Care Assistants 3 Month Vacancy Rate	0.0%	0.4%	0.1%	0.2%	0.1%	0.2%	0.0%	0.5%	0.5%	0.2%
Admin & Clerical and Managers 3 Month Vacancy Rate	0.0%	0.2%	0.1%	0.1%	0.2%	0.1%	0.0%	0.7%	0.2%	0.4%
All Ambulance Staff 3 Month Vacancy Rate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Notes:

- Uses the 10 SHA classification rather than the new 4 SHA cluster classification.
- SHAs ordered by non-medical geographical pay variation gap.
- Non-medical geographical pay variation gap calculated by deducting the staff Market Forces Factor Index from the DH measure of non-medical geographical pay variation index.
- Staff MFF data produced by the Health Economics Research Unit (HERU) in 2010 using ASHE earnings data from 2007 to 2009.
- DH measure of geographical pay variation estimated from 2010/11 Electronic Staff Record - Data Warehouse information, after the application of data cleaning filters. It looks at High Cost Area Supplement and Recruitment and Retention Premia Payments as a proportion of Basic Pay and converts this into an index in relation to the national average. The figures in this table are calculated at SHA level.
- Leaving rates taken from the quarterly supplement to the NHS Information Centre's monthly workforce statistics publication and refer to leavers from the NHS between July 2010 and July 2011.
- Share of wage bill on agency estimated using Electronic Staff Record - Data Warehouse extracts and data on agency spend from Monitor and Trust and PCT financial returns. It refers to 2010/11.
- Three month vacancy rates taken from NHS Information Centre's last vacancy rate publication and refer to March 2010.
- SHA level aggregate of the recruitment and retention indicators are unweighted averages for the constituent organisations.
- Some organisations are excluded from specific correlation analyses due to a lack of data availability.
- SHAs are considered unrepresentative of NHS organisations and excluded from the analysis.

2.29 Table 2.8 shows correlation coefficients between recruitment and retention indicators and geographical pay variation gaps at an SHA level. This suggests a correlation supporting the case for Market Facing Pay. This is wider than a London effect as the correlations seem to remain even when London is excluded from the analysis. However, it should be noted that the correlations are weaker when calculated separately for SHAs with a positive geographical pay variation gap (those outside London and the South East) and for those with a negative geographical pay variation gap[2].

[2] Note: Organisations in areas with negative geographical wage variation gaps would be offering geographical wage differentials less than private sector comparators ('underpaying'). Organisations in areas with positive geographical wage variation gaps would be offering geographical wage differentials greater than private sector comparators ('overpaying').

Table 2.8: SHA Level Correlations Between Geographical Pay Variation Gap and Recruitment and Retention Indicators

	Correlation between Geographical Pay Variation Gap and R&R Indicator Avg			
	All SHAs	Excl London	Positive Geog Pay Gap SHAs	Negative Geog Pay Gap SHAs
All Staff Leaving Rate	-0.49	-0.40	0.28	-0.15
Qualified Nursing Leaving Rate	-0.51	-0.40	-0.76	-0.07
Share of wage bill on agency	-0.61	-0.64	-0.12	0.37
Non-Medical 3 Month Vacancy Rate	-0.81	-0.84	-0.27	-0.56
Qualified Nurse 3 Month Vacancy Rate	-0.83	-0.87	-0.19	-0.51
Qualified AHP 3 Month Vacancy Rate	-0.57	-0.48	-0.35	-0.13
Qualified HCS 3 Month Vacancy Rate	-0.90	-0.88	-0.12	-0.12
Qualified other ST&T 3 Month Vacancy Rate	-0.67	-0.64	-0.36	0.92
Unqualified ST&T 3 Month Vacancy Rate	-0.30	0.16	-0.42	0.11
Health Care Assistants 3 Month Vacancy Rate	-0.45	-0.33	0.04	-0.34
Admin & Clerical and Managers 3 Month Vacancy Rate	-0.64	-0.62	-0.37	-0.49
All Ambulance Staff 3 Month Vacancy Rate	-0.57	-0.71	-0.08	-0.91

Notes:

- Uses the 10 SHA classification rather than the new 4 SHA cluster classification.
- SHAs ordered by non-medical geographical pay variation gap.
- Non-medical geographical pay variation gap calculated by deducting the staff Market Forces Factor Index from the DH measure of non-medical geographical pay variation index.
- Staff MFF data produced by the Health Economics Research Unit (HERU) in 2010 using ASHE earnings data from 2007 to 2009.
- DH measure of geographical pay variation estimated from 2010/11 Electronic Staff Record - Data Warehouse information, after the application of data cleaning filters. It looks at High Cost Area Supplement and Recruitment and Retention Premia Payments as a proportion of Basic Pay and converts this into an index in relation to the national average. The figures in this table are calculated at SHA level.
- Leaving rates taken from the quarterly supplement to the NHS Information Centre's monthly workforce statistics publication and refer to leavers from the NHS between July 2010 and July 2011.
- Share of wage bill on agency estimated using Electronic Staff Record - Data Warehouse extracts and data on agency spend from Monitor and Trust and PCT financial returns. It refers to 2010/11.
- Three month vacancy rates taken from NHS Information Centre's last vacancy rate publication and refer to March 2010.
- SHA level aggregate of the recruitment and retention indicators are unweighted averages for the constituent organisations.
- Some organisations are excluded from specific correlation analyses due to a lack of data availability.
- SHAs are considered unrepresentative of NHS organisations and excluded from the analysis.

Implications

2.30 The analysis above suggests that a greater alignment between geographical pay differentiation for AfC staff and that for private sector comparators, as indicated by the sMFF, could possibly improve recruitment and retention in high sMFF areas.

2.31 In addition, reducing excessive geographical pay differentials in low sMFF areas should increase the resources available for other types of spend (for example additional staff), but might cause recruitment and retention issues to worsen towards the national average in low sMFF areas.

2.32 The rest of the evidence focuses on how greater pay differentiation may be achieved.

Conclusion

2.33 The private sector appears to use significant geographical pay differentiation to compensate for differences in cost of living and amenities when attracting staff

across the country. These variations are not reflected in the arrangements for AfC which are comparatively flat across the country.

2.34 External evidence as well as DH analysis suggests a link between the geographical pay variation and recruitment and retention issues. The evidence suggests that areas with insufficient geographical pay differentials, compared to the private sector as indicated by the sMFF, are more likely to have greater recruitment and retention issues and vice versa.

2.35 Introducing greater geographical pay variation could therefore help make better use of NHS resources and help address NHS recruitment and retention issues.

2.36 HMT have separately submitted evidence on the overall economic case for Market Facing Pay.

2.37 The rest of the evidence addresses how greater geographical pay variation may be achieved.

CHAPTER 3

DESIGNING THE MODEL FOR MARKET FACING PAY

3.1 Chapter 2 outlined the case for moving towards greater Market Facing Pay. This chapter considers the design of Market Facing Pay measures. It addresses the following questions:

Chapter 3A	How centralised or decentralised should the approach to Market Facing Pay be?
Chapter 3B	How should Market Facing Pay measures apply across different staff groups?
Chapter 3C	What geographical design is appropriate for Market Facing Pay measures?
Chapter 3D	How should the value of geographical pay differentials be set?
Chapter 3E	Which contractual mechanism should be used to pay geographical pay differentials?

CHAPTER 3A

HOW CENTRALISED OR DECENTRALISED SHOULD THE APPROACH TO MARKET FACING PAY BE?

3.2 A fundamental question for the implementation of Market Facing Pay is the extent to which it should be centrally designed and operated.

3.3 Within the AfC framework individual employers already have the flexibility to vary the pay they offer through the application of local RRP. Foundation Trusts (FTs) also have the authority to renegotiate their own terms and conditions. Although in practice few FTs choose to do so, this may change as financial pressures grow, especially if national terms and conditions fail to adequately recognise the importance of differences in local labour markets.

3.4 This raises the possibility that Market Facing Pay could be implemented under a number of broad models from full local bargaining to decentralisation, where existing flexibilities are applied with local discretion, to a complete centralisation - with hybrid options in between the extremes.

3.5 However, any changes which are made to contractual arrangements would need a collective bargaining agreement. These invariably take time and are likely to be particularly difficult at the moment because of the current context of sustained pay restraint. Any proposal to introduce more Market Facing Pay needs to consider these implementation and industrial relations issues.

3.6 Furthermore, all models for Market Facing Pay will need to take account of Equal Pay legislation to ensure that pay policy is fair and legally sound.

Approaches Available for Implementing Market Facing Pay

3.7 There are a number of models which could be utilised for implementing Market Facing Pay. These are discussed in further detail in Chapters 3E and in Chapter 4, but overall these options are as follows;

- A de-centralised local bargaining system with local employers responsible for negotiating pay, terms and conditions for their workforce;
- A centralised pay framework which builds on the local flexibilities available, such as RRP within a particular geographic locality;
- Extending the use of national measures currently available within the existing AfC framework, such as HCASs or national RRPs.

3.8 The merits of each of these options are considered fully in Chapter 3E, but overall we know from feedback from employers that the current national contracts are not sufficiently flexible for addressing labour market issues and lock in unnecessary and unaffordable costs for some. This may not have been

a particular problem in the recent past when resources were growing ahead of inflation, and the industrial relations risks of moving away from national terms and conditions tended to outweigh the financial savings, but it is becoming a more serious concern as increasing demand and growing public expectations place increased financial pressure on the NHS.

3.9 In addition, as plurality of provision increases FTs are likely to have to compete with private sector providers, many of whom are not restricted to using national terms and conditions and have developed more flexible reward strategies that are more sensitive to local labour markets. The national AfC framework, in its current form, could therefore become unsustainable for some FTs.

3.10 However, expecting FTs to move solely to a system of local bargaining for Market Facing Pay, terms and conditions is high risk given the lack of capacity in HR, the transaction costs of making changes to contracts at a local level and the associated equal pay and unfair dismissal risks. We also know that decentralised Market Facing Pay bargaining in the NHS has a record of increasing costs.

3.11 The majority of NHS employers recognise these risks and would prefer to retain national terms and conditions of service provided that they remain fit for purpose, including appropriate recognition of local market factors. We therefore conclude that the mandatory devolution of pay bargaining to a local level should not be the preferred option. FTs should retain the ultimate freedom to set their own pay, but we they should also be able to continue to choose to use national terms that properly reflect local market factors. The question then becomes how national pay should address local market factors – should it adopt a centralised or de-centralised approach. These issues are considered further below.

Centralised Vs Decentralised Approaches

3.12 The choice between centralised and decentralised approaches to pay differentiation is not clear-cut. Individual employers are likely to be best placed to understand and respond to their local recruitment and retention issues. On the other hand, existing decentralised flexibilities are not well used currently, and are not favoured in the private sector, which may limit the extent that decentralised approaches can secure the benefits of Market Facing Pay.

3.13 Having assessed the options, the DH favours retaining the existing scope for local pay flexibilities to deal with local and staff group specific issues, and supplementing these with the introduction of some form of centrally agreed geographical pay differentiation that better reflects broad geographical issues.

3.14 This dual approach is thought to offer a balance between reflecting broad geographical issues through central measures and acknowledging the limits of centralised approaches for addressing local issues. These issues are explored in further detail below.

The case for retaining existing decentralised pay flexibilities

3.15 The DH view is that existing employer level flexibilities, as part of the AfC package, should remain a key tool in ensuring the appropriateness of pay to local market conditions.

3.16 The complexities and nuance underpinning local recruitment and retention problems are such that employers are best placed to understand and address them with bespoke flexible solutions. They have the potential to be responsive to local issues, understand what is driving their problems; and to explore a full range of targeted solutions.

3.17 This reflects the facts that:

- local recruitment and retention patterns do not wholly follow simple geographical patterns that can be reflected and influenced by centrally determined pay differentiation;

- issues are likely to vary across staff groups. Centralised schemes have limited scope to reflect such differentiation due to data gaps and Equal Pay legislation. Even without these constraints, the importance of staff group issues further complicates the task of any centralised scheme;

- local recruitment and retention patterns have a variety of underlying causes. Pay differentiation may not always be the optimal solution to these issues.

3.18 This assessment is based on DH analysis of recruitment and retention patterns and a review of relevant literature.

Analysis of recruitment and retention patterns

3.19 Chapter 2 has already indicated some of the nuance around local recruitment of retention situations. The correlations between geographical pay variation and recruitment and retention indicators are weaker at organisation level than at broader levels of detail. This is interpreted as the role of non-pay factors becoming more critical to understanding variation at local level.

3.20 Table 3.1 presents the distribution of the organisation level recruitment and retention indicators. It indicates a considerable variation in the recruitment and retention indicators across England. This is lower for the three-month vacancy rates (for the reasons in the notes to the table), but the variation across all indicators is particularly notable if the size of the standard deviations are considered in the context of median values. The greater the variation, the more potential difficulty there is in designing a one size fits all Market Facing Pay system from the centre.

Table 3.1: Distribution Statistics on Selected Recruitment and Retention Indicators

	Leaving Rates:		Share of wage bill on agency	Three Month Vacancy Rates:								
	All Staff	Qualified Nurses		All Non-Medical	Qualified Nurses	Qualified AHPs	Qualified HCSs	Qualified other ST&Ts	Unqualified ST&Ts	Health Care Assistants	Admin & Clerical and Managers	All Ambulance Staff
1st Percentile	4.4%	3.6%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
5th Percentile	5.3%	4.6%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
10th Percentile	5.6%	4.9%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25th Percentile	6.8%	6.1%	2.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Median	8.4%	8.5%	4.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
75th Percentile	11.3%	11.8%	6.4%	0.3%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
90th Percentile	18.4%	19.4%	10.2%	1.2%	2.2%	1.6%	1.2%	1.7%	0.0%	0.1%	0.5%	0.5%
95th Percentile	24.7%	24.7%	13.7%	2.5%	3.5%	3.2%	2.8%	4.3%	0.1%	1.1%	0.9%	0.7%
99th Percentile	37.5%	44.2%	22.8%	5.9%	7.1%	9.9%	7.1%	8.8%	16.0%	6.4%	4.2%	1.1%
Interquartile Range	4.5%	5.8%	4.0%	0.3%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
10th-90th Percentile Range	12.7%	14.5%	8.8%	1.2%	2.2%	1.6%	1.2%	1.7%	0.0%	0.1%	0.5%	0.5%
5th-95th Percentile Range	19.4%	20.1%	12.7%	2.5%	3.5%	3.2%	2.8%	4.3%	0.1%	1.1%	0.9%	0.7%
1st-99th Percentile Range	33.1%	40.6%	22.7%	5.9%	7.1%	9.9%	7.1%	8.8%	16.0%	6.4%	4.2%	1.1%
Standard Deviation	6.4%	9.4%	4.7%	1.1%	1.4%	2.0%	1.3%	1.9%	5.6%	1.3%	1.2%	0.3%

Notes:

- Leaving rates taken from the quarterly supplement to the NHS Information Centre's monthly workforce statistics publication and refer to leavers from the NHS between July 2010 and July 2011.
- Share of wage bill on agency estimated using Electronic Staff Record - Data Warehouse extracts and data on agency spend from Monitor and Trust and PCT financial returns. It refers to 2010/11.
- Three month vacancy rates taken from NHS Information Centre's last vacancy rate publication and refer to March 2010.
- Organisations with missing data are excluded from the analysis for specific indicators.
- Presented without minimum and maximums to allow for data issues in outlying results.

3.21 However, this overall variation across organisations may be more manageable if there are identifiable patterns within it. Table 3.2 highlights indicators of the variation in recruitment and retention indicators across organisations within SHA areas and within PCT areas.

Table 3.2: Variation in Selected Recruitment and Retention Indicators Within SHAs and PCTs

	Leaving Rates:		Share of wage bill on agency	Three Month Vacancy Rates:								
	All Staff	Qualified Nurses		All Non-Medical	Qualified Nurses	Qualified AHPs	Qualified HCSs	Qualified other ST&Ts	Unqualified ST&Ts	Health Care Assistants	Admin & Clerical and Managers	All Ambulance Staff
Average of within SHA standard deviations across constituents organisations:												
Mean	5.4%	7.7%	3.1%	0.8%	1.1%	1.3%	1.0%	1.6%	1.8%	0.9%	0.7%	0.2%
Median	4.9%	6.5%	2.6%	0.7%	1.0%	1.2%	1.2%	1.6%	0.0%	0.8%	0.5%	0.0%
Average of within PCT standard deviations across constituents organisations:												
Mean	5.2%	6.5%	3.2%	0.6%	0.7%	0.8%	0.6%	1.0%	0.3%	0.4%	0.4%	0.0%
Median	3.3%	3.9%	2.1%	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Notes:

- Uses the 10 SHA classification rather than the new 4 SHA cluster classification.
- The 'average of within SHA standard deviations across constituent organisations' is calculated by separately producing an organisation level standard deviation for each SHA and indicator combination and then taking an average of these SHA specific standard deviation results.
- Leaving rates taken from the quarterly supplement to the NHS Information Centre's monthly workforce statistics publication and refer to leavers from the NHS between July 2010 and July 2011.
- Share of wage bill on agency estimated using Electronic Staff Record - Data Warehouse extracts and data on agency spend from Monitor and Trust and PCT financial returns. It refers to 2010/11.
- Three month vacancy rates taken from NHS Information Centre's last vacancy rate publication and refer to March 2010.
- Organisations with missing data are excluded from the analysis for specific indicators.
- Presented without minimum and maximums to allow for data issues in outlying results.
- The three-month vacancy data has limitations in showing the distribution of recruitment and retention issues due to the prevalence of zeroes. According to the last set of data, no long term vacancy issues were recorded typically recorded across organisations and staff groups. With this lack of variation it is difficult to consider

patterns in any underlying issues. It should also be noted that this is the last set of data from a discontinued publication and refers to March 2010. This is a problem for designing and maintaining any Market Facing Pay system until a replacement is developed.

3.22 Within SHAs, the typical variation does not appear to be dramatically less than the variation across all organisations in England. This is likely to reflect the large size and non-homogeneity of SHAs.

3.23 Within PCTs, the typical variation is more reduced, but may still be regarded as notable for some indicators. Even if the data did indicate consistency across PCT areas, this would still suggest that any Market Facing Pay system aiming to fully reflect all issues would probably need to go a level of granularity at least equal to the old 152 PCTs. Designing, implementing and maintaining a centralised Market Facing Pay system with so many units would be massively challenging and liable to not appropriately reflect all local issues.

3.24 This case around complexity is intuitively strengthened by considering staff group specific issues. There are likely to be differences in the recruitment and retention problems facing different staff groups within a locality, differences in the underlying causes of these issues and differences in the optimal solution. This view is not, however, well supported by the available data.

3.25 The data on three month vacancy rates indicates a fairly high degree of consistency across staff groups. However, this is only one indicator and, as described in the notes for Table 3.3 the lack of variation and prevalence of zeroes in the vacancy data undermines its use in reflecting underlying recruitment and retention issues.

Table 3.3: Indications of Variation in 3 Month Vacancy Rates Across Staff Groups Within the Same Organisation

Average of within organisation standard deviations across staff groups	
Mean	0.6%
Median	0.0%
Organisation level correlation between: 3 month vacancy rate for all non-medical staff & 3 month vacancy rate for:	
Qualified Nurses	0.84
Qualified AHPs	0.68
Qualified HCSs	0.66
Qualified other ST&Ts	0.64
Unqualified ST&Ts	0.66
Health Care Assistants	0.68
Admin & Clerical and Managers	0.85
All Ambulance Staff	0.75

Notes:
- The average of within organisation standard deviations across staff groups is calculated by separately producing an standard deviation in rates across staff groups for each organisation and taking an average of these organisation specific standard deviation results.
- Three month vacancy rates taken from NHS Information Centre's last vacancy rate publication and refer to March 2010.
- The three-month vacancy data has limitations in showing the distribution of recruitment and retention issues due to the prevalence of zeroes. According to the last set of data, no long term vacancy issues were recorded

typically recorded across organisations and staff groups. With this lack of variation it is difficult to consider patterns in any underlying issues. It should also be noted that this is the last set of data from a discontinued publication and refers to March 2010. This is a problem for designing and maintaining any Market Facing Pay system until a replacement is developed.

- There are comparative few data items for Ambulance Staff so treat with caution.

3.26 This lack of data prevents drawing strong conclusions about staff group specific issues and further undermines the feasibility of designing a very detailed centralised system.

Literature review supporting the retention of decentralised pay flexibilities

3.27 Existing literature on recruitment and retention suggests a significant role for local and staff group specific factors and a variety of underlying causes of recruitment and retention issues that may or may not be best solved through pay. Annex E provides detailed references, but key messages include:

- Recruitment and retention issues are largely local rather than regional and can differ significantly by staff group.

- Occupational considerations are key. There may be issues of skills availability and different occupations operate in different labour markets (local, regional and national) with different issues.

- Individuals consider more than pay when making job choices. Other factors are also important including potential job satisfaction, location, working conditions, future employment prospects and non-pay rewards.

- Organisation specific factors can affect their recruitment and retention prospects. Relevant factors include:

  - Career development prospects;
  - Local reputations as employers;
  - Quality of local transport links and parking;
  - Cost of living differences;
  - Local skills availability, including literacy and numeracy;
  - Extent of competition with other NHS and non-NHS employers;
  - Opportunities of staff to commute to other NHS Trusts attracting High Cost Area Supplements;
  - Working conditions and management practices;
  - Recruitment processes and quality of recruitment advertising.

- Organisations should therefore manage turnover through identifying where problems lie and investigating the underlying causes before introducing remedies.

- Pay may not always be the optimal solution to local recruitment and retention issues. Other options include:

  - Striving to be seen as a good local employer;
  - Redesigning jobs to overcome reliance on shortage skills;
  - Reviewing vacancies to ensure they were necessary;
  - Improving advertising and recruitment processes;
  - Adjusting progression policy e.g. from Band 6 to 7 automatic for pharmacists;

- Working with local schools to ensure students looked on the NHS favourably;
- Recruiting unqualified staff to entry level jobs and developing them;
- Help with child care;
- More flexible hours;
- Key worker housing schemes;
- Shuttle buses and park and ride schemes.

3.28 The literature review suggests a complexity of recruitment and retention patterns at local and staff group specific level and the importance of understanding the underlying drivers of recruitment and retention difficulties and the role of non-pay influences.

3.29 This is not to say that pay is unimportant, even the literature that questions the importance placed on pay recognises it is one of a number of recruitment and retention factors, but rather indicates the potential validity of various responses to specific local circumstances.

3.30 However, the literature also contains IDS research which suggests that centralisation is the preferred model within the private sector[3] [4]. This would appear to run counter to DH's position around retaining flexibilities, but there are reasons to be wary of private sector comparators.

3.31 It is doubtful that many, if any, private sector comparators are as big or complex as the NHS. It is not hard to imagine sub-optimal outcomes from a completely centralised system. For example:

- Current NHS funding for organisations already includes a sMFF element. Centrally determined Market Facing Pay premia would initially be felt as a cost pressure and in some circumstances might be unaffordable. This is a particularly prominent risk in the current financial climate;

- If recruitment and retention issues reflect skills shortages then funding training of existing staff or returner schemes may be more cost effective than pay premia;

- Organisations may have already invested in non-pay measures to ensure recruitment and retention, such as child care provision. A centrally determined local pay premium would duplicate costs;

- Centrally determined pay premia are likely to be less effectively targeted towards specific local recruitment and retention risks. This implies additional costs for the same outcomes (a deadweight loss).

3.32 Another factor to consider is that some of the arguments against decentralisation point to the complexity of the resulting scheme. It is undeniable that an application of local flexibilities has the potential to be more

[3] Location-based pay differentiation: A research report for UNISON, Incomes Data Services, September 2011, page 22

[4] Geographical pay differentiation in multi-site private sector organisations: A research report by Incomes Data Services for the Office of Manpower Economics, Incomes Data Services (October 2008), page 2

complex than schemes designed centrally. However, this complexity arguably only mirrors the complexity of local situations.

3.33 Furthermore, centralisation has its own additional burdens. Whilst it avoids some duplication, there are likely to be additional resource costs in trying to reflect diverse local circumstances and in managing the process and dealing with local concerns and representations.

3.34 Finally, the argument that decentralisation creates overall budget risks may be overplayed. NHS organisations are already responsible for managing their finances. There are no central controls on staffing or skill mix decisions, both of which significantly affect paybill. Organisations already manage these issues themselves.

Conclusion on the case for retaining existing decentralised pay flexibilities

3.35 The DH therefore concludes that the evidence suggests that existing local flexibilities are best placed to deal with local and staff groups specific issues and that any centralised addition to geographical pay differentiation can only be used to reflect broader geographical issues.

3.36 A central Market Facing Pay scheme attempting to take full account of local circumstances would need to be unreasonably complex and in DH's view overambitious. The likelihood of appropriately reflecting all local and staff group specific issues is low.

