NHS
Pay Review
Body

NHS Pay Review Body

Twenty-Eighth Report 2014

Chair: Jerry Cope

Cm 8831

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Twenty-Eighth Report 2014

Chair: Jerry Cope

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

**Presented to the Scottish Parliament by the
First Minister and the Cabinet Secretary for Health and Wellbeing**

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

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

March 2014

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NHS Pay Review Body

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

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

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

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

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

the Government's inflation target;

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

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

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

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

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

Reports and recommendations should be submitted jointly to the Prime Minister, the Secretary of State for Health, the First Minister and the Cabinet Secretary for Health and Wellbeing in Scotland, the First Minister and the Minister for Health and Social Services of the National Assembly for Wales, and the First Minister, Deputy First Minister and Minister for Health, Social Services and Public Safety of the Northern Ireland Executive.

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

Members of the Review Body are:

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Professor David Blackaby
Dame Denise Holt, DCMG
Joan Ingram
Graham Jagger
Colin Kennedy[1]
Janet Rubin, MBE
Professor Anna Vignoles

The secretariat is provided by the Office of Manpower Economics.

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[1] Colin Kennedy was appointed to the NHS Pay Review Body by the Parliamentary Under Secretary of State for Health from 1 April 2013.

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Executive summary

Our 2014/15 recommendations are:

- **A 1 per cent increase to all Agenda for Change pay points from 1 April 2014.**
- **A 1 per cent increase to the High Cost Area Supplement minima and maxima from 1 April 2014.**
- **That the parties should take urgent steps to provide data on both long-term and short-term vacancies, to be available for consideration for our next review. We would expect the data available to allow us to identify whether there are any current and/or developing problems in specific geographies or sustained shortages in specific occupations.**

Our observations are:

- **Progress on a wider seven-day service is urgently needed. The parties should now rapidly negotiate and agree changes to Agenda for Change alongside negotiations for medical staff.**
- **There is a pressing need to manage and apply the agreed pay progression arrangements properly through the application of a simplified Knowledge and Skills Framework in order to ensure that pay progression is linked to competency development and performance, as was intended within Agenda for Change.**
- **We urge the parties to agree quickly a thorough review of the Agenda for Change pay structure, including the operation of incremental scales, so that it might better support the challenges facing the NHS in terms of both patient care and affordability. We suggest that if the parties find it difficult to agree we would be prepared to look into this if given an appropriate remit and evidence.**

Our remit

Our remit for 2014/15 was once again conducted against the background of the United Kingdom Government's public sector pay policy, which limits pay uplifts to an average of 1 per cent, and that of the Scottish Government, which places a cost cap of 1 per cent on pay increases, with the exception of staff earning less than £21,000, whom the policy states should receive a minimum increase of £300. In the event of any award being made, the Welsh Government preferred a focus on the lower paid, including the Living Wage, and queried both whether awards should be made in addition to increments and the appropriateness of an award to the highest paid. The Northern Ireland Executive asked us to consider whether it was appropriate to uplift NHS salaries in the light of available resources and demands on the service.

We continue to believe that our process has most value when we are able to bring independent and expert judgement to bear on all factors within our terms of reference. We also recognise the effect that continued restrictions could have on the parties' perceptions of our independence. However, the United Kingdom Government's approach not only anticipated the outcome of our deliberations, but crucially conditioned the expectations of the public sector staff affected and effectively set both a ceiling and a baseline to our deliberations.

The remits for the four countries for 2014/15 all asked for somewhat different outcomes. Agenda for Change was designed as a United Kingdom-wide framework, but we recognise that health is a devolved issue. We have had to decide whether to remain with United Kingdom-wide pay scales or recommend different awards for each of the four countries. In doing so, we have given full consideration to the evidence presented by all the parties in reaching our recommendations, notwithstanding these constraints on our remit.

The economy, labour market and pay

Although the economic recovery is gaining strength our assessment, from the evidence received and in relation to our terms of reference, is that the economy and the labour market are not currently putting significant pressure on Agenda for Change pay. However, we continue to recognise the effect of inflation in reducing real wages for those 47 per cent of Agenda for Change staff at the top of pay scales who are not in receipt of incremental progression, though we note that this effect is not unique to the NHS.

Funds available to the Health Departments

It is clear to us that growing financial pressures are a very significant issue for all four countries this year. Although all four countries had 1 per cent for public sector pay allocated in the Spending Round, there were a range of views on the affordability of a pay award for our remit group because of the varying cost pressures in each country and the requirements to make significant productivity improvements. However, at its highest level, funding is a matter of political choice. Our role is not to challenge this, but to seek to operate within our terms of reference for NHS staff, including taking into account the constraints of public expenditure policy on the one hand, and on the other the growing demand for high quality, patient-centred healthcare.

Recruitment, retention and motivation

We have deliberated upon the conflicting evidence from the parties with particular regard to the need to recruit and retain sufficient appropriately skilled staff, and to maintain staff motivation, which we recognise are essential factors in the provision of better quality patient care. We do not see any current signs of general recruitment and retention issues, and staff turnover is generally low. While there are shortages for certain occupations, we continue to think that any particular shortages are best dealt with through Recruitment and Retention Premia and improved workforce planning. The evidence on staff engagement differed between the countries and for some occupational groups, but the overall position remains relatively stable. We do, however, believe that staff engagement remains critical to the delivery of patient care, and we recognise both the stresses affecting staff, and that society expects a lot from NHS staff, who face greater scrutiny to deliver to the required standards, particularly following the Francis report.

The need for improved and consistent data collection on vacancy and attrition levels to enable effective workforce planning has been a longstanding concern for us since the collection of vacancy data in England ceased in 2011. It is increasingly apparent that there is a need for better data so that trusts can closely monitor the adequacy of their staffing levels to ensure high quality and safe patient care. Trusts need this information to make their decisions, and we need these data in making our recommendations and observations. This is so central to our remit that we have decided to make a recommendation aimed at improving the data underpinning our deliberations on recruitment and retention. **We recommend that the parties should take urgent steps to provide data on both long-term and short-term vacancies, to be available for consideration for our next review. We would expect the data available to allow us to identify whether there are any current and/or developing problems in specific geographies or sustained shortages in specific occupations.**

The Agenda for Change pay structure

We received a variety of evidence on Agenda for Change and we were asked to address a number of issues by the Secretary of State for Health. We recognise from the evidence received that the four countries of the United Kingdom have different policies for public sector pay.

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However, all parties favoured continuation of a United Kingdom-wide Agenda for Change structure, and we have concluded that pay levels for Agenda for Change should be maintained across the United Kingdom this year.

We have considered carefully whether the award should be tied to progress on Agenda for Change reform, as sought by the Department of Health, Health Education England, NHS England and NHS Employers. However, it is not clear to us in sufficient and open detail what specific changes the parties are seeking, nor how we could best support them. We have concluded that it would be neither appropriate nor feasible to make a recommendation specifically to tie the award in this way. However, we are mindful that lack of progress on reform may well mean that prospective future awards may have to be ruled out on the grounds of affordability and/or priority and we will need to take this into account in our future reports.

As with any pay system, Agenda for Change needs to respond to the pressures and direction of operational strategy, including the provision of seven-day services; we have not, however, been presented with either a specific remit or the necessary detailed evidence, including costs, to make other than general observations. **Progress on a wider seven-day service is urgently needed. The parties should now rapidly negotiate and agree changes to Agenda for Change alongside negotiations for medical staff.**

We were asked by the Secretary of State for Health to consider the existing progression structure for Agenda for Change staff and its distribution among staff. It is clear from the evidence presented to us that there is growing dissatisfaction with a range of factors around the progression structure of the Agenda for Change pay system. These include the number of points in each pay band, the spacing of these points, the inability to reward good performance for those at the top of pay scales, common pay points across bands, the appropriate rate for the job and the rigour and extent of the application of the Knowledge and Skills Framework underpinning progression. We were also constrained in the actions we could recommend by the integrated nature of the Agenda for Change pay scale; for example, where the top pay point for one band is tied to a point in a subsequent band. **We urge the parties to agree quickly a thorough review of the Agenda for Change pay structure, including the operation of incremental scales, so that it might better support the challenges facing the NHS in terms of both patient care and affordability. We suggest that if the parties find it difficult to agree we would be prepared to look into this if given an appropriate remit and evidence.**

We were also asked by the Secretary of State for Health to consider incremental pay for staff who had not yet reached the top of their pay scale. The evidence we received from the Department of Health and NHS Employers implied that incremental progression cost 2 per cent per annum. However, we understand that the net cost was 0.6 per cent in 2012/13 and may well be lower this year as more staff reach the top of their pay band. Therefore, we do not consider incremental pay to be costly, in net terms, because of new staff being recruited to the bottom of the scale, replacing, in general, staff at the top point. However, we do consider that the operation of the system is ineffective in rewarding performance because of widespread inadequacies in the appraisal and performance management system. **There is a pressing need to manage and apply the agreed pay progression arrangements properly through the application of a simplified Knowledge and Skills Framework in order to ensure that pay progression is linked to competency development and performance, as was intended within Agenda for Change.**

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Pay proposals and recommendations for 2014/15

In reaching our recommendations for 2014/15 we considered all the evidence presented to us. On affordability, we are in no doubt that trusts and some of the Devolved Administrations are in increasingly difficult financial circumstances. On the other hand, the Department of Health and the Scottish Government told us that funding was being made available to employers to cover a 1 per cent rise this year, and we hold to our view that it is neither desirable nor sustainable to substitute a pay squeeze for productivity and transformational reforms. Overall, we do not see any current signs of general recruitment and retention issues. There is limited evidence of early warning signals of potential recruitment or retention problems in certain specialisms or geographies, although as the United Kingdom economy improves, we believe these may become more serious.

In the light of this, we have considered what impact the possible outcomes of our deliberations would have on patients, who are the people at the centre of the NHS. In particular, we recognise the connection between quality patient care and the morale and motivation of the staff delivering that care. Our conclusion was that Government statements have led staff to expect a pay settlement this year of around 1 per cent. If these expectations were to be dashed, patients would be impacted through declining staff morale and engagement.

Taking all these factors into account, we have concluded that it is appropriate to award Agenda for Change staff a flat 1 per cent pay increase for 2014/15. At the same time, we think that if any pay rise is to be recommended next year, we would expect to see much more urgency on innovative reforms in the NHS. These reforms include: implementation of the agreed changes in England designed to increase the link between performance and pay; and a serious effort to raise management and leadership skills at all levels, particularly in the area of performance management. We would like to see far stronger evidence of effective workforce planning, including hard data on vacancies, skill shortages and attrition. **We recommend a 1 per cent increase to all Agenda for Change pay points from 1 April 2014.**

While we await the review of High Cost Area Supplements (HCAS), we have reviewed the levels of HCAS minima and maxima in line with our role under the parties' agreement as set out in the *NHS Terms and Conditions of Service Handbook*. Our conclusions in the *Market-Facing Pay* report were that recruitment and retention indicators for Agenda for Change staff were relatively less favourable in London and surrounding areas. Furthermore, we do not consider that Agenda for Change staff at the HCAS minima and maxima should be disadvantaged when other staff receiving HCAS payments would receive the full effect of the 1 per cent increase to basic pay. We have concluded, as in previous years, that staff receiving HCAS payments will regard these as part of basic pay. We estimate that a 1 per cent uplift to the HCAS minima and maxima would cost less than £5 million of the Agenda for Change basic pay bill in England. **We recommend a 1 per cent increase to the High Cost Area Supplement minima and maxima from 1 April 2014.**

Next steps

We conclude this report with a summary of the key messages that we consider cover the priority actions for the NHS in the future and that need to be addressed before the next round. These include:

- if the health budget does not increase in real terms for some time, greater improvements in productivity will be needed to meet the increasing demands for healthcare and the improvements in patient care following the Francis report; these will require high staff engagement and involvement, which in turn require an appropriate pay structure;
- there is therefore a need for further development of the Agenda for Change framework to enable it to play its role in supporting the wide-ranging programme of reforms across the NHS;

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- there is also a need to ensure that progress along the Agenda for Change pay scales reflects competence development, and performance; and
- urgent negotiations, alongside the negotiations for medical staff, are needed to progress the implementation of the necessary changes to Agenda for Change to enable a fuller range of the seven-day delivery of patient services.

