# NHS Pay Review Body

## Market-Facing Pay

*How Agenda for Change pay can be made more appropriate to local labour markets*

*Chair:* Jerry Cope

**Cm 8501**

**£38.50**

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*Chair:* Jerry Cope

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

**By Command of Her Majesty**
**December 2012**

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## NHS Pay Review Body

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

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

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

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

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

the Government's inflation target;

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

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

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

The Review Body is also required to take careful account of the economic and other evidence submitted by the Government, Trades Unions, representatives of NHS employers and others.

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

Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health, Wellbeing and Cities Strategy in the Scottish Government and, the First Minister and the Minister for Health and Social Services of the Welsh Government, and the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive.

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

Members[1] of the Review Body are:

Mr Jerry Cope (Chair)
Professor David Blackaby
Dame Denise Holt
Mrs Joan Ingram
Mr Graham Jagger
Mrs Janet Rubin
Mrs Maureen Scott
Professor Anna Vignoles

The secretariat is provided by the Office of Manpower Economics.

[1] Mr Philip Ashmore and Mr Ian McKay were members until 31 March 2012.

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## Executive Summary

### *Summary of Key Conclusions*

- ***We support market-facing pay for Agenda for Change (AfC) staff to support recruitment and retention of good quality staff to deliver patient care and where it can be shown to make more effective and efficient use of NHS funds.***
- ***The AfC system is comparable with current private and public sector practice for large national employers and has a number of flexibilities and key market-facing elements. AfC is perceived as fair and objective by all parties, supports stable industrial relations, and is viewed by the parties as compliant with equal pay principles.***
- ***Our analysis of recruitment, retention and geographical pay variation does not provide the firm evidence which would be essential to justify further investment in additional market-facing pay in the NHS at this time, although further development of AfC is needed to meet the challenges and cost pressures in the NHS.***
- ***AfC is the appropriate vehicle through which to develop market-facing pay as it already has positive market-facing features – we therefore specifically recommend a fundamental review of high cost area supplements, appropriate use of local recruitment and retention premia, and regular review of AfC, including its flexibilities, with any necessary negotiations brought to a conclusion at a reasonable pace.***
- ***Trusts should have transparent pay and reward policies which clearly state their approach to the use of AfC flexibilities.***

## Introduction

1. We set out in this report our conclusions and recommendations on how to make pay more market-facing in local areas for NHS AfC staff. The Chancellor of the Exchequer announced this remit in the Autumn Statement on 29 November 2011 and then wrote to us on 7 December 2011. Further detail was provided in the Secretary of State for Health's remit letter of 23 December 2011, which included specific factors for AfC staff for us to take into account. The remit is for England only.

2. We received evidence from our key stakeholders and from a range of other interested organisations, plus extensive information on market-facing pay from our secretariat including commissioned research on private sector geographical pay differentiation.

## Consideration of the Evidence on Market-Facing Pay

3. This remit comes at a time of significant developments such as: the public sector pay freeze coming to an end in 2013 and the UK Government's announcement of a further period of pay restraint through to 2015 with public sector pay awards that average at 1% per year; and the context of challenging NHS financial pressure, major structural NHS reforms and changes to pension arrangements, all of which will require evolving strategic approaches to pay and reward in the NHS. We are struck by the universal lack of support among the stakeholders for a move to full local pay bargaining in the NHS.

4. Our starting point is that we support market-facing pay for AfC staff to support recruitment and retention of good quality staff to deliver patient care and where it can be shown to make more effective and efficient use of NHS funds. In order to gain a better understanding of how to make pay more market-facing we review the evidence from the parties on the UK Government's

underlying arguments. In doing so, we distinguish between short term and more enduring features of the labour market. On the public sector pay differential with the private sector, we note that it is forecast to close as a result of further public sector pay restraint through to 2015, though some regional differences might remain. Our view is that there has yet to be hard evidence that a positive public sector pay differential is crowding out the private sector and hurting business.

5. We examine approaches to geographical pay differentiation in the private and public sectors which suggest a centrally controlled, simple and limited zonal approach is favoured by large national employers in both sectors. AfC is comparable with current practice elsewhere and has more flexibility for making pay more market-facing than most reward systems. Nonetheless, we examine whether the national AfC pay framework could be an obstacle to obtaining value for money for the taxpayer in whole or in part, and whether it needs further development to meet the challenges of delivering patient care against a backdrop of cost pressures in the NHS. It is important that AfC continues to be responsive to local needs, keeps pace with modern practice, provides value for money and makes more effective use of staff in the new NHS structure.

## Agenda for Change

6. We review the rationale for the introduction of AfC, its features, the flexibilities available and recent developments. AfC includes an incremental banded pay system supported by job evaluation, with sophisticated market-facing features such as recruitment and retention premia (RRP) and high cost area supplements (HCAS), and additional freedoms available to Foundation Trusts. AfC is perceived as fair and objective by all parties, supports stable industrial relations, and is viewed by the parties as compliant with equal pay principles.

7. However, employers have not, generally, taken advantage of the flexibility to establish local terms and conditions and do not always have a strategic approach to total reward. Unless AfC continues to develop and to reflect local needs there is a risk that Trusts will move away from the system with modifying AfC terms and conditions being the highest priority for employers. Changes proposed by the parties have proved slow to come to a conclusion and we consider greater impetus is required to take AfC developments forward.

## Proposals for Market-Facing Pay

8. The only specific proposal we received from stakeholders to make pay more market-facing was from the Department of Health, which considered that this could be achieved fairly, simply, safely and effectively through modest changes within the existing AfC pay framework. In summary, the Department proposed: to retain national agreements; flexibility for local and national RRP; to move towards having national AfC pay rates at the minimum level necessary to recruit sufficient high quality staff; and to extend HCAS. In this context, we note that the Department of Health has stated that it has no intention to reduce nominal basic pay rates for AfC staff. The Department's main proposal is to extend the use of HCAS, potentially to five or six zones. Further work would be needed to consider values, cliff edge effects and transition – the latter involving a prolonged period of constrained headline pay awards with headroom to move towards geographical differentiation without undermining affordability.

## Our Conclusions

9. Our conclusions start with the overall position on recruitment and retention which are important factors in considering how to make pay more market-facing. AfC staff recruitment continues to be healthy and retention stable with the position for shortage occupations easing slightly. This may or may not suggest that AfC, including RRP and HCAS is fulfilling its purpose at this time. However, in a dynamic situation, moving towards a more flexible system will ensure AfC can better respond to changing labour markets.

10. NHS recruitment, retention, motivation, earnings and patient experience across the country are indeed linked to NHS pay relative to local private sector pay, which might provide some

*prima facie* evidence in support of making pay more market-facing. However, our detailed analysis of geographical pay variation against recruitment and retention indicators does not provide the firm evidence which would be essential to justify further investment in additional market-facing pay in the NHS at this time. Our analysis does show that recruitment and retention indicators are relatively less favourable in London and areas surrounding London. If our research points to anything it would point to more investment in pay in parts of London rather than outside. However, any such regional pressures should be seen in the context of relatively high unemployment and may not be strongly linked to pay.

11. *Recruitment and retention premia*. We highlight that local recruitment and retention problems are driven by a series of pay and non-pay factors which need local assessment before deciding if a pay solution is required. Supply problems for specific AfC occupations can in some circumstances be addressed by more effective workforce planning and commissioning of training and education. Our analysis shows that the usage of local RRP is rare when legacy payments (pre-AfC Cost of Living Supplements) are excluded. We conclude local RRP are a key market-facing element to address AfC occupational shortages and we recommend a series of factors that should be taken into account to ensure their appropriate use.

12. *Extending HCAS*. We can see the logic of extending or adjusting HCAS but we have some reservations about doing so immediately without a clearer rationale and agreed methodology for defining and pricing new HCAS areas. Therefore, we recommend a fundamental review of HCAS, with the findings feeding into our next pay round. The review should focus on:

- The purpose of HCAS, how it should be configured, how any new HCAS zones might interact with existing local RRP or other arrangements, and appropriate review mechanisms;
- Funding arrangements including use of the staff index of the Market Forces Factor (sMFF) and how employers use current additional sMFF funding;
- Enabling any further HCAS flexibility to be available to respond to changing labour markets; and
- Boundary issues, including for the Devolved Administrations if appropriate.

13. *Transition and implementation*. Without the evidence to support new HCAS zones immediately, we have not as part of this review reached definitive conclusions on implementation. We do, however, share the Department's view that any changes can be implemented within the AfC Agreement and should apply to all staff rather than just new entrants. Affordability is an important factor and therefore: (i) any proposals need to be supported by robust costings and testing; (ii) we will consider any proposals in our next pay round in the light of the Government's announcement of further pay restraint through to 2015; and (iii) transitional funding for implementation and running costs should be considered including their affordability.

## Our Recommendations

14. We received no market-facing pay proposals for radical change to AfC, indeed all the stakeholders confirmed that full local pay bargaining was not appropriate for the NHS. We therefore focus on options for modifications to existing flexibilities and arrangements but against a background of continued NHS financial constraints. Any move to making pay more market-facing could only be undertaken incrementally over the long term within affordability limits. That said, further development of AfC is undoubtedly required. Our recommendations are built around our support for market-facing pay to support recruitment and retention of good quality staff to deliver patient care and where it can be shown to make more effective and efficient use of NHS funds and, in particular, supporting the NHS through significant structural change. If our recommendations are accepted we expect the parties to report on further work in evidence for our next pay round.

**Recommendation 1**. We support market-facing pay for AfC staff to support recruitment and retention of good quality staff to deliver patient care and where it can be shown to make more effective and efficient use of NHS funds. We recommend that AfC is the appropriate vehicle through which to make pay more market-facing.

**Recommendation 2**. We recommend the further review and development of AfC to support a more market-facing approach while stressing the importance of maintaining the integrity of the existing AfC system, including equal pay considerations.

**Recommendation 3**. We recommend that any agreed approaches to making pay more market-facing should be introduced incrementally taking full account of local and national affordability considerations.

As part of these financial considerations, we also recommend that the Department of Health with other stakeholders undertakes a full assessment of implementation and running costs of any new arrangements.

**Recommendation 4**. We recommend a fundamental review of HCAS – covering its purpose, how it is funded including the appropriateness and basis of the staff Market Forces Factor, its design and zone values, and boundary issues. The findings should be available in evidence for our next pay round.

We also expect the parties to consider:

- the appropriate mechanisms to keep zones under regular review;
- how to extend or reduce existing HCAS zones;
- how to add new zones and how to remove existing zones;
- how to increase or reduce rates; and
- whether rates should be expressed as percentages of basic pay or flat rates.

**Recommendation 5**. We recommend that the appropriate use of local RRP, as a key market-facing element of AfC to address occupational shortages, should ensure that local RRP:

- have appropriate review mechanisms in place;
- reflect employers' local needs;
- are supported by robust data on relevant local and regional labour markets;
- are simple to operate;
- are fully understood by staff; and
- good practice is shared.

**Recommendation 6**. We recommend that AfC, including its flexibilities, is kept under regular review by the parties to ensure it continues to be fit for purpose, reflects modern practice, and can respond to changing labour markets. Specifically, reviews could usefully focus on flexibility around terms and conditions as a priority.

If, as we have heard, the parties believe AfC is capable of responding to local and national market pressures, then we would expect to see discussions on particular issues brought to a conclusion at a reasonable pace, so that local NHS organisations can plan forward with greater certainty.

The parties may wish to examine how additional freedoms for Foundation Trusts in Annex K of the NHS Terms and Conditions Handbook could help Trusts and local staff to be better enabled to develop pay and conditions packages to meet local service needs.

**Recommendation 7**. We recommend that each Trust should have a transparent and open pay and reward policy contained within its business plan which clearly states its approach to the use of AfC flexibilities to meet the delivery of local services and to improve patient outcomes. Such policies should specifically include how Trusts will provide the HR capacity to support AfC flexibilities and how Trusts will approach total reward locally.

JERRY COPE *(Chair)*
DAVID BLACKABY
DENISE HOLT
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*4 July 2012*

# Chapter 1 – Introduction

## Introduction

1.1 We set out in this report our conclusions and recommendations on the market-facing pay remit given to us by the UK Government. We summarise the evidence provided by the parties and other interested organisations, and provide our analysis of this and other relevant data and information including our commissioned research. We see this report as the first step towards considering how to make pay more market-facing for Agenda for Change (AfC) staff in the NHS.

1.2 In this introduction we describe our remit, the process we have followed in producing this report, our sources of information, and the context of relevant developments in the NHS.

## The Remit

1.3 The Chancellor of the Exchequer announced in his Autumn Statement[1] on 29 November 2011 that the public sector pay freeze would end after 2012/13 but that, in order to support fiscal consolidation, for each of the following two years the UK Government would seek public sector pay awards that average at 1%. The Chancellor's statement said that Departmental budgets would be adjusted in line with this policy, with the exception of health and schools budgets where money would be recycled. The Chancellor told us that the Secretary of State for Health would write to us in advance of the 2013/14 pay round, in line with the normal process. The statement added that the UK Government did not control pay awards within local government or the Devolved Administrations and that budgets would be adjusted on the assumption of comparable action being taken and in line with devolved funding principles.

1.4 The Chancellor's statement said the UK Government would ask certain Pay Review Bodies to consider how public sector pay would be made more responsive to local labour markets, to report by July 2012.

1.5 The Chancellor continued that public and private sector organisations competed for employees in different markets across the UK. However, while private sector pay was set in accordance with local labour markets, public sector pay was usually set on a national basis. As a result, in many areas, public sector pay did not reflect local labour market conditions. He gave the example that the Institute for Fiscal Studies had found that public sector workers were paid similar wages to private sector workers in some parts of the country, but over 10% more in other locations. The Chancellor considered that such differences between public and private sector pay could adversely affect private sector businesses which had to compete with higher public sector wages. It also led to unfair variations in public sector service quality and limited the number of jobs that the public sector could support for any given level of expenditure. The Chancellor added that some public sector organisations, such as Her Majesty's Courts and Tribunals Service, had already successfully taken action to ensure that their pay was in line with local labour markets, but there was the potential for others to take a similar approach.

1.6 The Chancellor wrote to us on 7 December 2011 (see Appendix A) reiterating the points in his Autumn Statement and stating that the Government believed that there was a clear case for seeking to correct these problems, ensuring that public sector pay did not distort local markets. The Chancellor asked that we consider how to make pay more market-facing in local areas for NHS AfC staff taking into account:

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[1] HM Treasury (2011) *Autumn Statement 2011*, TSO (Cm 8231). Available at: http://cdn.hm-treasury.gov.uk/autumn_statement.pdf

- 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 pay bill 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 frameworks; and
- Whether proposals should apply to existing staff, or just to new entrants.

1.7 The Chancellor also wrote in similar terms to the Chairs of the School Teachers' Review Body, Senior Salaries Review Body and Prison Service Pay Review Body.

1.8 On 23 December 2011, the Secretary of State for Health provided more information in his remit letter to us (see Appendix A). He reaffirmed the overall position of the UK Government adding that we should take account of:

- The extent to which AfC already recognises the impact of local differences in pay through recruitment and retention premia (RRP) and high cost area supplements (HCAS) 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 Primary Care Trust (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;
- To consider what information in the future might be needed in order to make recommendations on local labour markets; and
- The need to submit our initial findings to Ministers by 17 July 2012 so that they could implement agreed recommendations in time for the 2013/14 pay review cycle.

1.9 In providing us with this remit the Secretary of State emphasised the value that the Government and he placed on our independent and expert view. The Secretary of State commented that this remit came from England alone and it would be for each of the Devolved Administrations to make their own decision whether or not to provide a separate remit and to communicate this to us.

## Positions of the Devolved Administrations

1.10 Following receipt of our remit for England, the Devolved Administrations set out their positions on market-facing pay for AfC staff in a series of correspondence.

1.11 The Minister for Finance and Personnel wrote to us on 31 January 2012 registering the Northern Ireland Executive's interest in the findings of this work and asking for a copy of our report when available. On 26 February 2012, the Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy in the Scottish Government and the Minister for Health and Social Services in the Welsh Government jointly wrote to us. They said that the introduction of market-facing pay raised a number of complex issues which they wished to consider carefully before committing to such a course of action. The Governments in Scotland and Wales confirmed that neither favoured this policy, nor did they see merit in taking such a proposal forward and, therefore, they would not be providing us with a remit. However, they noted that if England moved forward there might be a range of implications for the Devolved Administrations and they asked for our views on these implications.

1.12 The Scottish and Welsh Governments wrote further in response to the calls for evidence[2]. On 16 March 2012, the Cabinet Secretary for Finance, Employment and Sustainable Growth in the Scottish Government reaffirmed that it did not see merit in taking this approach forward and would not be providing a remit. The Cabinet Secretary added that such an approach could be damaging to local economies across Scotland and could place further pressure on family incomes, could damage the provision of public services in remote areas, would raise serious questions regarding equality of pay and work, and could inhibit the movement of public sector workers across the country. The Cabinet Secretary was not convinced that it would lead to improvements in service for the public or savings for the taxpayer and was concerned that it may be used as a vehicle to cut spending in certain parts of the UK in favour of higher public spending in London and the South East. On 24 May 2012, the Scottish Government submitted evidence confirming its position – the evidence is summarised in Chapter 2 of this report.

1.13 The Welsh Government's Minister for Finance and Leader of the House responded on 19 March 2012 confirming that the Welsh Government did not support the suggestion that there was an imbalance between private and public sector pay which required correction. The Minister said that pay relativities were complex and were often an appropriate reflection of factors such as qualifications, age and experience. The Minister added that fair and reasonable levels of public sector pay were an important contributor to economic performance in less advantaged areas and that this initiative risked recruitment and retention of skilled workers, might raise questions of equal pay and inhibited mobility of staff between public sector organisations. On 8 May 2012, the Welsh Government submitted detailed evidence on pay differentials which we summarise in Chapter 2 of this report.

1.14 We note the positions of the Devolved Administrations on the market-facing remit. Where appropriate in this report, we comment on any implications of our conclusions and recommendations for the Devolved Administrations. We also expect their further evidence for our next pay round in autumn 2012.

## Our Approach

1.15 Our approach is evidence-based and takes into account our standing terms of reference (see page iii). After receiving our remit letter from the Secretary of State, we issued a call for evidence on 16 January 2012 to the parties which usually contribute evidence to our pay rounds. The call for evidence set out the factors from the Secretary of State's remit letter and the Chancellor's letter including our interpretation of the issues for consideration to inform the parties' submissions. Responses were requested by 15 March 2012 and we are grateful to the following parties for their submissions[3] (copies of their evidence can be found on their websites listed in Appendix B):

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[2] Available at: www.ome.uk.com

[3] We also received submissions of evidence from a number of individuals.

- HM Treasury;
- Department of Health, England;
- Scottish Government;
- Welsh Government;
- Joint Staff Side[4];
- British and Irish Orthoptic Society;
- Royal College of Midwives;
- Unite the Union;
- NHS Employers (NHSE).

1.16 Responses were received from NHSE, the Joint Staff Side and individual unions by our requested submission date. Responses from HM Treasury followed on 20 March 2012, and afterwards from the Department of Health on 5 April 2012, the Welsh Government on 8 May 2012 and the Scottish Government on 24 May 2012.

1.17 The Government also issued similar remits to Pay Review Bodies covering school teachers, operational staff in public sector prisons, Very Senior Managers in the NHS and senior civil servants. On behalf of the Pay Review Bodies, the Office of Manpower Economics (OME) issued a further call for evidence[5] for any organisation or interested party to submit evidence relevant to these remits. We are grateful to the following respondents:

- Trades Union Congress;
- Confederation of British Industry;
- Local Government Association;
- Institute of Directors;
- Professor John Van Reenen;
- Mercer.

1.18 To understand the evidence further we held oral evidence sessions with: the Secretary of State of Health; HM Treasury representatives; officials from the Department of Health, England; NHSE; and the Joint Staff Side.

1.19 We also undertook a series of informal meetings separately with representatives from: NHS Trusts' Human Resources (HR) Networks (in London, South East and South Central, and East of England); HR staff from the University Hospitals (facilitated by the Association of UK University Hospitals); and the local Staff Side representatives on the Social Partnership Forum (South East and South Central, and East of England). We found these meetings very informative in setting our remit into the context of local circumstances and pressures and we summarise our observations in Chapter 4. We are grateful to all those who gave their time to participate.

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

[5] Available at: www.ome.uk.com

1.20 Our evidence base was extensively supported by additional information covering published research on local pay, public and private sector pay differentials, and approaches to geographical pay differentiation in the public and private sectors. The OME also commissioned, on behalf of the Pay Review Bodies, specific research covering case studies on geographically differentiated pay undertaken by Incomes Data Services[6]. These are summarised and assessed in the relevant sections of this report.

1.21 Throughout the evidence several terms are used in relation to market-facing pay. For the purpose of our assessment, we have interpreted these as follows:

- Local pay – where pay is determined with reference to local factors either within or outside a national pay framework;
- Regional pay – where pay is varied according to defined geographical regions;
- Zonal pay – where locations are allocated to one of a number of different pay bands/zones, according to specific labour market or other characteristics (these could include geographical zones or defined "hotspots"); and
- High cost areas – where pay is set with reference to defined areas having high costs of living.

1.22 Our approach to this remit is reflected in the structure of this report which first considers the overall case presented by the Government on how to make pay more market-facing. This assessment in Chapter 2 includes public and private sector pay differentials, whether the public sector crowds out the private sector, and, in Chapter 3, approaches in the private and public sectors to geographical pay differentiation. In Chapter 4, we then examine how the current AfC pay structure operates. Our assessment continues with the specific proposal from the Department of Health in Chapter 5, followed in Chapter 6 by our analysis of the available data. In Chapter 7, we draw these themes together into our conclusions and recommendations.

## Context

1.23 The remit for us to consider how to make pay more market-facing for AfC staff comes at a time of significant developments both in public sector pay policy and more widely in the NHS. Our assessment of how pay could be made more market-facing comes during the Government's public sector pay freeze, except for those staff earning £21,000 or less, and, although this comes to an end in 2013, a further period of pay restraint for 2013/14 and 2014/15 has been announced with the Government seeking public sector pay awards that average at 1%. These policies are part of the Government's plans for fiscal consolidation. The Chancellor asked us to take into account the affordability of any market-facing pay proposals in the light of the fiscal position and that these should not lead to any increase in pay bill in the short or long term.

1.24 The financial pressures being felt within the NHS are an important backdrop to this review. In evidence to our recent reports and again for this review, a major theme in the Department's and NHSE's evidence has been the need to deliver challenging efficiency savings of £20 billion by 2014/15 and the affordability of pay awards in this context. In an environment where funding and resources are scarce, we are aware of employers' efforts to control NHS pay bills. Our remit to examine how to make pay more market-facing in the NHS should be seen in the light of these significant financial pressures and therefore a major consideration for any changes to pay arrangements should be the need to make more effective and efficient use of NHS funds.

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[6] IDS (2012) *Case Studies on Geographically-Differentiated Pay in the Private Sector*. Available at: www.ome.uk.com

1.25 Any major change to NHS pay structures to incorporate a more market-facing element should also be seen in the context of major structural reforms now being implemented across the NHS. As these reforms take root we can expect a continuing need for evolving strategic approaches to pay and reward in the NHS. These strategies will sit alongside a range of developments including employers gaining freedoms through Foundation Trust status, reconfiguring workforces, adjusting skill mix, working in different environments and with non-AfC staff, accurate local workforce planning, effective delivery of local education and training provision, changes to pension arrangements, and increasing requirements for accurate data and information. We are also mindful that pay developments should focus on their contribution to effective service delivery and improving patient outcomes.

1.26 Our considerations of how to make pay more market-facing are set against this background of considerable financial pressure and service change. We therefore include throughout this report our views on where developments in pay need to take account of these wider reforms. We also emphasise, as we have in the recent past, that our independent review is particularly important in maintaining confidence in the Review Body process among AfC staff and the parties to our process.

# Chapter 2 – Pay Differentials and their Impact on Labour Markets and on the Quality of Public Services

## Introduction

2.1 We have been asked by the UK Government to review how pay for Agenda for Change (AfC) staff can be made more appropriate to local labour markets. In order to gain a better understanding of how to make pay more market-facing we review the substantial evidence that the parties provided on the UK Government's underlying arguments. These have centred on pay differentials between the public and private sectors; their impact on the quality of public services and patient care; their impact on local labour markets including whether the public sector crowds out the private sector; approaches to geographical pay differentiation in the public and private sectors; and the relative merits of centralised and decentralised pay determination. In many cases, the evidence and commentary has been common to the public sector as a whole, rather than applying to our remit group in particular.

2.2 In this Chapter we summarise the available evidence and the parties' views on pay differentials and their effects, and provide our own assessment of the evidence. Consideration of approaches to geographical pay determination is in Chapter 3.

## Public-Private Sector Pay Differentials

2.3 Pay in the public sector has been the subject of much recent debate – and necessarily so, given the size of the workforce, and the imperative to obtain maximum value for taxpayers' money. The debate has focused in particular on how pay for public sector employees compares with that for their "counterparts" in the private sector.

2.4 The public sector comprises about one fifth of the workforce in the UK, or just over 6 million employees[1]. It includes, among others, High Court judges, cleaners, teachers, doctors, care home staff, prison officers and police officers. In the case of the NHS, the AfC workforce (i.e. excluding doctors, dentists and Very Senior Managers) is around 1.4 million people or about one quarter of the total public sector workforce. It also encompasses a range of occupations, from nurses and managers to electricians and healthcare assistants.

2.5 For all these reasons, it is widely acknowledged that a simple, direct comparison between average pay in the public and private sectors is not appropriate: employees in the two sectors differ in terms of their occupational mix; gender balance; age; and level of qualifications, as highlighted in recent commentary from Incomes Data Services (IDS)[2] and the Office for National Statistics (ONS)[3]. Additionally, in the private sector there are higher proportions of small and medium sized enterprises, which are less common in the public sector.

2.6 A series of studies has been carried out which seek to correct for these observed differences in workforce characteristics, and so aim to make like-for-like comparisons between pay in the public and private sectors. Below we summarise recent research, describe its limitations, and go on to provide the parties' analysis of and comment on this research, before offering our own conclusions.

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[1] See Appendix C.

[2] IDS (June 2011), *Public and Private Sector Earnings: Fact and Fiction* (IDS Pay Report 1075).

[3] ONS (March 2012) *Estimating Differences in Public and Private Sector Pay – 2012*. Available at: http://www.ons.gov.uk/ons/dcp171776_261716.pdf

2.7 Commentary on this subject has referred variously to public sector pay "premia", "gaps" or "differentials". As public sector pay may be higher or lower than the private sector, at any given time or for a given characteristic, we use the term "differential" throughout.

## Research into Public-Private Sector Pay Differentials

### *Conceptual Basis*

2.8 Research in this area has taken the form of analysis of anonymised data from large sample surveys – typically, the *Labour Force Survey* (LFS, a quarterly survey of households) and the *Annual Survey of Hours and Earnings* (ASHE, an annual survey of employers); though, in one case, the *Workplace Employment Relations Survey* (WERS, a nationally representative survey of both workplaces and their employees).

2.9 Researchers have examined the characteristics of individuals working in the public and private sectors, including: their age; gender; occupation; place of residence; and (where available) qualifications. These data are then analysed using regression analysis: an arithmetic equation is applied to the data, which enables researchers to assess the extent to which pay varies when any one of the characteristics changes, while holding all other factors constant[4]. In this way, it is possible to estimate the average difference between public and private sector pay, for employees with similar observed characteristics such as age, gender and qualifications.

### *Recent Results*

2.10 Research into public sector pay differentials is longstanding[5]. Below we summarise the results of the most recent analyses for the UK, which relate to the public sector as a whole. Research on pay differentials and their impact on our remit group are presented in the sections which follow.

2.11 The ONS, using data from the April 2011 ASHE, estimated a differential of 8.2% in favour of the public sector[6]. Acknowledging that results from sample surveys are subject to a margin of error, ONS calculated that the differential was likely to be in the range 7.7% to 8.7%[7].

2.12 The Institute for Fiscal Studies (IFS)[8], using data from the LFS for the two-year period ending March 2011, estimated a differential of 8.3% in favour of the public sector. The differential for males was 5.5%, and for females 11.3%. IFS found that the differential varied for each gender across English Regions and Devolved Administrations (Figure 2.1). Using a similar methodology to IFS, HM Treasury estimated public sector pay differentials within regions and showed that these could be greater than between regions.

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[4] This is often referred to as "controlling" or "allowing" for these factors.

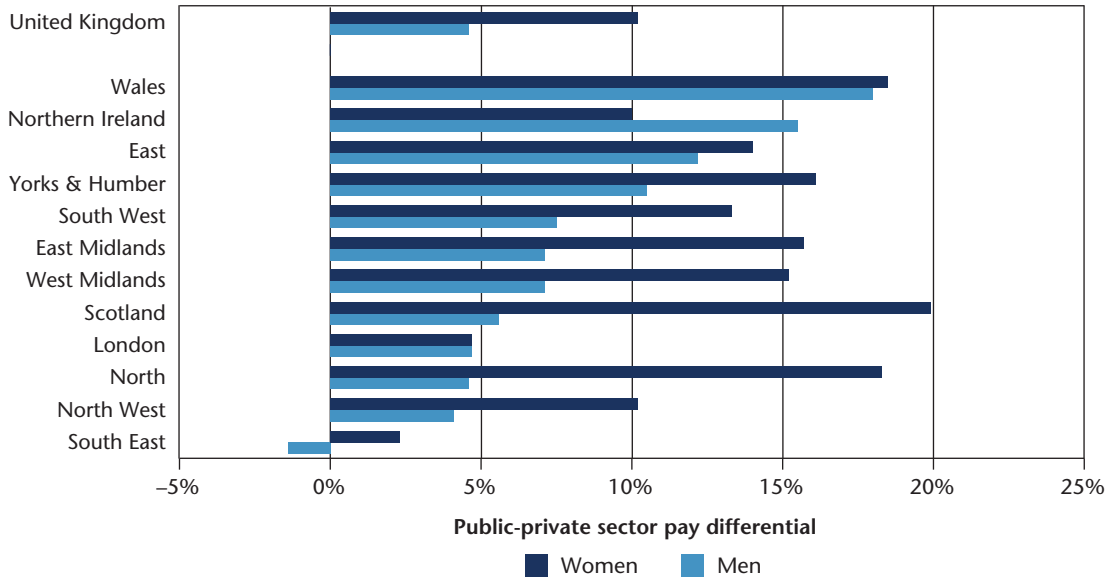
[5] See for example: Bender.K (1998) *The Central Government-Private Sector Wage Differential*, Journal of Economic Surveys (Vol. 12, Issue 2) pages 131-245; Nickel.S and Quintini.G (2002) *The Consequences of the Decline in Public Sector Pay in Britain: a little bit of evidence*, The Economic Journal (Vol. 112, No. 477) pages F107-F118; Disney.R, Gosling.A (1998) *Does it Pay to Work in the Public Sector?,* Fiscal Studies (Vol. 19, No. 4) pages 347-374; and Blackaby.D, Murphy.P, O'Leary.N (1999) *The Payment of Public Sector Workers in the UK: Reconciliation with North American Findings*, Economic Letters (Vol. 65, Issue 2) pages 239-243.

[6] *Op. cit. ONS, Estimating Differences in Public and Private Sector Pay – 2012.*

[7] The 95% confidence interval around its best estimate of 8.2%.

[8] IFS (2012) *The IFS Green Budget, Chapter 5 – Public Sector Pensions and Pay*, Carl Emmerson and Wenchao Jin. Available at: http://www.ifs.org.uk/budgets/gb2012/gb2012.pdf

**Figure 2.1: Estimated average public-private sector hourly pay differential by region 2009Q2–2011Q1**




*Source: IFS Green Budget 2012.*

2.13 Research by Blackaby et al[9] suggests that different results can be obtained by, for example, allowing for a fuller range of factors such as plant size. These researchers additionally found that simply replacing "actual hours worked" by "usual hours worked" reduced the size of the public sector differential across the spectrum.

2.14 Dolton and Makepeace[10] estimated that in 2009 male public sector workers earned about 1% *less* than comparable private sector workers (although the 1% differential was not statistically significant from zero), while for the same period females working in the public sector had a positive differential of about 6%.

2.15 Policy Exchange[11], using data from the LFS, estimated a differential of 8.8% in favour of the public sector for the 12-month period ending December 2010. Its subsequent analysis[12] estimated a differential of 8.9% for the 12-month period ending September 2011.

2.16 Earlier research by Chatterji and Mumford[13], using data from the 2004 WERS, found that full time male public sector workers in Britain earned on average 8.9% per hour more than those in the private sector, but this was before taking account of individuals' and workplace characteristics. Chatterji and Mumford concluded that the majority of the raw, unadjusted public sector pay differential was associated with public servants being more likely to have individual characteristics associated with higher pay. The authors also observed that workplace-specific effects worked in favour of the private sector because they were more likely to be employed in a higher paying workplace.

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[9] Blackaby.D, Murphy.P, O'Leary.N, and Staneva.A (2012) *An Investigation of the IFS Public-Private Sector Pay Differential: A Robustness Check*, Swansea University Department of Economics Discussion Paper No. 2012-09. Available at: http://www.swan.ac.uk/sbe/research/Papers.php

[10] Dolton.P, Makepeace.G, *Public and Private Sector Labour Markets*. From Gregg.P, Wadsworth.J (eds) (2011) *The Labour Market in Winter*, Oxford University Press.

[11] Holmes.E, Oakley.M (May 2011) *Public and Private Sector Terms, Conditions and the Issue of Fairness*, Policy Exchange.

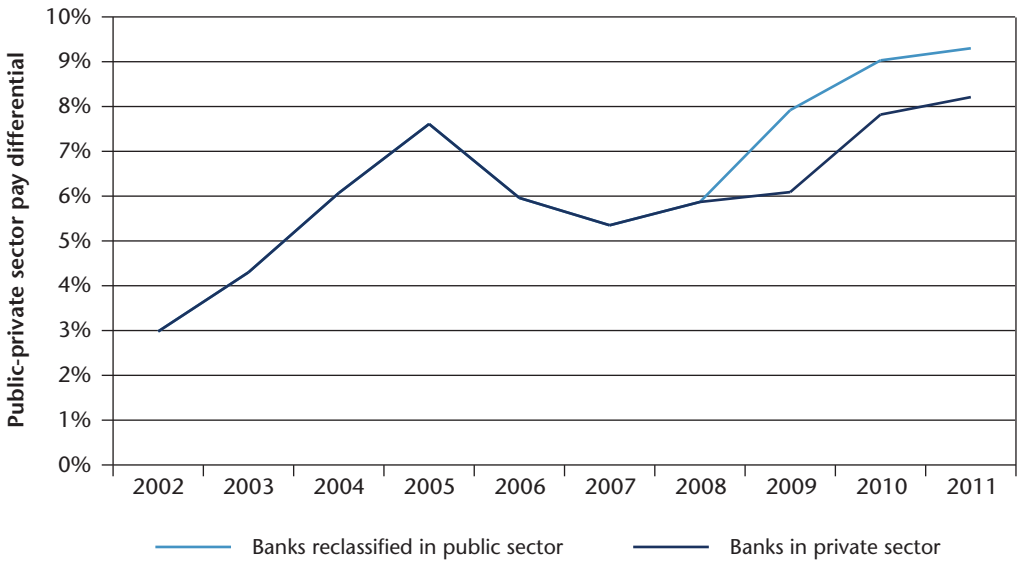
[12] Oakley.M (November 2011) *Further Analysis on the Public Sector Pay Premium*, Policy Exchange.

[13] Chatterji.M, Mumford.K (May 2007), *The Public-Private Wage Differential for Full-Time Male Employees in Britain: A Preliminary Analysis*, IZA Discussion Paper No. 2781.

*Changes in Pay Differentials Over Time*

2.17 ONS[14] produced estimates of the pay differential for the period 2002 to 2011 (Figure 2.2). The overall differential in favour of the public sector was at its lowest in 2002[15] at 3%, increasing to 7.6% in 2005, then falling to 5.3% in 2007. The differential increased year-on-year thereafter until 2011. ONS also produced separate estimates of the differential, which included the impact of assigning nationalised banks to the public sector. While their regression-based analysis, for the most part, is likely to have corrected for occupational restructuring between the public and private sectors, ONS observed that some lower skilled/paid jobs, such as cleaning, have been outsourced from the public to the private sector over the period. This would increase average earnings in the public sector and reduce them in the private sector. Some higher paid jobs, such as IT services, will have been contracted out too.

**Figure 2.2: Public-private sector pay differential, 2002–2011, April each year, UK**




*Sources: ONS.*

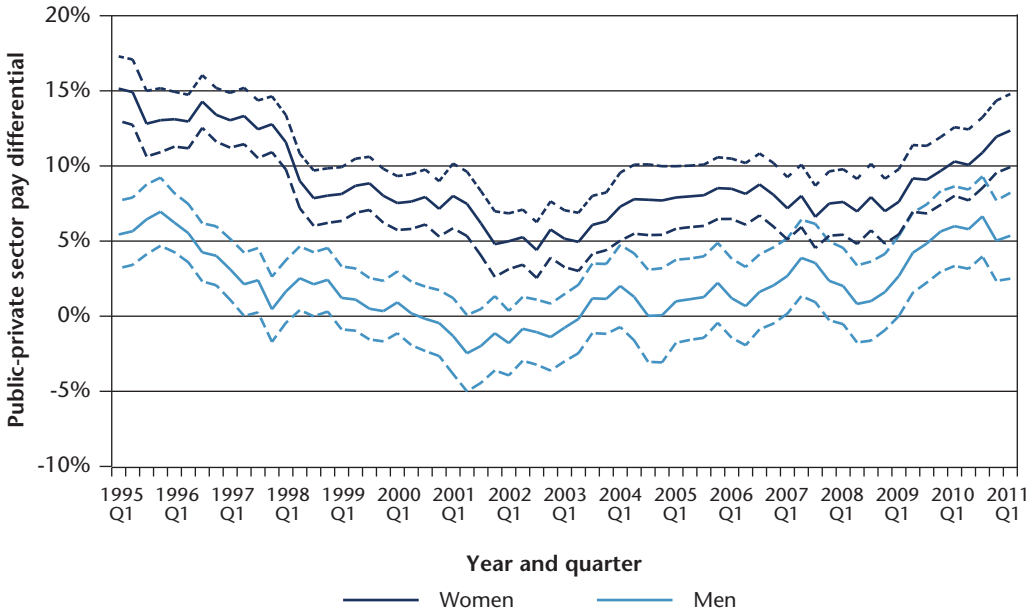
2.18 IFS[16] produced estimates of the differential for males and females for the period 1995 to 2011 (Figure 2.3). The differential for females was higher than that for males throughout this period. IFS estimated that in the ten years leading up to the 2008 recession, there was no statistically significant differential for men, and indeed a differential in favour of the private sector from 2001 to 2002 (albeit not statistically significant). IFS estimated a differential in favour of the public sector for males had started to emerge since 2008, and was at nearly 5% by the start of 2011. The differential for females had increased by a similar amount to males since 2008. IFS estimated that the UK Government's pay policies, in combination with a recovery in private sector pay growth as projected by the Office for Budget Responsibility, would reduce the differentials for both males and females back to pre-recession levels by 2014/15.

[14] *Op. cit. ONS, Estimating Differences in Public and Private Sector Pay – 2012.*

[15] The earliest year in which ONS could perform this analysis on a consistent basis.

[16] *Op. cit.* IFS (2012), *The IFS Green Budget.*

**Figure 2.3: Estimated average public-private sector wage differentials over time**




*Source: IFS Green Budget 2012. Dashed lines represent 95% confidence intervals.*

2.19 Policy Exchange estimated that the differential had increased from 4.3% in 2008 to 8.8% in December 2010[17]. Disney and Gosling[18] in 2008 concluded from their analysis of ASHE Panel Survey data that "long-run public sector pay differentials do not seem to depart strongly from zero". Using *unadjusted* average earnings indices for the period 1998 to 2009, Dolton and Makepeace[19] concluded that "over the last ten years the rate of growth in private sector earnings has, on average, matched – more or less exactly – the rate of growth in the public sector".

### *Distributional Differences in Pay Differentials*

2.20 Amongst others, the IFS[20] has calculated the conditional wage distributions in the public and private sectors, correcting for individual characteristics, and estimated that the differential in favour of the public sector was largest at the lowest end of the wage distribution, and that the estimated differential decreased gradually along the conditional wage distribution (Figure 2.4). IFS also estimated that the differential for males was in favour of the private sector at the upper end of the distribution (though not statistically significantly different from zero).

2.21 Further analysis by IFS suggested that the slope of the estimated premium along the distribution has changed little over time. For both sexes, the premium since 1995 had decreased gradually along the distribution, and there had been no obvious widening or narrowing trend of the premium across the distribution in the past ten years, for either men or women.

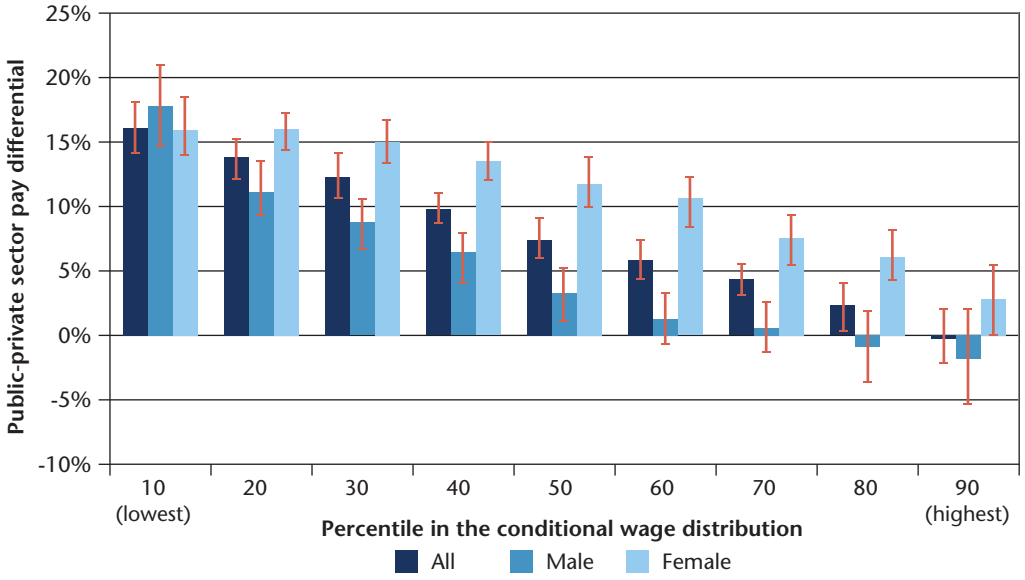
[17] *Op. cit.* Holmes & Oakley, *Public and Private Sector Terms, Conditions and the Issue of Fairness*.

[18] Disney.R, Gosling.A (February 2008) *Changing public sector wage differentials in the UK*, IFS. Available at: http://www.ifs.org.uk/wps/wp0802.pdf

[19] *Op. cit.* Dolton & Makepeace, *Public and Private Sector Labour Markets*.

[20] *Op. cit.* IFS (2012) *The IFS Green Budget*.

**Figure 2.4: Estimated public-private sector wage differential by percentile in the wage distribution, 2009Q2–2011Q1**




*Source: IFS Green Budget 2012.*
*Bar heights represent the gap between the relevant percentile of the public sector conditional wage distribution and that of the private sector. Red bars show the 95% confidence intervals.*

## *Limitations of These Analyses*

2.22 Although all these analyses go some way to estimating the pay differential between the public and private sectors in a like-for-like way, they remain subject to a number of caveats, each of which could have an effect – upwards or downwards – on the estimate of the differential. The limitations of these estimates include the following, some of which have also been highlighted by the parties:

- All analyses are based on sample surveys, and therefore earnings estimates produced from them are subject to sampling error: had a different sample been selected using the same method it may have produced slightly different results;
- There is no single definitive model to estimate the pay differential – all the above analyses have been conducted in slightly different ways, varying the dataset and controls used;
- Each dataset has its advantages and limitations, for example the LFS is not reckoned to be the best source of full time earnings data. In the LFS, earnings are self-reported by respondents[21]; by contrast the ASHE earnings data are reported by the employer on behalf of the employee;
- The LFS is known to over-estimate (by around one million employees) the size of the public sector[22];

[21] Also, proxy response is accepted if the chosen respondent is not at home: normally in the LFS about 30% of household member data are provided by proxy. ONS have tested the accuracy of proxy responses on income: 2 in 3 proxy responses matched *within 10%* the income estimates given by their "subjects". When proxy responses were restricted to spouses or cohabitees, the match was improved to around 80% when husbands answered for their wives and over 70% when wives answered for their husbands. (In the LFS the majority of proxies are women answering for their partners or parents for their offspring.) Apart from the problem of matching, the proportion of missing data for income through proxy inability or unwillingness to answer is higher than for most other variables. Thus if one is seeking a precise measure of earned income from LFS, ONS suggest that proxy non-response error is likely to be as important as proxy response error.

[22] ONS (2011) *A Brief guide to sources of Public Sector Employment Statistics* refers more specifically to the Annual Population Survey, which is derived from the LFS.

- The ASHE does not capture self-employed workers, which include some of the highest paid private sector workers (for example lawyers, businessmen and entrepreneurs), and also some of the highest paid public sector workers (for example general medical and dental practitioners);

- Owing to smaller sample sizes, regional and subregional estimates of the differential are subject to wider margins of error – or confidence intervals – than national estimates[23];

- A number of pay and non-pay benefits are not captured fully by the surveys, including: employers' pension contributions; company cars, health insurance and other on-pay benefits; and (for the ASHE in particular[24]) bonus payments; and

- In addition, many of the studies do not allow for a number of factors including the unobserved ability of workers; marked differences in age-earnings profiles between the public and private sectors; the fact that individuals self select into different occupations based on preferences which are not transparent to researchers; differences in public and private sector gender differentials or differences in the extent of unionisation of the sectors.

## The Impact of Pay Differentials

2.23 The Chancellor's letter to us said that: "there is substantial evidence that the differential between public and private sector wages varies considerably between local labour markets. This has the potential to hurt private sector businesses that need to compete with higher public sector wages; lead to unfair variations in public sector service quality; and reduce the number of jobs that the public sector can support for any given level of expenditure". It went on to say that: "the Government believes that there is a clear case for seeking to correct these problems, ensuring that public sector pay does not distort local labour markets".

2.24 Our wider call for evidence asked specifically for examples of where private or public sector employers have had difficulty in recruiting or retaining staff because of competition from employers of Pay Review Body remit groups.

### *Impact on Recruitment, Retention and on the Quality of Patient Care*

2.25 Some analyses are available on pay comparisons between occupations in our remit group and comparators in the private sector. The Department of Health has drawn our attention to a number of studies[25] specifically on the NHS which have been carried out using data up to 2005. For nurses, the research linked NHS and private sector geographical pay differentials to recruitment and retention indicators such as turnover rates, vacancy rates and the use of agency staff. Other work[26] linked a decline in relative pay to a decline in workforce quality.

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[23] For example, while the IFS has calculated that the 95% confidence interval around its UK best estimate of a public sector pay differential of 8.3% is approximately plus or minus 1.2 percentage points, at regional level the confidence intervals around estimates are typically of the order of plus or minus 4 percentage points, and considerably higher than this for Northern Ireland and Wales.

[24] The timing of the ASHE is such that it falls outside the main period in which bonuses are paid in the private sector and may under-represent this component of pay.

[25] Annex C of Department of Health's evidence cites a number of studies including: Elliott.R, Ma.A, Scott.A, Bell.D, Roberts.E (2007) *Geographically differentiated pay in the labour market for nurses*, Journal of Health Economics (Vol. 26, No. 1), pages 190-212; Elliott.R, Ma.A, Sutton.M et al (2010) *The role of the Staff Market Forces Factor in distributing NHS funding: taking account of differences in local labour market conditions*, Health Economics (Vol. 19, No. 5), pages 532-548.

[26] *Op. cit.* Disney & Gosling, *Changing public sector wage differentials in the UK*.

2.26 Research which examines a link between pay differentials and quality of patient care was brought to our attention. The first study by Hall, Propper and Van Reenan[27] used hospital level data from acute hospitals for the period 1995/96 to 2002/03 on quality (measured by Acute Myocardial Infarction (AMI) death rates) and productivity measures (by Finished Consultant Episode per clinical worker). These were then analysed against differences between nurses' pay and comparator groups' outside wage levels using techniques which took account of other influences such as hospital skill mix and labour inputs.

2.27 The authors found that hospitals in stronger labour markets with higher non-NHS comparator wages, showed worse outcomes in terms of quality and productivity. Their analysis suggested that a 10% increase in the non-NHS outside wage was associated with a 4% to 8% increase in AMI death rates. Similarly, a 10% increase in the outside wage was associated with up to a 6.6% decrease in productivity. They concluded that wages that more closely reflected the local market in higher outside wage areas would improve outcomes and productivity. An update on this work[28] using data to 2005/06 showed that a 10% increase in the outside wage was associated with a 7% increase in death rates.

2.28 An earlier study[29] examined the relationship between NHS Trust performance indicators and relative pay differentials with private sector alternatives for female nurses, based on 1999 data. The analysis suggested that some of the performance of NHS Trusts was related to the labour market in which they were located.

### *Impact on Local Labour Markets (including Crowding Out)*

2.29 A recent discussion paper[30] by Faggio and Overman reviews the available literature, considers the impact of public sector employment on local labour markets and presents some new analysis of the impact of new public sector jobs in an area, which we summarise below. Some early results were presented at a HM Treasury seminar in February 2012.

2.30 When a new job is created in an area additional jobs may be generated as a result of increased demand for locally produced goods and services. The positive effect on employment may be offset by other effects on the local economy induced by changing local wages or prices. In other words the multiplier effect of additional jobs may be offset by displacement or crowding out elsewhere in the local economy.

2.31 The study relates to England and uses data at the Local Authority level for 2003 to 2007 from the Annual Business Inquiry for employee job estimates as well as data from LFS and the Annual Population Survey. Using changes to employment over the period and regression techniques, the authors attempted to get round some of the more difficult measurement problems. They found that public sector employment had no identifiable effect on total private sector employment. However, public sector employment did affect the sectoral composition of the private sector with each additional public sector job creating 0.5 jobs in the nontradable sector (construction and services) while crowding out 0.4 jobs in the tradable sector (manufacturing). When using data for a longer time period (1999 to 2007) they found no multiplier effect for nontradables,

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[27] Hall.E, Propper.C and Van Reenen.J (2008) *Can Pay Regulation Kill? Panel Data Evidence on the Effect of Labor Markets on Hospital Performance*, Centre for Economic Performance (Discussion Paper No 843). Available at: http://cep.lse.ac.uk/pubs/download/dp0843.pdf

[28] Propper.C, Van Reenan.J (2010) *Can Pay Regulation Kill? Panel Data Evidence on the Effect of Labor Markets on Hospital Performance,* Journal of Political Economy (Vol.118, No. 2), pages 222-273.

[29] Burgess.S, Gossage.D, Propper.C (2003) *Explaining Differences in Hospital Performance: Does the answer lie in the labour market?* CMPO (Working Paper Series No. 03/091). Available at: http://www.bristol.ac.uk/cmpo/publications/papers/2003/wp91.pdf

[30] Faggio.G, Overman.H (2012) *The Effects of Public Sector Employment on Local Labour Markets*, SERC (Discussion Paper 0111). Available at: http://www.spatialeconomics.ac.uk/textonly/SERC/publications/download/sercdp0111.pdf

stronger crowding out for tradables and, consistent with this, crowding out for overall employment. However, these results for the longer period were not individually significant from those for the shorter period.

2.32 While they did not include the impact of wage differentials in their empirical research, they identified some recent theoretical work by Burdett[31] which showed that public sector employment could crowd out private sector employment in regions where public pay was higher than the outside option. In contrast, in regions where private employers offered a wage at least as large as the public sector, an increase in public sector workers would raise total employment leading to a multiplier effect. Though they did not identify any research which measured the effect on the labour market of a pay differential between the public and private sectors, they stated that in UK regions where a substantial public sector premium existed it would be consistent with theoretical predictions for displacement to dominate.

## Evidence from the Parties

### *HM Treasury*

2.33 **HM Treasury**, drawing on some of the above research, stated that there was an estimated pay premium of around 8% for those working in the public sector compared with those in similar jobs in the private sector but that the level of the premium was not uniform across the UK. HM Treasury considered that one reason for the variation in pay premia was that, unlike business in the private sector, there were few mechanisms for public sector pay to respond flexibly to differences.

2.34 HM Treasury argued that the existence of pay premia suggested that the public sector paid more than was necessary to recruit, retain and motivate staff in some areas. This in turn limited the number of jobs that the public sector could support for any given level of spending and diverted resources away from other ways to improve the quality of public services. HM Treasury considered that there were likely to be differences in the pay premia between public sector workforces, who recruited from a variety of different local labour markets, and that changes must therefore be implemented in a way that was appropriate for each individual workforce. HM Treasury stated that pay in the public sector did not adjust to local conditions as well as it did in the private sector. In HM Treasury's view, this could explain the existence of higher public sector pay premia where labour market conditions were less favourable to workers and price levels were lower.

2.35 HM Treasury highlighted that there had been a number of studies showing the detrimental impact of uncompetitive wages on the quality of hospitals and nursing including a study[32] which investigated the relationship between hospital performance and nurses' pay. It found that over one quarter of hospital targets were negatively associated with the public/private wage differential. HM Treasury also cited a study[33] which found that a 10% increase in wages outside of the nursing sector was associated with a 7.4% increase in mortality rates from heart attacks.

2.36 HM Treasury argued that public sector pay premia had a clear impact on the quality and effectiveness of public services around the county. Their existence implied a sub-optimal use of public resources. In some areas, there might not be sufficient incentives to recruit, retain and motivate quality public sector staff. In other areas, the public sector paid more than was necessary to recruit the right staff. Overpaying staff in poorer areas was a form

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[31] Burdett.K (2012) *Towards a theory of the labour market with a public sector*, Labour Economics (Vol. 19, No. 1), pages 68-75.

[32] *Op. cit*. Burgess, Gossage, Propper, *Explaining Differences in Hospital Performance: Does the answer lie in the labour market?*

[33] *Op. cit.* Hall, Propper, Van Reenen (2008) *Can Pay Regulation Kill? Panel Data Evidence on the Effect of Labor Markets on Hospital Performance.*

of redistribution, but it was not a particularly efficient one. If redistribution was the policy objective, then the same amount of money could be spent to employ more people at an efficient local market rate. Alternatively, the money could be used to improve other local services or infrastructure.

2.37 HM Treasury asserted that in places where private sector firms had to compete for workers with public sector employers offering a large pay premium, the introduction of more local, market-facing pay could help private businesses, particularly in some sectors, become more competitive and expand. HM Treasury also stated that private sector firms had to compete with public sector employers more in some areas than others.

### *Department of Health*

2.38 The **Department of Health** commented that there was considerable geographical pay variation in the private sector to reflect differences in cost of living and attractiveness of areas as places to work. There was much less geographical variation in NHS pay and in the public sector more widely. The Department provided detailed analysis on the link between NHS recruitment and retention, and relative pay variation in the NHS and the private sector, which we summarise in Chapter 5. The Department told us that where the geographical pay differential the NHS offered was low, compared to the local market, it created recruitment and retention difficulties that could manifest in higher agency spend, grade drift, higher turnover and recruitment costs, greater vacancies, lower productivity and lower quality. Where the geographical pay differential the NHS offered was high, there were fewer such difficulties, creating potential variations in quality.