3.37 Furthermore, such as centralised scheme would automatically spend local resources available for recruitment and retention measures on prescribed levels of pay. This precludes the possibility of using potentially more appropriate non-pay solutions.

The case for supplementing local flexibilities with additional centralised geographical pay differentiation

3.38 The DH view is that existing local flexibilities should be retained and supplemented by central initiatives to address the risks and barriers of a purely decentralised approach to Market Facing Pay.

3.39 Existing pay flexibilities are not widely used. Part of this may reflect that upward pay flexibilities are unnecessary in areas of the country offering sufficient or excess geographical pay differentials through national payscales. Part of this could also reflect the fact that adjusting pay is not always the optimal solution to local recruitment and retention issues.

3.40 However, it remains likely that the risks and barriers of decentralised pay differentiation have an important role in discouraging the use of flexibilities. They make high demands of management capacity and expertise and have risks around pay spirals, turnover, morale and equal pay.

3.41 The DH therefore believes additional central measures should be considered to supplement local flexibilities and reduce the risks and barriers to decentralised pay differentiation.

3.42 This assessment is based on DH analysis of the use of pay flexibilities and a review of relevant literature.

Current use of existing pay flexibilities

3.43 Despite their potential benefits, the existing flexibilities are not widely used as indicated by Electronic Staff Record (ESR) data. Annex F provides several tables indicating patterns in the use of Recruitment and Retention Premia (RRP), and for completeness High Cost Area Supplements (HCASs) (as indicated by the Geographical Allowance payments recorded in ESR).

3.44 The tables on HCAS mainly reflect the expected patterns from the current HCAS system with both the propensity and typical value of payments decreasing with distance from London.

3.45 The tables in Annex F indicate for RRPs that:

- Less than 6% of non-medical staff receive an RRP.
- By staff group, this skewed heavily towards Maintenance and Works staff (likely reflecting the previous national RRP for building and craft workers) and then towards professionally qualified staff groups particularly nurses and allied health professionals.
- By geography, RRP use is skewed away from the north towards the south (particularly when excluding London). This pattern may reflect a historical effect seeking to offset the replacement of 'Cost of Living Supplements (COLS)' with the current HCAS system which applies in fewer areas.
- Where RRPs are awarded they are equivalent to less than 4% of basic pay on average, though this varies considerably across SHAs and staff groups.
- Over 80% of organisations award RRPs, with similar high rates within most SHAs. This figure reflects the widespread use of RRPs for particular staff groups such as Maintenance and Works staff. Nevertheless, even without this, a meaningful proportion of organisations use RRPs for other staff groups.
- When organisations do give RRPs to some staff this rarely means that all, or even most, of the staff in the same staff group also receive an RRP.

3.46 Historical issues appear likely to account for much of the use of local pay flexibilities. Subsequent use has been relatively low. This may suggest some

reluctance or barriers in their use and raise questions about the confidence we can have in their potential to address local issues.

3.47 However, there are reasons to be optimistic about the prospects for addressing local issues with local flexibilities. These include:

- Pay flexibilities are all upwards and the case for Market Facing Pay would indicate there are many areas in the country already paying sufficient, if not excessive, geographical pay differentials. This means a high use of flexibilities would be unexpected. This situation could change with the introduction of a Market Facing Pay scheme.

- Although the number of RRP awards may be low, a high proportion of organisations use RRPs in some form or another. This suggests that there is sufficient familiarity, capacity and willingness in the system to use such flexibilities when appropriate.

Literature review supporting the use of centralised elements to Market Facing Pay

3.48 The literature review (see Annex E) supports the views that:

- There may be risks and barriers associated with decentralised pay flexibilities which may explain their uncommon use;

- Pay may not always be the solution for local recruitment and retention issues.

3.49 On the first point, identified risks and barriers from the literature [5] [6] [7] [8] [9] [10] include:

- Logistical / practical barriers:
  - Lack of local experience and expertise with pay bargaining;
  - Administration costs of developing and maintaining local data and intelligence, and applying this to pay;
  - Duplication of effort from local pay setting;
  - Complexity of practical design issues, for example dealing with geographical cliff edge issues.

- Other risks and disadvantages:

[5] Regional pay for NHS medical and non-medical staff: Final report for Department of Health (2005), Professor Bob Elliott, Professor Anthony Scott, Dr Diane Skåtun, Mr Divine Ikenwilo (University of Aberdeen) and Professor David Bell and Mrs Elizabeth Roberts (University of Stirling) pages 22, 34 & 37

[6] Location-based pay differentiation: A research report for UNISON, Incomes Data Services, September 2011, pages 17, 21 & 22

[7] Scoping Study on NHS Trusts' Coping Strategies for Local Recruitment & Retention Problems, NHS Partners (2007) pages 23-24

[8] Recruitment and retention: A public sector workforce for the twenty-first century, Audit Commission (2002), paragraph 39

[9] Poverty pay: How public sector pay fails deprived areas, Robin Harding (2007), The Social Market Foundation, pages 7, 8 & 25

[10] Regional pay, regional poverty? The implications of public sector pay flexibility for Wales, Victoria Winckler, Bevan Foundation Policy Paper 3 (2004), paragraphs 2.22, 2.24 & 2.25

- Does not deal with any underlying issues such as skills shortages;
- Affordability and reduced central control of the paybill;
- Increased turnover if underlying issues are not solved and a cycle of poaching begins either within the NHS or between sectors;
- Pay spirals associated with cycles of poaching;
- Divisiveness and perceptions of unfairness, generating resentment and undermining morale;
- Ripple effects of increased pay demands within organisations;
- Reduced labour mobility if staff are less willing to relocate to lower pay areas;
- Potential to undermine the consistency and coherence of pay levels across country.
- Potential impact of cliff edge effects where individual employers close to zone boundaries could under or overpay compared to nearby employers in other zones.

3.50 Perhaps due to these risks and barriers, IDS research suggests that centralisation is the preferred model of the private sector[11] [12]. However, it also appears legitimate to say that the evidence base around local recruitment and retention strategies is inconclusive.

3.51 There is a lack of formal evaluation of local recruitment and retention initiatives. That being said the identified issues do appear feasible and relevant to the NHS. However, without greater experience on local strategies it is difficult to add any quantitative assessment to this.

3.52 Another possibility is that pay flexibilities are not always the most appropriate response to local recruitment and retention issues. The literature review material supporting the retention of local flexibilities suggests the importance of the underlying causes of recruitment and retention problems and that sometimes non-pay solutions may be the appropriate response to specific local issues.

3.53 For example, a cost effective solution to some staff being discouraged by the difficulties of child care arrangements could be offering flexible working; or a cost effective solution to the impact of poor transport links or parking could be to offer a shuttle bus scheme.

3.54 It is difficult to determine centrally the extent to which such non-pay solutions are employed at a local level. Furthermore, a report for DH on regional pay by the University of Aberdeen[13] highlights the unproven nature of such initiatives. It reports on a literature review covering examples of the NHS using non-pay / in-kind incentives as a local recruitment and retention tool.

[11] Location-based pay differentiation: A research report for UNISON, Incomes Data Services, September 2011, page 22

[12] Geographical pay differentiation in multi-site private sector organisations: A research report by Incomes Data Services for the Office of Manpower Economics, Incomes Data Services (October 2008), page 2

[13] Regional pay for NHS medical and non-medical staff: Final report for Department of Health (2005), Professor Bob Elliott, Professor Anthony Scott, Dr Diane Skåtun, Mr Divine Ikenwilo (University of Aberdeen) and Professor David Bell and Mrs Elizabeth Roberts (University of Stirling) paragraphs 41-43

3.55 The report acknowledges the potential advantage of being better able to target in-kind benefits than financial incentives. Financial incentives are more likely to benefit wider groups of staff, not just those with the greatest recruitment and retention risks. This comes with a ‘deadweight loss’.

3.56 However, the Aberdeen report also points out that in in-kind benefits generally produce less benefit or utility for their recipients than equivalent cash values. Perhaps more significantly, they also highlight that although it is generally the case that such initiatives are thought to be successful, the evidence base to support this is typically weak. Most of the literature is descriptive in nature, does not rigorously assess costs and benefits, does not use control groups to identify counterfactuals and does not consider the knock on impacts when competition with other NHS organisations is considered.

Conclusion on the use of centralised elements to Market Facing Pay

3.57 The DH position is that the evidence does not support either a completely centralised or a completely decentralised approach. A more sophisticated approach to Market Facing Pay is required in which central measures are used to supplement local flexibilities.

3.58 Some form of centrally determined geographical pay differentiation could help mitigate issues around introducing competitive pay spirals and placing duplicative burdens on local management capacity.

3.59 In addition there may be additional central measures around supporting the provision of data, intelligence and recruitment and retention research that may help facilitate a stronger foundation to local decision making.

Conclusion

3.60 Within the AfC framework are a multitude of contractual mechanisms that could support either a decentralised or centralised approach to Market Facing Pay implementation or something in between. Neither extreme model appears to offer an ideal solution to the implementation of Market Facing Pay.

3.61 A fully centralised system cannot be expected to fully align to local conditions across multiple staff groups. Local issues are most appropriately dealt with through local flexibilities.

3.62 However, relying on existing flexibilities, with no further action, could be considered imprudent given their scant use now and the risks and barriers associated with their use.

3.63 The DH therefore suggests giving consideration to retaining the existing scope for local pay flexibilities and supplementing these with the introduction of some form of additional centrally agreed geographical pay differentiation to

reflect broad geographical issues. The rest of the evidence considers how best such an adjustment could be designed and implemented.

3.64 There may also be benefits in considering how the system can be supported to best use local flexibilities to address the local and staff group specific issues that centrally determined pay differentiation systems are not well placed to tackle. One option could be additional central provision of labour market indicators. This could be supplemented by supporting local intelligence gathering and analysis of recruitment and retention indicators such as exit interviews. There may also be merit in supporting additional research to formally evaluate the effectiveness of local recruitment and retention measures. These issues are considered further in Chapter 5.

3.65 This dual approach of utilising both additional centralised pay differentiation and supporting the use of local flexibilities would recognise the limits of centralised approaches while continuing to allow organisations to reflect the nuance of their local situation.

3.66 This approach is also consistent with the aspirations set out in the 2010 White Paper – Equity and Excellence, Liberating the NHS. The White Paper set the Government's view that pay decisions should be led by individual healthcare employers rather than imposed by the Government, and it reiterated that in the future all NHS employers will have the rights, as FTs have now, to determine pay for their own staff.

3.67 However, it also stated that many providers would want to continue to use national contracts as a basis for local terms and conditions and that the DH is committed to working with NHS employers and trade unions to explore appropriate arrangements for setting pay in the longer term. This work is being undertaken primarily through the NHS Staff Council which has an important role in ensuring that national contracts remain fit for purpose and attractive to FTs.

3.68 The White Paper also acknowledged that fiscal consolidation and maximising efficiency in the use of public sector resources is a priority. In line with our aim of a decentralised system, the main incentives for financial management and efficiency will in future come from tariff-setting (by the new economic regulator) and a transparent regulatory framework – not from central government controls on providers' pay and internal processes

3.69 The suggested approach balances supporting local freedoms whilst delivering improvements to national frameworks that the White Paper envisages will remain a key part of future pay setting.

CHAPTER 3B

HOW SHOULD MARKET FACING PAY MEASURES APPLY ACROSS DIFFERENT STAFF GROUPS?

3.70 Local recruitment and retention patterns and issues are likely to vary across staff groups. This raises the question of how to reflect staff group specific issues in Market Facing Pay implementation.

3.71 This decision needs to recognise the constraints of practical mechanisms to implement Market Facing Pay and the extent of the staff group issues that the system needs to cope with.

Constraints to contractual mechanisms for Market Facing Pay implementation

3.72 Whilst staff group specific issues can be addressed through local flexibilities, where objectively justified, there are equal pay risks associated with distinguishing between staff groups in the application of centrally / nationally determined pay adjustments.

3.73 As background, there was a concern that the NHS maintained its competitiveness in attracting and retaining certain staff groups during the process of introducing AfC from October 2004. This resulted in the introduction of national recruitment and retention premia (nRRP) for certain staff groups.

3.74 This arrangement raised equal pay concerns. The Employment Tribunal, in its judgment on the Hartley v Northumbria Healthcare NHS Trust and Others (2008) equal pay test case, ordered that existing nRRPs should be reviewed by the NHS Staff Council before 1 April 2011, and that if they were not so reviewed they should cease to have effect from that date.

3.75 In response, NHS Employers (on behalf of the Staff Council) commissioned an independent review. The review recommended that the nRRPs should be withdrawn and replaced, where appropriate, with a local RRP. The nRRPs are therefore now in the process of being phased out and will cease on 1 April 2013.

3.76 This suggests that seeking to differentiate pay by staff groups within the same AfC pay band is likely to fall foul of equal pay legislation, unless there is objective justification. This casts doubt on the feasibility of any centralised Market Facing Pay adjustments that seek to include a staff group specific element.

3.77 There remains scope for some differentiation by pay band in any centralised scheme such as giving different levels or percentages of additional pay to different pay bands, but the lack of sufficient robust data at this level of detail is likely to constrain design of such a sophisticated approach, at least initially. Furthermore, each payband covers multiple staff groups with quite diverse

needs for additional Market Facing Pay. Even quite sophisticated centralised differentiation by payband could therefore be an inadequate and poor substitute for more detailed local pay differentiation.

Staff group level recruitment and retention issues

3.78 Parts of the literature review in Annex E, referred in Chapter 3A suggest that recruitment and retention issues can differ significantly by staff group. Different occupations in the same pay band often operate in very different labour markets (local, regional and national) with different risks and issues, such as the availability of skills.

3.79 This is intuitive and likely to be the case, but as described in Chapter 3A, the available evidence on staff group specific issues is not strong and cannot confirm this. Moreover, the fact the evidence base on staff group issues is not strong undermines the DH's confidence in the prospects for a detailed staff group specific centralised approach to local pay.

3.80 The DH therefore considers that existing local flexibilities are best placed to deal with local and staff group specific issues and that any centralised addition to geographical pay differentiation can only be used to reflect broader geographical issues that should be applied to all staff within a particular AfC pay grade regardless of staff group.

Case for considering additional centralised geographical pay differentiation without a staff group dimension

3.81 The DH does not consider the nuance in local recruitment and retention situations to rule out some form of centrally determined geographical pay element that does not distinguish between staff groups.

3.82 The underpinning rationale behind Market Facing Pay is that where the NHS competes with the private sector for staff, the geographical pay premia that each sector offers (to compensate cost of living and amenity differences across areas) will influence their recruitment and retention prospects.

3.83 Even for staff groups where private sector competition is weaker, geographical pay differentiation could affect recruitment and retention prospects across the NHS. Trusts offering geographical pay premia that will compensate employees for the cost of living and amenity differences have better prospects than those where the reverse is true, although the extent of this effect will be influenced by the degree of staff mobility.

3.84 It therefore appears that there is a rationale for greater geographical pay differentiation for most, if not all, AfC staff groups on this basis.

3.85 Elliott et al (2010)[14] point out that:

> "NHS labour markets will be connected to private sector labour markets if the skills of NHS staff are transferable. There is evidently an external market for the skills of maintenance, ancillary, clerical and, administrative and managerial staff the NHS employs. The relevance of the spatial pattern of pay in the private sector for these groups has not been disputed"

3.86 This conclusion for staff with clear transferable skills is intuitive. The case for professionally qualified staff groups for whom there are relatively fewer employment prospects outwith the NHS may be less obvious. However, it remains possible for some NHS staff to leave the health sector entirely or to work for non-NHS health care employers such as care homes. The same study by Elliott et al finds a link between geographical pay premia and recruitment and retention prospects for qualified nurses. This is consistent with a number of other studies as set out in Annex C earlier in the evidence.

3.87 Other non-medical groups have received less attention in the literature than nurses. However, the DH analysis in Chapter 2 appears to show a link between recruitment and retention issues and geographical pay variation that goes beyond qualified nurses (although it should be noted that the relationship seen for qualified nurses is amongst the strongest).

3.88 Furthermore, even without connectedness to external markets, geographical pay variation could influence recruitment and retention patterns within the NHS so long as there is geographical labour mobility for NHS staff. Table 3.4 presents estimated moving rates between organisations, PCT area and SHA areas between September 2010 and September 2011.

[14] The role of the staff MFF in distributing NHS funding: Taking account of differences in local labour market conditions, Health Economics 19: 532-548 (2010), Robert Elliott, Ada Ma & Diane Skåtun *Health Economics Research Unit, University of Aberdeen,* Matt Sutton *Health Methodology Research Group, University of Manchester,* Nigel Rice *Centre for Health Economics, University of York,* Stephen Morris *Department of Epidemiology and Public Health, University College London,* Alex McConnachie *Robertson Centre for Biostatistics, University of Glasgow*

Table 3.4: Indications of Internal NHS Mobility for Non-Medical Staff

	Estimated Share of September 2011 FTEs which since September 2010 have moved:		
	Organisation	PCT Area	SHA Area
Qualified Nursing	8.1%	5.8%	0.9%
Unqualified Nursing, HCAs and Support	5.0%	3.6%	0.3%
Qualified AHPs	12.6%	8.9%	1.6%
Qualified Other ST&Ts	6.0%	4.6%	1.5%
Unqualified AHPs	9.3%	6.2%	0.4%
Unqualified Other ST&Ts	5.2%	3.9%	0.9%
Admin & Clerical	6.3%	4.5%	0.5%
Maintenance & Works	2.1%	2.0%	0.1%
Qualified Ambulance Staff	0.7%	0.6%	0.6%
Unqualified Ambulance Staff	1.0%	0.8%	0.3%
Managers	6.8%	5.6%	1.4%
All Non-Medical	6.9%	5.0%	0.8%

Notes:
- Uses the 10 SHA classification rather than the new 4 SHA cluster classification.
- Based on Electronic Staff Record - Data Warehouse extracts after the application of data cleaning filters.
- Transfers involving organisations not included in both extracts (i.e new or ceased organisations) are excluded from the analysis in an attempt to minimise the impact of service redesign and whole scale transfers of staff. This adjustment may still leave residual effects, but these are unlikely to be picked up in the transfers to new PCTs or SHAs estimates.

3.89 This table shows that transfer rates decrease as the geographical distance implied in the move increase. In particular, 6.9% of staff appear to have moved in the year to September 2011. Of these, 1.9 percentage points moved within the local PCT area; 5 percentage points moved to another PCT area and 0.8 percentage points of these moved to another SHA area.

3.90 Analysis by staff group reveals that the proportion of moves appears to be higher for qualified staff. These are the staff groups where the impact of private sector market wages on NHS recruitment and retention patterns may be less clear. The private sector is less likely to compete for the particular skills of clinically qualified staff than they are for the skills of staff with more generally applicable skills, although qualified NHS staff could still leave for unrelated private sectors jobs. This issue is sometimes referred to as the level of 'external connectedness' of the NHS to private sector labour markets.

3.91 However, the relatively high mobility rates for qualified staff indicates an alternative way in which NHS geographical pay variation could influence recruitment and retention patterns. Where NHS pay differentials do not appropriately compensate the cost of living and amenity differences across areas there are likely to be recruitment and retention consequences.

3.92 This suggests that there is wide scope for geographical pay variation to influence non-medical recruitment and retention issues, either through the influence of the private sector market or through internal competition for staff within the NHS. A universal geographical pay differentiation mechanism could therefore be appropriate in some circumstances.

3.93 The evidence in Chapter 3A suggests that any such mechanism should be centralised to reduce the risks and barriers of a decentralised solution such as additional administration burdens and the risk of pay spirals. However, the

DH recognises this would be an imperfect fit for all local circumstances, and that any proposal needs to allow room for residual issues to be more appropriately dealt with through individual employer flexibilities.

Conclusion

3.94 Using central mechanisms to differentiate pay by staff groups that fall within the same AfC pay band is likely to fall foul of equal pay legislation, unless there is objective justification and this may be vulnerable to legal challenge. This approach represents a significant and unnecessary risk which can be avoided.

3.95 Even if this were not the case, as described in Chapter 3A, the degree of nuance and complexity in recruitment and retention patterns across the country may be more than any centralised system could reasonably handle.

3.96 It is likely that staff group specific issues would further complicate the task. However, as described in Chapter 3A, the available evidence on staff group specific issues is not strong and cannot confirm this. The fact that the evidence base on staff group issues is not strong further undermines confidence is the prospects for a detailed and staff group specific centralised approach to local pay.

3.97 Combined, these issues appear to cast doubt on the feasibility of using centralised solutions for staff group specific problems. The DH therefore recommends that staff group specific issues should be primarily addressed through the application of existing local flexibilities.

3.98 However, staff group issues are important so the DH believes that any proposal for local pay must provide some local flexibilities to deal with local and staff group specific issues.

3.99 Despite this, the DH believes there remains scope to consider additional centralised geographical pay differentiation to cope with general market circumstances that apply broadly across all AfC staff groups.

CHAPTER 3C

WHAT GEOGRAPHICAL DESIGN IS APPROPRIATE FOR MARKET FACING PAY MEASURES?

3.100 As set out in earlier chapters, there is potentially scope to consider additional centralised geographical pay differentiation as supplement to the use of local pay flexibilities in facilitating Market Facing Pay.

3.101 This raises the questions around the geographical organisation of such pay differentiation. For example - How many levels of geographical pay differentiation should there be? How can employers be assigned to geographical pay differentiation groups? How can issues such as cliff edges be dealt with? and so on. This chapter deals with these questions of how pay differentiation should operate.

Options available

3.102 Research by Incomes Data Services (IDS) identifies six main approaches to varying pay by location[15][16]:

- National payscales with London / South East additions
- National payscales with London / South East additions and hot spots;
- Regional paybands;
- Zonal pay;
- Top-up allowances
- Complex localism.

3.103 All of these are possible options for AfC. The current AfC model is based on national payscales with additional pay for London / South East. Adding additional hotspots, or zonal pay (which is effectively similar) would also be possible as is pay differentiation by region. Local RRP could be used more extensively to act as top-up allowances. Finally, complex localism could be achieved through local pay flexibilities or centrally through the application of employer level staff market forces factor adjustments which already exist for making tariff payments. This chapter considers the merits of these options, taking account of approaches in use in both the public and private sectors.

Models used by other employers

3.104 The IDS research, mentioned above, finds that complex local systems are rare in the private sector. Most large multi-site private sector organisations

[15] Geographical pay differentiation in multi-site private sector organisations: A research report by Incomes Data Services for the Office of Manpower Economics, Incomes Data Services (October 2008)
[16] Location-based pay differentiation: A research report for UNISON, Incomes Data Services, September 2011

have the traditional national pay structures with London / South East additions, but zonal pay systems have become common in certain sectors. These systems tend to be relatively straight-forward and often reflect a hierarchy of London, the South East and the rest of the country, but with the possibility of recognising 'hot spots'.

3.105 The IDS also identify a variety of systems within the public sector. Local government, universities and police staff employers operate decentralised local pay – but in these cases local organisations do not operate under a national pay framework as does the NHS.

3.106 Examples of zonal pay in national public sector are identified – the Department of Work and Pensions (DWP) and The Ministry of Justice (MOJ). The DWP example has four zones reflecting inner London, outer London, hot spots and the rest of the country. The MOJ example which relates to the courts service has five zones: Inner London, Outer London and South East hot spots, Hot spots, National + and National.

3.107 Complex local systems are considered rare due to the complications and resources involved in implementing and managing them and their potential to become unwieldy and inconsistent.

3.108 Zonal pay models may, when implemented appropriately, offer a flexible yet straight-forward way of targeting pay differentiation at recruitment and retention pressures without being constrained by geographical boundaries and without exposing organisations to the risks of decentralised solutions.

Potential Model for the NHS

3.109 Current DH pay policy for AfC staff is based on the principle that local recruitment and retention issues are best addressed through decentralised solutions, such as the use of local pay flexibilities. Chapter 3A outlines the DH view that this approach should be retained, but that some form of centralised pay adjustment should be considered to address wider geographical issues.

3.110 On this basis, DH consider a zonal pay or hotspot framework (which in practice are likely to be very similar in application) appear to be the most promising option for delivering any centralised geographical pay differentiation because:

- Top-up allowances and complex localism are more relevant to the local recruitment and retention issues that DH believe should not be tackled centrally;

- Regional pay offers insufficient sensitivity to sub-regional labour market issues and hot spots.
  Table 3.6 presents analysis of sub-SHA variation in staff market forces factors.

- National payscales with London / South East additions offer insufficient scope to reflect differences across labour markets in the rest of the country.
  Table 3.6 shows how much staff market forces factor data varies across the rest of the country.