JERRY COPE *(Chair)*
PROFESSOR DAVID BLACKABY
DAME DENISE HOLT, DCMG
JOAN INGRAM
GRAHAM JAGGER
COLIN KENNEDY
JANET RUBIN, MBE
PROFESSOR ANNA VIGNOLES

25 February 2014

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Chapter 1 – Introduction

Introduction

1.1 For 2014/15 we have received remits from the United Kingdom Government and the Devolved Administrations. For the first time, these remits differ, although the theme of affordability runs through them all. We therefore have received, and considered, separate pay propositions for each of the countries in the United Kingdom, whilst noting all stakeholders' expressed preference to remain with a single pay system across the United Kingdom.

1.2 With these remits in mind we have applied the considerations in our standing terms of reference. In addition to the overall pay uplift, we considered whether High Cost Area Supplements should be changed and we reviewed the evidence for any new national Recruitment and Retention Premia, under our role in the parties' agreement as set out in the *NHS Terms and Conditions of Service Handbook.*[1] In this report we set out the evidence presented by the parties on these matters, and our conclusions and recommendations under the various elements of our terms of reference. Our recommendations apply to all NHS staff paid under Agenda for Change.

Structure of the Report

1.3 This report has been divided into seven chapters comprising: this introduction; and chapters covering the economy, labour market and pay; funds available to the Health Departments; recruitment, retention and motivation; the Agenda for Change pay structure; our pay proposals and recommendations for 2014/15; and next steps. The remit letters from the parties are at Appendix A. The recommended Agenda for Change pay scales, with effect from 1 April 2014 can be found at Appendix B. Appendix C contains data on the composition of our remit group. The Department of Health's pay metrics are at Appendix D. Links to the evidence on the parties' websites are at Appendix E. A list of the previous reports published by the Review Body is at Appendix F and a key to the abbreviations used in this report at Appendix G. We summarise our requirements for future evidence at the end of the relevant chapters. Our terms of reference are set out at the beginning of this report.[2]

Twenty-Seventh Report 2013[3]

1.4 Our *Twenty-Seventh Report* was submitted to the Prime Minister, Secretary of State for Health and the relevant ministers for the Devolved Administrations on 14 February 2013. Our recommendations were constrained by the public sector pay policies of the United Kingdom Government and the Scottish Government. We recommended a 1 per cent increase to all Agenda for Change pay points and to the High Cost Area Supplements minima and maxima from 1 April 2013. The United Kingdom Government accepted our recommendations on 13 March 2013; the Health Departments in England, Wales and Northern Ireland confirmed acceptance of our report. The Scottish Government also accepted our recommendation for a 1 per cent pay uplift, with those staff on £21,000 or less receiving a minimum of £250, the top up paid as a non-consolidated award.

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[1] NHS Staff Council. *NHS terms and conditions of service handbook.* Amendment number 29. Pay Circular (AforC) 3/2013, Sections 4 and 5. Available from: http://www.nhsemployers.org/PayAndContracts/AgendaForChange/TermsAndConditionsOfServiceHandbook/Pages/Afc-Handbookrp.aspx

[2] The NHS Pay Review Body terms of reference can be found on page iii of this report.

[3] NHS Pay Review Body. *Twenty-seventh report.* Cm 8555. TSO, 2013. Available from: https://www.gov.uk/government/publications/nhsprb-report-number-27-2013

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Remits for our Twenty-Eighth Report

1.5 Our remit covers 1.36 million (headcount) Agenda for Change staff across the whole of the United Kingdom in England, Wales, Scotland and Northern Ireland. The detailed composition of our remit group can be found at Appendix C. Unless we state otherwise, our comments apply to the entire United Kingdom.

1.6 This year we received different remit letters from all four countries of the United Kingdom. The letters are included in full at Appendix A and summarised below.

HM Treasury

1.7 The remit for this report was first announced by the Chancellor of the Exchequer in his Autumn Statement[4] in November 2011. The Chancellor said 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 United Kingdom Government would seek public sector pay awards that averaged 1 per cent. The Chancellor also stated 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 2011 Autumn Statement added that the United Kingdom 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.

1.8 The Chief Secretary to the Treasury wrote to us on 23 July 2013 reiterating the United Kingdom Government's public sector pay policy that public sector pay awards would again average 1 per cent in 2014/15 (i.e. the second year following the pay freeze) and confirming that the case for continued pay restraint across the public sector remained strong. He said that at the highest level there were unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year. On affordability, he said that pay restraint remained a crucial part of the consolidation plans that would help to put the United Kingdom back on the path of fiscal sustainability, and continued restraint of public sector pay would help to protect jobs in the public sector and support the quality of public services. The Chief Secretary to the Treasury asked us to consider what award was justified and whether there was a case for a higher award to particular groups of staff relative to the rest of the workforce, due to particular recruitment and retention difficulties. He advised that pay awards should be applied to basic salary, based on the normal interpretation of basic salary in each workforce, and that this did not include overtime or any regular payments such as London weighting, recruitment and retention premia or other allowances. The letter noted that the Government would welcome our contribution on additional elements of reward such as non-pay terms and conditions and specific allowances as part of total reward. It invited us to consider the impact of our remit group's progression structure and its distribution among staff when we made our recommendations on the annual pay awards.

Department of Health

1.9 The Parliamentary Under Secretary of State for Health wrote to us on 6 August 2013, following up and elaborating on the Chief Secretary's letter of 23 July 2013 which set out Government pay policy. His letter clarified the remit further in relation to Agenda for Change staff in England and stated that while our remit covered the whole of the United Kingdom, it was for each of the United Kingdom administrations to decide on its own approach to this year's pay review round and communicate this to us. He reiterated that we should consider the existing progression structure for Agenda for Change staff and its

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[4] HM Treasury. *Autumn Statement 2011.* Cm 8231. TSO, November 2011. Available from: http://www.official-documents.gov.uk/document/cm82/8231/8231.pdf

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distribution among staff when considering and recommending the annual pay award. He said that for the NHS, affordability and the level of incremental pay that staff would receive, alongside recruitment and retention pressures, would be critical elements as we determined whether any award was justified. In addition to the usual terms of reference, his letter asked us to: make recommendations for the basic pay of the NHS staff within our remit for 2014/15; and to consider the level of incremental pay that staff who had not yet reached the top of their scale would receive.

Welsh Government

1.10 The Minister for Health and Social Services wrote to us on 25 September 2013. His letter noted the increasing demand for health services in Wales combined with a budget for 2014/15 that in real terms would be 12 per cent lower than in 2010/11. In making our recommendations, he asked us to consider whether:

- in the current financial environment it was appropriate to uplift NHS salaries;
- any award should be confined to the lower pay bands in recognition of the tackling poverty agenda;
- any award should be confined to raising the starting rates for employees in the NHS to a salary equal to the Living Wage level;
- it would be more appropriate to provide staff with a fixed sum increase rather than a percentage uplift; and
- a pay freeze would be appropriate for higher earners if an award were given.

Scottish Government

1.11 The Cabinet Secretary for Health and Wellbeing wrote to us on 12 September 2013, following the announcement of the Scottish Government's Public Sector Pay Policy for 2014/15, which was intended to inform considerations around pay for public sector groups including NHSScotland staff. The relevant features of the Public Sector Pay Policy were:

- a provision for an increase in basic pay for all staff. This increase was subject to an overall cost cap of 1 per cent, although there was no assumption that this would equate to a 1 per cent uplift. The cost cap did not include any pay progression or measures put in place for staff earning under £21,000; and
- a minimum increase of £300 for staff earning less than £21,000.

1.12 His letter said that beyond these parameters the Scottish Government wished the Review Body to be as free as possible in considering the issues and making recommendations for Scotland in 2014/15. It recognised the challenges presented to the Review Body that the differences between Scottish and English policies might present in making recommendations to cover the whole of the United Kingdom, particularly since the Scottish Government's preference would be to maintain one unified Agenda for Change system.

Northern Ireland Executive

1.13 The Minister for Health, Social Services and Public Safety wrote to us on 18 October 2013. He said that Northern Ireland was facing significant financial pressure against a backdrop of increasing needs across health and social services. He asked us to consider whether it was appropriate to provide a pay uplift in the light of available resources and demands on the service. He also confirmed that Northern Ireland supported the maintenance of a unified Agenda for Change pay system and that there was a need for continued restraint.

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Our comment on the 2014/15 remits

1.14 The remits for 2014/15 all asked for somewhat different outcomes. Agenda for Change was designed as a United Kingdom-wide framework, but health is a devolved issue, and each of the four Governments is responding to its own political and economic priorities according to its own democratic mandate. We have had to decide whether to remain with United Kingdom-wide pay scales or recommend different awards for each of the four countries. In doing so, we gave full consideration to the evidence presented by all the parties in reaching our recommendations, notwithstanding these constraints on our remit. We address this issue in Chapter 5.

1.15 In addition our remit was again constrained by the different public sector pay policies of the United Kingdom and Scottish Governments, both of which have been widely publicised, thus inevitably raising expectations amongst the relevant staff groups. We continue to remain concerned that a constrained remit necessarily limits the scope of the evidence we receive from the parties and consequently reduces our ability to produce recommendations drawing on the widest evidence base.

1.16 Given the significance of public sector pay bills in overall public spending, it is understandable that Governments feel a need to shape the outcome of pay reviews. However, we are increasingly of the view that this is detrimental to the Review Body process, and is at worst counter productive. We continue to believe that our process has most value when we are able to bring independent and expert judgement to bear on all factors within our terms of reference, which naturally include the latest economic and labour market conditions and the affordability of pay awards. We consider and balance all these factors in reaching our independent judgements.

1.17 The Government's approach to limiting public sector pay awards not only anticipated the outcome of our deliberations, but crucially conditioned the expectations of the public sector staff affected. By seeking pay awards that average 1 per cent, the United Kingdom Government, based largely on affordability grounds across the public sector, effectively set both a ceiling and a baseline to our considerations. However, we have a range of other factors to take into account.

Our Market-Facing Pay Report 2012[5]

1.18 We address the progress being made on the recommendations in our *Market-Facing Pay* report in Chapter 5. We continue to be disappointed at the slow rate of progress being made on our recommendations and we expect to see real and meaningful progress being made during 2014/15.