2.39 The Department said that there was considerable evidence supporting the case for market-facing pay and provided a summary of its literature review of external research. For nurses, the research linked the gap among NHS and private sector geographical pay differentials to recruitment and retention indicators such as turnover rates, vacancy rates and the use of agency staff. The Department added that some studies took this further and considered the knock-on impacts on productivity and quality indicators[34].

2.40 The Department of Health commented that where the NHS pay premium was relatively high there was potential for private sector enterprise to be crowded out with adverse impact on the prospects for local economic growth. The Department considered that a greater alignment between the geographical variation in NHS pay and that of the private sector could help to address these issues.

2.41 The Department concluded that there was a prima facie case for the introduction of more market-facing pay for AfC staff. The NHS allocation process already took into account geographical variations of staffing costs. The Department considered that current rates of NHS pay varied geographically but less so than the pay of comparable staff in the private sector. More market-facing pay would, in the Department's view, enable more efficient and effective use of NHS funds.

### *Scottish and Welsh Governments*

2.42 The **Scottish Government** told us it was not convinced by the evidence on public-private sector wage differentials. It noted that such studies, including those by the IFS and ONS, came with significant caveats. These included:

- Major methodological challenges in estimating differences in pay between jobs in the public sector and jobs in the private sector. This made it difficult to ascertain whether there was a like-for-like premium and, while attempts were made to account for variations in qualification, skills or occupation, proxies used to account for these differences might not fully reflect variations in roles or responsibilities;

[34] *Op. cit.* Disney & Gosling, *Changing public sector wage differentials in the UK.*

- Pay patterns across the private sector were not uniform – overall the distribution of earnings was wider compared to the public sector and there were also differences between sectors and between different sized firms; and
- There were also limitations in the available pay data, e.g. ASHE did not include self-employed workers, and the measures of pay did not fully take into account all forms of remuneration and benefit such as bonuses. In addition the survey takes place in April of each year which is outside the main private sector bonus season of January to March.

2.43 The Scottish Government added that estimates of the pay gap might also be misleading if there were factors that drive differences in labour market participation and/or choice of sector amongst the workforce. One study[35] which attempted to address this, suggested a positive wage differential for males in the private sector in Scotland. The Scottish Government[36] cited the IFS forecast that, as a result of the policies of pay restraint in the public sector, the average public-private pay premium would fall by 4.4 percentage points between 2010/11 and 2014/15 and by 7.8 percentage points by 2016/17.

2.44 The Scottish Government did not accept the economic or public service efficiency arguments put forward by the UK Government. It did not consider there to be evidence that crowding out of the private sector was the key concern in most areas; rather it was often a lack of overall aggregate demand in the local economy. Reducing public spending in certain areas would only suppress local economies even more and perhaps further embed structural weaknesses. The Scottish Government presented evidence that there was no obvious link between output growth between 2007 and 2010 and the estimates of the public sector wage premium. Scotland's output growth had been second highest in the UK, while Scottish employment rates were better than for the UK as a whole. Since devolution – and up to the start of the recession – the public sector accounted for 19% of total employment growth in Scotland over the period 1999 to 2008 – slightly less than its pro-rata share. Public sector employment had increased by just under 49,000 over the period, whilst private sector employment had risen by over 210,000.

2.45 The **Welsh Government** did not support the suggestion that there was an imbalance between private and public sector pay which required correction and stated that the available evidence did not demonstrate the existence of a persistent average public sector pay premium. The Welsh Government considered that the pay relativities between the two sectors were complex and were often an appropriate reflection of a range of factors such as qualifications, age and experience.

2.46 The Welsh Government argued that the pay differential in Wales in the model cited by HM Treasury could not be taken as representative of the true differential between pay in the public and private sectors in Wales. It said that broader evidence showed that a range of other factors were also important in explaining differences in average wages, but these had not been included in the HM Treasury model.

2.47 The Welsh Government considered that there was compelling evidence that public-private sector pay differentials varied markedly across the economic cycle, and that the most recent data was not reflective of the longer-run position. Taking a longer-run average measure of pay would markedly reduce any differential and the Welsh Government doubted that there was reliable evidence of any persistent public-private sector pay differential in Wales.

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[35] Heitmueller.A (November 2006) *Public-Private Sector Pay Differentials in a Devolved Scotland*, Journal of Applied Economics (Vol. 9, No.2), pages 295-323.

[36] The Scottish Living Wage applies to NHS AfC pay scales – see NHSPRB (2012) *Twenty-Sixth Report*, TSO (Cm 8298) paragraph 3.69.

2.48 The Welsh Government pointed to the importance of undertaking more disaggregated analysis, rather than referring to a single, unified public-private sector pay differential, and to consider differences between the genders and across the pay distribution. It considered that the average differential cited in HM Treasury's evidence was in large part attributable to the lower part of the wage distribution and to women's pay. The Welsh Government's own analysis of the *Annual Population Survey* suggested that the mean difference in public-private sector pay in Wales was likely to be driven, at least in part, by relatively high wages for women and the low paid which was also confirmed in other studies[37]. Any attempt to slightly reduce the differential would need to target the pay of the low paid and women, in contradiction to both the Welsh Government's policy and to the stated objectives of the UK Government regarding public sector pay and conditions.

2.49 In its initial letter to us, the Welsh Government expressed concern about the potential impact local market pay would have on both public service workers and the wider economy at a time of financial pressure. It took the view that fair and reasonable levels of public sector pay were an important contributor to economic performance in less advantaged areas. It said that reasonably paid, high quality public sector employment supported growth and prosperity in its local economies, which in turn created demand for the products and services of the wider private sector. It considered that this support was particularly important in the current economic climate.

2.50 In its analysis of regional and local market pay in Wales, the Welsh Government said that some commentators had asserted that "excessive" public sector pay crowds out private sector employment, particularly in more peripheral regions. The Welsh Government added that there was no credible academic evidence or research to indicate that crowding out had been happening in practice. Available statistics for Wales provided no support to the suggestion and showed that since 1999 more jobs had been created in the private sector than in the public sector – with the opposite true for the UK as a whole. The Welsh Government concluded that, if crowding out was an issue, it was most likely to occur where and when labour markets were tight. This suggested that Wales was one of the areas where crowding out was least likely to occur.

### *NHSE*

2.51 **NHSE** commented that general levels of pay varied by region in the private sector. They cited the IFS[38] estimate that the public sector paid about 8.3% more to comparable workers in the private sector with a premium across all regions (up to 18.3% for women working in the North) with the exception of the South East (where men earned 1.4% less on average in the public sector). NHSE said that IFS concluded that there were higher levels of NHS vacancies in areas of higher levels of private sector pay which might be expected to affect the quality of public services. NHSE analysis showed that NHS vacancies and turnover were highest in London and the South East corresponding broadly to areas where private sector pay was highest. NHSE considered that making generic comparisons between the pay of public and private sector employers was difficult due to differences in the skill mix, qualifications and roles of the two sectors – in the NHS, for example, some lower paid roles had been contracted out while the rest of the workforce was skewed to high skill graduate level roles.

2.52 NHSE also highlighted Incomes Data Services analysis of ASHE data in 2011 which concluded that there continued to be little variation in pay outside of London and the South East.

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[37] *Op. cit*. Heitmueller, *Public-Private Sector Pay Differentials in a Devolved Scotland; op. cit*. IFS (2012) *The IFS Green Budget*; and Lucifora.C, Meurs.D (2006) *The Public Sector Pay Gap in France, Great Britain and Italy*, Review of Income and Wealth (Vol. 52, No. 1), pages 43-59.

[38] *Op. cit*. IFS (2012), *The IFS Green Budget*.

2.53 NHSE commented that the NHS employed the majority of registered nurses and most health professional groups and, therefore, in effect set the market rate for these groups. However, around one-third of non-medical NHS roles were comparable with similar roles in the private sector and, for these comparable groups, NHS average pay was at least as high as that of the private sector. In oral evidence, NHSE added that pay rates for some AfC groups could be above market rate in some areas potentially crowding out the private sector but generally competition for these staff was with other local public sector organisations.

*Staff Bodies*

2.54 The **Staff Side** noted that comparisons of public and private sector wages were complex and fraught with problems. The Staff Side quoted an Incomes Data Services[39] account of the complexities of such comparisons and that, by analysing 2010 ASHE data, varying the measure of average pay produced opposite results – using the median of annual gross pay the public sector exceeded the private sector but the private sector exceeded the public sector when using mean annual gross pay. The Staff Side noted that comparisons by IFS and ONS claimed to have taken account of the different workforce profiles. However, ONS acknowledged that the picture was more complex than the headline figure, for example, the ONS comparison stated that public sector employees with a degree or equivalent qualification earned 5.7% less than those in the private sector[40]. The Staff Side noted that this was significant for the NHS as around 48% of the non-medical workforce were defined as professionally qualified requiring a degree or equivalent qualification.

2.55 Other studies by the Trades Union Congress (TUC)[41] confirmed the disadvantage for degree level staff and that staff educated to A-Level standard or higher failed to find a pay advantage in the public sector. The Staff Side also referred to the Dolton and Makepeace[42] study which found that, by taking account of "human capital" factors of age, occupation and qualification, public sector male workers earned 1% less than their private sector counterparts while female workers earned 6% more. The Staff Side suggested that the only substantial variation in gaps between public and private sector pay across regions lay between London/South East area and the rest of the country which accorded with the existing structure of AfC.

2.56 The Staff Side commented that the national evidence presented a conflicting picture of whether NHS wages were significantly different to comparable private sector jobs. In the Staff Side's view, the most probable picture was that the professionally qualified half of the non-medical workforce was paid less than comparable private sector workers and the lowest paid, female dominated workforce was paid more than private sector counterparts. However, the Staff Side rejected any suggestion of levelling wages down and that any disadvantages should only be addressed by levelling pay up.

2.57 The Staff Side examined pay trends since 2005 using ASHE data and concluded that: public sector earnings growth ran faster than in the private sector in 2005; the picture was reversed between 2006 and 2008; the private sector fell back again from late 2008; and the two sectors had been tracking one another more closely since mid-2010 with signs that private sector earnings were starting to pick up again. The Staff Side therefore considered that it was not justified to make such a fundamental change to pay determination based on short term, relative differences between public and private sector earnings.

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[39] *Op. cit.* IDS, *Public and Private Sector Earnings: Fact and Fiction.*

[40] Though the ONS acknowledges that this result does not correct for other factors.

[41] Stanley.N (2009) *More About Public Versus Private Sector Pay*. Available at: http://touchstoneblog.org.uk/2009/12/more-about-public-versus-private-sector-pay

[42] *Op. cit.* Dolton & Makepeace, *Public and Private Sector Labour Markets*.

2.58 The Staff Side added that NHS performance figures offered no obvious correlation between service quality and region to draw any conclusions about the impact of pay differentials. NHS Performance Framework scores by region (Quarter 2 2011/12) suggested, according to the Staff Side, that of the three regions with the highest public-private sector pay differential – the South West, North West and East Midlands – two were in the bottom half of performance as measured against standards and integrated performance measures. The Staff Side questioned research findings[43] and disputed the premise that the nationally set pay ceiling deterred nurses in high cost regions from working in hospitals in that area, thereby resulting in shortages, leading to a detrimental impact on patient care. They commented that nurses and other healthcare workers did not base their decisions to work in the NHS purely on remuneration or solely on comparing pay to the cost of living.

2.59 The Staff Side commented on the Government's assertion that public-private sector pay differentials had the potential to hurt private sector business competing with higher public sector wages. They argued that company profitability did not vary across English regions other than the London and South East corner drawing on ONS breakdowns of gross operating surplus by regional population at June 2011. ONS data on company survival rates at June 2011[44] also led the Staff Side to challenge the damaging impact on the private sector citing the South West and North West regions as those with the largest "raw" pay differential but the highest survival rates of company start-ups. Additionally, the Staff Side asserted that the public sector crowding out the private sector could only happen when all resources in the economy were utilised and not at the current, high levels of unemployment. The Staff Side considered that there was no evidence that the private sector would automatically create jobs if public sector workers were paid less.

2.60 **Unite** rejected the premise that the Government's proposals were in response to immediate pressures to boost private sector employment and economic growth. It said that national pay bargaining in the NHS bore little or no relevance to the performance of private sector employers and was an over-simplistic and ideological understanding of economics. Unite considered that simply cutting pay for health workers would do little to raise employer's expectations or to stimulate the economy and would have no effect on recruitment to the private sector as the vast majority of jobs were not equivalent or comparable. It felt that this strategy was likely to lead to money leaving local and regional economies, stifling the private sector in those areas. Unite argued that if the Government's assertions were correct then real term pay cuts, due to below inflation pay rises and pay freezes, would have benefited those local private sector markets in recruiting staff.

## Evidence from the Trades Union Congress (TUC), Institute of Directors (IoD) and Confederation of British Industry (CBI)

2.61 The **TUC** stated that median pay in the public sector was higher than that in the private sector but argued that this was driven by a number of important differences between the sectors. They considered that a fundamental difference was that the gap between the low and high earners in the public sector was narrower than in the private sector. Low paid workers did better in the public sector and higher paid workers (with degrees) were on average 5.7% worse off than their private sector equivalents[45]. The TUC told us that data from the LFS showed that a greater proportion of public sector workers had higher levels

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[43] *Op. cit.* Hall, Propper & Van Reenen (2008) *Can Pay Regulation Kill? Panel Data Evidence on the Effect of Labor Markets on Hospital Performance*.

[44] ONS (2011) *Regional Trends Online Table 03: Economy*. Available at: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-254270

[45] ONS (2011) *Estimating differences in public and private sector pay 2011*. Available at: http://www.ons.gov.uk/ons/dcp171776_233736.pdf

of qualifications: 55.8% compared with 28.5% of private sector employers. This effect had been magnified by the outsourcing of lower paid roles such as cleaning and catering to the private sector.

2.62 Other influences mentioned by the TUC were that public sector workers tended to be older, to have more accumulated experience, were more likely to work in London and that recent figures had included employees of the nationalised banks in the public sector.

2.63 The TUC referred to the forecast 730,000 public sector jobs set to be cut by 2017[46] as demonstrating that public sector talent, far from squeezing out the private sector, was available for employers to draw on. The TUC believed that the idea that the private sector was being "squeezed out" as a result of an inability to match public sector wages was not credible, particularly in the current economic context. The TUC suggested that with unemployment so high, an otherwise healthy private sector would be able to recruit irrespective of public sector wages. That this was not happening suggested to the TUC that the problem lay elsewhere, most likely in low demand and the unavailability of affordable credit.

2.64 In November 2011, the **IoD** carried out an online survey of 1,051 of IoD members which found that 27% of respondents stated that they had found it difficult to attract skilled staff at least once because of public sector pay levels[47]. The IoD concluded that given a significant minority of businesses had found it difficult to compete with public sector pay levels, making public sector pay more market-facing would be likely to lead to increased private sector employment outside of London and the South East.

2.65 The **CBI** argued that addressing public sector pay premia benefitted both public and private sectors and promoted jobs and growth. They referred to the IFS study[48] which had estimated that across the UK, average hourly wages in the public sector were 24.3% higher than those found in the private sector, but, when differences in age, experience and qualifications were controlled for, the public sector pay premium was 8.3%.

2.66 The CBI commented that the public sector pay freeze which came into force in 2011 had not yet reduced substantially the public sector pay premium[49] and that the full two years of pay freeze in the public sector followed by two years of pay restraint would be required just to eliminate the increase in the pay differential that had grown since 2007/08[50].

2.67 The CBI asserted that the goal of hiring in the private sector was "hobbled" by the public sector pay premium. The CBI gave the example of men facing a public sector pay premium of over 7% in more than half the UK regions[51] and private sector employers needed to factor in this significant pay premium to compete for high quality staff.

2.68 The CBI considered that supply-side crowding out effects would vary according to the relative size of the public sector across localities. The CBI commented that national pay scales undermined the less affluent regions' major competitive advantage of lower wages. They also prevented the private sector from fully utilising these comparative advantages by essentially establishing a pay floor at public sector rates for the wages a private sector employer could offer to compete for the best staff in less economically successful areas.

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[46] Office for Budget Responsibility (March 2012) *Economic and Fiscal Outlook*, TSO (Cm 8303). Available at: http://cdn.budgetresponsibility.independent.gov.uk/Autumn2011EFO_web_version138469072346.pdf

[47] Though the IoD did not specify over what period respondents had encountered this difficulty.

[48] *Op. cit.* IFS (2012) *The IFS Green Budget*.

[49] *Op. cit.* Oakley, *Further Analysis on the Public Sector Pay Premium*.

[50] *Op. cit.* IFS (2012) *The IFS Green Budget*.

[51] *Ibid.* Table 5.A1.

## Our Comment

2.69 In order to gain a better understanding of how to make pay more market-facing we have reviewed the substantial evidence that the parties provided on the UK Government's underlying arguments. We comment in the following paragraphs on the evidence on pay differentials, their impact on patient outcomes, their impact on the labour market for our remit group as well as on the wider labour market including crowding out.

2.70 Though there are various caveats around the data and the analysis there seems to be consistency between the sources with the available evidence suggesting that there is a positive pay differential between the public and private sectors in the UK especially for women[52]; which has widened recently; that it varies geographically; and that it is greater for those at the lower end of the pay distribution.

2.71 Long-run analysis of changes in average earnings in the public and private sectors suggests that in the upswing of the cycle private sector workers in general fare relatively better than their public sector counterparts, while public sector workers tend to fare better on average in recessions[53]. We note that several of the recent studies comparing public and private sector earnings draw primarily on data from the 2009 to 2011 period, during which time Government measures for public sector pay in response to the recession[54] would not have had their full effect on public sector earnings. It may well be the case that the differential was at its peak over this period, and analysis of later data may show a convergence in average pay in the public and private sectors. Looking forward, the Government has announced a further period of public sector pay restraint through to 2015 which is forecast to reduce the size of the differential though some regional differences might remain.

2.72 We note the higher earnings differential for women who constitute over 80% of our remit group[55]. This higher differential may be, in part, a consequence of a larger gender pay gap in the private sector because gender pay equality is more widely recognised to be a feature of public sector employment. Other explanatory factors might include a greater presence of family-friendly work practices and a larger degree of unionisation in the public sector. A large proportion of women in the public sector (as in our remit group) are graduates, which may further reduce the differential.

2.73 Analysis for periods to 2005 for our remit group implies a relationship between pay differentials and recruitment and retention particularly for nurses. We explore these relationships further in Chapter 6. Evidence on the geographical variation in pay differentials has generally been at the regional or sub-regional level, which is difficult for us to apply to our remit to make pay more market-facing in local areas.

2.74 We agree that pay should be set at an appropriate level to enable NHS employers to recruit and retain an adequate supply of qualified staff to deliver high quality patient care. While we recognise that pay levels which are consistently below market rates in high cost areas could have an adverse effect on the patient outcomes, the available evidence is limited and relates largely to periods prior to the introduction of AfC in 2004. More

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[52] Some research (for example the *IFS Green Budget 2012*), suggests that for men, the differential has not been statistically significantly different from zero for most of the last decade.

[53] Disney and Gosling in their 1998 article say that "levels of pay are likely to be pro-cyclical in both the private and public sectors, but the greater pro-cyclicality of the former generates the observed counter-cyclical public sector 'premium' ". See *op. cit.* Disney & Gosling, *Does it Pay to Work in the Public Sector?*

[54] Namely, the 2011-2013 freeze on pay uplifts for public sector workers except for those paid £21,000 or less; and for each of the following two years to 2015 the Government has announced that it will seek pay awards that average at 1%.

[55] See Appendix C.

extensive and up to date analysis on this and other areas outlined above in relation to our remit group would be necessary to inform decisions on market-facing pay for AfC staff in the future.

2.75 We recognise that crowding out and multiplier effects are very difficult to observe in practice and to measure reliably. Recently published research seeks to measure the size of the effects through changes in public sector employment as a whole with data to 2007 for England. Though some early evidence is therefore available on the effects of public sector employment on the private sector a degree of caution is needed in understanding any implications for our remit group. Since the results seem to be sensitive to the time period chosen it is not clear what these might be in the current labour market with high unemployment. On the specific issue of the impact of public private sector pay differentials on local economies there appears to be little hard evidence available. Wages that are too high in relation to the private sector could clearly have the potential to hurt private sector businesses, but we have not been presented with any substantive evidence that crowding out by AfC staff groups is in fact causing any specific issues.

2.76 Our overall conclusions on pay differentials are that: (i) such pay differentials are dynamic and vary significantly over time, and therefore there are risks in choosing data based on a short period on which to base major public policy; (ii) the sizes of the differentials are sensitive to the methodology used in their calculations (and comparisons by sector or occupation might also show different results); and (iii) pay restraint in the public sector through to 2015 is forecast to reduce the size of the differential though some regional differences might remain.

# Chapter 3 – Approaches to Geographical Pay Differentiation

## Introduction

3.1 In asking us to consider how public sector pay can be made more responsive to local labour markets, the Chancellor's Autumn Statement commented that public and private sector organisations competed for employees in different markets across the UK. However, the Chancellor considered that while private sector pay was set in accordance with local labour markets, public sector pay was usually set on a national basis.

3.2 Reference was included to approaches in some public sector organisations, such as Her Majesty's Courts and Tribunals Service, and that there was the potential for others to take a similar approach. The Secretary of State for Health's remit letter reiterated that the Government was concerned with ensuring that overall public sector pay systems were most appropriate for the modern labour market.

3.3 As part of our evidence base we have therefore reviewed current practice. In this part of the report we summarise how the private and public sectors approach geographical pay differentiation and the evidence submitted by the parties on this subject, before turning to the relative merits of centralised and decentralised pay determination.

## Geographical Pay Differentiation in the Private Sector

3.4 Previous research on how private sector employers determine wages for staff in different areas of the country on this issue was commissioned by the Office of Manpower Economics (OME) on behalf of the Pay Review Bodies in 2002, 2003 and 2008[1].

3.5 The 2003 research first set out the different approaches and found that:

- Most large companies with a network of branches operated within nationally determined pay structures;
- Local pay bargaining was not common among national employers, and those with local bargaining tended to see only minimal variation in pay outcomes;
- It was common for organisations to have multi-layered pay systems incorporating two or more mechanisms to enable them to respond to short and long term local market pressures;
- Within national structures there was often scope to pay more to employees in some areas through the use of allowances or regional/zonal pay bands;
- The criteria by which pay could be varied at local level tended to be very closely controlled from the centre; and
- In most of the companies looked at, the majority of employees remained on national pay rates, with only a minority receiving premium payments paid for specific locations.

3.6 The OME commissioned further research from Incomes Data Services (IDS) in January 2012 to inform the current remits and to ensure that we had an up-to-date picture of private sector practice in geographical pay differentiation[2]. Nine detailed case studies were undertaken, focusing on large, multi-site companies that were most pertinent to the public sector, with a range of professional and front-line staff. The organisations were

[1] Available at: http://www.ome.uk.com/Cross_cutting_Research.aspx

[2] IDS (2012) *Case Studies on Geographically-Differentiated Pay in the Private Sector*. Available at: http://www.ome.uk.com/Cross_cutting_Research.aspx

in the following sectors: financial services, retail, utilities, transport and communications, manufacturing, healthcare and professional services and employed between 7,000 and 300,000 staff. The case studies were not chosen because of the type of pay system they operated, or to provide a representative sample, although in total they covered 700,000 employees.

3.7 These case studies found that:

- Employers' objectives for their local pay systems were the same as those for their pay setting practices and policies as a whole, with competitiveness with the external labour market being key;
- The nine firms used three different forms of geographically-differentiated pay
    - location-specific pay bands/zones e.g. London, M25 outside London, home counties, larger towns, national
    - traditional London allowances
    - no specific location payments but regional differentials arising from the use of market data;
- Some companies used different forms of locational pay for different occupational groups, most frequently but not always, management and non-management staff;
- Locational pay differentials were highest for the most junior staff and lowest for the most senior staff;
- The recent trend, if anything, was away from locational pay differentiation. This was largely due to the lack of labour market pressures that would normally drive higher local allowances;
- Private sector organisations had a limited number of bands/zones for differentiating pay by location. The typical number was four geographical bands including a national payband, and the range was from two to five. There were no attempts to recognise small differences between labour markets;
- The case study companies set great store by controlling pay, both basic and location-based, centrally. This was because of the need for tight cost control, a lack of confidence in the ability of local managers to manage pay, and the risk of inconsistent decisions on pay at local level;
- Despite companies citing a market pay policy, it was often the case that internal factors outweighed external factors in determining local pay allowances. This might be history or industrial relations, or simply a pragmatic resistance to the short term fluctuations in pay than an explicit market link might dictate;
- In some organisations there was difficulty in removing allowances that no longer needed to be paid. Several employers reported that although they could reduce or remove location payments they had little desire to do so and would only proceed cautiously, in order to maintain stability and consistency.

## Evidence from the Parties

*HM Treasury*

3.8 **HM Treasury** stated that private sector pay was more responsive to differences in local labour markets and price levels than public sector pay. Many businesses (particularly small and medium sized enterprises) were entirely locally based and responded to local labour market conditions when setting pay. However, employers with sites across the UK

tended to retain a national bargaining structure; this not only avoided the duplication of the bargaining process across multiple sites, but also reduced payroll management costs.

3.9 Evidence from HM Treasury highlighted the use of zonal pay, an approach that was common in retail banking and among retailers, that allowed extra payments in particular "hotspots" across the country where there was greater competition for labour. It also said that the most tailored pay frameworks took local labour market conditions and performance criteria into account.

### *NHSE*

3.10 **NHSE** pointed to evidence that suggested private sector organisations with sites across the country tended to determine pay nationally even if there was regional or zonal differentiation. NHSE indicated that research had found that large private sector organisations had national pay frameworks to avoid the time and additional costs of multiple local bargaining units. NHSE cited that IDS[3] had found nationally determined zonal approaches were common in the retail sector while banks tended to use regional pay bands. NHSE said that these might involve splitting the country into four or five zones based on geographical areas or "hotspots" or major cities.

### *Staff Bodies*

3.11 The **Staff Side** considered that private sector labour markets did not provide an appropriate framework on which to map NHS pay and that this would replicate the private sector's market failures, distortions and inequalities. A feature of the private sector was income inequality which had risen faster in the UK than in any other rich nation since the mid-1970s[4] – pay differentials between the highest and lowest earners and between men and women were larger in the private sector than the public sector. Income inequality had also grown between London and the rest of the country over the last decade and therefore reducing NHS pay rates in low income areas would widen the gap as the private sector competed for staff in a labour market with a reduced "going rate".

3.12 The Staff Side drew on IDS commentary that most large private sector companies continued to operate with national pay structures with the aim of controlling costs and also preventing locations from "leapfrogging" each other in pay terms. These structures usually incorporated supplements for London and its environs which was "arguably the sole distinct regional labour market in the UK". IDS added that zonal pay systems, common in retail and finance, tended to pay only relatively small premia for "hotspots" outside London.

3.13 **Unite** commented that, as a private sector union covering many different national and transnational companies, there was little evidence that private sector employers were considering NHS pay rates when setting their own rates. These companies based the pay predominantly on their expectations and the profitability of their product or service markets and the pay rates of their competitors. Unite considered that companies using regional variations tended to use a system much the same as the NHS with base pay accompanied by zonal uplifts for high cost areas or shortage occupations. Zonal pay systems common in retail and finance tended only to pay relatively small premia for "hotspots" outside London.

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[3] IDS (September 2011) *Location-Based Pay Differentiation – A Research Report for UNISON*. Available at: http://www.unison.org.uk/file/IDS%20research%20paper%20for%20UNISON%20FINAL%2016%2009%2011%20(2).pdf

[4] *Ibid.*

## Our Comment

3.14 The evidence presented by the parties and the research commissioned on our behalf provides us with a fuller picture of how comparable large, multi-site, national private sector employers approach geographical pay differentiation. This enables us to draw a number of high level conclusions on private sector approaches to inform how more market-facing pay might apply to the NHS. Our overall conclusion from the research is that, generally, private sector organisations operating nationally favour central control over local pay differentiation because this provides simplicity, avoids duplication and enables employers to control costs.

3.15 We note from the research that private sector approaches to pay to reflect the local labour market are driven largely by specific business need and can vary by sector. The research indicated that where the private sector does use pay differentiation it only uses typically up to four or five geographical bands and these include a national scale and specific rates for London and the South East. This is similar to current practice in the NHS, which differentiates pay in four zones (including national rates). We also note from those organisations included in the research that the recent trend was towards simpler geographical pay differentiation reflecting current labour market circumstances.

3.16 We conclude that large, multi-site, national organisations are the closest comparator to the NHS within the private sector – small and medium sized enterprises, while being more attuned to local labour markets, do not reflect the size and complexity of the NHS. The NHS has a key role in its own workforce planning, ensuring there is an adequate supply of well-trained staff, and avoiding an excessive amount of labour market turnover through competition for staff.

## Geographical Pay Differentiation in the Public Sector

3.17 We summarise below information provided by OME on the use of geographical pay differentiation across the public sector, covering approaches in central government, Her Majesty's Courts and Tribunals Service, local government, other public sector groups (police, fire and probation service) and groups covered by Pay Review Bodies[5].

3.18 The public sector has adopted different (and overlapping) approaches to geographical pay differentiation – summarised as follows:

- **Separate London and national pay scales** – used in central government departments;
- **Local grading on a national pay spine** – used in local government and for police staff;
- **Relatively high London allowances** – paid in the fire service and to police officers and coupled with Fringe allowances in neighbouring areas to limit staff transfers;
- **Relatively low London allowances** – for lower ranks in the armed forces, doctors and dentists;
- **Nominal zonal pay** – used in Her Majesty's Revenue and Customs (HMRC), the Ministry of Justice (MoJ) and, to an extent, the prison service, although there is limited evidence of the use of the flexibility these might offer in terms of moving locations between pay zones.

[5] This summary draws on information from IDS (2011) *Pay in the Public Services 2011* (updated using www.idspayreport.co.uk) and previous Pay Review Body reports.

## Central Government

3.19 The most common approach to geographical pay differentiation among central government departments is to have two sets of pay bands: National and London. Some departments pay additional location allowances on top of these pay bands. Many departments are limited in the locations where they employ staff and, therefore, in their need for a sophisticated approach to local pay. Only a few, notably HMRC (UK coverage), Department for Work and Pensions (DWP) (GB coverage) and MoJ/Courts and Tribunals Service (England and Wales) have a national spread of staff.

**Table 3.1: Approach to geographical pay differentiation in central government departments**

| Approach | Departments |
|---|---|
| National and London pay ranges | Department for Education |
| | Department for Environment, Food and Rural Affairs |
| | Department of Health (separate Inner London, Outer London, and National) |
| | Department for Transport |
| | Her Majesty's Revenue & Customs |
| | Civil Aviation Authority (Inner London, Gatwick and elsewhere) |
| National and London pay ranges plus further allowance(s) | Crown Prosecution Service (London and Hertfordshire recruitment and retention allowances) |
| | Department for Business, Innovation and Skills (specialist pay enhancements with London/National variation) |
| | Department of Energy and Climate Change (specialist pay enhancements with London/National variation) |
| | Home Office (Inner/Intermediate/Outer London allowances) |
| | Ministry of Defence – staff (Inner and Outer London weighting) |
| Local pay variation beyond London | Department for Work and Pensions |
| | Ministry of Justice |

## Ministry of Justice and Courts and Tribunals Service

3.20 The MoJ introduced a new pay structure for the majority of its employees (excluding National Offender Management Service) in 2007, including its staff in the Courts and Tribunals Service. The pay structure had five regional pay ranges (zones): Inner London; Outer London and South East hotspots (typically to the South West of London); hotspots (e.g. Manchester, Brighton); National plus (e.g. Norwich, Exeter, Newcastle); and National. Locations were allocated to pay zones based on an analysis of the different factors, including economic data and local salary surveys.

3.21 In determining the approach, MoJ studied the pay systems of organisations similar to MoJ finding that private sector organisations typically divided the UK into a number of geographic pay zones, each with their own pay ranges. MoJ also gathered data

on average earnings in each of the government regions of Great Britain and further economic and demographic data for sub-regions including average weekly earnings, unemployment rates, the percentage of the workforce with no qualifications and the percentage of establishments with hard to fill vacancies. MoJ analysed the different factors driving pay levels in the markets in which it operated to create five different "market" based pay zones with their own ranges and then applied the information to specific MoJ locations aligning the location to a pay zone. The five zone model was applied to all grades up to Higher Executive Officer but the data for Senior Executive Officer and above supported a three zone model (Inner and Outer London, and National).

3.22 Initially, the lowest pay zone (National) was only for new staff, with existing staff on at least the National plus pay zone. The National pay zone was abolished in 2010 following a management decision, however, with all staff moved onto the National plus zone (renamed National), effectively moving the system from five to four pay zones. The system also allows local management or the trade unions to apply to change the allocation of a court, tribunal or office to a pay range if there is evidence of sustained recruitment and retention difficulties that are pay-related or a significant change in the local employment market such as the relocation of major employers to an area.

3.23 MoJ implemented the new system through an extensive mapping exercise of 27,000 jobs to common pay bands that would then be slotted into the regional pay model. The job mapping exercise was undertaken using internally developed grading guidance that was underpinned by job evaluations of 200 common roles. Staff were given the choice of opting-in to the new system resulting in an initial opt-in rate of 95% rising to 97% over the course of the next 12 months as appeals against mapping decisions and individual grievances were resolved.

3.24 In 2009, MoJ refreshed the economic and demographic data and supplemented them with a market pricing exercise to provide a clearer picture of the variances for a number of MoJ locations. Only a small number of locations warranted further investigation although an analysis of recruitment data showed compelling evidence that the MoJ salary rates were competitive enough to attract sufficient applicants.

## Local Government

3.25 There is a national pay spine for local government in England and Wales, with individual local authorities adopting their own grading structure using the national spine. A separate pay structure that covers all the London boroughs was introduced in 2000, with Inner and Outer London pay spines. Individual authorities have the freedom to offer higher spine points if required. In the late 1980s and early 1990s, around 45 councils in and around the South East opted out of national pay bargaining in favour of local negotiations, largely as a result of recruitment and retention difficulties.

## Other Public Sector Groups

3.26 *Police Service*. Police officers across the UK are employed on common rates of pay with those in London receiving London weighting of £2,277 plus a London allowance of £4,388. Officers in London also receive free travel at any time throughout London and on the overground national rail system up to 70 miles outside London. Police forces in the counties around London pay location allowances to limit the loss of officers and potential recruits to the Metropolitan Police. Officers in the five forces immediately bordering London – Essex, Hertfordshire, Kent, Surrey and Thames Valley – receive an extra £2,000 on top of basic salary. Officers in the surrounding forces – Bedfordshire, Hampshire and Sussex – receive £1,000. In 2011, it was agreed that these South East allowances could be increased to £3,000 and £2,000 respectively for some officers, based

on local recruitment and retention considerations. In 2010, 58,273 officers – 41% of all police officers in England and Wales – were eligible to receive regional allowances. The first Winsor report[6] on police pay recommended that regional allowances should remain unchanged in the short term.

3.27 Police staff are paid according to local grading structures determined by each individual police authority using a nationally-determined pay spine (for England and Wales). There are no explicit local allowances, although forces have the option to offer different spine points. The Metropolitan Police Service uses a different pay spine, with additional allowances for Inner and Outer London boroughs.

3.28 *Fire Service.* The Fire Service operates with a single London allowance (currently £5,021) on top of national rates of pay that is negotiated separately to the general pay award. It also pays additional Fringe allowances (Surrey £1,213; Langley and Slough £790; Bracknell, Maidenhead & Windsor, £550).

3.29 *Probation Service.* The Probation Service operates with a single London allowance (of £3,850), on top of national rates of pay, with the option to pay a geographical supplement to groups of posts at specific locations within a Probation Board area, in recognition of high living costs in the Travel To Work Area, as well as major comparative recruitment and retention problems (Level 1: £3,600; Level 2: £1,800; Level 3: £900).

## Pay Review Body Groups

3.30 *Prison Service (England and Wales).* From April 2012, the system changed as part of wholesale changes to pay in the Prison Service including: a shorter working week where staff can agree to work longer hours with additional hours paid at a premium; and separate unsocial hours supplements. Changes initially applied to new staff and those earning less than £21,000 (who can choose to opt-in). Other existing staff would have the option to move to the new system from April 2013. The new structure replaces locality pay with a new system of Inner London, Outer London and National pay ranges. The value of the London differential varies by grade and position on the pay scale, rather than being the same flat rate for all staff at a location. For all grades on the maxima of pay scales and working 37 hours per week, the Inner London premium is £3,800 and the Outer London premium £2,500.

3.31 *School Teachers.* The school teachers' pay structure for England and Wales went through some restructuring in 2003/04 to address local recruitment and retention issues, which replaced the system of location allowances that had been in place since 1974 with locality pay spines. Initially, the Inner London allowance was replaced by a separate Inner London pay spine from April 2003. This increased the Inner London pay differential from 10% (at its lowest) to 20% (at its highest) for classroom teachers. This was followed in 2004, by new pay spines for Outer London and Fringe to replace the previous allowances, effectively providing four geographically determined pay bands. The Fringe payment was kept at the same level, while the Outer London pay spine was increased by a higher amount in 2005. In 2008, the School Teachers' Review Body recommended higher starting salaries for teachers in Inner and Outer London from September 2008, with consequential amendments to the main and upper pay scales in these pay bands, and a further increase in the minimum starting salary (and consequential amendments) to the Inner London pay band in 2009 and 2010. Schools may also pay time-limited recruitment or retention incentives and benefits to individual teachers. HM Treasury stated in their evidence on market-facing pay that academy schools had the freedom to set their own pay based on their local recruitment and retention needs. However, they

[6] Winsor.T (2011) *Independent Review of Police Officer and Staff Remuneration and Conditions Part 1 Report*, TSO (Cm 8024).

had tended not to use this flexibility and had kept to the parameters of national pay agreements.

3.32 *Armed Forces.* A recruitment and retention allowance of £1,400 a year was paid to service personnel up to rank OF5 (Brigadier and equivalents) based in London. The Ministry of Defence announced that this payment ceased for personnel above rank OR4 (Corporal and equivalents) from April 2012.

3.33 *Judiciary.* Judges in grade 7 posts (e.g. district judges, the lowest but most populous grade) receive a London salary lead of £2,000 and a London allowance of £2,000. The Senior Salaries Review Body (SSRB) recommended in 2011 that these should not be paid to new appointees, concluding that it was no longer appropriate to pay allowances at this salary level[7]. The Government has not yet responded to this recommendation.

3.34 *NHS Very Senior Managers.* The Department of Health published a new pay framework for Very Senior Managers (VSMs) in the NHS in May 2012. This pay framework applies to newly created posts and to new appointments to existing posts in "arm's length bodies". Existing VSMs in arm's length bodies and all VSM posts in Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs) and Ambulance Trusts remain on their previous pay arrangements. However, the number of VSMs on previous pay arrangements will reduce rapidly as SHAs and PCTs are due to be abolished in 2013 while Ambulance Trusts are expected to become Foundation Trusts. The new pay framework determines a basic salary by assigning a role to one of a set of pay ranges based on its job evaluation score. VSMs are paid a spot rate within that pay range and, in addition, are eligible for a performance-related bonus. VSMs posts can attract recruitment and retention premia (RRP) of up to 10% (and possibly more in exceptional circumstances) when market pressures lead to difficulties in recruiting or retaining staff at the normal basic pay rate for the post. This means RRP could be used as a form of locality pay in any area where the arm's length body had difficulties in recruiting or retaining suitably qualified VSMs[8].

3.35 *Senior Civil Service.* There is no explicit mechanism within the Senior Civil Service pay framework for local pay, or any London allowance. Pay is set within a broad minimum and maximum. However, staff are often promoted from grades (6/7) that contain a London payment, and receive a fixed increase on promotion (typically 10%) so that London pay ends up higher on average.

## Evidence from the Parties

### *HM Treasury*

3.36 **HM Treasury** considered that the public sector pay premia existed because there were few mechanisms for public sector pay to respond flexibly to labour market and price condition differences. HM Treasury stated that public sector pay was typically set on a sectoral basis with national bargaining and national pay structures.

3.37 HM Treasury believed that some current flexibility existed, allowing certain public services to set pay that responded to the local labour market. Academy schools and Foundation Trusts, for example, both had the freedom to set their own pay based on local recruitment and retention needs. However, they had tended not to use this flexibility and have kept to the parameters of national pay agreements.

3.38 HM Treasury referred to the introduction of a local pay model for Courts Service staff in 2007 by MoJ which included a detailed analysis of economic data and local salary surveys, before developing a zonal pay model. The zones did not conform to regional

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[7] SSRB (2011) *Thirty-Third Report on Senior Salaries 2011*, TSO (Cm 8026). Available at: http://www.ome.uk.com/SSRB_Reports.aspx

[8] *Ibid.*

boundaries but took the particular local economy into account. Pay bargaining still took place at a national level in the Courts Service but pay rates more closely reflected local markets. HM Treasury added that analysis of recruitment data showed that after the changes, salaries were still competitive enough to attract sufficient numbers of applicants and there was no significantly high turnover.

*Department of Health*

3.39 The **Department of Health** cited research by IDS[9,10] , from which the Department noted that local government, universities and police staff employers operated decentralised local pay – but in these cases local organisations did not operate under a national pay framework as did the NHS. The Department further highlighted the zonal pay approaches in the public sector that IDS had identified in the DWP and the MoJ. The Department stated that the DWP example had four zones reflecting Inner London, Outer London, hotspots and the rest of the country. The MoJ example which related to the Courts Service originally had five zones: Inner London, Outer London and South East hotspots, hotspots, National plus and National.

3.40 The Department considered that, within the public sector, complex local systems were considered rare due to the complications and resources involved in implementing and managing them and their potential to become unwieldy and inconsistent.

*Staff Bodies*

3.41 The **Staff Side** reported that very few NHS Trusts had introduced local pay and, even in these cases, not all had markedly different terms and conditions and that a number of local schemes had been imposed, rather than negotiated.

## Evidence from the Trades Union Congress (TUC), Confederation of British Industry (CBI) and Local Government Association (LGA)

3.42 The **TUC** considered that the current national pay arrangements in the public sector had been designed with a focus on the need to deliver equal pay and minimise the risk of challenges.

3.43 The **CBI** believed that unlike the private sector, the public sector was unable to respond flexibly and efficiently to the recent recession because they lacked the tools and that public sector employers did not have the ability to cope in the way private sector firms did because they did not own the pay and conditions of their staff. Furthermore, the CBI considered that in many parts of the public sector pay structures remained inflexible, leaving pay largely dependent on factors such as grade and length of service rather than performance.

3.44 The CBI considered that where there were national pay structures in place the public sector instead imposed a one-size-fits-all pay policy regardless of local labour market pressures. As a result the public sector faced deadweight costs from paying high cost public sector salaries in low pay areas, while simultaneously facing recruitment and retention challenges in areas where pay rates were not competitive.

3.45 The **LGA** provided information relating to how the local government workforce was governed with regard to pay. The majority of the local government workforce was covered by eight employer/trade union negotiating bodies with most covered by the National Joint Council for Local Government Services. Each of the 401 councils in England, Wales and Northern Ireland was an independent employer and was free to decide the contractual terms on which it employed its staff. About 10% of these councils

[9] Available at: http://www.ome.uk.com/Cross_cutting_Research.aspx

[10] *Op. cit.* IDS, *Location-Based Pay Differentiation – A Research Report for UNISON.*

(predominately in the South East and the East of England) chose to determine any annual pay increase locally; all others supported the process of national pay bargaining for the majority of their employees.

3.46 For those local government staff covered by national pay bargaining, while the pay spine and any rate of increase in that spine were negotiated nationally, grading structures and the positioning of jobs within grades were determined entirely at local level. This arrangement allowed for far more local flexibility than existed in some other parts of the public sector where there were nationally determined grades and pay ranges for certain roles and the only variation was through the application (where appropriate) of a regional allowance, such as Inner or Outer London weighting.

3.47 In addition to pay, the National Joint Council agreement included a range of core conditions determined nationally and the LGA stated that these basic provisions ensured a degree of fairness and consistency that helped in facilitating movement between local authority employers. The same agreement also included a range of other conditions that could be varied locally. The LGA considered that there was a clear case for the annual pay bargaining cycle for local government to be carried out at national level due to economies of scale and the resources that authorities possessed.

### Our Comment

3.48 Our assessment of geographical pay differentiation in the public sector has covered a wide range of public sector employers. In general, public sector pay systems possessing National and London zones are the most widespread. Such pay systems are generally designed to provide overall value for money and to protect against equal value claims. However, there are models in the public sector that incorporate a small number of zones nationwide to reflect local labour markets, such as the systems used by MoJ and DWP.

3.49 In the case of MoJ, the zonal pay system was introduced following extensive analysis of economic and demographic data which supported the approach. We note, however, that staff in the Courts and Tribunals Service operate in very small groups across different locations and are from a narrow range of occupational groups. We are mindful in the light of this evidence that the Chancellor's letter to us specifically recognised that any market-facing pay solutions should be appropriate to individual workforces.

3.50 As we concluded in assessing private sector approaches, where public sector pay systems possess elements of pay which reflect local labour market conditions they are generally centrally controlled and limited to a small number of zones. Indeed, the AfC framework in the health service already, potentially, provides much more flexibility to local employers than in comparable public and private sector organisations, as we set out in Chapter 4 of this report.

## Centralised and Decentralised Pay

3.51 As part of our review of geographical pay variation, we also assess the parties' evidence on the merits or otherwise of centralised and decentralised pay. This includes responses from other interested organisations and a brief overview of some external research.

### Evidence from the Parties

*Department of Health*

3.52 The **Department of Health** considered that AfC could support either a decentralised or centralised approach to the implementation of market-facing pay but concluded that neither extreme model appeared to offer an ideal solution. The Department believed that it would be unrealistic to expect a completely centralised system to reflect the infinite

variety of local circumstances across multiple staff groups and that local issues were most appropriately dealt with through local flexibilities. The Department set out three options for market-facing pay: a decentralised local bargaining system; a centralised pay framework building on local flexibilities available; and extending existing national measures such as high cost area supplements or national RRP. As the plurality of provision increased, Foundation Trusts were likely to have to compete with private sector providers with more flexible reward strategies. However, expecting Foundation Trusts to move solely to a system of local bargaining was high risk given the lack of capacity in HR, the transaction costs, and associated equal pay and unfair dismissal risks.

3.53 The Department concluded that the mandatory devolution of pay bargaining to a local level should not be the preferred option. On balance, that the current approach in which Foundation Trusts had the right but not the obligation to determine pay locally was most efficient in that it provided a pressure for national negotiators to ensure that national terms and conditions are affordable and fit for purpose, but avoided the costly overhead and risks of mandatory local negotiations.

### *Scottish and Welsh Governments*

3.54 The **Scottish and Welsh Governments** jointly confirmed that they did not favour a policy to introduce market-facing pay. The **Scottish Government** did not support the UK Government's proposals on economic, public sector efficiency or equity grounds and was unconvinced by the evidence base which had been used to support this proposal. It confirmed that it had no intention of implementing such a policy in Scotland. It pointed to a number of challenges in making relevant comparisons of pay between the private and public sector. The Scottish Government considered that a move toward market-facing pay: had the potential to damage local economies; could seriously hamper the provision of public services; would not lead to savings to the taxpayer or promote growth; and would be relatively expensive and inefficient compared to other methods. The Scottish Government was also concerned that such a policy might be used as a vehicle to cut spending in certain parts of the UK with a negative impact on many areas in Scotland.

3.55 The **Welsh Government** concluded from its own analysis that there was no clear evidence of a persistent or uniform public-private pay differential in Wales. Overall, the Welsh Government dismissed any market-facing pay on grounds that it would target the low paid and women, contrary to Welsh Government policy and the stated objectives of the UK Government regarding public sector pay and conditions, and reductions in public sector pay would more likely have adverse consequences for the private sector by reductions in spending power.

### *NHSE*

3.56 **NHSE** reported that there was a limited appetite from employers for full local pay bargaining and moving away from AfC which raised issues of a lack of capacity regarding skills and expertise within HR departments, increased administration costs and risked pay inflation as employers competed directly for staff on pay. NHSE added that getting rewards wrong could have a significant impact on the quality of patient care and safety. Employers had also recognised that fundamentally changing a pay system was not a quick fix.

3.57 NHSE recognised that employers operated in different local labour markets and some pay flexibility would potentially lead to more efficient use of the pay bill. However, the NHS had a wide-ranging sophisticated workforce that operated at international, national, regional and local levels which required careful consideration to ensure that any changes did not lead to pay escalation or labour market instability.

3.58 In oral evidence, NHSE said that market-facing pay was not a priority for individual employers at present – other key priorities were achieving challenging efficiency savings, and reconfiguring services and the workforce. In written evidence, NHSE considered that there was a desire from employers for more flexibility around pay and conditions of service which could seem more generous in some places compared to other comparable employers. However, most employers would like this to be delivered through a development of the national framework. NHSE also commented that there was some evidence that regional and local labour markets influenced the NHS with turnover rates and recruitment and retention pressures differing across the NHS in England.

*Staff Bodies*

3.59 The **Staff Side** emphasised their strong commitment to national pay determination and national pay structures in the NHS and other parts of the public sector. The Staff Side believed that the current UK-wide pay system set a floor for NHS pay, allowed for adjustments in high cost areas or local areas with particular recruitment difficulties and had proved a robust, effective pay system that closely followed the realities of geographic variations in the UK labour market. The Staff Side added that the NHS and other parts of the public sector should be a model employer, providing high quality pay and reward packages, training and development, and promoting equality so supporting the recruitment and retention of a highly motivated workforce. The Staff Side rejected the Government's call to make pay more market-facing in local areas as they saw it as an attempt to drive down public sector pay in lower cost areas in England, to break up national pay determination and to introduce local pay structures. The Staff Side also argued that market-facing pay would lead to a reduction in public sector pay in some areas of the UK which, in turn, would not stimulate economic growth but only take demand out of the economy.

3.60 The Staff Side summarised a series of arguments against market-facing pay in the NHS as follows:

- The proposals would damage recruitment and retention;
- The justification for market-facing pay was misplaced, based on over-simplistic comparisons between the private and public sectors;
- Market-facing pay would be highly impractical and inefficient – the current system sufficiently adapted to regional cost of living variations; and
- National pay structures and AfC provided a level playing field, were efficient and reduced organisational conflict.

3.61 In addition, the Staff Side drew on a paper by Ian Kessler[11] which examined the benefits of national pay determination and specifically the AfC system. The Staff Side said that any move to local pay determination would significantly increase transaction costs, would also reduce career mobility and dissuade health workers from moving to lower cost areas requiring higher wages to attract staff.

3.62 The Staff Side commented further that any moves to market-facing pay in local areas would undermine the whole infrastructure leading to damaging competition between Trusts and organisations for staff, equal pay issues and a threat to the UK-wide AfC structure forcing the hand of the other UK countries.

[11] Kessler.I (2011) *National Pay Determination in the NHS: Resilience and Continuity*. Available at: http://www.unison.org.uk/file/Market%20based%20pay%20-%20Kessler%20appendix.pdf

3.63 The Staff Side cited the Governor of the Bank of England's[12] view that linked falling real wages and consumer spending to the UK's current weak economic growth. It said that reductions in pay levels in the public sector were bound to have a knock-on impact on the private sector, further damaging spending power and slowing down recovery. In the Staff Side's view, the Government's approach to pay would weaken the spending power of the largest workforce in the UK, would weaken the economy and have a disproportionate effect on a predominantly female workforce.

3.64 The Staff Side concluded that these proposals followed public sector redundancies, further pay constraint and increasing pension contributions. Public sector and NHS staff would see this as an attack on pay, terms and conditions, risking damage to morale, motivation, recruitment and retention, which were all linked to the level and quality of service provision.

3.65 The **Royal College of Midwives** (RCM) believed that any move to locally determined pay would be costly and overly bureaucratic. The RCM said that consideration of the cost of proposals assumed that locally determined pay would ultimately result in lower pay but could not result in higher pay. The RCM added that if pay awards were determined locally there would be no way of nationally controlling pay.

3.66 The RCM further considered that developing a system of market-facing pay in local areas would be likely to lead to an inefficient and unequal pay structure. The RCM said that for midwives, the proposals for market-facing pay followed on from a period of pay freeze, the announcement of a two-year pay cap, increased pension contributions, reductions in the number of Band 7 midwives and reductions in incomes through benefit cuts. The RCM commented that NHS pay should be determined by equal pay for equal work and that there was no difference in the roles and responsibilities of midwives in different areas of the country and therefore there should be no difference in pay. The RCM added that it was problematic comparing public and private sector pay and almost impossible to do so for midwifery as the majority of midwives worked in the NHS.

3.67 **Unite** did not share the Government's view that labour market regulations were obstacles to an efficient labour market and a functioning market economy. Unite contrasted how national pay structures worked in other European countries such as France, Scandinavia and Germany.

## Other Evidence

3.68 The **CBI** said that unemployment did not rise as steeply as expected during the downturn because businesses and employees cooperated to find ways to reduce costs and retain jobs and skills – with pay restraint, reduced overtime and flexible working all playing a part. It said that such flexibility required pay and conditions to be managed at a local level and that public sector employers have not been similarly responsive because they lacked the tools. The CBI went on to say that a move to responsive, market-facing public sector pay would create a more efficient, effective and responsive public sector where making the most appropriate decisions on pay at a local level was not hindered by rigid and old fashioned national pay bargaining structures. More flexible and localised pay offered significant benefits for the public sector – as a tool for performance management, reward and retention, to reduce deadweight costs – and allowed for more efficient public spending, and improved public service delivery in those areas where the public sector was not currently competitive. To minimise inefficiencies, it continued, pay should be devolved to the lowest possible level: the employer.

3.69 The CBI pointed to the example of the decentralisation of public sector pay in Sweden which they considered allowed managers to be genuinely flexible in creating posts and

[12] Speech given by the Governor of the Bank of England on 24 January 2012. Available at: www.bankofengland.co.uk/publications/speeches/2012/speech541.pdf

roles and allowing wages to reflect local circumstances and priorities. The CBI stated that although local pay negotiations involved some trade-off in terms of administration, expense and time taken to negotiate at an individual level, these costs had been more than offset by the benefits of allowing local managers to decide what was most efficient and effective.

3.70 The **TUC** was concerned that moves to localise pay would undermine the ability to plan and deliver services in a consistent and co-ordinated way. It argued that if public sector wages were to fall in the poorer regions and nations of the UK, it would make it more difficult to attract senior and specialist staff to posts outside London and the South East, and create a perverse "internal market" with competition over pay rates leading to increased turnover. Recruitment and retention issues such as this would drive up the costs of delivering public services, diverting money and staff resources into dealing with this churn rather than putting in place sustainable staffing arrangements.

3.71 A paper by Wolf[13] in 2010 was cited in the Department of Health's evidence. The paper commented that 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. The paper concluded that Britain needed to rid itself of rigid centralised wage bargaining as these systems were economically harmful, undermined quality in public services and perpetuated disadvantage. In commenting on the difficulties of reform, the paper pointed to the example of Sweden which had moved from a centralised system to one in which public sector employees all had their own contracts and centrally set pay spines no longer existed.

## Our Comment

3.72 In the longer term, the potential benefits of greater pay decentralisation must be kept under review as the health service is restructured, all Trusts gain foundation status and competition increases among providers.

3.73 The Swedish example is interesting but requires further investigation. The British Embassy in Stockholm told us that that while pay is decentralised in the public sector, local arrangements focused on improvements to national agreements covering pay and general conditions of employment. This is not unlike the AfC arrangements currently in place in the UK. However, it is difficult to make a full assessment as there appears to be little information evaluating the impact of decentralisation of public sector pay. We are grateful for the help provided by the British Embassy in Stockholm in providing us with further information.