3.111 Zonal pay is consistent with recommendations set out in research papers by NHS Partners and the Social Market Foundation[17] [18]. This model can offer benefits in terms of:

- Facilitating responsiveness of pay to broad recruitment and retention issues across 'zones';
- Sensitivity to labour market differences within regions or areas defined by administrative boundaries;
- Retaining the advantages of national pay frameworks;
- Reduces the need for decentralised solutions to recruitment and retention issues and their associated risks;
- Simplicity and administrative feasibility.

3.112 Zonal pay has its own risks, which are similar (although perhaps weaker) than those for decentralisation in pay setting, as set out below[19]:

- Equal pay issues remain a risk. It is critical that zone decisions are clearly objectively justifiable and up to date;
- Staff morale may be harmed by perception of pay differentials across areas even if objectively justified;
- Lack of flexibility to adjust geographical premia down when circumstances change;
- Additional complexity in maintaining the pay structure and setting pay;
- Some risk of pay spirals remains;
- Staff mobility may be constrained.
- For the NHS, significant consideration must be given to industrial relations issues. Prior to the implementation of any model, there would be a need for a full impact assessment considering all of its potential implications including consideration economic, equality, contractual and collective bargaining issues.

3.113 However, these risks arguably exist to some extent for all methods of using pay differentiation as a recruitment and retention tool. On balance, the DH considers that zonal pay offers the most appropriate balance between moving towards a greater degree of Market Facing Pay and minimising these risks.

[17] High Cost Area Supplements and Recruitment & Retention Premia: A Report for the Office of Manpower Economics by NHS Partners Research & Information (May 2005), page 36
[18] Poverty pay: How public sector pay fails deprived areas, Robin Harding (2007), The Social Market Foundation, section 5
[19] List informed by High Cost Area Supplements and Recruitment & Retention Premia: A Report for the Office of Manpower Economics by NHS Partners Research & Information (May 2005), page 23-24

Design of Zones

3.114 AfC can already be described as operating a four-zone geographical pay system. Organisations in most parts of the country pay according to national scales. There are then three additional zones of HCASs in and around London.

3.115 The addition of further zones to increase geographical pay differentiation can be informed by staff Market Forces Factor (sMFF) data. sMFF data is well established in NHS funding methodologies, It is produced by external academic researchers; is robustly based and widely understood by employers and staff side.

3.116 The sMFF therefore provides an objectively justifiable indicator of the geographical variation in pay that would offset differences in cost of living and general amenities across areas for non-medical staff. More details on the basis of the sMFF and its role in NHS finances are provided in annex Annex B on sMFF mechanics from Finance.

Geographical patterns in staff Market Forces Factor data

3.117 Table 3.5 presents summary statistics on the range of the latest sMFF scores. Organisation level sMFF scores range from 0.87 to 1.23. A score of 1 indicates average staff costs, 1.1 indicates staff costs 10% higher than average, 0.9 indicates staff costs 10% lower than average and so on.

Table 3.5: Variation in Staff Market Forces Factors

	All Organisation sMFFs	PCT as Providers' sMFFs	PCT Allocation Aggregation sMFFs	SHA Aggregation sMFFs
Minimum	0.87	0.88	0.88	0.92
Maximum	1.23	1.23	1.20	1.18
Range	0.36	0.35	0.31	0.26

3.118 Aggregations at PCT level and SHA level (using the recent 10 SHAs grouping rather than the new 4 groupings) are also available and have narrower ranges. These can be useful in summarising the data, but it should be noted that they are partly influenced by staff costs outside the area. The aggregations are a weighted average of the sMFFs of the organisations services are commissioned from. Whilst generally this will reflect local staff costs, the (likely small) element of services commissioned from elsewhere will influence the aggregation. An alternative way of summarising the data into geographical units is to take the organisation level sMFF assigned to each PCT as a provider as broadly indicative of the area. This indicator is not be affected by the extent to which the PCT commissions services from elsewhere. In practice the two PCT indicators are very closely correlated.

3.119 Table 3.6 gives further contextual information on the variation of sMFFs across and within SHAs (using the recent 10 SHAs grouping rather than the new 4 groupings).

Table 3.6: Variation in sMFFs across and within SHAs

	SHAs ordered by Staff MFF Index									
	North East Q30	Yorkshire & the Humber Q32	West Midlands Q34	East Midlands Q33	North West Q31	South West Q39	East of England Q35	South East Coast Q37	South Central Q38	London Q36
Staff MFF Index	0.92	0.93	0.94	0.94	0.94	0.95	1.01	1.05	1.06	1.18
Distribution of PCT Allocation sMFFs within SHA										
Median	0.92	0.93	0.93	0.94	0.95	0.97	1.01	1.01	1.03	1.17
Minimum	0.91	0.90	0.91	0.91	0.92	0.88	0.91	0.94	0.96	1.14
Maximum	0.92	0.94	0.96	0.97	0.97	1.03	1.11	1.14	1.15	1.20
Range	0.01	0.04	0.05	0.06	0.05	0.14	0.20	0.20	0.18	0.05
Standard Deviation	0.00	0.01	0.02	0.02	0.01	0.05	0.06	0.07	0.06	0.02
Distribution of PCT Provider sMFFs within SHA										
Median	0.92	0.93	0.94	0.95	0.95	0.97	1.00	0.99	1.04	1.17
Minimum	0.90	0.91	0.91	0.90	0.91	0.88	0.91	0.91	0.96	1.11
Maximum	0.94	0.96	0.99	0.97	0.99	1.04	1.11	1.13	1.17	1.23
Range	0.04	0.05	0.08	0.07	0.08	0.16	0.20	0.22	0.21	0.12
Standard Deviation	0.01	0.02	0.03	0.02	0.02	0.05	0.07	0.07	0.06	0.04
Distribution of Organisation sMFFs within SHA										
Median	0.92	0.93	0.94	0.94	0.95	0.96	1.01	1.02	1.04	1.18
Minimum	0.90	0.90	0.91	0.90	0.91	0.87	0.90	0.91	0.96	1.11
Maximum	0.94	0.96	0.99	0.97	0.99	1.04	1.13	1.15	1.17	1.23
Range	0.04	0.06	0.08	0.07	0.08	0.17	0.23	0.24	0.21	0.12
Standard Deviation	0.01	0.01	0.02	0.02	0.02	0.05	0.07	0.08	0.05	0.03

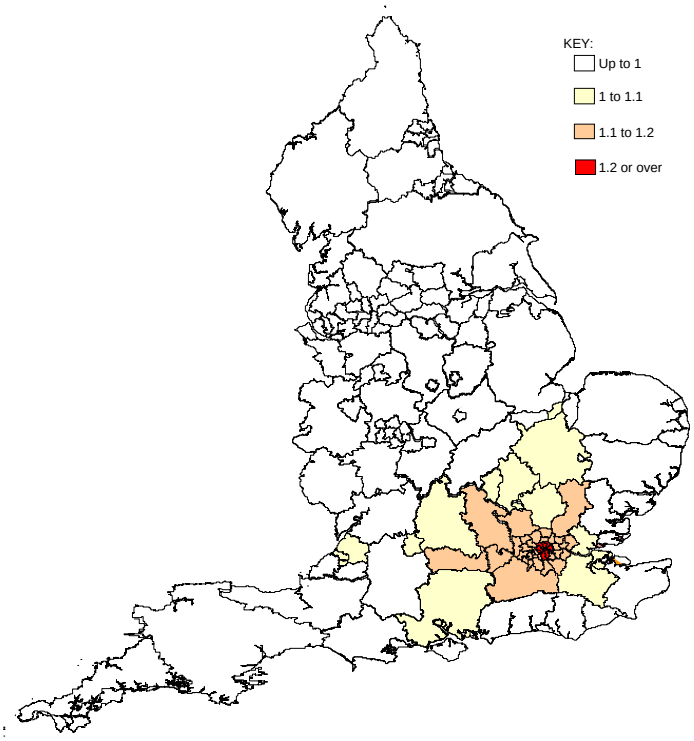
3.120 At SHA level, the six SHAs outside London and the South East (North East, Yorkshire and the Humber, West Midlands, East Midlands, North West and South West) have similar average sMFFs ranging from 0.92 to 0.95. The other four SHAs are more varied ranging from 1.01 for East of England to 1.18 for London.

3.121 Within SHAs, there is variation in the sMFFs of component providers and PCTs. The variation observed is more modest for the five SHAs with the lowest sMFF scores (North East, Yorkshire and the Humber, West Midlands, East Midlands and North West) and greater for the other non-London SHAs (South West, East of England, South East Coast and South Central) with the variation within London lying in between.

3.122 The patterns of sMFF values can be better illustrated using maps. Figures 3.1 to 3.3 show the patterns in sMFF values, in bands, across the old 152 PCT groupings. The PCT provider values are shown, but there is negligible difference with the PCT allocation values.

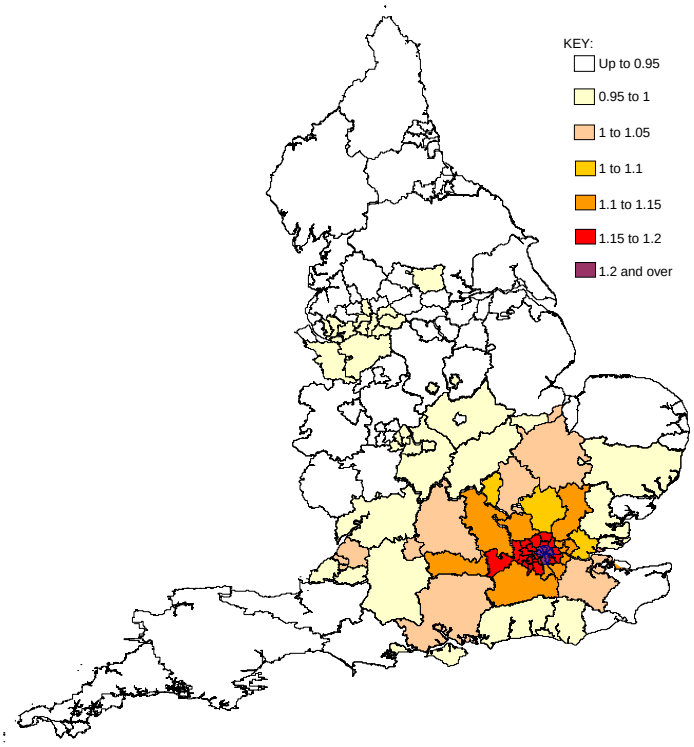
3.123 The apparent patterns depend on the width of the sMFF bands under consideration. Figure 3.1 uses increments of 0.1, equivalent to staff cost differences of 10%.

Figure 3.1: Pattern of Staff Market Forces Factors Across Old PCT Areas Wide Bands – Increments of 0.1



3.124 Figure 3.1 looks quite close to current geographical pay variation under AfC. There are clear hotspots in keeping with the London and London Fringe HCAS zones and indications of further hotspots in the wider surrounding areas and around Bristol. However, a more detailed account of sMFF variation suggests a more complicated situation. Figure 3.2 presents sMFF bands with increments of 0.05, equivalent to staff cost differences of 5%.

Figure 3.2: Pattern of Staff Market Forces Factors Across Old PCT Areas Medium Width Bands – Increments of 0.05

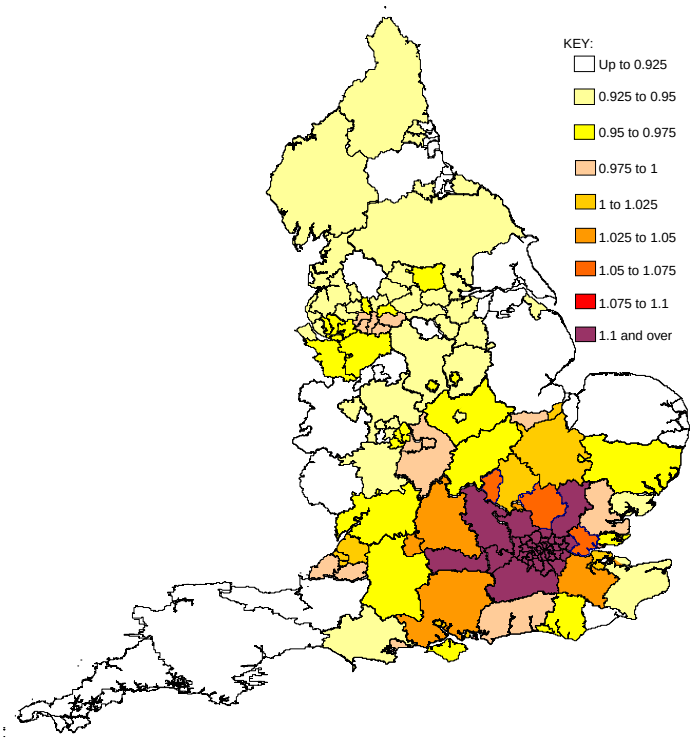


3.125 Figure 3.2 shows a more nuanced situation with greater variation in the southern hotspots and additional hotspots in the Midlands and around Manchester and Leeds.

3.126 Figure 3.3 is yet more detailed and presents sMFF bands with increments of 0.025, equivalent to staff cost differences of 2.5%. This appropriately reflects the nuance in the midlands and the north with greater sensitivity.

Note: This presentation collapses the level of detail at the top end of the scale for technical reasons

Figure 3.3: Pattern of Staff Market Forces Factors Across Old PCT Areas
Medium Width Bands – Increments of 0.025



Zone design options

3.127 The maps above demonstrate the unavoidable trade-off between the simplicity of zonal pay systems and how well their zones are suited to their component areas.

3.128 Figures 3.4 to 3.7 below convert the maps above into indicative zoning arrangements of varying levels of complexity. These are not intended to be final proposals. Should zonal pay be adopted, detailed consideration of cliff edge issues would be required and the consistency with the geographical units of the NHS after reform would need to reviewed using the latest available sMFF data at that time. Instead, the indicative maps below are intended to give a flavour of broad options available if a zonal pay approach were adopted.

3.129 Before outlining these indicative zoning options, it should be noted that they are based on the provider sMFF scores of the old 152 PCTs. These do not represent an average of the component organisations in the area, but are still considered a reasonable basis for zone design as:

- There is 0.99 correlation coefficient between PCT provider sMFFs and PCT allocation sMFFs (which are a weighted average of the sMFFs of the organisations that PCTs commission from, which are more likely to be

local). There are negligible differences between the patterns indicated by PCT provider sMFFs and PCT allocation sMFFs.

- When individual organisations are mapped to PCTs there is little deviation in the sMFFs of organisations and the PCT provider sMFF score used as proxy. Across PCTs the mean range in sMFFs of their organisations is 0.02 and the equivalent mean standard deviation is only 0.01. Even at the 75th percentile PCT the range is limited to 0.02 and the standard deviation to 0.01. There are examples of PCTs with greater internal variation, but outlying organisations are considered to be better dealt with using local flexibilities.

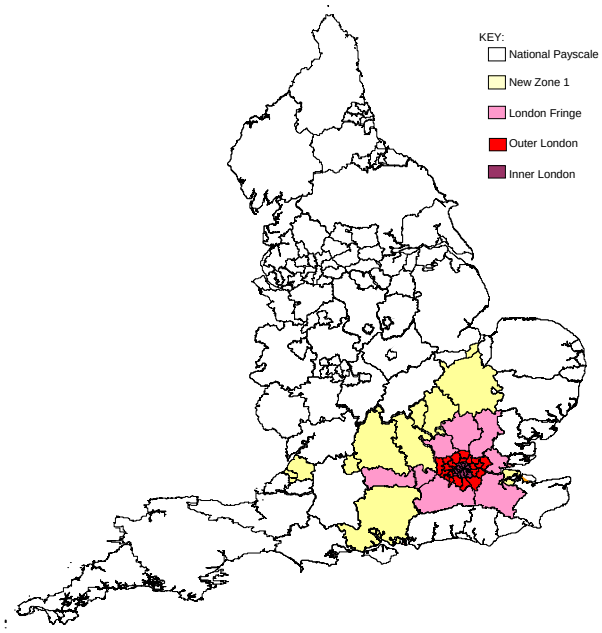
3.130 The ambiguities around the presentation of existing the London Fringe HCAS zone should also be highlighted. PCT boundaries have changed since HCAS were introduced. The London Fringe zone does not map neatly to the PCT boundaries used in this analysis. For the purposes of this presentation, PCTs containing areas previously designated as London Fringe are denoted Fringe. In reality some organisations in these PCTs will be paying London Fringe HCASs and some will not. This ambiguity is another issue that would need to be resolved in any detailed design work on a Market Facing Pay system.

3.131 Figure 3.4 labelled '5 Zone System – Version A' presents a zoning option built from an analysis of sMFF bands of 0.1 increments. Essentially, this adds an additional zone of southern hotspots to the current system. Figure 3.5 labelled '5 Zone System – Version B' presents an equally simple zonal system, in terms of the number of zones, but built from an analysis of sMFF bands of 0.05 increments. This version has a wider additional zone that also captures hotspots in the Midlands and around Manchester and Leeds.

Note: The analysis of sMFFs by bands were taken as starting points to identify potential zones. These were overlayed with indications of current London and London Fringe zones and then obvious anomalies smoothed out through a manual reassignment of zones. A similar, but more involved, process would be necessary to finalise zone designs.

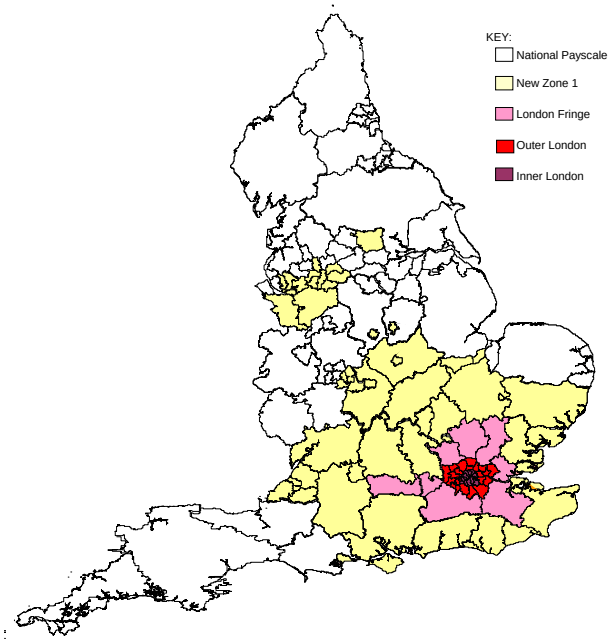
3.132 In Version B, the new zone has a greater variation in sMFFs across the component PCTs. This arguably makes the new zone less precise in targeting areas with similar staff cost issues. However, the counterpoint of this is that Version A has a greater variation in sMFFs across the component PCTs in the national payscale zone. Tables 3.7 and 3.8 present material on the distribution of sMFFs by zone under the various indicative zoning options and is discussed further below.

Figure 3.4: Indicative Zoning Options
5 Zone System – Version A (Narrow Additional Zone)



Note:
- Presents PCT sMFF data.
- PCT boundaries have changed since the London Fringe zone was introduced. This zone does not map to current PCT areas. For the purposes of this presentation, PCTs containing areas in the London Fringe zone are denoted as 'London Fringe'. In reality, some organisations in these PCT areas will not be paying HCASs. Such boundary ambiguities will need to be resolved in the final design of any zonal pay system.

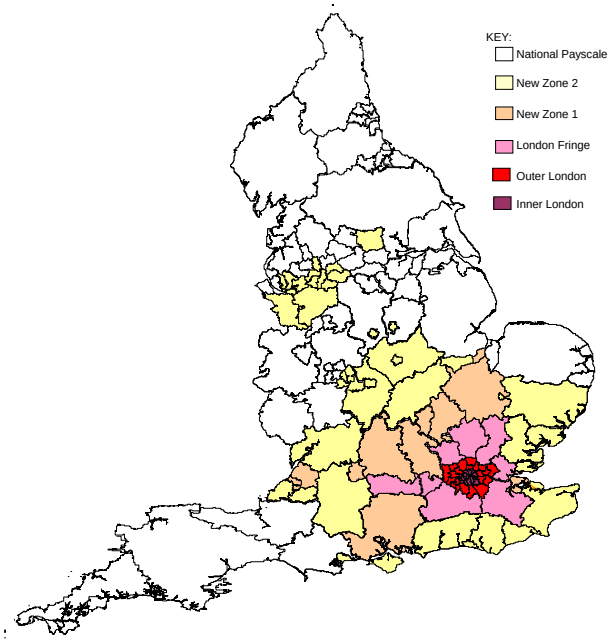
Figure 3.5: Indicative Zoning Options
5 Zone System – Version B (Wide Additional Zone)



Note:
- Presents PCT sMFF data.
- PCT boundaries have changed since the London Fringe zone was introduced. This zone does not map to current PCT areas. For the purposes of this presentation, PCTs containing areas in the London Fringe zone are denoted as 'London Fringe'. In reality, some organisations in these PCT areas will not be paying HCASs. Such boundary ambiguities will need to be resolved in the final design of any zonal pay system.

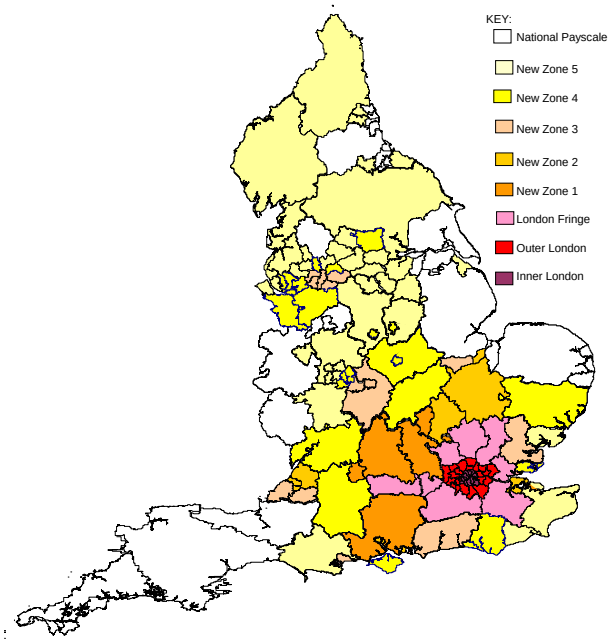
3.133 Figures 3.6 and 3.7 present two more extensions of this approach to generate indicative zoning arrangements increasing the detail inline with sMFF bands of 0.05 and 0.025 increments respectively. These generate a six zone system and a more complex nine zone system.

Figure 3.6: Indicative Zoning Options
6 Zone System



Note:
- Presents PCT sMFF data.
- PCT boundaries have changed since the London Fringe zone was introduced. This zone does not map to current PCT areas. For the purposes of this presentation, PCTs containing areas in the London Fringe zone are denoted as 'London Fringe'. In reality, some organisations in these PCT areas will not be paying HCASs. Such boundary ambiguities will need to be resolved in the final design of any zonal pay system.

Figure 3.7: Indicative Zoning Options
9 Zone System



Note:
- Presents PCT sMFF data.
- PCT boundaries have changed since the London Fringe zone was introduced. This zone does not map to current PCT areas. For the purposes of this presentation, PCTs containing areas in the London Fringe zone are denoted as 'London Fringe'. In reality, some organisations in these PCT areas will not be paying HCASs. Such boundary ambiguities will need to be resolved in the final design of any zonal pay system.

3.134 With more zones, there is less variation in the underlying sMFFs within zones. Each zone can be more precisely calibrated to the situation of its constituent parts. However, more zones adds complexity in implementation and maintenance. A balance between precision and simplicity must be struck.

3.135 Tables 3.7 and 3.8 presents data on the pattern of sMFFs across and between zones under the different indicative zoning options (the first considering variation in PCT sMFFs, the second considering variation across all providers) to help inform a decision on this trade-off.