Parties Giving Evidence for our Twenty-Eighth Report

1.19 We received written evidence from 13 organisations (listed below) for this round and the parties provided supplementary written evidence in response to our requests and the other parties' evidence.

Government Departments

Department of Health, England
Department of Health and Social Services, Welsh Government
Department of Health, Social Services and Public Safety, Northern Ireland Executive
Health Education England
NHS England
Scottish Government Health and Social Care Directorates

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[5] NHS Pay Review Body. *Market-facing pay: how Agenda for Change pay can be made more appropriate to local labour markets.* Cm 8501. TSO, 2012. Available from: https://www.gov.uk/government/publications/nhs-local-pay-2012

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Employers' Bodies

Foundation Trust Network
NHS Employers

Bodies representing NHS staff

Joint Staff Side
Royal College of Midwives
Royal College of Nursing
Unison
Unite the Union

1.20 Changes in the structure of the NHS in England have led to the creation of new bodies, such as Health Education England and NHS England, from whom we received written evidence for the first time.

1.21 We held oral evidence sessions over four days in November 2013 with: the Secretary of State for Health, the Parliamentary Under Secretary of State for Health, and officials from HM Treasury and the Department of Health; the Minister for Health and Social Services and officials from the Welsh Government; the Cabinet Secretary for Health and Wellbeing and officials from the Scottish Government; the Minister for Health, Social Services and Public Safety and officials from the Department of Health, Social Services and Public Safety, Northern Ireland Executive; the Joint Staff Side; the Foundation Trust Network; and NHS Employers. We valued the oral evidence from ministers in all four countries of the United Kingdom. Oral evidence is an important part of our review process as it enables us to inform our views by following up and discussing issues that have arisen in the written evidence and elsewhere.

1.22 Our work programme to produce this particular report included 13 Review Body meetings in which we considered the written and oral evidence, examined information on the economy and labour market and formed our conclusions, observations and recommendations.

1.23 We offer our thanks to all the parties for submitting written evidence and attending our oral evidence sessions. We work to a very tight time schedule, so we were particularly grateful to receive most of the written evidence on time. We ask the parties to meet the deadlines that we set for the submission of the written evidence as delays not only impact on our schedule but on the time available for the other parties to comment on the evidence, which is an important element of the process. We greatly appreciate the time and effort spent by the parties in preparing and presenting evidence to us, albeit we would prefer some of the evidence to be more focused. We remind the parties that although there is inevitably a degree of judgement and opinion in the evidence submitted to us, conclusions that are backed up by hard data carry the greatest weight. We are particularly grateful for the speed with which they responded to our questions. Links to the evidence on the parties' websites can be found at Appendix E. Where appropriate, we have summarised at the end of the chapters, the evidence requirements that we have identified for our next review.

1.24 We also take this opportunity to remind all parties to the process that an essential element of the independent and transparent Review Body process is the sharing of all evidence between the parties and publicly via the parties' websites. We are not able to consider, or treat as evidence, any information that cannot be shared. We also ask the parties to place their main and supplementary evidence on their websites as soon as possible after submission.

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Review Body Visits in 2013

1.25 Our annual programme of visits to NHS organisations is an important addition to the parties' evidence. During the visits, which take place across a range of organisations in the United Kingdom, meeting a varied cross-section of both types of organisation and geographies across a few years, we discuss issues with members of our remit group and NHS management. Once again, we extend our thanks to all those who gave generously of their time in order to meet us, for the frank opinions expressed and to those staff organising our visits.

1.26 Between May and July 2013 we visited the following organisations:

Belfast Health and Social Care Trust;
County Durham and Darlington NHS Foundation Trust;
Croydon Health Services NHS Trust;
Hinchingbrooke Health Care NHS Trust;
The Ipswich Hospital NHS Trust;
NHS Grampian;
North Staffordshire Combined Healthcare NHS Trust; and
Taunton and Somerset NHS Foundation Trust.

NHS Developments

1.27 We provide a brief update below on a range of developments across the NHS which currently or in the near future will impact on the employment and pay arrangements of NHS Agenda for Change staff.

Total reward and pensions

1.28 In our *Market-Facing Pay* report we recommended that each NHS trust should have a transparent and open pay and reward strategy including its use of Agenda for Change flexibilities to meet the delivery of local services and to improve patient outcomes.[6] However, anecdotal evidence from our visits programme suggests that many trusts and boards still do not have a reward strategy. We note that NHS Employers' website now contains the reward strategy toolkit[7] and we hope that this will go some way in assisting all employing bodies to develop and implement an appropriate total reward pay strategy.

1.29 We are conscious that the NHS Pension Scheme is currently undergoing significant change and modernisation and that there will be a new NHS scheme in 2015. In addition we note that NHS organisations are also fulfilling their legal duties around automatic enrolment, which require employers automatically to enrol eligible jobholders into a qualifying pension scheme.

1.30 We recognise that continued pay restraint will have an impact on individual staff, many of whom will have had to meet the cost of higher pension contributions. We also recognise that a further very significant financial pressure for the NHS has been raised by HM Treasury's recently circulated consultation paper, on draft directions to recalculate the

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[6] NHS Pay Review Body. *Market-facing pay: how Agenda for Change pay can be made more appropriate to local labour markets.* Cm 8501. TSO, 2012. Recommendation 7. Available from: https://www.gov.uk/government/publications/nhs-local-pay-2012

[7] NHS Employers. *Reward strategy toolkit.* Available from: http://www.nhsemployers.org/PayAndContracts/Reward-Strategy-toolkit/Pages/default.aspx

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value of public sector pensions. NHS Employers told us that independent actuaries had calculated that it would result in additional costs of around £1.7 billion from 2015, if the draft remained unchanged, which it believed would be unaffordable for the NHS.[8]

Legal obligations on the NHS

1.31 Our terms of reference require us to take account of the legal obligations on the NHS, including anti-discrimination legislation regarding age, gender, race, sexual orientation, religion and belief and disability. This underpins all that we do and while we do not receive evidence on this from the parties as a matter of course, we take it into account when formulating our recommendations.

Patients at the heart

1.32 One of the elements of our terms of reference is that we should have regard to the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which it is achieved. There have been a number of reports published during the past year which relate to this and which have led to reforms in the NHS. NHS Employers described the various reports as having had a significant impact on the workforce.

1.33 The Francis Report[9] of the inquiry into the "serious failings" at the Mid Staffordshire NHS Foundation Trust was published in February 2013, shortly before our *Twenty-Seventh Report* was submitted. It investigated the "appalling suffering of many patients" and made many detailed recommendations to improve patient care and services in the NHS. The report referred to incentivising and rewarding compassionate and excellent nursing care. **NHS Employers** noted that the Government's response to the report particularly referred to pay and contractual issues and strongly encouraged employers to use the full flexibilities in existing pay and contracts so that pay progression was linked to quality of care, not time served. This has been a theme throughout the evidence we received. **NHS England** said that the Francis Report, the Government's initial response and the subsequent review by the NHS England Medical Director had highlighted the scale of the quality and organisational challenges facing the NHS. It believed that any changes to national pay, terms and conditions had to be seen in this context, not as changes for their own sake, but as a way of delivering more care, more appropriately.

1.34 A number of reviews followed in the wake of the Francis Report including: the Cavendish Review[10] into healthcare assistants and support workers; the Keogh Mortality Review,[11] conducted across 14 hospitals; and the Berwick Review[12] into patient safety.

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[8] NHS Employers. *Response to Her Majesty's Treasury's consultation on draft directions titled "The Public Service Pensions (Valuations and Employer Cost Cap) Directions 2013"*: 19 July 2013. Available from: http://www.nhsemployers.org/SiteCollectionDocuments/Consultation%20response%20on%20valuation%20directions%20FINAL.pdf

[9] Robert Francis QC, chairman. *Report of the Mid Staffordshire NHS foundation trust public inquiry.* HC 947. TSO, 2013. Available from: http://www.midstaffspublicinquiry.com/report

[10] *The Cavendish Review: an independent review into healthcare assistants and support workers in the NHS and social care settings.* July 2013. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf

[11] Professor Sir Bruce Keogh. *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. NHS, 16 July 2013. Available from: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

[12] National Advisory Group on the Safety of Patients in England. *A promise to learn – a commitment to act: improving the safety of patients in England.* August 2013. Available from: https://www.gov.uk/government/publications/berwick-review-into-patient-safety

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1.35 In parallel with these reports, since the publication of *Equality for all: delivering safe care – seven days a week,*[13] the NHS has been moving towards provision of a seven-day service whereby more routine services will be made available seven days a week. **NHS England** described seven-day services as a priority and a potential driver of service redesign and transformation. However, it told us that current terms and conditions for staff impeded change and constrained efforts to move towards seven-day services. **NHS Employers** said that evidence had shown that the limited availability of some hospital services at weekends could have a detrimental impact on outcomes for patients, including an increased mortality risk. The key issue for employers was to prevent extended services adding unnecessary costs and they would be reviewing the balance between plain time and premium time payments.

Key Themes for this Report

1.36 Our report is influenced by a range of themes which apply across the United Kingdom. These include:

- *the amount, focus and affordability of any pay uplift.* We have been influenced by the very strong arguments on affordability, which seem to us to be greater this year. However, a number of Government announcements have led staff to expect a 1 per cent uplift. In addition, we are mindful that a 1 per cent uplift would represent a real-terms pay cut for those at the top of the pay scale, approaching half our remit group (47 per cent), who will not receive a progression increase;
- *whether to tie the award to any other issues.* We have also considered whether the award should be tied to progress on Agenda for Change reform, as requested by some of the parties;
- *recruitment, retention and motivation.* We do not see any current signs of general recruitment and retention issues, although we note the recent improvement in the strength of the overall economy and the marked fall in unemployment across all areas of the United Kingdom. Staff turnover is generally low and although the evidence on staff engagement differs between countries and some occupational groups, the overall position remains relatively stable;
- *incremental progression.* Much of the evidence focused on the cost of incremental scales, but we find the operation of the system ineffective in rewarding performance rather than costly. We were also constrained in the actions we could recommend by the integrated nature of the Agenda for Change pay scale; for example, where the top point for one band is tied to a point in a subsequent band;
- *the diverging approach of the four countries of the United Kingdom.* The remits for 2014/15 have all asked for somewhat different outcomes. We have had to decide whether to remain with United Kingdom-wide pay scales or recommend different awards to each of the four countries. We are also conscious of the differing approach to NHS developments across the United Kingdom and note that the changes agreed to Agenda for Change in England have not been implemented in the other countries;
- *transformational change.* This should free up resources to improve patient care and outcomes and we are concerned by the slow progress. We are uncertain whether the delays in making these changes are a result of reluctance by a variety of stakeholders, or the lack of capacity or capability of employers. We are disappointed that the fundamental review of High Cost Area Supplements, which we recommended in our *Market-Facing Pay* report, has not yet taken place;

[13] NHS Improving Quality. *Equality for all: delivering safe care – seven days a week.* January 2012. Available from: http://www.nhsiq.nhs.uk/resource-search/publications/nhs-imp-seven-days.aspx

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- *outcomes for patients.* We are conscious that a number of issues arising from the Francis Report have been highlighted in the evidence, for example staff appraisal. These may also affect workforce planning and staff numbers, particularly recruitment of staff from overseas. We also note the consequent affordability issues, especially over the need for increased staffing levels; and
- *the role of the Review Body and our independence.* We continue to think that our process has most value when we are able to bring independent and expert judgement to bear on all factors within our terms of reference. The reference to a specific figure by the Chancellor over two years has influenced expectations across the public sector and within the NHS; it has also affected some of the parties' perceptions of our independence.