3.74 We also examined further research on approaches to pay determination in the health care sector across Europe[14]. It highlighted that in most European countries the structure of collective bargaining in the health sector is conditioned by the nature, funding and organisation of provision including the mix of public, private and voluntary provision and the level of responsibility for managing the service. In the public sector, wage setting tends to be centralised either at national or regional level. However, collective bargaining arrangements were complex with differences in the nature of the parties in the process, the level of bargaining, the level of detail covered at central level and the extent of local leeway to further shape pay and conditions. Collective bargaining at regional level takes place in Austria, Denmark, Finland, Germany, Spain and Sweden.

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[13] Wolf.A (2010) *More Than We Bargained For – the Social and Economic Costs of National Wage Bargaining*, CentreForum. Available at: http://www.centreforum.org/assets/pubs/more-than-we-bargained-for.pdf

[14] Weber.T (2011) *Employment and Industrial Relations in the Health Care Sector*, European Foundation for the Improvement of Living and Working Conditions.

3.75 We are grateful for the Department's assessment of the various options to introduce market-facing pay in the NHS. We concur with the overall conclusions of the parties that full local pay bargaining would be inappropriate in the NHS at this stage. There are risks involved in decentralising pay in the NHS not least affordability and unnecessary competition for AfC staff in shortage occupations. We also comment through this report on the capacity required in Trusts' HR departments to implement full local bargaining successfully.

## Our Overall Assessment

3.76 After considering all the evidence on market-facing pay in Chapters 2 and 3, our view is that pay should continue to be market-facing for AfC staff to support recruitment and retention of good quality staff to deliver patient care and where this can be shown to make more effective and efficient use of NHS funds. However, there is also a premium in favour of simplicity and we would need to be satisfied that any possible developments go in the direction of enhancing the flexibility of AfC while ensuring value for money. Our next chapter therefore reviews the AfC system.

# Chapter 4 – Agenda for Change

## Introduction

4.1 In this section we explain the development of Agenda for Change (AfC) since its introduction in 2004. The description includes the rationale for AfC, its features and flexibilities, developments, comments from our previous reports and the parties' evidence followed by an assessment of equal pay considerations and total reward. At the end of the chapter we set out our overarching commentary on AfC.

## Supporting Rationale for AfC

4.2 The Government published AfC proposals in 1999 to modernise the NHS pay system commenting that the Whitley arrangements were no longer able to adapt to service needs. Following negotiations, a Framework Document for AfC was published in December 2002 and 12 Early Implementer sites were agreed from June 2003. The pay system was then agreed by the UK Health Departments, NHS Confederation, Unions and Professional Bodies and rolled out from December 2004 supported by a three-year pay settlement to 2006.

4.3 AfC is a simpler and more flexible approach. It is based on the principle of equal pay for work of equal value and is underpinned by a tailored NHS job evaluation scheme. On its introduction, AfC represented the most radical modernisation of the NHS pay system since its foundation in 1948; however, it took longer to negotiate and implement than had been anticipated and also proved more costly than expected. Therefore, the new pay system was beginning to function just as the NHS in England was moving from relative funding growth to one of fiscal constraint.

4.4 At the time AfC was regarded as being an integral element in the Government's overall approach to modernising the NHS through the *NHS Plan* for investment and reform of 2000 and the *HR in the NHS Plan* of 2002 which was aimed at achieving a significant increase in staff numbers together with facilitating a major redesign of jobs and ways of working to improve patient care standards and productivity. It replaced an NHS pay system based on occupational groups with 11 different Whitley councils for different staff groups which by the mid-1990s had come to be regarded as being complex and inflexible; as both constraining the development of new roles and multidisciplinary team working and being unresponsive to the contribution made by experienced clinical staff; and as being vulnerable to equal pay for work of equal value challenges.

4.5 The 1999 Government proposals for AfC pay modernisation[1] were that:

- Automatic annual increments under the previous Whitley contracts should be replaced by career progression based on responsibility, competence and satisfactory performance;
- 650 Whitley pay grades should be replaced by nine pay bands with defined pay thresholds;
- Team bonuses to reward team performance should be considered; and
- Conditions of service should be simplified and modernised with NHS wide core conditions and local flexibility.

[1] *Agenda for Change – Modernising the NHS Pay System.* Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_120619.pdf

4.6 In 2004, a pay system was agreed based on:

- All posts placed into pay bands by the application of a common job evaluation system;
- The replacement of several thousand different Whitley allowances by harmonised conditions of employment covering all staff groups;
- Pay progression being dependent on staff being able to demonstrate that they are applying the knowledge and skills required in their jobs at key stages within each pay band;
- New freedoms and flexibilities for local NHS employers to pay extra where they face recruitment and retention pressures;
- Foundation Trusts being able to devise additional performance reward schemes; and
- Increasing incentives for staff to join or rejoin the NHS in those parts of the country where labour shortages are most serious by introducing a Market Force Supplement to increase the pay of staff in high cost areas of labour market shortage.

4.7 On its introduction in 2004, the AfC Agreement stated that: *All parties agree to work in partnership to deliver a new NHS pay system which supports NHS service modernisation and meets the reasonable aspirations of staff. The signatories to the agreement will accordingly work together to meet the reasonable aspirations of all the parties to:*

- *Ensure that the new pay system leads to more patients being treated, more quickly and being given higher quality care;*
- *Assist new ways of working which best deliver the range and quality of services required, in as efficient and effective a way as possible, and organised to best meet the needs of patients;*
- *Assist the goal of achieving a quality workforce with the right numbers of staff, with the right skills and diversity, and organised in the right way;*
- *Improve the recruitment, retention and morale of the NHS workforce;*
- *Improve all aspects of equal opportunity and diversity, especially in the areas of career and training opportunities and working patterns that are flexible and responsive to family commitments;*
- *Meet equal pay for work of equal value criteria, recognising that pay constitutes any benefits in cash or conditions;*
- *Implement the new pay system within the management, financial and service constraints likely to be in place.*

4.8 The Agreement added that all parties *"will make every effort to support, encourage and promote a partnership approach to the implementation of the new pay system at local level"*.

## Features of AfC

4.9 In summary, the AfC pay system comprises:

- *Basic pay* – a single 54 point pay spine divided into nine pay bands applying in all NHS organisations across the UK (see also specified additional freedoms for Foundation Trusts – paragraph 4.14). Each band has a number of incremental pay points which vary from band to band. On assimilation, AfC staff were assigned to one of the pay bands on the basis of their job weight, measured by a national NHS job evaluation scheme and using national job profiles or local evaluations;

- *Knowledge and Skills Framework (KSF)* – this describes the knowledge and skills that staff in particular posts need to demonstrate based on locally-agreed job descriptions and standards in "KSF post outlines". There are two pay "gateways" in each pay band where the knowledge and skills necessary to progress are assessed before progressing to the next pay increment: (i) the "foundation gateway" – applied to staff new to a band no later than 12 months after appointment; and (ii) the "second gateway" – applied near the top of the band (varying by band) requiring demonstration of the *full* range of knowledge and skills within the KSF post outline without continued supervision and support inappropriate to the post;
- *High cost area supplements (HCAS)* – replacing the pre-existing mix of London allowances and cost of living supplements. HCAS covers Inner London, Outer London and Fringe areas with any new HCAS areas requiring our approval;
- *Recruitment and retention premia (RRP)* – including: (i) national RRP for specified staff groups that were agreed by the parties for introduction under the AfC agreement; (ii) any new national RRP would require our approval, and; (iii) scope for local RRP.

**Table 4.1: Summary of the features and flexibilities of Agenda for Change**[2]

| | All staff | Some occupations/individuals |
|---|---|---|
| **National** | • Job evaluation framework<br>• Basic pay<br>• Pay progression<br>• KSF<br>• Most terms and conditions (e.g. overtime, unsocial hours, leave, sick pay) | • National RRP |
| **Local** | • HCAS<br>• Application of KSF<br>• Some terms and conditions<br>• Additional freedoms (Foundation Trusts) | • Local job evaluation using the national framework<br>• Local RRP<br>• Some terms and conditions<br>• Additional freedoms (Foundation Trusts) |

4.10 The following boxes provide further information on the application and the operation of RRP and HCAS.

[2] A full explanation of how these AfC features operate either nationally or locally is provided in the *NHS Terms and Conditions of Service Handbook*. Available at: http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf

**Box 4.1: Recruitment and Retention Premia**

RRP are additions to the pay of an individual post, or specific group of posts, where market pressures would otherwise prevent an employer from being able to recruit staff to, or retain staff in, sufficient numbers for the posts concerned, at the normal salary for a job of that weight.

RRP can be awarded locally by employers, or nationally on the basis of our recommendations. All national RRP currently in payment are in the process of being withdrawn as a result of the findings of an independent review[3].

RRP can be awarded on a short- or long-term basis. A short-term RRP may be awarded as a one-off or for a fixed term, and are not pensionable. Long-term RRP are pensionable. Both types should be reviewed annually to ensure that the payment – or the level of payment – remains appropriate[4].

RRP apply to *posts*, not individuals. Where an employee moves to a different post that does not attract RRP, their entitlement ceases. The combined value of any nationally-awarded and locally-awarded RRP for any given post should not normally exceed 30% of basic salary.

Equal pay – the principle consistent with equal pay for work of equal value should be that where the need for a RRP is reduced or has ended, short-term premia should be reduced or withdrawn as soon as possible, consistent with the protection period in Section 5 of the AfC Handbook. Long-term premia should be adjusted or withdrawn for anyone offered a qualifying post after the decision to withdraw or reduce the premium has been made.

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

[4] NHS Staff Council, *NHS Terms and Conditions of Service Handbook (amendment number 26), Pay Circular (AforC) 2/2012*, Annex J. Available at: http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf

### Box 4.2: High Cost Area Supplements (HCAS)

HCAS were introduced as part of the AfC Agreement. As the name implies, they acknowledge the higher cost of living in areas in and around London. They replaced London weighting, Fringe allowances and cost of living supplements[5], which were paid under pre-AfC pay arrangements; and apply to the areas shown in Figure 4.2, which reflect Primary Care Trust (PCT) areas in existence in 2004.

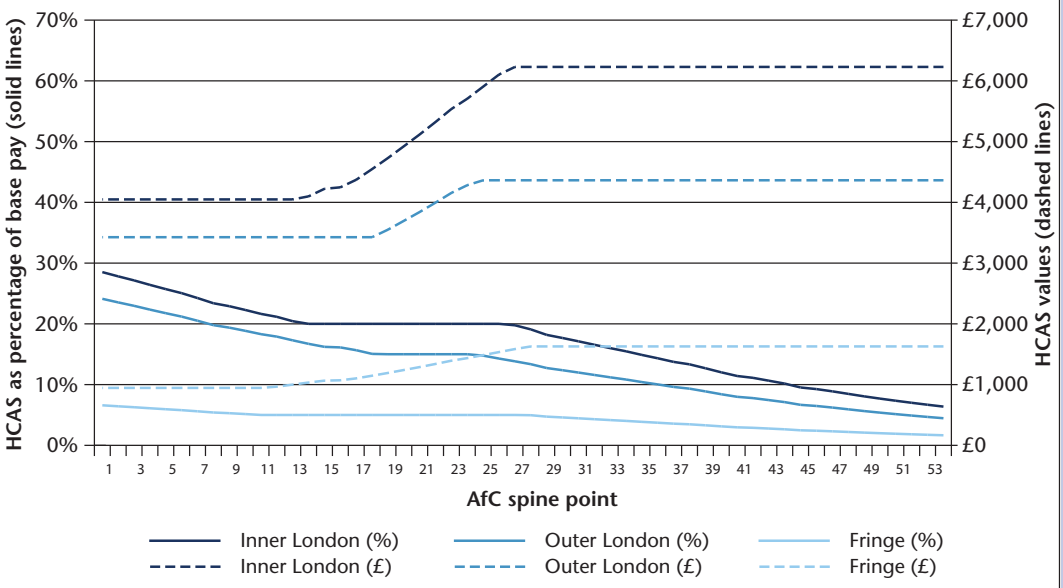
HCAS currently apply to around 195,000 full time equivalent (FTE) staff (216,000 headcount), or approximately 21% of the non-medical workforce in England. Supplements are expressed as a percentage of basic pay (inclusive of any long-term recruitment and retention premium[6]), subject to minimum and maximum values, as shown in Table 4.2 and Figure 4.1. In all, HCAS payments account for around 2.7% of average total earnings in England.

**Table 4.2: HCAS coverage, minimum and maximum values, and values for specified pay bands, April 2012**

| HCAS zone | FTE staff | % of salary | Payment values £ | | | | |
|---|---|---|---|---|---|---|---|
| | | | Minimum | Maximum | Band 3 | Band 5 | Band 7 |
| Inner London | 94,498 | 20 | 4,036 | 6,217 | 4,036 | 4,911 | 6,217 |
| Outer London | 54,286 | 15 | 3,414 | 4,351 | 3,414 | 3,684 | 4,351 |
| Fringe | 45,864 | 5 | 933 | 1,616 | 933 | 1,228 | 1,616 |
| Total | 194,648 | | | | | | |

Note: HCAS values for Bands 3, 5 and 7 have been calculated using the midpoints of the scales.

**Figure 4.1: HCAS percentages and values by spine point, April 2012**

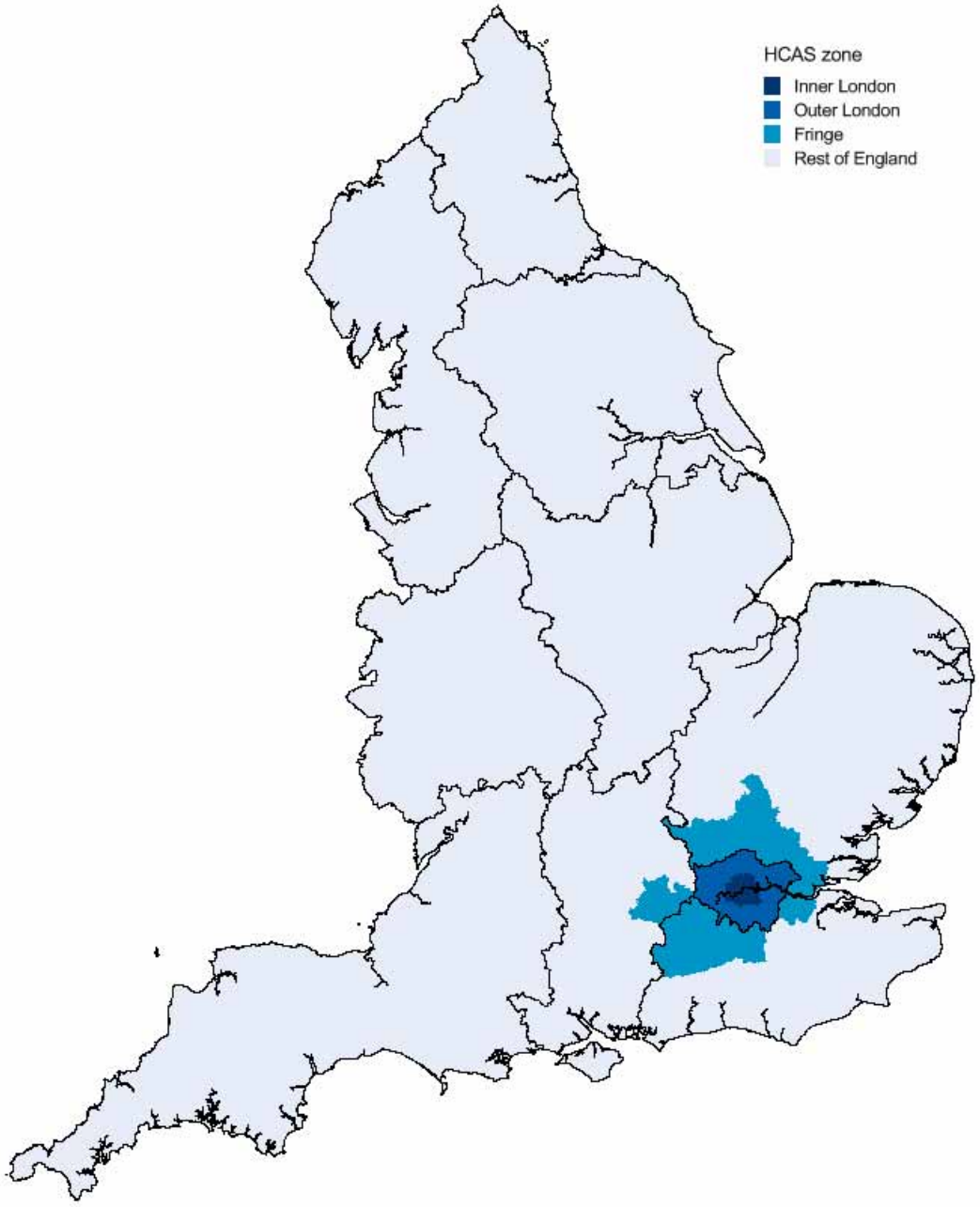



*Source: Agenda for Change Handbook.*

[5] See Box F1 in Appendix F.

[6] See Box 4.1.

**Figure 4.2: Boundaries of HCAS zones**




*Source: Agenda for Change Handbook.*
*Crown copyright and database right 2012.*

4.11 Additionally, AfC introduced common terms and conditions of service for all NHS non-medical staff, including: continuity of service; annual leave; sick pay; maternity leave and pay; redundancy pay; mileage allowances; and subsistence allowances. Part of the AfC Agreement in 2004 included interim on-call arrangements and, in November 2010, the NHS Staff Council published national principles[7] to support local negotiations.

## Our Role Under the AfC Agreement

4.12 Aside from our overall role of recommending on AfC pay rates under our standing terms of reference, the AfC Agreement also set out two additional roles:

- The first relates to HCAS[8] whereby the value was to be reviewed annually based on our recommendations. We were also invited to make recommendations on the future geographic coverage of HCAS and the value of such supplements; and
- Second, the Agreement specified that RRP[9] may be awarded on a national basis to particular groups of staff on our recommendation where there were national recruitment and retention pressures. We are required to seek evidence or advice from NHSE, staff organisations and other stakeholders in considering the case for any such payments.

4.13 Current HCAS zones are based on the Strategic Health Authority (SHA) and PCT boundaries that existed between 2004 and 2006[10] and have not been altered since the inception of AfC. The values of HCAS have been uprated every year[11] – initially in line with the level of our recommended pay uplift although we were not party to the increases in the period of the three-year pay agreement between 2008 and 2011. HCAS values, while pensionable, have not been uprated during the Government's two-year pay freeze between 2011 and 2013. There have been no further reviews of HCAS other than uprating since the supplements were introduced in 2004 and no cases for new HCAS zones have been presented in evidence aside from the proposal with regard to South Cambridgeshire (see paragraph 4.19 below).

## AfC Flexibilities and Additional Freedoms for NHS Foundation Trusts

4.14 We understand from the parties that they are discussing proposals in the NHS Staff Council to amend part of the AfC Agreement. Proposals had been put forward by employer representatives on: (i) incremental pay progression – linking these to performance standards determined locally, progression at the top of pay bands to be non-consolidated, and national principles underpinning locally developed performance systems; (ii) staff on sick leave should not receive unsocial hours payments; and a Staff Side proposal for (iii) national principles on workforce reprofiling which emphasises the need to follow the process set out in the Job Evaluation Handbook.

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7 *Op. cit.* NHS Staff Council, *NHS Terms and Conditions of Service Handbook*, Annex A3.

8 *Ibid.* paragraphs 4.3 and 4.8.

9 *Ibid.* paragraph 5.3.

10 *Ibid.* Annex H.

11 *Ibid.* Annex I.

4.15 In the context of the flexibilities currently available under AfC, we note that all Trusts in England are expected to become Foundation Trusts by 2014 under the ongoing NHS reforms. The NHS Terms and Conditions of Service Handbook[12] identifies the following "specified local freedoms" for NHS Foundation Trusts:

- Freedoms which require good management
    - To offer alternative packages of benefits of equivalent value to the standard benefits in the AfC Agreement, among which the employee can make a personal choice
    - To negotiate local arrangements for compensatory benefits which differ from those in the handbook
    - To award RRP above 30% of basic pay where justified, without prior clearance by the NHS Staff Council or SHA;
- Freedoms which must be part of a properly constituted reward scheme for individual, team or organisational performance related to genuinely measurable targets, offering equal opportunities for all staff in the relevant organisation, unit or work area to participate
    - Establishment of new team bonus schemes and other incentive schemes
    - Establishment of schemes offering additional non-pay benefits above the minimum specified elsewhere in the agreement
    - Accelerated development and progression schemes.

4.16 We note that Southend University Hospital NHS Foundation Trust operates locally determined terms and conditions. There may well be other locally determined flexibilities operating within the NHS but they have not come to our attention and are not widespread.

## Our Comment

4.17 We noted in our Twenty-Sixth Report[13] that negotiations relating to flexibilities within the AfC Agreement on pay and conditions were underway in the NHS Staff Council. We commented that these would be an important backdrop to this remit on how to make pay more market-facing and we are grateful to the parties for keeping us up to date with progress.

4.18 In evidence for this remit, NHSE commented on employers' desire for more flexibility around pay and conditions of service. We welcome the discussions under the NHS Staff Council and encourage this to be part of a longer term strategy to ensure that terms and conditions within the AfC Agreement are regularly reviewed to ensure they are fit for their intended purpose. However, we also note that changes proposed by any of the parties have proved difficult and slow to come to a conclusion. We would encourage parties to ensure that any negotiations are concluded in a timely manner. In addition, the parties may wish to examine how the additional freedoms for Foundation Trusts in Annex K of the NHS Terms and Conditions of Service Handbook, could help Trusts and local staff to be better enabled to develop pay and conditions packages to meet local service needs.

[12] *Ibid.* Annex K.

[13] NHSPRB (2012) *Twenty-Sixth Report*, TSO (Cm 8298), paragraph 6.8.

## AfC Developments

4.19 The following developments were noted in our reports from 2006:

*Basic Pay*

- In 2006, the Department estimated the additional cost of AfC (in England) at between 1% and 1.7% of the AfC pay bill (between £220m to £390m);
- Also in 2006 the Department of Health suggested moving to an "X + Y" approach where "X" represented a national uplift and "Y" an element to be used flexibly to address issues affecting one particular remit group or locality. However, no further evidence was presented on the proposal;
- In 2007, following a European Court of Justice judgment[14], the Department was confident that the AfC job evaluation system, underpinned by annual personal review to support progression through the grade, was demonstrably consistent with the judgment and the Age Discrimination Regulations;
- Also in 2007, the Government widened our remit to all AfC staff including former Pay Negotiating Council groups and to cover Northern Ireland[15]. AfC structural changes were also agreed for a £400 flat rate uplift to pay points 1-7, an additional £38 to staff on pay points 8-18, funding of £25 for training projects for each member of staff not requiring clinical professional registration, and a £38 payment for clinical staff on Bands 5-8A towards their mandatory professional registration fees;
- In 2008, the parties reached a three-year pay agreement within an pay bill envelope set by Government including pay uplifts for 2008/09 of 2.75% (as we recommended), 2009/10 of 2.4% and 2010/11 of 2.25%. Structural and other changes were agreed – for 2009/10, removing the bottom point of Band 1, the increment date for all those on Band 1 moved to 1 April and an increase to top of Band 5 (point 25) by 0.33% – for 2010/11, a reduction in Band 5 from 9 to 8 points, a re-spread of the remaining points across the band and a reset of the incremental date on the removed point to 1 April, an increase to the top point of Band 5 by 0.33% (and the same increase in 2011/12) and a flat rate increase of £420 for points 1-13 (equivalent to 2.25% at point 14). Future talks were also planned on reducing the number of incremental points (starting with Bands 6 and 7) that were affordable within the context of future pay awards;

*Consideration of HCAS proposal*

- A case was presented for a new HCAS for South Cambridgeshire in 2007 (and again in 2008) but we rejected it on grounds of insufficient evidence on the extent of the labour market difficulties;

*Consideration of national RRP proposals*

- Between 2006 and 2012, we were asked by the Staff Side and individual unions to consider a series of cases for national RRP. In 2006, national RRP were considered for pharmacists, cytology screeners, occupational therapists, radiographers and orthoptists and, although a case had not been made for awarding RRP, we requested discussions on the requirements for supporting data. In 2007, we did not recommend national RRP for pharmacists and radiographers but we considered that the case for a national RRP for pharmacists warranted joint investigation by the parties;

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[14] Judgement of the European Court of Justice (2006) *Cadman v. Health & Safety Executive*, C-17/05.

[15] NHSPRB (2008) *Twenty-Third Report*, TSO (Cm 7337), paragraph 1.9.

- During the three-year pay agreement in 2008, RRP applications were made for midwives and an extension to the national RRP for maintenance craft workers to include building craft workers – we concluded there was not sufficient evidence to support either case. In 2009, we concluded that pharmacist shortages carried considerable risk to service delivery and staff morale and recommended a national RRP for Bands 6 and 7 pharmacists (starting at £5,000 and decreasing in stages to £500) from 1 October 2009 for a fixed term until 31 March 2012. In July 2009, the Government rejected our recommendation on the grounds that recruitment and retention difficulties varied widely, that local difficulties were best addressed by increasing supply and using local RRP, and that it would not be affordable;

- In a letter to the parties in late 2009, we re-emphasised our approach to considering cases for new national RRP and that new evidence on pharmacist shortages reinforced our view that a short-term national RRP remained appropriate. We also noted that the national RRP for maintenance craft workers was to be reviewed before 1 April 2011 and that the available evidence did not support the case for a national RRP for building craft workers. In 2011, we considered an application for pharmacists but we did not recommend a national RRP as our concerns about previous shortages had been acted upon and vacancy rates were generally falling. For building craft workers, we concluded that there were few indications of national or widespread recruitment and retention problems to support a national RRP and we reached the same conclusion in 2012;

- The compliance of the RRP for maintenance craftspersons and chaplains with equal pay law was tested as part of an employment tribunal case in England[16] (the *Hartley* judgment in April 2009). The tribunal upheld the RRP, but (endorsing our previous comments) ordered that the RRP for qualified maintenance craftspersons and technicians must be reviewed by the NHS Staff Council before April 2011, or otherwise cease to have effect on that date. We were consulted on the review[17] and commented on the specification which fulfilled our requirement under the *Hartley* judgment. Following a report by the Institute of Employment Studies[18], the NHS Staff Council agreed that: the national RRP for maintenance craft workers should cease after 31 March 2011 with transitional protection arrangements for two years; the national RRP for chaplains should be withdrawn and replaced, where appropriate with a local RRP; and employers should review national RRP paid under Annex R of the NHS Terms and Conditions Handbook.

## Our Previous Commentary on AfC Developments

4.20 Since 2004 we have raised a series of issues relating to the operation and development of AfC. In 2004 and 2005, we produced two reports reviewing 12 AfC Early Implementer Trusts in England which identified issues of concern around: affordability including comment that costs had not been accurately predicted; provision of staff resources covering costs of implementation and backfill staff; provision of central support for job matchers and assessors; remunerating unsocial hours; and implementation of the KSF.

4.21 In 2006, the Department of Health commissioned and presented in evidence to us research undertaken by Aberdeen University[19] which concluded that there was a

[16] Reserved judgment of the employment tribunal, Newcastle upon Tyne (2009) *Ms S C Hartley and Others v Northumbria Healthcare NHS Foundation Trust, Unison and other Unions, the Secretary of State for Health, NHS Confederation (Employers) Company Ltd and the GMB*. A senior nurse and other claimants argued that the AfC pay system, and the job evaluation arrangements used in its introduction, were discriminatory on grounds of gender.

[17] *Op. cit*. NHS Staff Council, *NHS Terms and Conditions of Service Handbook*, Paragraphs 16-18. The tribunal amended paragraph 13 of Annex H of *op. cit. Agenda for Change: Final Agreement*.

[18] *Op. cit.* Institute for Employment Studies, *Review of National Recruitment and Retention Premia in the NHS 2010*.

[19] Health Economics Research Unit, Aberdeen University (2005) *Regional Pay for NHS Medical and Non-Medical Staff: Final Report for Department of Health*.

local labour market for nurses in England but an inconclusive picture for allied health professionals. The research also found a significant relationship between nurse vacancies at the local level and the gap between nurse and private sector wages which supported the case for HCAS and local RRP. In this respect, we commented that HCAS was a form of local pay and that the structure of HCAS was intended both as compensation payments in areas of high cost and pay adjustments to reflect particular difficulties in certain geographical labour markets. We added that the Aberdeen study showed that the level of nurses' earnings across the country appeared greater than could be accounted for by prevailing Cost of Living Supplements (replaced by HCAS under AfC) payable in certain designated areas. We therefore concluded that there was a *prima facie* case for wider geographical pay variation than existed, certainly for nursing staff in London, and invited further evidence including how NHS funding might accommodate such variation.

4.22 In each of our reports between 2007 and 2012, we have highlighted the importance of correctly applying the KSF. We commented that the KSF was crucial to the efficient delivery of current and future services and until fully implemented the NHS would not reap the benefits that AfC was designed to deliver. As KSF was an integral part of the AfC structure, we were concerned that staff appraisals were at low levels (according to staff surveys) and that the use of the KSF remained patchy.

## Evidence from the Parties

### *Department of Health*

4.23 The Department stated that market-facing pay needed to be reflected in AfC more effectively to ensure it remained affordable and fit for purpose. The Department reported that employers had provided feedback that the current national contracts were not sufficiently flexible for addressing labour market issues and, for some, locked in unnecessary and unaffordable costs.

4.24 The Department regarded that, as the plurality of provision increased, Foundation Trusts were likely to have to compete with private sector providers, many of whom were not restricted to using national terms and conditions and had developed flexible reward strategies that were more sensitive to local labour markets. The Department considered that the national AfC framework, in its current form, could therefore become unsustainable for some Foundation Trusts. Most NHS employers preferred to retain national terms and conditions of service provided that they remained fit for purpose, including appropriate recognition of local market factors.

4.25 The Department stated that the NHS Staff Council had an important role in ensuring that national contracts remained fit for purpose and attractive to Foundation Trusts. The Department considered that there would be significant benefits if the pay of AfC staff could be made more responsive to local labour markets as a number of employers 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.

### *NHSE*

4.26 **NHSE** informed us that, generally, individual employers were still supportive of the national frameworks subject to them being made more affordable and having greater local flexibility. The results of the NHSE survey indicated that there was no common view from employers on whether AfC offered sufficient flexibility to address recruitment and retention issues. NHSE said that comments from employers included calls for increased local flexibility, as current rates were in some areas above the market rate, and in others insufficient to compete.

*Staff Side*

4.27 The **Staff Side** stated that the current UK-wide pay system, which set a floor pay rate for the NHS and allowed for adjustments in high cost areas or local areas with particular recruitment difficulties had proven itself as a robust, effective pay system that closely followed the realities of geographic variations in the UK labour market. The Staff Side considered that national pay determination, allied to AfC, was the most effective and appropriate way of ensuring discipline and control over pay settlements, of delivering cost efficiency, and providing transparency and fairness.

4.28 The Staff Side commented that the only substantial variation in gaps between public and private sector pay, housing costs and cost of living across English regions lay between London/South East area and the rest of the country. They considered that this accorded with the existing AfC structure, with national rates, plus high cost area payment zones covering London and the London Fringe.

4.29 The Staff Side said that the current pay system included sufficient flexibilities to allow the NHS to adapt to local pressures and demands, without resorting to local pay determination. Moreover, the system provided a level playing field, preventing a race to the bottom or the top on pay and avoiding damaging competition for staff. It minimised transactional costs involved in pay determination and removed pay as a source of industrial relations conflict at an organisational level.

4.30 To maintain a consistent level of service the Staff Side stated that the NHS needed to be able to attract a workforce of the same quality in different parts of the country. They maintained this was best achieved by a national system for pay and reward. AfC, underpinned by a robust job evaluation scheme, ensured that job roles and worth were assessed relative to other roles.

4.31 The Staff Side considered that AfC encapsulated the ability to support organisational change and innovation through pay and grading structures which rewarded the acquisition of skills and/or the achievement of high performance.

4.32 The Staff Side provided a paper by Ian Kessler[20] which stated that:

- AfC provided discipline and control, allowing central government some control over pay settlements. National pay determination minimised the transaction costs expended by Trusts and provided transparency and consistency by contributing to the perceived fairness of the pay system;
- Commentators and practitioners had raised residual AfC implementation concerns, particularly the time taken to embed the KSF, but this did not detract from the perceived overall value of AfC;
- The resilience and continuity of national pay determination in the NHS could be related to distinctive contextual features – multiple stakeholders, political contingency, goal dispersion and a professional workforce;
- Following a National Audit Office report[21], the Department for Health calculated that NHS pay modernisation in England had delivered at least £1.3 billion net savings over the first five years;

[20] Kessler.I (2011) *National Pay Determination in the NHS: Resilience and Continuity*. Available at: http://www.unison.org.uk/file/Market%20based%20pay%20-%20Kessler%20appendix.pdf

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

- Two independent studies assessed the roll-out and consequences of AfC: a King's Fund study[22], and a National Audit Office report[23]. The conclusions of these reports were relatively consistent suggesting that AfC has been welcomed by stakeholders as an improvement on the previous fragmented and complex national arrangements, and was seen as a firm basis for taking forward important substantive issues, particularly equal pay and new ways of working;

- The King's Fund study found that most of the NHS Trust managers interviewed were in favour of AfC believing that, in part at least, it assisted in delivering improvement in patient care and staff experience that were its stated objectives[24];

- The Hartley Judgement ruled that the job evaluation scheme was robust and that the pay system was fair.

4.33 The **Royal College of Midwives** (RCM) considered that the nationally determined pay system for the NHS, along with AfC, was the most transparent, fair and equitable system. Underpinning and supporting the whole system was a robust job evaluation scheme that was fundamentally based on equal pay for equal work. The RCM also stated that the current UK-wide system was the most efficient and cost effective way to determine pay. There were local flexibilities within the NHS pay system that allowed for adjustments for high cost areas and allowed for adjustments for local areas to deal with particular recruitment difficulties.

4.34 **Unite** considered that the only substantial variation in pay across regions lay between London and the South East area and the rest of the county. Unite felt that this reinforced the existing structure of AfC, with national rates providing a floor rate of pay reflecting the similar conditions prevailing across most of England, while allowing for high cost area payment zones covering Inner London, Outer London and the London Fringe. Unite said that AfC offered a robust, flexible and equality proofed pay system that had served the NHS well and that the flexibilities in AfC allowed employers to adapt to any local market issues they thought existed while preventing damaging competition for staff between Trusts.

### Our Informal Meetings with HR Networks and Local Staff Side Representatives

4.35 Although not formal evidence, we drew a series of observations from our informal meetings with NHS Trusts' HR Networks, HR staff from the University Hospitals and local Staff Side representatives on the Social Partnership Forum (see paragraph 1.19). Generally, these meetings supported the overall views in the parties' evidence. We observed that the introduction of market-facing pay was not seen as a priority although there was a desire for local flexibility around AfC terms and conditions and, for employers, a greater link between performance and the award of increments. NHS organisations faced significant cost pressures and therefore there was anxiety about the financial impact of any imposed extension of HCAS. Finally, we observed that local RRP were not being widely used and some were being removed as recruitment and retention difficulties no longer existed or on cost grounds.

## Equal Pay

4.36 The Chancellor's letter asked us to take into account *"the need to ensure that proposals are consistent with law on equal pay"*. In assessing the implications of market-facing pay for the different staff groups in AfC at a local level, the Secretary of State asked us to consider any implications for equal pay.

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[22] Buchan.J and Evans.D (2007) *Realising the Benefits? Assessing the Implementation of Agenda for Change*, King's Fund.

[23] *Op. cit*. National Audit Office, *NHS Pay Modernisation in England: Agenda for Change*.

[24] *Op. cit*. Buchan & Evans, *Realising the Benefits? Assessing the Implementation of Agenda for Change*.

## Evidence from the Parties

*Department of Health*

4.37 The **Department of Health** stated that it would engage closely with trades unions and NHSE 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.

4.38 The Department said that, while staff group specific issues could be addressed through local flexibilities where objectively justified, there were equal pay risks associated with distinguishing between staff groups in the application of centrally/nationally determined pay adjustments. The Department commented that seeking to differentiate pay by staff groups within the same AfC pay band was likely to fall foul of equal pay legislation unless there was objective justification. In the Department's view, this cast doubt on the feasibility of any centralised market-facing pay adjustments that included a staff group specific element. There remained scope for some differentiation by pay band in any centralised scheme but the lack of sufficient robust data at this level was likely to constrain design of such a sophisticated approach. The Department added that each pay band covered multiple staff groups with quite diverse needs for additional market-facing pay and therefore even sophisticated central differentiation by pay band could be an inadequate and poor substitute for more detailed local pay differentiation.

4.39 The Department told us that it had taken legal advice on equal pay and that its proposals for market-facing pay were mindful of equal pay legislation. Therefore the Department recommended that any change should apply to all AfC staff not just new entrants. In order for equal pay comparisons to be made between Trusts, it would need to be shown that workers' terms and conditions were attributable to a "single source" which was responsible for the inequality and could restore equal treatment. The Department advised that current case law confirmed that an employee in one Trust could not compare themselves to an employee in another Trust for equal pay purposes. Trusts were responsible for the terms and conditions of their own staff and could not therefore remedy any inequality in respect of staff which they did not employ.

*NHSE*

4.40 **NHSE** stated that the AfC pay system was underpinned by an equality proofed job evaluation system. This ensured compliance with equal pay principles by assessing and placing equivalent job weights in the same pay bands. NHSE added that any additional pay supplements in the form of an RRP had to be justified by evidence that this was needed to support recruitment and retention. NHSE considered that equal pay requirements limited the scope for much pay differentiation for staff with the same AfC pay band at employer level.

*Staff Bodies*

4.41 The **Staff Side** noted that the current pay system was equality proof, both promoting a sense of fairness and ensuring equal pay for work of equal value. The Staff Side cited the following:

- Kessler's review[25] of national pay determination in the NHS stated that "in ensuring the pay structure is equality proof, the arrangements have also promoted a sense of fairness ...";

[25] *Op. cit.* Kessler, *National Pay Determination in the NHS: Resilience and Continuity.*

- A King's Fund Report[26] underlined that AfC supported fairness particularly in addressing pay equalities and "... while it cannot be confirmed that AfC has guaranteed equal pay, it does appear to have been an important factor in limiting the exposure of the NHS to equal pay claims"; and

- The *Hartley*[27] judgement also confirmed that AfC is an equal pay proofed system, with the tribunal ruling that the job evaluation scheme was robust and that the pay system was fair.

4.42 The **RCM** considered that underpinning and supporting the AfC system was a robust job evaluation scheme that was fundamentally based on equal pay for equal value. The RCM felt a move to market-facing local pay would undermine the whole system and open the NHS to equal pay issues.

4.43 **Unite** added that AfC had offered a robust, flexible and equality proofed system that had served the NHS well.

## Summary of Key Aspects of Equal Pay

### *The Legal Framework*

4.44 The law relating to equal pay is governed by the Equality Act 2010, the core provisions of which came into force on 1 October 2010[28]. The broad thrust of the law is as follows:

- A woman may claim that she should be paid equally with a man who works for the same employer or for an associated employer. He does not have to work on the same premises as the woman;

- A woman's work is equal to a man's work if it is like work, work rated as equivalent to his work or work of equal value to his work;

- An employer can argue that, although a female employee has not been paid equivalently with a male employee who does equal work, the difference is due to a material factor that is a material difference between the woman's case and the man's case.

### *Genuine Material Factor (GMF)*

4.45 A GMF defence is a defence from an employer or respondent that the difference in pay between the man and woman can be shown to relate to a provable, objective and material factor and is not to do with the relative genders. If, however, this factor is found to be tainted in some way by sex discrimination, the employer cannot rely upon it, unless it can be shown that the factor is objectively justified.

4.46 The legal test in relation to objective justification is still developing, with European case law having significant impact. The key appears to be that a respondent has to be able to demonstrate the reasons behind any differences in pay between comparable groups of women and men are not associated with the gender of the job holders but:

- Are necessary to meet genuine business objectives; and

- Actually result in these objectives being met; and

- That there is not a less discriminatory way of meeting the objectives.

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[26] *Op. cit.* Buchan & Evans, *Realising the Benefits? Assessing the Implementation of Agenda for Change*.

[27] *Op. cit.* Reserved judgement in *Hartley*.

[28] Sources include: IDS (2012) *Employment Law Brief 940*; Burn.D (2010) *Guide to Discrimination Law and Pay*. Available at: http://www.ome.uk.com/Cross_cutting_Research.aspx; www.idsbrief.co.uk (case law); www.nhsemployers.org; and www.xperthr.co.uk.

## *Market Forces*

4.47 There are a number of circumstances whereby market forces may be pleaded as constituting a material factor defence, and these arise from various situations which are dictated by the particular labour market in which the employer's enterprise operates. For example, they may include: factors related to a shortage of the skills that the comparator has and the claimant does not; the fact that the claimant and comparator are being paid the "going" (or "market") rate for their respective jobs; the need to pay a higher rate to the comparator in order to retain his or her class of employee in a job; the need to pay a higher "market" rate in order to recruit employees; and the fact that, because of the weak bargaining power of the group of workers to which the claimant belongs, the claimant needs only to be paid the lowest rate necessary to attract workers such as herself[29].

4.48 There is no *prima facie* problem with paying employees different rates in different locations. Geographical pay differentiation may carry the risk of equal pay claims in certain circumstances:

- Where the premium is not given to all employees in a location, so it effectively becomes an occupational premium, which may or may not be justified by market data;
- Occupations are unevenly distributed e.g. a (male-dominated) IT centre has a location premium, but a (female-dominated) customer service centre does not, with no market justification beyond the location.

4.49 Giving a pay supplement to maths teachers, for example, may disproportionately advantage men over women on average, if maths teachers are more likely to be men. This kind of policy, however, can be justified by current data that shows differential recruitment and retention rates for maths teachers over other subject areas.

4.50 In *Hartley*[30], the tribunal was satisfied that the RRP payable to chaplains under AfC to replace previous accommodation allowances had nothing to do with gender and did not deem it necessary for the respondents to demonstrate that there was objective justification for this group receiving additional payments.

4.51 With respect to qualified maintenance craftspersons and technicians, the *Hartley* tribunal noted that the fixed-rate RRP had been the product of NHS Staff Council negotiations in relation to a group consisting almost entirely of men. The tribunal therefore considered it necessary to examine in detail whether there was objective justification for the specified level of payments. The tribunal found that the objectives for the payment were legitimate and that, on balance, the level of payment was proportionate to achieve those objectives. However, it considered that, since the effect of the RRP was to give a pay increase to the staff concerned and since the evidence in support of that increase (which was to do with external market rates) was anecdotal rather than statistical, the period for which the increase could be objectively justified, without further research, was another two years, until 31 March 2011[31].

4.52 A market forces argument may be indirectly discriminatory, however, if the market forces in question are those that dictate that women should earn less than men for similar

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[29] IDS (2002) *Brief 711*.

[30] *Op. cit*. Reserved judgment in *Hartley*.

[31] National RRP for both of these groups (maintenance craft workers and healthcare chaplains) were stopped for new staff from 1 April 2011 and will be withdrawn over a two-year period for existing staff (with protection arrangements), so that on 1 April 2013 all payments will cease, subject to the outcome of a NHS Staff Council review demonstrating evidence to support continuation of a National RRP. See NHS Staff Council (2011) *Pay Circular (AforC) 3/2011*. Available at: http://www.nhsemployers.org/Aboutus/Publications/PayCirculars/Documents/Pay_Circular_AforC_3-2011.pdf

work[32]. In a case involving Newcastle upon Tyne NHS Trust[33], a group of predominantly female domestic workers lost their bonuses as a result of the Trust's successful in-house bid during a compulsory competitive tender exercise in 1985. The Employment Appeal Tribunal held that the employment tribunal was entitled to find that the material factor relied on by the Trust was "tainted by sex" because it originated in its intention to match market rates that the Trust appreciated were depressed by factors peculiar to women, and that the continuation of the resulting differential had not been objectively justified by the costs or industrial relations implications of removing it or by the Trust's attempts to phase it out.

## Our Comment on Equal Pay

4.53 The Secretary of State's remit letter asked us to take account of the need to recognise the implications of market-facing pay for different staff groups within AfC at a local level, including any implications for equal pay. The Chancellor's letter to us highlighted the need to ensure that proposals are consistent with law on equal pay. Our standing terms of reference also require us to have regard to the principle of equal pay for work of equal value.

4.54 The parties have confirmed to us in recent years that there were no specific equal pay issues within AfC for consideration under our standing terms of reference. In evidence for this market-facing pay remit, the general views of the parties are that the current pay system under AfC complies with equal pay principles. However, we note the Staff Side's overall concerns about the potential for market-facing pay to undermine the equality aspects of the current pay system. Similarly, we note the views of the Department of Health and NHSE that pay differentiation by staff groups within the same pay band risks equal pay challenge and therefore limits the scope for differentiation by staff group without objective justification.

4.55 We have summarised some of the equal value considerations relating to market forces and the justification required when pay premia are not given to all employees in a location. We are grateful to the Department of Health for responding to our further questions on equal pay considerations clarifying the risks associated with distinguishing between staff groups in centrally determined pay adjustments. From our discussions with the parties in oral evidence, there appears to be recognition that, while equal pay risks would need to be further scoped prior to implementation, an approach which applies to all AfC staff groups within one particular HCAS zone could be objectively justifiable.

4.56 In taking forward our recommendations in this report, we are reassured that the Department of Health intends to engage closely with the Staff Side and NHSE to ensure any market-facing pay system takes due account of national collective agreements, employment law and equality legislation. We ask that future evidence makes clear reference to any equal pay considerations supported by any required legal advice.

## Total Reward

4.57 The Chancellor asked us to consider *"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"*.

[32] Ratcliffe and Others v North Yorkshire County Council (1995) IRLR 439 HL.

[33] Newcastle upon Tyne NHS Hospitals Trust v Armstrong and ors. EAT, 22.2.10 (0069/09).

## Evidence from the Parties

*NHSE*

4.58 **NHSE** referred to the very limited information available that would allow for occupation specific comparisons between the NHS and employers from other sectors. They commented that earnings information might be less robust when broken down by occupation, sector and geographical area. NHSE were not aware of any analysis which took into account total reward and up-to-date geographic information would be needed for any future analysis.

*Staff Bodies*

4.59 The **Staff Side** commented that bonuses were a much more significant part of total pay in the private sector. Bonus payments were 58% higher than in 2000/01 and, according to the Staff Side, appeared to have been largely unaffected by the recession. The Staff Side's assessment of Annual Survey of Hours and Earnings data in 2011 suggested full-time nurses gross annual pay was £30,742 (including 1.9% bonuses) compared with £35,185 median gross earnings for civil engineers (4.5% bonuses) and £32,074 for office managers (7.8% bonuses).

## Other Evidence

4.60 Work by the Office for National Statistics[34] compared total reward (pay plus employers' pension contributions) in the public and private sectors, using 2009 data. Total reward for full time employees was higher in the public sector than the private sector, predominately due to the larger proportion of employees who did not belong to employer pension schemes (with zero pension contributions) in the private sector[35]. A comparison of total reward on a like-for-like basis, comparing full time employees with pensions in both sectors, showed that total reward was higher in the private sector than the public sector. Further analysis showed that the gap between private and public sector employees was particularly marked at the top end of the distribution (13% on average (mean) compared with 28% at the 9th decile). The advantage of private sector employees with pensions over their public sector counterparts was not, for the most part, due to higher pension contributions, but to higher levels of pay.

4.61 A recent paper[36] has sought to compare total reward in the public and private sectors, by constructing a measure[37] of pay, pensions and other benefits (health insurance, paid leave) as well as working hours and the probability of employment. This is then evaluated over the lifetime for graduates in the UK. The results suggest that total reward is broadly equalised over the lifecycle for male graduates, while female graduates have a clear total reward advantage in the public sector by the end of their career.

## Our Comment

4.62 Our call for evidence set out a series of issues for consideration although the evidence we received in return was understandably limited on this complex issue. There is little

[34] Levy.S, Mitchell.H, Guled.G and Coleman.J (2010), *Total Reward: Pay and Pension Contributions in the Private and Public Sectors*, ONS Labour Market Review (Vol. 4, No. 9). Available at: http://www.ons.gov.uk/ons/rel/elmr/economic-and-labour-market-review/no--9--september-2010/total-reward--pay-and-pension-contributions-in-the-private-and-public-sectors.pdf

[35] ONS used 2009 ASHE data which showed that 90% of full time public sector workers and 43% of full time private sector workers were in employer pension schemes – of these 95% of full time public sector workers and 35% of full time private sector workers were in defined benefit schemes.

[36] Danzer.A and Dolton.P (2011) *Total Reward and Pensions in the UK in the Public and Private Sectors*, Institute for the Study of Labor (IZA Discussion Paper No. 5656).

[37] They use cross section earnings data from ASHE for the period 1997 to 2009 as well as data from LFS, the English Longitudional Survey of Ageing and the British Household Panel Survey.

existing evidence that would enable meaningful comparisons between the NHS package and appropriate comparators in the private sector for this report.

4.63 We are therefore unable to make any substantial comment on the difference in total reward between the NHS workforce and those of similar skills working in the private sector by location. However, there are a number of aspects of the NHS total reward package on which we should comment. It was clear that NHS employers viewed AfC terms and conditions as the highest priority. This needs to be acted upon quickly by the parties within the national framework. We welcome the further ongoing work within the NHS Staff Council to promote awareness of the value of the total reward package in the NHS to its staff. Finally, we have commented in the past on the value of the NHS pension within the package and its importance to the recruitment, retention and motivation of staff. Therefore, the impact of pension changes on AfC staff needs to be kept under review.

## Our General Comment on AfC

4.64 Having examined how pay systems operate within the public and private sectors, we consider it appropriate in this section to have set out an extensive description of the current pay system for non-medical staff within the NHS. AfC offers an incremental banded pay system supported by job evaluation and the KSF, with market-facing features and further flexibilities for Foundation Trusts. AfC is perceived as fair and objective by all parties and contributes to staff morale and motivation. AfC has also supported the maintenance of a stable industrial relations climate since its introduction which is greatly valued by all parties. We note that employers have not generally taken advantage of the flexibility to establish local terms and conditions and do not always have a strategic approach to total reward. We note the Department's view that unless AfC continues to develop and to be used fully to reflect local needs, there is a risk that Trusts will move away from the system and risk fragmentation as affordability considerations bite and all Trusts move towards foundation status.

4.65 We agree with the Department of Health, NHSE and the Staff Side that AfC includes sufficient flexibilities to address difficulties of recruitment and retention for specific occupational groups and, indeed, that these flexibilities are ahead of commensurate pay systems of those in the private and public sector. Individual employers can respond locally to occupational labour markets by offering local RRP. As mentioned earlier, the transition to Foundation Trust status for all Trusts, along with the abolition of SHAs, will allow Foundation Trusts to decide on implementation of flexibilities without consulting other Trusts within their SHA. However, Trusts will need to be mindful that such competition for staff in occupational shortage groups could lead to pay escalation which could be unnecessary as the cause is not pay but insufficient supply. Local RRP will continue to require a robust business case supported by accurate local labour market data. We summarise in Chapter 7 our views on taking forward the use of local RRP.

4.66 AfC also operates pay variation through a number of high cost area supplements – Inner London, Outer London and Fringe areas. This appears to be in line with pay practices for large national firms in the private sector and where limited systems are operated in the public sector. We set out the Department of Health's proposals for extending HCAS in Chapter 5, analyse data on correlations between geographical pay variations and recruitment and retention indicators in Chapter 6, and explore taking HCAS forward in Chapter 7.

4.67 The Department of Health has stated that it did not advocate reducing basic AfC pay rates. We will examine AfC basic pay rates as part of our autumn pay round when we will be able to take account of all the factors in our standing terms of reference.

4.68 From the evidence available, we consider that the AfC pay system compares favourably with most reward systems operated by large national public and private sector employers. Indeed, AfC has more flexibility for developing market-facing pay than most systems in either the private or public sector. Market-facing features such as RRP and HCAS have the potential to give AfC more flexibility to respond to local labour markets. We have seen no evidence in our research that other private or public sector organisations have better mechanisms than local RRP to respond to occupational shortages. However, these AfC market-facing features have not typically been used as tools for employers to manage their workforce, to control pay bill costs, and to improve service delivery and patient outcomes. We also note that changes proposed by any of the parties have proved difficult and frustratingly slow to negotiate and to come to a conclusion.

4.69 We highlight two specific aspects of AfC which continue to need further attention. KSF can have more impact on achieving value for money but its operation remains patchy. We have consistently emphasised that KSF is an integral part of the AfC structure which is intended to link an individual's pay and career progression to their acquisition and demonstration of key job competencies. Making progress with modifying AfC terms and conditions is the highest priority for employers. Employers wish to ensure that terms and conditions can support changing working practices to ensure delivery of high quality patient services.

4.70 Our general conclusion is that the AfC system has positive market-facing features but needs development to ensure employers have the flexible tools to respond to local labour markets in an increasingly fragmented health system in order to improve service delivery and outcomes for patients. We set out our conclusions and proposals on these aspects in Chapter 7.

# Chapter 5 – Proposals for Market-Facing Pay

## Introduction

5.1 This section sets out the parties' evidence on proposals for how to make pay more market-facing for NHS Agenda for Change (AfC) staff. It covers the specific proposal made by the Department of Health for extending high cost area supplements (HCAS), using the staff Market Forces Factor (sMFF). We received no other specific market-facing pay proposals from the parties.

5.2 We summarise the evidence taking account of the five main factors in the Secretary of State's remit letter as follows:

- The extent to which AfC already recognises the impact of local differences in pay through RRP and HCAS 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 Primary Care Trust (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; and
- To consider what information in the future might be needed in order to make recommendations on local labour markets.

5.3 We have already covered some of the factors in previous sections of this report and these are cross-referenced where appropriate. Our earlier assessments also included the specific factors from the Chancellor's letter to us including: total reward; private sector pay approaches; and consistency with equal pay. We address the remaining factors from the Chancellor's letter in the relevant sections as follows:

- Recruitment, retention and motivation;
- The most appropriate areas or zones by which to differentiate pay;
- Affordability of any proposals;
- Delivery within national frameworks; and
- Applying proposals to existing or just new entrants.

5.4 We comment on individual sections within this chapter as appropriate. However, our detailed assessment of the supporting research and analysis follows in Chapter 6 and our main commentary, conclusions and recommendations, including those on the Department's proposals, are in Chapter 7.

## Recruitment, Retention and Motivation

5.5 Our assessment starts with the first factor to take into account from the Chancellor's letter, namely *"the need to recruit, retain and motivate suitably able and qualified staff across the UK"*. These are major drivers of pay and are significant considerations under our standing terms of reference.