Table 3.7: PCT level variation in provider sMFFs under the indicative zoning options

System	Zone #	Zone Label	Number of PCTs	Provider sMFF Minimum	25th Percentile	Median	75th Percentile	Maximum	Range	Standard Deviation
4 Zone (Current)	1	Inner London	11	1.18	1.21	1.23	1.23	1.23	0.05	0.02
	2	Outer London	20	1.11	1.15	1.16	1.17	1.19	0.08	0.02
	3	London Fringe	8	1.04	1.06	1.10	1.11	1.17	0.13	0.04
	4	National Payscale	113	0.88	0.93	0.95	0.97	1.11	0.23	0.04
5 Zone (A)	1	Inner London	11	1.18	1.21	1.23	1.23	1.23	0.05	0.02
	2	Outer London	20	1.11	1.15	1.16	1.17	1.19	0.08	0.02
	3	London Fringe	8	1.04	1.06	1.10	1.11	1.17	0.13	0.04
	4	"Other Hot Spots"	13	1.01	1.01	1.02	1.04	1.11	0.10	0.03
	5	National Payscale	100	0.88	0.92	0.94	0.96	1.00	0.11	0.03
5 Zone (B)	1	Inner London	11	1.18	1.21	1.23	1.23	1.23	0.05	0.02
	2	Outer London	20	1.11	1.15	1.16	1.17	1.19	0.08	0.02
	3	London Fringe	8	1.04	1.06	1.10	1.11	1.17	0.13	0.04
	4	"Other Hot Spots"	53	0.91	0.96	0.98	1.00	1.11	0.20	0.04
	5	National Payscale	60	0.88	0.92	0.93	0.94	0.95	0.07	0.02
6 Zone	1	Inner London	11	1.18	1.21	1.23	1.23	1.23	0.05	0.02
	2	Outer London	20	1.11	1.15	1.16	1.17	1.19	0.08	0.02
	3	London Fringe	8	1.04	1.06	1.10	1.11	1.17	0.13	0.04
	4	"Southern Hotspots"	13	1.01	1.01	1.02	1.04	1.11	0.10	0.03
	5	"South & Other Hotspots"	40	0.91	0.96	0.97	0.98	1.00	0.09	0.02
	6	National Payscale	60	0.88	0.92	0.93	0.94	0.95	0.07	0.02
9 Zone	1	Inner London	11	1.18	1.21	1.23	1.23	1.23	0.05	0.02
	2	Outer London	20	1.11	1.15	1.16	1.17	1.19	0.08	0.02
	3	London Fringe	8	1.04	1.06	1.10	1.11	1.17	0.13	0.04
	4	"Level 5"	6	1.03	1.04	1.05	1.06	1.11	0.08	0.03
	5	"Level 4"	7	1.01	1.01	1.01	1.02	1.02	0.02	0.01
	6	"Level 3"	14	0.98	0.98	0.98	0.99	1.00	0.02	0.01
	7	"Level 2 "	23	0.95	0.96	0.96	0.97	0.97	0.03	0.01
	8	"Level 1"	39	0.91	0.93	0.94	0.94	0.95	0.04	0.01
	9	National Payscale	24	0.88	0.91	0.91	0.92	0.92	0.04	0.01

Table 3.8: Organisation level variation in provider sMFFs under the indicative zoning options

System	Zone #	Zone Label	Number of Orgs	Provider sMFF Minimum	25th Percentile	Median	75th Percentile	Maximum	Range	Standard Deviation
4 Zone (Current)	1	Inner London	33	1.18	1.19	1.20	1.22	1.23	0.06	0.02
	2	Outer London	37	1.11	1.15	1.17	1.18	1.19	0.08	0.02
	3	London Fringe	26	1.03	1.07	1.11	1.13	1.17	0.14	0.04
	4	National Payscale	293	0.87	0.93	0.94	0.97	1.11	0.23	0.04
5 Zone (A)	1	Inner London	33	1.18	1.19	1.20	1.22	1.23	0.06	0.02
	2	Outer London	37	1.11	1.15	1.17	1.18	1.19	0.08	0.02
	3	London Fringe	26	1.03	1.07	1.11	1.13	1.17	0.14	0.04
	4	"Other Hot Spots"	35	1.00	1.01	1.02	1.04	1.11	0.11	0.03
	5	National Payscale	258	0.87	0.92	0.94	0.96	1.10	0.23	0.03
5 Zone (B)	1	Inner London	33	1.18	1.19	1.20	1.22	1.23	0.06	0.02
	2	Outer London	37	1.11	1.15	1.17	1.18	1.19	0.08	0.02
	3	London Fringe	26	1.03	1.07	1.11	1.13	1.17	0.14	0.04
	4	"Other Hot Spots"	144	0.91	0.96	0.97	1.00	1.11	0.20	0.04
	5	National Payscale	149	0.87	0.92	0.93	0.94	1.00	0.13	0.02
6 Zone	1	Inner London	33	1.18	1.19	1.20	1.22	1.23	0.06	0.02
	2	Outer London	37	1.11	1.15	1.17	1.18	1.19	0.08	0.02
	3	London Fringe	26	1.03	1.07	1.11	1.13	1.17	0.14	0.04
	4	"Southern Hotspots"	35	1.00	1.01	1.02	1.04	1.11	0.11	0.03
	5	"South & Other Hotspots"	109	0.91	0.95	0.96	0.98	1.10	0.19	0.02
	6	National Payscale	149	0.87	0.92	0.93	0.94	1.00	0.13	0.02
9 Zone	1	Inner London	33	1.18	1.19	1.20	1.22	1.23	0.06	0.02
	2	Outer London	37	1.11	1.15	1.17	1.18	1.19	0.08	0.02
	3	London Fringe	26	1.03	1.07	1.11	1.13	1.17	0.14	0.04
	4	"Level 5"	17	1.02	1.03	1.04	1.07	1.11	0.09	0.03
	5	"Level 4"	18	1.00	1.01	1.01	1.01	1.06	0.06	0.01
	6	"Level 3"	41	0.96	0.97	0.98	0.99	1.10	0.15	0.03
	7	"Level 2 "	62	0.93	0.95	0.96	0.96	1.02	0.09	0.02
	8	"Level 1"	99	0.91	0.93	0.94	0.94	0.95	0.04	0.01
	9	National Payscale	56	0.87	0.90	0.91	0.92	1.00	0.13	0.02

Assessment of options

3.136 The DH considers that five or six zones most appropriate, at least in the first instance. Having more zones would allow greater theoretical precision, but:

- this greater theoretical precision can only be realised when affordability and transition issues permit sufficient pay differentiation between the zones to be generated. This could be a gradual process.
  Note: Transition and implementation issues are considered further in Chapter 4.
- it adds complexity.
- the design of a more complex system would probably require a greater evidence base on the recruitment and retention implications.

3.137 If a five zone system is adopted, under the DH indicative options, there could potentially be a choice between Version A and Version B. Version B creates more equally sized zones and does something to reflect hotspots outside the South. However, with the current evidence base, the link between sMFF and recruitment and retention issues is perhaps most clear on the top end of the sMFF distribution and Version A would target this more directly.

3.138 Starting with fewer zones does not preclude the option of adding additional zones at some point in the future if:

- the impact of adding initial new zones has been assessed and supports the case for further geographical pay variation.
- the evidence base is sufficient to support a more complicated system.
- the experience of handling the administrative burden and complexity of introducing the initial new zones suggests the system can cope with additional zones.
- affordability and transition issues permit the generation of meaningful pay differentiation between the zones.

3.139 The DH considers that the initial introduction of one, or perhaps two, additional zones of geographical pay differentiation may be feasible in the short term. However, the evidence base on Market Facing Pay would need to be further developed to permit consideration of the case for introducing further additional zones in the future. Any introduction of new zones would need to be accompanied by more work to consider implementation issues, such as cliff edge effects, and transition issues, such as pace of change and industrial relations. These issues are covered further in Chapter 4.

Conclusion

3.140 The DH considers that zonal pay could be used to implement any additional centralised geographical pay differentiation, beyond the use of existing pay flexibilities to deal with local issues. However, an impact assessment (including industrial relations benefits and risks) would be required and further work would need to be done to consider implementation and transitional issues.

3.141 A wide range of options for the operation of geographical pay differentiation have been considered. The DH considers that local issues are best dealt with though existing employer flexibilities and that only broader geographical issues should be addressed centrally. As regional pay insufficiently reflects variations in recruitment and retention situations within administrative boundaries, zonal pay or the introduction of additional payment 'hotspots' are considered the most promising options. In practice, these two models are likely to be very similar in application.

3.142 Recognising the trade-off between precision and simplicity in designing zonal pay systems, the DH considers that thought could be given to the initial introduction of one, or perhaps two, additional zones of geographical pay differentiation. Figures 3.4, 3.5, 3.6 and 3.7 provide an initial indication of how these may be designed. These introductions could then be assessed and the evidence base on Market Facing Pay further developed to permit consideration of the case for introducing further additional zones in the future.

3.143 Any introduction of new zones would need to be accompanied by more work to consider implementation issues, such as cliff edge effects, and transition issues, such as pace of change and industrial relations issues. These issues are covered further in Chapter 4.

CHAPTER 3D

HOW SHOULD THE VALUE OF GEOGRAPHICAL PAY DIFFERENTIALS BE SET?

3.144 In previous sections, the DH considered how it might improve Market Facing Pay using an additional centralised element of geographical pay differentiation though zonal pay. This chapter considers how to determine the appropriate value of the zones.

3.145 This section considers the advantages of using sMFF data, rather than other options, to inform geographical pay differentiation. It then discusses how sMFF data could be used to inform the value of any geographical pay supplements.

The case for using sMFF data to inform geographical pay differentiation

3.146 The DH strongly recommends the use of the latest available sMFF data at the time as the means to inform any centralised Market Facing Pay elements. See Annex B for more details on the sMFF.

3.147 The DH does not favour the main other alternatives which are:

- Using a 'Specific Cost Approach' to pay differentiation;
- Setting pay differentiation using cost of living differences;
- Setting pay differentiation using recruitment and retention indicators.

3.148 This section explains the disadvantages of the dismissed options before expanding on the case for using sMFF data.

Using a 'Specific Cost Approach' (SCA) to pay differentiation

3.149 The sMFF is based on a General Labour Market (GLM) approach to quantifying appropriate geographical pay differentials. This uses the private sector to indicate the appropriate geographical pattern of pay, reflecting differences in cost of living and amenity, in the public sector. An alternative is the SCA, which reflects the actual labour cost differentiation that employers face.

3.150 The SCA approach is arguably more straight forward than the GLM approach, but has been considered and rejected a number of times in the development of NHS allocations methodology.

3.151 It was most recently reviewed by a team lead by Crystal Blue Consulting Ltd in 2007[20]. This study represents the most detailed attempt to investigate the SCA. It concluded that:

- spatial variation in staff costs reflects the pattern of the existing staff MFF for non-medical staff and supports the use of a GLM based approach as a proxy for unavoidable costs in the NHS;

- avoidable and unavoidable cost differences are very difficult to distinguish in the financial information provided by trusts. Avoiding circularity between observed cost differences and the recommendations of SCA is therefore very difficult;

- implementing an SCA approach is infeasible due to data availability and the conceptual problems of circularity.

Setting pay differentiation using cost of living differences

3.152 Cost of living differences are often used to explain and justify geographical pay differences but fail to take account of the relative attractiveness of living or working in a particular area. To equalise recruitment and retention incentives, geographical pay differentiation needs to take account not only of cost of living differences but also of factors affecting the amenity associated with working in an area. The GLM approach underpinning the sMFF picks up both.

Setting pay differentiation using recruitment and retention indicators

3.153 Recruitment and retention indicators are often raised as important intelligence in determining appropriate pay rates. This is true:

- at a local level, recruitment and retention indicators are important for managing pay flexibilities and other tools;

- at a central level, the link between sMFFs and recruitment and retention indicators justifies geographical pay differentiation.

3.154 However, these indicators do not in themselves quantify the appropriate value of pay differentiation. The sMFF offers a guide to reasonable geographical pay differentiation which is underpinned by theory and evidence.

The case for using sMFF data

3.155 Staff MFF data provides an objectively justifiable indicator of the geographical pay differentiation that would offset differences in cost of living and general amenities across areas. See Annex B for more details on the sMFF.

[20] Reported in Review of Specific Cost Approach to Staff Market Forces Factor (RARP 31)

3.156 Chapter 2 described the underlying evidence behind Market Facing Pay. It suggests that if the geographical differentiation of NHS pay more closely matched staff MFF data there would be an equalisation of recruitment and retention across areas, and a greater consistency in the relative attractiveness of employment between the NHS and the private sector across the country.

3.157 Moreover, the sMFF data is already used in NHS allocations as an adjustment to tariff payments. Using this same data in pay differentiation would offer consistency and administrative simplicity.

3.158 The DH acknowledges, however, that the application of staff MFF data cannot be considered a perfect automatic solution to local recruitment and retention issues. As set out in earlier chapters, there are local and staff group specific issues that cannot be addressed through crude centralised regional pay adjustments. Some recruitment and retention problems need to addressed locally and may be better addressed through various combinations of pay or non-pay solutions. However, this does not prevent the benefit of applying staff MFF data as means of reflecting broad geographical issues.

3.159 These arguments support the DH view, which is also common in the private sector, that central geographical pay adjustments should be made at a zonal rather than local level.

3.160 Theoretically, as employer level tariff revenue is already adjusted by specific sMFFs, geographical pay differentiation could be readily applied at employer rather than zonal level. DH have not recommended this because:

- the link between staff MFF and recruitment and retention indicators is less clear at organisation level than it is across broader zones (see Chapter 2);
- employers favour a simple system;
- it is harder to explain and justify complex systems to staff and gain their acceptance;
- there needs to remain decentralised scope to deal with local issues;
- the latest sMFF data available at that time.

Method for using sMFF data to inform a geographical pay adjustment

3.161 The DH is not making proposals on the specific long or short term values of geographical pay differentials in this initial evidence. These values will depend on:

- the chosen zoning option (see Chapter 3C), which itself will need further work and consideration before finalisation.
- national and local affordability, taking account of any recommendations by the NHS PRB about the need to set any minimum basic pay award.
- pace of change decisions.
- the extent to which minimum and maximum values will be applied as for the existing London and Fringe HCAS zones.

Note: This issue will need to be considered further in designing any Market Facing Pay imitative.

3.162 Instead, this chapter considers the broad issues involved in using the sMFF data to inform the value of any geographical allowances. The starting point would be to consider the 'untempered' pay differentials for each zone as implied by sMFF data. Other factors would then need to be considered such as affordability and pace of change so that practical recommendations can be developed. These issues are discussed in Chapter 4.

Untempered application of staff Market Forces Factors

3.163 Tables 3.9 and 3.10 present the data on adjusted sMFF data for the zones in the indicative zoning options outlined in Chapter 3C. We have converted the sMFF data from a index centred around 1 to an index with a minimum of 1 attached to the lowest score. The resulting converted index can then be interpreted as indicating an uplift to national pay scales.

Table 3.9: PCT level variation in provider sMFFs (converted to a minimum of 1 basis) under the indicative zoning options

				Provider sMFF Converted to a min =1 basis						
System	Zone C	Zone Label	Number of PCTs	Minimum	25th Percentile	Median	75th Percentile	Maximum	Range	Standard Deviation
4 Zone (Current)	1	Inner London	11	1.35	1.38	1.40	1.40	1.41	0.06	0.02
	2	Outer London	20	1.27	1.31	1.33	1.33	1.36	0.09	0.02
	3	London Fringe	8	1.19	1.21	1.26	1.27	1.33	0.15	0.05
	4	National Payscale	113	1.01	1.06	1.08	1.11	1.27	0.26	0.04
5 Zone (A)	1	Inner London	11	1.35	1.38	1.40	1.40	1.41	0.06	0.02
	2	Outer London	20	1.27	1.31	1.33	1.33	1.36	0.09	0.02
	3	London Fringe	8	1.19	1.21	1.26	1.27	1.33	0.15	0.05
	4	"Other Hot Spots"	13	1.04	1.09	1.12	1.14	1.27	0.23	0.04
	5	National Payscale	100	1.01	1.05	1.06	1.07	1.09	0.08	0.02
5 Zone (B)	1	Inner London	11	1.35	1.38	1.40	1.40	1.41	0.06	0.02
	2	Outer London	20	1.27	1.31	1.33	1.33	1.36	0.09	0.02
	3	London Fringe	8	1.19	1.21	1.26	1.27	1.33	0.15	0.05
	4	"Other Hot Spots"	53	1.04	1.09	1.12	1.14	1.27	0.23	0.04
	5	National Payscale	60	1.01	1.05	1.06	1.07	1.09	0.08	0.02
6 Zone	1	Inner London	11	1.35	1.38	1.40	1.40	1.41	0.06	0.02
	2	Outer London	20	1.27	1.31	1.33	1.33	1.36	0.09	0.02
	3	London Fringe	8	1.19	1.21	1.26	1.27	1.33	0.15	0.05
	4	"Southern Hotspots"	13	1.15	1.16	1.17	1.19	1.27	0.12	0.03
	5	"South & Other Hotspots"	40	1.04	1.09	1.10	1.12	1.14	0.10	0.02
	6	National Payscale	60	1.01	1.05	1.06	1.07	1.09	0.08	0.02
9 Zone	1	Inner London	11	1.35	1.38	1.40	1.40	1.41	0.06	0.02
	2	Outer London	20	1.27	1.31	1.33	1.33	1.36	0.09	0.02
	3	London Fringe	8	1.19	1.21	1.26	1.27	1.33	0.15	0.05
	4	"Level 5"	6	1.18	1.19	1.20	1.22	1.27	0.09	0.03
	5	"Level 4"	7	1.15	1.16	1.16	1.16	1.17	0.02	0.01
	6	"Level 3"	14	1.12	1.12	1.12	1.13	1.14	0.02	0.01
	7	"Level 2 "	23	1.08	1.09	1.09	1.10	1.11	0.03	0.01
	8	"Level 1"	39	1.04	1.06	1.07	1.08	1.09	0.05	0.01
	9	National Payscale	24	1.01	1.04	1.04	1.05	1.06	0.05	0.01

Table 3.10: Organisation level variation in provider sMFFs (converted to a minimum of 1 basis) under the indicative zoning options

System	Zone C	Zone Label	Number of Orgs	Provider sMFF Converted to a min =1 basis						
				Minimum	25th Percentile	Median	75th Percentile	Maximum	Range	Standard Deviation
4 Zone (Current)	1	Inner London	33	1.35	1.36	1.37	1.39	1.41	0.07	0.02
	2	Outer London	37	1.27	1.32	1.33	1.35	1.36	0.09	0.02
	3	London Fringe	26	1.18	1.23	1.27	1.30	1.33	0.16	0.04
	4	National Payscale	293	1.00	1.06	1.08	1.11	1.27	0.27	0.05
5 Zone (A)	1	Inner London	33	1.35	1.36	1.37	1.39	1.41	0.07	0.02
	2	Outer London	37	1.27	1.32	1.33	1.35	1.36	0.09	0.02
	3	London Fringe	26	1.18	1.23	1.27	1.30	1.33	0.16	0.04
	4	"Other Hot Spots"	35	1.14	1.16	1.17	1.19	1.27	0.12	0.03
	5	National Payscale	258	1.00	1.06	1.07	1.09	1.26	0.26	0.03
5 Zone (B)	1	Inner London	33	1.35	1.36	1.37	1.39	1.41	0.07	0.02
	2	Outer London	37	1.27	1.32	1.33	1.35	1.36	0.09	0.02
	3	London Fringe	26	1.18	1.23	1.27	1.30	1.33	0.16	0.04
	4	"Other Hot Spots"	144	1.04	1.09	1.11	1.15	1.27	0.23	0.04
	5	National Payscale	149	1.00	1.05	1.06	1.07	1.15	0.15	0.02
6 Zone	1	Inner London	33	1.35	1.36	1.37	1.39	1.41	0.07	0.02
	2	Outer London	37	1.27	1.32	1.33	1.35	1.36	0.09	0.02
	3	London Fringe	26	1.18	1.23	1.27	1.30	1.33	0.16	0.04
	4	"Southern Hotspots"	35	1.14	1.16	1.17	1.19	1.27	0.12	0.03
	5	"South & Other Hotspots"	109	1.04	1.09	1.10	1.12	1.26	0.22	0.03
	6	National Payscale	149	1.00	1.05	1.06	1.07	1.15	0.15	0.02
9 Zone	1	Inner London	33	1.35	1.36	1.37	1.39	1.41	0.07	0.02
	2	Outer London	37	1.27	1.32	1.33	1.35	1.36	0.09	0.02
	3	London Fringe	26	1.18	1.23	1.27	1.30	1.33	0.16	0.04
	4	"Level 5"	17	1.16	1.18	1.19	1.22	1.27	0.11	0.03
	5	"Level 4"	18	1.14	1.15	1.16	1.16	1.21	0.07	0.02
	6	"Level 3"	41	1.09	1.10	1.12	1.13	1.26	0.17	0.03
	7	"Level 2 "	62	1.06	1.08	1.09	1.10	1.17	0.10	0.02
	8	"Level 1"	99	1.04	1.06	1.07	1.08	1.09	0.05	0.01
	9	National Payscale	56	1.00	1.03	1.04	1.05	1.15	0.15	0.02

3.164 The data in the tables can be used to indicate the pure or untempered geographical pay supplement values indicated by sMFFs. For example, in the indicative 6 zone system a supplement of 14%-27% of basic pay would appear appropriate for the “southern hotspots” zone. Or, in the indicative 9 zone system a supplement of 4%-9% of basic pay would appear appropriate for the “Level 1” zone.

3.165 Rather than indicating an untempered supplement value in the middle of these ranges, the minimum is more appropriate. This avoids the risk that the sMFF adjustment to organisational income would be insufficient to cover the cost of any recommended supplement. It also ensures that organisations with higher sMFFs would still have some flexibility within their current resource allocation to address residual recruitment and retention issues locally. In the examples given, this suggests untempered supplement values of 14% and 4%, respectively.

Further issues in setting appropriate geographical supplement values

3.166 However, an untempered application of the minimum staff MFF score for the zone is unlikely to be appropriate. It is notable that the value of the current HCAS zones does not match that implied by the untempered allocation of sMFF data. The rationale for not applying the untempered values to the new zones relate to:

- National affordability concerns.
    - In the short term, pay growth is constrained to an average of 1% per year. In the longer term, affordability will remain an issue. The generation of appropriate pay differentiation will need to operate within these constraints.

- Local affordability concerns.
    - Without specific transitional adjustments, the application of geographical pay differentiations will not alter allocations or tariff payments. Both are already informed by sMFFs. Geographical pay differentiation would then be a cost pressure, over the previous year, for some organisations.

- This issue could be eased through limiting the pace of transition to the new pay differentials. It could also eased by transitional funding arrangements, but the merits and affordability of this would need to be considered.

- The need for some of the funds distributed by the sMFF to be left to address local issues through local pay flexibilities and other tools.

3.167 In practical terms the appropriate value of any geographical supplement will therefore be informed by:

i. Considering the sMFF values for each zone in the chosen zoning options to determine appropriate untempered supplement values.

ii. Considering how close the implemented supplement values should be to the untempered implications of sMFF data, taking into account:

- The need to ensure appropriate differentials between the zones;

- The need to ensure resource remains available for local flexibilities to deal with local and staff group specific issues;

- The need to ensure local and national affordability in implementation allowing for the costs of any basic pay award and any possibility of transitional funding arrangements;

- The aim to maximise the pace of change towards preferred geographical pay differentiation subject to these constraints.

- The extent to which absolute minimum and maximum values will be applied to proportional HCAS rates.

3.168 More work will be needed to consider the appropriate values for any geographical supplements when there is greater certainty about the preferred direction of travel for Market Facing Pay, including the choice of zones, and greater certainty about the timing of implementation and the affordability situation at that point.

The benefits of incremental implementation of Market Facing Pay

3.169 Implementation issues are considered further in Chapter 4, but at this point it is worth noting the DH view of the benefits of this process happening incrementally.

3.170 The zonal pay approach could be implemented by setting long term aims for geographical supplement values and a rigid timetable for reaching these over a number of years. The DH view is that, while there is some benefit to both employers and staff in having the certainty that accompanies a rigid plan, the inflexibility of this approach means that we would lose the important benefits of being able to adapt our proposals in light of experience. Monitoring the impact of introducing a new policy such as Market Facing Pay, monitoring the emerging financial circumstances, and having the ability to adjust the plan in light of experience will be important.

3.171 Instead, the DH suggests a more incremental approach where, at least in the first instance, changes to geographical pay supplements are considered year by year alongside headline pay settlements perhaps under the broad framework of a published direction of travel. This seems prudent given the uncertain economic environment and the possibility of strengthening the evidence base on Market Facing Pay implementation through experience.

Conclusion

3.177 The DH already uses sMFF data to inform financial allocations to commissioners and to adjust tariff payments to providers. sMFF data provides an objectively justifiable indicator of the geographical pay differentiation to offset differences in cost of living and general amenities across areas. The DH therefore believes that sMFF data offers the best prospects for informing the value of geographical pay differentiation.

3.178 However, the DH considers that an untempered application of sMFF data in setting the value of geographical supplements would be inappropriate. The value of supplements should reflect the need to leave some resources for use at local employer discretion to address local issues. It should also reflect national and local affordability issues allowing for the costs of any basic pay award and any possibility of transitional arrangements.

3.179 The DH are not making proposals on the specific long or short term values of new geographical pay adjustments in this initial evidence. These values will depend on the chosen zoning option (see Chapter 3C); national and local affordability issues; pace of change decisions; and the extent to which minimum and maximum values should be applied as they are for the existing London and Fringe HCAS zones. More work will be needed to consider the appropriate value for any new geographical supplements when there is greater certainty on these factors.