Future evidence requirements

The specific evidence requirements that we have identified in this chapter for our next review are:

- We ask the parties to meet the deadlines that we set for the submission of the written evidence and to provide succinct, self-standing, focused, analytical papers.
- We remind the parties that although there is inevitably a degree of judgement and opinion in evidence submitted to us, conclusions that are backed up by hard data carry the greatest weight.
- We remind all parties to the process that an essential element of the independent and transparent Review Body process is the sharing of all evidence between the parties and publicly via the parties' websites. We are not able to consider, or treat as evidence, any information that cannot be shared.
- We ask the parties to place their main and supplementary evidence on their websites as soon as possible after submission.

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Chapter 2 – The Economy, Labour Market and Pay

Introduction

2.1 In this chapter we analyse the latest available data on the economy, on the labour market and on pay (as published by end January 2014). They provide an essential backdrop to our consideration of pay recommendations for Agenda for Change staff, as required by our terms of reference. The parties' evidence was presented in late September 2013 and therefore reflects the position at that time. We conclude this chapter with an assessment of the earnings, including take-home pay of Agenda for Change staff, by drawing on NHS information and data from the 2013 Annual Survey of Hours and Earnings (ASHE). We also monitor data on membership of the NHS Pension Scheme.

Economic Growth

2.2 Economic growth in the United Kingdom is modest but positive. Gross Domestic Product (GDP) grew by 1.9 per cent in 2013 compared to 2012. The United Kingdom economy is now 6.3 per cent larger than at the depth of the recession, but remains 1.3 per cent below its pre-recessionary peak.

2.3 Economic growth in Scotland has kept pace with the United Kingdom as a whole over the last five years, while the economic recovery in Northern Ireland has been more variable (see Figure 2.1). Since the low-point of the recession (2009 quarter 3), the United Kingdom economy has grown by 6.3 per cent, the Scottish economy has grown by 4.9 per cent (with a quarter's less data),[14] and the Northern Ireland economy has shrunk by a further 0.7 per cent (also with a quarter's less data).[15] Separate GDP data is not available for Wales; the index of market services for Wales grew by 0.1 per cent in the year to 2013 quarter 3 (compared to 2.2 per cent growth across the United Kingdom as a whole).[16] Since 2009 quarter 3 (the United Kingdom low-point), growth in the index has been 14.4 per cent for Wales, and 7.8 per cent for the whole United Kingdom.

2.4 The Bank of England reported in November 2013 that it considered the economy to be growing robustly, as reducing uncertainty and thawing credit conditions started to unlock pent-up demand.[17] It expected GDP growth to be 2.5 per cent in the four quarters to the end of 2014.

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[14] Scottish Government. *Gross Domestic Product 3rd quarter 2013.* Available from: http://www.scotland.gov.uk/Topics/Statistics/Browse/Economy/GDP2013Q3

[15] The Northern Ireland Composite Economic Index is an experimental quarterly measure of the performance of the Northern Ireland economy based on available official statistics, which was first published in January 2013. It is not possible to provide a comprehensive measure of quarterly GDP for Northern Ireland due to the lack of suitable data sources. Comparisons with United Kingdom GDP measures are therefore approximate. Department of Enterprise, Trade and Investment. *Northern Ireland Composite Economic Index Quarter 3 2013 results.* Available from: http://www.detini.gov.uk/deti-stats-index/stats-surveys/ni-composite-economic-index-_nicei_.htm

[16] The Index of Market Services is a quarterly index showing short-term movements in the output of market service sector companies within Wales and the United Kingdom. The Index of Market Services accounts for approximately 45 per cent of the Welsh economy. Available from: https://statswales.wales.gov.uk/Catalogue/Business-Economy-and-Labour-Market/Economic-Indices/Index-of-Market-Services

[17] Bank of England. *Inflation Report.* November 2013. Available from: http://www.bankofengland.co.uk/publications/Pages/inflationreport/2013/ir1304.aspx

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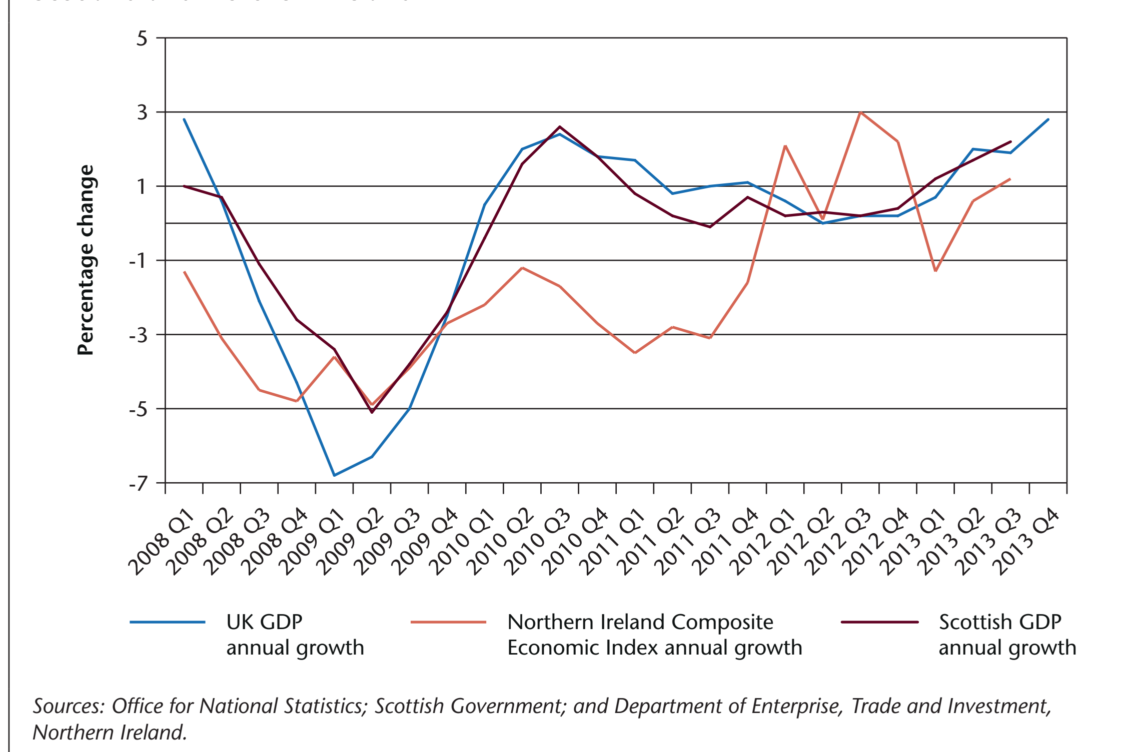
Figure 2.1: Annual growth in Gross Domestic Product, 2008 to 2013, United Kingdom, Scotland and Northern Ireland



Sources: Office for National Statistics; Scottish Government; and Department of Enterprise, Trade and Investment, Northern Ireland.

2.5 The Office for Budget Responsibility does not expect the pace of quarterly expansion seen during 2013 to be sustained in 2014 and expects growth to slow to rates of around 0.5 per cent a quarter through 2014.[18] In December 2013, it said that, while consumer confidence had recovered, credit conditions had eased and prospects for the housing market had improved, productivity and real earnings growth remained weak. The Office for Budget Responsibility pointed out that the unexpected strength of private consumption in 2013 had come largely from lower saving, not higher income, and that productivity-driven growth in real earnings was necessary to sustain the recovery and raise living standards. It therefore expected quarterly GDP growth to slow into 2014, gradually strengthening thereafter as productivity picks up and real earnings growth provides the foundation for a stronger and more sustained upswing.

The Government's Fiscal Position

2.6 The United Kingdom Government's stated 'fiscal mandate' aims to balance the cyclically-adjusted current budget five years ahead and also to have public sector net debt falling as a share of GDP in 2015/16. The programme of deficit reduction followed since 2010 has meant that our recommendations on pay for Agenda for Change staff have been made in the context of an explicit government policy on public sector pay since that time. This policy has been to pursue a pay freeze in 2011/12 and 2012/13, a policy of pay awards that average 1 per cent in 2013/14 and 2014/15 and, as announced in Budget 2013, an average of up to 1 per cent in 2015/16. Based on stated Government policies and its own macroeconomic projections, the Office for Budget Responsibility forecasts that the cyclically-adjusted current budget will show a surplus (of 1.6 per cent of GDP) for the first time for some years in the target year of 2018/19 but that public sector net debt will still be rising in 2015/16, only falling significantly in 2017/18.

[18] Office for Budget Responsibility. *Economic and Fiscal Outlook*. December 2013. Available from: http://budgetresponsibility.org.uk/economic-fiscal-outlook-december-2013/

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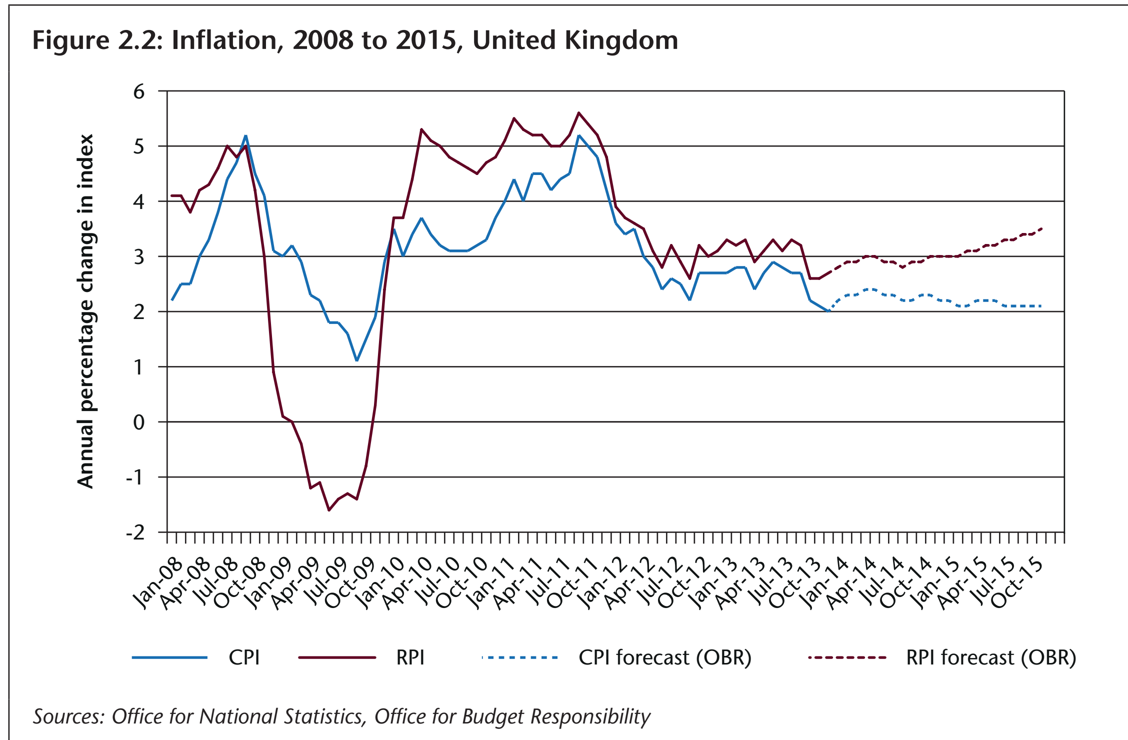
Inflation

2.7 In December 2013, headline Consumer Prices Index (CPI) inflation was 2.0 per cent and the Retail Prices Index (RPI) inflation rate was 2.7 per cent. Fluctuations over the last year have come particularly from tuition fees, petrol prices and air fares. (See Figure 2.2)

Figure 2.2: Inflation, 2008 to 2015, United Kingdom



Sources: Office for National Statistics, Office for Budget Responsibility

2.8 The Bank of England forecasts inflation to be around its 2 per cent target over 2014. It expects a gradual revival in productivity growth, together with a persistent margin of spare capacity, to be enough to counteract upward pressures from fuel and energy prices. The Office for Budget Responsibility expected, in December 2013, a CPI inflation rate of 2.2 to 2.4 per cent through 2014, held above target by utility price increases. The Office for Budget Responsibility forecasts RPI inflation at around 3 per cent through 2014, boosted above the CPI rate by house price increases (see Figure 2.2 above).