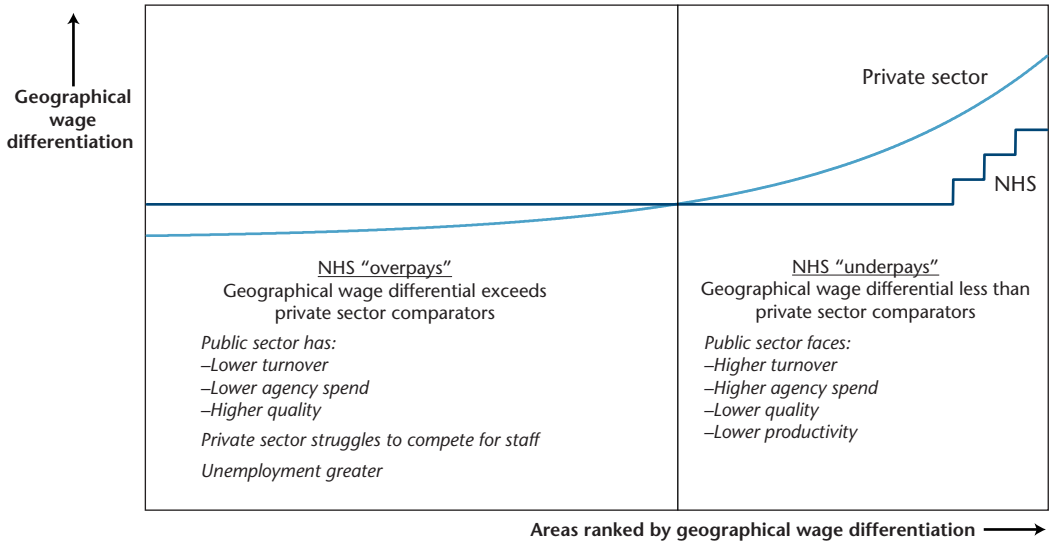
## Evidence from the Parties

*Department of Health*

5.6 The Department told us that in the NHS, and the public sector more widely, there was much less geographical variation in pay than in the private sector. The Department considered that for some staff groups this was not justified by market conditions and could have the following impacts, illustrated in Figure 5.1:

- In areas where the geographical pay differential the NHS offered was low, compared to the local market, it created recruitment and retention difficulties that could 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 offered was high, compared to the local market, there were fewer such difficulties creating potential variations in quality.

**Figure 5.1: Stylised representation of the impact of national public sector pay structures**




*Source: Reproduced from written evidence from the Department of Health.*

5.7 The Department provided analyses of geographical variation in NHS pay including estimates of average basic salaries and total earnings for non-medical staff across Strategic Health Authorities (SHAs) in 2010/11. These showed variations from the national average although the Department noted they could be skewed by staff group mix and working patterns. The Department considered that better indicators might be the distribution of HCAS and RRP payments as a share of basic pay, which in the Department's view effectively controlled for differences in staff groups, skill mix, experience mix and working patterns. It found there was less variation in pay between different geographical SHA areas than there was in private sector comparators.

**Table 5.1: SHA level staff MFF data and 2010/11 indications of geographical pay differentiation**

| SHA | Staff MFF Index | Estimated average payments relative to basic pay | | | | | |
|---|---|---|---|---|---|---|---|
| | | HCAS | | RRP | | HCAS + RRP | |
| | | *as %* | as an index | *as %* | as an index | *as %* | as an index |
| North East | 0.92 | *0.0%* | 0.97 | *0.1%* | 1.00 | *0.1%* | 0.97 |
| Yorkshire & the Humber | 0.93 | *0.0%* | 0.97 | *0.1%* | 1.00 | *0.1%* | 0.97 |
| West Midlands | 0.94 | *0.0%* | 0.97 | *0.1%* | 1.00 | *0.1%* | 0.97 |
| East Midlands | 0.94 | *0.0%* | 0.97 | *0.2%* | 1.00 | *0.2%* | 0.97 |
| North West | 0.94 | *0.0%* | 0.97 | *0.1%* | 1.00 | *0.1%* | 0.97 |
| South West | 0.95 | *0.0%* | 0.97 | *0.4%* | 1.00 | *0.4%* | 0.97 |
| East of England | 1.01 | *1.2%* | 0.98 | *0.4%* | 1.00 | *1.5%* | 0.98 |
| South East Coast | 1.05 | *1.4%* | 0.99 | *0.6%* | 1.00 | *2.0%* | 0.99 |
| South Central | 1.06 | *0.6%* | 0.98 | *0.5%* | 1.00 | *1.0%* | 0.98 |
| 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 |

*Source: Reproduced from written evidence from the Department of Health.*

5.8 The Department constructed an index of HCAS and RRP payments as a percentage of basic pay, and compared this to the sMFF, an index of private sector pay, to produce a variable which it called the 'geographical pay variation gap' (GPVG). This in effect measures the difference between an NHS organisation's pay relative to the NHS average, and private sector pay in that location relative to the private sector average. For example, an NHS organisation which paid 5% more than the NHS average, but which was located in an area where private sector pay was 10% above the private sector average, would have a GPVG of -5%.

5.9 The Department told us that the external research suggested that there would be a link between local recruitment and retention indicators and geographical pay patterns. It explained that there would be a negative relationship between GPVG and recruitment and retention indicators, with lower GPVG associated with better recruitment and retention and vice versa.

5.10 The Department provided correlations between geographical pay variation and recruitment and retention indicators (shown in Table 5.2 below) which tended to be negative, which in the Department's view suggested a case for market-facing pay, but it concluded that these correlations were weaker at organisation level than at broader levels. The distribution of organisation level recruitment and retention levels showed considerable variation across England from which the Department stated that the greater the variation the more potential difficulty designing a "one size fits all" pay system from the centre. The Department considered this complexity would be added to by differences in recruitment and retention facing different staff groups within a locality.

**Table 5.2: 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 healthcare science 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 |
| Healthcare 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 |

*Source: Reproduced from written evidence from the Department of Health.*

5.11 From these comparisons and correlations, the Department concluded that a greater alignment between geographical pay differentiation for AfC staff and that for private sector comparators (as indicated by the sMFF) could improve recruitment and retention in high sMFF areas. The Department also concluded that reducing excessive geographical pay differentials in low sMFF areas should increase the resources available for other types of spend but could worsen recruitment and retention in low sMFF areas.

5.12 From its literature review, the Department suggested the key recruitment and retention messages were: issues were largely local rather than regional; occupational considerations included skills availability and different local, regional and national labour markets; individuals considered more than pay when making job choices; organisation specific factors could be influential; the need to identify problems and investigate the underlying causes before introducing remedies; and pay might not always be the optimal solution.

5.13 The Department observed that geographical pay variation could influence recruitment and retention patterns within the NHS so long as there was geographical labour mobility for NHS staff. Mobility data indicated that, in the year to September 2011, 6.9% of non-medical staff moved within the NHS – of these, 1.9% moved within local PCT area, 5% to another PCT area and 0.8% to another SHA area (Table 5.3). Analysis by staff group revealed that the proportion of moves appeared higher for qualified staff. The Department said that where NHS pay differentials did not appropriately compensate for the cost of living and amenity differences there were likely to be recruitment and retention consequences.

**Table 5.3: 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%** |

*Source: Reproduced from written evidence from the Department of Health.*

5.14 The Department asked us to consider how we might best ensure the future recruitment and retention of AfC staff in some new organisations, such as the National Trust Development Agency, Health Education England and the NHS Commissioning Board. Roles were still under development and some might be peripatetic. The Department also advised that attracting and retaining high calibre leaders and "atypical roles" or those not fitting into market-facing arrangements (e.g. individuals required to work across a number of different regions) would need consideration.

*NHSE*

5.15 **NHSE** considered that any changes to the pay system should support employers in delivering services to patients and/or contribute to supporting recruitment, retention, motivation or morale of their workforce. NHSE said that local RRP were intended to address market problems where there was evidence that the reason for the difficulty in recruiting or retaining staff was directly related to levels of pay. They added that local RRP were not appropriate where the reason for failing to recruit was due to a lack of supply of health-related specialists. Issues other than pay could influence recruitment and retention, such as good employment practices, scope for career development, working conditions, flexibility, employer reputation and quality of local transport.

5.16 NHSE pointed to local RRP not being widely used mainly due to the prevailing depressed labour market. Some employers reported difficulties in a limited number of specialties, according to NHSE, and generally employers were not finding the need for additional pay to recruit and retain staff. In most parts of the country employers reported no particular recruitment problems and some reported large numbers of applicants for advertised vacancies. NHSE analysed NHS vacancies and turnover and found regional variations – the North experiencing lower turnover and vacancies than London and surrounding regions.

*Staff Bodies*

5.17 The **Staff Side** commented that, to maintain a consistent level of service, the NHS needed to be able to attract a workforce of the same quality in different parts of the country – this was best achieved by a national system for pay and reward. The Staff Side drew on its supporting research[1] to comment that current arrangements provided transparency and consistency by contributing to the perceived fairness of the pay system which was crucial in stimulating employee motivation.

5.18 The **Royal College of Midwives** (RCM) emphasised that the current nationally determined pay system, along with AfC, was the best way to recruit, retain and motivate suitably able and qualified midwives across the UK. The RCM said that a move to market-facing local pay would create poor morale in the NHS and would lead to great uncertainty and a lack of trust in the pay system.

5.19 **Unite** added that the flexibilities in AfC allowed employers to adapt to any local market issues while preventing damaging competition for staff between Trusts. In recent years, many roles in the NHS had been treated as acting in an international, rather than local, market as shown in the Migration Advisory Committee's list of NHS roles as shortage occupations[2]. Unite also commented that many healthcare professionals were extremely specialised and could easily relocate to anywhere in the country or abroad.

## Our Comment

5.20 We concluded in our Twenty-Sixth Report[3] that, for AfC staff, recruitment continued to be healthy and retention stable. Generally supply and demand were in balance and turnover among AfC staff was low. We commented that NHS recruitment and retention had to be seen in the light of prevailing economic circumstances. However, we noted that there were concerns about pressures on staff potentially affecting morale and motivation but there was no evidence these were feeding through to major recruitment and retention difficulties. Although the position for shortage occupations was easing slightly, we asked to be kept informed of any related pay and workforce issues. For this remit, we saw no new evidence to change this overall assessment. In particular, we received no evidence that recruitment and retention issues, aside perhaps from a few professions in particular locations, were causing undue difficulties to employers.

5.21 Turning to the factors raised in evidence for this review, we note the Department of Health's position that national AfC rates should be set at the minimum level necessary to ensure adequate recruitment of sufficient high quality staff in low staff cost areas. The Secretary of State also confirmed in oral evidence that the Department of Health was not proposing to reduce nominal basic AfC pay rates as part of any move to market-facing pay. Recruitment, retention and motivation are major considerations under our standing terms of reference, alongside a range of other factors, in setting basic AfC pay rates. We will return to this issue in our autumn pay round.

5.22 The Department has suggested that there is a link between NHS recruitment and retention, and the relative pay variation between the NHS and the private sector. We examine this further in Chapter 6.

5.23 We agree with the parties' views that the current AfC structure can accommodate proposals to address specific recruitment and retention problems either nationally or locally. We consider the flexibility of RRP should be retained to address local problems. In our view, individual employers are best placed to make decisions based

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[1] Kessler.I (2011) *National Pay Determination in the NHS: Resilience and Continuity*. Available at: http://www.unison.org.uk/file/Market%20based%20pay%20-%20Kessler%20appendix.pdf

[2] NHSPRB (2012) *Twenty-Sixth Report*, TSO (Cm 8298), paragraph 5.12.

[3] *Ibid.* paragraphs 3.88-3.90, and paragraphs 5.15-5.16.

on local circumstances, to assess the required response and to judge appropriate cost-effectiveness. We provide a more detailed assessment of the use of local RRP in Chapter 6 of this report and we also comment on how these might be used more to ensure they support employers in addressing local needs.

5.24 The causes of local recruitment and retention difficulties can be complex. Comprehensive assessments are needed to arrive at whether there is a pay problem or whether other factors are at work. Various aspects of the employment package can influence recruitment and retention for AfC staff, such as: the employers' reputation or type of organisation; leadership and management practices; pay relative to the local economy; additional benefits such as pensions; flexible working arrangements and leave entitlements; the availability of additional earnings; access to education and training; and transport links. Assessment of the local influence of these factors is important before determining whether a pay solution is required. It may also be that a combination of measures are required at local level. More sophisticated approaches may better ensure the attraction and retention of the high quality staff required to ensure effective delivery of services.

5.25 We note from the evidence that new NHS organisations are coming into operation some of which will be employing AfC staff, and which may be affected by any proposals for market-facing pay. We would welcome further information on the numbers of AfC staff in these organisations, their roles and any specific pay or related matters arising.

5.26 Any consideration of making pay more market-facing needs to consider the recruitment and retention implications of the labour markets in which AfC staff operate – international, national, regional and local. While the Department of Health provided some useful data on internal mobility within the NHS, further data on the operation of various labour markets for AfC staff would help plan future requirements and responses to occupational shortages.

5.27 We also commented in our Twenty-Sixth Report[4] that shortages can arise from weaknesses in establishing sufficient training commissions, in workforce planning and in making available appropriate education and training. Our concerns relate to the potential for dealing with avoidable shortage groups through expensive and difficult to remove pay solutions, which could lead to unnecessary pay escalation and not resolve shortages.

5.28 In conclusion, we consider it essential that any modifications to the AfC pay structure, including any move towards more market-facing pay, would need a full assessment of how that would impact on recruitment, retention and motivation. Such an assessment should also focus on the implications of any change, particularly the impact on the range of pay and non-pay measures that NHS employers may already have implemented to address local concerns. In addition, we stress that effective staff communication and engagement in introducing any new arrangements can also aid recruitment, retention and motivation.

## Department of Health's Proposals for Market-Facing Pay

5.29 We now turn to the Department of Health's approach to pay differentiation as presented in its evidence. The Secretary of State specifically asked us to take into account *"the extent to which AfC already recognises the impact of local differences in pay through RRP and HCAS and whether these could be used more effectively"*. We set out below the evidence on the Department's considerations of a zonal pay approach, the specific proposal to extend HCAS, and the MFF and its staff index which underpin this proposal. We also consider the parties' evidence on affordability, cliff edges and future evidence requirements.

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[4] *Ibid.* paragraph 5.16.

## Approach to Pay Differentiation

5.30 The Department believed that the most simple, cost-effective and safe way to introduce market-facing pay would be to:

- Retain national collective agreements;
- Retain the flexibility for individual employers to use local RRP to address local specific recruitment and retention issues;
- Retain the ability for us to consider the need for national RRP, noting that these were rarely if ever likely to be more appropriate than local RRP;
- Move towards a position where national AfC pay rates were set at the minimum level necessary to ensure adequate recruitment of sufficient high quality staff in geographical areas where the sMFF is relatively low; and
- Extend the use of HCAS 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 RRP and non-pay incentives and rewards.

5.31 The Department highlighted research from Incomes Data Services, which identified six main approaches to varying pay by location, ranging in complexity from national pay scales with London/South East additions to "complex localism". The Department noted that all these approaches were possible options for AfC. The Department considered the merits of each of the six options, taking account of the approaches used in the public and private sectors, and concluded that a zonal pay or hotspot framework (which, in the Department's view, were likely in practice to be very similar) appeared to be the most promising option for delivering any centralised geographical pay differentiation because:

- Top-up allowances and complex localism were more relevant to the local recruitment and retention issues that the Department believed should not be tackled centrally;
- Regional pay offered insufficient sensitivity to sub-regional labour market issues and hotspots;
- National pay scales with London/South East additions offered insufficient scope to reflect differences across labour markets in the rest of the country.

5.32 The Department argued that a zonal pay model offered the benefits 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;
- Reducing the need for decentralised solutions to recruitment and retention issues and their associated risks; and
- Simplicity and administrative feasibility.

5.33 The Department also highlighted the risks of zonal pay, arguing that these were similar to, though perhaps weaker than, those for decentralised pay setting:

- Equal pay issues remained a risk. It would be critical that zone decisions were clearly objectively justifiable and up to date;
- Staff morale could be harmed by perception of pay differentials across areas even if objectively justified;
- Lack of flexibility to adjust geographical premia downwards when circumstances changed;
- Additional complexity in maintaining the pay structure and setting pay;
- Some risk of pay spirals;
- Staff mobility could be constrained; and
- For the NHS, significant consideration needed to 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 of economic, equality, contractual and collective bargaining issues.

5.34 The Department commented that a centralised market-facing pay system might have sub-optimal outcomes, such as: being seen as a cost pressure and might be unaffordable; funding training of existing staff or returner schemes might be more cost effective than pay premia; organisations might have already invested in non-pay measures; and less effective targeting towards specific local recruitment and retention risks.

5.35 The Department argued that these risks existed to some extent for all methods of using pay differentiation as a recruitment and retention tool. The Department concluded that zonal pay offered the most appropriate balance between moving towards a greater degree of market-facing pay and minimising these risks.

### *HCAS Zone Design*

5.36 The Department considered that AfC could already be described as operating a four-zone geographical pay system, with most organisations paying staff according to the national scales, with three additional zones covering HCAS in and around London. In the Department's view, the addition of further zones to increase geographical pay differentiation could be informed by the sMFF data, which provided an objectively justifiable indicator for geographical variation in pay that would offset differences in the cost of living and general amenities across areas for non-medical staff.

5.37 The Department showed that the sMFF data – and therefore private sector pay – varied across England, with the highest values in London and the South East, with additional hotspots in the Midlands and around Manchester and Leeds.

5.38 The Department provided some indicative options for new zoning arrangements, of varying levels of complexity, which the Department did not intend to represent final proposals. These are reproduced in Appendix D. 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 zones were intended to give a flavour of broad options available if a zonal pay approach was adopted. The Department presented indicative options for five, six or nine zones, and explained that with more zones, there was less variation in the underlying sMFFs within zones, and each zone could be more precisely calibrated to the situation of its constituent parts. However, more zones added complexity in implementation and maintenance. A balance between precision and simplicity needed to be struck.

5.39 The Department considered that five or six zones (i.e. one or two new zones) would be most appropriate, at least in the first instance. Having more zones would allow greater theoretical precision, but:

- This could only be realised when affordability and transition issues permitted sufficient pay differentiation between the zones to be generated, which could be a gradual process;
- It added complexity; and
- The design of a more complex system would probably require a greater evidence base on the recruitment and retention implications.

5.40 The Department also noted that starting with fewer zones did not preclude the option of adding additional zones at some point in the future if:

- The impact of adding initial new zones had been assessed and supported the case for further geographical pay variation;
- The evidence base was sufficient to support a more complicated system;
- The experience of handling the administrative burden and complexity of introducing the initial new zones suggested the system could cope with additional zones; and
- Affordability and transition issues permitted the generation of meaningful pay differentiation between the zones.

5.41 The Department said that the introduction of any 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.

*Values of any Geographical Pay Differentiation*

5.42 The Department strongly recommended the use of the latest available sMFF data as the means to inform any centralised market-facing pay elements, not favouring the alternatives which were:

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

5.43 The Department argued that the sMFF data provided an objectively justifiable indicator of the geographical pay differentiation that would offset differences in cost of living and general amenities across areas. The underlying evidence behind market-facing pay suggested that if the geographical differentiation of NHS pay more closely matched sMFF 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. Moreover, the sMFF data were already used in NHS allocations as an adjustment to tariff payments. Using this same data in pay differentiation would offer consistency and administrative simplicity.

5.44 The Department stopped short of making proposals on the specific long or short term values of geographical pay differentials in its evidence for this review. The Department considered that the values would depend on: the chosen zoning option; national and local affordability; pace of change decisions; and the extent to which minimum and maximum values for supplements would be applied.

5.45 The Department instead considered the broad issues involved in using the sMFF data to inform the values of any geographical allowances. Table 5.4 shows the range of sMFF values for the indicative zoning options presented by the Department, with the sMFF converted to an index with 1 as the minimum score, such that the resulting converted index could be interpreted as indicating an uplift to the national pay scales.

**Table 5.4: Organisation level variation in provider sMFFs (converted to a minimum of 1 basis) under the indicative zoning options**

| Zone no. | Zone label | No. orgs | Provider sMFF | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | 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 hotspots" | 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 hotspots" | 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 |

*Source: Reproduced from written evidence from the Department of Health.*
*The Department's indicative zoning options are presented in Appendix D.*

5.46 The Department explained that the data in the table could be used to indicate the pure, or untempered, geographical pay supplement values indicated by sMFFs. For example, in the indicative six zone system a supplement of 14% – 27% of basic pay would appear appropriate for the "southern hotspots" zone, with the minimum rather than the midpoint of this range being more appropriate. However, the Department argued that an untempered application of the minimum sMFF score for the zone was unlikely to be appropriate, noting that the value of the current HCAS zones did not match that implied by the untempered allocation of sMFF data. The rationale for not applying the untempered values to the new zones related to national and local affordability concerns, and 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.

5.47 The Department suggested that the most appropriate value of any geographical supplement should be informed by considering how close the implemented supplement values should be to the untempered applications of sMFF data, taking into account the factors above and: the need to ensure appropriate differentials between zones; the aim to maximise the pace of change towards the preferred zoning option; and the extent to which absolute minimum and maximum values would be applied to proportional HCAS rates.

*Implementation and Contractual Issues*

5.48 The Department considered that the introduction of additional HCAS zones was the most appropriate mechanism for introducing market-facing pay, rather than the options of recruitment and retention premia, regional pay scales, and locally negotiated pay. HCAS was already a part of the AfC collective agreement, with the values of HCAS reviewed annually. It was already open to us to make recommendations on the future coverage of HCAS and on the value of such supplements, and HCAS was designed to work alongside local and national RRP, meaning that employers in HCAS zones could continue to make use of these additional pay flexibilities when appropriate. The Department believed that additional HCAS zones could be introduced without the need to change existing contracts of employment, or any fundamental change within the AfC Agreement. In addition, the Department recognised the balance to be struck in introducing new HCAS zones where existing RRP or non-pay recruitment initiatives may already be in place.

5.49 The Department believed that it should be possible to begin implementation of additional HCAS zones with effect from April 2013, beginning in an incremental way. The Department suggested that market-facing pay measures should be introduced equally for both existing and new staff, as applying changes to new starters only would slow the pace towards overall geographic pay differentiation, and could harm the perceived fairness of the pay system and increase equal pay risks.

5.50 The pace of change, in the Department's view, would involve managing the trade-offs between faster geographical pay differentiation and: managing national and local affordability and employer stability; maintaining adequate recruitment and retention in the NHS; and delivering adequate earnings growth for all staff. The Department noted that organisations in the new HCAS zones would have additional pay bill pressures from the payment of HCAS, but their incomes, which already reflect sMFF, might not change substantially, and suggested that there was a case for limiting the pace of change to a locally manageable level; or, if a faster transition was sought then the Department would need to consider whether any transitional measures to ease implementation issues were justified. The Department explained that freezing national pay scales and diverting all available resources into HCAS payments would promote a relatively fast geographical redistribution of pay; however, there was a need to be mindful of the effect on recruitment and retention in low sMFF areas of such an approach.

5.51 The Department considered that the broad framework for managing the transition would involve:

- A prolonged period of constrained headline pay awards to provide the headroom for earnings growth in the new HCAS zones;
- Consideration of the appropriate headline basic pay award, delivering a balance between pace of change, recruitment and retention in the "National" zone, and offering any relief to the low paid that was considered appropriate; and
- Consideration of the appropriate values of HCAS payments, to deliver movement towards the desired geographical differentiation without undermining the stability of employers and local and national affordability.

5.52 The Department favoured an approach which balanced these factors, starting the transition as soon as possible but recognising that full implementation could take several years. The Department proposed that this should be managed incrementally, suggesting that we review progress during the annual pay rounds, with each step being informed by the emerging economic environment, new data and better intelligence from the introduction of market-facing pay to date.

## Market Forces Factor

5.53 The Secretary of State specifically asked us to consider *"the way in which the Department uses the Market Forces Factor to reflect local labour market costs in PCT allocations and whether these might be used (or amended) to support more market-facing pay"*. As the MFF underpins the Department of Health's proposal, we provide a brief description of the operation of the MFF and its staff index before setting out the parties' evidence and our comment.

### Operation of the Market Forces Factor

5.54 NHS financial allocations are based on a weighted capitation formula which is designed to account for the cost of commissioning or providing healthcare services being different in separate areas of England 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 Payment by Results (PbR) tariffs paid to NHS providers.

5.55 The MFF consists of elements for: staff (excluding medical and dental); medical and dental London pay weighting; buildings; and land. Individual indices for each of these elements are determined and combined into an overall index for both provider Trusts and PCTs. Other costs (e.g. equipment, consumables, drugs, etc.) are assumed not to vary across the country.

5.56 Of principal interest for this review is the staff element of the MFF which is known as the sMFF. The sMFF aims to provide like-for-like comparisons of average private sector pay between geographical areas. It represents the geographical variability in private sector pay, after accounting for differences in each area's workforce.

5.57 In order to produce the sMFF, 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. The latest source data is taken from anonymised, individual level data from the Office for National Statistics' Annual Survey of Hours and Earnings (ASHE) for the three years 2007 to 2009. This is a survey of employers requiring information on pre-selected employees, based on National Insurance numbers. It therefore provides robust data on earnings from payroll systems. The ASHE survey includes information on employees' age, occupation and industrial sector.

5.58 Statistical modelling of the sMFF is undertaken at PCT level and can result in the estimated private sector pay rates at neighbouring Trusts differing by large margins. As these disparities are considered to be due to the use of PCTs as artificial boundaries, and therefore cutting across local labour markets, a method, known as smoothing[5], is then used to reduce these cliff edges, and produce a sMFF value for each healthcare provider.

5.59 The MFF has been reviewed on a regular basis since its introduction with the last review carried out in 2010[6,7]. Under the Health and Social Care Act[8], responsibility for pricing will move to Monitor and the NHS Commissioning Board. Monitor will be responsible for price setting, including pricing methodology, while the Commissioning Board will be responsible for currency and tariff design. However, the Act requires Monitor and the NHS Commissioning Board to agree all aspects of price setting. The Department of Health stated that in future funding allocations will be made by Clinical Commissioning Groups and it was expected that the current approach, taking account of variations in the sMFF, will continue for the foreseeable future.

## Evidence from the Parties

### *Department of Health*

5.60 The **Department of Health** commented that it did not wish to change the allocation methodology which was academically well-founded and well understood by the NHS. The Department considered that the sMFF could be thought of as an index of differences in the cost of living across the country as pay in the private sector tended to reflect those differences. The controls used as part of the sMFF were those which economic research had consistently found to influence pay and for which robust data were available for areas below regional level.

5.61 The Department added that when PCTs were abolished as part of the NHS reform agenda there might be a case for reviewing the sMFF methodology to use alternative units of geography, but this would be a matter for the NHS Commissioning Board.

5.62 The Department stated that as wages in the NHS were determined through national pay structures, there was clear evidence for non-medical staff that indirect staff costs across the country varied in line with the going local labour market rate in the private sector. If wages in the NHS in a given area were below the going rate set in the private sector, this led to higher indirect costs in the form of recruitment and retention difficulties, increased reliance on bank and agency staff, and lower productivity.

5.63 The Department concluded that the sMFF data provided 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. It therefore believed that sMFF data offered the best prospects for informing the value of geographical pay.

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[5] The smoothing process 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. The second stage then takes 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.

[6] Eliot.R et al (2010) *The Staff Market Forces Factor Component of the Resource Allocation Weighted Capitation Formula: New Estimates*, University of Aberdeen. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_122621.pdf

[7] Ma.A et al (2010) *The Staff Market Forces Factor Component of the Resource Allocation Weighted Capitation Formula: Refinements to Method*, University of Aberdeen. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123703.pdf

[8] Health and Social Care Act 2012 (c.7). Available at: http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

*NHSE*

5.64 **NHSE** considered that the allocation of funding in the NHS recognised that it was more expensive to provide services in some parts of the country than in others. It added that the MFF was the mechanism which took all these factors into account in the allocation of funding to NHS commissioners and the prices they paid to providers of care. NHSE stated that financial allocations informed by the sMFF were a well established mechanism which aligned funding with local pay costs. NHSE explained that, rather than the financial allocation mechanism changing to cope with market-facing pay, employers would like to see the existing relationship between financial allocation and pay levels maintained. While the funding mechanism might be able to ensure that any increased pay costs would be sufficiently funded over the long term, there were concerns that the introduction of market-facing pay was likely to cause unmanageable increased financial pressures in the short term. NHSE considered that to alleviate this risk the funding mechanism might require amendment to cope with the transition period.

*Staff Bodies*

5.65 The **Staff Side** and the **RCM** stated that the MFF was another example of the flexibility of AfC, since 67% of the MFF payment was pegged to geographical variations in private sector wages, enabling Trusts to utilise extra funding that recognised local circumstances.

## Our Comment

5.66 The Secretary of State's remit letter asked us to look at the way in which the Department uses the MFF to reflect local labour market costs in PCT allocations and whether these might be used (or amended) to support more market-facing pay. We assess in Chapter 6 the analysis of how the sMFF might indicate geographical pay variation and its relationship with recruitment, retention and other indicators.

5.67 We note the Department of Health's view that it did not wish to change a well-founded allocation system. The Department also considers the sMFF to be an objectively justifiable indicator of geographical pay variation. However, it is not clear to us that the sMFF is sufficiently robust to underpin a zonal pay system. The funding formula was designed primarily to ensure the correct allocation of resources to Trusts rather than to determine geographic differences in pay rates. The Department's evidence indicated that it would not be appropriate to apply an untempered sMFF and we agree that further work would need to be done to provide objective justification on how the sMFF might be adjusted to fund pay variations. Also, the sMFF methodology does not allow for factors known to drive private sector pay, such as employee qualifications and organisation size.

5.68 Our other concern is that there was little evidence that extra pay monies being allocated through sMFF were finding their way into pay systems locally in a consistent manner. On the one hand, it is appropriate that employers should have the flexibility to use additional sMFF funding as befits the local solution required and meets the local service need (and using relatively expensive agency staff and locums can be appropriate in certain circumstances). On the other hand, evidence on the lack of widespread use of local RRP may be an indicator that Trusts where market rates are high are reluctant to pass on the additional funding received in staff pay and also an indicator reflecting current labour market conditions. The varied use of the funding across the country could lead to unequal outcomes for patients and therefore further information on these areas would help to clarify the position.

5.69 Finally, despite the Department of Health's view, we do not agree that the MFF and the sMFF are well understood by other stakeholders on the front line. If it is to be used as the basis for making pay more market-facing then a greater degree of transparency

is essential and any such move would need to be accompanied by a communication exercise.

## Affordability

5.70 In the light of the Department's specific proposal and its proposed implementation, we describe and comment on the evidence on affordability. The Chancellor asked us to consider *"the affordability of any proposals in light of the fiscal position – these should not lead to any increase in pay bill in the short or long term"*.

### Evidence from the Parties

*Department of Health*

5.71 The Department concluded that its proposed approach of retaining national agreements, flexibility for local and national RRP, moving to national AfC pay rates at the minimum level necessary to recruit high quality staff and extending HCAS would offer the most cost-effective and efficient use of the NHS pay bill. This would overcome the growing problem that employers in low cost areas were currently locked into relatively expensive national contracts for NHS staff. Failure to address this anomaly, in the Department's view, risked forcing those employers to abandon national collective agreements as unaffordable or becoming uncompetitive with private sector providers in their areas.

5.72 The Department commented that affordability would be key to the implementation of market-facing pay and that our remit included a requirement that proposals should not lead to any increase in pay bill in the short or long term. The Department considered it crucial that any proposals were robustly costed and tested to ensure they would not jeopardise local or national affordability and that scheme designs should remain within affordability constraints.

*NHSE*

5.73 **NHSE** highlighted that the NHS would need to achieve unprecedented levels of efficiency savings of up to £20 billion before 2014/15 to meet growing demand and that restraining pay bill costs remained a key priority for employers. NHSE noted that employers operated in different local labour markets and some pay flexibility would potentially lead to more efficient use of the pay bill. However, there was limited appetite from employers for full local pay bargaining which would raise issues of local capacity, increased administration costs and risks of pay inflation.

5.74 NHSE referred to headline pay increases for public sector pay being restricted to an average of 1% in 2013/14 and 2014/15 suggesting that there would be little scope for meaningful pay differentiation between regions or zones during those years.

5.75 NHSE commented that any move towards greater regional or local pay differentiation would have to be of benefit to local employers and patients. In view of financial challenges, NHSE said that any changes would need to be reflected in the NHS financial arrangements. They added that if funding consistently fell short of staffing costs it was ultimately likely to be reflected in reduced provision of patient services and, conversely, employers would not benefit if savings on staff costs were reflected in reduced funding. It was the balance between funding arrangements, pay administration costs and the potential to destabilise labour movement on zone borders that was most likely to concern employers.

## Our Comment

5.76 We note that there are several affordability concerns associated with making pay more market-facing in the NHS. Overall, if a more market-facing approach is favoured over the longer term we see merit in the Department of Health's suggestion that this is achieved in a paced and incremental manner. Not least this would help to monitor the effectiveness of any more market-facing pay solutions but also in managing the affordability of such proposals. In this regard, we echo the views of NHSE that public sector pay awards that average at 1% increases would limit severely the scope for making pay more market-facing in 2013/14 and 2014/15. In our view, it could take several years and beyond the current spending review period to implement new arrangements that achieved any meaningful geographical pay differentiation.

5.77 Having said this, we agree with the Department that further work on robust costings and testing of any proposals is essential for a more market-facing approach to be implemented. Based on the Department's indicative proposals for possible additional HCAS zones drawing on sMFF data, we examined broad potential pay bill costings, which are provided in more detail in Appendix E. We estimate that:

- One additional, narrow HCAS zone covering parts of South East England and around Bristol would cover around 10% of the AfC remit group with each percentage point on the new HCAS value costing an estimated £17.8 million excluding on-costs, or 0.07% of current total earnings – which we use as a proxy for the total pay bill in England. For example, a 3% value for an additional HCAS zone would cost £53.5 million or 0.21% of total earnings; and

- One additional, broader HCAS zone covering the whole of South East England, parts of the Midlands and areas around Manchester and Leeds would cover around 41% of the AfC remit group with each percentage point on the new HCAS value costing an estimated £75.9 million or 0.3% of current total earnings.

5.78 Adding more than one additional zone would, in our view, require the level of the Fringe supplement – and potentially those in Inner and Outer London – to be increased. For example, we estimate that increasing the Fringe supplement from 5% to 10% would cost an additional £50.2 million (excluding on-costs) or 0.2% of current total earnings[9]. We estimate that adding two additional zones would cost approximately 1.24% of current total earnings, and adding five additional zones would cost approximately 3.11%.

5.79 These broad costings should be viewed in the light of the Government's announcement that the public sector pay freeze will end after 2012/13 but that for each of the following two years the UK Government would seek public sector pay awards that average at 1%. This limits the scope for making pay more market-facing during 2013/14 and 2014/15. However, if market-facing pay is pursued it does allow for very moderate new pay arrangements to be introduced incrementally. This is a matter for our autumn pay round in which will consider any costed proposals for making pay more market-facing against all the factors in our standing terms of reference.

5.80 In the current financial climate and acknowledging the financial pressures on the NHS, we consider affordability a key factor in determining any market-facing pay. There is only anecdotal information on how employers use additional funding through the sMFF and it would be helpful to understand further how this is used. There is also the question of how to manage the situation where Trusts have already invested in other recruitment and retention measures. Affordability considerations should include any transitional costs to any new arrangements incurred by employers. In our view, in the public and private sector the introduction of new pay arrangements is usually supported by transitional funding. Currently, such transitional costs may be unfunded and therefore unaffordable.

[9] See Appendix E, Tables E4 and E5.

## Cliff Edges

5.81 The Secretary of State asked us to consider *"the impact of any cliff edges in pay between different local labour markets and how these might be managed"*.

### Evidence from the Parties

*Department of Health*

5.82 The **Department of Health** stated that any introduction of new zones would need to be accompanied by more work to consider implementation issues, such as cliff edge effects. It expected that issues were likely to be minimised as the value of new zones would only grow incrementally.

5.83 The Department explained that the initial calculations in the sMFF methodology often resulted in cliff edges because PCTs' geographical boundaries did not necessarily correspond to local labour markets and statistical variation arose due to relatively small sample numbers in ASHE for some PCTs. These discontinuities might lead to inequitable sMFFs, particularly for providers in close proximity and facing similar local labour market pressures but which were in different PCTs. The Department used smoothing techniques within sMFF, a form of averaging, to soften cliff edges to produce a more continuous profile across PCTs.

5.84 The Department commented that the average change as a result of smoothing was plus or minus 1.7%. Much larger gains were experienced by Outer London PCTs where wages were low (by London standards) but, in reality, they were part of a wider London labour market.

*NHSE*

5.85 **NHSE** considered that regardless of the approach to pay differentiation, there were likely to be issues along the boundaries where there was significant contrast between higher and lower paying areas. Staff that were within commuting distance of both employers on both sides of the boundary might be expected to opt for the employer offering the highest reward, making recruitment and retention very difficult for the employer on the lower paying side of the boundary. NHSE said that any financial incentives offered in order to improve recruitment and retention could lead to "pay spirals", where employers competed to retain staff in limited supply. NHSE reported that due to good transport links, proximity of employers and staff shortages, some employers outside of the Inner London zone had already experienced this difficulty.

5.86 NHSE considered that organisations near to boundaries of differentiated pay levels were likely to experience an impact on their recruitment and retention levels where the pay differences were significant. It was suggested that employees considered a whole range of factors when applying for jobs, which might not be sensitive to small pay variations. NHSE commented that recruitment and retention difficulties could be caused where the neighbouring organisations share Travel To Work Areas (TTWAs), and therefore much of the same labour pool e.g. London where there were good transport links. More rural areas might find that their recruitment and retention levels were affected less by the pay of neighbouring organisations.

5.87 NHSE also suggested that tapering of pay rates might be built into the design of zones to minimise the existence of cliff edges. Where there were significant cliff edges, NHS organisations on the lower paying side might respond to competition for skills from a higher paying employer, by introducing a RRP payment to supplement pay to a level closer to that of the higher paying organisation. NHSE considered that it was likely that proximity to a cliff edge would affect staff groups differentially. Staff groups where there was a plentiful supply of suitable applicants, or those with less occupational mobility were

unlikely to need to pay a RRP. Staff groups where there were skill shortages were those where a RRP might be required to avoid losing staff to higher paying neighbours.

5.88 NHSE suggested that whilst the introduction of market-facing pay would not directly change the aggregate supply of skilled staff, it might change the distribution at a local level and appropriate use of RRP would require an understanding of whether difficulties recruiting were due to an underlying skill shortage or insufficient pay levels. NHSE commented that "pay spirals" were most likely to occur as a result of an underlying skill shortage.

*Staff Side*

5.89 The **Staff Side** were particularly concerned about the impact on cross-border labour markets as our market-facing pay remit only covered England. The Staff Side considered that if, for example, a market-facing pay system imposed lower pay on large sections of the North while Scotland continued to pay existing AfC rates, employment patterns were likely to respond accordingly. The Staff Side had anecdotal information that significant numbers of staff commuted across the Wales/England and Scotland/England borders.

5.90 Examining the West Midlands and its five main TTWAs, the Staff Side concluded that there were inherent difficulties of defining local labour markets and the possibility of an NHS worker living in one area but receiving a salary associated with a different area.

5.91 The **RCM** commented that there were cliff edges created by the existing high cost area supplements as the surrounding areas had recruitment problems. The RCM considered that local RRP could be awarded in the short term, which could help employers solve their immediate problem of a shortage of staff, but did not allow them to become complacent by not training and developing their staff in the long term and allowing cliff edges to become entrenched.

### Evidence from the Trades Union Congress (TUC)

5.92 The **TUC** stated that there was a risk that skilled public sector workers working in economically disadvantaged areas might be tempted to move in search of higher wages and would exacerbate regional inequalities in service provision by taking staff away from the areas that had the highest levels of need.

### Our Comment

5.93 We did not receive much evidence of major problems created around adjoining areas or cliff edges in current HCAS or RRP usage, which are a long-standing feature of NHS pay arrangements. While there are some reports of difficulties involving cliff edges, particularly around specialist staff, they do not appear to be causing a great deal of difficulty for Trusts. We are mindful that any geographical boundaries currently in use, or proposed for future HCAS, should be appropriate given the changing NHS landscape and problems accurately defining TTWAs.

5.94 Although existing cliff edges only appear to have a limited impact, the introduction of any new HCAS zones would require an assessment of the potential effect of creating new cliff edges. We also ask that any border issues with the Devolved Administrations are included in autumn evidence to us including both how areas just across the Devolved Administrations borders might be affected and the impact on adjoining areas in England.

### Future Evidence Requirements

5.95 In looking forward, the Secretary of State asked us *"to consider what information in the future might be needed in order to make recommendations on local labour markets"*.

## Evidence from the Parties

*Department of Health*

5.96 The Department said that the number, size and shape of HCAS zones would need to be reviewed periodically, which would include 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. The Department suggested that consideration after the initial implementation period would benefit from an assessment of the impact to date of introducing new HCAS zones and greater geographical pay differentiation.

5.97 The Department highlighted the data and intelligence that would help inform these judgements:

- Affordability intelligence;
- Geographical pay differentials for AfC staff;
- sMFFs;
- Detailed recruitment and retention indicators (as granular and staff group specific as possible) such as vacancy and turnover rates, agency usage, staff satisfaction and absence rates; and
- Wider, qualitative intelligence such as issues which become apparent to employers before they are conclusively reflected in the data.

5.98 The Department believed there was particular scope for improvement around the availability of vacancy rate data, the collection of which had been suspended since the March 2010 survey. The Department told us that trends in job advertisements from the new *NHS Jobs* website[10], due to be implemented on 1 October 2012, could be used as a proxy for vacancy information but could not be used in direct comparison to the suspended vacancy survey.

5.99 The Department also considered that their management of local issues would benefit from maximising the availability of recruitment and retention indicators, particularly those at staff group level. These would be similar in scope to the list above but may also include 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; and
- Additional local intelligence regarding the local labour market, for example utilising exit interviews.

5.100 The Department sought our views on any central measures considered advisable to promote the prospects for local flexibilities without disproportionate additional administrative burden. The Department suggested such measures could include: central gathering, collection and analysis of local labour market indicators; commissioning further research to assess recruitment and retention tools; and 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.

[10] www.jobs.nhs.uk

## Our Comment

5.101 We agree that HCAS zones and levels should be subject to regular, evidence-based reviews to ensure that they remain appropriate, with payments allowed to increase or decrease as necessary. The range of indicators suggested by the Department, supplemented by local labour market intelligence, seems sensible, though the current absence of publicly available vacancy data is regrettable and may undermine the transparency of such reviews. We discuss reviews of HCAS further in Chapter 7.

5.102 We additionally agree that individual employers should have easy access to data on the recruitment and retention situation in their own organisation, and the ability to compare it with other organisations. The facility to analyse NHS recruitment and retention data already exists through the HSCIC's iView Workforce service[11], which allows employers to analyse staffing levels, earnings, sickness absence and turnover broken down by occupation, AfC band, gender and in other ways. The ability to make comparisons with other organisations will depend on staff capacity, so the Department or NHSE may wish to explore whether it could add value to this service by, for example, regularly informing NHS organisations of adverse trends in these data, relative to other local or similar organisations. The Department's suggestion for central gathering, collection and analysis of local labour market indicators also seems sensible, as it would avoid duplicating effort in NHS organisations and allow more time to analyse them in the context of other local intelligence.

[11] www.ic.nhs.uk/services/nhs-iview

# Chapter 6 – Our Research

## Introduction

6.1 In Chapters 2 to 5, we have drawn together the parties' evidence as it relates to market-facing pay. In this Chapter, we present our own detailed research and analysis of the variation in recruitment and retention and earnings of our remit group. We also investigate further the pay relativities between the NHS and the private sector, and their link with recruitment and retention, which underpinned the Department's rationale for making pay more market-facing.

6.2 The analysis presented in this Chapter relates to England only, and draws on published statistics from the Health and Social Care Information Centre (HSCIC); we have also drawn on detailed data produced at our request by both the HSCIC and the Department of Health. We are grateful to these organisations for their assistance. The analyses and associated conclusions contained in this Chapter are however our own.

6.3 Most datasets in our analysis relate to the 2010/11 financial year or close to this period, representing the latest available data published at the time we conducted our research, or at the time our requests for data were made to the HSCIC or the Department. Our conclusions may have differed, had we examined earlier or later data.

## Summary of Our Findings

6.4 We find that recruitment and retention indicators for our remit group vary across the country. All indicators appear to be less favourable on average in London in particular, as well as areas surrounding London and major cities. However, this general trend has exceptions: neighbouring organisations can have quite different recruitment and retention situations. Organisations in London with the highest vacancy rates, for example, are adjacent to organisations with no apparent problems.

6.5 Our analysis of the data on the usage of recruitment and retention premia (RRP) shows that usage of RRP by employers is rare and does not show a distinct geographical pattern. Misleadingly, the majority of these payments are likely to have resulted from pre-Agenda for Change (AfC) "Cost of Living Supplements" (CoLS) (paid to nurses and professions allied to medicine from 2001) being re-expressed as long term RRP on implementation of AfC. We think it likely that many other RRP in payment are those national RRP agreed under AfC transitional arrangements for certain occupations, but we were not able to quantify the effect of this. There may also be limited capacity within local employers properly to evaluate the greater use of local RRP, partly because of prevailing labour market conditions limiting their need.

6.6 Examining data on average total earnings and basic pay, we found that staff in organisations in London were paid significantly more on average than staff in the Rest of England, taking into account the type of organisation and an allowance for workforce composition. Our further analysis of the distribution of certain occupations on AfC pay bands finds that some large occupational groups such as nurses and administrative and clerical staff have proportionally more staff on higher pay bands in Inner London than in the Rest of England. It could be that organisations in London respond to recruitment and retention pressures by offering higher basic pay to staff, rather than using the specific flexibility of RRP, but there could be many other factors driving this pattern, such as workforce configuration and skill mix, and further work is required to clarify the position.

6.7 Our analysis shows that NHS recruitment, retention, motivation, earnings and patient experience across the country is indeed linked to NHS pay relative to local private sector pay, which might provide some prima facie evidence in support of more market-facing

pay. However, relative pay is not as important as NHS organisation type in explaining differences in these indicators, and together these factors are just some of many which influence differences in recruitment, retention, motivation and patient experience.

6.8 On the whole, our research does not provide the firm evidence which would be essential to justify further investment in additional market-facing pay in the NHS at this time, even though recruitment and retention indicators are relatively less favourable in London and areas surrounding London. Indeed, if our research points to anything it would point to more investment in pay in parts of London rather than outside. However, any such regional pressures should be seen in the context of relatively high unemployment and may not be strongly linked to pay, but to the different types of organisation, and to specific local issues, including workforce planning, that are particular to individual organisations.

6.9 We set out below and in Appendix F our detailed analysis; our overall conclusions and recommendations on market-facing pay for AfC staff are in Chapter 7.

## Recruitment and Retention

6.10 In this section, we review the available evidence on the recruitment and retention of our remit group, with a focus on the variation across England. We begin by examining vacancy rates, move on to leaving rates, and finally examine the amount that Trusts spend on agency staff.

### Vacancy Rates

6.11 Figure 6.1 shows the distribution at organisation level of "total" vacancy rates[1] for all non-medical staff in March 2010 – the latest available data. The overall total vacancy rate in England was 1.9%, but it is clear that the organisation-level data are heavily skewed, with most organisations having a total vacancy rate below the average, and a few organisations with vacancy rates in excess of 10%. Of those organisations with the highest vacancy rates, a disproportionate number are located in London and the Fringe.

6.12 Figure 6.2 shows the distribution of "three-month" vacancy rates[2] in March 2010. The overall three-month vacancy rate in England was 0.4%, and there was much less variation than for total vacancy rates – in fact, the majority of organisations reported that they did not have any vacancies that had lasted for three months or more on the survey date.

6.13 When examining vacancy rates by staff group, we observe that variations in vacancy rates can be as marked *within* organisations as *between* them (Figures 6.3 and 6.4). This is also likely to be true for leaving rates[3].

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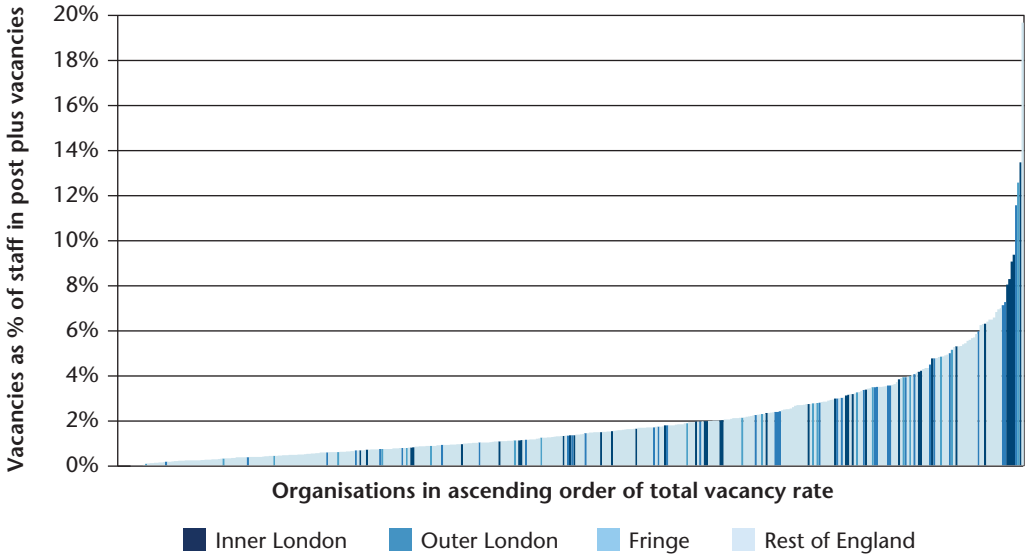
[1] "Total vacancies" are all vacancies, regardless of duration, reported on the survey date. The total vacancy rate is calculated as total vacancies divided by staff in post plus vacancies.

[2] "Three-month vacancies" are all vacancies reported on the survey date that had been vacant for three months or more. The three-month vacancy rate is calculated as three-month vacancies divided by staff in post plus vacancies.

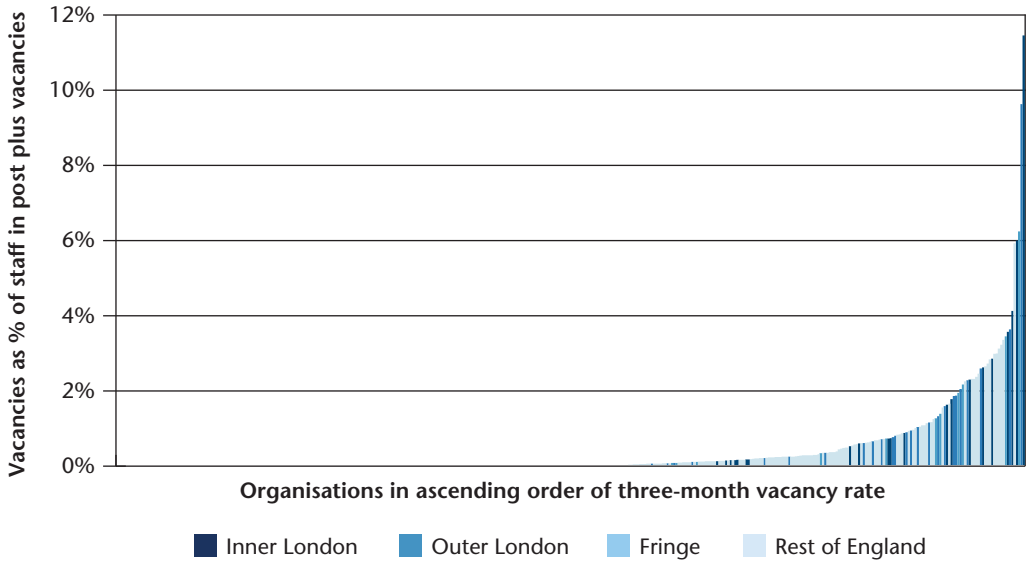
[3] Organisation-level leaving rate data are not available broken down by staff group. The latest available national data on turnover by staff group showed leaving rates ranging from 3.4% (for trainee ambulance staff) to 17.5% (for trainee scientific, therapeutic and technical staff); it is logical to assume that there will be similar variations within individual organisations. See HSCIC (2009) *NHS Staff Turnover Statistics 2007-2008*.