3.180 Careful consideration must also be given to implementation. These issues are considered further in the Chapter 4, but it should be noted initially that DH favour an incremental approach where, at least in the first instance, changes to geographical supplement values are considered year by year alongside headline pay settlements perhaps under the broad framework of a published direction of travel. Such an approach would be more prudent given the current difficult economic environment. It would also allow increased flexibility and the opportunity to strengthen the evidence base on Market Facing Pay implementation as the DH and NHSPRB build experience of Market Facing Pay. This seems more appropriate than setting any target values for geographical supplements and a rigid timetable for reaching them.

CHAPTER 3E

Which contractual mechanism should be used to pay geographical pay differentials?

3.181 As outlined in earlier chapters, AfC already includes a wide range of flexibilities which could be extended to better reflect Market Facing Pay

3.182 This chapter describes the potential mechanisms available for implementing any centrally determined geographical pay adjustment.

3.183 The four main options, for introducing a market-facing element to the NHS pay system are:

- Recruitment and Retention Premia;
- Introduction of Regional Pay Scales;
- Locally Negotiated Pay;
- Introduction of additional HCAS zones.

3.184 As ultimately each mechanism has the effect of distributing pay differently across England, they each need to be considered against a number of criteria including:

- *their efficiency and cost-effectiveness, particularly their impact on the cost and quality of staff that the NHS is able to recruit and retain.*
- *the ease with which they can be implemented from a contractual perspective.*
- *the extent to which their use would encourage buy-in from employers, Trades Unions and individual members of staff.*
- *the administrative burden of setting up and maintaining the system recognising the degree of geographical variation the system would need to support.*
- *the flexibility to vary additional pay rates as required.*

Recruitment and Retention Premia (NRRP)

National Recruitment & Retention Premia

3.185 At the moment, AfC includes provision for recruitment and retention premia to be awarded on a national basis to particular groups of staff on the recommendation of the NHS Pay Review Body (NHSPRB) where this can be objectively justified because there are national recruitment and retention difficulties.

3.186 There is also a list of staff groups for which a national RRP was introduced in 2004 as part of the assimilation of staff to AfC[21]. However, this list was

[21] Chaplains, Clinical coding officers, cytology screeners, dental nurses, technicians. Therapists and hygienists, estates officers, financial accountants invoice clerks, biomedical scientists, payroll team leaders,

reviewed following the land mark equal pay case of Hartley vs Northumbria Healthcare NHS Foundation Trust (2008) and is being phased out.

3.187 In particular, the Employment Tribunal in the case of Hartley advised that national RRPs for the maintenance craft workers group had to be objectively justified or removed. This led to an independent review of all national RRPs which concluded that there is no evidence or justification for their continuation. The NHS Staff Council therefore decided that these RRPs should be phased out in 2 stages; they will be reduced to half their full value with effect from 1 April 2012 and will cease altogether on 1 April 2013.

3.188 The DH has considered whether national RRPs might be used to promote Market Facing Pay, but believes that this would not be the most appropriate way forward. Previous chapters have made it clear that any centralised geographical pay adjustment should be applicable to all staff within a region. Adjustments for particular staff groups should be made separately through the normal routes of national of local RRPs.

3.189 However, national RRPs are traditionally used to provide additional pay for selected staff groups rather than for all staff within a particular geographical zone. The use of national RRPs for all professions is possible but would risk confusing staff and employers about the purpose of RRPs.

3.190 Moreover, the introduction of national RRPs for selected staff groups, without strong evidence and justification, might undermine the important principle under equal pay legislation that staff receive equal pay for work of equal value or work that is rated as equal under a bona fide job evaluation system.

Local Recruitment & Retention Premia

3.191 The second form of additional pay flexibility which employers may use to take account of local labour market pressures and aid recruitment and retention is a local RRP. This is an addition to the pay of an individual post or specific group of posts where market pressures in the locality would otherwise prevent the employer from being able to recruit or retain staff in sufficient numbers for the posts concerned, at the normal salary for a job of that weight.

3.192 RRPs can be used by individual employers locally to help resolve recruitment and retention difficulties with specific staff groups or bands within a staff group. They are a targeted tool to be used to address imbalances within local labour markets and are not designed to be used across the whole workforce or whole staff groups.

3.193 They can be used on a short or long term basis. Short-term RRPs will apply where the labour market conditions giving rise to recruitment and retention problems are expected to be short-term and where the need for the premium

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pharmacists, qualified maintenance crafts persons, qualified maintenance technicians, qualified medical technical officers, qualified midwives, qualified perfusionists.

is expected to disappear or reduce in the foreseeable future. They should be regularly reviewed and may be withdrawn or have their value adjusted subject to a notice period of six months.

3.194 Long-term RRPs will apply where the relevant labour market conditions are more deep-rooted and the need for the premium is not expected to vary significantly in the foreseeable future. Nevertheless, they should also be reviewed regularly.

3.195 The combined value of any nationally awarded and any locally awarded recruitment and RRPs for a given post is not normally permitted to exceed 30 per cent of basic salary. It is the responsibility of individual employers to ensure that employees do not receive in excess of this amount. However, RRPs can be used alongside HCAS payments.

3.196 RRPs are used as a flexible tool to deal with recruitment and retention difficulties in specific posts or staff groups. They are not mutually exclusive with the concept of a centralised geographical allowance. Indeed, they may be used alongside one to address specific recruitment problems. The DH believes that employers will continue to need this flexibility even if more Market Facing Pay is introduced and that the purpose of RRPs should not be confused by using them to address recruitment and retention issues that apply to the workforce as a whole.

Introduction of Regional Pay Scales

3.197 The DH has considered whether it should introduce different pay scales for different, defined areas in the UK. However, it is considered that the introduction of such an arrangement would be very complex, time-consuming, expensive and unnecessary.

3.198 The DH recommends instead that Market Facing Pay could be introduced more easily by setting the AfC pay rates at the minimum level required in England and making more extensive use of HCASs to add to this wherever required.

3.199 This approach would also avoid the need to renegotiate national terms and conditions which is normally time-consuming and costly. For example, the introduction of AfC took over 2 years and increased the NHS paybill considerably.

3.200 The annual cost of employing Agenda for Change staff in the NHS (England) rose by £7.4 billion (36%) from £20.8 billion in 2003-04 to £28.2 billion in 2007-08[22]. Increases were due to:

[22] The NAO in their 2009 report on AfC presented two counterfactuals with regard to costs.
a) One is to use the 5% p.a. historic figure. This suggests Agenda for Change has helped contain wage costs. The NAO conclude with this model that implementation of Agenda for Change has led, over the years 2003/4 to 2007/8 to a paybill cost of £604m (0.8%) lower than it might have been has AfC not been implemented

- 13% growth in the size of workforce;
- 22% employers' increase in National Insurance contribution;
- 65% higher levels of earnings, at 4.9% p.a. over the 5 year period comprising pay awards, pay drift and the impact of Agenda for Change

3.201 In addition to the time and cost associated with the relatively recent introduction of AfC, we do not consider that there is the appetite amongst employers to introduce regional payscales. Rather, we understand that employers would prefer to retain a national pay framework, with appropriate recognition of local market factors through existing HCAS arrangements, and increased flexibility for local discretion .

3.202 The Trades Unions are also unlikely to agree to the re-negotiation of AfC payscales without seeking considerable concessions in other areas. At a time of low growth and fiscal restraint, this could have a significant and costly effect, for relatively little return. It could also impact adversely on national and local Industrial Relations.

3.203 As a result, the DH does not consider that replacing national AfC pay-scales with a number of regionally-based pay-scales would be cost-efficient or meet the needs of employers across the service.

Locally Negotiated Pay

3.204 Foundation Trusts already have delegated authority to determine their own pay. Consideration has therefore been given to whether Market Facing Pay would be best introduced by devolving responsibility to local employers for negotiation.

3.205 Pay decisions could be made at the local level. However, this has not been particularly successful in the NHS in the past and would require a significant step change in the capability and capacity of local organisations. (i.e. local HR professionals and local staff representatives to manage pay negotiations locally).

3.206 In addition, the framework to introduce local negotiations would require careful consideration so that the necessary administrative processes were in place to ensure affordability, transparency and fairness, and to do so in a way that would not divert scarce HR resources from focusing front line services or risk introducing industrial relations problems at a local level.

3.207 A great deal of consideration would also need to be given to equal pay issues within a locally negotiated system. Currently, the AfC framework is

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b) The alternative, which NAO favour, assumes 5% pay increase to 2004-05 and 4.5% in the three subsequent years 2005-06, 2006-07 and 2007-08. This results in an estimate that implementation of Agenda had a net cost of £186m (0.6%) higher than it might have been has AfC not been implemented.

underpinned by a job evaluation system consistent with equal pay principles. Differential pay increases across the country for staff in the same pay bands could raise equal pay risks.

3.208 On balance therefore, the DH believes that the current approach in which FTs have the right but not the obligation to determine pay locally is most efficient in that it provides a pressure for national negotiators to ensure that national terms and conditions are affordable and fit for purpose, but avoids the costly overhead and risks of mandatory local negotiations.

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Introduction of Additional High Cost Area Supplement (HCAS) Zones

3.209 Prior to the introduction of AfC in 2004, a system of London Weighting Allowances was in operation, which reflected geographical pay variations across the NHS.

3.210 HCAS zones, which reflect the intention of the previous London Weighting Allowances, were introduced as part of AfC. How HCAS operates and the values of individual supplements are detailed within the AfC handbook and are reviewed annually. As a collective agreement, any changes would be made in partnership between NHS Employers and NHS trades unions.

3.211 HCASs are pensionable and currently apply to whole workforces in inner, outer and fringe London zones and are based on current PCT geographical boundaries.

3.212 Employers outside of these zones can put forward a case for new zones beyond those already established, provided that criteria for their introduction is agreed by the local employing Trusts in that area.

3.213 Funding for HCAS is met from employer budgets, derived from central allocations which are adjusted to take account of the MFF. No further additional funding is provided centrally to support the cost of HCASs.

3.214 The value of HCAS is reviewed annually, based on the recommendations of the NHSPRB and it is open to the NHSPRB to make recommendations on the future geographic coverage of HCAS and on the value of such supplements.

3.215 HCAS is designed to work within the national AfC framework and alongside national and local RRPs. This means that employers in HCAS zones can continue to make use of these additional pay flexibilities locally where considered appropriate.

Conclusion

3.216 Bearing in mind that any change to terms and conditions would be subject to national collective bargaining, and that employers and staff are content with the current principle of using RRPs and HCASs, the DH believes that the most simple, cost-effective and safe way to introduce more Market Facing Pay would be to:

i) Retain national collective agreements.
ii) Retain the flexibility for individual employers to use local RRPs to address local specific recruitment and retention issues.
iii) Retain the ability for the NHS PRB to consider the need for national RRPs, noting that these are rarely if ever likely to be more appropriate than local RRPs.
iv) Move towards a position where national AfC pay rates are set at the minimum level necessary to ensure adequate recruitment of sufficient high quality staff in geographical areas where the sMFF is relatively low.
v) Extend the use of HCASs where required to enable employers in areas where the sMFF is higher to recruit and retain sufficient high quality staff in most staff groups, whilst leaving local employers sufficient resource flexibility to address specific recruitment and retention needs locally using local RRPs and non-pay incentives and rewards.

3.217 The DH believes that this approach would offer the most cost-effective and efficient use of NHS pay bill. It would also overcome the growing problem that employers in low sMFF areas are currently resourced to take account of cheaper local labour markets but are locked into relatively expensive national contracts for NHS staff. Failure to address this anomaly risks forcing those employers to abandon national collective agreements as unaffordable or become uncompetitive with private sector providers in their areas.

CHAPTER 4

IMPLEMENTATION AND TRANSITION ISSUES

4.1 The earlier chapters set out the DH's view that whilst individual employers such as FTs should retain the freedom to determine what they pay their staff, the majority of employers prefer to use national terms and conditions provided that they remain affordable and fit for purpose. A number of employers, especially those in low sMFF areas, felt that the current national pay arrangements failed to take full account of variations in regional pay outside of London and the South East of England. The DH therefore feel that there would be significant benefits if the pay of Agenda for Change staff could be made more responsive to local labour markets.

4.2 The DH had considered a range of options to achieve this and had concluded that the safest, quickest and most appropriate way forward would be to build on existing facilities within the AfC pay framework. In particular, the DH proposed to:

- continue to allow individual employers the freedom to determine their own pay, terms and conditions, subject to the normal conditions of employment law;
- retain a single national pay framework which is negotiated and maintained centrally by the NHS Staff Council;
- continue to give individual employers the freedom to determine RRPs to address local recruitment and retention issues; and
- introduce one or more additional HCAS zones, with the geographical boundary and value of additional pay for each zone to be recommended by the NHS PRB taking account of the sMFFs for each area.

4.3 More work is required to flesh out the detail behind this broad direction of travel, but the DH believes that it should be possible to begin implementation with effect from April 2013, beginning in an incremental way that sets strong foundations but allows sufficient flexibility to adapt our approach in the light of experience. The DH further believes that such an approach would provide best value for money for the tax-payer.

4.4 As with any proposed new policy, however, it is important that the DH identifies and mitigates any risks and issues to ensure smooth implementation and that there are no unforeseen consequences. This includes careful consideration of any implementation and transitional issues. This chapter explores these issues and presents current DH thinking on how they could be addressed, recognising the need for further work to ensure effective implementation with a minimum of delay.

4.5 The main challenge facing the implementation of Market Facing Pay is how to manage the trade offs in achieving greater geographical pay differentiation whilst:

- Maintaining national affordability;
- Maintaining local affordability and employer stability;
- Maintaining adequate recruitment and retention in all areas of the NHS;
- Delivering adequate earnings for all staff.

4.6 Alongside this, is a need to manage the contractual, logistical, and legal issues around Market Facing Pay implementation as well as any industrial relations concerns. This chapter considers these important issues first before covering the management of the trade-offs between a quick transition to greater Market Facing Pay and other objectives.

Managing the Logistical, Contractual, Legal and Industrial Relations Issues.

Logistical – System Reform

4.7 There are a number of wider changes that are taking place across the NHS in England. The key changes are that the NHS Commissioning Board will be set up and eventually take on the responsibilities of the SHAs and PCTs, The four broad phases of development until April 2013 are as follows and further detail is set out at Annex G;

- **October 2011 to March 2012:** the NHS Commissioning Board, a special health authority (Board Authority) is established. It is responsible for developing clinical commissioning groups as well as designing the new commissioning architecture and developing the Board itself.

- **April 2012 to September 2012:** the Board Authority takes over some National Patient Safety Agency functions and, subject to its successful passage through Parliament, the Bill is enacted.

- **October 2012 to March 2013:** the Board Authority becomes an Executive Non-Departmental Public Body (ENDPB), responsible for planning for 2013/14.

- **April 2013:** strategic health authorities (SHAs) and primary care trusts (PCTs) will be abolished, and the NHS Commissioning Board (the Board) will take on its full statutory responsibilities.

4.8 As a result of these reforms, there are a considerable number of changes to the workforce. These include staff transferring to new organisations under compulsory and voluntary arrangements, staff at risk of redundancy and staff

who may be at risk, but are performing ‘close-down’ or time-limited roles to facilitate the abolition of existing structures and transfer to organisations.

4.9 It is envisaged that changes within the NHS workforce as a result of system reform, will be completed for the majority of staff by April 2013, with changes relating to smaller residual groups completing around six months after by October 2013. At this point, the expectation is that the NHS workforce will return to a relatively stable position in its new functions.

4.10 However, we would need to be mindful of the significant scale of these reforms and the demands that they place on local employers, especially HR staff. Further detailed work would therefore be needed to ensure that local employers have the capacity and capability to support Market Facing Pay.

4.11 That said, the DH believe that introducing Market Facing Pay by building on the existing AfC pay framework should be possible without putting reform at risk. In particular, the staff transfers that will take place as a result of the reforms will have limited impact on the provider side which employs the majority of staff. And, any move towards Market Facing Pay would help those organisations that are striving to achieve FT status who are in low sMFF areas and are currently saddled with paying national rates of pay that do not correctly reflect their lower local market rates of pay.

Contractual Issues

4.12 The discussion so far has focused on introducing additional HCAS zones to reflect local labour market issues, whilst retaining the AfC framework at a national level. The DH believes that this could be introduced without the need to change existing contracts of employment or any fundamental change within the AfC agreement. We would however need to discuss the details with the NHS Staff Council once the NHSPRB recommendations are clear.

4.13 Careful consideration would also need to be given to how zonal HCAS pay will interact, with existing HCAS and RRPs and how this is managed during transition to avoid additional financial pressure on employers who are already paying local RRPs or offering other incentives that may no longer be necessary or appropriate once Market Facing Pay has been introduced.

4.14 There will be other issues to consider too. For example, whether new pay elements should be paid to both existing and new staff. The DH is working on the basis that Market Facing Pay measures will be introduced equally for both existing and new staff. Applying changes to new starters only may be initially seen as easing transitional issues, but it would slow the pace towards overall geographical pay differentiation, and could harm the perceived fairness of the pay system and increase equal pay risks.

4.15 In addition, we will need to consider carefully the need for special arrangements for a number of potentially ‘atypical roles’, particularly in relation to the new national organisations that are being set up.

4.16 While the vast majority of AfC posts fit within the Market Facing Pay arrangements proposed, a small minority of roles may not fit neatly into Market Facing Pay arrangements, where for example individuals are required to work across a number of different regions.

4.17 Leaders and other staff in some of the new national NHS organisations will be responsible for transforming delivery and will need to attract and retain high calibre leaders and staff with the right skills and experience.

4.18 The Health and Social Care Act fundamentally reforms the architecture of the healthcare system with the abolition of SHAs and PCTs and the creation of a number of new national bodies such as the NHS Commissioning Board - as well as new local bodies in the shape of Clinical Commissioning Groups. It also requires a step change in the provider side with a push to all Foundation Trust status by 2014 and the prospect of more NHS provision by the independent and private sector. At this stage in the transition it is impossible to fully understand how new NHS organisations will use the flexibilities they have around pay, or exactly how the new national bodies will operate. Therefore it is difficult to give definitive advice and evidence about how local pay might be applied sensibly to these new organisation, and it will be important to consider this going forwards.

4.19 Some new national organisations, for example, the National Trust Development Agency, Health Education England and the NHSCB, will not be finally established until April 2013. It will be important to ensure the recruitment and retention prospects in these organisations are not adversely affected. However, the structure and roles for these new national organisations are still under development and we cannot at this very early stage accurately predict or provide the evidence (as we have provided for other NHS organisations) on the precise nature of every role, some of which may be peripatetic.

4.20 Clearly there are risks in applying market facing pay to national organisations – a perception by staff that they are unfair, a potential increase in equal pay claims. However, broadly speaking we think we can manage these risks, such as equal pay claims.

4.21 It is clear however that some roles will need to be recruited from within national rather than local labour markets, regardless of where they are based. Some of these may be Very Senior Managers (VSMs), which are covered by separate VSM rather than AfC arrangements. However, some of these may also be AfC staff. In these circumstances, it may be that the application of Market Facing Pay arrangements could impede their recruitment and retention prospects. For example, the NHS CB is likely to have staff with national roles which have a notional base in one area but are regularly required to work across a broad geographical area that might span two or more pay zones. If such staff operate in a national market then zonal pay could lead to unequal recruitment and retention prospects across the organisation.

4.22 In addition, one of the real new strengths of having these national organisations is the opportunity they will have to deploy talented people to areas of the country where it is most needed because of the challenges being faced. In those circumstances it will be crucial that the application of MFP does not restrict that ability which will be so important in driving the kinds of improvements in services that the Bill envisages.

4.23 As the organisational design of the new bodies develops over the next few weeks we feel it is very important that the new bodies have the opportunity to provide further evidence to the PRB for them to consider in their deliberations before they reach any final recommendations. It would be helpful if this could be part of a two way dialogue which we could look to set up between the relevant people in the national bodies and the PRB next month.

4.24 The Department therefore invites the NHS PRB to consider such issues and make recommendations that ensure the recruitment and retention prospects of such roles are not adversely affected in such organisations

Managing the pace of change

4.25 Notwithstanding the contractual, legal and logistical issues described earlier, the implementation of greater Market Facing Pay would involve managing the trade-offs between faster transition to greater geographical pay differentiation and:

- Maintaining national affordability;
- Maintaining local affordability and employer stability;
- Maintaining adequate recruitment and retention in all areas of the NHS;
- Delivering adequate earnings growth for all staff.

National affordability

4.26 Affordability will be key to the implementation of Market Facing Pay. The NHS PRB's remit includes taking account of the affordability of proposals in light of the fiscal position. It states Market Facing Pay should not lead to any increase in paybill in the short or long term. It is therefore crucial that any proposals are robustly costed and tested to ensure that they will not jeopardise local or national affordability. It is also critical that the proposals leave sufficient resources available to fund local initiatives to deal with local and staff group specific issues.

4.27 The broad direction of travel of Market Facing Pay suggested by DH is yet to have been worked up into a level of detail where meaningful costing are possible. Costings will be a part of more detailed work in the future. and will ensure that scheme designs remain within affordability constraints.

Local affordability and employer stability

4.28 As described in Annex B, sMFFs are already reflected in both the financial allocations received by NHS commissioners and also in the tariff income received by providers. This financial distribution promotes financial equity across the NHS and is consistent with the underpinnings of Market Facing Pay. In the longer term, this puts the NHS in a strong position for implementing Market Facing Pay. We do not therefore wish to change our allocation methodology which is academically well- founded and well understood by the NHS.

4.29 However, in the shorter term there may be particular issues for some employers. Organisations in the new HCAS zones may have additional paybill pressures from the payment of HCASs, depending on previous decisions to use existing pay flexibilities. However, their incomes, which already appropriately reflect sMFFs, may not change substantially. Absorbing the resulting pressure may be challenging depending on the value of the HCAS and wider financial circumstances. In addition it is important to note that employers outside the new HCAS zones would not face these pressures

4.30 From the point of view of facilitating local affordability and stability, this suggests a case for limiting the pace of change to a locally manageable level. If a faster transition is sought then the DH would need to consider whether any transitional measures to ease implementation issues were justified. The merits and affordability of any adjustment would need to be considered carefully.

4.31 Another risk to the stability of individual organisations is the possibility that employers within the newly designated HCAS zones may already be incurring costs through the use of pay or non-pay flexibilities to promote recruitment and retention. Adding a HCAS payment could duplicate costs and over-compensate for recruitment and retention issues.

4.32 For example, some existing RRPs may be effectively compensating cost and amenity differences to boost recruitment and retention in particular areas. As presented in Chapter 3A, there is a skew towards their use in SHAs with high sMFF other than London (although some of this may reflect historical issues relating to the withdrawal of Cost of Living Supplements (COLS).

4.33 In any case, some RRPs may be generating the geographical pay differentiation that would be sought by introducing new HCAS zones. Paying HCASs on top of the existing RRPs may offer inappropriate double reward.

4.34 The pattern of RRPs is not consistent enough to consider adjusting the HCAS values centrally in response. Other options to be considered include: giving enough notice of HCAS introduction to facilitate the withdrawal of RRPs; defining the HCAS system such that employers would determine appropriate top up values to reach central HCAS value taking into account RRPs already in place; or by setting recommended rather than required HCAS values (at least in the first instance).

4.35 There is a similar issue for non-pay recruitment initiatives that may already be in place. One option may therefore be to recommend new HCASs rather than

require them (at least for an initial period). However, this would weaken the impact of HCASs which would be undesirable. A delicate balance must be struck.

4.36 These uncertainties aside, it is clear that the scale of variation in sMFFs is substantial. Even if only a fraction of this variation is to be addressed immediately through new HCASs, it would be helpful.

Maintaining adequate recruitment and retention in all areas of the NHS

4.37 A faster achievement of greater geographical pay differentiation could be achieved by maximising the gap between pay growth in low sMFF areas and that in high sMFF areas. For example, freezing national payscales and diverting all available resources into HCAS payments would promote a relatively fast geographical redistribution of pay.

4.38 However, there is a need to be mindful of the recruitment and retention prospects that remain in areas where pay growth is most restrained. Whilst low sMFF areas already receive greater geographical pay differentials than private sector comparators, the experience and perception of continued pressure on real earnings after an existing period of headline pay restraint may have a bearing on recruitment and especially retention. Although, it is also fair to say that alternative prospects with other employers will also play a role and could be limited.

4.39 As such, this risk will need to be monitored and managed. As imbalances in geographical pay differentiation compared to area cost and amenity differences are smoothed out, we would expect recruitment and retention indicators to equalise across the country. This may imply a deterioration for low sMFF areas currently offering excess geographical pay differentials. The key will be to ensure that such areas retain adequate recruitment and retention prospects in line with the rest of the NHS.

Delivering adequate earnings growth for all staff.

4.40 In terms of promoting efficiency in the use of public resources, the level of earnings growth that is deemed adequate is that which delivers adequate recruitment and retention prospects.