Labour Market

2.9 Employment has been rising gradually since the end of 2011, reaching 30.15 million in the three months to November, half a million higher than the pre-recessionary peak. The employment rate has risen by 0.7 percentage points over the last year, to 72.1 per cent, but is still below the pre-recession peak of 73.0 per cent. The recent employment growth has been concentrated among full-time employees in the private sector.

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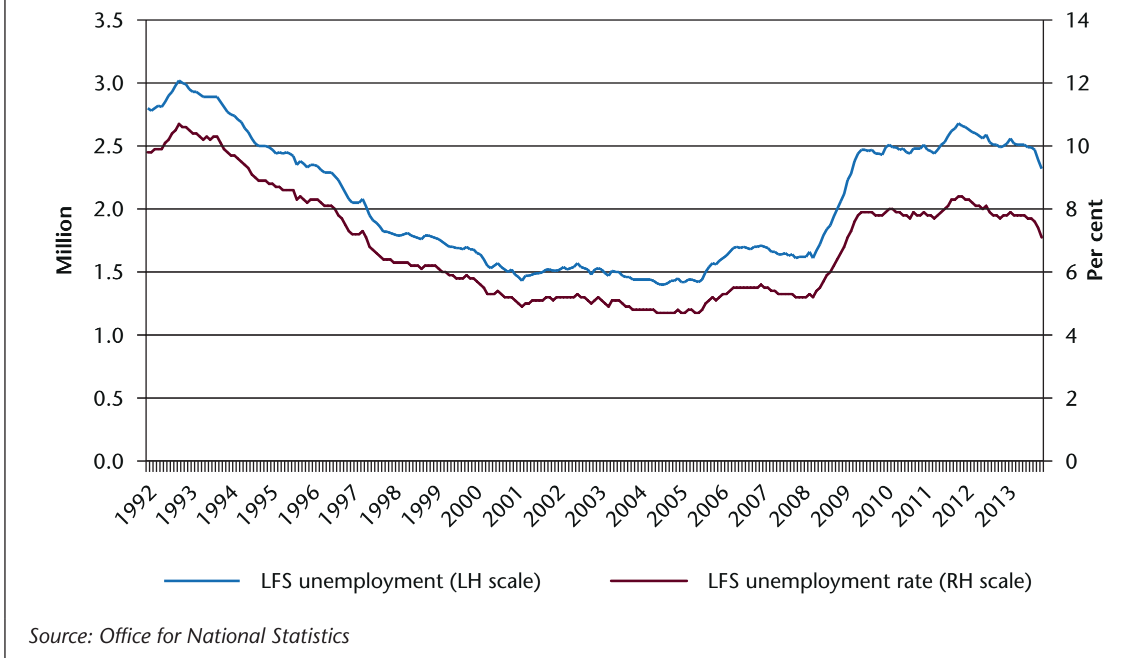
Figure 2.3: Labour Force Survey unemployment level and rate, 1992 to 2013, United Kingdom



Source: Office for National Statistics

2.10 The level of unemployment, measured by the Labour Force Survey, (Figure 2.3) has been falling since the end of 2011, but by less than the rise in employment. The latest figures, for the three months to November 2013, put unemployment at 2.32 million (7.1 per cent), having fallen by 172,000 over the year. The medium-term picture is of steadily falling unemployment, with the current rate down by 0.6 percentage points over the year.

2.11 Employment rates in Scotland and England are at similar levels (see Figure 2.4). The Scotland employment rate was above the England rate prior to the recession (reaching a peak of 74.9 per cent in 2007, compared to a peak of 73.2 per cent in England a year later), when it declined more rapidly, but employment growth over the last year has taken it back above the England rate, to 72.7 per cent in the most recent figures, for the three months to October, compared to 72.3 per cent in England.

2.12 Employment rates for Wales, and particularly Northern Ireland, have lagged behind England and Scotland. Northern Ireland was hit hard by the recession, but recovered quickly, although the employment rate has been broadly stable over the last two years, and was at 67.0 per cent in the latest figures available to us, for the three months to November 2013. The employment rate in Wales has been growing markedly over the last two years, to 71.1 per cent in the latest figures.

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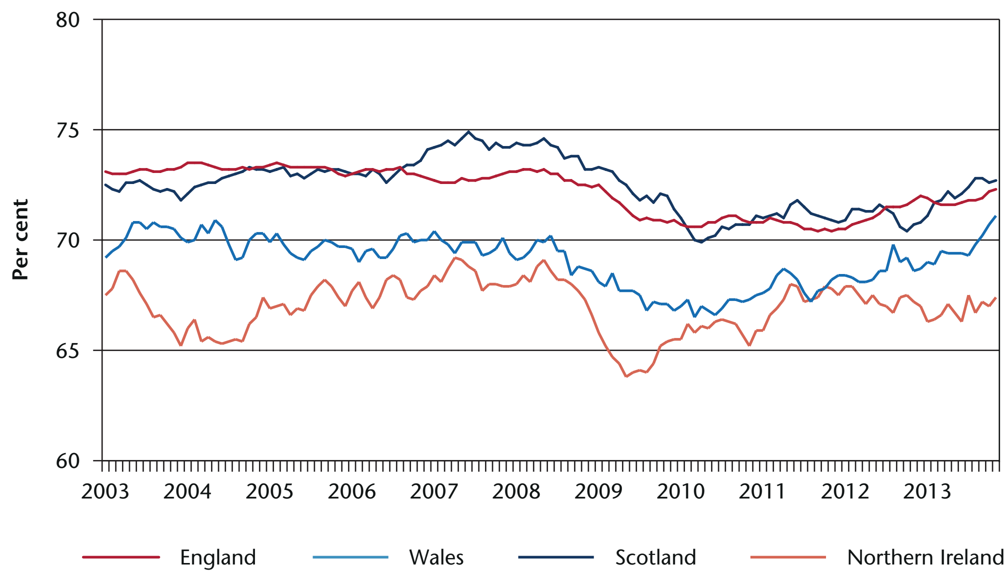
Figure 2.4: Employment rates by country, 2003 to 2013

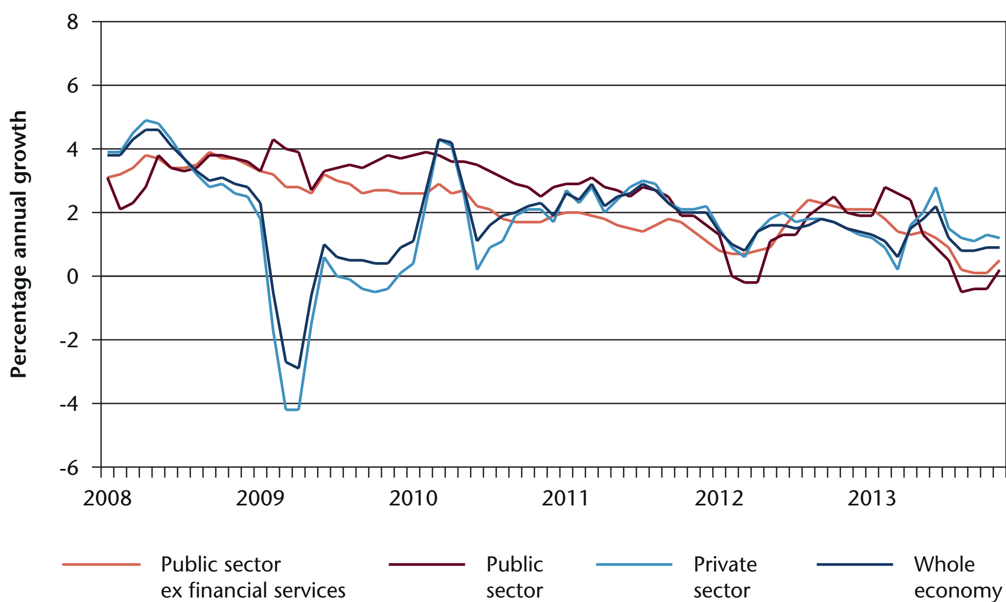


Source: Office for National Statistics

Average Earnings Growth and Pay Settlements

2.13 Average earnings growth, measured by the Average Weekly Earnings Index, has been subdued throughout 2012 and 2013 (Figure 2.5). The three months to November 2013 saw whole economy annual average earnings growth of 0.9 per cent. Average earnings growth was 1.2 per cent in the private sector and 0.5 per cent in the public sector (the latter excluding financial services).