**Figure 6.1: Distribution of total vacancy rates for all non-medical staff, England, March 2010**



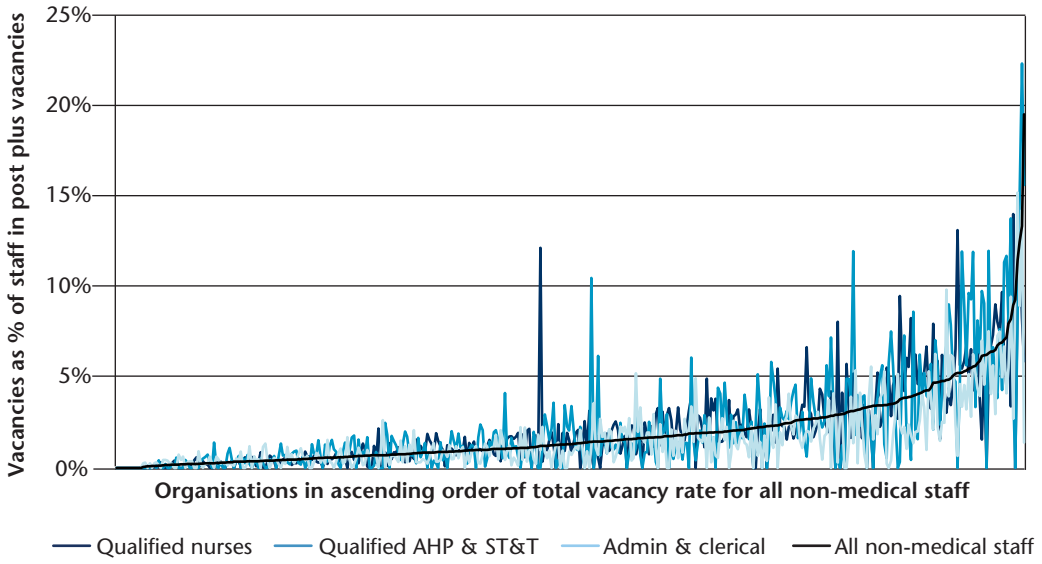

*Source: HSCIC.*

**Figure 6.2: Distribution of three-month vacancy rates for all non-medical staff, England, March 2010**



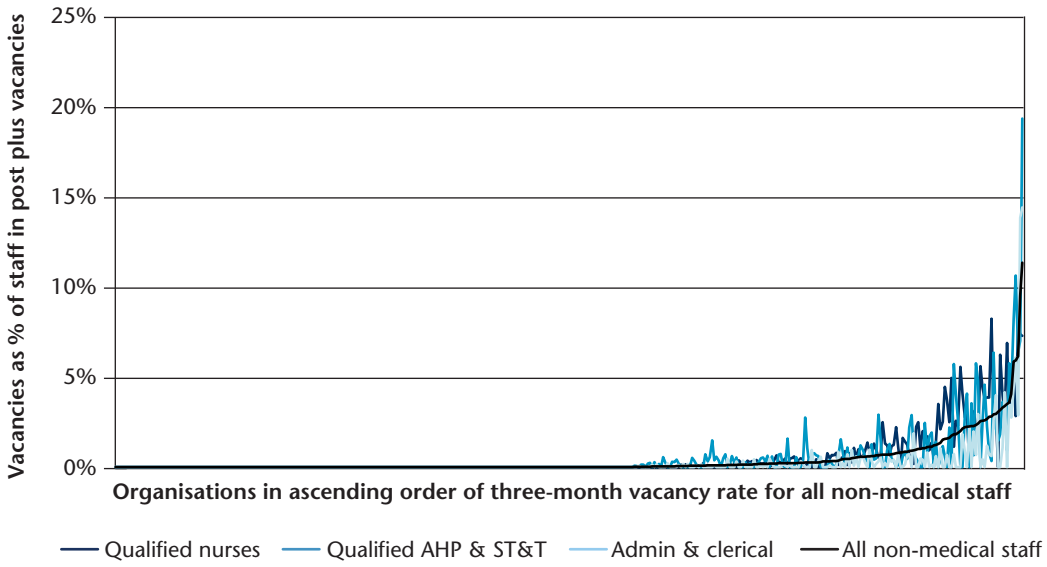

*Source: HSCIC.*

**Figure 6.3: Total vacancy rates by staff group and organisation, March 2010**




*Source: HSCIC.*

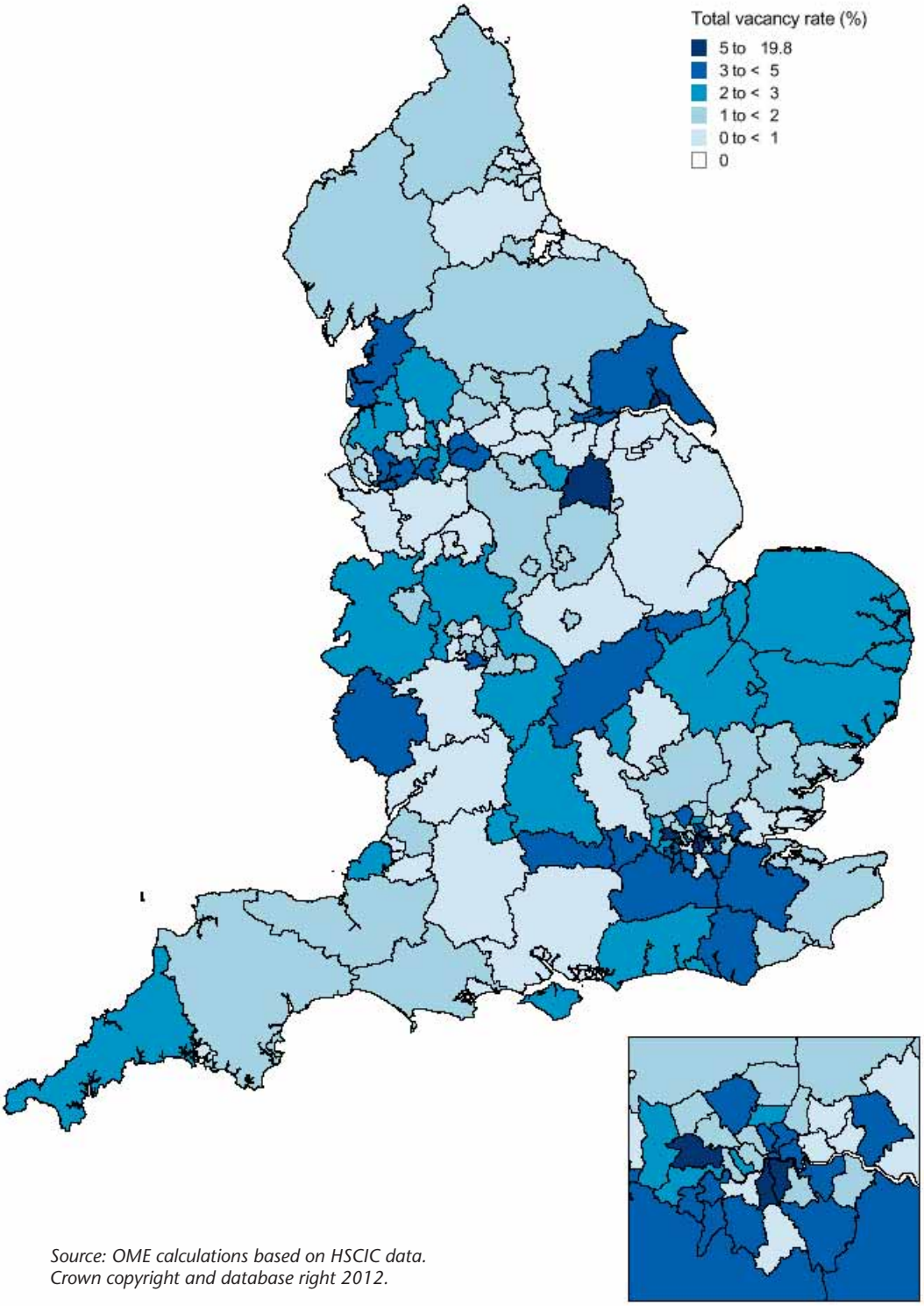
**Figure 6.4: Three-month vacancy rates by staff group and organisation, March 2010**




*Source: HSCIC.*

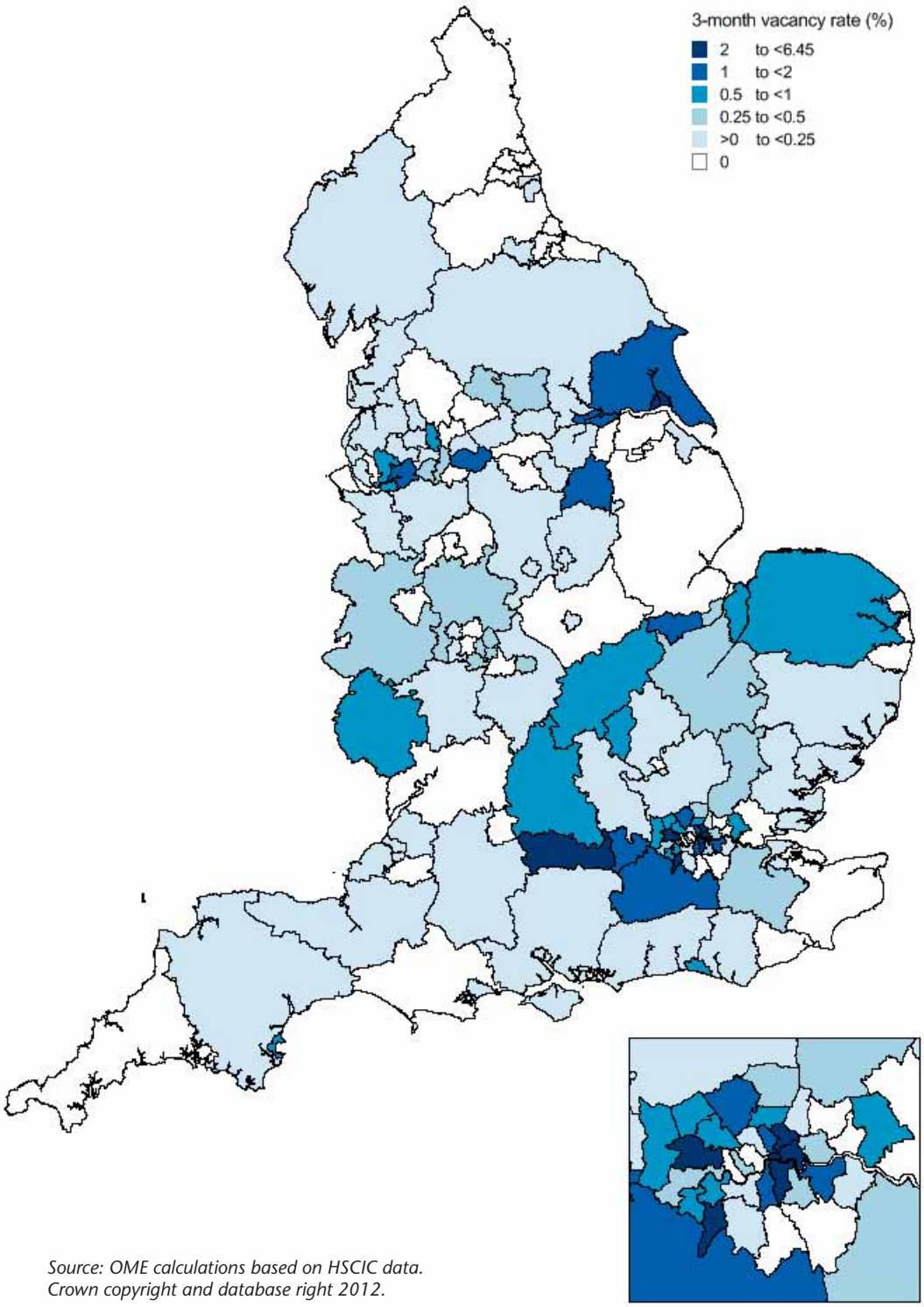
6.14 Figure 6.5 shows the variation in total vacancy rates, with organisation-level data aggregated to Primary Care Trust (PCT) level. Darker areas indicate higher total vacancy rates. In addition to organisations in and around London, higher than average total vacancy rates were also reported in Manchester and Birmingham, among others. Three-month vacancy rates also tended to be higher than average in these locations (Figure 6.6).

**Figure 6.5: Total vacancy rates for non-medical staff by PCT area, March 2010**




*Source: OME calculations based on HSCIC data.*
*Crown copyright and database right 2012.*

**Figure 6.6: Three-month vacancy rates for non-medical staff by PCT area, March 2010**



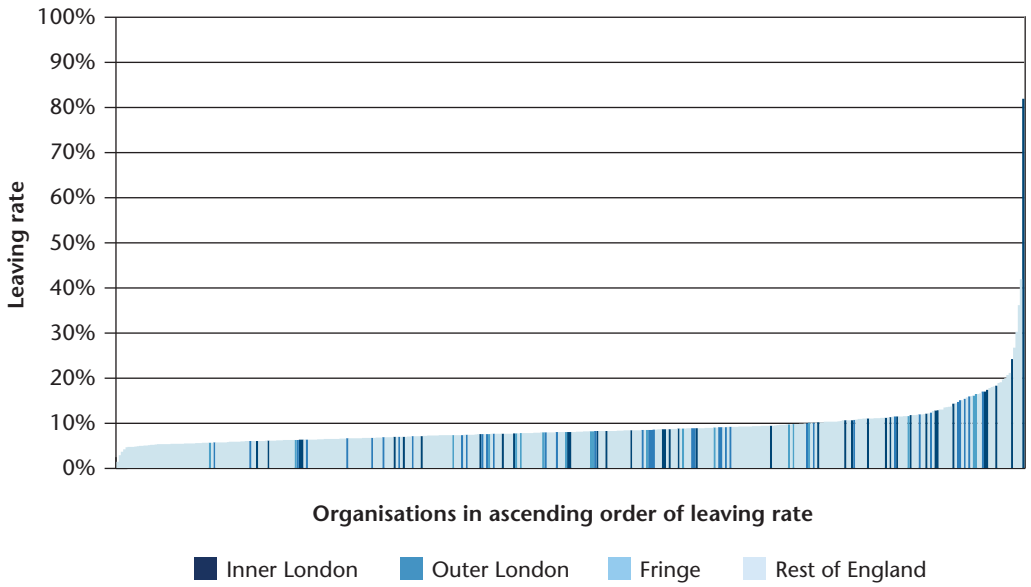

*Source: OME calculations based on HSCIC data.*
*Crown copyright and database right 2012.*

## Leaving Rates

6.15 Figure 6.7 shows the distribution at organisation level of leaving rates[4] from the NHS in England for the 12-month period ending January 2011. The overall leaving rate in England was 8.2%, and again it can be seen that the distribution is positively skewed. Figure 6.8 shows the variation in leaving rates across England, with data aggregated to PCT level. Leaving rates, like vacancy rates, tended to be highest in Southern England and large cities – but some of the highest leaving rates were found in parts of the East Midlands, the North East and in Lancashire.

6.16 It should be noted that some of the largest leaving rates were observed for PCTs and Strategic Health Authorities (SHAs), which over this 12-month period were undergoing significant organisational change, including mergers, and transferring out the provider arms of their organisations.

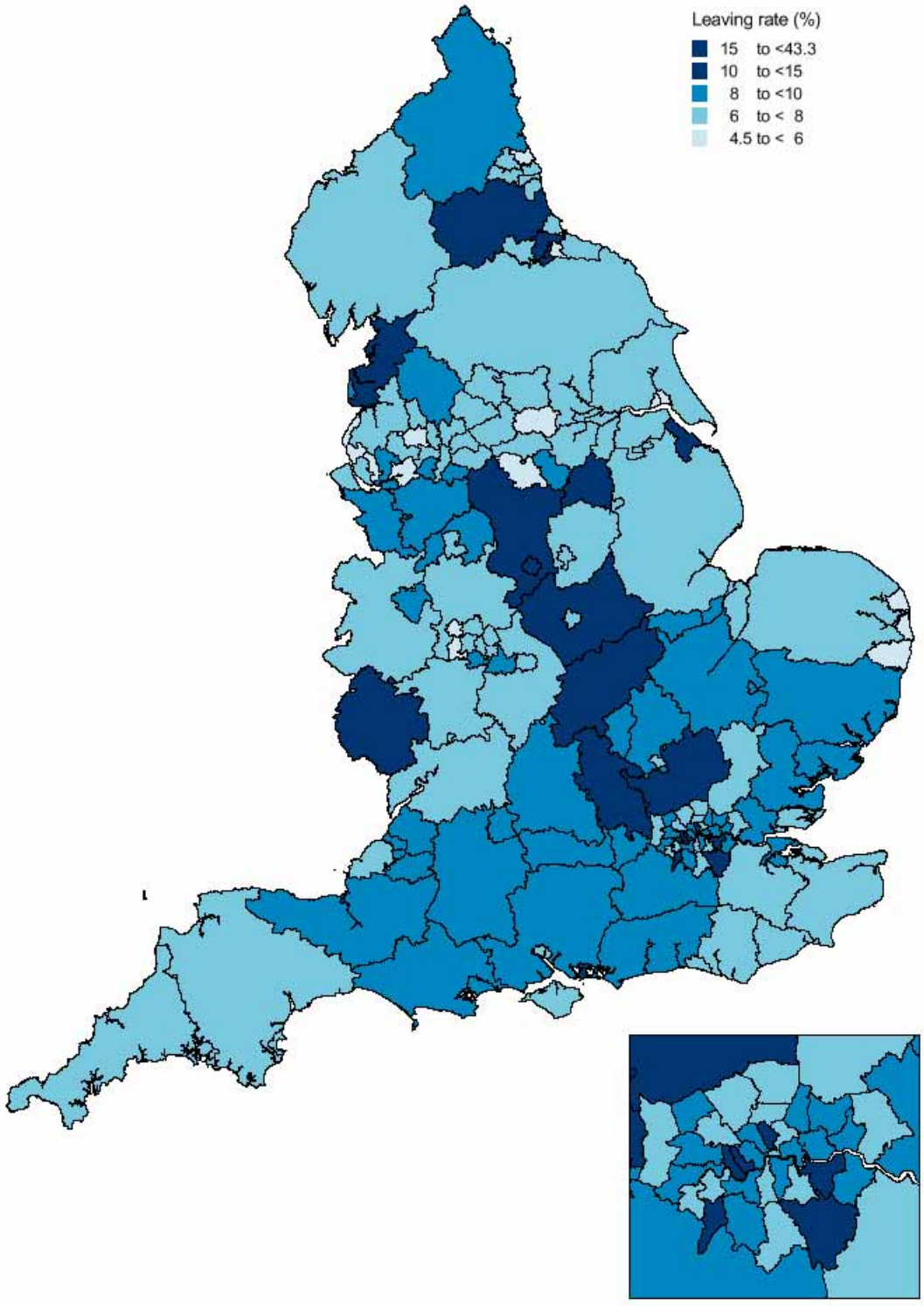
**Figure 6.7: Distribution of leaving rates for NHS staff excluding bank staff, locums and trainee doctors, January 2010 – January 2011**




*Source: HSCIC.*

[4] Leaving rates show the percentage of staff that have left the NHS in England over a given time period, divided by the number of staff. Data include medical and dental staff, but exclude bank staff, locums and trainee doctors.

**Figure 6.8: Leaving rates for NHS staff by PCT area, January 2010-2011**



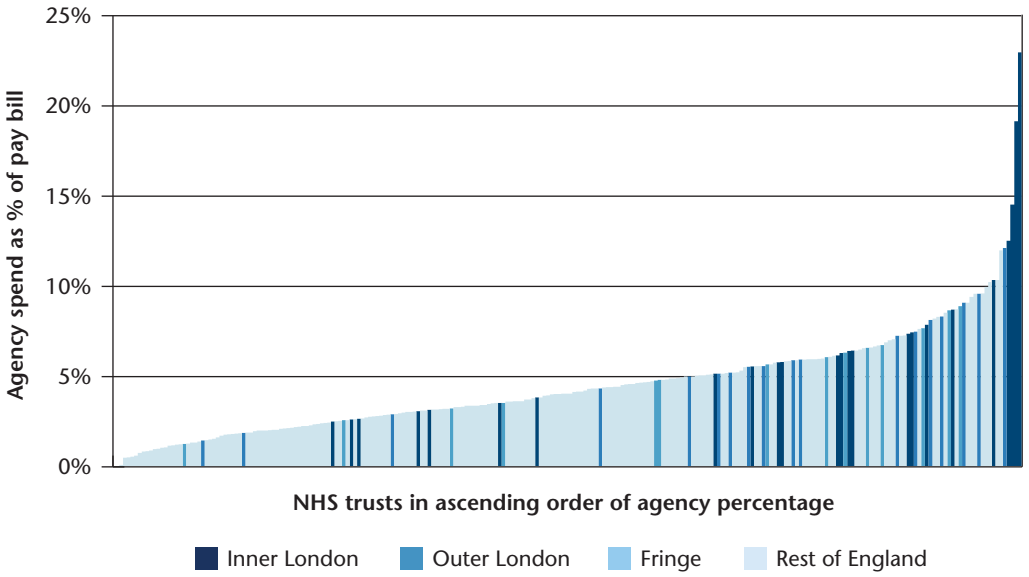

*Source: OME calculations based on HSCIC data.*
*Data include medical and dental staff, but exclude bank staff, locums and trainee doctors.*

## Spending on Agency Staff

6.17 It was not possible to obtain data on agency spend specifically for our remit group: the data therefore include spend on medical and dental agency staff. In 2010/11, NHS Trusts[5] on average spent 4.5% of pay bill[6] on agency staff, with half of all Trusts spending between 2.6% and 5.9%. Total agency expenditure by Trusts was £1.68 billion out of total staff costs of £36.8 billion. Figure 6.9 shows the distribution of agency spend as a percentage of pay bill, across NHS Trusts in England. Trusts in London are again disproportionately represented at the upper end of the distribution.

6.18 Figure 6.10 shows the variation in spend on agency staff as a percentage of pay bill. Trusts with the highest spend on agency staff on this measure were predominately located in London and South East England, as well as Birmingham, Manchester and Leeds.

**Figure 6.9: Distribution of agency spending as a percentage of total pay bill by NHS Trust, England, 2010/11**

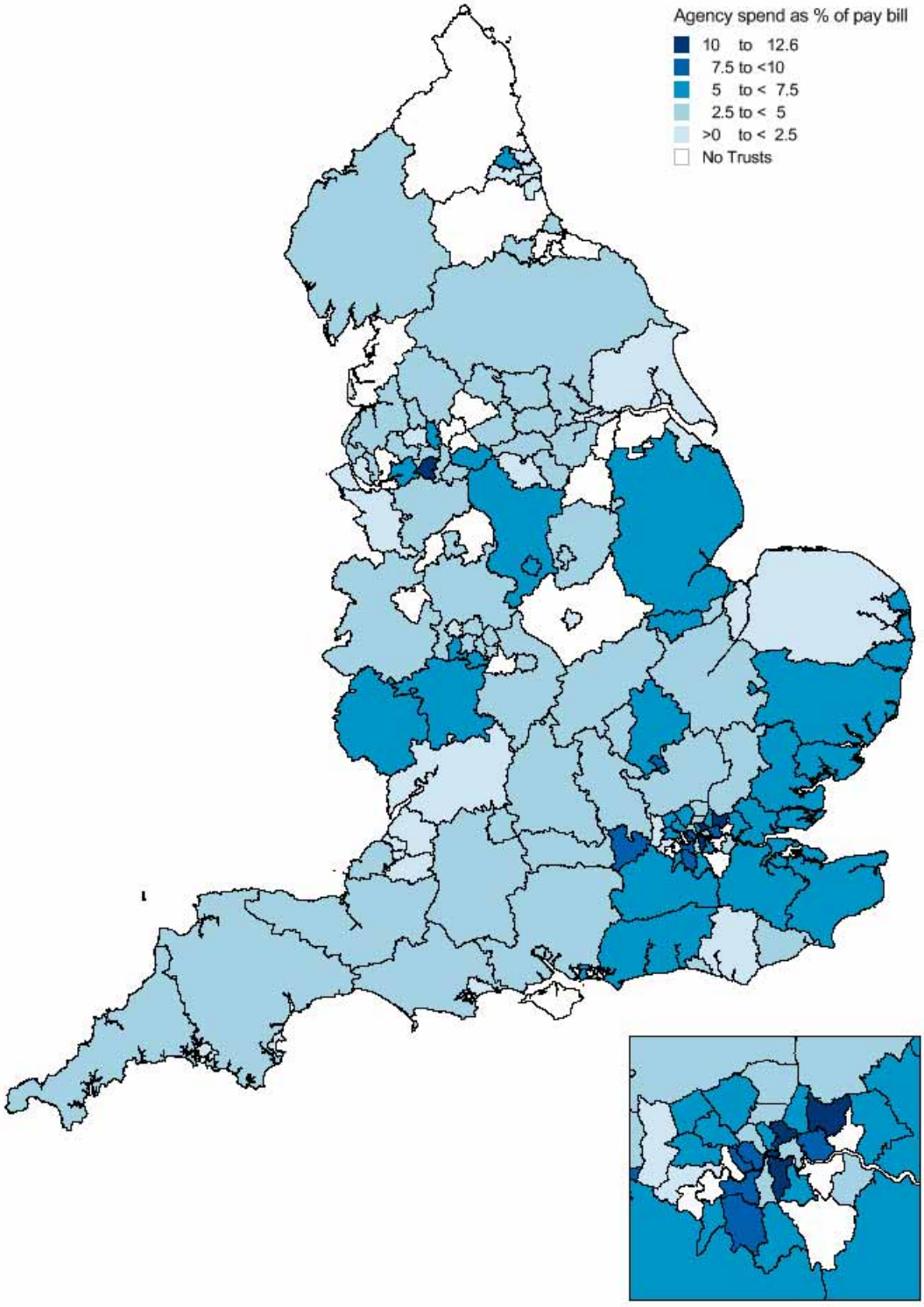



*Source: Department of Health.*

[5] Acute, mental health, ambulance and community provider Trusts.

[6] Data include medical and dental pay bill and spend on agency staff, and are inclusive of employers' on-costs.

**Figure 6.10: Agency spending as a percentage of total pay bill in NHS Trusts, by PCT area, 2010/11**




*Source: OME calculations based on data supplied by the Department of Health.*
*Includes medical and dental agency spend and pay bill.*

## Our Comment

6.19 The national data, as we noted in our Twenty-Sixth Report, give a fairly stable and healthy impression of recruitment and retention[7]. These more detailed data, however, show that circumstances in individual organisations can be very different to the more benign national-level statistics, with recruitment and retention indicators tending to be relatively worse on average in London and, albeit to a lesser extent, areas surrounding London – despite the existence of high cost area supplements (HCAS) – as well as large cities elsewhere in England.

6.20 However, this general trend has exceptions: neighbouring organisations can have quite different recruitment and retention situations; and few organisations have consistently good or poor results across all indicators in our analysis. This may be one factor underlying the current low usage of RRP, the data for which we explore in more detail below.

## Usage of RRP

6.21 Previous analysis of the usage of RRP has been at the aggregated levels of SHA and staff group totals, to which both the Department and NHS Employers (NHSE) have referred in their evidence for this review.

6.22 The Department of Health provided, at our request, detailed data on the usage of RRP in each organisation in England, identifying the number of staff in each staff group in receipt of RRP, as well as the distribution of the size of these payments.

6.23 Table 6.1 shows the number and percentage of staff[8] paid a "long-term" or a "general" RRP[9]. The vast majority of RRP in payment are long-term, so these form the initial focus of the analysis.

**Table 6.1: Number and percentage of staff paid a RRP in England, September 2010**

| | Number | % of total |
|---|---|---|
| Total FTE staff in the sample | 883,586 | 100 |
| Total paid long-term RRP | 49,479 | 5.60 |
| Total paid general RRP | 2,154 | 0.24 |

*Source: Department of Health.*

## Long-Term RRP

6.24 Long-term RRP (LTRRP) are defined on the Electronic Staff Record HR System (ESR)[10] as "any form of RRP funded from the Department of Health"[11]. This does not correspond to its definition under AfC (see Box 4.1), and does not make the distinction between local and national RRP, so we are unable to establish which payments denoted as LTRRP on ESR have been determined by local employers, and which payments have resulted from national negotiation. The analysis which follows necessarily uses the ESR definition, which limits the conclusions we are able to draw.

[7] NHSPRB (2012) *Twenty-Sixth Report*, TSO (Cm 8298), paragraph 3.88.

[8] All data relate to full time equivalent (FTE) staff and are as at September 2010, the latest published census at the time the data were provided. The data have been subject to certain filters by the Department, meaning that our analysis is based on a sample of NHS non-medical staff, representing 90% of the total.

[9] The Electronic Staff Record HR system, used in all but two NHS organisations, classifies RRP differently to the Handbook: Long-term RRP are defined as being those funded by the Department of Health; General RRP are defined as being any form of RRP excluding those funded by the Department of Health.

[10] A HR and payroll database used by all NHS organisations in England, with the exception of two Foundation Trusts.

[11] Source: HSCIC.

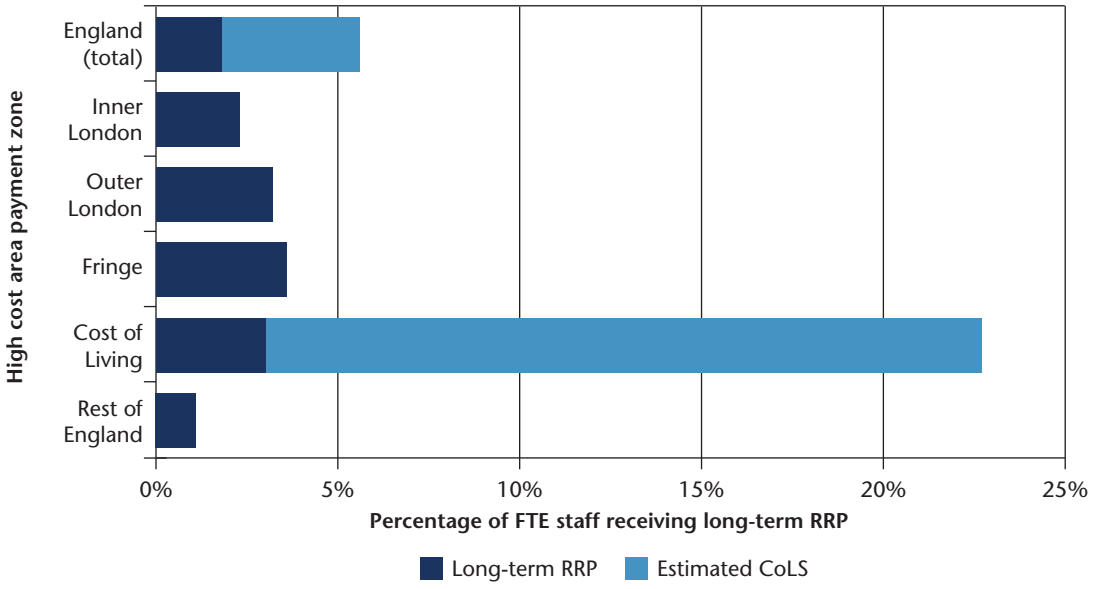
6.25 Table 6.1 above shows that around 5.6% of full time equivalent (FTE) staff were paid a LTRRP in September 2010, which would appear to indicate that the usage of and familiarity with such payments is common. However, we show in Appendix F that the majority of LTRRP are likely to be pre-AfC legacy payments known as CoLS, which were paid to nurses and professions allied to medicine in the South of England from 2001[12]. We have therefore calculated revised figures for LTRRP, excluding the estimated number of CoLS.

*Revised Figures*

6.26 Figure 6.11 shows the *revised* percentage of staff paid a LTRRP, and separately the estimated percentage paid CoLS, by high cost area payment zone (which correspond to the zones in Figure F3 in Appendix F). Of the 22.6% of FTE staff in the former Cost of Living zone who were paid a LTRRP, an estimated 19.6% were CoLS – i.e. all these payments had a value of £600 or less, and were paid to staff groups formerly eligible for CoLS.

6.27 The revised percentage of staff in England paid a LTRRP in September 2010 was 1.8%, and the revised number of LTRRP was 16,154 – less than a third of the figure in Table 6.1. Within this revised figure, about a quarter are likely to be the national RRP for maintenance craft workers, which in September 2010 (the reference date for our analysis) were not yet in the process of being withdrawn[13].

**Figure 6.11: Revised percentage of staff paid a LTRRP, and estimated CoLS, by high cost area payment zone, England, September 2010**




*Source: OME calculations based on data supplied by the Department of Health.*

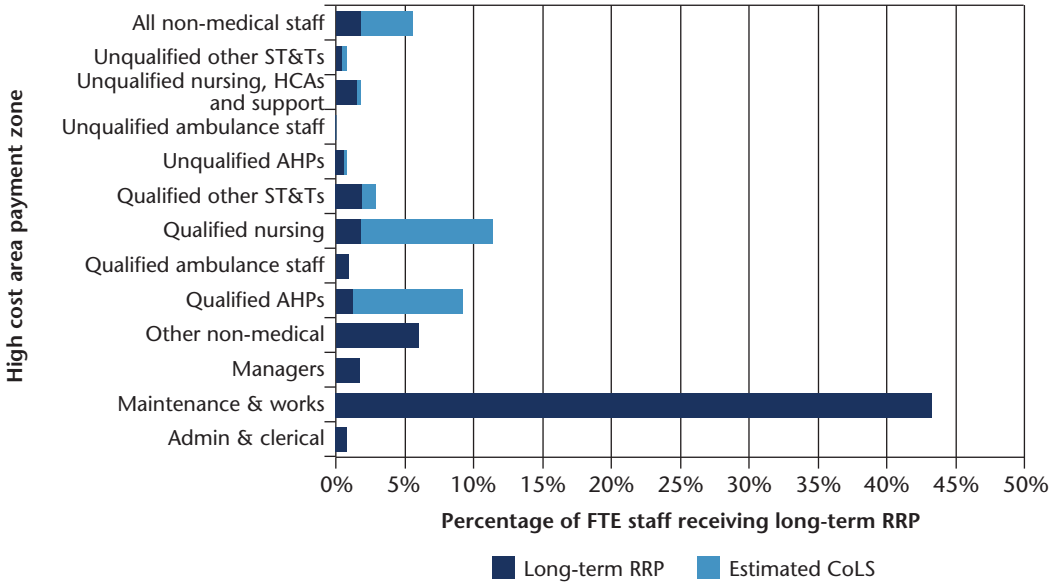
6.28 Figure 6.12 shows the revised percentage of each staff group paid a LTRRP. Only maintenance and works, and "other" staff[14], have more than 2% of FTE staff paid a LTRRP when estimated CoLS are accounted for.

[12] Further information on Cost of Living Supplements is in Box F1 in Appendix F.

[13] The National RRP for maintenance craft workers ceased on 1 April 2011, with payments being protected over a two-year period. See NHS Staff Council (2011) *Pay Circular (AforC) 3/2011*. Available from: http://www.nhsemployers.org/Aboutus/Publications/PayCirculars/Documents/Pay_Circular_AforC_3-2011.pdf

[14] "Other" staff comprised around 1,000 FTE in the sample, and our examination of the data suggests that it is very likely that nearly all the LTRRP in the data can be associated with CoLS.

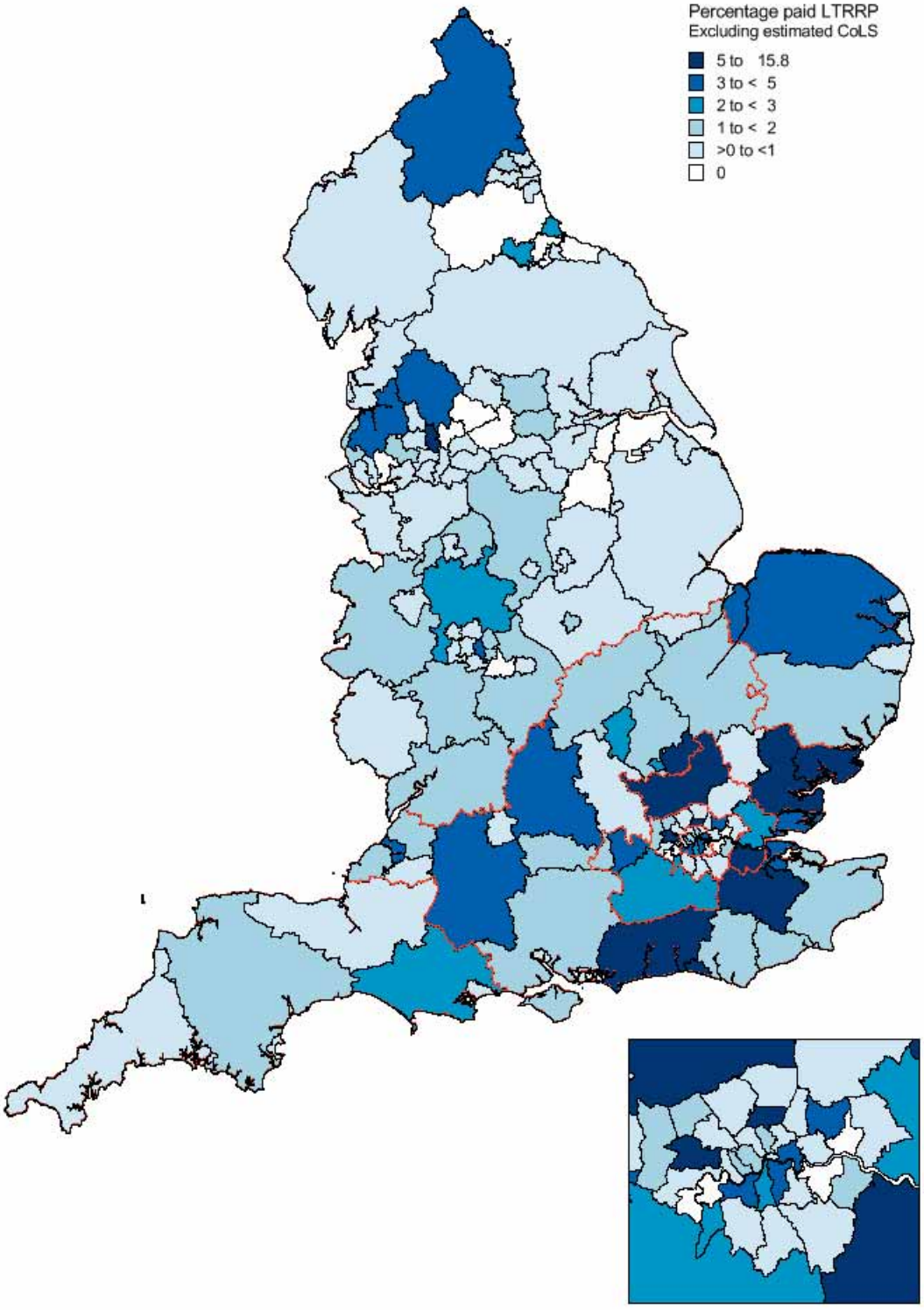
**Figure 6.12: Revised percentage of FTE staff paid a LTRRP, and estimated CoLS, by staff group, England, September 2010**




*Source: OME calculations based on data supplied by the Department of Health.*

6.29 Figure 6.13 shows the variation in the revised percentage of staff paid a LTRRP (excluding CoLS) at PCT level. A minority of PCTs – predominately in the South East and cities – paid more than 2% of staff a LTRRP.

**Figure 6.13: Revised percentage of FTE staff paid a LTRRP by PCT area, September 2010**




*Source: OME calculations based on data supplied by the Department of Health.*
*Red lines indicate the boundaries of pay supplement zones (see Figure F3 in Appendix F).*

## General RRP

6.30 General RRP (GRRP) are defined on ESR as "any form of RRP excluding those funded from the Department of Health"[15]. This does not correspond to any AfC definition of RRP, but could arguably be said to align most closely with local RRP.

6.31 As shown in Table 6.1 above, there were very few GRRP in payment in September 2010. The majority of organisations (275 out of 420) did not pay any GRRP in September 2010, and only 23 organisations paid more than 1% of their staff a GRRP.

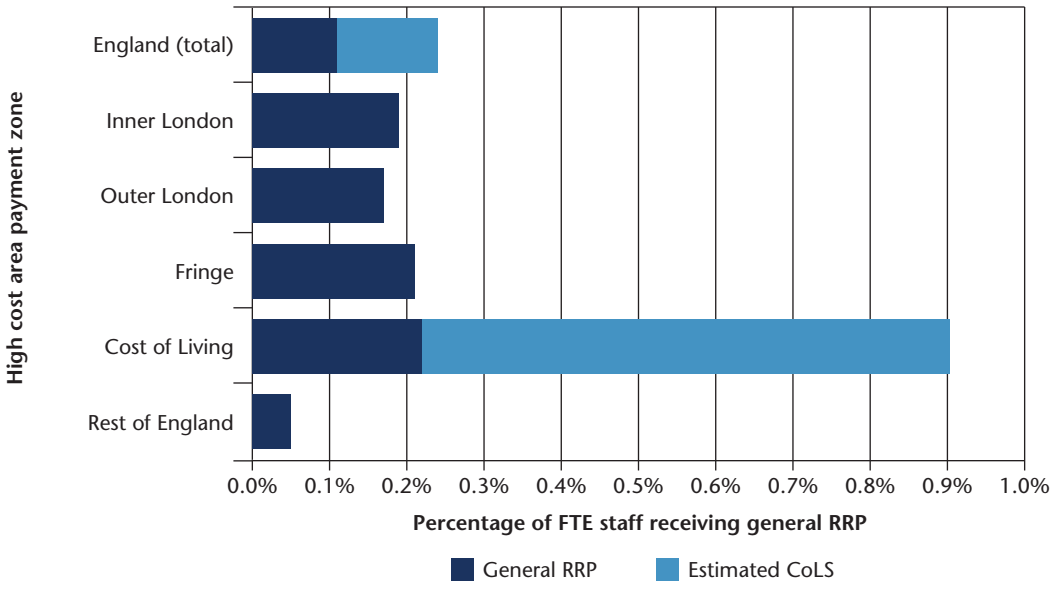
6.32 Despite the ESR definition that GRRP excludes those funded from the Department of Health, our analysis has found that, of those organisations with the highest (albeit still quite small) percentages of FTE staff paid a GRRP, a disproportionate number of them were again located in the geographical area formerly covered by CoLS. It therefore seems likely that some CoLS were erroneously recorded on ESR as GRRP, instead of LTRRP. We have estimated the number of CoLS using the same assumptions as before in order to calculate revised figures for the number of GRRP in payment.

### *Revised Figures*

6.33 The revised percentage of staff paid a GRRP is 0.11%, as shown in Figure 6.14. The revised percentage of staff in the former Cost of Living zone paid a GRRP is 0.22%, substantially lower than the initial estimate of 0.9%, and more in line with the percentages in the London and Fringe areas. Maintenance and works staff were the most likely to be paid a GRRP, followed by managers (Figure 6.15).

6.34 Figure 6.16 shows the revised variation in the percentage of staff paid a GRRP at PCT level. Percentages are very low throughout – the maximum being 1.3%[16] – but were highest in the South of England.

**Figure 6.14: Revised percentage of staff paid a GRRP, and estimated CoLS, by high cost area payment zone, England, September 2010**

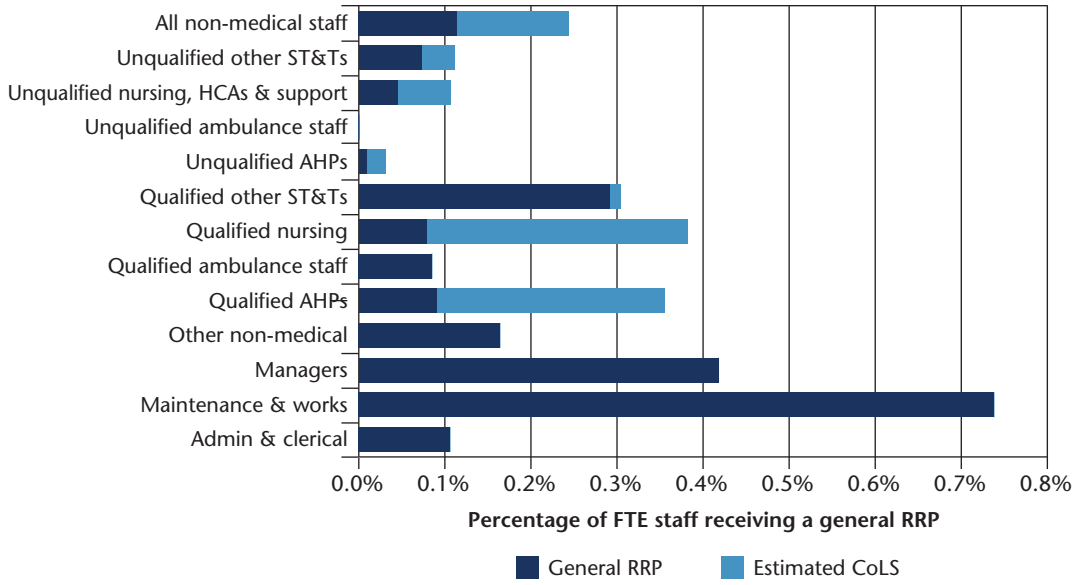



*Source: OME calculations based on data supplied by the Department of Health.*

[15] Source: HSCIC.

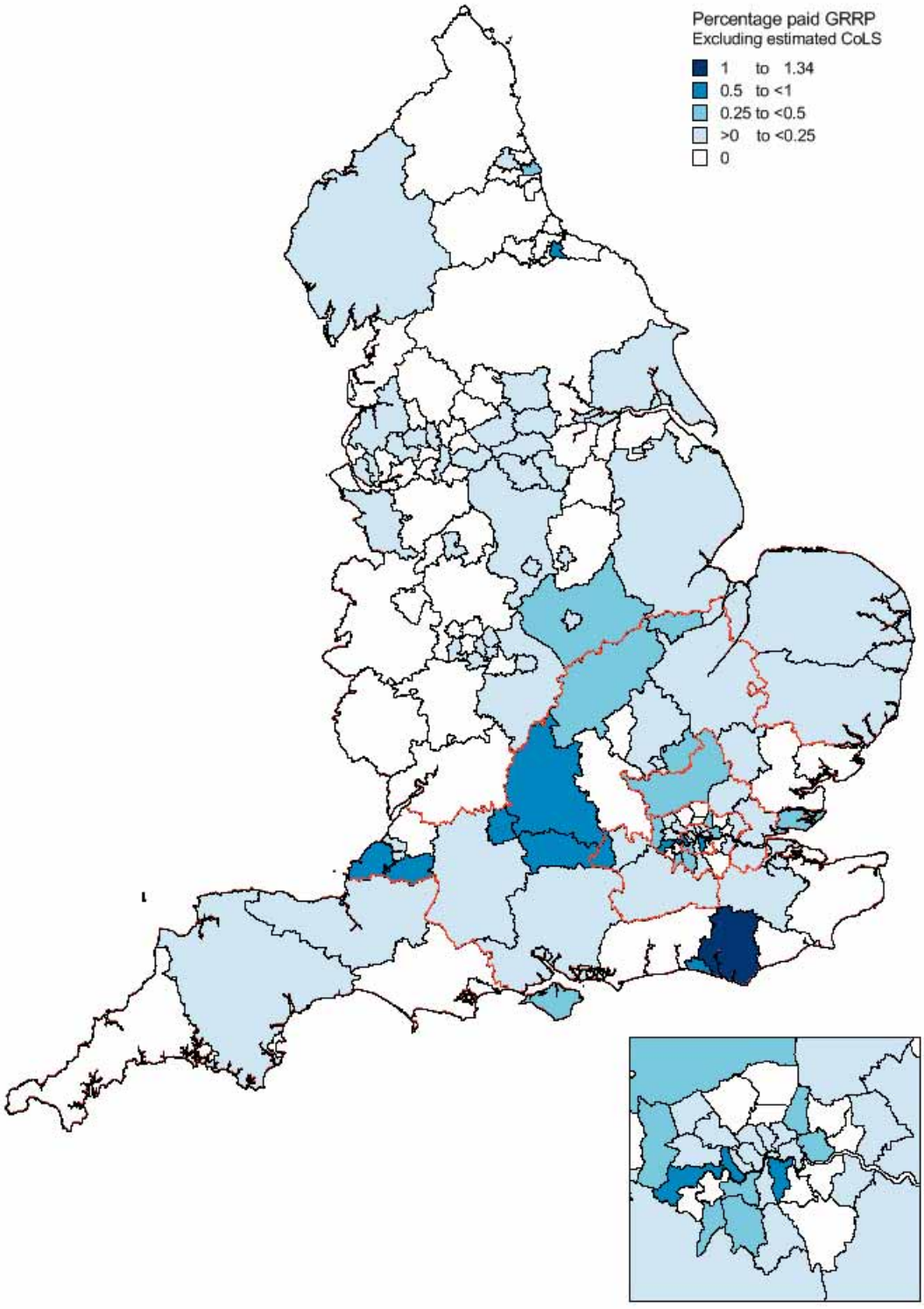
[16] The highest percentage in any single organisation was 2.3%.

**Figure 6.15: Revised percentage of FTE staff paid a GRRP, and estimated CoLS, by staff group, England, September 2010**




*Source: OME calculations based on data supplied by the Department of Health.*

**Figure 6.16: Revised percentage of FTE staff paid a GRRP by PCT area, September 2010**




*Source: OME calculations based on data supplied by the Department of Health.*
*Red lines indicate the boundaries of pay supplement zones (see Figure F3 in Appendix F).*

## Our Comment

6.35 The majority of RRP in payment are likely to be legacy CoLS payments. Once these are accounted for, it is clear that NHS organisations make very little use of RRP, as shown in Table 6.2. Furthermore, the revised totals include the national RRP for maintenance craft workers, and are likely to include other "transitional" national RRP for a range of other occupations. The low usage of this mechanism could be due to a number of factors, including:

- Trusts being unwilling to "bid-up" the price of staff or cause pay spirals where the problem is one of national skill shortages, related to inaccurate workforce planning and lack of sufficient education and training;
- Employers seeing RRP as a last resort, to be used only when all other avenues have been exhausted;
- The need for non-Foundation Trusts to consult neighbouring organisations and their SHA;
- Lack of awareness that this measure exists in the recruitment toolkit;
- Local affordability concerns; and
- RRP not being necessary because of the current prevailing labour market conditions.

**Table 6.2: Revised number and percentage of staff paid a RRP in England, September 2010**

| | All RRP in payment | | Revised RRP in payment | |
|---|---|---|---|---|
| | Number | % of sample | Number | % of sample |
| Total paid LTRRP | 49,479 | 5.60 | 16,154 | 1.83 |
| Total paid GRRP | 2,154 | 0.24 | 1,006 | 0.11 |

*Source: OME calculations based on data supplied by the Department of Health.*

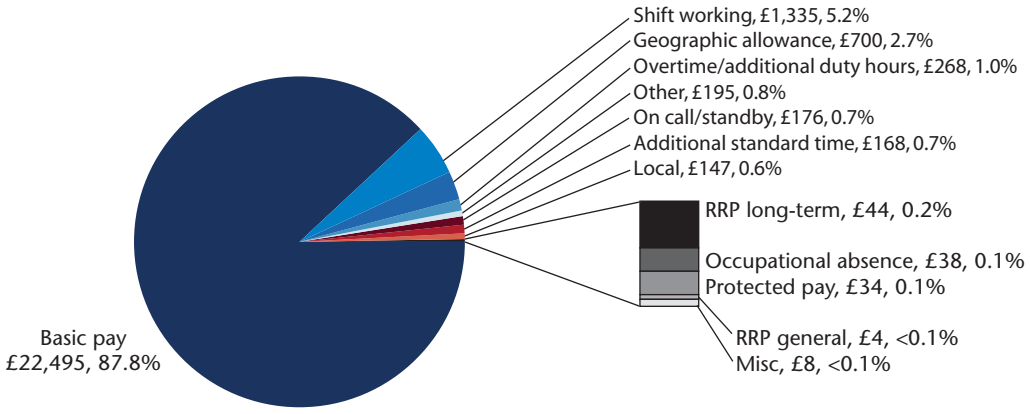
## Variation in Basic Pay and Total Earnings

6.36 Having determined that the specific flexibility of RRP is rarely used, we now explore the extent to which pay in the NHS varies in other ways.

## Breakdown of Total Earnings

6.37 For non-medical staff in England in the calendar year 2011, average total earnings per headcount staff were around £25,600, of which all but one-eighth was basic pay (Figure 6.17). The next largest component of total earnings was shift working, which relates to payments for shifts and unsocial hours, but not to overtime which is shown separately. Geographical allowances and RRP together comprised 3.1% of total average earnings in England.

**Figure 6.17: Estimated breakdown of average total earnings for non-medical staff in England, 2011**




*Source: OME calculations based on organisation-level data supplied by the HSCIC.*
*National averages were calculated by weighting organisation-level data by staff numbers as at October 2011.*

## Variation by Organisation

6.38 Figure 6.18 shows the distribution of mean total earnings in NHS organisations[17]. Average total earnings ranged from £16,800 to £57,000, and organisations in London and the Fringe were clustered at the upper end of the distribution, reflecting that all staff in these organisations are paid HCAS.

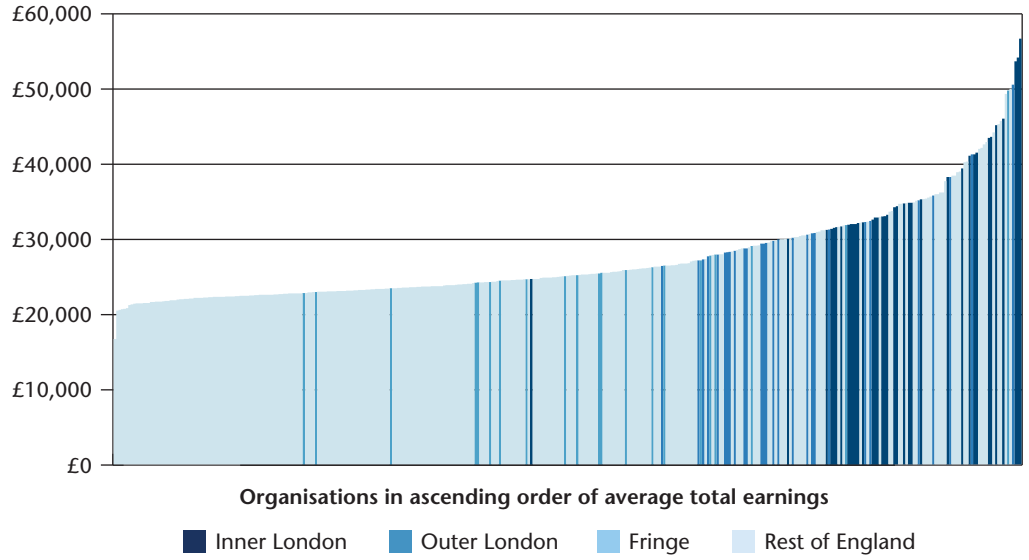
6.39 Figure 6.19 shows the distribution of mean basic salary in NHS organisations, which ranged from £14,700 to £48,000. Organisations in London again dominated the upper end of the distribution, despite removing the effect of HCAS. This could be due to differences in skill mix and organisation type, which we explore later in this section; it could also be due in part to higher proportions of staff working full time in London than outside[18]: as these figures are based on headcount staff this is not addressed. Figure 6.20 shows the variation in average basic pay across England, aggregated to PCT level: organisations in Manchester, Liverpool and Birmingham also had higher than average basic pay[19].

[17] This is limited to those organisations which had 12 months of earnings data in 2011, so organisations established or closed during that time have been excluded.

[18] As shown by a comparison between headcount and FTE staffing levels by SHA. See HSCIC (2012) *NHS Non-Medical Workforce Census 2011 (Detailed Results)*, Table 2.1.

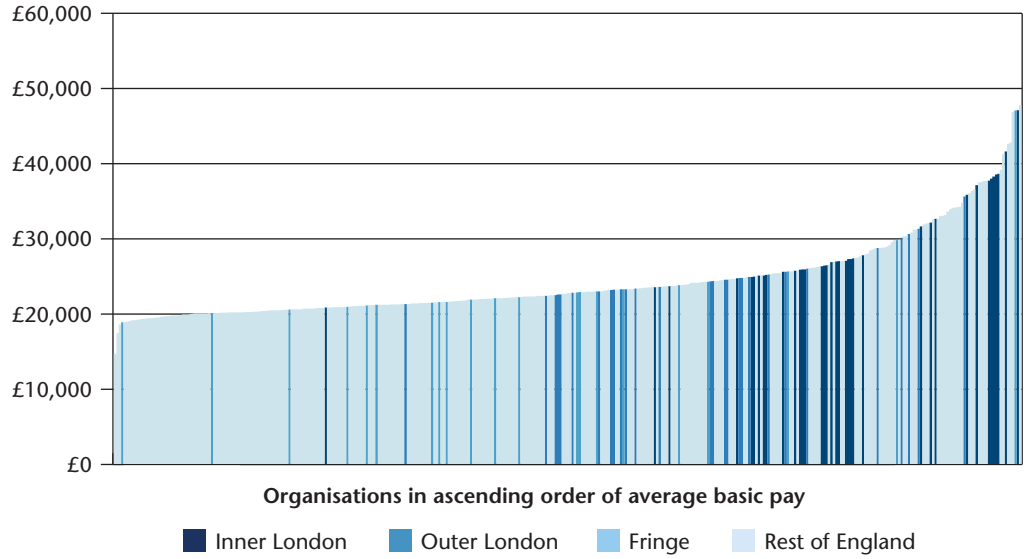
[19] Higher than average basic pay in parts of the North East and Lincolnshire reflect that only one organisation – a Primary Care Trust – is headquartered within each of these boundaries, and organisations of this type tend to employ a higher proportion of managerial staff.