4.41 However, there may be instances where a wider perspective is relevant. For example, PRB remits in the past two years have asked the review bodies to specifically consider lower earners. Similar considerations in the future would imply an additional objective to be managed in pace of change decisions.

Potential framework for managing pace of change

4.42 A faster transition towards greater geographical pay differentiation increases the potential risks around the issues described above. The more these risks

are mitigated the slower the realisation of the benefits of greater Market Facing Pay.

4.43 As well as shaping the initial design of Market Facing Pay, the DH would envisage the NHS PRB to have a key role in informing these trade-off in future evidence rounds.

4.44 The DH considers the broad framework for managing this transition to involve:

i) A prolonged period of constrained headline pay awards:

To provide the headroom for earnings growth in the newly designated HCAS zones to generate pay differentiation without undermining overall affordability.

ii) Consideration of the appropriate headline basic pay award:

To deliver a balance between:
- *The pace at which the desired geographical pay differentiation can be achieved;*
- *Maintaining adequate recruitment and retention possibilities in areas outside HCAS zones;*
- *Offering any relief to the low paid that is deemed appropriate.*

iii) Consideration of the appropriate value of HCAS zones:

To deliver movement towards the desired geographical differentiation without undermining the stability of employers and local and national affordability (allowing for the costs of basic pay awards).

4.45 A faster transition that did not compromise national affordability could theoretically be achieved through reductions in nominal basic pay. However, this is not an approach that the DH would advocate. In a period of low growth and other competing pressures on the workforce such an approach could have serious consequences for industrial relations locally and nationally; it may also be contractually difficult to implement.

4.46 Instead, the DH favours a more measured approach balancing the speed of geographical pay distribution against affordability, recruitment, retention, and other risks. This could make the transition towards desired geographical pay distribution, starting as soon as possible but recognising that full implementation would be a long-term task, perhaps taking several years. If a faster transition is sought then the DH would need to consider whether any transitional measures to ease implementation issues were justified. The merits and affordability of any adjustment would need to be considered carefully.

Timing

4.47 It is the Government's high-level aspiration to move towards more local, Market Facing Pay from April 2013. The DH believes that this is possible, especially if the NHS PRB accepts the DH's proposal to build upon existing facilities within AfC. However, further work may be needed once the NHSPRB has produced its initial findings and recommendations, and detailed implementation plans cannot be drawn up until that time.

4.48 The initial progress towards full implementation will depend on the trade-offs mentioned earlier; the level of completeness of the evidence base on Market Facing Pay and the degree of stability required of pay systems in the current context of NHS reform. The progress made in setting a direction of travel, by this specific evidence round, will help solidify the issues.

4.49 We expect the next evidence round to provide more information about how long it might take to fully introduce Market Facing Pay. This is difficult to accurately assess now as it will depend on the degree of geographical redistribution being sought, the level of basic pay awards and affordability constraints.

Incrementally Determined Vs Pre-Specified Transition

4.50 The transition to a new geographical pay differentiation is unlikely to happen in one step. It is more usual for the NHS to implement such changes at an agreed pace of change which has been informed by the trade-offs described earlier.

4.51 Transition could follow two broad models.

i) 'pre-specified':
In this model, the eventual target values of a HCAS zone would be set in advance [by the Government following advice from the NHS PRB] (say at 5% of basic pay) and the movement towards this also set in advance [or capped at an agreed rate] (say increasing in 0.5 percentage point intervals over 10 years).

ii) 'incremental':
In this model, a broad direction of travel and pace of change would be considered in the first instance and then HCAS values set for the next year. In following years this assessment would be revisited taking advantage of newly available data and the experience of introducing Market Facing Pay to date.

4.52 It is important the change is delivered safely, minimising risks around affordability and recruitment and so on. As such, the DH favours the incremental approach (at least in the first instance) with NHS PRB reviewing progress and informing each next step through the annual pay rounds. Given the uncertain economic environment, ongoing NHS system reform and the possibility of strengthening the evidence base on Market Facing Pay implementation through experience, this seems more prudent than setting target values for HCAS and a rigid timetable for reaching them.

4.53 This incremental approach may also provide useful flexibilities for other aspects of Market Facing Pay design. Chapter 3C already raises the possibility of refining the design of Market Facing Pay over time, for example by changing the number of HCAS zones. Initially, the number of zones may be constrained by: the evidence base supporting Market Facing Pay design; the administrative difficulty of managing multiple zones; and, by the affordability difficulties of generating meaningful pay differentials. Over time, these constraints may relax and appropriate refinements to the Market Facing Pay approach could be made.

Conclusion

4.54 A key challenge facing the implementation of Market Facing Pay is how to manage the trade-offs of achieving greater geographical pay differentiation while:

- Maintaining national affordability;
- Maintaining local affordability and employer stability;
- Maintaining adequate recruitment and retention in all areas of the NHS;
- Delivering adequate earnings for all staff.

4.55 Alongside these, is a need to manage the contractual, logistical, and legal issues around Market Facing Pay implementation as well as the implications for industrial relations.

4.56 As set out in earlier chapters, we would need to consider carefully the wider system reform in the NHS and the resulting organisational changes for the workforce, which are still taking place. It would be important to plan the introductory point for a Market Facing Pay system at an appropriate stage taking account of wider system reform. It would also be necessary to define any additional organisational roles and responsibilities with regard to setting or informing local pay. Some of these changes may effect the basis of sMFF data.

4.57 The DH would wish to engage closely with Trades Unions and NHS Employers through the NHS Staff Council to ensure that the introduction of Market Facing Pay took due account of national collective agreements, employment law and equality legislation.

4.58 Pace of change decisions would need careful consideration to balance a faster realisation of the benefits of Market Facing Pay, against the potential risks around affordability and recruitment and retention and so on.

4.59 The DH envisages a key role for NHS PRB in helping manage these issues. The trade-offs could be managed in the context of a framework where basic pay awards are constrained to generate headroom for greater pay differentiation through HCAS payments. A balance would need to be struck between the basic pay awards necessary to deliver adequate earnings for all staff and protect the lower paid, and the levels required to maximise the funds

available for HCASs to ensure sufficient geographical differentiation in pay to recognise local market factors.

4.60 The DH proposes managing this balance incrementally, year by year, at least in the first instance, to facilitate informing this with the emerging economic environment, new data and better intelligence from the introduction of Market Facing Pay to date.

4.61 As described in Annex B, sMFFs are already reflected in both the financial allocations received by NHS commissioners and also in the tariff income received by providers. This financial distribution promotes financial equity across the NHS and is consistent with the underpinnings of Market Facing Pay. In the longer term, this puts the NHS in a strong position for implementing Market Facing Pay.

4.62 However, in the shorter term there may be particular issues for some employers. Organisations in the new HCAS zones may have additional paybill pressures from the payment of HCASs, depending on previous decisions to use existing pay flexibilities. However, their incomes, which already appropriately reflect sMFFs, may not change substantially. Absorbing the resulting pressure may be challenging depending on the value of the HCAS and wider financial circumstances.

4.63 From the point of view of facilitating local affordability and stability, this suggests a case for limiting the pace of change to a locally manageable level. If a faster transition is sought then the DH would need to consider whether any transitional measures to ease implementation issues were justified. The merits and affordability of any adjustment would need to be considered carefully.

CHAPTER 5

MAINTAINING THE MARKET FACING PAY SYSTEM OVER TIME?

5.1 The previous chapters have set out the DH's position on how the pay of Agenda for Change staff can be made more responsive to local labour market conditions.

5.2 In summary, the DH supports introducing one or more additional High Cost Area Supplement (HCAS) zones, with the geography and value of zones informed by staff Market Forces Factors (sMFFs), whilst retaining the scope for existing employer flexibilities to deal with local and staff group specific issues.

5.3 The previous chapter discussed issues relating to the initial implementation of Market Facing Pay measures. This chapter covers how the proposed Market Facing Pay system might operate over time.

Supporting a centralised zonal HCAS system

5.4 DH believe that Market Facing Pay issues will form a key element of the annual PRB process in the future. The DH expects the annual rounds to inform the management of the HCAS zones, their value and the total level of geographical pay differentiation for Agenda for Change staff.

5.5 After the initial design and implementation of new HCAS zones this will involve considering:

- The appropriate value of headline basic pay awards;
- The appropriate number, size and shape of HCAS zones; and,
- The appropriate value of HCAS zones.

5.6 Considerations of HCAS and basic pay values will need to be mindful of the trade-offs between the pace of change towards target geographical pay differentiation and risks to the system. The previous chapter sets these out these risks in more detail. It highlights that faster pace of change has risks around: national affordability; local affordability and employer stability; and offering adequate earnings to secure adequate recruitment and retention in low sMFF areas and to offer appropriate pay protection (if required) for the lower paid.

5.7 The number, size and shape of HCAS zones will need to reviewed periodically. This will involve reconsideration of similar issues and analysis as presented in this evidence. This includes the consideration of patterns in sMFF data; the relationship between it and recruitment and retention indicators; the appropriate level of complexity of HCAS systems; and the level of differentiation between zones, including affordability and pace of change issues.

5.8 In addition, consideration of these issues after the initial implementation period will benefit from an assessment of the impact to date of introducing new HCAS zones and greater geographical pay differentiation, especially the impact on recruitment, retention, staff turnover, vacancy rates, agency usage and the morale and motivation of the workforce in different zones.

Data and intelligence needs

5.9 The data and intelligence that will help inform these judgements is similar to that used in this evidence:

- Affordability intelligence;
- Geographical pay differentials for Agenda for Change staff.
- Staff Market Forces Factors;
- Detailed recruitment and retention indicators (as granular and staff group specific as possible) such as:
- Vacancy rates;
- Turnover rates;
- Agency usage;
- Staff satisfaction;
- Absence rates.

5.10 Whilst the data needed going forward is similar to that used in this evidence, the potential to improve the data should continually be considered, as should any risks to data availability in the future. We would therefore welcome any views from the NHS PRB on how we can improve the quality of data to support this process. In particular, the DH would welcome views on how consideration of total reward could be supported.

Potential issues for future data availability

5.11 However, the DH believes that there is particular scope for improvement around the availability of vacancy rate data. As the NHS PRB is aware, the NHS Information Centre suspended collection of vacancy data in March 2010. There are plans to provide a replacement to this through the re-procurement of NHS Jobs.

5.12 There is also a need to be mindful during the re-procurement of ESR of the NHS PRB's requirements for any additional data on Market Facing Pay. Any reasonable requirements may then be built into the reprocurement specification.

5.13 The possibility that sMFF data may change must also be recognised. sMFF calculations are updated periodically as a matter of course. These changes would need to be appropriately reflected into HCAS values and zone designs as part of maintaining the system. There is also a possibility of more fundamental updates to sMFF data. For example, there is no expectation that sMFF data will cease to be a part of NHS financial flows, but, for example, the organisational make up of sMFF data might potentially be affected by NHS reforms.

Wider intelligence

5.14 The discussion so far has focused on quantitative and central financial planning analysis data. This is not to downplay the importance of wider intelligence such as that provided by NHS employers. Indeed, it may be possible that Market Facing Pay issues could become apparent to employers before they are conclusively reflected in hard data. Qualitative data from NHS Employers will therefore continue to be helpful.

Downward revisions to HCAS values

5.15 So far, managing the value of HCASs has been considered as a challenge of working towards a target geographical pay differentiation through incremental upward adjustment in HCAS values. However, over the longer term wider labour market changes, apparent in sMFFs, may reduce appropriate HCAS values for some areas.

5.16 Under current arrangements HCAS are subject to regular independent review by the PRBs. They have risen normally in line with annual uplifts in headline pay rates; some have been frozen, but none have ever been reduced, albeit that there is no regulational restriction to prohibit this. Consideration should therefore be given to whether HCASs should be more flexible downwards. The NHS PRB may wish to consider this, including any restrictions on downward flexibility or the need for notice of any such changes. One option might be total downward flexibility. Another might be to place a limit on annual reductions. Alternatively, one might just freeze the absolute value of HCASs in affected areas until their value as a proportion of basic pay reaches appropriate levels. At this point, the HCAS payments would resume growing in line with basic pay.

Supporting the use of local flexibilities

Data and intelligence

5.17 The management of local issues will benefit from maximising the availability of recruitment and retention indicators, particularly those available at staff group level.

5.18 The data needed to support the use of local flexibilities to address local and staff group specific issues are fundamentally similar to those for the centralised zonal HCAS system. However, there may be valid extensions when considering local requirements.

5.19 The material in this evidence, and in much of the academic research supporting geographical pay variation, focuses on identifying appropriate pay differentials across geographical areas within an industry by looking at the differentiation observed in comparator industries. Where an industry offers an insufficient geographical pay premium for an area it is expected to suffer worse recruitment and retention in that area.

5.20 This approach does not make direct comparisons in earnings across employers within geographical areas i.e. identifying that particular employees could earn £x more with another employer. These types of comparisons are difficult to draw firm conclusions from as they are confounded by other differences across the employers (such as wider non-pay remuneration, working conditions, culture and training opportunities).

5.21 Whilst total reward issues may be difficult to assess using central data, it may be easier to draw conclusions from these comparisons at a local level. Employers are likely to have more contextual information available about key competitors for staff, local labour market conditions and the motivations of staff that can help interpret the data. As such, there may be benefit to individual employers in considering additional local indicators such as:

- Local labour market information such as unemployment rates;
- Local earnings data;
- Information on the pay and conditions offered by key competitors;
- Cost of living data.

5.22 Beyond this, there is scope for additional intelligence and understanding of the local labour market and the underlying causes of their recruitment and retention situation. Utilising exit interviews, for example, may be a valuable source of information though they are not always valid and reliable. Less formal means of understanding the local situation are also likely to be important.

Assessing recruitment and retention tools

5.23 Once data and intelligence on local recruitment and retention situations are gathered, there is still a question of the appropriate response for organisations to make.

5.24 Chapter 3A discussed the potential variety in underlying causes of recruitment and retention indicators and the associated variety of appropriate responses – not all of which will relate to pay. However, the chapter also points to a lack of rigorous assessments of recruitment and retention tools. Local responses to recruitment and retention indicators could therefore benefit from a greater evidence base.

Facilitating the application of local flexibilities

5.25 The DH would welcome the NHSPRB's views on any central measures considered advisable to promote the prospects for local flexibilities that would add real value without disproportionate additional administrative burden. For example, options could include:

- Central gathering, collation and analysis of local labour market / recruitment and retention indicators to reduce duplication of effort and take advantages of synergies of production;

- Commissioning of further research to assess recruitment and retention tools. This research could also consider the impact of Market Facing Pay measures for the NHS;

- Encouraging and supporting organisations to routinely collate and analyse their own data on their specific recruitment and retention situation, for example, on reasons for leaving.

Conclusion

5.26 The maintenance of DH's preferred model for moving towards greater Market Facing Pay can be split into two areas:

- Supporting a centralised HCAS system;
- Supporting the use of employer flexibilities to address local issues.

5.27 The data needed to support a centralised HCAS system is similar to that used in this evidence:

- Affordability intelligence;
- Geographical pay differentials for Agenda for Change staff.
- Staff Market Forces Factors;
- Detailed recruitment and retention indicators.

5.28 This information will be needed to manage the value of HCASs, headline pay awards and the size, shape and number of HCAS zones. The DH expects these issues to be a key element of NHSPRB rounds in the future.

5.29 There will also be benefit in regularly considering how recruitment and retention indicators can be improved, and there are some specific data issues to be mindful of and to address for the future.

5.30 The same information described above will also be useful for employer level consideration of flexibilities to address local issues. However, they may also benefit from the following additional data items that are most useful when they can be interpreted with the aid of specific local contextual intelligence:

- Local labour market information such as unemployment rates;
- Local earnings data;
- Information on the pay and conditions offered by key competitors;
- Cost of living data.

5.31 Decisions on applying local flexibilities also benefit from wider intelligence, for example exit interviews may give some indication about whether there are any underlying recruitment and retention issues among particular pay groups, and

whether these are related or might be solved by additional pay or some other form of incentive or reward, including non-pay recruitment tools.

5.32 The DH would welcome the NHSPRB's views on any central measures that might promote the prospects for local flexibilities without adding disproportionate administrative burdens upon the NHS.

Annex A - HM Treasury Chapter

Government Evidence to the Pay Review Bodies: Economics of Local Pay.[23]

http://www.ome.uk.com/Article/Detail.aspx?ArticleUid=a782b32d-b08b-423b-8061-361211188711

Adobe Acrobat Document

[23] The Government submitted evidence to the NHS Pay Review Body on the Economics of Local Pay.

ANNEX B

BACKGROUND TO THE STAFF MARKET FORCES FACTOR

Summary

1. The staff Market Forces Factor (sMFF) is part of an overall Market Forces Factor (MFF) used to inform NHS financial allocations and to adjust Payment by Results (PbR) payments to NHS providers.

2. NHS financial allocations are based on a weighted capitation formula designed to account for the fact that the cost of commissioning or providing healthcare services is not the same in every part of the country due to the impact of market forces on local costs. The MFF is included in the weighted capitation formula to allow for these unavoidable geographical variations in costs. It is also applied to PbR tariffs paid to NHS providers.

3. A key element of the overall MFF is the sMFF. Although wages in the NHS are determined through national pay structures, there is clear evidence for non-medical staff that indirect staff costs across the country vary in line with the going local labour market wage rate in the private sector. If wages in the NHS in a given area are below the going rate set in the private sector, this leads to higher indirect costs in the form of recruitment and retention difficulties, increased reliance on bank and agency staff, and lower productivity.

4. To calculate the non-medical staff MFF, statistical modelling of hourly pay in the private sector is undertaken controlling for the influence on private sector earnings of age, gender, industry and occupation to reveal underlying differences in earnings across geographical areas. This independent geographical effect is the basis of the sMFF.

5. In practice, deriving the sMFF involves the calculation of Standardised Spatial Wage Differentials (SSWDs) at each PCT. Some of the resulting estimated private sector pay rates differ markedly, and unrealistically, between neighbouring PCTs' areas. These "cliff edges" are unlikely to represent accurately the true underlying differences in pay, not least near the borders of PCT areas, but instead are likely to reflect to some extent the effect of, unavoidably, using a geography of administrative boundaries to estimate private sector pay rates which cut across local labour markets. The technique of smoothing, a form of averaging, is used to reduce these cliff edges.

6. Smoothing is undertaken in two stages. The first stage smoothes the estimated pay rates for PCT areas. For a given PCT, the smoothed sMFF is the weighted average of the estimated pay rates for all PCTs, with the pay rate of the PCT in question being given the largest weight, and the weights of the other PCTs declining the further the geographical distance from the PCT in question.

7. The second stage of smoothing, termed interpolation, is used to avoid cliff edge effects between neighbouring providers which operate in the same labour

market, but are located in different PCT areas. Interpolation is designed to take account of the extent to which the local labour market of an individual NHS provider site is represented by the sMFF of its PCT area. A second stage sMFF is calculated for each provider site using the weighted average of the first stage smoothed PCT sMFFs, with the weights taken as the distance of the PCT area to the provider site in question. This gives the sMFF value for each provider.

Note: The existing sMFF does not cover hospital doctors. Apart from some allowance for London weighting, the resource allocation formula effectively assumes that the costs involved in recruiting and employing hospital doctors do not vary around the country.

Further Details

The Market Forces Factor

8. The weighted capitation formula, used in NHS allocations, has to take account of the fact that the cost of commissioning or providing healthcare is, unavoidably, not the same in every part of the country. The MFF is therefore included in the weighted capitation formula to compensate for these unavoidable costs. Under PbR, a MFF is included also in the tariffs paid to providers.

9. The MFF consists of four separate elements for:

- Staff (excluding medical and dental);
- Medical and dental (M&D) London pay weighting;
- Buildings;
- Land.

10. Separate indices for each of these are calculated and then combined into an overall index for both provider Trusts and PCTs. Other costs (equipment, consumables, drugs etc) are assumed not to vary across the country.

Staff MFF (exclusive of medical and dental staff)

11. Economic theory underpins the staff MFF. The theory predicts that it is more expensive to employ staff in some areas, notably London, than others, due to market forces. Competitive wages will rise or fall according to the cost of living, plus the relative amenity of different geographical areas.

12. In the NHS, where wages are determined by national pay structures, Trusts in areas with a relatively low cost of living and low local market wage rates (low sMFF areas) will be paying above the going rate for staff, in contrast to Trusts in relatively high cost and high wage areas (high sMFF areas) which will be paying staff below the market rate.

13. The theory predicts that this asymmetry between NHS and general labour markets will lead low MFF areas to attract relatively more staff of better quality, who will stay longer, reflecting better recruitment and retention conditions. The outcome is expected to be higher productivity, lower turnover and fewer

vacancies. Conversely, the theory predicts that high MFF areas will attract a relatively poorer quality workforce and experience greater difficulty in recruitment and retention, reflected in higher turnover rates, increased reliance on bank and agency staff and lower productivity. Economic theory also suggests that the NHS wage in high MFF areas will have a tendency to drift upwards (as employers strive to recruit) and be measurably higher for the same role than wages in low MFF areas.

14. Two methods of estimating the staff MFF are available:

- The Specific Cost Approach (SCA), which is based on the actual costs borne by NHS organisations;

- The General Labour Market (GLM) approach, which is based on geographical variations in pay rates in the private sector.

Specific Cost Approach

15. The SCA approach was most recently reviewed by a team led by Crystal Blue Consulting Ltd in 2007, and reported in *Review of Specific Cost Approach to Staff Market Forces Factor* (RARP 31). This study represents the most detailed attempt to date to investigate the SCA in relation to an area cost adjustment in the NHS or government services generally.

16. The study was divided into a micro study of Trusts with different MFF rankings, and a macro study using national datasets on NHS costs. It had three main conclusions:

- Spatial variation in staff costs reflected the pattern of the existing staff MFF. With the exception of medical staff, the researchers therefore found strong evidence to support the use of a GLM approach as a proxy for NHS unavoidable costs;

- It was virtually impossible to separate avoidable and unavoidable cost differentials from Trusts' financial records, partly due to cause and effect (the costs under investigation were at least part the product of resource allocation already shaped by the staff MFF);

- The feasibility of implementing the SCA as an alternative to the current GLM method was rejected on the grounds of cost and practicality (the absence of a suitable nationally available dataset), the lack of a unified methodology, and conceptual problems with cause and effect.

General Labour Market approach

17. The sMFF has always been based on the GLM approach and was most recently updated by a team led by HERU of the University of Aberdeen. Their report is *The Staff Market Forces Factor Component of the Resource Allocation Weighted Capitation Formula: New Estimates* (RARP 34a) which employs the same methodological approach as their earlier study used for 2009-10 and

2010-11 allocations (*Review of the Market Forces Factor Following the Introduction of Payment by Results (2005): Exploring the General Labour Market Approach* (RARP 32)).

18. The GLM approach is based on variation in wages in the private sector as a proxy for the variation in indirect staff costs faced by providers and commissioners in different parts of the country, such as vacancy rates, staff turnover rates, and use of agency staff.

19. The GLM approach uses a multiple regression analysis of earnings data for the private sector. Economists have been studying the pattern of wage differentials for many years. The work shows that average wages exhibit substantial variation between areas because of differences in the composition and skills of the workforce in different areas. In order to isolate the impact of location alone it is necessary to control for these other factors, and therefore the regression equation has the following general form:

$$\text{Log (earnings)} = a + \Sigma b_i \text{ (age dummies)} + \Sigma c_j \text{ (industry dummies)} + \Sigma d_k \text{ (occupational dummies)} + e \text{ (sex dummy)} + \Sigma g_f \text{ (area dummies)}$$

20. The dependent variable is hourly wages, calculated by dividing the gross weekly pay in the reference week by the sum of basic and overtime hours worked during the reference week. The sample includes employees aged 16 to 70 whose pay had not been affected by absence during the reference week.

21. The explanatory variables are age, gender, industry, occupation and geographical work area. These explanatory factors have been singled out in economic research as systematic influences on earnings, and after controlling or standardising for the influence of age, gender, industry and occupation, it is possible to isolate the independent effect of work area on relative earnings – the coefficients g on the area dummies in the above equation. These are known as Standardised Spatial Wage Differentials (SSWDs).

22. The updated SSWDs from the HERU research were calculated using anonymised, individual level data from ONS's Annual Survey of Hours and Earnings (ASHE) for the three years 2007 to 2009. The then 152 PCTs were used as the relevant geography in the modelling. Employees in the ASHE sample in Wales and Scotland were included in the estimates of the SSWDs for England and in the smoothing options. This increases the robustness of the estimates of SSWDs and the validity of smoothing, especially for PCTs near the borders with Wales and Scotland (smoothing is defined below).