Figure 2.5: Average weekly earnings (total pay), three-month average, 2008 to 2013, Great Britain



Source: Office for National Statistics

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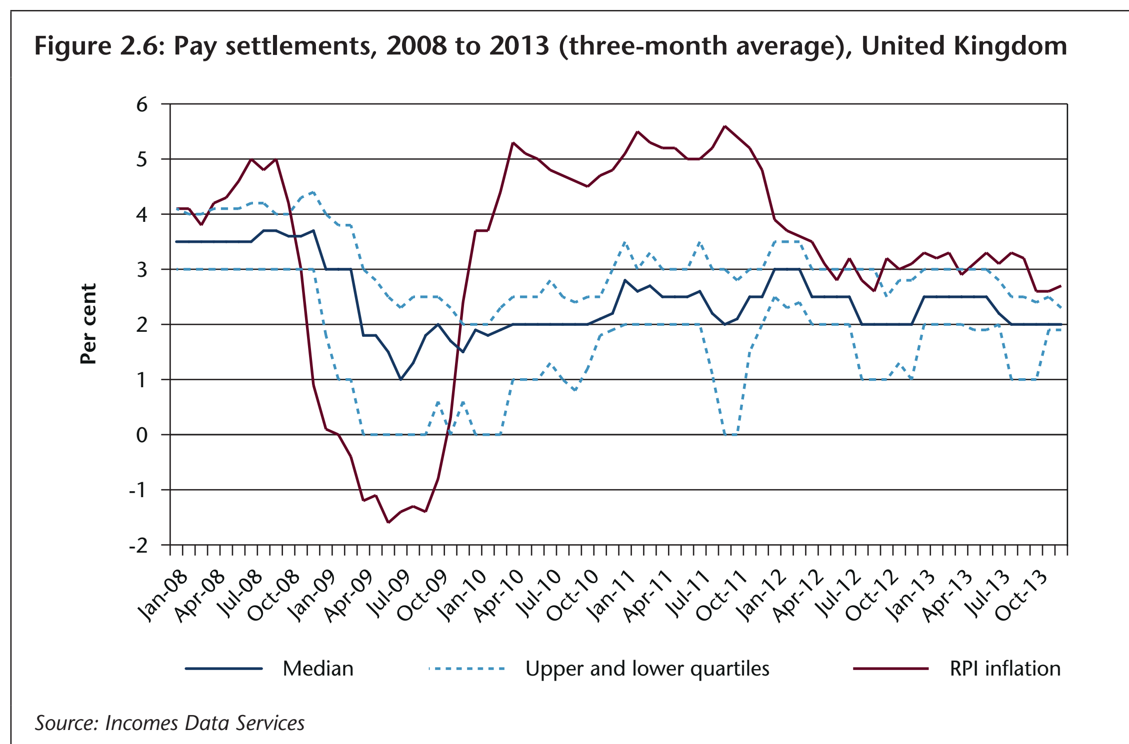
2.14 Since the start of 2011, pay settlement medians have been fairly stable, at around 2.0 to 3.0 per cent (Figure 2.6). Pay settlements remain below the level of inflation. The two main settlement providers have a private settlement median pay rise of 2.5 per cent (Incomes Data Services) and 2.0 per cent (XpertHR) for 2013. Both agree that the median for the public sector is 1 per cent for 2013.

2.15 This raises the question of why average earnings growth across the whole economy is so persistently low, and below pay settlements. There are a number of possible explanations. For example, it may be that new employees are being recruited on lower salaries than incumbent staff, given the ease of recruitment. Furthermore, there may be a restructuring of the reward package for the highest-paid employees away from cash bonuses towards longer-term incentives, which is distorting the average. Separate data from ASHE indicates pay growth closer to 2 per cent at the median, closer to the measure of pay settlements.

Figure 2.6: Pay settlements, 2008 to 2013 (three-month average), United Kingdom



Source: Incomes Data Services

Public-Private Sector Pay Differentials

2.16 We summarise below results of recent research into estimates of public-private sector pay differentials.

2.17 In December 2013 the Institute for Fiscal Studies[19] used Labour Force Survey data for the year to end-June 2013 to examine the average difference between private and public sector hourly wages and the extent to which this is explained by observed characteristics. This updated their earlier analysis published in February 2013.[20] They again used a rolling four-quarter sample of Labour Force Survey data to provide new estimates of the United Kingdom hourly public-private sector pay differential for those aged 20 to 59, separately for men and women, over time, from the year to end-March 1999 through to the year to end-June 2013.

[19] Jonathan Cribb et al. *The public-private sector pay differential in the UK*. Institute for Fiscal Studies, December 2013. Available from: http://www.ifs.org.uk/publications/7008

[20] Carl Emmerson et al. *The IFS Green Budget*. February 2013. Pages 176-9 consider public-private sector pay differentials. Available from: http://www.ifs.org.uk/publications/6562

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2.18 Rather than citing raw pay differential figures which exaggerate the size of true differentials due to known compositional differences between the two sectors, the Institute for Fiscal Studies estimated differentials using regression analysis to ‘control for’ several background factors, including the highest qualification, age and experience of respondents, among others.[21] Partly because of the possibility of unobserved[22] differences between public and private sector workers that have not been adequately controlled for in their analysis, the Institute for Fiscal Studies emphasised that the focus should be on how the estimated public-private sector differentials change over time, rather than their absolute levels. The results of the Institute for Fiscal Studies analysis are shown in Figure 2.7 below. The dashed lines represent 95 per cent confidence intervals around the main estimates.

Figure 2.7: Estimated average public-private hourly wage differential over time through to end-June 2013, United Kingdom

Source: The Institute for Fiscal Studies

2.19 The Institute for Fiscal Studies’ calculations suggested that following the 2008 financial crisis the estimated public-private sector differential had increased in size from -1.4 per cent for men and 5.8 per cent for women to reach peaks during 2011 of 1.7 per cent for men and 9.1 per cent for women. By mid-2013, the size of the differentials had decreased a little to reach -0.4 per cent for men and 8.4 per cent for women, still above 2007/08 levels but closer to the pre-crisis level for men than for women.

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[21] The Institute for Fiscal Studies also ‘trimmed’ the data, by removing the lowest 1 per cent of wage earners whose self-reported hourly wages were too low to be credible, and those observations in the top 10 per cent of the wage distribution if the individuals worked ten or fewer hours per week, because these low hours led to implausibly high hourly wages.

[22] Furthermore there may be differences in non-pay elements of workers’ remuneration, for example, pension benefits, pay in kind and holiday rights, or differences in the risk to employment or in the flexibility of working arrangements that mean that total remuneration is more [or less] comparable than a difference in pay alone would suggest.

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2.20 In a separate short 'Observation',[23] also published in December 2013, the Institute for Fiscal Studies revised its view of how quickly the size of the public-private sector pay differential would return to pre-crisis levels. This was due to recently-revised Office for Budget Responsibility forecasts of public sector pay growth. At the time of the Spending Round in June 2013, the Institute for Fiscal Studies had commented that the headline public-private sector pay differential was likely to return to its pre-recession level by 2015/16. In December 2013, however, the Institute for Fiscal Studies said that its analysis based on the latest Office for Budget Responsibility forecasts suggested that public sector pay relative to the private sector would return to its pre-crisis level in 2013/14, two years earlier than implied by previous forecasts.

2.21 The Institute for Fiscal Studies commented that the revised forecasts implied that by 2018/19 public sector pay would be 6.4 percentage points lower, relative to private sector pay, than it had been before the crisis in 2007/08. It also stated that it was likely that public sector pay would fall lower relative to private sector pay than its level in the early 2000s when parts of the public sector had experienced difficulties in recruiting and retaining staff.

2.22 More recent research estimating the public-private sector wage differential, by Blackaby et al,[24] drew on data from the Skills and Employment Survey carried out in 1997, 2001, 2006 and 2012. This data set included information on the intrinsic quality of work, such as job skills, discretion and autonomy in the workplace, work intensity and insecurity and anxiety at work, all factors which have been found to influence wages but which are rarely collected by data sets such as the Labour Force Survey and ASHE on which most of the recent public-private sector pay gaps estimates are based. Similar to earlier work[25,26,27] and using the Labour Force Survey and ASHE data sets, they controlled for personal characteristics such as gender, age and educational qualifications and found a public-private sector wage differential of 7.4 per cent. When the above intrinsic quality of work variables were included, the overall public-private sector wage gap became negligible for all employers except for the bottom quarter of the earnings distribution where the public sector wage premium was positive. For women the wage gap was 2.3 per cent, while for men the wage gap disappeared completely and was negative, although not statistically significant. This research challenged the idea that working in the public sector attracts a 'double premium' of better pay and better quality jobs. It suggested instead that wage differentials compensated for differences in the characteristics of work and its intrinsic features.

[23] Jonathan Cribb and Luke Sibieta. *Hard choices ahead for government cutting public sector employment and pay.* Institute for Fiscal Studies, December 2013. Available from: http://www.ifs.org.uk/publications/7009

[24] D Blackaby et al. 'Better quality work and better pay in the public sector?' 2014. In: A Felstead et al (eds). *Unequal Britain at Work*. Oxford University Press, 2014 (forthcoming).

[25] Office for National Statistics. *Estimating differences in public and private sector pay.* March 2012. Available from: http://www.ons.gov.uk/ons/dcp171776_261716.pdf

[26] Carl Emmerson and Wenchao Jin. 'Public sector pensions and pay'. In: Institute for Fiscal Studies. *The IFS green budget.* 2012. Chapter 5. Available from: http://www.ifs.org.uk/budgets/gb2012/12chap5.pdf

[27] D Blackaby et al. *An investigation of the IFS public-private sector pay differential: a robustness check.* Discussion paper no. 2012-09. Swansea University Department of Economics, 2012. Available from: http://www.swan.ac.uk/sbe/research/papers/SBE-E-2012-9.pdf

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Our comment

2.23 Analysis of public-private sector wage differentials provides important context to our deliberations enabling us to monitor how pubic sector pay is moving relative to the economy generally. We have reviewed studies in previous reports[28,29] and concluded that such differentials varied significantly over time and that there were risks in choosing data based on a short period. We also noted that public-private sector wage differentials tended to favour the public sector at the bottom of the earnings distribution and the private sector at the top. The most recent studies summarised above suggest that much of the observed differential compensates for differences in job characteristics and that the overall public sector premium is narrowing at a faster pace than previously forecast. We wish to continue to keep this under review in future reports. We draw on the analysis at the end of the chapter and elsewhere in the report.

Evidence from the parties

2.24 We are conscious that the parties' written evidence was presented in late September 2013 and reflects the position at that time. We include a selection of the evidence received, but we have not summarised the general economic data, which has now been overtaken by more recent data.

2.25 The **Department of Health** said that the Government's economic strategy set out in the June Budget 2010 was designed to protect the economy through the recent period of global uncertainty and to provide the foundations for recovery. It told us that this strategy was restoring public finances to a sustainable path and that the deficit had been reduced by a third in the three years from 2009/10. The Government remained committed to reducing the deficit and addressing the permanent structural deterioration in the public finances caused by the lasting impact of the financial crisis. It said that public sector pay restraint had been a key part of the fiscal consolidation so far. It noted that Budget 2013 had announced that public sector pay awards in 2015/16 would be limited to an average of up to 1 per cent.

2.26 **NHS Employers** updated us on progress towards a total reward strategy. They had identified five areas of work that would enable the NHS to achieve a more strategic approach to reward, in a way that was consistent with our recommendation in our report on market-facing pay. These were: education and training; the establishment of an employer reward network; the development of tools and products; the establishment of a collaborative approach to work across a number of work streams; and gathering and sharing intelligence. They told us that a toolkit of resources was being developed, which would enable human resources directors to deliver a more strategic approach to pay and reward. The first part of this toolkit focused on how to develop a local reward strategy, and was published in the autumn of 2013.

2.27 The **Welsh Government** noted that after more than two years when the economies in Wales and the United Kingdom had effectively flat-lined, growth was now becoming more firmly entrenched. It believed that there was a good chance that economic growth would gain further momentum over the next few years. It said that since 2008 earnings growth in both Wales and the United Kingdom had been much lower than pre-recession rates. Although earnings growth had been positive, once inflation was taken into account, earnings had fallen in real terms since 2008 in both Wales and the United Kingdom. It expected earnings to increase at less than inflation until 2014.