**Figure 6.18: Distribution of mean total earnings in NHS organisations in England, 2011**



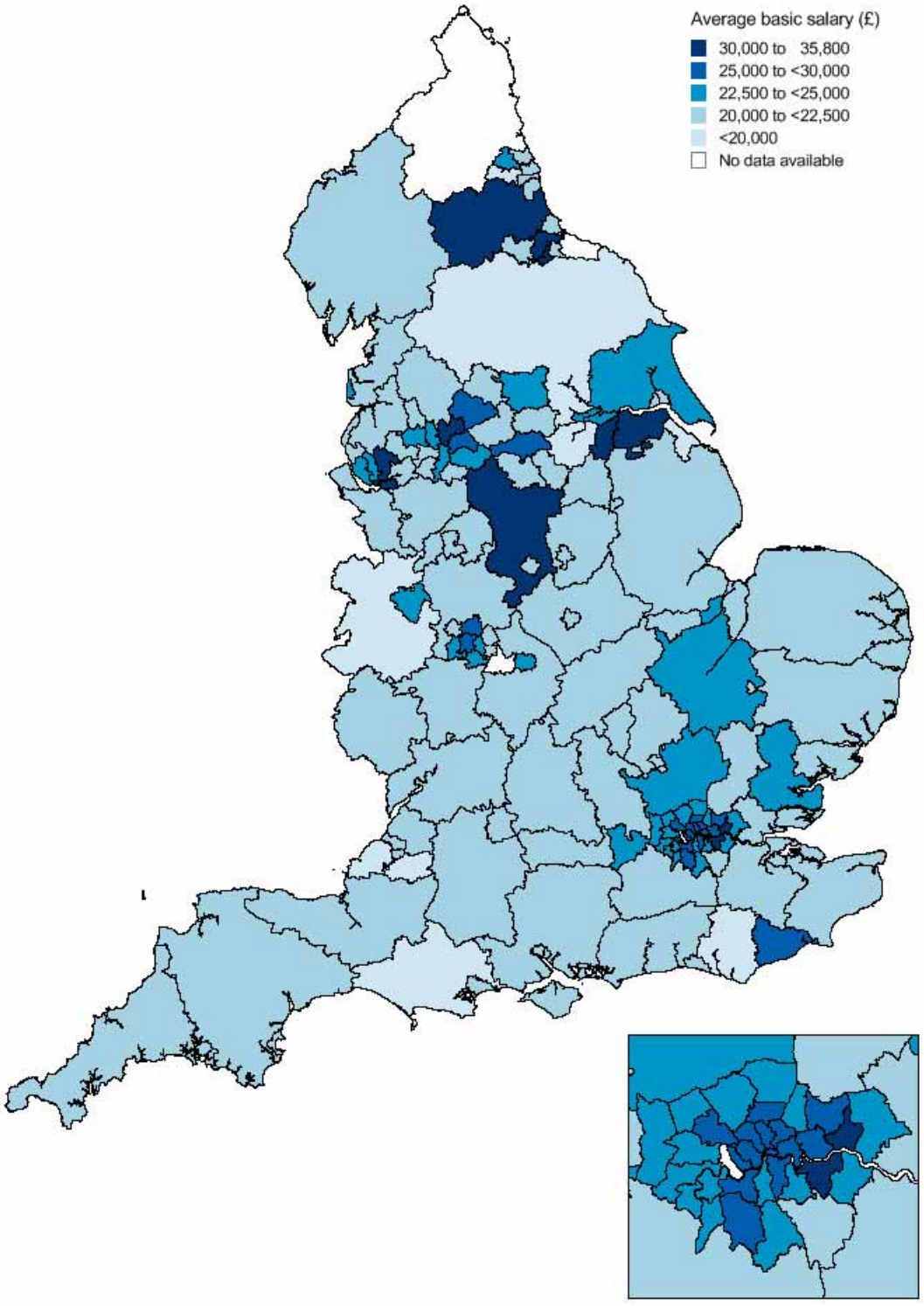

*Source: HSCIC.*

**Figure 6.19: Distribution of mean basic pay in NHS organisations in England, 2011**




*Source: HSCIC.*

**Figure 6.20: Mean basic salary for non-medical staff by PCT area, 2011**

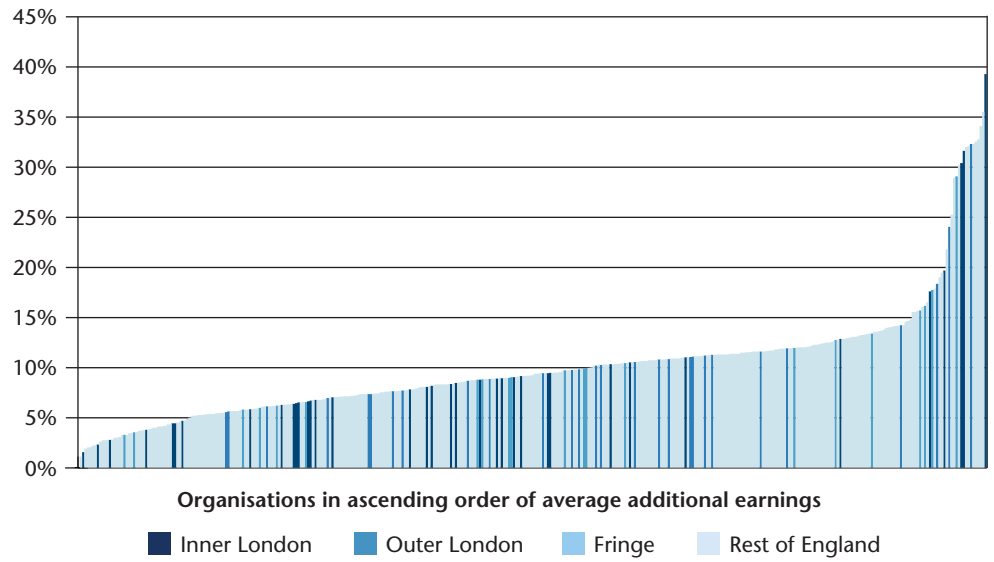



*Source: OME calculations based on data supplied by the HSCIC.*
*Crown copyright and database right 2012.*

*Variable Elements of Pay*

6.40 Figure 6.17 above showed that additional elements of pay – excluding HCAS – comprised 9.5% of total average earnings in England. Figure 6.21 expresses these additional elements – excluding HCAS – as a percentage of average basic pay, by NHS organisation. On average, staff in organisations in London appear to have relatively lower additional earnings (in the form of overtime, etc.) than is the case in the Rest of England. As shown above, however, this is offset by higher basic pay. Staff in Ambulance Trusts have the highest additional earnings on average, reflecting high levels of shift work and overtime.

**Figure 6.21: Distribution of additional earnings (excluding HCAS) as a percentage of basic pay, NHS organisations in England, 2011**




*Source: OME calculations based on data supplied by the HSCIC.*

*Factors Influencing Average Basic Pay and Total Earnings*

6.41 It is clear that organisations in London and cities have higher than average basic pay per headcount staff, but our analysis shows that average basic pay is also influenced by differences in workforce composition and organisation type.

6.42 We have used regression analysis to quantify the influences of geography[20], organisation type[21] and the composition of the workforce[22] in each organisation, on organisation-level average total earnings and basic salary. Regression coefficients for the models fitted are in Tables F2 and F3 in Appendix F.

- All other things being equal (i.e. allowing for organisation type and workforce composition), organisations in Inner and Outer London respectively had average total earnings £9,400 and £5,800 higher than the Rest of England[23]. Average total earnings in the Fringe were not significantly different to the Rest of England;

[20] Dummy variables identifying whether organisations are located in Inner London, Outer London or the Fringe.

[21] Dummy variables identifying the 13 types of organisation, for example large acute Trust, specialist acute Trust, and Primary Care Trust.

[22] In this analysis the workforce was divided into 12 occupational groups: qualified nurses; qualified AHPs; qualified healthcare scientists; qualified other ST&T; qualified ambulance; support to doctors and nursing staff; support to ST&T staff; support to ambulance staff; central functions; hotel, property and estates; senior managers; and managers.

[23] Excluding London and the Fringe HCAS zones.

- Average total earnings for staff employed in SHAs were £7,650 higher than in large acute Trusts (the reference group), all other things being equal. Average total earnings in mental health/learning disability Trusts were £1,700 higher than in acute Trusts, with other types of organisation not having significantly different earnings;

- All else being equal, average basic salaries in Inner and Outer London were respectively £4,200 and £1,500 higher than in the Rest of England. Basic salaries in the Fringe zone were not significantly different to the Rest of England;

- Average basic salaries in SHAs were £9,000 higher than in large acute Trusts, controlling for geography and workforce composition; average basic salaries in mental health/learning disability Trusts and PCTs were also significantly higher.

6.43 Further regression analysis, using the sMFF instead of London and Fringe variables, shows that an increase of 0.01 in the sMFF is associated with an increase of £251 in average total earnings per headcount, and an increase of £95 in basic pay per headcount, allowing for organisation type and workforce composition (see Tables F4 and F5 in Appendix F).

## Our Comment

6.44 There is considerable variation in average basic pay and total earnings when comparing NHS organisations. Some of this variation can be explained by differences in organisation type and workforce composition, but after allowing for these factors it can be shown that average basic pay in London is significantly higher than in the Rest of England. More generally, we have found that organisations with higher sMFF values tend to pay, on average, higher basic salaries and total earnings, though this follows from the fact that sMFF values are highest in London and the Fringe.

6.45 The finding that average *total earnings* in Inner and Outer London are higher than the rest of the country is self-evident, given that HCAS are worth 20% and 15% respectively in these zones (subject to minima and maxima). An unexpected finding is that average *basic salaries* are significantly higher in London, even after allowing for differences in organisation type and workforce composition. We have already shown that usage of RRP in London is only slightly higher than in the rest of the country, so it could be that London-based NHS organisations respond to labour market conditions instead by offering higher basic salaries, i.e. higher AfC bands. This is explored further below.

## Variation in AfC Pay Bands by Occupation

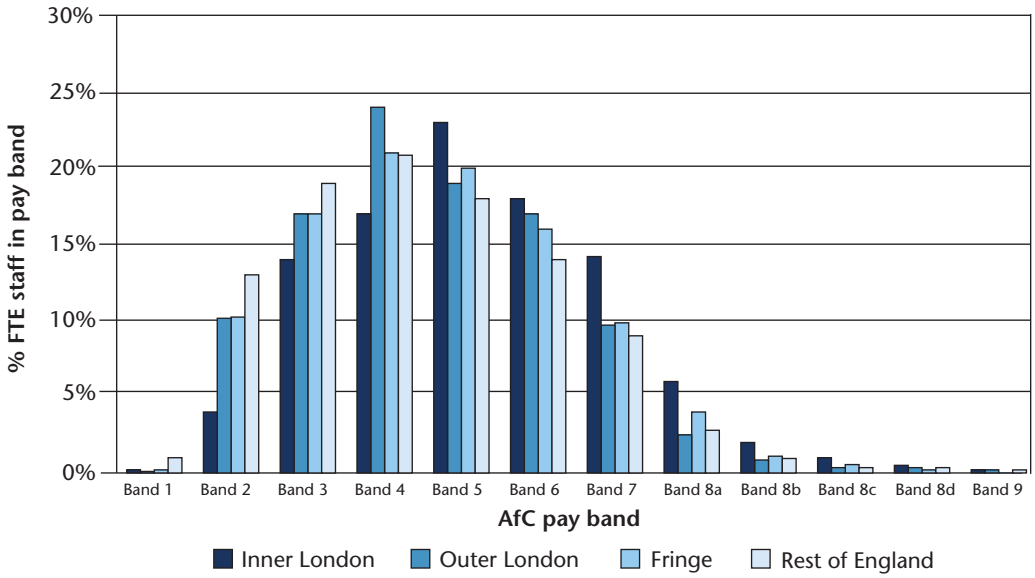
6.46 The HSCIC provided, at our request, the distribution on AfC pay bands of 14 specific NHS occupations[24]. We have examined these data to see whether there is a general pay differential in London over and above that provided by high cost area supplements.

6.47 The 14 occupations were chosen such that there was a spread of occupation types, each with a "critical mass", that is, there being a good chance of most NHS organisations employing staff of this type. Between them, these occupations comprised over half (51%) of the non-medical workforce. All data relate to full time equivalents as at November 2011, and were obtained on request from the HSCIC.

[24] As defined by the three-character standard occupation codes, of which there are over 400, used by NHS organisations: **G2A** (Central Functions – Clerical & Administrative); **G2D** (Clinical Support – Clerical & Administrative); **H1A** (Acute, Elderly & General – Healthcare Assistants); **N2C** (Maternity Services (including special care baby units) – Qualified Midwife); **N3H** (Community Services – Health Visitor); **N6A** (Acute, Elderly & General – Nurse – Other 1st level); **N9A** (Acute, Elderly & General – Nursing Assistant/Auxiliary); **NCA** (Acute, Elderly & General – Nurse – Modern Matron); **NFA** (Acute, Elderly & General – Nursing Assistant Practitioner); **S1C** (Occupational Therapy – AHP – Therapist); **S1E** (Physiotherapy – AHP – Therapist); **S1F** (Radiography (Diagnostic) – **AHP** – Therapist); **S2P** (Pharmacy – Qualified – Scientist); **S3P** (Pharmacy – Qualified – Scientific Officer).

6.48 The distribution on AfC bands of clerical and administrative staff, based in central functions (coded as G2A on the ESR system) is shown in Figure 6.22. This occupation code encompasses a broad range of job roles such as receptionists, medical records staff, and middle managers; the distribution of staff on AfC pay bands is therefore similarly broad. The distribution on pay bands of G2A staff in Inner London, and to a lesser extent Outer London and the Fringe, is different to that in the Rest of England: there are proportionally more staff on higher pay bands in London.

**Figure 6.22: Distribution of G2A* staff on AfC pay bands, by HCAS zone, England, November 2011**

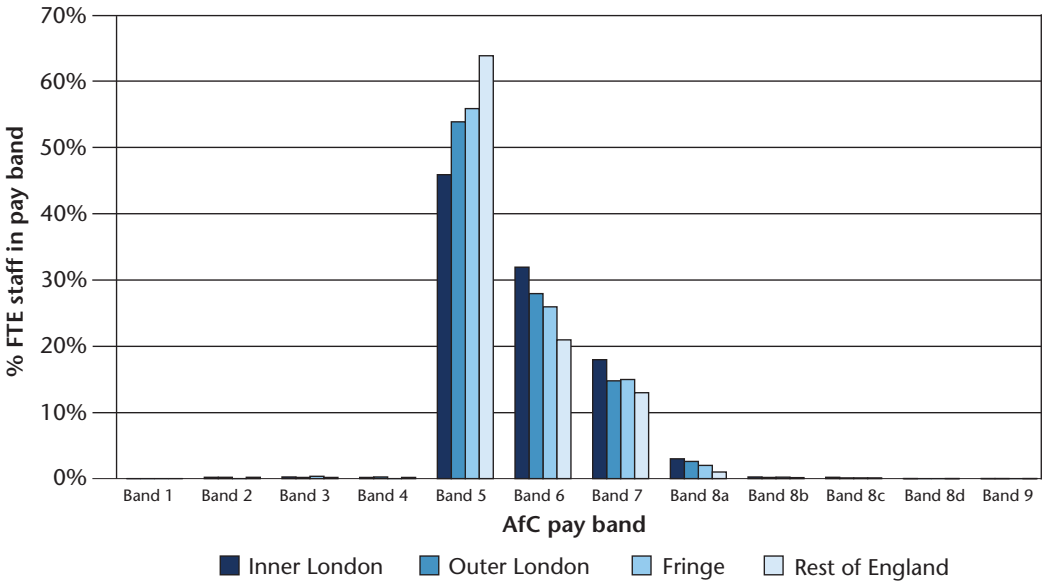



** Clerical and administrative – central functions.*

*Source: HSCIC.*

6.49 Figure 6.23 shows the distribution on AfC bands of "Other 1st Level Nurses", working in acute, elderly and general care (coded as N6A on ESR) – the most populous occupation code for qualified nurses. The starting salary for N6A staff is Band 5 and few staff are paid below this level (and those that are, are likely to have been erroneously recorded as such). Nurses can then progress through the bands by becoming team leaders, ward managers and so on. In London and the Fringe, proportionally more N6A staff are paid on higher pay bands than in the Rest of England.

**Figure 6.23: Distribution of N6A* staff on AfC pay bands, by HCAS zone, England, November 2011**



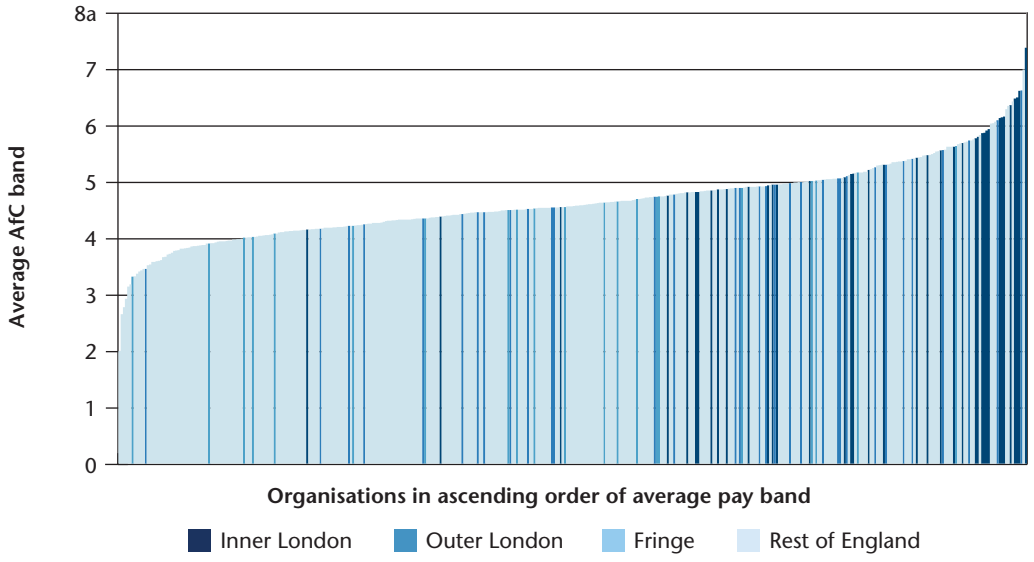

** Other 1st level nurse – acute, elderly & general care.*

*Source: HSCIC.*

6.50 By expressing AfC bands in a wholly numeric scale[25], the mean average pay band can be calculated. For G2A in England as a whole, the average pay band was 4.5; for N6A staff, the average pay band was 5.6.

6.51 Figures 6.24 and 6.25 show respectively the distribution at organisation level of the average pay band for G2A and N6A. A large proportion of the organisations at the upper end of the distributions were located in London or the Fringe, which follows from the Figures above.

**Figure 6.24: Distribution of the average AfC pay band for G2A* staff in NHS organisations in England, November 2011**

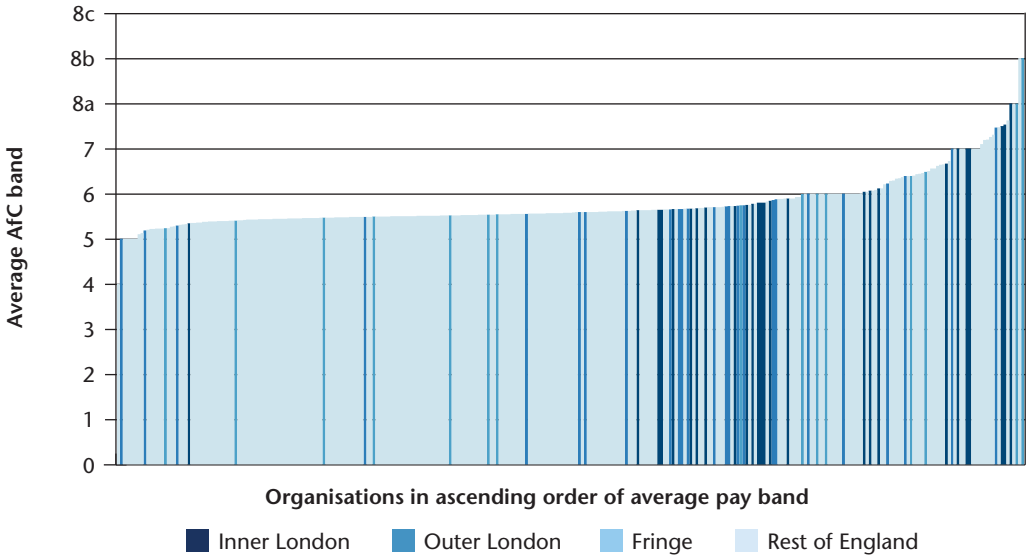



** Clerical and administrative – central functions.*

*Source: OME calculations based on data supplied by the HSCIC.*

[25] Band 1=1 and so on until Band 8a=8, Band 8b=9, 8c=10, 8d=11 and Band 9=12.

**Figure 6.25: Distribution of the average AfC pay band for N6A* staff in NHS organisations in England, November 2011**




** Other 1st level nurse – acute, elderly & general care.*
*Source: OME calculations based on data supplied by the HSCIC.*

6.52 Using regression analysis to control for organisation type, we have found that G2A staff in Inner and Outer London respectively had an average pay band 0.83 and 0.38 higher than the Rest of England (see Table F6 in Appendix F) – i.e. there were proportionally more G2A staff on higher bands in London than in the Rest of England. The average band in the Fringe was not statistically significantly different from the Rest of England. For N6A staff, the average pay band in Inner London was 0.47 higher than the Rest of England (see Table F7 in Appendix F), but average bands in Outer London and the Fringe were not statistically significantly different from the Rest of England.

6.53 Other occupations which demonstrate a statistically significant upward bias in average AfC banding in Inner London included clerical and administrative staff based in clinical support (for example ward clerks), qualified midwives, occupational therapists and diagnostic radiographers. Other occupations in the analysis either had no statistically significant difference in average bands for London-based staff[26], or else the regression model was not robust[27]. It should also be noted that even where the London effect is statistically significant, the regression model explains only a fraction of the variability in the data: there are other, unobserved, factors influencing average pay bands, beyond organisation type and HCAS zone.

## Our Comment

6.54 Earlier in this chapter, we demonstrated that average basic pay was significantly higher in London than in the Rest of England, allowing for organisation type and workforce composition. Looking more closely at the grade mix of certain large occupational groups, we have found some evidence that, for some occupations, there are proportionally more staff on higher bands in Inner London than in the Rest of England.

[26] This result was found for: healthcare assistants in acute, elderly and general care (code H1A); qualified pharmacists (S2P); and pre-registration pharmacists (S3P).

[27] This result was found for: health visitors (code N3H); nursing assistants/auxiliaries in acute, elderly and general care (N9A); modern matrons in acute, elderly and general care (NCA); nursing assistant practitioners in acute, elderly and general care (NFA); and physiotherapists (S1E).

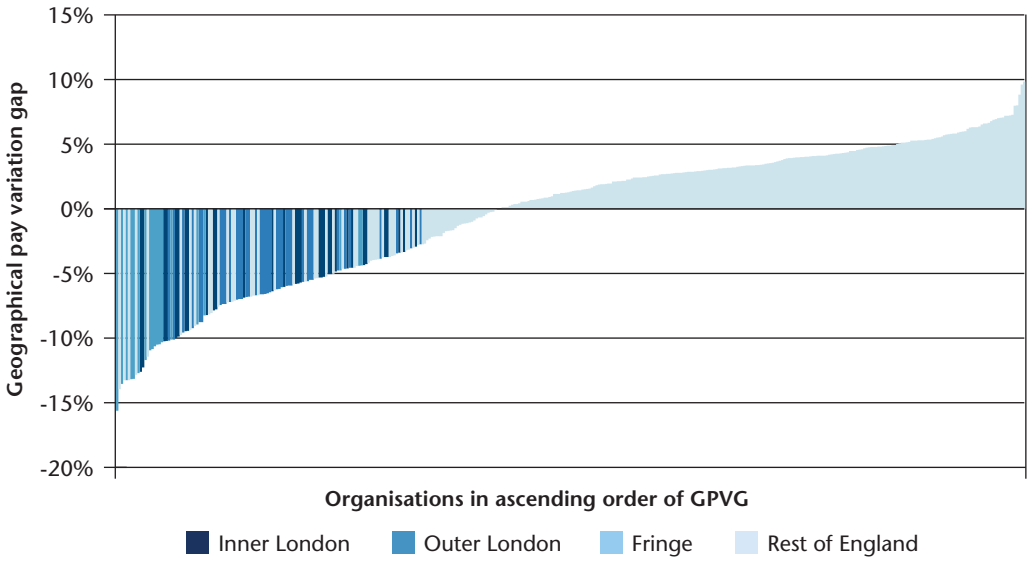
6.55 It could be that NHS organisations in London, instead of using the flexibilities afforded by RRP, use basic pay as a recruitment and/or retention tool – either by redesigning posts such that they can be placed in a higher band, or through grade drift, but many other factors could also be driving this pattern, such as the mix of job roles in Inner London possibly being different to the Rest of England, or greater proportions of lower-paying jobs having been outsourced in London.

## The Relationship Between Relative Pay in the NHS and Private Sector, and Recruitment, Retention, Motivation and Patient Experience

6.56 In paragraphs 5.6 to 5.11, we summarised the Department's evidence relating to the relative pay variability in the NHS and the private sector: the Department constructed an index of HCAS and RRP payments as a percentage of basic pay, and compared this to the sMFF, an index of private sector pay, to produce a variable which it called the "geographical pay variation gap" (GPVG). This in effect measures the difference between an NHS organisation's pay relative to the NHS average, and private sector pay in that location relative to the private sector average. For example, an organisation which paid 5% more than the NHS average, but which was located in an area where private sector pay was 10% above the private sector average, would have a GPVG of -5%. Figure 6.26 shows the distribution of GPVG for NHS organisations.

- No organisations within current HCAS zones have a positive GPVG – in fact, none are higher than -2.7%. Even with HCAS, NHS pay in these areas, relative to the average, is lower than the relative position in the private sector.
- Most organisations in the Rest of England have a GPVG greater than zero. Although these organisations all have below-average NHS pay on the Department's measure[28], private sector pay in these areas is lower still (relative to its own average).

**Figure 6.26: Distribution of GPVG across NHS organisations**




*Source: Department of Health.*

[28] Most organisations have below-average NHS pay on the Department's measure, as the mean average is skewed upwards because of HCAS payments.

6.57 Figure 6.27 shows GPVGs for NHS provider organisations on a map of England. Organisations in the Fringe have the most negative values, followed by North and West London and areas just outside the Fringe, then South and East London and the wider South East of England. This pattern suggests that HCAS payments have not kept pace with relative pay in the private sector.

6.58 The Department provided correlation statistics showing the relationship between GPVG and recruitment and retention indicators (see paragraphs 5.10 to 5.11), which in the Department's view supported the case for more market-facing pay: in areas where the NHS "underpays", average vacancy rates, leaving rates and usage of agency staff were all higher than in areas where the NHS "overpays". We explore these relationships in more detail below, and supporting Figures can be found in Appendix F.

6.59 Recruitment, retention and earnings:

- Total vacancy rates (Figure F5), leaving rates (Figure F6) and the percentage of pay bill spent on agency staff (Figure F7) all increase, the more negative the GPVG. This is consistent with the Department's view that recruitment and retention indicators worsen where the NHS "underpays";
- The percentage of staff paid a long term (Figure F8) or general (Figure F9) RRP also increases the more negative the GPVG. This suggests that organisations which "underpay" are more likely to respond with RRP;
- The charts of GPVG against average basic salary (Figure F10) and total earnings (Figure F11) also suggest that NHS organisations which "underpay" are more likely to offer higher pay than those which "overpay".

6.60 Motivation:

- Overall job satisfaction, and satisfaction with levels of pay, increase as the GPVG increases (Figures F12 and F13). The latter shows the strongest correlation of all these 12 indicators, and suggests that in locations where NHS pay is highest relative to the private sector, staff are most satisfied with their pay;
- Staff motivation and engagement (Figures F14 and F15) are *negatively* correlated with GPVG – an unexpected result, but not statistically significant.

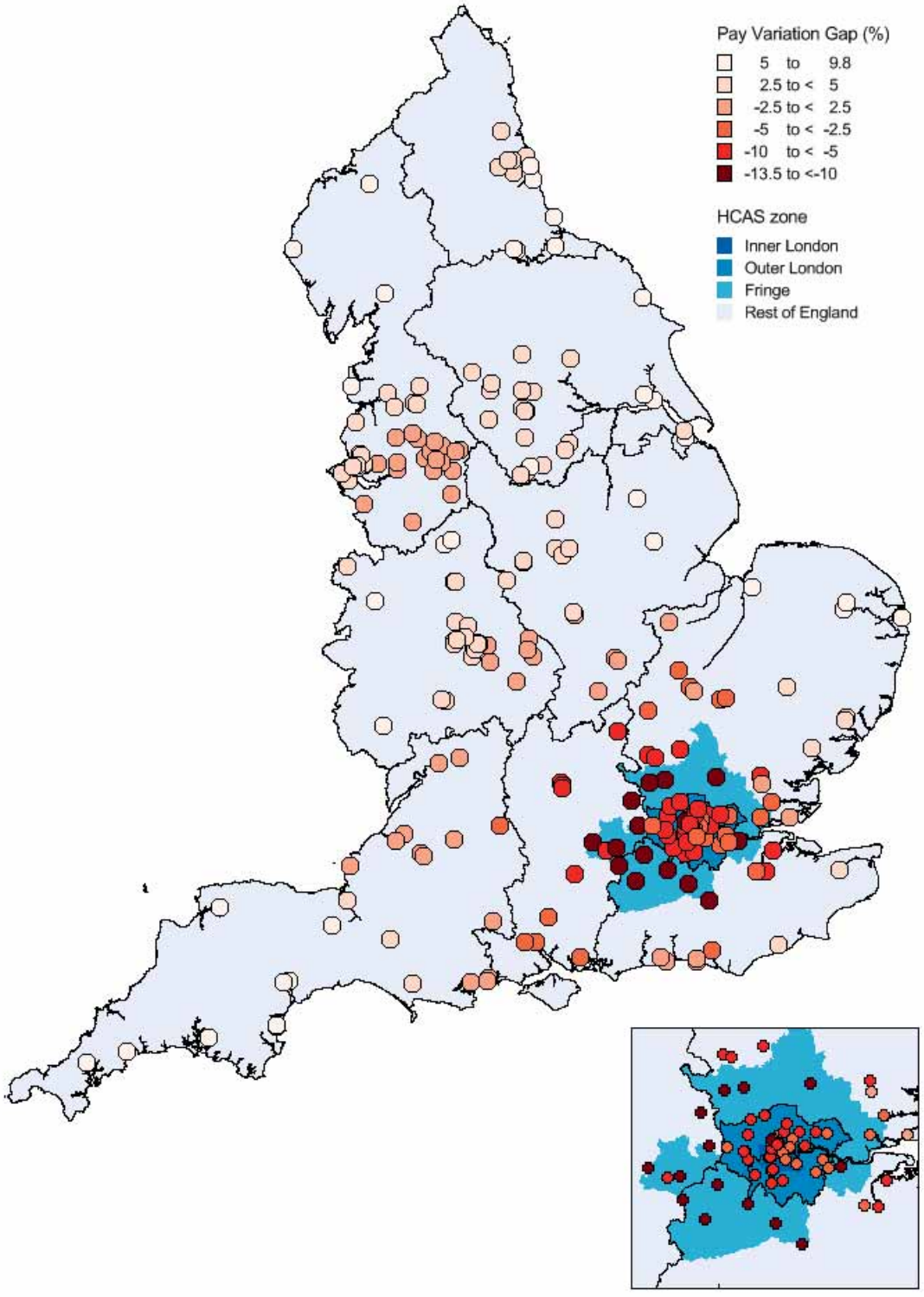
6.61 Outcomes:

- Patient experience increases in line with the GPVG (Figure F16) – the more the NHS pays relative to the private sector, the better the patient experience.

6.62 These correlations, though statistically significant[29], are at best modest: the strongest correlation in our analysis is between the GPVG and staff satisfaction with their level of pay (Figure 6.28), but the correlation between GPVG and vacancy rates is more typical (Figure 6.29). Clearly the variation in these data is being driven by more than just the relative pay variation in the NHS and the private sector.

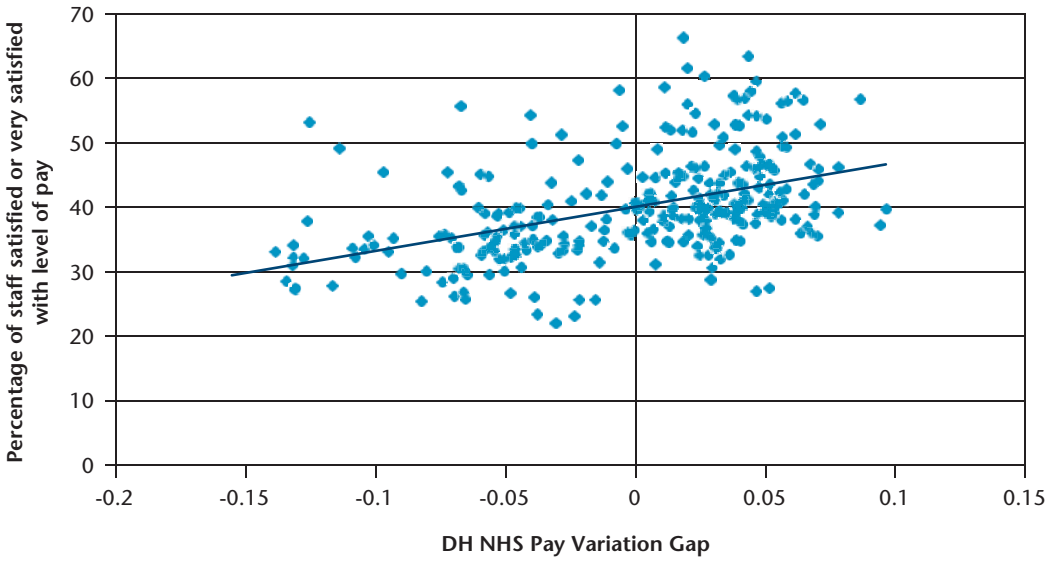
[29] With the exceptions of staff motivation and engagement, correlation coefficients for each of these comparisons are significant at the 5% level, i.e. they are unlikely to have occurred by chance.

**Figure 6.27 Geographical pay variation gaps for NHS provider organisations**



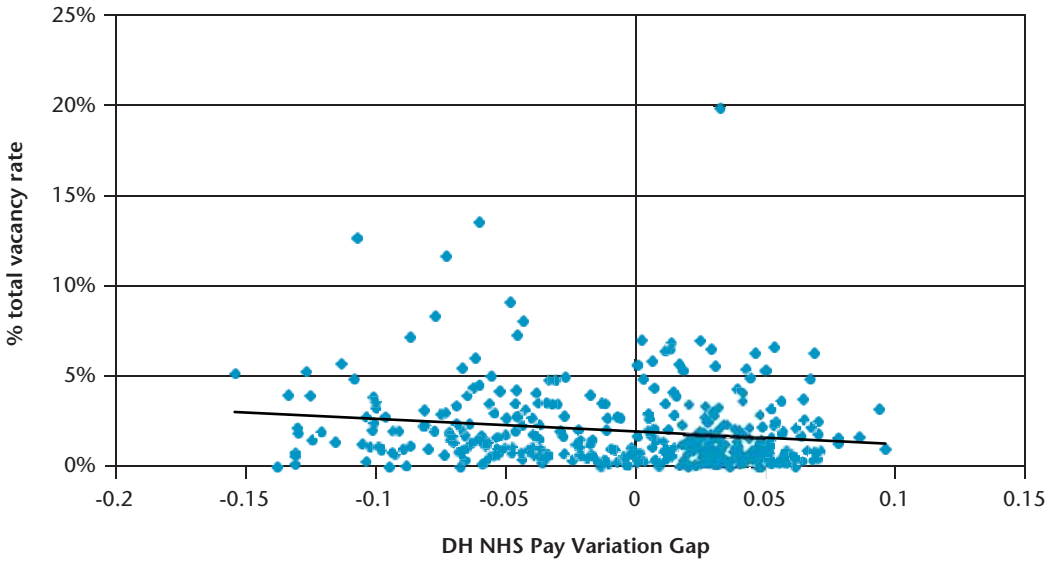

*Source: Department of Health.*
*Excludes Primary Care Trusts, Strategic Health Authorities and Special Health Authorities.*

**Figure 6.28: Relationship between GPVG and satisfaction with pay, 2011**




*Sources: Department of Health, Care Quality Commission.*

**Figure 6.29: Relationship between GPVG and total vacancy rate, March 2010**




*Sources: Department of Health, HSCIC.*

6.63 Further statistical analysis suggests that the GPVG is a small – and usually secondary – factor in the variability of these indicators. Table 6.3 shows the amount of variability explained individually by the GPVG and by organisation type, and by combining these factors along with staff composition[30]. The variability in these indicators is explained to a greater degree by the type of organisation, than it is the GPVG, with two exceptions. We note that the variability in some indicators (namely vacancy rates, agency spend as a percentage of pay bill, and the percentage of staff paid a general RRP) is hardly explained

[30] Three separate regression models were fitted to each indicator, and the overall model fit ($R^2$) observed.

at all by these three factors; indeed, for half of the indicators in Table 6.3, our statistical model leaves more than half of the variability unexplained[31].

**Table 6.3: Variation in recruitment, retention, earnings, motivation and patient experience explained by GPVG, organisation type and workforce composition**

| Measure | No. orgs | Variability in the measure explained by these variables, or $R^2$ (%) | | |
|---|---|---|---|---|
| | | GPVG only | Org type only | GPVG & org type & staff composition |
| Total vacancy rate for all non-medical staff (March 2010) | 374 | 2.8 | 3.0 | 9.0 |
| Leaving rate (year to Jan 11) | 374 | 5.8 | 21.6 | 39.8 |
| % pay bill spent on agency (2010/11) | 233 | 8.7 | 7.2 | 20.3 |
| % staff paid long term RRP (Sep 2010)* | 375 | 1.8 | 27.1 | 30.5 |
| % staff paid general RRP (Sep 2010)* | 375 | 3.2 | 1.7 | 16.1 |
| Average basic salary (2011) | 343 | 4.4 | 29.4 | 68.6 |
| Average total earnings (2011) | 343 | 11.7 | 17.0 | 56.1 |
| Staff motivation at work (autumn 2011)** | 309 | 1.2 | 47.1 | 52.1 |
| Staff job satisfaction (autumn 2011) | 309 | 1.4 | 45.9 | 50.5 |
| Staff satisfaction with pay (autumn 2011) | 309 | 20.0 | 46.8 | 64.9 |
| Staff engagement (autumn 2011)** | 309 | 0.2 | 38.6 | 43.0 |
| Patient experience of hospital care (2010/11) | 159 | 6.4 | 48.6 | 61.9 |

** Revised to remove estimated CoLS.*
*** Association with GPVG not statistically significant.*
*Sources: Department of Health, HSCIC, Care Quality Commission.*

## Our Comment

6.64 Our earlier analysis has shown that recruitment, retention and earnings data vary across the country. We have further demonstrated that recruitment, retention, motivation, earnings and patient experience are indeed linked to relative pay (i.e. NHS pay relative to local private sector pay). This might provide some prima facie evidence in support of making pay more market-facing.

6.65 However, relative pay is not as important as NHS organisation type in explaining differences in these indicators – for example, average scores for staff engagement and patient experience are highest in specialist acute Trusts, and indicators of staff motivation are lower on average in ambulance Trusts than other types of organisation – and there may be common examples of good practice in certain types of organisations which if shared could improve recruitment, retention, motivation and the quality of care across the NHS.

6.66 Further, our modelling suggests that relative pay, and indeed organisation type, were just some among many factors influencing the variation in recruitment, retention, motivation and patient experience across the NHS.

[31] The size of the $R^2$ statistic, useful for assessing variability in the dependent variable "explained" by the model, is not the only indicator of the appropriateness or *goodness-of-fit* of a regression model. Cursory analysis of the residuals – the differences between the observed data and the regression model's "predictions" – suggests that these residuals may not be normally distributed, so inferences should be treated with caution.

6.67 On the whole, our research does not provide the firm evidence which would be essential to justify further investment in additional market-facing pay in the NHS at this time, even though recruitment and retention indicators are relatively less favourable in London and areas surrounding London. Indeed, if our research points to anything it would point to more investment in pay in parts of London rather than outside. However, any such regional pressures should be seen in the context of relatively high unemployment and may not be strongly linked to pay, but to the different types of organisation, and to specific local issues, including workforce planning, that are particular to individual organisations.

# Chapter 7 – Our Conclusions and Recommendations

## Introduction

7.1 We set out our conclusions and recommendations on making pay more market-facing for NHS Agenda for Change (AfC) staff in this chapter of the report. We reiterate our conclusions on the evidence presented on pay differentials, crowding out, and geographical pay differentiation in the private and public sectors. Drawing on our own analysis of geographical pay variation in the NHS, we summarise our assessment of the Department of Health's proposed approach for AfC staff, our recommendations and the next steps.

## The Context for the Remit

7.2 We commented in Chapter 1 that the remit for making pay more market-facing for AfC staff in England must be seen in the wider context of the UK Government's public sector policy of pay restraint and developments in the NHS. AfC staff are subject to a pay freeze[1] through to April 2013, except for those earning £21,000 or less; and the Government has announced further public sector pay restraint through to 2015 and that it will seek pay awards that average at 1% per year over this period which is likely to result in a significant cut in pay in real terms.

7.3 The NHS is also faced with financial pressures and challenging efficiency savings to 2014/15 and beyond. We note that managing NHS pay bills is an important consideration for employers given the high proportion of total expenditure spent on pay. There are also major structural NHS reforms underway which will have an impact on how workforces are managed and which will require evolving strategic approaches to NHS pay and conditions. This context is important to our overall conclusions.

## Consideration of the Evidence on Market-Facing Pay

7.4 We have been asked by the UK Government to review how the pay for AfC staff can be made more appropriate to local labour markets. Our starting point is that AfC pay should continue to be market-facing to support recruitment and retention of good quality staff to deliver patient care and where this can be shown to make more effective and efficient use of NHS funds. However, there is also a premium in favour of simplicity, not least in keeping management costs to a minimum. We would need to be satisfied that any possible developments go in the direction of enhancing the flexibility of AfC. In order to gain a better understanding of how to make pay more market-facing we review the substantial evidence that the parties provided on the UK Government's underlying arguments.

7.5 HM Treasury argued that the existence of a pay premium suggested that the public sector was paid more than was necessary to recruit, retain and motivate staff in some areas and that this diverted resources away from improving the quality of public services. HM Treasury also argued that the pay differential had the potential to hurt private sector businesses that needed to compete with higher public sector wages. HM Treasury, supported by the Department of Health, concluded that there was a clear case to correct these problems ensuring that public sector pay did not distort local markets.

[1] The public sector pay freeze applied to uplifts to pay scales.

## Pay Differentials

7.6 We note that the Institute for Fiscal Studies (IFS) estimates a public sector pay differential of 8.3% for the UK as a whole and that the Office for National Statistics (ONS) estimates it at 8.2%. We examine these differentials closely and conclude that: such differentials are dynamic and vary significantly over time – therefore there are risks in choosing data based on a short period on which to base major public policy; the results on differentials are sensitive to the methodology used in their calculations (and comparisons by sector or occupation might also show different results); and the differential is forecast to be eroded by 2015, as indicated by IFS, although we note that some regional variations might remain.

7.7 In the context of pay differentials, we examine the parties' evidence and other published research and recognise that crowding out is very difficult to observe in practice and to measure reliably. We have not received any substantive evidence that crowding out by AfC staff groups is in fact causing specific issues.

## Geographical Pay Differentiation in the Private and Public Sectors

7.8 The parties' evidence and research commissioned on our behalf provides us with a fuller picture of comparable large, multi-site, national private sector organisations' approaches to geographical pay differentiation. These generally favour central control because this provides simplicity, avoiding duplication and enabling employers to control costs. Typically, private sector organisations using pay differentiation use only four or five zones including London variations and a national pay scale. Private sector approaches are also driven largely by specific business need and can vary by sector. We conclude that these large, multi-site, national organisations are the closest comparator to the NHS, which similarly differentiates pay in four zones, and that small and medium sized enterprises, while being more attuned to local labour markets, do not reflect the size and complexity of the NHS.

7.9 Our assessment of public sector pay systems suggests that any geographical pay differentiation is generally centrally controlled and use of National and London zones are the most widespread. Such pay systems are generally designed to provide overall value for money, and to protect against equal value claims. There are models in the public sector that incorporate a small number of zones to reflect local labour markets, for instance in the Courts and Tribunals Service.

7.10 The parties also presented evidence on centralised and decentralised pay. The Department of Health believed that market-facing pay could be achieved fairly, simply, safely and effectively through modest changes within the existing AfC pay framework. NHS Employers indicated that employers generally did not support full local pay bargaining or any move away from AfC which would raise issues of local HR capacity, increased administration costs and pay inflation risks. The Staff Side rejected the Government's call to make pay more market-facing and emphasised its strong commitment to national pay determination. The Scottish and Welsh Governments also refuted the UK Government's claims regarding both pay differentials and crowding out.

## Our Comment

7.11 We consider it important to distinguish between short term and more enduring features of the labour market. We note that the public sector pay differential with the private sector is expected to close in the future, influenced by further pay restraint to 2015, though some regional differences might remain. Also, there has yet to be hard evidence that a positive public sector pay differential is crowding out the private sector and hurting business. Against these short term issues, we are struck by the universal lack of support among the stakeholders for a move to full local pay bargaining in the NHS.

7.12 Our examination of approaches to pay differentiation in the private and public sector suggests AfC is comparable with current practice for large national employers. Indeed, our investigations show that the existing AfC system has more flexibility for developing local market-facing pay than most reward systems generally in either the private or public sectors. We note the need to control pay bills is important to all employers not least in the NHS. Approaches to geographical pay variation in the private and public sector also suggest a centrally controlled, simple and limited zonal approach is appropriate.

7.13 Nonetheless, further development of AfC is required to meet the challenges and cost pressures in the NHS. Changes proposed by any of the parties seem slow to come to a conclusion. Therefore greater impetus is required so that employers can make more use of the significant flexibilities available within AfC. Developments on terms and conditions should be taken forward quickly so that AfC continues to be responsive to local needs, keeps pace with modern practice, provides value for money and makes more effective use of staff in the new NHS structure.

7.14 We were not presented with any evidence from stakeholders in favour of radical options for making pay more market-facing with all parties confirming that they did not seek any move to full local pay bargaining. We share that position.

7.15 In conclusion, we consider that AfC needs to be reviewed regularly in order to maintain its ability to recruit, retain and motivate staff of the required quality and for employers to manage their workforce, improve service delivery and patient outcomes, and control pay bill costs.

## Agenda for Change

7.16 We note from the rationale for the introduction of AfC in 2004 that there was a strong focus on: supporting high quality patient care; ways of working to best deliver the range and quality of service; achieving a quality workforce, organised in the right way; improving recruitment, retention and morale; meeting equality, diversity and equal pay requirements; and implementation within management, financial and service constraints. We conclude that the purpose of the system continues to be relevant and is of even more importance to the NHS during periods of financial challenge and major structural reform.

7.17 We draw the following conclusions about the current system:

- AfC is perceived as fair and objective by AfC staff, contributes to morale and motivation, supports stable industrial relations, is valued by the parties and is viewed by the parties as compliant with equal pay principles;
- Employers do not always have a strategic approach to total reward and, in this context, modifying AfC terms and conditions rather than market-facing pay is the highest priority for employers;
- Our previous reports have commented extensively on the need to ensure that the Knowledge and Skills Framework is an integral part of AfC[2]; and
- AfC has market-facing features suggesting that it could respond effectively to local labour markets. Use of recruitment and retention premia (RRP) (national and local) is an appropriate mechanism for occupational groups which are difficult to recruit and retain. Use of high cost area supplements (HCAS) already offers a four-zone approach to pay differentiation.

7.18 We understand from the parties that negotiations are ongoing within the NHS Staff Council regarding flexibilities under AfC. As more Trusts gain Foundation status, the parties may also wish to revisit the additional freedoms offered to Foundation Trusts

[2] NHSPRB (2012) *Twenty-Sixth Report,* TSO (Cm 8298), paragraph 5.64.

through Annex K in the NHS Terms and Conditions of Service Handbook again as a way to help AfC meet the requirements of local labour markets. We also consider that Trusts should have a transparent and open pay and reward policy contained within its business plan which clearly states its approach to the use of AfC flexibilities to meet the delivery of local services and improve patient outcomes. This should include appropriately trained HR capability to assess fully the implementation of local flexibilities for pay and conditions.

7.19 We also note from the Department's evidence that from April 2013 AfC staff will be employed in new national organisations, such as the National Trust Development Agency, Health Education England and the NHS Commissioning Board. These new organisations include new roles under development and other AfC roles which could involve work in a number of different regions. We ask that these organisations and the parties keep us informed of these developments.

## Proposals for Market-Facing Pay

7.20 As context for our conclusions and recommendations, we briefly set out the Department of Health's proposals for making pay more market-facing for AfC staff. We received no other specific proposals in evidence from stakeholders.

7.21 The Department's proposals are set out in detail in Chapter 5 of this report and include our assessment against the relevant factors in the Secretary of State's remit letter. In summary, the Department's proposed approach was: to retain national agreements; flexibility for local and national RRP; to move towards having national AfC pay rates at the minimum level necessary to recruit high quality staff; and to extend HCAS. The Department considered these proposals offered the most cost-effective and efficient use of the NHS pay bill.

7.22 The main feature of the Department's evidence was that a zonal pay or "hotspot" framework appeared to be the most promising option. This would include additions to the current four AfC zones (national plus three HCAS zones) which it proposed would be informed by the staff Market Forces Factor (sMFF) data as this provided an objectively justifiable indicator of the geographical variation in pay. The Department considered that five or six zones would be most appropriate, at least in the first instance, with more work needed to consider implementation issues, such as values, cliff edge effects and transition.

7.23 The Department has said its proposals could be introduced without the need for any fundamental change within the AfC Agreement possibly from April 2013, with measures introduced equally for both existing and new staff. The Department added that managing the transition would involve: a prolonged period of constrained headline pay awards to provide the headroom for earnings growth in the new HCAS zones; consideration of the appropriate headline basic pay award, delivering a balance between pace of change, recruitment and retention in the "national" zone, and offering any relief to the low paid that was considered appropriate; and consideration of the appropriate values of HCAS payments, to deliver movement towards the desired geographical differentiation without undermining the stability of employers and local and national affordability.

## Our Conclusions

7.24 Our conclusions are framed around a series of key considerations with the overriding premise that market-facing pay proposals support recruitment and retention of good quality staff to deliver patient care and make more effective and efficient use of NHS pay bills and therefore NHS funds. The first consideration is that recruitment, retention and motivation of AfC staff is fully taken into account in any proposals and, in this regard, we

add our own assessment to that of the Department. Second, we consider the application and effectiveness of current RRP. Third, the basis for extending or adjusting HCAS and whether it is appropriate at this stage. Finally, how it might be implemented, including transition and affordability concerns.

## Recruitment, Retention and Motivation

7.25 Recruitment, retention and motivation are key considerations for us as an independent Pay Review Body operating under our standing terms of reference. Any case for making pay more market-facing in the NHS must be seen against the prevailing position of recruitment, retention and motivation. We were not provided with specific evidence by the parties for this remit but we have examined available data and conclude that, for AfC staff, recruitment continues to be healthy and retention stable with the position for shortage occupations easing slightly. We received no evidence that recruitment and retention issues, aside from a few professions in particular locations, were causing undue difficulty to employers. We provide further detailed commentary in Chapter 5. In our view, the current position on recruitment, retention and motivation should be a major influence on any case for making pay more market-facing and may indicate that AfC, including RRP and HCAS, is fulfilling its purpose at this stage. However, developments towards a more flexible system will help ensure AfC can respond to future changes in local labour markets.

7.26 We note that the Staff Side place great emphasis on the fairness of the AfC pay system and the Department of Health comment that market-facing pay could be achieved fairly through modest changes within the existing AfC framework. Fairness in the pay system is likely to support the morale and motivation of AfC staff. Similarly, ensuring compliance with equal pay principles is important to AfC staff morale.

7.27 In Chapter 6 of this report, we present our own detailed research and analysis of geographical pay variation against recruitment and retention indicators. From these, on the whole, our research does not provide the firm evidence which would be essential to justify further investment in additional market-facing pay in the NHS at this time. The relationships between pay variation and recruitment and retention indicators cited in the Department's evidence do exist, but they are not strong and do not provide a compelling argument that further pay differentiation might be needed. A much stronger relationship exists between these indicators and the type of NHS organisation. There is evidence that recruitment and retention indicators are relatively less favourable in London and areas surrounding London. If our research points to anything it would point to more investment in pay in parts of London rather than outside. However, any such regional pressures should be seen in the context of relatively high unemployment in the labour market and may not be strongly linked to pay.

7.28 A common theme from our visits programme since AfC was implemented has been staff perceptions that there were inconsistencies in pay bands for similar roles in different – often neighbouring – organisations. We have found some evidence (see Chapter 6) which – though not conclusive – points to organisations in London placing proportionally more staff in higher bands. We also note that "upbanding", in particular, is a highly inefficient way of using pay to address recruitment and retention issues: pay bands are consolidated, pensionable and effectively permanent, whereas RRP – used correctly in the right circumstances – are a much more flexible and market-facing tool. Anecdotally, we have also been told about "downbanding" – usually occurring in the context of posts being reviewed when vacant, but occasionally for existing staff when services are redesigned. We remind all parties of the importance of using the AfC job evaluation framework appropriately, to ensure that the principal of equal pay for work of equal value is maintained in practice.

## Recruitment and Retention Premia

7.29 Despite the overall healthy position of AfC recruitment and retention, in our Twenty-Sixth Report[3] we continued to highlight ongoing shortages for specific occupational groups. We agree with all parties that, where objectively justified and supported by a robust business case, these shortages are best addressed by introducing either national or local RRP. However, our analysis, previous reports and our visits, continue to highlight that often local recruitment and retention problems are driven by a series of pay and non-pay factors. It is for Trusts locally to ensure that other factors are taken into account before deciding whether a pay solution is required and they may need to improve their capability, such as management information systems and local labour market analysis, to support cases.

7.30 We would also highlight the importance to any considerations of making pay more market-facing that supply problems for specific AfC occupations can arise from ineffective workforce planning and consequently shortfalls in training commissions. Shortages created by an inadequate supply may not be best addressed through local pay arrangements as these lead simply to unnecessary pay escalation without solving the root of the problem. Such pay solutions can be expensive and difficult to withdraw when no longer required. In addition, we have commented on the importance of delivering effective local education and training which can help to fill staff gaps. We have commented extensively in our previous reports on the importance of effective workforce planning and commissioning of training and education to ensure adequate supply of specific AfC occupations.

7.31 Our analysis of the usage of RRP shows that the majority of these are likely to be a legacy from pre-AfC Cost of Living Supplements (paid to nurses and professions allied to medicine) and converted to long term RRP when AfC was introduced in 2004. When these legacy payments are excluded, the usage of RRP by employers is rare and does not show a distinct geographical pattern. There is limited HR capacity with local employers properly to evaluate the greater use of local RRP. The absence of widespread use of local RRP could suggest that employers are not currently struggling to recruit staff or that the funding for local RRP is constrained. Employers may also recognise that some shortages could be caused by ineffective workforce planning, education and training.

7.32 We conclude that local RRP are a key market-facing element of AfC to address occupational shortages and therefore we recommend their appropriate use ensuring that they reflect employers' local needs, that they are simple to operate and are fully understood by staff, that appropriate review arrangements are in place, and that good practice is shared.

## Extending HCAS

7.33 The Department has proposed a limited and incremental extension to HCAS with the initial addition of one or two zones based on supporting data from the sMFF. A series of options were presented rather than specific proposals on the precise definitions, designs and values for additional zones and their payments. We can see the logic of this approach as HCAS is simple to understand and easy to administer and therefore we will consider extending or adjusting HCAS in the future as appropriate. In oral evidence, the parties confirmed that, while equal pay risks would need to be scoped further prior to implementation, an approach which applied to all AfC staff groups within a particular HCAS zone could be objectively justifiable. However, we have some reservations about introducing this approach before further work has been undertaken to justify modifying arrangements including any extension or adjustment to HCAS.

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[3] NHSPRB (2012) *Twenty-Sixth Report*, TSO (Cm 8298), paragraphs 5.9 to 5.16.