23. Jobs with the same title often have different roles and levels of responsibility according to the size of firms and managerial role. There will be greater managerial responsibility in areas with higher proportions of large firms, such as metropolitan areas. For example, a banker in central London is likely to have a different role than a banker in a different part of the country. The HERU research applied a job responsibility adjustment to take account of these differences. This adjustment acknowledges the relationship between higher

responsibility and higher wages. Data for this adjustment are not available in the ASHE survey, but are available in the Labour Force Survey (LFS). As the LFS has a smaller sample size than ASHE, the job responsibility adjustment was estimated at Government Office Region level rather than at PCT level.

Smoothing

24. The sMFF methodology often results in 'cliff edges,' which is when neighbouring PCTs have markedly different SSWDs. This is because PCTs' geographical boundaries do not necessarily correspond to local labour markets and statistical variation arising due to relatively small sample numbers in ASHE for some PCTs. These discontinuities may lead to inequitable MFFs, particularly for providers in close proximity and facing similar local labour market pressures but which are in different PCTs. Smoothing techniques, a form of averaging, soften cliff edges to produce a more continuous profile of SSWDs across PCTs.

25. The HERU team recommended that smoothing should take into account the SSWDs of all PCTs rather than just the neighbouring ones, as was the case for the sMFFs prior to 2009-10, to recognise the fact that NHS organisations in one PCT might draw their labour force from a variety of PCT areas. The smoothed SSWDs for a given PCT is the weighted average of the SSWDs for all PCTs, with the PCT in question having the highest weight, and the weights of the SSWDs of the surrounding areas falling with distance from the base PCT. The rate at which the weights fall as distance increase is governed by an exponential distance decay function which has the following form:

    exp(-cd)

    where d is the distance from each PCT's geographical centroid and c, which has a value of 0.01, is the constant that controls the influence that distance has on the weights. The smoothed SSWDs give the values of PCTs' staff MFFs for services provided from many sites across the whole of the PCTs' geographical areas (termed 'host' services below, paragraph 40).

26. Smoothing brings each PCTs' sMFF more in line with those of its neighbours. It also increases the sample size, reduces the confidence interval around the estimate and reduces instability. Exponential smoothing gives proportionately more emphasis to those areas in closer proximity than those further away. This is what would be expected if labour markets could be accurately observed.

Interpolation

27. Under PbR the MFF is paid to NHS Trusts as part of the tariff in respect of the activity they carry out. The sMFF therefore has a direct impact on Trust income. If Trusts are assigned the smoothed SSWDs for PCTs described above for the PCT where they are located, this would still result in cliff edges between the sMFFs for Trusts.

28. There is likely to be spatial variation of pay rates within the PCT areas that have been used to construct the SSWDs, and Trusts are not located across a whole PCT area but at a point within the area. The going local labour market rate of pay faced by a Trust may therefore differ from that for the PCT as a whole. For example, two Trusts operating near the border of neighbouring PCTs might have different sMFFs (if assigned those of their PCT areas) but operate in the same labour market.

29. Interpolation is a technique that uses two or more values to create an intermediate value. It is in effect a second stage smoothing carried out at Trust site level, after smoothing at PCT level, to reduce further cliff edges for providers. It works the same way as smoothing in that the MFF of a Trust is the distance weighted average of the surrounding PCTs' sMFFs.

30. Interpolation is carried out at Trust site level. Where a Trust has more than one site, the different indices after interpolation for each site are weighted together in proportion to activity on each site. The most consistent indication of activity by site held centrally is the 2008-09 Estates Return Information Collection (ERIC) return on numbers of beds. The interpolation of the smoothed PCT sMFFs gives the relative sMFF index for each provider Trust.

31. Ambulance Trusts are assigned a MFF based on the (population weighted) average sMFFs of the PCT areas they serve.

Medical and dental London pay weighting

32. A MFF based on pay rates in the private sector is not applied to expenditure on medical and dental staff. Both the *Review of the Market Forces Factor Following the Introduction of Payment by Results (2005): Exploring the General Labour Market Method* (RARP32) and the *Review of Specific Cost Approach to Staff Market Forces Factor* (RARP 31) found strong evidence that the GLM is inappropriate for medical and dental staff, because their indirect costs do not vary differentially across the country as they do for other NHS staff.

33. Instead, there is a separate index based on the direct, higher costs of employing medical and dental staff in London, ie on the London pay weighting. It is calculated as the ratio of the average pay bill per doctor for hospital doctors in 2008-09 including London pay weighting to the average pay bill excluding the London pay weighting, and then applied to Trusts in London.

Building MFF

34. The buildings index uses relative location factors calculated by the Building Cost Information Service (BCIS) from an analysis of tender prices for public and private contracts at LAD level. BCIS provided a set of average location factors for the period between January 2007 and June 2010 for the then 152 PCTs.

35. Provider Trusts were assigned values depending on the PCT in which they are located, with account taken of multi-site Trusts in the same way as for the staff MFF.

Land MFF

36. A land index based on land value per hectare is calculated for each NHS Trust and PCT. This uses the net book value of land at 31 March 2009 reported in the audited summarisation schedules of PCTs and Trusts 2008-09. Monitor provided the same data for NHS Foundation Trusts. The land values were divided by land areas from 2008-09 ERIC returns to give relative land value per hectare. These are turned into an index in which national average land value per hectare has the index value of one.

37. There are two technical adjustments made in the calculation of this index. A small number of PCTs do not own any land due to leases and two trusts had net book values of zero. In these cases the relevant county average is assigned. Second, two central London Trusts that also have a significant non-London site have land indices weighted in proportion to activity on each site (to reflect that land is used more intensively in central London compared to less urban areas).

Providers' Overall MFFs

38. An overall MFF is calculated for each provider by combining the four separate MFF indices for staff (exclusive of medical and dental staff), medical and dental staff London pay weighting, buildings and land. The relative weights for each of these elements are national expenditure as shown in Table B.1.

39. Table B.1 is based on an analysis of 2008-09 expenditure from the financial returns and accounts of PCTs, NHS Trusts and NHS Foundation Trusts. The reason for using national expenditure weights is so that local decisions on the mix of inputs do not affect PCT target allocations or PbR tariffs.

Table B.1: HCHS MFF weights

	%
Staff	54.9
Medical and dental London weighting	13.9
Buildings	2.7
Land	0.4
Other	28.1
Total HCHS	**100.0**

Final MFF index for PCTs

40. Each PCT's final MFF is comprised of two elements:

    - The MFFs for each of the providers from which it commissions. This is designated non-host provision. The weights are calculated though a purchaser-provider matrix (PPM);

    - In the case of maternity and community programmes it is assumed that they are provided wholly within the host PCT's geographical area and across many sites within the PCT's area. These are designated host provision and assigned the MFF for the PCTs' geographical area (which is after smoothing has been applied).

41. The PPM is derived from the application of 2009-10 mandatory PbR tariffs to admitted patient and outpatient care activity data by commissioning PCT from 2008-09 HES. The HES data only provide information on admissions to NHS hospitals and outpatients. There are no equivalent national datasets for other HCHS programmes which allow providers to be mapped to PCTs. To overcome this, it is assumed that most other programmes follow the pattern of inpatients and outpatients.

42. The final, overall MFFs for each element for PCTs are from combining the MFF for host and MFF for non-host activity. As described above, provider MFF indices are passed through the PPM to which a non-host weight of 81.1% is applied (derived from the 2008-09 HCHS expenditure excluding maternity, community health services and HIV/AIDS). The weight for host provision is 18.9% (from maternity, community health services and HIV/AIDS expenditure). More information on the data underpinning these weights is available in http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124949

Annex C: Literature Review of External Research Supporting Market Facing Pay

Title	Author(s)	Summary	Outline Methodology
Explaining differences in hospital performance: Does the answer lie in the labour market? *Centre for Market and Public Organisation (CMPO) Working Paper Series No. 03/091 (September 2003)*	Simon Burgess *CMPO and Department of Economics, University of Bristol, CEPR and CEP, LSE* Denise Gossage *CMPO, University of Bristol* Carol Propper *CMPO and Department of Economics, University of Bristol, CEPR and CASE, LSE*	Performance ratings of NHS Trusts show a regional divide not explained by medical need. In 2001, 7 of 21 performance indicators are found to be negatively associated with private sector wage premiums. In 2002, the equivalent figure is 11 of 37. The affected indicators cover areas such as inpatient waiting, outpatient waiting, trolley waiting, hospital cleanliness, vacancy rates, and clinical negligence risk management compliance. Analysis suggests some of the performance of NHS Trusts is related to the labour market in which they are located. This suggests greater flexibility of pay at regional level may be one way to improve the performance of the NHS.	The relationship between NHS Trust performance indicators, published in 2001 and 2002, and relative pay differentials with private sector alternatives for female nurses, based on 1999 data, is examined controlling for confounding influences such as underlying need.
Regional Pay for NHS Medical and Non-Medical Staff: Final report for Department of Health *Health Economics Research Unit, University of Aberdeen (June 2005)*	Professor Bob Elliott, Professor Anthony Scott, Dr Diane Skåtun and Mr Divine Ikenwilo *University of Aberdeen* Professor David Bell and Mrs Elizabeth Roberts *University of Stirling*	The spatial dimensions of labour markets in which NHS staff work will determine the degree to which it is both desirable and appropriate to offer different levels of pay for work in different areas. The spatial dimensions of labour markets for doctors differ to those for non-medical staff. The labour market for doctors is national and mostly confined to the NHS. Hospitals compete for doctors on the basis of reputation, opportunities for promotion and potentially opportunities for private practice. Non-medical labour markets are more likely to be local and to involve non-NHS and non-health care alternatives for staff. There is substantial spatial variation in pay in the private sector reflecting the cost of living and amenities of areas. Employers pay more to attract staff to high cost or low amenity areas. There is considerably less spatial variation in NHS pay. The gap in spatial pay variation between NHS professions and private sector comparators provides a significant explanation of vacancy rates for nurses, but not for doctors or AHPs.	Literature review of past research. Standardised Spatial Wage Differentials (SSWDs) calculated for doctors, nurses. allied health professionals (AHPs) and private sector comparator groups. Regression analysis to estimate the effect of SSWD gaps on NHS vacancy rates. Additional analysis on the impact of teaching hospital status and violent incident rates on vacancy rates.

		NHS specific factors affecting the attractiveness of different areas would not be captured by SSWD gaps. Doctor vacancy rates are lower with teaching hospital status and lower violent incident rates, but these effects are not seen for nurses or AHPs. There is a case for further changes to the structure of regional pay for qualified nurses, but no recruitment and retention case for further changes for doctors or AHPs. Further analysis with improved data is required to firm up conclusions.	
Review of specific cost approach to staff market forces factor *Report to DH by research consortium of Crystal Blue Consulting Ltd, York University and City University (November 2006)*	Tessa Crilly, John Crilly, Roy Carr-Hill, David Parkin, Margaret Conroy	The study considered a range of evidence that might be used to construct a staff market forces factor, and included interviews with a small number of trusts, consideration of management data and analysis of national data. The interviews covered trusts in the south west, London and the north of England, and they suggested: Trusts in the south west have a stable long serving workforce facing high housing costs. Trusts in the north have a similar staff profile to the south west, but with lesser housing cost issues. London trusts have a younger workforce with less part time working, higher turnover and higher vacancy rates. The full range of evidence suggested: • Higher MFF trusts have: • Greater nurse turnover; • Greater vacancy rates for ward nurses; • Greater use of bank and agency staff; • Lower productivity.	As part of a wider review into the basis for calculating the staff MFF, material relevant to the case for Market Facing Pay is generated through: - A micro study based on 14 trusts selected to achieve a spread across MFF areas with a quantitative component based on payroll / general ledger data and a qualitative element based on interviews with the trusts. - A macro study of all acute trusts considering the relationship between the 2005/6 staff MFF index (split into quintiles) and indicators of recruitment and retention difficulties.
The pattern and evolution of geographical wage differentials in the public and private sectors in Great Britain *The Manchester School Vol 75*	David Bell *University of Stirling* Robert F. Elliott *University of Aberdeen* Ada Ma	In high cost - low amenity areas, such as the south-east of England, the public sector underpays relative to the private sector, therefore creating problems in recruitment to, and provision of, public services. Public sector labour markets are around 40% as responsive to area cost and amenity differences as private sector labour markets.	Size and evolution of public-private sector wage differentials across geographical areas and over time analysed using SSWDs and quantile regressions.

No. 4 Special Issue 2007 386-421	*University of Aberdeen* Anthony Scott Melbourne Institute of Applied Economic & Social Research, University of Melbourne Elizabeth Roberts *University of Stirling*	Differences in spatial pay variation across sectors are likely to create persistent problems for the delivery of public services in some parts of the UK. Reform of public sector pay structures is likely to be costly, and so other non-pay policies need to be considered to increase the attractiveness of public sector jobs.	
Geographically differentiated pay in the labour market for nurses *Journal of Health Economics 26 (2007) 190-212*	Robert F. Elliott and Ada H.Y. Ma *Health Economics Research Unit, University of Aberdeen* Anthony Scott *Melbourne Institute of Applied Economic & Social Research* David Bell and Elizabeth Roberts *Department of Economics, University of Stirling*	The gap between the relative pay of nurses and comparator jobs varies systematically across areas. The vacancy rate for nurses in local markets is negatively correlated with the SSWD gap between nurses and comparator jobs. The competitiveness of nursing pay is shown to have a strong effect on the ability of the NHS to attract and retain nurses.	Using 1999 to 2002 data, SSWDs are calculated for nurses and comparators. An SSWD gap is constructed and its relationship to vacancies estimated.
Poverty pay: How public sector pay fails deprived areas The Social Market Foundation (2007)	Robin Harding *The Social Market Foundation*	Public sector pay suffers from central planning with too little regard for local conditions. It should be based, instead, on the market signals coming from local labour markets and, in particular, the signals those markets give about deprivation and the load placed on local public services. The result is a workforce of uneven quantity and quality, with a knock-on effect on public services. The government should introduce a zonal pay system in the public sector, as part of national pay bargaining, to deal with shortages of well-qualified public sector workers in specific areas, where they receive what effectively amounts to poverty pay. If particular organisations faced recruitment and retention problems they should move to a higher paid zone and vice versa.	Consideration of regional recruitment and retention patterns. Literature review. Consideration of private sector experience. Review of policy history and options.
Can pay regulation kill? Panel data evidence on the effect of labour markets on hospital performance	Emma hall and Carol Propper *Centre for Market and Public Organisation, University of Bristol* John Van Reenen	Hospitals in stronger local labour markets, with higher non-NHS comparator wages, show worse outcomes in terms of quality and productivity. This is consistent with predictions that limited geographical pay variation in the	Hospital level panel data, covering 1995/6 to 2002/3, from Acute hospitals, on quality (measured by AMI death rates) and productivity

Centre for Economic Performance (CEP) Discussion Paper No. 843 (January 2008)	*Centre for Economic Performance, London School of Economics*	NHS will be associated with problems for areas with stronger labour markets in recruiting, retaining and motivating high quality staff with a knock-on impact on hospital performance. Analysis suggests a 10% increase in the non-NHS outside wage is associated with a 4% to 8% increase in Acute Myocardial Infarction (AMI) death rates. Similarly, a 10% increase in the outside wage is associated with up to a 6.6% decrease in productivity. Part of this effect is found to operate through hospitals in high outside wage areas having to rely on agency staff as they are unable to increase regulated wages to attract permanent staff. Similar effects are not found in other service sectors (including nursing homes) where pay is unregulated. Wages more closely reflecting the local market in higher outside wage areas would improve outcomes and productivity.	(measured by Finished Consultant Episodes per clinical worker) is constructed. These indicators are analysed against differences between nurse pay and comparator outside wage levels controlling for confounding influences such as hospital skill mix and labour inputs. Similar analysis is conducted for other service industries without national wage structures to further test the impact of the NHS wage structure. The relationships between intensity of agency use and outside wages and with AMI death rates and productivity are analysed to consider the mechanism by which higher outside wages affect hospital outcomes.
IFS Green Budget 2008 January 2008 p158	Institute of Fiscal Studies	Public sector pay is much lower relative to private sector pay in London and the South East than in other parts of the country. If the government wishes to broadly equalise the quality of public services across the country, it should increase public sector pay more quickly in areas where it is relatively low.	
Distributing public funding to the NHS in England: Taking account of differences in local labour market conditions on NHS recruitment and retention *Health Economics Research Unit Briefing Paper Jan 2009*	Health Economics Research Unit, University of Aberdeen	The costs of recruiting and retaining nurses differ between localities. This reflects differences in costs of living and amenities. Where the regional pattern of pay in the private sector differs from the regional pattern of nurse pay, this will affect the ability of the NHS to attract and retain nurses. The NHS will experience higher indirect labour costs, higher labour turnover and vacancies in those areas in which the regional wage premium is less than in the private sector. This supports the application of a market forces factor to nurse pay.	Using 2003 to 2005 data, SSWDs are calculated for nurses, hospital medical staff and private sector comparators . Multiple regression techniques used to estimate the relationship between regional patterns of pay and vacancy rates as an indicator of recruitment and retention

		In contrast, analysis reveals no association between spatial pay patterns and doctor vacancy rates. The analysis suggests higher cost areas actually find it easier to fill medical vacancies. A market forces factor adjustment is not appropriate for doctors pay.	difficulties.
IFS Green Budget 2010 February 2010 p219	Institute of Fiscal Studies	With regard to public sector pay setting, one would usually expect the level of remuneration in the public sector to follow the trend for similarly-qualified workers in the private sector. If pay settlements happen to be lower in the public sector than in the private, it is likely to lead to recruitment problems and falls in staff quality and in the quality of services provided. We had reached that situation in some parts of the public sector by about the year 2000. Conversely, if remuneration in the public sector is too high, then all else equal, it might lead to excessive crowding out of skills for the private sector, wage inflation and an inappropriately higher burden for the taxpayer. This may be a problem now, in particular in regions outside London and the South-East.	
The role of the staff MFF in distributing NHS funding: taking account of differences in local labour market conditions *Health Economics. 19: 532-548 (2010)*	Robert Elliott, Ada Ma & Diane Skåtun *Health Economics Research Unit, University of Aberdeen* Matt Sutton *Health Methodology Research Group, University of Manchester* Nigel Rice *Centre for Health Economics, University of York* Stephen Morris *Department of Epidemiology and Public Health, University College London* Alex McConnachie *Robertson Centre for Biostatistics, University of Glasgow*	Nurse vacancies rates are linked to SSWD gaps with the private sector. Higher gaps, indicating greater geographical pay premiums in the private sector, are associated with high vacancy rates. In contrast, for doctors greater geographical pay premiums in the private sector are associated with lower vacancy rates. Doctors' vacancies are lower in high cost / less desirable areas. It is speculated that there may be other advantages of these areas. There is empirical support for applying a staff market forces factor (MFF) to the pay of hospital nurses, but not medical staff.	Using 2003 to 2005 data, SSWDs are constructed for doctors, nurses and private sector comparators. Vacancy rates, as a measure of NHS indirect labour costs, are regressed on the differences between the SSWDs for the NHS staff and private sector comparators controlling for confounding influences.
More than we bargained for: the social and economic costs of national wage bargaining	Alison Wolf *King's College London*	National pay scales in the public sector penalise poorer regions by distorting their labour markets and hindering economic growth. Private sector pay is inflated in these areas to compete with nationally set public sector pay. This impedes their economic development.	Articulation of the background to and implications of national pay bargaining including a references to analysis and other academic research in this area.

CentreForum 2010		They also affect the quality of public services. In high wage areas, it is difficult to get good quality staff which impacts on service quality and productivity. Even within lower wage areas, relatively deprived areas lose out as higher amenity areas find it easier to attract staff. Rigid national bargaining systems prevent responding to local conditions and perpetuates regional inequalities.	

Annex D: 2010/11 Estimated Earnings per FTE Relative to National Average by SHA and Non-Medical Staff Groups

Staff Group	2010/11 Estimated Total Earnings per FTE Relative to National Average									
	North East Q30	North West Q31	Yorkshire & the Humber Q32	East Midlands Q33	West Midlands Q34	East of England Q35	London Q36	South East Coast Q37	South Central Q38	South West Q39
Qualified Nursing	-2.6%	-2.8%	-3.4%	-2.6%	-2.7%	-1.9%	11.8%	-1.0%	-1.3%	-3.0%
Unqualified Nursing, HCAs and Support	0.7%	-2.1%	-3.4%	-2.6%	-3.3%	0.1%	15.5%	-1.7%	-0.5%	-3.2%
Qualified AHPs	-1.7%	-1.7%	-3.1%	-5.0%	-3.1%	-2.9%	13.7%	-1.4%	-2.1%	-3.7%
Qualified Other ST&Ts	-4.1%	-4.3%	-4.2%	-4.8%	-5.0%	-3.0%	15.0%	0.2%	-2.2%	-5.7%
Unqualified AHPs	-2.4%	-2.4%	-5.0%	5.1%	-2.5%	-2.1%	17.0%	-2.4%	-3.7%	-5.2%
Unqualified Other ST&Ts	-5.8%	-1.4%	-3.5%	-3.8%	1.2%	-7.0%	16.0%	-1.5%	-3.0%	-5.5%
Admin & Clerical	-6.3%	-5.9%	-5.8%	-5.7%	-4.0%	-4.7%	20.3%	-3.2%	-1.7%	-5.6%
Maintenance & Works	-0.7%	0.1%	-5.2%	-6.9%	1.1%	-2.4%	16.8%	-3.7%	-2.9%	-5.7%
Qualified Ambulance Staff	-3.8%	-3.1%	1.4%	-2.3%	0.8%	5.2%	2.5%	5.9%	-0.5%	-8.0%
Unqualified Ambulance Staff	8.1%	-0.6%	-2.8%	-0.4%	-7.0%	8.8%	11.5%	3.4%	-4.7%	-5.9%
Managers	-3.2%	-3.9%	-0.3%	-5.0%	-4.8%	-1.5%	11.2%	-3.1%	-2.5%	-3.1%
Aggregate	**-4.7%**	**-4.0%**	**-5.9%**	**-4.8%**	**-3.8%**	**-1.7%**	**18.5%**	**-1.9%**	**-1.1%**	**-5.1%**

Staff Group	2010/11 Estimated Basic Earnings per FTE Relative to National Average									
	North East Q30	North West Q31	Yorkshire & the Humber Q32	East Midlands Q33	West Midlands Q34	East of England Q35	London Q36	South East Coast Q37	South Central Q38	South West Q39
Qualified Nursing	-0.2%	0.3%	-0.5%	-0.6%	0.1%	-0.7%	0.9%	-0.3%	-0.4%	-0.9%
Unqualified Nursing, HCAs and Support	2.2%	0.6%	-1.9%	-1.5%	-0.4%	0.8%	1.3%	-1.2%	0.7%	-1.2%
Qualified AHPs	0.7%	1.0%	-0.3%	-1.7%	-0.1%	-1.4%	1.8%	-0.7%	-0.7%	-0.8%
Qualified Other ST&Ts	-0.9%	-1.9%	-1.9%	-1.7%	-1.2%	-1.1%	4.7%	0.7%	0.9%	-2.7%
Unqualified AHPs	0.2%	1.1%	-3.0%	5.4%	-0.1%	-0.7%	0.6%	-0.3%	-1.9%	-2.2%
Unqualified Other ST&Ts	-1.7%	3.1%	-1.7%	1.0%	5.1%	-4.9%	-0.4%	1.8%	-0.4%	-2.6%
Admin & Clerical	-3.4%	-2.6%	-2.9%	-2.8%	-0.7%	-2.6%	5.8%	-0.8%	0.9%	-2.2%
Maintenance & Works	4.7%	2.2%	-1.3%	-5.3%	3.2%	-3.1%	-1.6%	1.4%	-0.5%	-3.0%
Qualified Ambulance Staff	-3.5%	-2.5%	1.1%	-1.7%	3.6%	3.3%	-3.6%	6.1%	3.0%	-2.2%
Unqualified Ambulance Staff	3.2%	2.5%	1.7%	-2.0%	-5.9%	6.8%	-1.8%	-5.3%	-2.0%	-3.8%
Managers	-1.4%	-2.2%	0.7%	-3.5%	-2.1%	0.2%	4.3%	-1.2%	-0.4%	-0.5%
Total	**-2.8%**	**-1.3%**	**-3.8%**	**-2.9%**	**-1.0%**	**-0.4%**	**6.9%**	**-1.1%**	**0.5%**	**-2.6%**

Notes: Uses the 10 SHA classification rather than the new 4 SHA cluster classification.
Based on Electronic Staff Record - Data Warehouse (ESR-DW) extracts after the application of data cleaning filters.
Presentation excludes Special Health Authorities.