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[28] NHS Pay Review Body. *Market-facing pay: how Agenda for Change pay can be made more appropriate to local labour markets.* Cm 8501. TSO, 2012. Available from: https://www.gov.uk/government/publications/nhs-local-pay-2012

[29] NHS Pay Review Body. *Twenty-seventh report.* Cm 8555. TSO, 2013. Available from: https://www.gov.uk/government/collections/nhsprb-annual-reports

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2.28 The **Scottish Government** believed that the recession in Scotland was less severe than in the rest of the United Kingdom. It said that Scotland had experienced a recessionary fall in output of 5.6 per cent, compared to 7.3 per cent in the United Kingdom as a whole. Labour market statistics for Scotland continued to show improvements and employment was at the highest level since August to October 2008. The unemployment rate remained below that of the United Kingdom as a whole.

2.29 The **Northern Ireland Executive** said that the Northern Ireland economy continued to show signs of improvement, particularly across the range of labour market indicators, although economic inactivity remained a persistent feature of the local labour market. Business activity was on the increase, but the rate of growth was slower than for the United Kingdom as a whole. It noted that public sector earnings in Northern Ireland outstripped those of the private sector, but it told us that this was due more to the relatively lower private sector earnings. It said that, overall, private sector earnings in Northern Ireland had consistently been the lowest of the United Kingdom regions and at £479.40 per week were significantly below the United Kingdom average of £598.80.

2.30 The **Joint Staff Side** told us that it fully understood the economic context, but remained extremely concerned about the erosion in the real value of pay due to high levels of inflation combined with low awards and changes to NHS pensions over the last few years. In its view, by 2014, Agenda for Change staff would have lost between 8 per cent and 12 per cent of their purchasing power based on their 2010 pay rates. It said that the Joint Staff Side had consistently maintained that the RPI measure of inflation represented the best measure of changes in prices faced by NHS staff, as it included housing costs. It told us that medium-range forecasts from the Treasury suggested that inflation rates would continue to take additional bites out of the value of NHS wages and impact significantly on the lower pay bands of Agenda for Change if the annual rise was limited to 1 per cent. It said that while earnings growth in the NHS had kept pace in comparison to other occupations in recent years, this had now slowed and it was reasonable to assume that with the bounce back of private pay settlements, the NHS was now likely to be losing ground to these comparators. It noted that according to Incomes Data Services, pay settlements in the private sector were currently higher in comparison to the public sector. It said that as public sector pay reform was higher on the Government's agenda, with proposed pay caps at 1 per cent for the next two years, it was likely that the attractiveness of a career in the NHS would decline relative to the private sector.

2.31 The Joint Staff Side believed that pension contribution increases had added another component to the decline in take home pay. It said that it knew from union surveys that a high proportion of NHS staff paid into the NHS pension scheme, although this year a small percentage of staff in Unison's pay survey had indicated that they had deferred from the NHS pension scheme. It was concerned that pensions could become an unaffordable luxury. It noted that pensions contributions were set to increase again in 2014, and the Government had disclosed a 0.13 per cent shortfall in the NHS pension yield as at April 2013. The Joint Staff Side's position was that any cash loss as a direct outcome of Government policy to reduce the workforce and depress pay should not be passed onto NHS staff in increased contributions above those already proposed.

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2.32 The **Royal College of Nursing** added that nursing staff faced falling pay in real terms, with earnings between 6 per cent to 9 per cent lower than if they kept in line with inflation since 2009. It said that this was equivalent to a loss of between £1,048 and £2,824 in earnings. It drew our attention to High Fliers Research,[30] which showed that starting salaries for qualified nurses had consistently fallen behind median graduate salaries across the whole United Kingdom economy. The Royal College of Nursing asked us to recognise that the impact of inflation had damaged the living standards of NHS staff and that continued stagnation of wages risked damaging future recruitment and retention. Its 2013 Employment Survey had found a high level of financial anxiety, with 83 per cent of all respondents experiencing static or decreasing household incomes, while 86 per cent said that their expenditure was increasing. Primary concerns were increasing fuel and transport costs, food costs and other household bills while others pointed to worries about cuts to their income and increased pension contributions.

2.33 **Unison** said that RPI continued to be used as a benchmark in other national Pay Review Body processes and negotiations. It asked us to support its case for the use of RPI as a more appropriate measure than CPI for costing the impact of inflation on NHS staff. It also asked us to recognise that inflation was consistently running well above NHS pay awards year on year which, coupled with the two-year pay freeze imposed on staff, followed by successive 1 per cent caps on NHS pay, had had a negative impact on the living standards of NHS staff.

2.34 **Unite** believed that by 2014 Agenda for Change staff would have lost between 12.4 per cent to 15.5 per cent of their purchasing power based on their 2010 pay rates. It noted that pay specialists, Incomes Data Services, continued to show that other sectors of the economy had enjoyed much higher pay rises at an average of 2.5 per cent throughout 2013. It said that the Government perpetuated a false impression that public sector workers were somehow 'overpaid' compared to workers in the private sector, and that these were myths based on poor understanding of pay statistics and a failure to compare like with like.

Earnings of our Remit Group

2.35 In this section we look at the mean and relative earnings of our remit group, and at changes in the Agenda for Change pay spine over the last few years.

Mean earnings

2.36 Figure 2.8 shows the mean annual basic salary[31] per person and total earnings[32] per person by Agenda for Change staff group between 2011 and 2013. Senior managers had the highest basic salary and total earnings, which in 2013 were around £71,700 and £78,600 respectively. In 2013, the mean total earnings of the next highest earning group, managers, were £45,300 and £49,300. After management grades, the next highest earning group was qualified healthcare scientists with total earnings at around £36,800, closely followed by qualified ambulance staff, £36,400. In each year, the mean basic salary for qualified ambulance staff was substantially lower than total earnings, because of significant overtime and shift working.

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[30] High Fliers Research. *The graduate market in 2013*. Available from: http://www.highfliers.co.uk/download/GMReport13.pdf

[31] *Basic salary* is an individual's Agenda for Change spine point.

[32] *Total earnings* include: basic salary (per person) and non-basic salary (per person). *Non-basic salary* includes hours-related pay, such as on-call, shift working and overtime; location payments such as location allowances and other local payments; recruitment and retention premia; and 'other' payments such as occupational absence and protected pay. A full list of non-basic pay elements can be found in the Health and Social Care Information Centre's publication *NHS staff earnings estimates to September 2013.* Available from: http://www.hscic.gov.uk/searchcatalogue?productid=13833&topics=1%2fWorkforce%2fStaff+earnings&sort=Relevance&size=10&page=1#top

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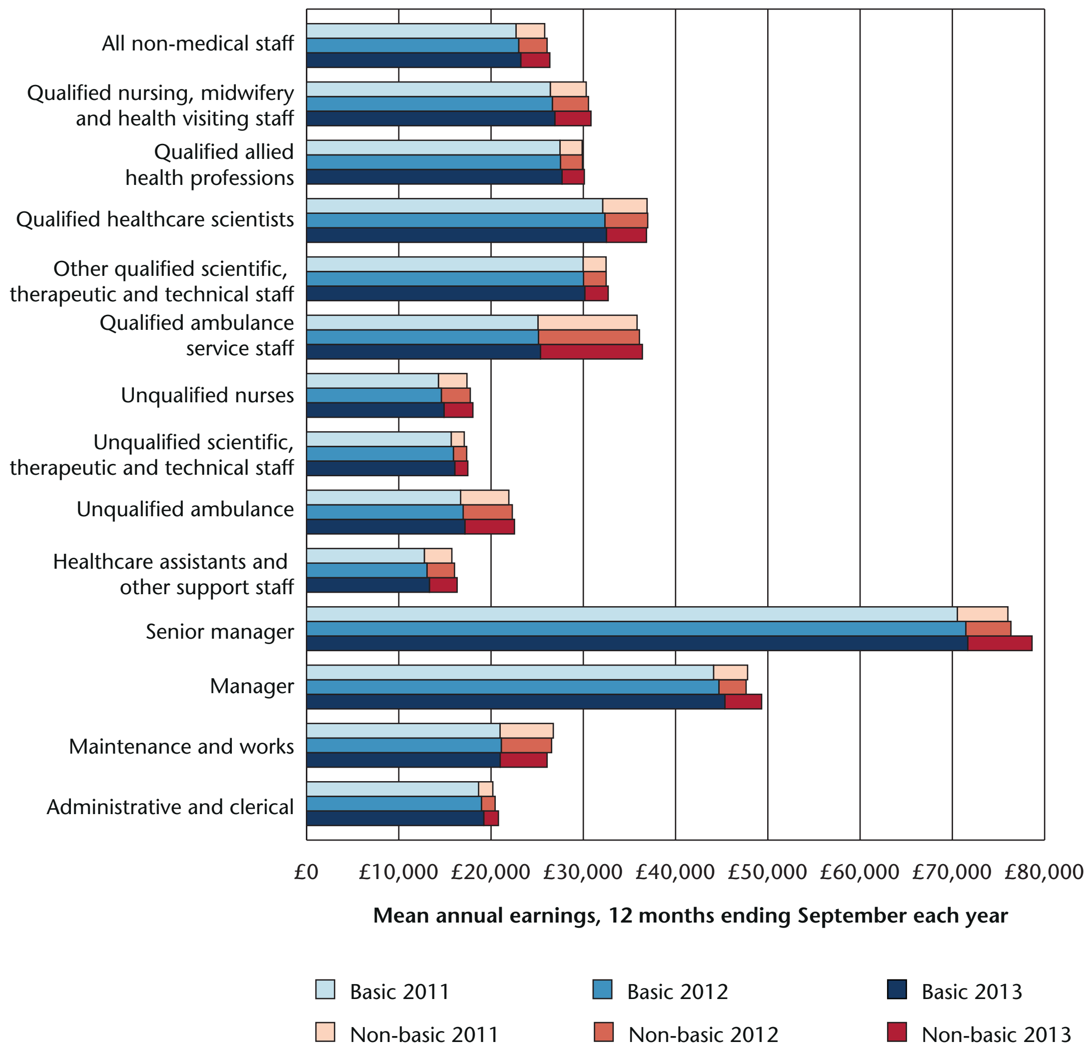
Figure 2.8: Mean basic salary and mean non-basic salary per person by main staff groups,[33] 2011 to 2013, England



Source: Health and Social Care Information Centre.