7.34 Our first concern is that HCAS has not been fully reviewed since its introduction in 2004. While HCAS minima and maxima have been increased, there has been no fundamental review of values or definitions of areas. As a starting point for extending or adjusting HCAS, the parties would wish to be reassured that the existing system is fit for its intended purpose and can achieve its aims. For this reason, we recommend a fundamental review of HCAS by the parties with the findings feeding into our autumn pay round. Such a review will necessarily cover the purpose of HCAS, how it is funded, its design, definition of zones, value of payments, boundary issues and how any new HCAS zones would interact with existing local RRP or other arrangements. The parties should also consider the appropriate mechanisms to keep zones under review, add or remove zones, to increase or reduce rates and whether rates should be expressed as percentages of basic pay or flat rates or set relative to cost of living indicators. As HCAS is pensionable, it will be important to assess the pension implications of any changes. It is also unclear to us whether, as the name suggests, HCAS is simply a "higher cost" allowance or whether it should be triggered by recruitment and retention issues or a combination of both. Care also needs to be taken that employers are not paying for the same recruitment and retention difficulties through two different mechanisms. Should the parties decide on modified arrangements, including those proposed by the Department for this remit, they will need to decide whether to re-draw existing HCAS or adapt it for new zones only.

7.35 Second, we have concerns that the sMFF is the appropriate mechanism to link funding to geographical pay differentiation – our detailed comments are in Chapter 5. We note that the Department does not wish to change the system and considers sMFF an objectively justifiable indicator of geographical pay variation. However, its purpose is a funding allocation method and it therefore requires further review before it is fit to act as a driver to determine AfC pay rates. We are also not clear what modifications the Department intend to make to sMFF before applying it to new HCAS zones. We consider that more information is required on how employers use additional funding through the sMFF, whether this flexibility would be curtailed if imposing new HCAS zones, and whether extra monies were consistently finding their way into pay systems locally. Finally on sMFF, we do not share the Department's view that it is well understood by other stakeholders which would be essential if used as the basis on which to differentiate pay.

7.36 Third, our research was inconclusive on the relationships between pay variations and recruitment and retention to justify new HCAS zones at this stage. Against a background of healthy recruitment and stable retention it is difficult to justify additional payments and if anything further payment might be more justified in some of the existing HCAS zones than elsewhere. However, as mentioned earlier, AfC should be developed to improve its responsiveness to local labour markets and therefore our recommendation for a fundamental review should enable such HCAS flexibility to be available when needed in the future.

7.37 Fourth, we were asked to examine the issue of cliff edges between neighbouring areas. We did not receive much evidence of major problems created around adjoining areas in current HCAS or RRP arrangements. In any future zone design, we ask that boundary issues are reviewed taking into account the changing landscape for NHS providers, relevant Travel To Work Areas, any particular concerns for specialist staff and any issues for the Devolved Administrations, if appropriate.

7.38 Finally, HCAS could be viewed as a blunt instrument in that it is paid to all staff in the designated area. In a difficult financial climate and with employers seeking value for money from their pay bills, there may be more targeted approaches available to employers. In our view, if HCAS and its extension is to be the chosen method for more market-facing pay, it requires evidence of value to the taxpayer.

## Transition and Implementation

7.39 As we have not found sufficient evidence to warrant the introduction of additional HCAS zones at this stage without further preparatory work by the parties, we have not fully framed conclusions on transition and implementation. It seems clear, however, that such changes as may result can be implemented within the AfC Agreement and without the need to change contracts of employment. The Department also suggested that any changes should be applied to all staff rather than just new entrants, a view which we share.

7.40 There are a series of transitional issues that we would ask the parties to consider in our proposed fundamental review of HCAS and discussions on any new HCAS zones. These include: whether existing HCAS zones would need to be re-drawn and re-valued; the relative values of new zones to existing HCAS; whether to phase in implementation; whether any pay protection is needed; and to review how new HCAS zones will fit with existing arrangements, for example local RRP or other local initiatives.

7.41 We share the Department of Health's position that national AfC rates should be set at the minimum level necessary to ensure adequate recruitment of sufficient high quality staff in low staff cost areas. However, we are assured by the Secretary of State that the Department of Health has no intention to reduce nominal basic pay rates for AfC staff.

7.42 We see affordability as the main implementation issue. Overall, if making pay more market-facing is favoured over the longer term we see merit in the Department of Health's incremental approach over a period of years although we are sceptical that new zones could be either justified, or agreed by the parties in time for implementation from April 2013. We also agree that further work on robust costings and testing of any proposals is essential. Based on the Department's proposals we have examined some broad potential pay bill costings in Chapter 5 of this report.

7.43 Affordability of new market-facing pay arrangements needs to be seen in the context of the Government's announcement of a further period of public sector pay restraint through to 2015 where it will seek pay awards that average at 1% per year over this period. This limits the cash available to extend existing HCAS boundaries and to boost existing payments. We are aware that the Department favoured managing transition through a prolonged period of constrained headline pay awards to provide headroom for earnings growth in the new HCAS zones including a movement towards the desired geographical differentiation without undermining the stability of employers and local and national affordability. We comment in Chapter 5 that this is a matter for our autumn pay round in which we will consider any costed proposals for making pay more market-facing against all the factors in our standing terms of reference.

7.44 The Market Forces Factor is a funding allocation mechanism which includes extra funding to account for the geographical variability in private sector pay. The Department argues that Trusts already receive additional funding to account for geographical differences in staff costs. Nonetheless, the introduction of new HCAS zones based on sMFF data could cause difficulties for employers in the new zones particularly where sMFF additional funds have already been used on a range of alternatives. The Staff Side and NHS Employers highlighted that market-facing pay could introduce additional costs. In our view, this will place additional funding constraints on employers – some of whom will not see the merits of centrally imposed additional pay. Generally, when new pay systems are introduced they are accompanied by transitional funding (for both implementation and additional pay bill costs) to support employers through the initial period before a steady state can be achieved. We would ask the Department to look at how this might best be achieved including affordability of such costs.

## Our Recommendations

7.45 We received no market-facing pay proposals for radical change to AfC, indeed the stakeholders confirmed that full local pay bargaining was not sought for the NHS. We therefore discounted this as an option, focusing instead on options for modifications to existing arrangements, including HCAS and RRP. However, against a background of continued financial constraints on NHS budgets, it becomes clear that any move to making pay more market-facing could only be undertaken incrementally over the long term within affordability limits.

7.46 That said, further development of AfC is undoubtedly required. Our recommendations are built around our support for market-facing pay to support recruitment and retention of good quality staff to deliver patient care and where it can be shown to make more effective and efficient use of NHS funds and, in particular, supporting the NHS through significant structural change.

7.47 To achieve this aim, our detailed recommendations start with reaffirming AfC as the appropriate vehicle to deliver more market-facing pay and its comparability to private and public sector approaches. AfC has the supporting infrastructure and negotiating machinery to enable vigorous pursuit of a more market-facing approach. AfC also provides the benefit of consistency while the NHS goes through major structural change. Additionally, we recommend the continuation, with further development, of market-facing features of AfC including RRP, HCAS and additional freedoms for Foundation Trusts. However, we recommend that features such as HCAS require further review and development before firm proposals, such as that from the Department of Health, can be implemented. While our research did not provide conclusive evidence for extending or adjusting HCAS at this stage, our recommendation for a fundamental review is intended to ensure such a flexibility is available when labour market circumstances demand a pay response. We also recommend the incremental transition to more market-facing arrangements to take account of their affordability in the current financial climate. Finally, we consider Trusts should have a more strategic approach to AfC flexibilities which should be reflected in transparent and open pay and reward policies. Accordingly our recommendations are set out below.

**Recommendation 1. We support market-facing pay for AfC staff to support recruitment and retention of good quality staff to deliver patient care and where it can be shown to make more effective and efficient use of NHS funds. We recommend that AfC is the appropriate vehicle through which to make pay more market-facing.**

**Recommendation 2. We recommend the further review and development of AfC to support a more market-facing approach while stressing the importance of maintaining the integrity of the existing AfC system, including equal pay considerations.**

**Recommendation 3. We recommend that any agreed approaches to making pay more market-facing should be introduced incrementally taking full account of local and national affordability considerations.**

**As part of these financial considerations, we also recommend that the Department of Health with other stakeholders undertakes a full assessment of implementation and running costs of any new arrangements.**

**Recommendation 4. We recommend a fundamental review of HCAS – covering its purpose, how it is funded including the appropriateness and basis of the staff Market Forces Factor, its design and zone values, and boundary issues. The findings should be available in evidence for our next pay round.**

**We also expect the parties to consider:**

- **the appropriate mechanisms to keep zones under regular review;**
- **how to extend or reduce existing HCAS zones;**
- **how to add new zones and how to remove existing zones;**
- **how to increase or reduce rates; and**
- **whether rates should be expressed as percentages of basic pay or flat rates.**

**Recommendation 5. We recommend that the appropriate use of local RRP, as a key market-facing element of AfC to address occupational shortages, should ensure that local RRP:**

- **have appropriate review mechanisms in place;**
- **reflect employers' local needs;**
- **are supported by robust data on relevant local and regional labour markets;**
- **are simple to operate;**
- **are fully understood by staff; and**
- **good practice is shared.**

**Recommendation 6. We recommend that AfC, including its flexibilities, is kept under regular review by the parties to ensure it continues to be fit for purpose, reflects modern practice, and can respond to changing labour markets. Specifically, reviews could usefully focus on flexibility around terms and conditions as a priority.**

**If, as we have heard, the parties believe AfC is capable of responding to local and national market pressures, then we would expect to see discussions on particular issues brought to a conclusion at a reasonable pace, so that local NHS organisations can plan forward with greater certainty.**

**The parties may wish to examine how additional freedoms for Foundation Trusts in Annex K of the NHS Terms and Conditions Handbook could help Trusts and local staff to be better enabled to develop pay and conditions packages to meet local service needs.**

**Recommendation 7. We recommend that each Trust should have a transparent and open pay and reward policy contained within its business plan which clearly states its approach to the use of AfC flexibilities to meet the delivery of local services and to improve patient outcomes. Such policies should specifically include how Trusts will provide the HR capacity to support AfC flexibilities and how Trusts will approach total reward locally.**

## Next Steps

7.48 We would hope that even though our remit was confined to England, that our recommendations could also be taken forward as appropriate by the Devolved Administrations. If our recommendations are accepted we expect the parties to report on further work in evidence for our autumn 2012 pay round.

## Appendix A – Remit Letters

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

7 December 2011

Jerry Cope
Chair
Pay Review Body - NHS
Office of Manpower Economics
6th Floor
Victoria House
Southampton Row
London
WC1B 4AD

Dear Mr Cope,

Following my recent announcements at the Autumn Statement, I am writing to set out the Government's view on the critical role of the NHS Pay Review Body in the years ahead.

The Government continues to value the independent and expert view that the Review Bodies provide – and I appreciate that you are currently engaged in taking evidence in relation to pay awards for 2012-13.

You will be aware that, at the Autumn Statement, I announced that the public sector pay freeze will end after 2012-13 – but that in order to support fiscal consolidation, for each of the following two years the Government will seek public sector pay awards that average at 1 per cent. The Secretary of State will write to you in advance of the 2013-14 pay round, in line with normal process.

However, when it comes to setting pay policy after the freeze, the Government is concerned not only with the appropriate annual uplift, but also ensuring that overall public sector pay systems are the most appropriate for the modern labour market.

In particular, as Review Bodies have noted in the past, there is substantial evidence that the differential between public and private sector wages varies considerably between local labour markets. This has the potential to hurt private sector businesses that need to compete with higher public sector wages; lead to unfair variations in public sector service quality; and reduce the number of jobs that the public sector can support for any given level of expenditure.

The Government believes that there is a clear case for seeking to correct these problems, ensuring that public sector pay does not distort local markets. Therefore – following my

announcement in the Autumn Statement, I am now writing to ask that you consider how to make pay more market-facing in local areas for NHS Agenda for Change staff.

In taking forward this analysis, you should 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 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 frameworks; and
- whether proposals should apply to existing staff, or just to new entrants.

The Secretary of State will follow this letter with a detailed remit in relation to the NHS workforce, which may also raise other pay reform issues.

I would be grateful if you could submit initial findings by 17 July 2012. It will then be possible to feed these findings into the evidence provided by Government and other parties, to the 2013-14 pay round.

I am copying this letter to the Chief Secretary to the Treasury, the Secretary of State for Health and the Minister for the Cabinet Office.

Best wishes.

GEORGE OSBORNE

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

Department of Health

POC1_668026

*Richmond House*
*79 Whitehall*
*London*
*SW1A 2NS*

*Tel: 020 7210 3000*
*Mb-sofs@dh.gsi.gov.uk*

Jerry Cope
Chair - NHS Pay Review Body
6th Floor, Victoria House
Southampton Row
London WC1B 4AD

23 DEC 2011

Dear Jerry.

**NHS PAY REVIEW BODY REMIT**

As you are aware, the Chancellor of the Exchequer set out in his Autumn Statement that the Government is concerned not only with the appropriate annual uplift for each remit group, but also with ensuring that overall public sector pay systems are the most appropriate for the modern labour market. In particular, he highlighted that the Government is concerned that inappropriate differentials between public and private sector wages could hurt private sector businesses; lead to unfair variations in the quality of public services; and, reduce the number of jobs that the public sector can support for any given level of expenditure.

The Chancellor therefore wrote to you on 7 December 2011 to ask the NHS Pay Review Body to consider how to make pay more market-facing for Agenda for Change staff and advised you that I would write to confirm the remit for this work. This letter sets out that remit.

In particular, the Government would like the NHS PRB to review how the pay of staff within Agenda for Change in England could be made more appropriate to local labour markets. In undertaking this review, the PRB is asked to take account of the factors set out by the Chancellor in his letter of 7 December 2011 and which are attached at Annex A for ease of reference. The PRB is also requested to take account of:

- the extent to which Agenda for Change already recognise the impact of local differences in pay through recruitment and retention premia and High Cost Area Supplements and whether these could be used more effectively.

- the way in which the Department uses the Market Forces Factor 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 Agenda for Change 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.

- to consider what information in the future might be needed in order to make recommendations on local labour markets.

- the need to submit your initial findings to Ministers by 17 July 2012 so that we can implement agreed recommendations in time for the 2013/14 pay review cycle.

I am aware that the NHS PRB makes recommendations for the whole of the United Kingdom and that this remit comes from England alone. It will be for each of the devolved administrations to make their own decision whether to provide a separate remit and to communicate this to you. My officials have been closely in touch, and remain closely in touch, with their counterparts in the other countries and will do all they can to support you in handling the consequences of any different approaches taken by each country.

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

I am copying this letter to Nicola Sturgeon, Edwin Poots, Lesley Griffiths and representatives of the staff side and NHS Employers.

Yours ever,

**ANDREW LANSLEY CBE**

Department of Health

**ANNEX A**

**CHANCELLOR'S LETTER - ISSUES 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 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 frameworks; and
- whether proposals should apply to existing staff, or just to new entrants.

## Appendix B – The Parties' Website Addresses

| | |
|---|---|
| Department of Health | http://www.dh.gov.uk/en/index.htm |
| HM Treasury | http://www.hm-treasury.gov.uk/home.htm |
| NHS Employers | http://www.nhsemployers.org/ |
| NHS Staff Side (Joint Staff Side) | http://www.unison.org.uk/<br>http://www.rcn.org.uk |
| British and Irish Orthoptic Society | http://www.orthoptics.org.uk/ |
| Royal College of Midwives | http://www.rcm.org.uk/ |
| Unite the Union | http://www.unitetheunion.org/ |

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

Responses to the generic call for evidence by the Office of Manpower Economics (OME) can be found at www.ome.uk.com.

# Appendix C – Employment in the Public Sector and the NHS

C1 This Appendix provides data on the size of the public sector and Agenda for Change (AfC) workforces in the UK as well as a breakdown by occupational group, gender and geographical area for AfC staff in England.

C2 Public sector employment (headcount) in the UK[1] was just over 6 million (6.054m) in 2011, about one-fifth (20.8%) of total UK employment of 29.2 million. Estimates from the Office for National Statistics (ONS) Annual Population Survey 2010 suggest that women comprised some two-thirds of the UK public sector workforce.

C3 The NHS is a significant employer, with our remit group accounting for 1.4 million workers in the UK or about one-quarter of the public sector workforce. The NHS in England in 2011 employed 1.1 million non-medical staff (headcount) or about 0.9 million full time equivalents (FTEs). The workforce is predominantly female (over 80%, see Table C1) and a significant proportion of employees work part time. Table C2 below presents the geographical distribution of FTE and headcount staff in the UK, by Strategic Health Authority area and Devolved Administration.

**Table C1: Non-medical staff in England by staff group and gender, September 2011**

| | Headcount | | | Percentage headcount | |
|---|---|---|---|---|---|
| | Male | Female | Total | Male | Female |
| **All non-medical staff** | **206,792** | **876,845** | **1,083,637** | **19.1** | **80.9** |
| ***Professionally qualified clinical staff*** | ***81,642*** | ***437,730*** | ***519,372*** | ***15.7*** | ***84.3*** |
| Qualified nursing, midwifery and health visiting | 35,761 | 312,932 | 348,693 | 10.3 | 89.7 |
| Allied health professions | 10,742 | 63,905 | 74,647 | 14.4 | 85.6 |
| Qualified healthcare scientists | 11,927 | 19,554 | 31,481 | 37.9 | 62.1 |
| Other qualified scientific, therapeutic and technical (ST&T) | 11,279 | 34,888 | 46,167 | 24.4 | 75.6 |
| Qualified ambulance service staff | 11,997 | 6,690 | 18,687 | 64.2 | 35.8 |
| ***Support to clinical staff total*** | ***54,241*** | ***292,823*** | ***347,064*** | ***15.6*** | ***84.4*** |
| Support to doctors & nursing staff | 35,471 | 235,913 | 271,384 | 13.1 | 86.9 |
| Support to ST&T staff | 11,325 | 50,732 | 62,057 | 18.2 | 81.8 |
| Support to ambulance service staff | 7,495 | 6,743 | 14,238 | 52.6 | 47.4 |
| ***NHS infrastructure support total*** | ***71,275*** | ***148,349*** | ***219,624*** | ***32.5*** | ***67.5*** |
| Central functions | 26,431 | 82,884 | 109,315 | 24.2 | 75.8 |
| Hotel, property & estates staff | 29,437 | 42,846 | 72,283 | 40.7 | 59.3 |
| Managers & senior managers | 15,455 | 22,759 | 38,214 | 40.4 | 59.6 |
| Other staff or those with unknown classification | 12 | 254 | 266 | 4.5 | 95.5 |

*Source: Health and Social Care Information Centre (HSCIC).*

*Scotland, Wales and Northern Ireland have been omitted from this table because of differences in the way in which staff are categorised in each UK country.*

[1] ONS (14 March 2012), *Public Sector Employment, Statistical Bulletin, Q4 2011,* Table 5.

**Table C2: Non-medical staff by Devolved Administration and Strategic Health Authority area, September 2011**

| SHA Area | Headcount | Full time equivalent |
|---|---|---|
| North East | 65,523 | 57,055 |
| North West | 166,168 | 143,504 |
| Yorkshire and the Humber | 120,631 | 102,380 |
| East Midlands | 84,784 | 71,966 |
| West Midlands | 116,633 | 100,091 |
| East of England | 99,463 | 85,072 |
| London | 155,309 | 142,686 |
| South East Coast | 76,849 | 65,249 |
| South Central | 69,527 | 59,221 |
| South West | 108,333 | 90,257 |
| Special Health Authorities and others | 21,092 | 19,082 |
| England | 1,083,637 | 936,563 |
| Scotland | 141,203 | 119,379 |
| Wales | 78,145 | 66,005 |
| Northern Ireland | 60,984 | 49,634 |
| **UK** | **1,374,637** | **1,181,101** |

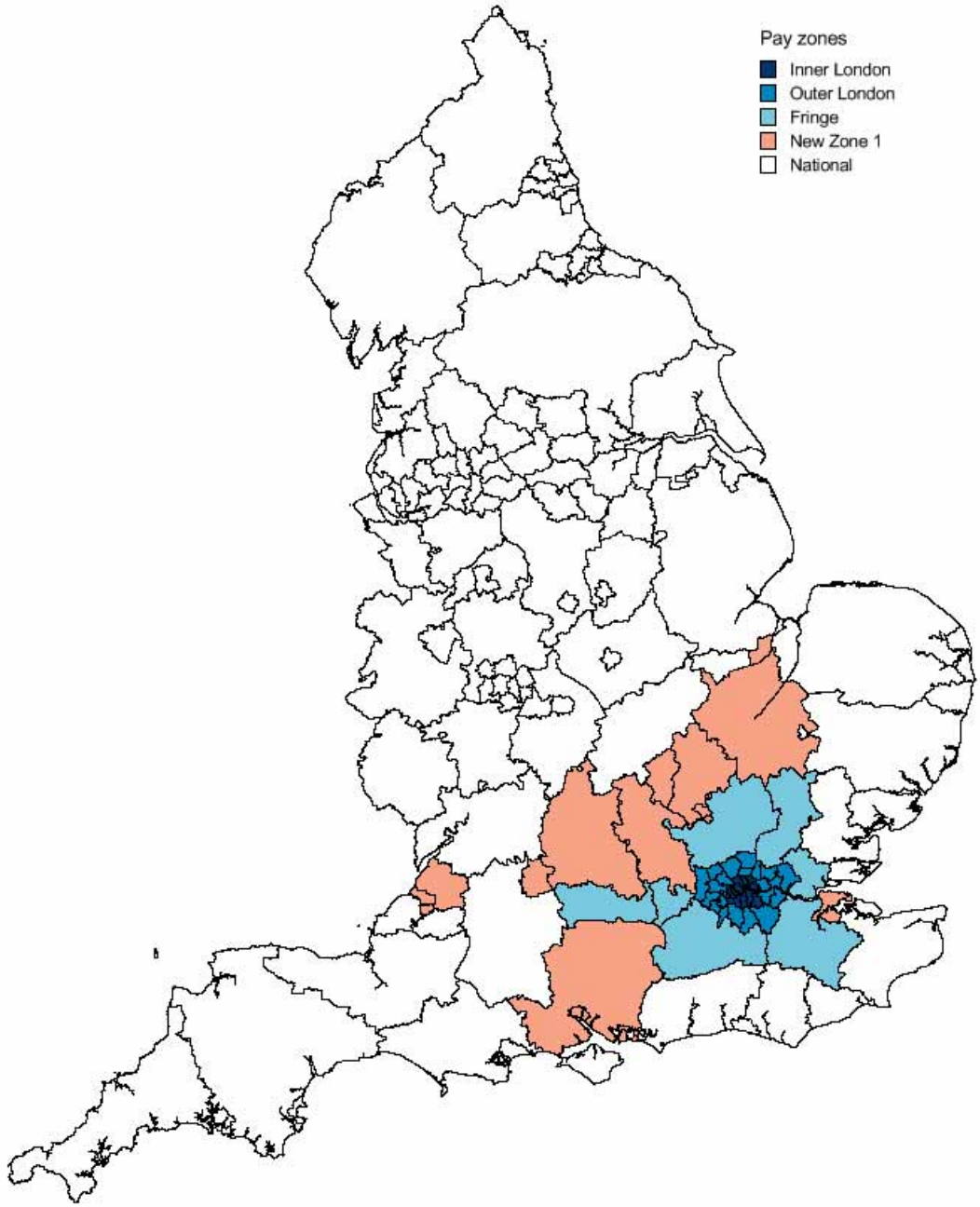
*Sources: HSCIC; Information Services Division Scotland; StatsWales; Department of Health, Social Services and Public Safety in Northern Ireland.*

## Appendix D – The Department of Health's Indicative Zoning Options

D1 In Chapter 5, we summarise the Department's proposal to extend high cost area supplement (HCAS) zones. Figures D1 to D4 are reproduced from the Department's written evidence, and show indicative zoning arrangements of varying levels of complexity, which the Department did not intend to be final proposals.

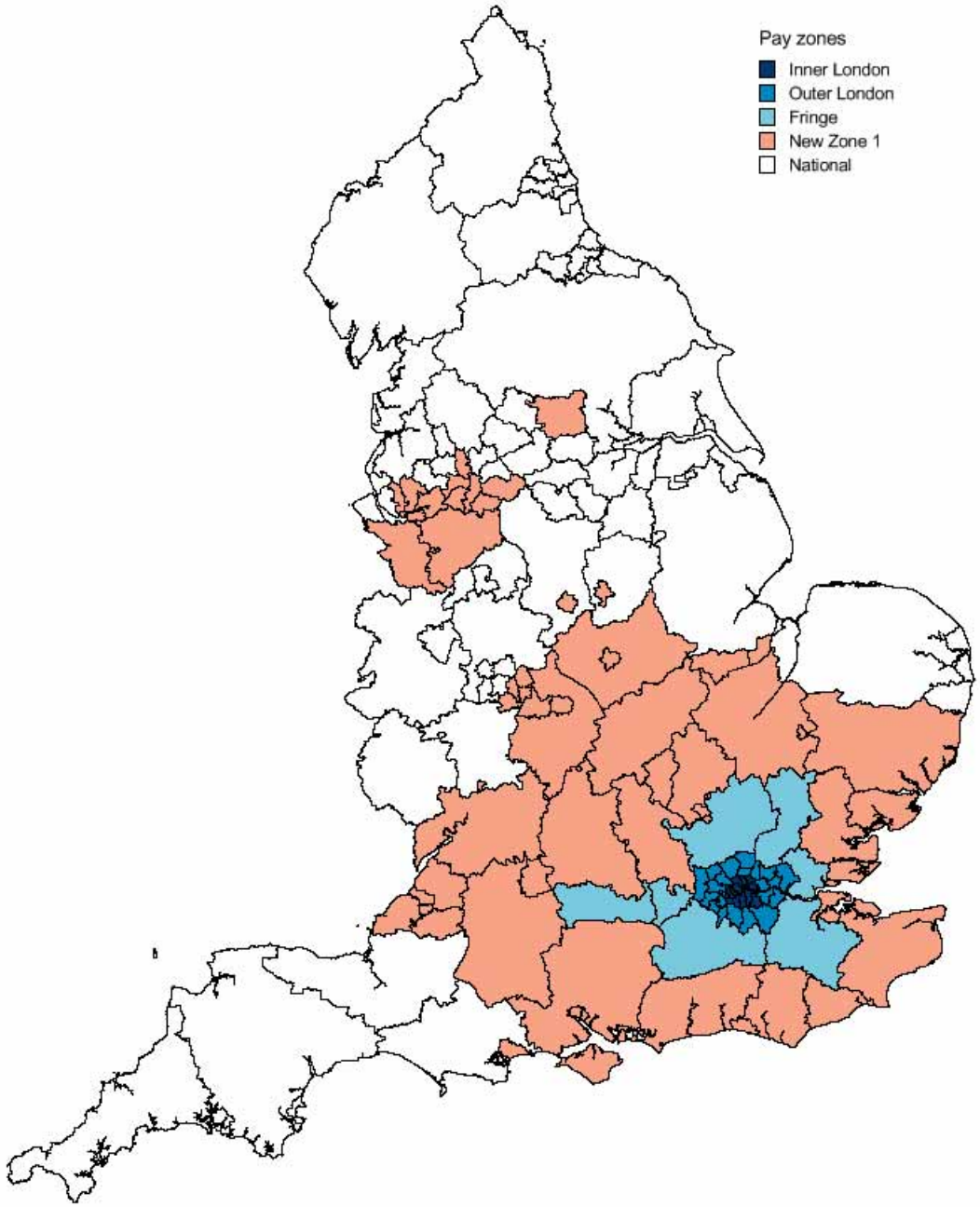
D2 The Department noted that the zoning options were based on Primary Care Trust (PCT) areas under the 152 PCT arrangement. The Department also noted that PCT boundaries had changed since the London Fringe HCAS zone was introduced. This zone did not map to current PCT boundaries. For the purposes of these maps, PCT areas containing at least one organisation in the London Fringe zone were denoted as "Fringe", but some organisations in these PCT areas would not be paying HCAS. Such boundary ambiguities would need to be resolved in the final design of any zonal pay system.

**Figure D1: Illustrative 5 Zone System – Version A (Narrow Additional Zone)**



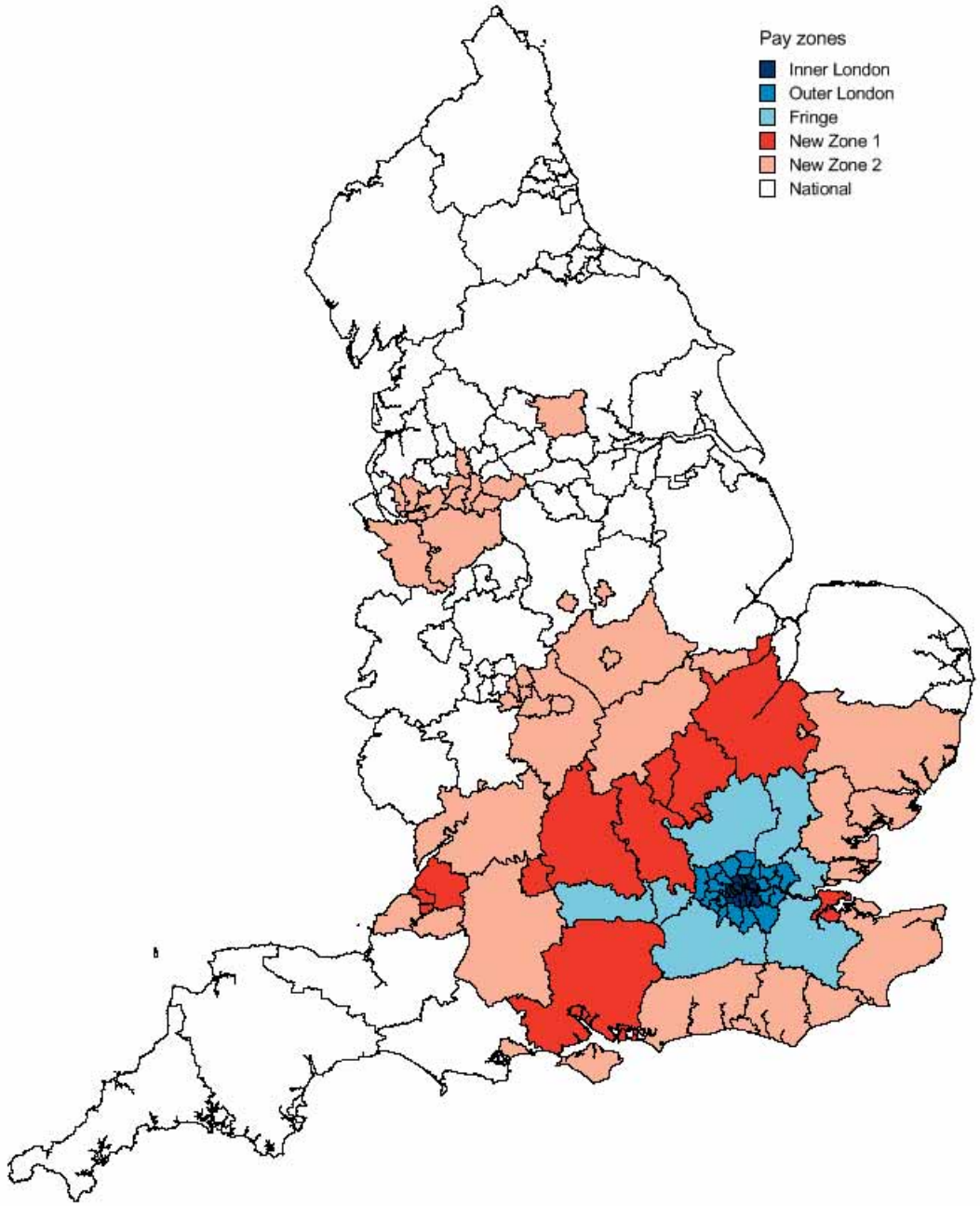

*Source: Reproduced from written evidence from the Department of Health. Crown copyright and database right 2012.*

**Figure D2: Illustrative 5 Zone System – Version B (Wide Additional Zone)**



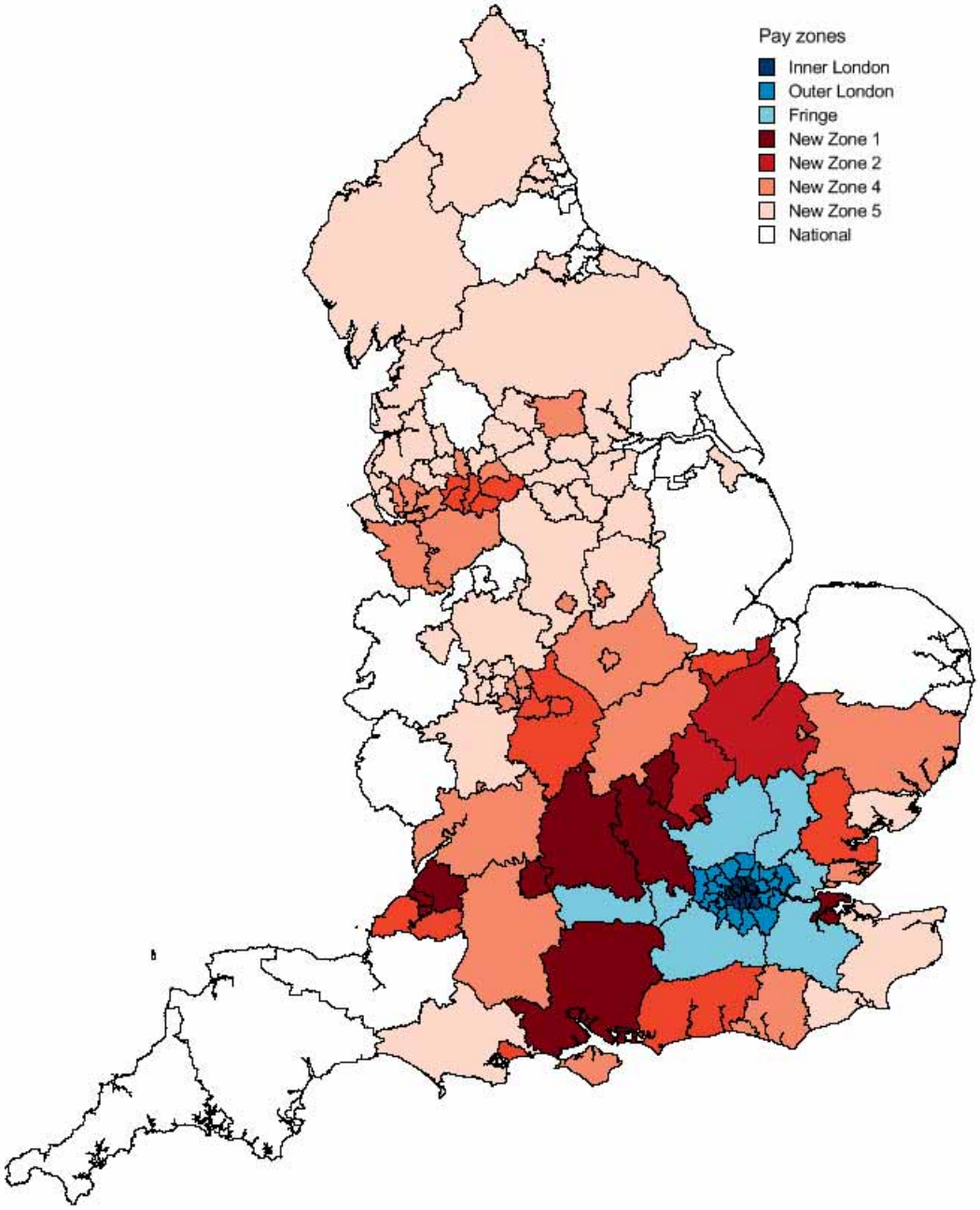

*Source: Reproduced from written evidence from the Department of Health. Crown copyright and database right 2012.*

**Figure D3: Illustrative 6 Zone System**




*Source: Reproduced from written evidence from the Department of Health. Crown copyright and database right 2012.*

**Figure D4: Illustrative 9 Zone System**




*Source: Reproduced from written evidence from the Department of Health. Crown copyright and database right 2012.*

## Appendix E – Estimated Costs of Additional HCAS Zones

E1 This appendix provides estimates of the effect on the total earnings[1] in England from increasing the number of pay zones, based on the four indicative zone design options provided by the Department (see Appendix D)[2].

E2 All costs have been estimated using data on organisation-level average basic pay and total earnings, provided by the Health and Social Care Information Centre (HSCIC). Organisations which did not have 12 months of earnings data were excluded from the dataset, so our estimates are based on a sample. Additionally, our estimates are on an 'all else being equal' basis – i.e. there are no changes to average pay or the number of staff, beyond the increase in geographical supplements. The effect on total earnings of increasing the number of zones should therefore be treated with caution, but provide an indication of costs.

E3 Table E1 shows the estimated number of staff that would be covered by high cost area supplement (HCAS) zones under each of the Department's indicative options, and the aggregate total earnings of these staff at present, excluding on-costs. The final columns show the marginal cost of adding one percentage point to HCAS payments in that zone, in cash and percentage terms[3].

E4 We estimate that one additional (narrow) zone, for parts of South East England and around Bristol, would cover approximately 10% of the remit group, and each percentage point added to HCAS in this new zone would cost approximately 0.07% of current total earnings – which we use as a proxy for the total pay bill in England[4]. Thus a differential over the national rate, of say 3%, would cost approximately 0.21% of total earnings.

E5 We further estimate that:

- One additional (broad) zone, covering the whole of South East England, as well as parts of the Midlands, and areas around Manchester and Leeds, would cover around 41% of the remit group, and each percentage point on HCAS in the new zone would cost 0.3% of total earnings – so a HCAS of 3% would cost approximately 0.9% of the total pay bill in England;
- In a six zone system, the new Zone 1 would cost 0.07% of total earnings for each percentage point on HCAS, and the new Zone 2 would cost 0.23%;
- In a nine zone system, only around 13% of staff would be on the "National" rate.

[1] Total earnings are used in place of pay bill in this analysis, as these were the only data available at the time we conducted our analysis, and which allowed for geographical payments to be separately identified.

[2] The Department's indicative zone designs overstate the size of the Fringe zone. Our estimates are based on the correct boundaries for the Fringe (see Figure 4.1).

[3] Based on the observed relationship between HCAS payments as a percentage of average basic pay, and HCAS rates, we have assumed that each additional percentage point on HCAS would add around 0.85% on average to basic salaries in each zone.

[4] Percentage increases to total earnings should correspond to percentage increases in pay bill, but cash-terms increases will not include employers' pension and National Insurance contributions, which add around 28% to costs.

**Table E1: Coverage of new HCAS zones and estimated effect on earnings for each percentage point added to HCAS**

| Zone | Headcount staff in sample | Total earnings (exc. on-costs) £m | Impact of additional 1% on HCAS | |
|---|---|---|---|---|
| | | | Total earnings (exc. on-costs) £m | As % of total earnings in England |
| Total remit group | **989,561** | **25,343** | | |
| *Current HCAS zones* | | | | |
| Inner London (currently 20%) | 101,888 | 3,390 | 22.9 | 0.09 |
| Outer London (15%) | 57,078 | 1,707 | 11.7 | 0.05 |
| Fringe (5%) | 53,459 | 1,365 | 10.0 | 0.04 |
| *5 Zone system – version A (narrow additional zone) (Figure D1)* | | | | |
| Zone 1 | 95,882 | 2,347 | 17.8 | 0.07 |
| *5 Zone system – version B (broad additional zone) (Figure D2)* | | | | |
| Zone 1 | 402,845 | 9,862 | 75.9 | 0.30 |
| *6 Zone system (Figure D3)* | | | | |
| Zone 1 | 95,882 | 2,347 | 17.8 | 0.07 |
| Zone 2 | 306,963 | 7,515 | 58.0 | 0.23 |
| *9 Zone system (Figure D4)* | | | | |
| Zone 1 | 73,519 | 1,764 | 13.5 | 0.05 |
| Zone 2 | 22,363 | 583 | 4.4 | 0.02 |
| Zone 3 | 102,615 | 2,487 | 19.3 | 0.08 |
| Zone 4 | 193,091 | 4,765 | 36.6 | 0.14 |
| Zone 5 | 254,086 | 6,162 | 46.8 | 0.18 |

*Source: OME calculations based on data supplied by the HSCIC.*

E6 Table E1 also shows the estimated marginal cost of increasing the payments in current HCAS zones by one percentage point, which may be necessary to maintain appropriate differentials between zones. For example, increasing the supplement in the current Fringe zone would cost an estimated 0.04% of pay bill per percentage point, and therefore increasing it by five percentage points to 10% would cost an estimated 0.2% of pay bill.

E7 Tables E2 to E5 provide indicative costs for illustrative levels of HCAS payments under each of the Department's zoning options. These each assume an immediate implementation; a phased introduction would smooth out the transitional costs over a number of years. In Tables E4 and E5, we make adjustments to the levels of payment in current HCAS zones to allow for differentials between zones.

**Table E2: Illustrative levels of HCAS payments and associated costs – 5 zone system (narrow additional zone)**

| Zone | Supplement | Effect on total earnings in England (exc. on-costs) | |
|---|---|---|---|
| | % | £m | % |
| Inner London | 20 | 0.0 | 0.00 |
| Outer London | 15 | 0.0 | 0.00 |
| Fringe | 5 | 0.0 | 0.00 |
| Zone 1 | 3 | 53.5 | 0.21 |
| **Total cost** | | **53.5** | **0.21** |

*Source: OME calculations based on data supplied by the HSCIC.*

**Table E3: Illustrative levels of HCAS payments and associated costs – 5 zone system (broad additional zone)**

| Zone | Supplement | Effect on total earnings in England (exc. on-costs) | |
|---|---|---|---|
| | % | £m | % |
| Inner London | 20 | 0.0 | 0.00 |
| Outer London | 15 | 0.0 | 0.00 |
| Fringe | 5 | 0.0 | 0.00 |
| Zone 1 | 3 | 227.6 | 0.90 |
| **Total cost** | | **227.6** | **0.90** |

*Source: OME calculations based on data supplied by the HSCIC.*

**Table E4: Illustrative levels of HCAS payments and associated costs – 6 zone system**

| Zone | Supplement | Effect on total earnings in England (exc. on-costs) | |
|---|---|---|---|
| | % | £m | % |
| Inner London | 20 | 0.0 | 0.00 |
| Outer London | 15 | 0.0 | 0.00 |
| Fringe | 10 | 50.2 | 0.20 |
| Zone 1 | 5 | 89.2 | 0.35 |
| Zone 2 | 3 | 174.0 | 0.69 |
| **Total cost** | | **313.4** | **1.24** |

*Source: OME calculations based on data supplied by the HSCIC.*

**Table E5: Illustrative levels of HCAS payments and associated costs – 9 zone system**

| Zone | Supplement | Effect on total earnings in England (exc. on-costs) | |
|---|---|---|---|
| | % | £m | % |
| Inner London | 20.0 | 0.0 | 0.00 |
| Outer London | 17.5 | 29.2 | 0.12 |
| Fringe | 15.0 | 100.4 | 0.40 |
| Zone 1 | 12.5 | 168.4 | 0.66 |
| Zone 2 | 10.0 | 43.7 | 0.17 |
| Zone 3 | 7.5 | 145.1 | 0.57 |
| Zone 4 | 5.0 | 183.2 | 0.72 |
| Zone 5 | 2.5 | 117.0 | 0.46 |
| **Total cost** | | **786.9** | **3.11** |

*Source: OME calculations based on data supplied by the HSCIC.*

# Appendix F – Supplementary Research

F1 This appendix presents more detailed data, which we have drawn on in our research in Chapter 6.

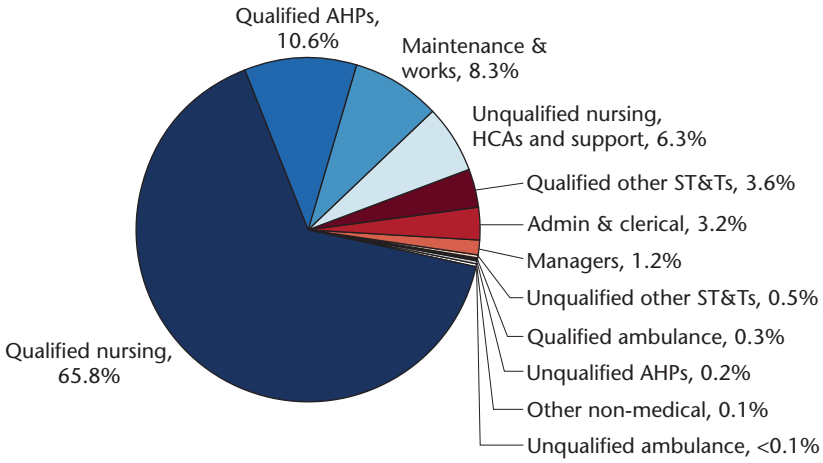
## Usage of Recruitment and Retention Premia (RRP)

F2 Figure F1 shows that nearly two-thirds of long-term RRP (LTRRP) – 32,534 out of the total of 49,479 – were paid to qualified nurses[1], with the next most common groups being qualified allied health professionals (AHPs)[2]; maintenance and works; unqualified nurses, healthcare assistants (HCAs) and support staff; and qualified scientific, therapeutic and technical staff (ST&Ts).

F3 Figure F2 shows the distribution of LTRRP in payment, by the size of the payment[3]. The mode of the distribution is at £501 to £600: 2.2% of full time equivalent (FTE) staff were paid a LTRRP of this amount. Overall, 3.9% of staff were paid a LTRRP of £600 or less.

F4 The Department, NHS Employers and the Staff Side have suggested that the relatively high usage of RRP for qualified nurses and health professionals is likely to be reflective of pre-Agenda for Change (AfC) "Cost of Living Supplements" (CoLS), which were converted to LTRRP on implementation of AfC (Box F1).

**Figure F1: Breakdown of the number of LTRRP by staff group, England, September 2010**



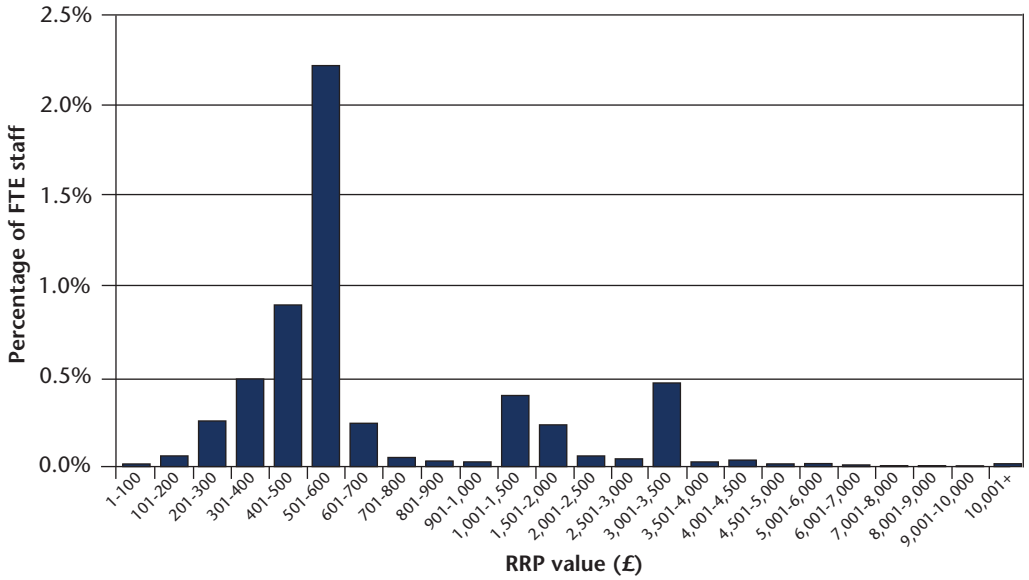

*Source: Department of Health.*

[1] This staff group includes midwives and health visitors.

[2] Allied health professionals include: chiropodists; dieticians; occupational therapists; orthoptists; physiotherapists; radiographers; art/music/drama therapists; and speech & language therapists.

[3] Note that the bands are not equal in width: they increase in increments of £100 until £1,000, then £500 increments until £5,000, then £1,000 increments thereafter.

**Figure F2: Distribution of LTRRP values for all non-medical staff, England, September 2010**




*Source: Department of Health.*

## Box F1: Cost of Living Supplements

Cost of Living Supplements (CoLS) were introduced in April 2001 as one of a number of initiatives to improve the recruitment and retention of NHS staff[4]. CoLS were specifically designed to target low participation rates among staff covered by the former Review Body for Nurses and Professions Allied to Medicine (PAMs).

CoLS were payable to staff in designated Health Authority areas (which later merged to form Strategic Health Authorities) on the basis of their staff Market Forces Factor. The geographical area covered by CoLS was extended in April 2002 to the area shown in Figure F3[5].

CoLS were funded by the Department of Health, and were paid to nurses in Whitley grades C to I and nurse consultants, and to PAMs in basic grade and above. Under AfC, this equates roughly to all qualified nurses (AfC Band 5 and above), qualified AHPs, and some qualified scientific, therapeutic and technical (ST&T) staff[6]. It also includes some unqualified / unregistered staff in these groups.

CoLS were based on 2.5% of basic salary (excluding leads or allowances), with a minimum payment outside London of £400, and a maximum of £600[7]. The minimum and maximum were never uprated. Part time staff were paid CoLS on a pro rata basis.

The AfC Handbook stated that CoLS – outside the London and Fringe high cost area supplement (HCAS) zones – would continue to be paid after assimilation to AfC but would be re-expressed as long-term RRP[8].

Reports from the press[9] and feedback from our programme of visits note that some Trusts have or intend to withdraw these LTRRP from staff.

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[4] NHS Executive (8 March 2001) *Guidance on Cost of Living Supplements*, Department of Health. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014707.pdf

[5] Department of Health (26 February 2002) *Cost of Living Supplements (COLS) for Qualified Nurses, Midwives, Health Visitors and PAMs 2002/2003*. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4013711.pdf

[6] Some ST&Ts are covered because some staff previously classified as diagnostic radiographers were subsequently assigned to the healthcare science staff group (part of "other ST&T" in the analysis). See HSCIC (2006) *NHS Hospital and Community Health Services Non-Medical staff in England: 1995-2005*, Table 4a, Note 2.

[7] The CoLS within London had a minimum of £600 and a maximum of £1,000, but this was superseded by high cost area supplements (HCAS) under AfC).

[8] NHS Staff Council (2012) *NHS Terms and Conditions of Service Handbook Amendment Number 26, Pay Circular (AforC) 2/2012*, paragraph 4.7.

[9] See for example BBC News (2011) *Royal Berkshire Hospital nurses to lose £600 pay*. Available at: http://www.bbc.co.uk/news/uk-england-berkshire-15000613

**Figure F3: Boundaries of HCAS and former CoLS zones**

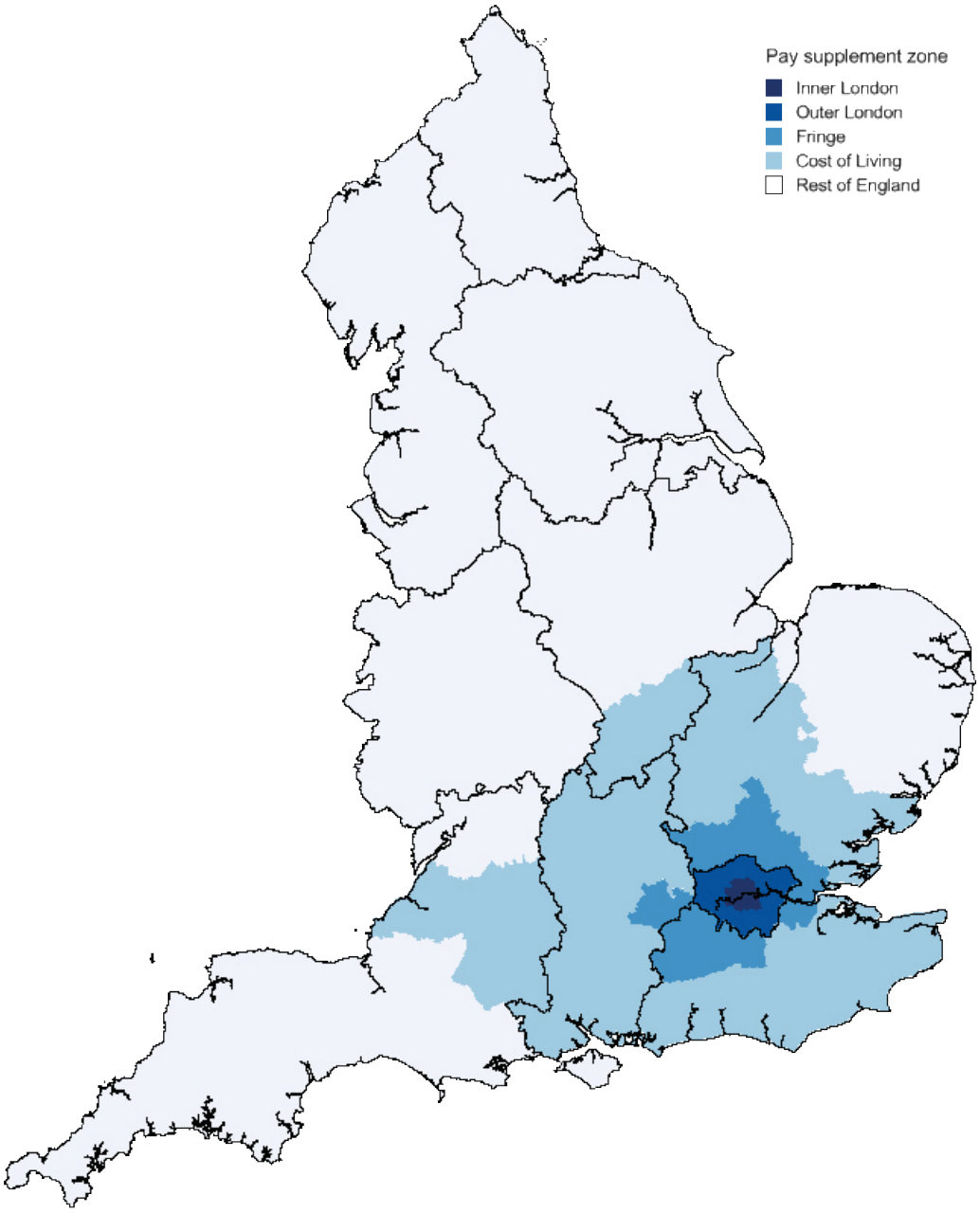
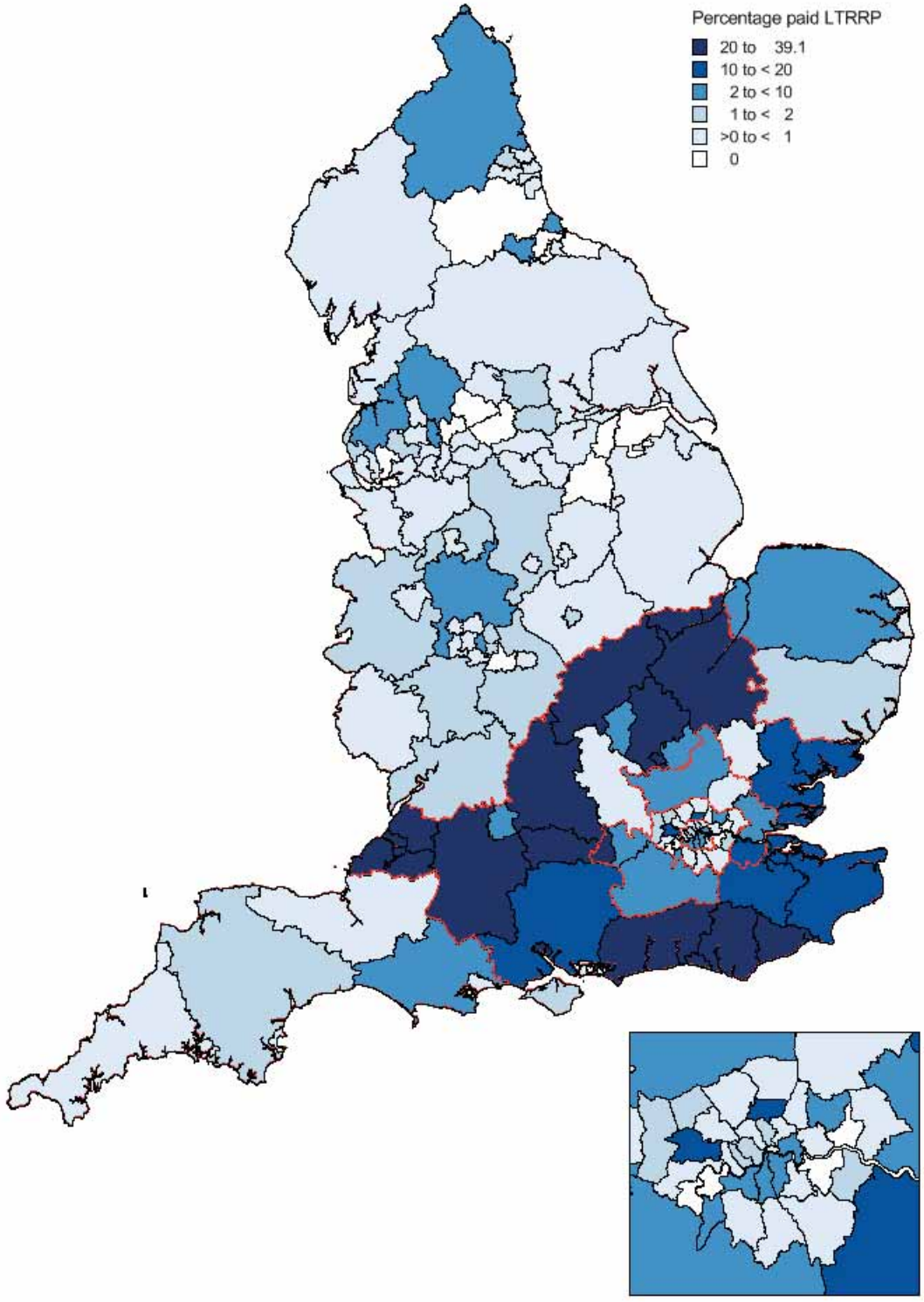


**Figure F4: Percentage of FTE staff paid a long term RRP by PCT area, September 2010**




*Source: OME calculations based on data supplied by the Department of Health.*
*Red lines indicate the boundaries of pay supplement zones (see Figure F3).*

F5 Figure F4 shows the percentage of staff in each PCT area paid a LTRRP. Darker marks indicate a higher percentage of staff. The map shows clearly that those areas with the highest percentage of staff paid a LTRRP tended to be in the zone previously covered by CoLS; overall, 22.6% of FTE staff in the former Cost of Living zone were paid a LTRRP, compared with the national average of 5.6%.