Annex E: Literature Review on the Case for Decentralised Application of Pay Flexibilities

Reference		Material
DH literature review on the underlying case for Market Facing Pay in this evidence	Annex C of this evidence	The underlying case for greater geographical pay differentiation varies across NHS staff groups and can be influenced by organisation specific factors such as teaching status.
Recruitment and retention: A public sector workforce for the twenty-first century Audit Commission (2002)	Paragraph 37	In surveys, "the level of pay was cited as the third most important reason why workers left their jobs, and was the single biggest factor that could have enticed them to stay. However, few people … said that pay influenced their choice of job. Instead … discussions revealed that people see pay as one part of a bigger reward package that includes pensions, bonus schemes, annual leave entitlement, job flexibility and, crucially, whether the work itself is rewarding."
	Paragraph 44	"People choose their job after balancing how well it will match up against what they want from their working life, how well it is rewarded, and how positively it is perceived, weighed against the other options that are open to them."
	Paragraph 74	We "found a wide and creative range of activities at local level aimed at increasing recruitment, improving retention, and making the best use of available staff resources. The best local case studies demonstrate the interdependency of recruitment, retention, diversity, morale, motivation and performance improvement. There are indications of a shift away from a primary focus on recruitment to an increasing focus on retention, the 'whole work experience' and using available staff creatively to deliver service outcomes."
Regional pay, regional poverty? The implications of public sector pay flexibility for Wales Victoria Winckler, Bevan Foundation Policy Paper 3 (2004)	Page 3	"Responses to the proposals (for greater geographical variation in public sector pay) have highlighted existing pay flexibilities, the complexity of the public sector labour market, the importance of local, occupational and sectoral variations in pay, and the overall effectiveness of pay flexibility. Any new public pay system will need to take account of these points"
	paragraph 2.20	On geographical pay differentiation, "Surprisingly few commentators have considered the question of occupations, even though there are considerable differences between occupations in terms of whether their labour markets are local, sub-regional or national, the transferability of skills outside the public sector, and recruitment and retention. For example, occupations such as cleaners and school meals supervisors have highly localised labour markets whereas senior management occupations are regional or national; skills in IT and administrative occupations may be transferable between the public and private sector, whereas the skills of, say, environmental health officers, are almost exclusively sought after in the public sector"
	paragraph 2.23	"Pay is not the only determinant of the labour market. Recruitment and retention is also shaped by factors such as hours of work, levels of responsibility and workload, and the esteem associated with an occupation. In some cases, changing pay rates may not be sufficient alone to overcome these factors and so geographical pay flexibility alone may be insufficient to address recruitment and retention problems."
	paragraph 2.27	"Whatever the extent of geographical flexibility eventually introduced by whichever models, they will need to be sensitive to local and occupational differences as well as regional variations, and be well coordinated and controlled."
High Cost Area Supplements and Recruitment & Retention Premia: A Report for the Office of Manpower Economics, NHS Partners Research & Information (May 2005)	Page 3	"The general view now seems to be that differences between local labour markets are at a micro or local rather than a macro or regional level. The Treasury's Spending Review, published in July 2002, for example says that 'variations in the public sector labour market are largely local rather than regional and can differ significantly by occupation."
	paragraph 3.11	"Pay may not be that influential in determining people's choice of job. Recruitment problems can for example be caused by unattractive recruitment advertising, or long complicated application forms which people find difficult to complete, or the public's perception of the employer and the jobs offered. Retention problems are often caused by poor working conditions, poor management practice or a lack of career development opportunities."
Poverty pay: How public sector pay fails deprived areas, Robin Harding (2007), The Social Market Foundation,	page 19	"Cost and standard of living are not the only factors in choosing a job: stimulation, work environment, stress, danger and money all matter."

Reference		Material
Scoping Study on NHS Trusts' Coping Strategies for Local Recruitment & Retention Problems NHS Partners (2007)	-	Trust interviews suggested the recruitment and retention of staff is influenced by the wider attractiveness of the Trust, not just its pay rates. Relevant factors included: - Local reputations as employers; - The quality of local transport links and parking; - Cost of living differences; - The extent of competition with other NHS and non-NHS employers; - The opportunity to commute to other NHS Trusts attracting High Cost Area Supplements; - Experience and promotion opportunities offered, for example through teaching status; - Local skills availability, including literacy and numeracy; - Wider skills availability for posts peculiar to the NHS. Pay was seen to have a relatively minor role in causing and solving recruitment and retention difficulties, but the study did acknowledge examples implying financial incentives affecting recruitment and retention. Examples included: - Acknowledging pay as a response to competition from other employers; - Support of flexible cost of living adjustments; - Improved retention under Agenda for Change credited to longer pay scales; - Improved recruitment for administrative and ancillary staff due to more competitive pay under Agenda for Change; - Increased turnover of IT staff thought to relate to insufficient job gradings (and pay); - Detrimental effect of reduced flexibility to reward (non-NHS) experience.
	Page 31	Local recruitment and retention solutions may not necessarily relate to pay. Interviews with Trusts identified several non-pay strategies used by Trusts to overcome recruitment and retention difficulties. These included: - Striving to be seen as a good local employer; - Redesigning jobs to overcome reliance on shortage skills; - Reviewing vacancies to ensure they were necessary; - Improving advertising and recruitment processes; - Making progression from Band 6 to 7 automatic for pharmacists; - Working with local schools to ensure students looked on the NHS favourably; - Recruiting unqualified staff to entry level jobs and developing them; - Help with child care; - More flexible hours; - Key worker housing schemes; - Shuttle buses and park and ride schemes.
The pattern and evolution of geographical wage differentials in the public and private sectors in Great Britain The Manchester School Vol 75 No.4 Special Issue 2007 386-421; David Bell *University of Stirling*, Robert F Elliott and Ada Ma *University of Aberdeen*, Anthony Scott *Melbourne Institute of Applied Economic & Social Research*, and Elizabeth Roberts *University of Stirling*		"The costs of reforming public sector pay bargaining are likely to be high. Much of the public sector operates under tight budget caps and if more flexibility is introduced this will involve a spatial redistribution of existing resources. Such redistribution is likely to be resisted and would therefore be costly to implement locally. Other policies to support public services in areas where the private sector standardised spatial wage differentials are high have been used to a lesser extent. These have focused on non-pay factors, including housing subsidies and improving the quality of public sector jobs through investment in infrastructure and training. The relative costs and effects of pay versus non-pay policies therefore become an important area of future research."
Review of National Recruitment and Retention Premia in the NHS Institute for Employment Studies (2010)	page 1-2	"Employers consult a variety of internal and external evidence in assessing the appropriateness and value of recruitment and retention premia. Data measures, such as vacancy rates, local unemployment rates, competitor pay rates and staff turnover rates, are considered necessary and may be supplemented by responses from staff attitude surveys or exit interviews. The latter may help understand whether recruitment and retention problems are pay related, due to a labour market shortage or for some other reason"

Annex F: Indications of the Payment of Recruitment and Retention Premia and High Cost Area Supplement Payments to Non-Medical Staff (September 2010)

A) Data on Recruitment and Retention Premia Use

Table 3.Ai: Estimated % of Individuals Receiving a RRP

	Estimated % of Individuals Receiving a RRP Payment										
	All	North East Q30	North West Q31	Yorkshire & the Humber Q32	East Midlands Q33	West Midlands Q34	East of England Q35	London Q36	South East Coast Q37	South Central Q38	South West Q39
Qualified Nursing	12%	1%	1%	0%	11%	1%	26%	3%	45%	35%	27%
Unqualified Nursing, HCAs and Support	2%	1%	1%	0%	0%	1%	3%	4%	3%	4%	1%
Qualified AHPs	10%	0%	0%	0%	10%	1%	21%	1%	35%	28%	23%
Qualified Other ST&Ts	3%	2%	2%	1%	3%	2%	5%	3%	10%	6%	6%
Unqualified AHPs	1%	0%	0%	0%	0%	0%	2%	2%	1%	2%	1%
Unqualified Other ST&Ts	1%	1%	0%	0%	1%	0%	1%	1%	2%	3%	2%
Admin & Clerical	1%	1%	0%	0%	0%	1%	2%	1%	1%	1%	1%
Maintenance & Works	42%	33%	41%	36%	42%	50%	41%	46%	38%	49%	52%
Qualified Ambulance Staff	1%	0%	0%	0%	0%	0%	0%	5%	2%	0%	0%
Unqualified Ambulance Staff	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Managers	2%	0%	1%	1%	3%	1%	3%	2%	3%	3%	2%
Total	**5.8%**	**1.2%**	**1.0%**	**0.7%**	**4.9%**	**1.3%**	**11.5%**	**2.7%**	**18.7%**	**15.7%**	**11.5%**

Table 3.Aii: Estimated % of FTEs Receiving a RRP

	Estimated % of FTEs Receiving a RRP Payment										
	All	North East Q30	North West Q31	Yorkshire & the Humber Q32	East Midlands Q33	West Midlands Q34	East of England Q35	London Q36	South East Coast Q37	South Central Q38	South West Q39
Qualified Nursing	12%	1%	1%	0%	11%	1%	25%	3%	44%	34%	27%
Unqualified Nursing, HCAs and Support	2%	1%	1%	0%	0%	1%	3%	4%	3%	4%	1%
Qualified AHPs	9%	0%	0%	0%	9%	1%	19%	1%	34%	27%	22%
Qualified Other ST&Ts	3%	2%	1%	1%	2%	1%	5%	3%	10%	6%	5%
Unqualified AHPs	1%	0%	0%	0%	0%	0%	2%	2%	1%	2%	1%
Unqualified Other ST&Ts	1%	1%	0%	0%	1%	0%	1%	1%	2%	3%	2%
Admin & Clerical	1%	1%	0%	0%	0%	1%	2%	1%	1%	2%	1%
Maintenance & Works	44%	34%	42%	38%	43%	51%	43%	48%	41%	50%	53%
Qualified Ambulance Staff	1%	0%	0%	0%	0%	0%	0%	5%	2%	0%	0%
Unqualified Ambulance Staff	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Managers	2%	0%	1%	1%	3%	1%	3%	2%	3%	3%	2%
Total	**5.8%**	**1.3%**	**1.1%**	**0.7%**	**4.9%**	**1.4%**	**11.5%**	**2.8%**	**18.6%**	**15.5%**	**11.7%**

Table 3.Aiii: Estimated Average Value of RRPs as a % of the Basic Earnings of Recipients

	Estimated Average Value of RRP Payments as a % of Basic Earnings										
	All	North East Q30	North West Q31	Yorkshire & the Humber Q32	East Midlands Q33	West Midlands Q34	East of England Q35	London Q36	South East Coast Q37	South Central Q38	South West Q39
Qualified Nursing	2%	6%	5%	5%	2%	6%	2%	5%	2%	2%	2%
Unqualified Nursing, HCAs and Support	7%	9%	9%	12%	7%	8%	6%	8%	6%	4%	7%
Qualified AHPs	2%	5%	5%	5%	2%	7%	2%	7%	2%	2%	2%
Qualified Other ST&Ts	7%	9%	10%	10%	8%	8%	5%	9%	5%	5%	5%
Unqualified AHPs	5%		9%	7%	4%	7%	6%	6%	4%	3%	3%
Unqualified Other ST&Ts	5%	12%	8%	15%	4%	9%	5%	7%	4%	4%	4%
Admin & Clerical	9%	8%	9%	11%	9%	8%	6%	13%	5%	8%	8%
Maintenance & Works	15%	14%	14%	15%	14%	14%	14%	14%	14%	19%	15%
Qualified Ambulance Staff	10%	2%	11%	5%		1%		10%	8%		
Unqualified Ambulance Staff	10%			10%							
Managers	9%	9%	12%	10%	9%	12%	6%	9%	7%	5%	9%
Total	**3.8%**	**9.6%**	**10.0%**	**12.5%**	**3.2%**	**9.7%**	**2.8%**	**8.5%**	**2.5%**	**2.7%**	**3.0%**

Table 3.Aiv: Estimated % of Organisations Paying RRPs

	Estimated % of Organisations Paying RRPs										
	All	North East	North West	Yorkshire & the Humber	East Midlands	West Midlands	East of England	London	South East Coast	South Central	South West
		Q30	Q31	Q32	Q33	Q34	Q35	Q36	Q37	Q38	Q39
Qualified Nursing	36%	23%	15%	13%	30%	17%	80%	23%	88%	76%	39%
Unqualified Nursing, HCAs and Support	30%	29%	15%	8%	36%	13%	62%	18%	75%	54%	35%
Qualified AHPs	30%	6%	8%	9%	24%	9%	79%	16%	87%	76%	42%
Qualified Other ST&Ts	59%	48%	48%	51%	71%	51%	82%	47%	83%	79%	66%
Unqualified AHPs	8%	0%	2%	3%	5%	5%	17%	7%	17%	24%	8%
Unqualified Other ST&Ts	18%	19%	8%	3%	25%	7%	32%	15%	39%	48%	22%
Admin & Clerical	48%	25%	30%	26%	43%	28%	73%	51%	86%	80%	56%
Maintenance & Works	75%	81%	80%	69%	72%	82%	72%	67%	77%	82%	75%
Qualified Ambulance Staff	26%	50%	50%	33%	0%	100%	0%	100%	33%	0%	0%
Unqualified Ambulance Staff	6%	0%	0%	100%	0%	0%	0%	0%	0%	0%	0%
Managers	48%	17%	20%	45%	61%	28%	78%	49%	68%	88%	56%
Total	**84%**	**60%**	**79%**	**84%**	**92%**	**85%**	**98%**	**78%**	**93%**	**96%**	**93%**

Table 3.Av: Estimated % of FTEs Receiving RRPs in Organisations Paying RRPs

	Estimated Share of FTEs Receiving RRPs in Organisations Paying RRPs										
	All	North East	North West	Yorkshire & the Humber	East Midlands	West Midlands	East of England	London	South East Coast	South Central	South West
		Q30	Q31	Q32	Q33	Q34	Q35	Q36	Q37	Q38	Q39
Qualified Nursing	30%	4%	7%	1%	33%	6%	33%	7%	48%	36%	70%
Unqualified Nursing, HCAs and Support	5%	2%	3%	3%	1%	11%	4%	12%	3%	6%	3%
Qualified AHPs	29%	2%	3%	1%	55%	5%	24%	6%	37%	35%	54%
Qualified Other ST&Ts	4%	2%	2%	2%	3%	2%	5%	3%	10%	7%	6%
Unqualified AHPs	10%		22%	4%	2%	6%	9%	21%	7%	7%	13%
Unqualified Other ST&Ts	4%	5%	2%	0%	4%	1%	2%	7%	6%	4%	8%
Admin & Clerical	2%	2%	1%	0%	1%	2%	2%	2%	1%	2%	2%
Maintenance & Works	47%	35%	45%	40%	48%	52%	46%	51%	48%	52%	55%
Qualified Ambulance Staff	2%	0%	0%	0%		0%		5%	2%		
Unqualified Ambulance Staff	0%			0%							
Managers	4%	2%	3%	3%	4%	2%	4%	3%	4%	4%	3%
Total	**6.1%**	**1.4%**	**1.2%**	**0.8%**	**4.8%**	**1.5%**	**11.6%**	**3.0%**	**18.8%**	**15.5%**	**12.0%**

Notes:

- Based on Electronic Staff Record - Data Warehouse extracts after the application of data cleaning filters.
- Uses the 10 SHA classification rather than the new 4 SHA cluster classification.
- Considers 'General' and 'Long Term' Recruitment and Retention Premia as a joint total.
- Presentation excludes Special Health Authorities

B) Data on High Cost Area Supplement Use

Table 3.Bi: Estimated % of Individuals Receiving a HCAS

	Estimated % of Individuals Receiving a HCAS Payment										
	All	North East Q30	North West Q31	Yorkshire & the Humber Q32	East Midlands Q33	West Midlands Q34	East of England Q35	London Q36	South East Coast Q37	South Central Q38	South West Q39
Qualified Nursing	22%	0%	0%	0%	0%	0%	25%	98%	29%	26%	2%
Unqualified Nursing, HCAs and Support	14%	0%	0%	0%	0%	0%	24%	96%	30%	8%	0%
Qualified AHPs	22%	0%	0%	0%	0%	0%	24%	100%	27%	23%	2%
Qualified Other ST&Ts	24%	0%	0%	0%	0%	0%	23%	99%	28%	8%	0%
Unqualified AHPs	16%	0%	0%	0%	0%	0%	24%	100%	27%	15%	0%
Unqualified Other ST&Ts	18%	0%	0%	0%	0%	0%	20%	100%	28%	8%	0%
Admin & Clerical	20%	0%	0%	0%	0%	0%	24%	96%	27%	9%	0%
Maintenance & Works	18%	0%	0%	0%	0%	0%	24%	100%	23%	8%	0%
Qualified Ambulance Staff	22%	0%	0%	0%	0%	3%	26%	100%	35%	10%	0%
Unqualified Ambulance Staff	11%	0%	0%	0%	0%	0%	16%	100%	49%	12%	0%
Managers	22%	0%	0%	0%	0%	0%	22%	90%	33%	13%	0%
Total	**19.6%**	**0.0%**	**0.0%**	**0.0%**	**0.1%**	**0.1%**	**23.9%**	**97.3%**	**28.6%**	**15.6%**	**0.8%**

Table 3.Bii: Estimated % of FTEs Receiving a HCAS

	Estimated % of FTEs Receiving a HCAS Payment										
	All	North East Q30	North West Q31	Yorkshire & the Humber Q32	East Midlands Q33	West Midlands Q34	East of England Q35	London Q36	South East Coast Q37	South Central Q38	South West Q39
Qualified Nursing	23%	0%	0%	0%	0%	0%	25%	98%	29%	25%	2%
Unqualified Nursing, HCAs and Support	15%	0%	0%	0%	0%	0%	25%	97%	30%	9%	0%
Qualified AHPs	22%	0%	0%	0%	0%	0%	24%	100%	27%	22%	2%
Qualified Other ST&Ts	24%	0%	0%	0%	0%	0%	22%	99%	27%	8%	0%
Unqualified AHPs	17%	0%	0%	0%	0%	0%	23%	100%	28%	15%	0%
Unqualified Other ST&Ts	19%	0%	0%	0%	0%	0%	19%	100%	27%	7%	0%
Admin & Clerical	21%	0%	0%	0%	0%	0%	24%	96%	26%	9%	0%
Maintenance & Works	18%	0%	0%	0%	0%	0%	25%	100%	23%	8%	0%
Qualified Ambulance Staff	22%	0%	0%	0%	0%	3%	26%	100%	34%	10%	0%
Unqualified Ambulance Staff	12%	0%	0%	0%	0%	0%	17%	100%	48%	12%	0%
Managers	22%	0%	0%	0%	0%	0%	21%	90%	32%	13%	0%
Total	**20.5%**	**0.0%**	**0.0%**	**0.0%**	**0.1%**	**0.1%**	**24.0%**	**97.6%**	**28.4%**	**15.4%**	**0.8%**

Table 3.Biii: Estimated Average Value of HCASs as a % of the Basic Earnings of Recipients

	Estimated Average Value of HCAS Payments as a % of Basic Earnings										
	All	North East Q30	North West Q31	Yorkshire & the Humber Q32	East Midlands Q33	West Midlands Q34	East of England Q35	London Q36	South East Coast Q37	South Central Q38	South West Q39
Qualified Nursing	13%		18%		6%		5%	16%	5%	3%	2%
Unqualified Nursing, HCAs and Support	17%				9%		6%	22%	7%	6%	3%
Qualified AHPs	12%						5%	15%	4%	3%	2%
Qualified Other ST&Ts	12%	2%	17%		6%	9%	5%	14%	4%	4%	
Unqualified AHPs	16%						6%	21%	6%	5%	2%
Unqualified Other ST&Ts	18%					5%	6%	21%	6%	5%	
Admin & Clerical	16%				9%	7%	5%	18%	6%	5%	8%
Maintenance & Works	15%						6%	19%	5%	6%	
Qualified Ambulance Staff	14%					7%	5%	16%	5%	5%	
Unqualified Ambulance Staff	15%						5%	21%	6%	5%	
Managers	9%	9%	10%		12%	9%	3%	10%	3%	3%	6%
Total	**13.4%**	**7.0%**	**13.7%**		**8.0%**	**6.7%**	**4.9%**	**16.4%**	**5.1%**	**3.3%**	**2.1%**

Table 3.Biv: Estimated % of Organisations Paying HCASs

	Estimated % of Organisations Making HCAS Payments										
	All	North East Q30	North West Q31	Yorkshire & the Humber Q32	East Midlands Q33	West Midlands Q34	East of England Q35	London Q36	South East Coast Q37	South Central Q38	South West Q39
Qualified Nursing	31%	0%	2%	0%	13%	0%	33%	100%	54%	64%	2%
Unqualified Nursing, HCAs and Support	28%	0%	0%	0%	5%	0%	33%	99%	42%	58%	3%
Qualified AHPs	28%	0%	0%	0%	0%	0%	34%	100%	48%	57%	3%
Qualified Other ST&Ts	28%	5%	2%	0%	10%	2%	26%	100%	42%	46%	0%
Unqualified AHPs	25%	0%	0%	0%	0%	0%	31%	100%	43%	33%	3%
Unqualified Other ST&Ts	25%	0%	0%	0%	0%	2%	27%	100%	43%	29%	0%
Admin & Clerical	33%	0%	0%	0%	4%	4%	37%	99%	75%	48%	7%
Maintenance & Works	25%	0%	0%	0%	0%	0%	25%	100%	41%	24%	0%
Qualified Ambulance Staff	30%	0%	0%	0%	0%	100%	33%	100%	100%	50%	0%
Unqualified Ambulance Staff	47%	0%	0%	0%	0%	0%	100%	100%	100%	50%	0%
Managers	33%	8%	2%	0%	17%	2%	37%	100%	54%	52%	10%
Total	**39%**	**8%**	**5%**	**0%**	**24%**	**9%**	**46%**	**99%**	**79%**	**72%**	**12%**

Table 3.Bv: Estimated % of FTEs Receiving HCASs in Organisations Paying HCASs

	Estimated Share of FTEs Receiving HCAS Payments in Organisations Making HCAS Payments										
	All	North East	North West	Yorkshire & the Humber	East Midlands	West Midlands	East of England	London	South East Coast	South Central	South West
		Q30	Q31	Q32	Q33	Q34	Q35	Q36	Q37	Q38	Q39
Qualified Nursing	78%		0%		2%		80%	98%	55%	36%	58%
Unqualified Nursing, HCAs and Support	71%				3%		69%	100%	80%	13%	1%
Qualified AHPs	83%						75%	100%	61%	37%	84%
Qualified Other ST&Ts	77%	1%	0%		2%	0%	80%	99%	68%	16%	
Unqualified AHPs	87%						73%	100%	72%	58%	3%
Unqualified Other ST&Ts	79%					2%	80%	100%	69%	43%	
Admin & Clerical	66%				2%	1%	60%	96%	42%	20%	0%
Maintenance & Works	85%						87%	100%	55%	30%	
Qualified Ambulance Staff	47%					3%	26%	100%	34%	11%	
Unqualified Ambulance Staff	39%						17%	100%	48%	12%	
Managers	57%	1%	1%		1%	1%	50%	90%	54%	25%	3%
Total	**59.5%**	**0.1%**	**0.1%**		**0.7%**	**0.5%**	**56.2%**	**98.0%**	**43.1%**	**21.5%**	**5.6%**

Notes:
- Based on Electronic Staff Record - Data Warehouse extracts after the application of data cleaning filters.
- Uses the 10 SHA classification rather than the new 4 SHA cluster classification.
- Considers 'General' and 'Long Term' Recruitment and Retention Premia as a joint total.
- Presentation excludes Special Health Authorities

ANNEX G

Timeline for changes across the healthcare system

October 2011
- NHS Commissioning Board established in shadow form as a special health authority
- SHA cluster arrangements in place

During 2012
- Health Education England and the NHS Trust Development Authority are established as Special Health Authorities, but in shadow form, without full functions

April 2012
- The next step in extending the choice of Any Qualified Provider, which will be phased in gradually

By October 2012
- NHS Commissioning Board is established as an independent statutory body, but initially only carries out limited functions – in particular, establishing and authorising clinical commissioning groups

October 2012
- Monitor starts to take on its new regulatory functions
- HealthWatch England and local HealthWatch are established

April 2013
- SHAs and PCTs are abolished and the NHS Commissioning Board takes on its full functions
- Health Education England takes over SHAs' responsibilities for education and training
- The NHS Trust Development Authority takes over SHA responsibilities for the FT pipeline and for the overall governance of NHS Trusts
- Public Health England is established
- A full system of clinical commissioning groups is established. But the NHS Commissioning Board will not authorise groups to take on their responsibilities until they are ready.

April 2014
- Our expectation is that the remaining NHS trusts will be authorised as foundation trusts by April 2014. But if any trust is not ready, it will continue to work towards FT status under new management arrangements

April 2016
- Monitor's transitional powers of oversight over foundation trusts will be reviewed (except for newly authorised FTs, where Monitor's oversight will continue until two years after the authorisation date if that is later)