F6 It follows that it is likely that a number of LTRRP are former CoLS payments, as the parties have suggested. We estimate that over two-thirds of the total LTRRP in payment are former CoLS, by defining them as all LTRRP in the former Cost of Living zone with a value of £600 or less paid to certain staff groups[10]. Of the 49,479 LTRRP in payment in September 2010, we estimate that 33,324 were former CoLS payments (Table F1). The remainder, 16,154, is therefore our estimate of the *revised* number of LTRRP (i.e. excluding our estimate of the number of former CoLS); this represents 1.8% of the sample.

**Table F1: Breakdown of the number of LTRRP in payment by geographical area, staff group and value, England, September 2010**

| Area | Staff groups formerly eligible for CoLS | | Other staff |
|---|---|---|---|
| | LTRRP up to £600 | LTRRP over £600 | All LTRRP |
| Cost of Living zone | 33,324 | 3,346* | 1,650 |
| Rest of England (inc. London) | 718 | 5,593 | 4,848 |

** Of which 1,841 had a value between £601-£700.*
*Source: OME calculations based on data supplied by the Department of Health.*

F7 Our revised estimate of 16,154 LTRRP is likely to overstate the true position: some of the remaining LTRRP could be national RRP agreed by the parties under the AfC transitional period[11], i.e. not locally agreed in response to a specific recruitment and retention problem in individual organisations. It was not possible from the data supplied by the Department to identify these jobs, so the impact on the overall percentage of staff paid a LTRRP is unknown.

F8 Additionally, of the 3,346 LTRRP in the Cost of Living zone that had a value greater than £600, 1,841 were in the range £601-£700. It may be that these are also former CoLS payments, which have since 2004 been uprated by individual employers in line with annual pay awards, and which therefore had increased to values beyond the parameters in paragraph F6.

## Variation in Basic Pay and Total Earnings – Regression Outputs

F9 Table F2 shows the regression coefficients for the statistical model we fitted to the data on organisation-level average total earnings. In our model, we sought to explain the variation in average total earnings using three groups of variables: HCAS zone; organisation type; and the percentage of staff in each of 12 staff groups[12].

F10 The column labelled "B" shows the estimated difference between average total earnings in the reference group, and the group we wish to investigate. For example, the "B" value for Inner London is £9,389: we infer that average total earnings in Inner London are £9,389 higher than in the rest of England.

[10] Qualified nurses, qualified AHPs, qualified ST&Ts, and unqualified staff in these groups.

[11] NHS Staff Council (2012) *NHS Terms and Conditions of Service Handbook Amendment Number 26, Pay Circular (AforC) 2/2012*, Annex R.

[12] Interactions between these variables are likely – for example, ambulance Trusts have higher percentages of qualified ambulance staff than other organisations – which if accounted for may have changed the regression coefficients.

F11 The column labelled "Sig" shows the probability of this difference occurring through random chance. A value of less than 0.05 implies there is less than a 5% probability of the result occurring by random chance. The "Sig" value for Inner London is zero, so we infer that the difference between Inner London and the Rest of England is statistically significant at the 5% level.

F12 Another, equivalent, test is to examine the lower and upper bounds for the margin of error (or "confidence interval") around the estimate of the difference. For Inner London, the range is £8,202 to £10,576: since this range does not include zero, we conclude that the difference in average total pay between Inner London and the Rest of England is statistically significantly different from zero.

F13 The $R^2$ statistic in the table title shows the amount of variability in average total earnings explained by our model. For total earnings, 78.8% of the variability was explained by the three groups of variables, leaving 21.2% unexplained. The size of the $R^2$ statistic, useful for assessing variability in the dependent variable 'explained' by the model, is not the only indicator of the appropriateness or *goodness-of-fit* of a regression model. Cursory analysis of the residuals – the differences between the observed data and the regression model's 'predictions' – suggests that these residuals may not be normally distributed, so inferences should be treated with caution.

F14 Table F3 shows the regression coefficients for the model we fitted to the data on organisation-level average basic salary, which can be interpreted in the same way.

**Table F2: Regression coefficients – dependent variable: total earnings** ($R^2$ = 0.788)

| Variable | Unstandardised coefficients | | Standardised coefficients | | | 95.0% Confidence interval for B | |
|---|---|---|---|---|---|---|---|
| | B | Std. error | Beta | t | Sig. | Lower bound | Upper bound |
| (Constant) | 47,041 | 5,397 | | 8.716 | 0.000 | 36,426 | 57,657 |
| **Geographical variables (reference group: Rest of England)** | | | | | | | |
| Fringe | 993 | 725 | 0.035 | 1.369 | 0.172 | -434 | 2,420 |
| Outer London | 5,791 | 642 | 0.236 | 9.026 | 0.000 | 4,529 | 7,052 |
| Inner London | 9,389 | 603 | 0.433 | 15.559 | 0.000 | 8,202 | 10,576 |
| **Organisation type variables (reference group: large acute Trusts)** | | | | | | | |
| Acute – Medium | -351 | 746 | -0.015 | -0.471 | 0.638 | -1,819 | 1,116 |
| Acute – Multi-service | -244 | 1,860 | -0.003 | -0.131 | 0.896 | -3,903 | 3,414 |
| Acute – Small | -251 | 723 | -0.011 | -0.347 | 0.729 | -1,672 | 1,171 |
| Acute – Specialist | 1,297 | 931 | 0.042 | 1.394 | 0.164 | -534 | 3,129 |
| Acute – Teaching | 493 | 812 | 0.019 | 0.607 | 0.544 | -1,105 | 2,091 |
| Ambulance Trust | -37,688 | 31,129 | -0.843 | -1.211 | 0.227 | -98,913 | 23,537 |
| Care Trust | -436 | 1,402 | -0.009 | -0.311 | 0.756 | -3,193 | 2,321 |
| Community Trust | -599 | 1,232 | -0.014 | -0.486 | 0.627 | -3,022 | 1,824 |
| Mental Health/Learning Disability Trust | 1,690 | 791 | 0.088 | 2.136 | 0.033 | 134 | 3,246 |
| Primary Care Trust | 839 | 747 | 0.062 | 1.124 | 0.262 | -629 | 2,308 |
| Special Health Authority | -247 | 1,402 | -0.006 | -0.176 | 0.860 | -3,005 | 2,511 |
| Strategic Health Authority | 7,657 | 1,442 | 0.191 | 5.312 | 0.000 | 4,822 | 10,492 |
| Unknown | -994 | 3,226 | -0.008 | -0.308 | 0.758 | -7,338 | 5,350 |
| **Workforce composition variables (omitted percentage: senior managers)** | | | | | | | |
| Qualified nurses | -225 | 56 | -0.455 | -3.992 | 0.000 | -336 | -114 |
| Qualified AHPs | -348 | 72 | -0.288 | -4.840 | 0.000 | -489 | -206 |
| Qualified healthcare scientists | -231 | 89 | -0.116 | -2.590 | 0.010 | -407 | -56 |
| Qualified other ST&T | -286 | 81 | -0.163 | -3.524 | 0.000 | -446 | -126 |
| Qualified ambulance staff | 220 | 369 | 0.247 | 0.597 | 0.551 | -505 | 945 |
| Support to doctors and nursing staff | -239 | 58 | -0.422 | -4.090 | 0.000 | -354 | -124 |
| Support to ST&T staff | -217 | 81 | -0.140 | -2.701 | 0.007 | -376 | -59 |
| Support to ambulance staff | 264 | 349 | 0.232 | 0.757 | 0.450 | -422 | 950 |
| Central functions | -182 | 59 | -0.538 | -3.096 | 0.002 | -297 | -66 |
| Hotel, property & estates | -316 | 60 | -0.290 | -5.239 | 0.000 | -434 | -197 |
| Managers | -9 | 64 | -0.014 | -0.148 | 0.883 | -134 | 116 |

*Source: OME calculations based on data supplied by the HSCIC.*

**Table F3: Regression coefficients – dependent variable: basic pay** ($R^2$ = 0.817)

| Variable | Unstandardised coefficients | | Standardised coefficients | | | 95.0% Confidence interval for B | |
|---|---|---|---|---|---|---|---|
| | B | Std. error | Beta | t | Sig. | Lower bound | Upper bound |
| (Constant) | 44,369 | 4,197 | | 10.572 | 0.000 | 36,115 | 52,624 |
| **Geographical variables (reference group: Rest of England)** | | | | | | | |
| Fringe | -32 | 564 | -0.001 | -0.056 | 0.955 | -1,141 | 1,078 |
| Outer London | 1,520 | 499 | 0.074 | 3.047 | 0.002 | 539 | 2,501 |
| Inner London | 4,228 | 469 | 0.233 | 9.010 | 0.000 | 3,305 | 5,151 |
| **Organisation type variables (reference group: large acute Trusts)** | | | | | | | |
| Acute – Medium | -379 | 580 | -0.019 | -0.653 | 0.514 | -1,520 | 762 |
| Acute – Multi-service | -234 | 1,446 | -0.004 | -0.162 | 0.872 | -3,079 | 2,611 |
| Acute – Small | -207 | 562 | -0.011 | -0.369 | 0.713 | -1,312 | 898 |
| Acute – Specialist | 1,177 | 724 | 0.045 | 1.626 | 0.105 | -247 | 2,601 |
| Acute – Teaching | 296 | 632 | 0.014 | 0.469 | 0.639 | -946 | 1,539 |
| Ambulance Trust | -22,269 | 24,205 | -0.596 | -0.920 | 0.358 | -69,876 | 25,338 |
| Care Trust | 686 | 1,090 | 0.017 | 0.629 | 0.530 | -1,458 | 2,829 |
| Community Trust | 319 | 958 | 0.009 | 0.333 | 0.740 | -1,565 | 2,203 |
| Mental Health/Learning Disability Trust | 2,108 | 615 | 0.131 | 3.427 | 0.001 | 898 | 3,318 |
| Primary Care Trust | 1,379 | 581 | 0.121 | 2.374 | 0.018 | 236 | 2,521 |
| Special Health Authority | 1,484 | 1,090 | 0.046 | 1.361 | 0.174 | -660 | 3,629 |
| Strategic Health Authority | 9,007 | 1,121 | 0.269 | 8.035 | 0.000 | 6,802 | 11,211 |
| Unknown | -413 | 2,508 | -0.004 | -0.165 | 0.869 | -5,346 | 4,520 |
| **Workforce composition variables (omitted percentage: senior managers)** | | | | | | | |
| Qualified nurses | -210 | 44 | -0.508 | -4.791 | 0.000 | -296 | -124 |
| Qualified AHPs | -285 | 56 | -0.282 | -5.104 | 0.000 | -395 | -175 |
| Qualified healthcare scientists | -158 | 69 | -0.095 | -2.276 | 0.023 | -294 | -21 |
| Qualified other ST&T | -221 | 63 | -0.151 | -3.506 | 0.001 | -345 | -97 |
| Qualified ambulance staff | -4 | 287 | -0.006 | -0.015 | 0.988 | -568 | 559 |
| Support to doctors and nursing staff | -266 | 45 | -0.562 | -5.864 | 0.000 | -356 | -177 |
| Support to ST&T staff | -242 | 63 | -0.187 | -3.866 | 0.000 | -365 | -119 |
| Support to ambulance staff | 47 | 271 | 0.050 | 0.174 | 0.862 | -486 | 580 |
| Central functions | -196 | 46 | -0.694 | -4.295 | 0.000 | -286 | -106 |
| Hotel, property & estates | -323 | 47 | -0.354 | -6.892 | 0.000 | -415 | -231 |
| Managers | -16 | 49 | -0.029 | -0.319 | 0.750 | -113 | 81 |

*Source: OME calculations based on data supplied by the HSCIC.*

F15 Tables F4 and F5 show regression coefficients for the alternative model we fitted to average total earnings and basic pay: in this model, we replaced variables representing HCAS zones with a single variable representing the sMFF value for each organisation. For every increase of 0.01 in the sMFF[13], holding all other variables constant, average total earnings increased by £251, and average basic pay increased by £95.

[13] In our fitted model, we multiplied the sMFF value for each organisation by 100. An increase of 0.01 in sMFF is therefore equivalent to an increase of 1 in our transformed variable.

F16 Note that the $R^2$ statistics for these tables are not as high as for Tables F2 and F3: the model using sMFF values does not fit the data as well as the model using HCAS zones.

**Table F4: Regression coefficients – dependent variable: total earnings (2)** ($R^2$ = 0.660)

| Variable | Unstandardised coefficients | | Standardised coefficients | | | 95.0% Confidence interval for B | |
|---|---|---|---|---|---|---|---|
| | B | Std. error | Beta | t | Sig. | Lower bound | Upper bound |
| (Constant) | 17,258 | 6,480 | | 2.663 | 0.008 | 4,509 | 30,007 |
| **Staff Market Forces Factor** | | | | | | | |
| sMFF * 100 | 251 | 19 | 0.451 | 13.035 | 0.000 | 213 | 288 |
| **Organisation type variables (reference group: large acute Trusts)** | | | | | | | |
| Acute – Medium | -996 | 781 | -0.053 | -1.276 | 0.203 | -2,532 | 539 |
| Acute – Multi-service | -1,202 | 1,952 | -0.021 | -0.616 | 0.538 | -5,042 | 2,638 |
| Acute – Small | -155 | 773 | -0.009 | -0.201 | 0.841 | -1,675 | 1,365 |
| Acute – Specialist | 1,391 | 1,013 | 0.056 | 1.373 | 0.171 | -602 | 3,383 |
| Acute – Teaching | 1,248 | 850 | 0.061 | 1.467 | 0.143 | -425 | 2,920 |
| Ambulance Trust | -31,549 | 32,775 | -0.886 | -0.963 | 0.336 | -96,028 | 32,930 |
| Care Trust | 1,298 | 1,576 | 0.034 | 0.823 | 0.411 | -1,803 | 4,399 |
| Community Trust | -41 | 3,352 | 0.000 | -0.012 | 0.990 | -6,636 | 6,553 |
| Mental Health/Learning Disability Trust | 2,399 | 993 | 0.156 | 2.416 | 0.016 | 445 | 4,353 |
| Primary Care Trust | 1,550 | 959 | 0.140 | 1.616 | 0.107 | -337 | 3,437 |
| **Workforce composition variables (omitted percentage: senior managers)** | | | | | | | |
| Qualified nurses | -140 | 65 | -0.310 | -2.157 | 0.032 | -268 | -12 |
| Qualified AHPs | -313 | 81 | -0.301 | -3.861 | 0.000 | -473 | -154 |
| Qualified healthcare scientists | -59 | 176 | -0.025 | -0.333 | 0.739 | -405 | 288 |
| Qualified other ST&T | -185 | 90 | -0.127 | -2.052 | 0.041 | -363 | -8 |
| Qualified ambulance staff | 299 | 387 | 0.422 | 0.772 | 0.441 | -463 | 1,060 |
| Support to doctors and nursing staff | -221 | 67 | -0.436 | -3.306 | 0.001 | -353 | -90 |
| Support to ST&T staff | -168 | 90 | -0.129 | -1.865 | 0.063 | -346 | 9 |
| Support to ambulance staff | 144 | 367 | 0.159 | 0.393 | 0.695 | -578 | 867 |
| Central functions | -127 | 67 | -0.400 | -1.894 | 0.059 | -259 | 5 |
| Hotel, property & estates | -267 | 68 | -0.299 | -3.950 | 0.000 | -400 | -134 |
| Managers | 44 | 84 | 0.053 | 0.528 | 0.598 | -121 | 210 |

*Source: OME calculations based on data supplied by the HSCIC.*

**Table F5: Regression coefficients – dependent variable: basic pay (2)** ($R^2$ = 0.709)

| Variable | Unstandardised coefficients | | Standardised coefficients | | | 95.0% Confidence interval for B | |
|---|---|---|---|---|---|---|---|
| | B | Std. error | Beta | t | Sig. | Lower bound | Upper bound |
| (Constant) | 30,767 | 4,590 | | 6.704 | 0.000 | 21,738 | 39,797 |
| **Staff Market Forces Factor** | | | | | | | |
| sMFF * 100 | 95 | 14 | 0.224 | 6.999 | 0.000 | 69 | 122 |
| **Organisation type variables (reference group: large acute Trusts)** | | | | | | | |
| Acute – Medium | -615 | 553 | -0.043 | -1.113 | 0.267 | -1,703 | 473 |
| Acute – Multi-service | -501 | 1,382 | -0.011 | -0.362 | 0.717 | -3,220 | 2,219 |
| Acute – Small | -79 | 547 | -0.006 | -0.144 | 0.886 | -1,155 | 998 |
| Acute – Specialist | 1,353 | 717 | 0.071 | 1.886 | 0.060 | -58 | 2,764 |
| Acute – Teaching | 813 | 602 | 0.052 | 1.350 | 0.178 | -372 | 1,997 |
| Ambulance Trust | -19,985 | 23,213 | -0.733 | -0.861 | 0.390 | -65,654 | 25,683 |
| Care Trust | 1,694 | 1,116 | 0.058 | 1.517 | 0.130 | -502 | 3,890 |
| Community Trust | 814 | 2,374 | 0.011 | 0.343 | 0.732 | -3,857 | 5,485 |
| Mental Health/Learning Disability Trust | 2,571 | 703 | 0.219 | 3.655 | 0.000 | 1,187 | 3,955 |
| Primary Care Trust | 2,065 | 679 | 0.243 | 3.040 | 0.003 | 729 | 3,402 |
| **Workforce composition variables (omitted percentage: senior managers)** | | | | | | | |
| Qualified nurses | -153 | 46 | -0.442 | -3.325 | 0.001 | -244 | -63 |
| Qualified AHPs | -268 | 57 | -0.337 | -4.668 | 0.000 | -381 | -155 |
| Qualified healthcare scientists | -38 | 125 | -0.021 | -0.303 | 0.762 | -283 | 207 |
| Qualified other ST&T | -144 | 64 | -0.128 | -2.243 | 0.026 | -269 | -18 |
| Qualified ambulance staff | 63 | 274 | 0.115 | 0.228 | 0.820 | -477 | 602 |
| Support to doctors and nursing staff | -246 | 47 | -0.631 | -5.181 | 0.000 | -339 | -152 |
| Support to ST&T staff | -195 | 64 | -0.195 | -3.052 | 0.002 | -321 | -69 |
| Support to ambulance staff | 10 | 260 | 0.015 | 0.039 | 0.969 | -502 | 522 |
| Central functions | -154 | 47 | -0.634 | -3.245 | 0.001 | -247 | -61 |
| Hotel, property & estates | -281 | 48 | -0.410 | -5.866 | 0.000 | -375 | -187 |
| Managers | 13 | 60 | 0.020 | 0.214 | 0.830 | -104 | 130 |

*Source: OME calculations based on data supplied by the HSCIC.*

## Variation in Average Pay Bands

F17 Tables F6 and F7 show regression coefficients for the model we fitted to organisation-level data on average pay bands for clerical and administrative staff working in central functions (occupation code G2A), and "other 1st Level nurses" working in acute, elderly and general care (code N6A).

F18 Although the amount of variability explained by the model is fairly poor, there is evidence of a statistically significant difference in the average pay band for G2A staff in Outer and Inner London, compared with the Rest of England. For N6A staff, the difference is significant in Inner London only.

F19 Regression coefficients for the other 12 occupations in our analysis are available on request.

**Table F6: Regression coefficients for G2A average pay band** ($R^2$ = 0.396)

| Variable | Unstandardised coefficients | | Standardised coefficients | | | 95.0% Confidence interval for B | |
|---|---|---|---|---|---|---|---|
| | B | Std. error | Beta | t | Sig. | Lower bound | Upper bound |
| (Constant) | 4.22 | 0.08 | | 49.86 | 0.000 | 4.05 | 4.38 |
| **Geographical variables (reference group: Rest of England)** | | | | | | | |
| Fringe | 0.07 | 0.14 | 0.02 | 0.49 | 0.626 | -0.20 | 0.34 |
| Outer London | 0.38 | 0.10 | 0.15 | 3.76 | 0.000 | 0.18 | 0.58 |
| Inner London | 0.83 | 0.10 | 0.36 | 8.59 | 0.000 | 0.64 | 1.02 |
| **Organisation type variables (reference group: large acute Trusts)** | | | | | | | |
| Acute – Medium | 0.09 | 0.13 | 0.04 | 0.71 | 0.478 | -0.16 | 0.34 |
| Acute – Multi-service | -0.05 | 0.28 | -0.01 | -0.17 | 0.866 | -0.61 | 0.51 |
| Acute – Small | 0.01 | 0.12 | 0.00 | 0.06 | 0.950 | -0.23 | 0.24 |
| Acute – Specialist | 0.16 | 0.15 | 0.05 | 1.03 | 0.303 | -0.14 | 0.45 |
| Acute – Teaching | 0.12 | 0.14 | 0.04 | 0.87 | 0.385 | -0.15 | 0.38 |
| Ambulance Trust | 0.17 | 0.18 | 0.04 | 0.94 | 0.347 | -0.19 | 0.54 |
| Care Trust | 0.32 | 0.19 | 0.07 | 1.68 | 0.093 | -0.05 | 0.70 |
| Community Trust | -0.06 | 0.14 | -0.02 | -0.39 | 0.699 | -0.34 | 0.23 |
| Mental Health/Learning Disability Trust | 0.25 | 0.11 | 0.12 | 2.23 | 0.026 | 0.03 | 0.47 |
| Primary Care Trust | 0.64 | 0.10 | 0.44 | 6.70 | 0.000 | 0.46 | 0.83 |
| Shared Services | 0.06 | 0.39 | 0.01 | 0.16 | 0.875 | -0.71 | 0.83 |
| Special Health Authority | 0.83 | 0.19 | 0.20 | 4.35 | 0.000 | 0.46 | 1.21 |
| Strategic Health Authority | 1.45 | 0.19 | 0.32 | 7.57 | 0.000 | 1.07 | 1.83 |
| Unknown | 0.74 | 0.55 | 0.05 | 1.35 | 0.179 | -0.34 | 1.82 |

*Source: OME calculations based on data supplied by the HSCIC.*

**Table F7: Regression coefficients for N6A average pay band** ($R^2$ = 0.242)

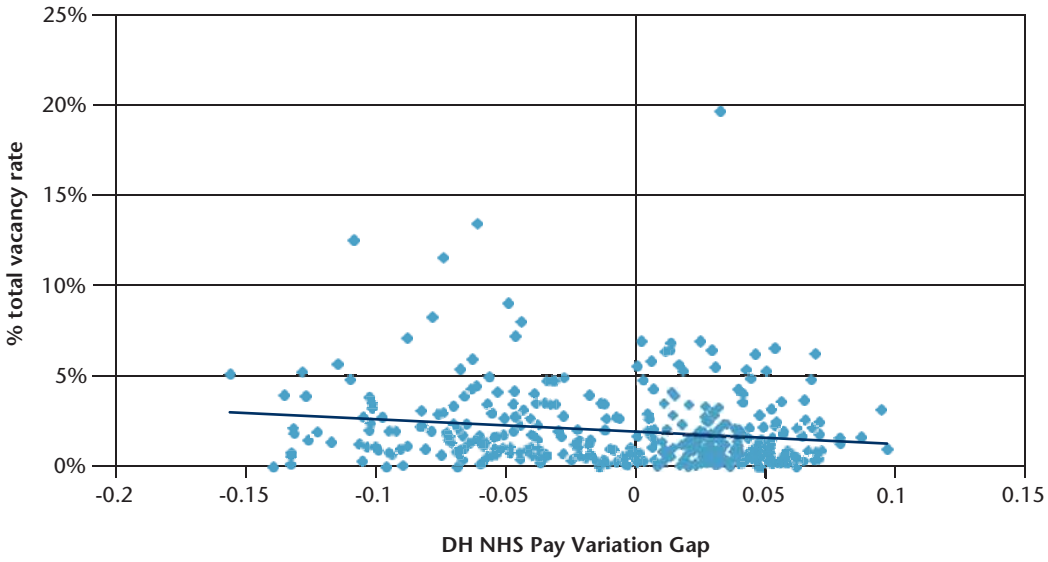
| Variable | Unstandardised coefficients | | Standardised coefficients | | | 95.0% Confidence interval for B | |
|---|---|---|---|---|---|---|---|
| | B | Std. error | Beta | t | Sig. | Lower bound | Upper bound |
| (Constant) | 5.50 | 0.08 | | 64.80 | 0.000 | 5.33 | 5.66 |
| **Geographical variables (reference group: Rest of England)** | | | | | | | |
| Fringe | 0.23 | 0.16 | 0.08 | 1.43 | 0.153 | -0.09 | 0.55 |
| Outer London | 0.03 | 0.12 | 0.02 | 0.30 | 0.768 | -0.20 | 0.27 |
| Inner London | 0.47 | 0.12 | 0.22 | 4.05 | 0.000 | 0.24 | 0.69 |
| **Organisation type variables (reference group: large acute Trusts)** | | | | | | | |
| Acute – Medium | -0.01 | 0.13 | -0.01 | -0.08 | 0.933 | -0.26 | 0.24 |
| Acute – Multi-service | 0.04 | 0.28 | 0.01 | 0.14 | 0.888 | -0.52 | 0.60 |
| Acute – Small | 0.01 | 0.12 | 0.01 | 0.10 | 0.919 | -0.22 | 0.25 |
| Acute – Specialist | 0.20 | 0.16 | 0.07 | 1.24 | 0.217 | -0.12 | 0.51 |
| Acute – Teaching | -0.07 | 0.14 | -0.03 | -0.54 | 0.591 | -0.34 | 0.20 |
| Ambulance Trust | 0.93 | 0.26 | 0.19 | 3.61 | 0.000 | 0.42 | 1.43 |
| Care Trust | 0.84 | 0.24 | 0.19 | 3.54 | 0.000 | 0.37 | 1.31 |
| Community Trust | 0.41 | 0.15 | 0.16 | 2.76 | 0.006 | 0.12 | 0.71 |
| Mental Health/Learning Disability Trust | 0.46 | 0.12 | 0.24 | 3.69 | 0.000 | 0.21 | 0.70 |
| Primary Care Trust | 0.45 | 0.10 | 0.32 | 4.32 | 0.000 | 0.25 | 0.66 |
| Special Health Authority | 1.12 | 0.40 | 0.15 | 2.78 | 0.006 | 0.33 | 1.92 |
| Unknown | 0.51 | 0.55 | 0.05 | 0.93 | 0.354 | -0.57 | 1.59 |

*Source: OME calculations based on data supplied by the HSCIC.*

## The Relationship Between Relative Pay in the NHS and Private Sector, and Recruitment, Retention, Motivation and Patient Experience

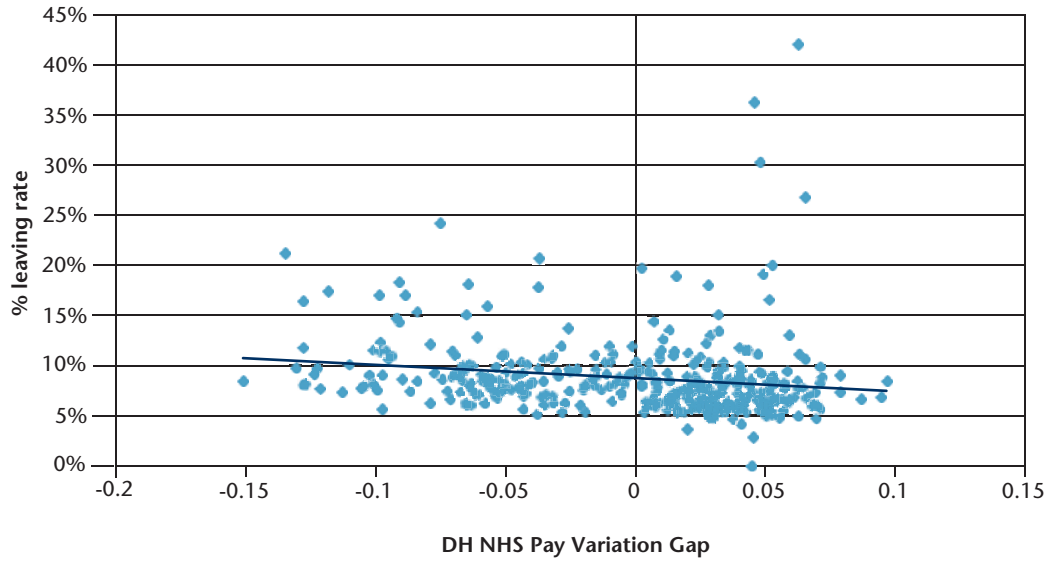
F20 Figures F5 to F16 show the relationship between the Department's measure of the geographical pay variability gap (GPVG) between the NHS and the private sector, and a range of measures relating to recruitment, retention, motivation, earnings and patient experience. Our interpretation of these data is in paragraphs 6.59-6.61.

**Figure F5: Relationship between GPVG and total vacancy rate, March 2010**



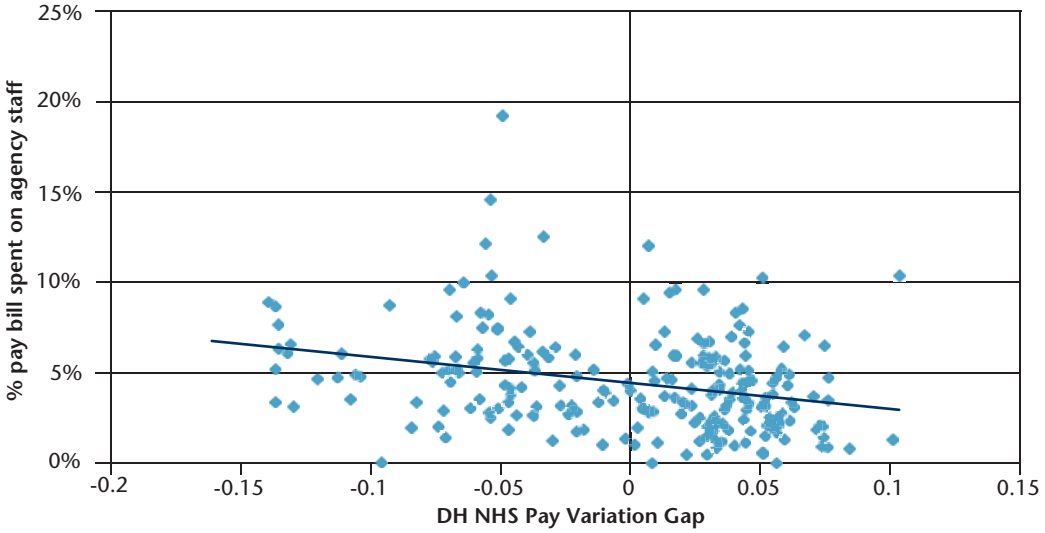

*Sources: Department of Health, HSCIC.*

**Figure F6: Relationship between GPVG and leaving rate, January 2010-2011**



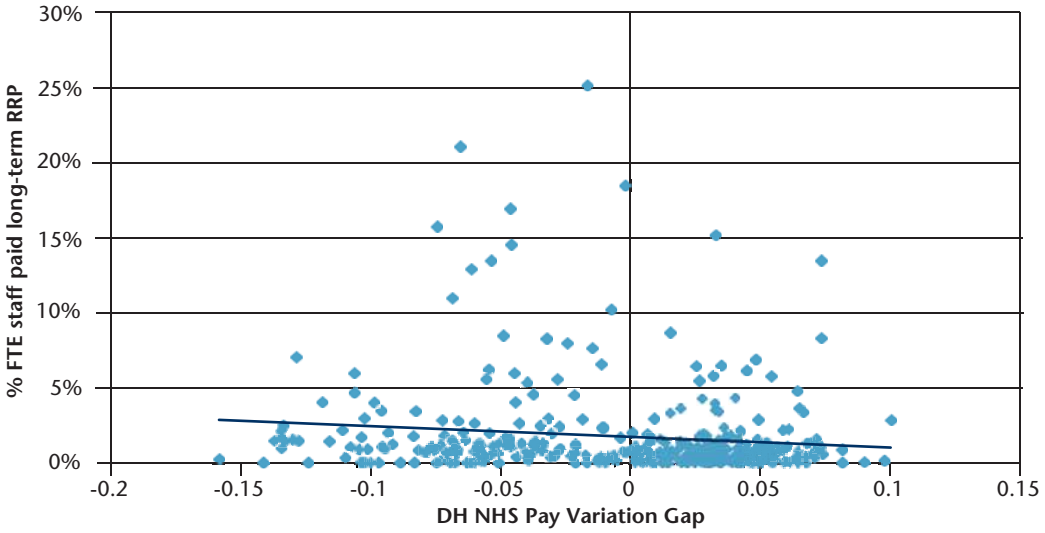

*Sources: Department of Health, HSCIC.*

**Figure F7: Relationship between GPVG and the percentage of pay bill spent on agency staff, 2010-2011**



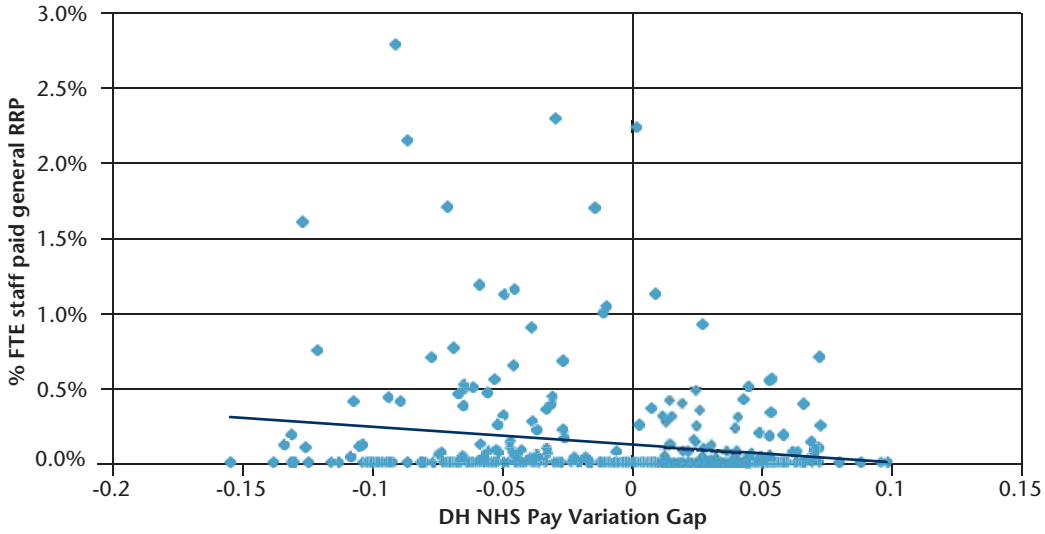

*Source: Department of Health.*

**Figure F8: Relationship between GPVG and the percentage of staff paid a long-term RRP, excluding estimated CoLS, September 2010**



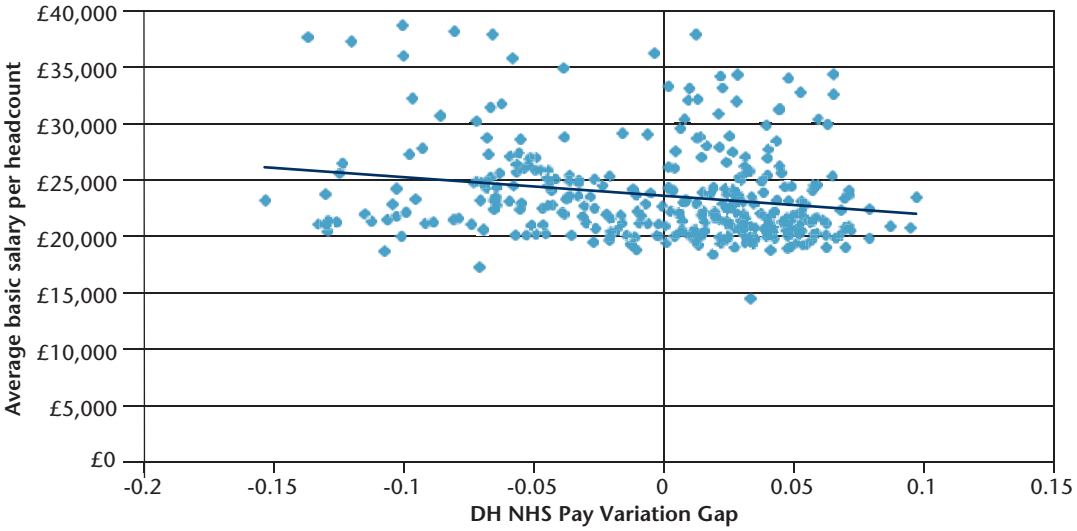

*Sources: Department of Health, OME calculations.*

**Figure F9: Relationship between GPVG and the percentage of staff paid a general RRP, excluding estimated CoLS, September 2010**



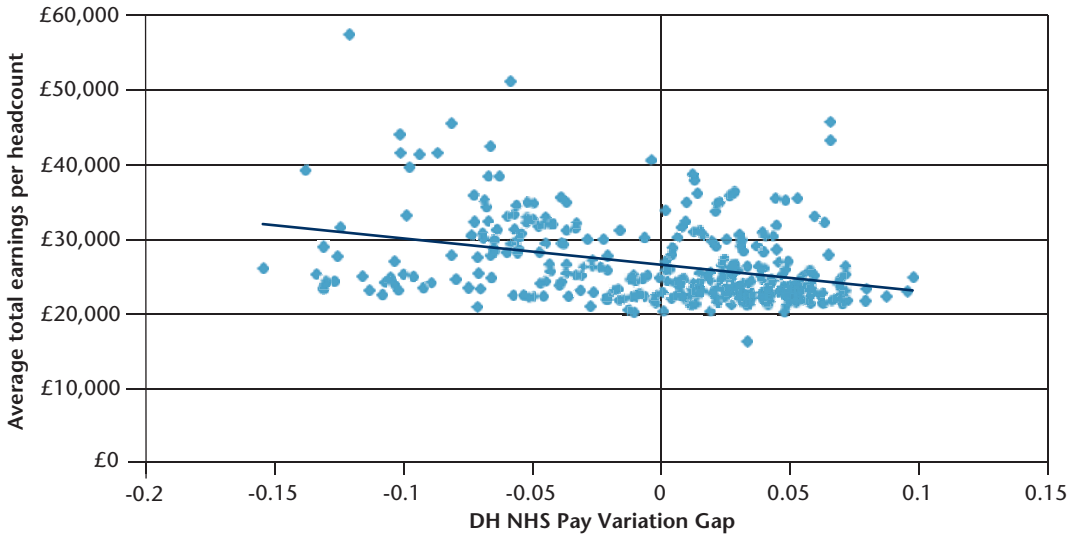

*Sources: Department of Health, OME calculations.*

**Figure F10: Relationship between GPVG and average basic salary, 2011**



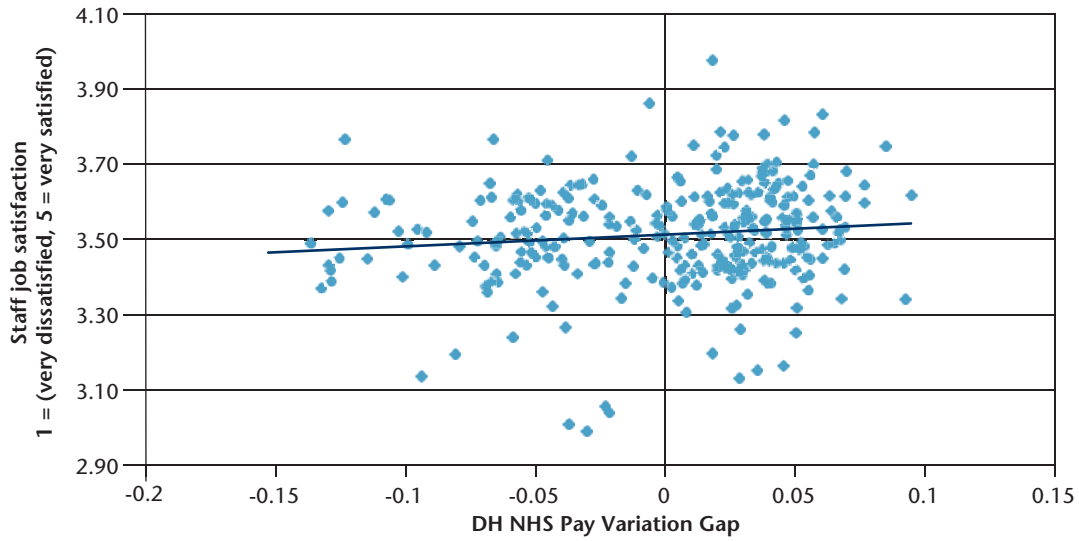

*Sources: Department of Health, HSCIC.*

**Figure F11: Relationship between GPVG and average total earnings, 2011**



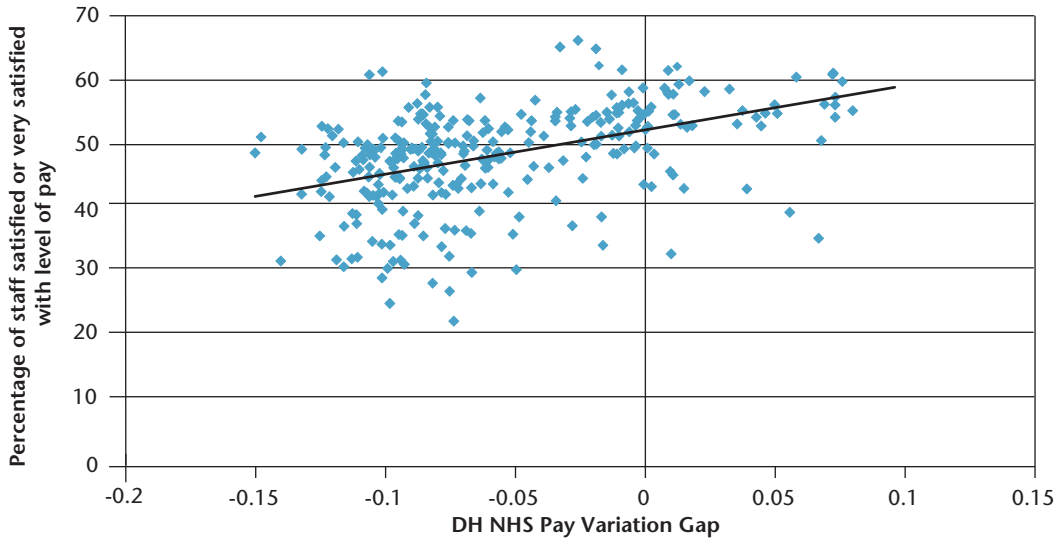

*Sources: Department of Health, HSCIC.*

**Figure F12: Relationship between GPVG and staff job satisfaction, 2011**



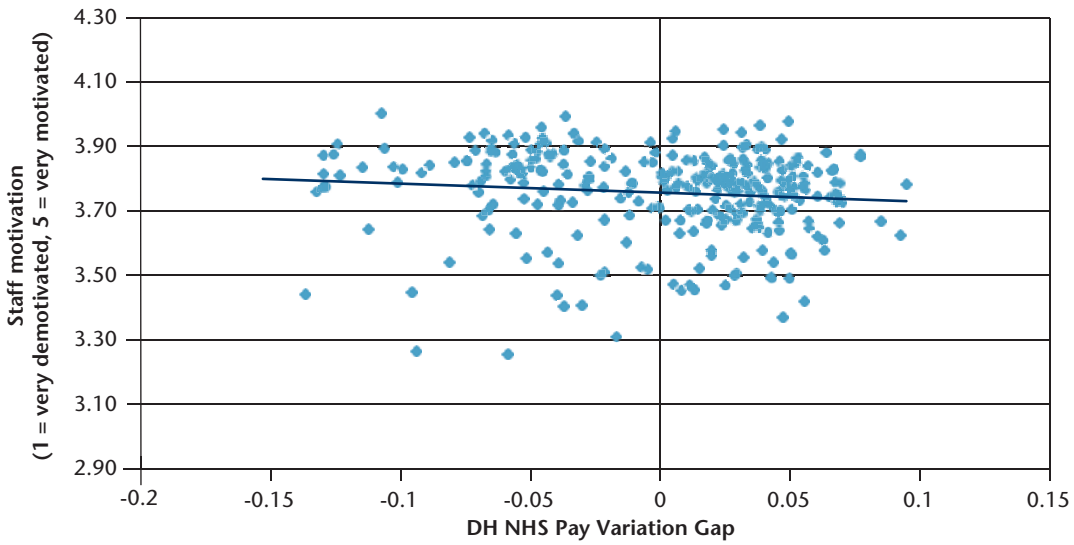

*Sources: Department of Health, Care Quality Commission.*

**Figure F13: Relationship between GPVG and satisfaction with pay, 2011**



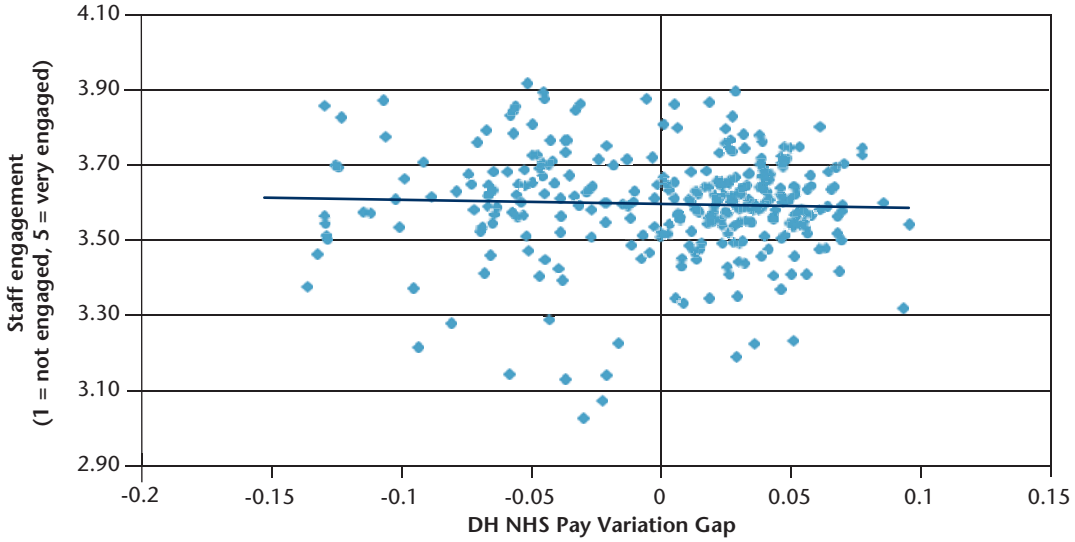

*Sources: Department of Health, Care Quality Commission.*

**Figure F14: Relationship between GPVG and staff motivation at work, 2011**



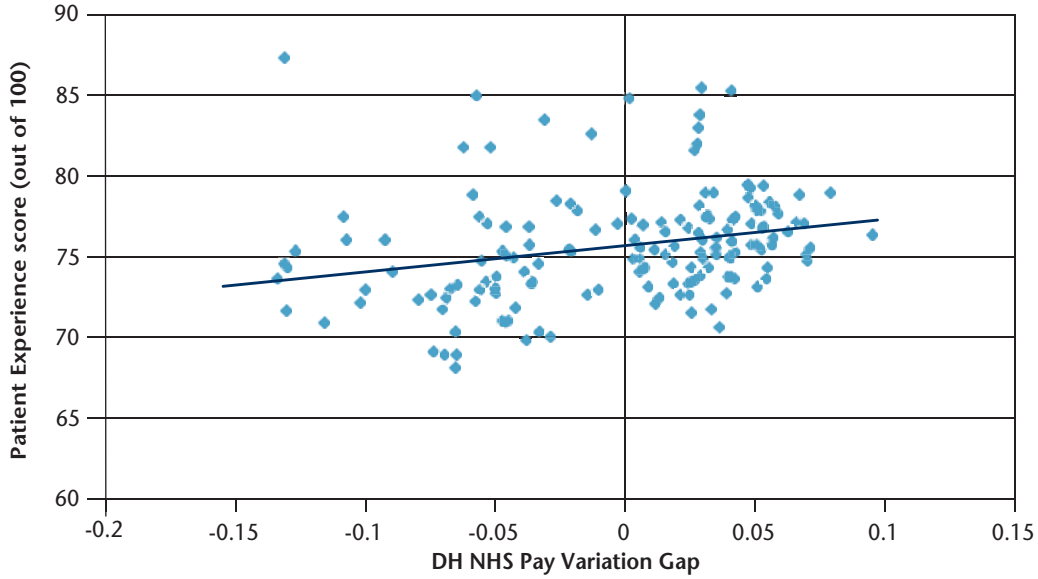

*Sources: Department of Health, Care Quality Commission.*

**Figure F15: Relationship between GPVG and staff engagement, 2011**




*Sources: Department of Health, Care Quality Commission.*

**Figure F16: Relationship between GPVG and patient experience, 2010/11**




*Sources: Department of Health, HSCIC.*

## Appendix G – Previous Reports of the Review Body

### NURSING STAFF, MIDWIVES AND HEALTH VISITORS

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

## PROFESSIONS ALLIED TO MEDICINE

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

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

| | |
|---|---|
| Twentieth Report on Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine | Cm 5716, August 2003 |
| Twenty-First Report on Nursing and Other Health Professionals | Cm 6752, March 2006 |
| Twenty-Second Report on Nursing and Other Health Professionals | Cm 7029, March 2007 |

## NHS PAY REVIEW BODY

| | |
|---|---|
| Twenty-Third Report, NHS Pay Review Body 2008 | Cm 7337, April 2008 |
| Twenty-Fourth Report, NHS Pay Review Body 2009 | Cm 7646, July 2009 |
| Decision on whether to seek a remit to review pay increases in the three year agreement – http://www.ome.uk.com/review.cfm?body=6 | December 2009 |
| Twenty-Fifth Report, NHS Pay Review Body 2011 | Cm 8029, March 2011 |
| Twenty-Sixth Report, NHS Pay Review Body 2012 | Cm 8298, March 2012 |

## Appendix H – Abbreviations

| | |
|---|---|
| **AfC** | Agenda for Change |
| **AHPs** | Allied Health Professionals |
| **AMI** | Acute Myocardial Infarction |
| **ASHE** | Annual Survey of Hours and Earnings |
| **CBI** | Confederation of British Industry |
| **CEP** | Centre for Economic Performance |
| **CoLS** | Cost of Living Supplement |
| **DWP** | Department for Work and Pensions |
| **ESR** | Electronic Staff Record |
| **FTE** | Full Time Equivalent |
| **GB** | Great Britain |
| **GDP** | Gross Domestic Product |
| **GPVG** | Geographical Pay Variation Gap |
| **GRRP** | General Recruitment and Retention Premia |
| **HCAs** | Healthcare Assistants |
| **HCAS** | High Cost Area Supplements |
| **HERU** | Health Economics Research Unit |
| **HMRC** | Her Majesty's Revenue and Customs |
| **HR** | Human Resources |
| **HSCIC** | Health and Social Care Information Centre |
| **IDS** | Incomes Data Services |
| **IFS** | Institute for Fiscal Studies |
| **IoD** | Institute of Directors |
| **IT** | Information Technology |
| **KSF** | Knowledge and Skills Framework |
| **LFS** | Labour Force Survey |
| **LGA** | Local Government Association |
| **LTRRP** | Long Term Recruitment and Retention Premia |
| **MFF** | Market Forces Factor |
| **MoJ** | Ministry of Justice |

| | |
|---|---|
| **NHS** | National Health Service |
| **NHSE** | NHS Employers |
| **NHSPRB** | NHS Pay Review Body |
| **NOHPRB** | Review Body for Nursing and Other Health Professions |
| **OBR** | Office for Budget Responsibility |
| **OME** | Office of Manpower Economics |
| **ONS** | Office for National Statistics |
| **PAM** | Professions Allied to Medicine |
| **PbR** | Payment by Results |
| **PCT** | Primary Care Trust |
| **RCM** | Royal College of Midwives |
| **RRP** | Recruitment and Retention Premia |
| **SERC** | Spatial Economics Research Centre |
| **SHA** | Strategic Health Authority |
| **sMFF** | Staff Market Forces Factor |
| **SSRB** | Senior Salaries Review Body |
| **STRB** | School Teachers' Review Body |
| **ST&T** | Scientific, Therapeutic and Technical |
| **TSO** | The Stationery Office |
| **TTWA** | Travel To Work Area |
| **TUC** | Trades Union Congress |
| **UCATT** | Union of Construction, Allied Trades and Technicians |
| **UK** | United Kingdom |
| **VSMs** | Very Senior Managers |
| **WERS** | Workplace Employment Relations Survey |

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