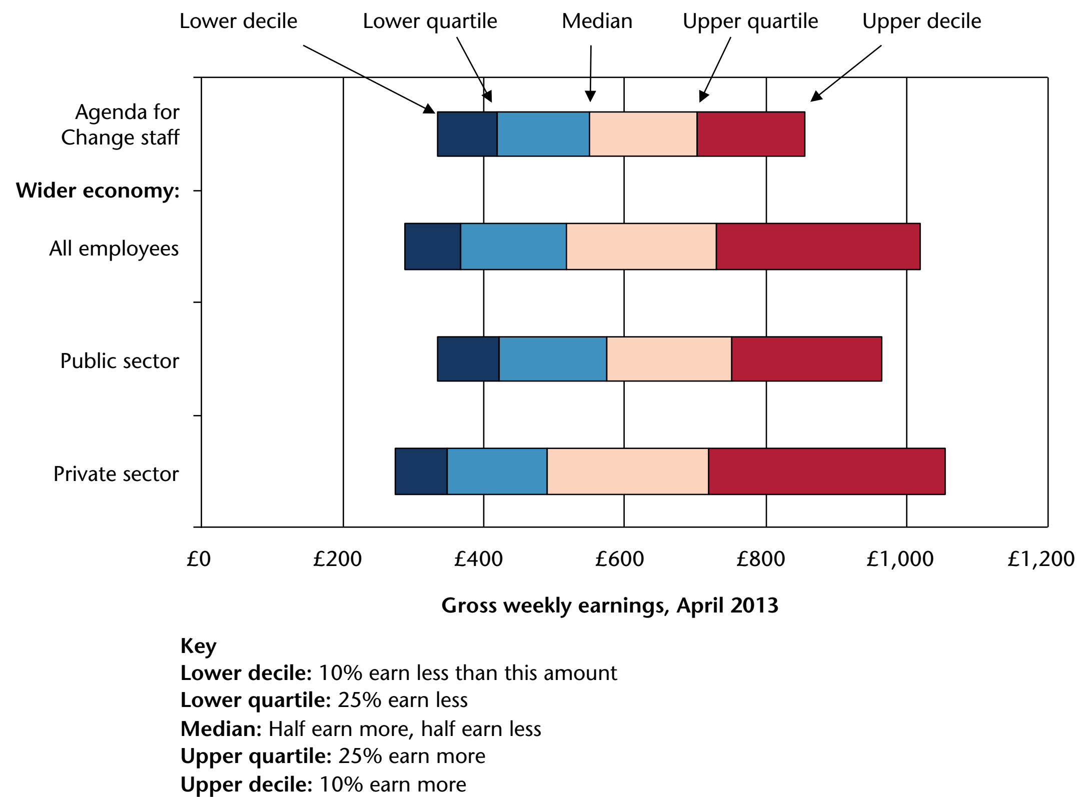
Relative earnings

2.37 We have again used data from ASHE to track changes in gross weekly pay for full-time Agenda for Change staff in the United Kingdom compared with other full-time employees although such comparisons do not take into account differences in workforce characteristics. Figure 2.9 shows the distribution of gross weekly pay for our remit group alongside those for other groups of employees:

- the earnings distribution for Agenda for Change staff was more compressed than that for all employees. The middle 50 per cent of staff (between the lower and upper quartiles) were contained in a much narrower range of earnings;
- the lower decile and lower quartile earnings for the remit group were higher than those for all employees (implying a smaller proportion of "low" earners); conversely, the upper quartile and upper decile were at a lower level (implying few "high" earners); and
- the distribution of Agenda for Change earnings was also slightly narrower than that for the wider public sector, particularly at the upper end of the earnings distribution.

[33] In all staff groups there may be staff who are not on Agenda for Change terms and conditions.

Figure 2.9: Estimated earnings distributions for full-time employees, Agenda for Change staff and wider economy, April 2013, United Kingdom



Key
Lower decile: 10% earn less than this amount
Lower quartile: 25% earn less
Median: Half earn more, half earn less
Upper quartile: 25% earn more
Upper decile: 10% earn more

Sources: Office of Manpower Economics analysis of Annual Survey of Hours and Earnings microdata (Agenda for Change staff) and Office for National Statistics (wider economy).

2.38 Changes in median gross weekly pay for Agenda for Change staff, and certain broad occupational groups, are shown in Table 2.1 below. Between April 2012 and 2013, median gross weekly pay for full-time employees in the remit group increased by 1.5 per cent, a similar rate to that for the public sector as a whole (1.6 per cent) though at a slower rate than for all employees (2.2 per cent) and for private sector employees (2.3 per cent).

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Table 2.1: Change in median gross weekly pay for full-time employees at adult rates, 2009 to 2013, April each year, United Kingdom

	Change in median gross weekly pay (%)			
	2009/2010	2010/2011*	2011/2012*	2012/2013*
Agenda for Change staff	1.9	1.0	1.4	1.5
All employees	2.1	0.4	1.6	2.2
Public sector	3	0.3	1.8	1.6
Private sector	1.9	0.8	1.6	2.3
Professional occupations[34]	1.2	1	1.4	1.1
Associate professional and technical occupations[35]	2.1	-0.4	0.8	1.2
Administrative and secretarial occupations	2.1	0.5	1.1	1.7
Skilled trades occupations	1.8	0.3	0.5	2.2
Caring, leisure and other service occupations[36]	2.3	-0.2	-0.1	1.1

Sources: Office of Manpower Economics analysis of Annual Survey of Hours and Earnings microdata (Agenda for Change staff) and Office for National Statistics (other groups).
* Changes up to 2011 calculated using Standard Occupational Classification 2000 occupational groups.
Changes between 2011 and 2013 calculated using Standard Occupational Classification 2010 occupational groups.

Changes in Agenda for Change pay since 2010/11

2.39 The United Kingdom Government and the Department of Health in their remits invited us to consider the impact of our remit group's progression structure and its distribution amongst staff in making our recommendations on annual pay awards. The Joint Staff Side has presented cases for pay differentiation for lower paid Agenda for Change staff including comparisons with inflation and the Living Wage.

2.40 We made estimates of changes to illustrative take-home pay over the two years from 2010/11 to 2012/13[37] for notional individual Agenda for Change staff in England who were at the bottom, middle and top of each pay band in April 2010. (See Figure 2.10 and Table 2.2) Our analysis took into account changes since 2010/11 in: base Agenda for Change pay; incremental progression; additional non-basic pay; tax and National Insurance thresholds and marginal rates; and employee pension contributions. It did not take into account the impact of CPI and RPI inflation since 2010/11, although we note that between the financial years 2010/11 and 2012/13 CPI inflation increased by 7.1 per cent and RPI inflation by 8.0 per cent. We also note that some commentators[38] believe that recent inflation has had a greater proportionate effect on those on lower pay. For this report we have updated 2012/13 estimates to take into account more reliable full year estimates of additional non-basic pay.

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[34] *Professional occupations:* includes, for example, teachers, solicitors, accountants, doctors and some allied health professionals and scientific, therapeutic & technicals. Nurses and midwives are in this group from April 2011.

[35] *Associate professional and technical occupations:* includes, for example, police officers and some allied health professionals and scientific, therapeutic & technicals. Nurses and midwives were in this group until April 2010.

[36] *Caring, leisure and other service occupations:* this group was until 2010 named "Personal Services Occupations". In 2011 it was known as "Personal service".

[37] It is not yet possible to estimate reliably take-home pay for 2013/14. This is because the Health and Social Care Information Centre has advised that estimating whole year additional earnings for individual pay points from less than a full 12 months of data is likely to prove unreliable, particularly for those staff towards the top of the Agenda for Change pay spine.

[38] Peter Levell and Zoe Oldfield. *Poor experience higher inflation than the rich.* Institute for Fiscal Studies Press Release, 14 June 2011. Available from: http://www.ifs.org.uk/publications/5605

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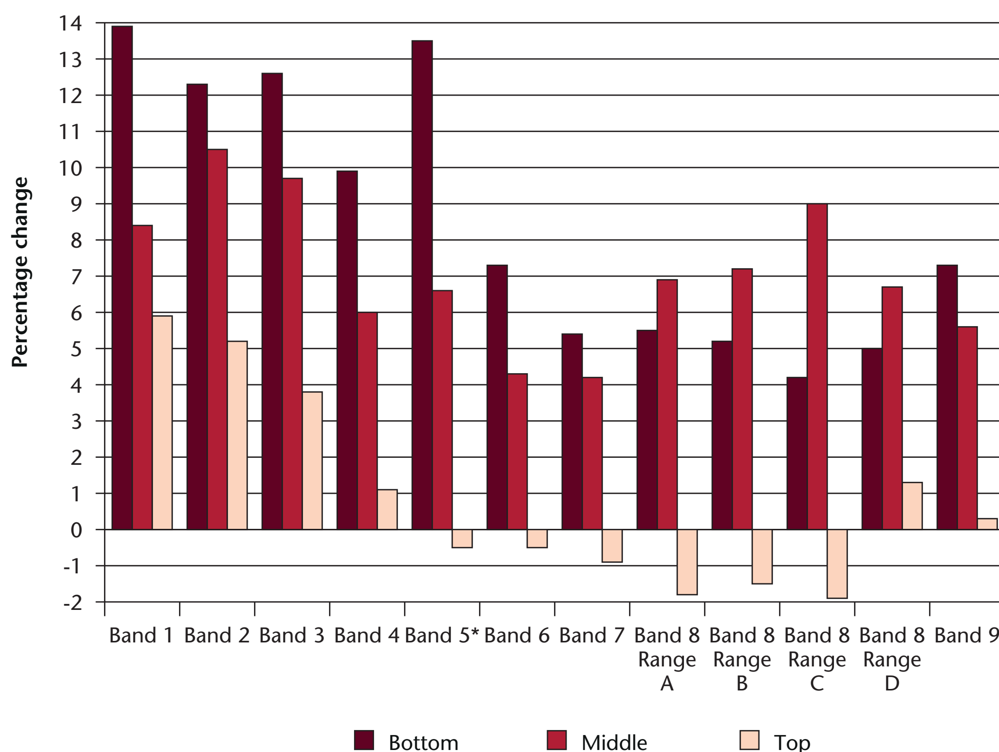
Figure 2.10: Estimated change in net take-home pay (using pay scales and mean non-basic pay, by pay-point), disregarding inflation, 2010/11 to 2012/13, England



Source: Office of Manpower Economics calculations based on data from the Health and Social Care Information Centre, HM Revenue and Customs, and the Department of Health.
* Staff starting in April 2010 from the bottom pay point in pay band 5 are assumed to receive two increments at the end of the first year (preceptorship).

Table 2.2: Estimated change[39] in net take-home pay, (using pay scales and mean non-basic pay, by pay-point), disregarding inflation, 2010/11 to 2012/13, England

	Cash change (£)			Percentage change		
	Bottom	**Middle**	**Top**	**Bottom**	**Middle**	**Top**
Band 1	1,693	1,075	772	13.9	8.4	5.9
Band 2	1,501	1,378	757	12.3	10.5	5.2
Band 3	1,708	1,441	604	12.6	9.7	3.8
Band 4	1,505	968	198	9.9	6.0	1.1
Band 5	2,387	1,300	-116	13.5	6.6	-0.5
Band 6	1,499	1,037	-141	7.3	4.3	-0.5
Band 7	1,283	1,118	-283	5.4	4.2	-0.9
Band 8 Range A	1,579	2,119	-602	5.5	6.9	-1.8
Band 8 Range B	1,717	2,569	-595	5.2	7.2	-1.5
Band 8 Range C	1,630	3,688	-862	4.2	9.0	-1.9
Band 8 Range D	2,237	3,199	709	5.0	6.7	1.3
Band 9	3,700	3,144	161	7.3	5.6	0.3

Source: Office of Manpower Economics calculations based on data from the Health and Social Care Information Centre, HM Revenue and Customs, and the Department of Health.
Columns show different starting points on pay band in April 2010.

[39] Normal incremental progression is assumed over the two-year period, except staff at the bottom of band 5 in 2010 who progressed three scale points over the period. This accelerated pay progression for preceptorship in band 5 was discontinued from 1 April 2013.

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2.41 Overall, we conclude that, in terms of illustrative take-home pay across the Agenda for Change pay band distribution between 2010/11 and 2012/13 (without accounting for changes in inflation):

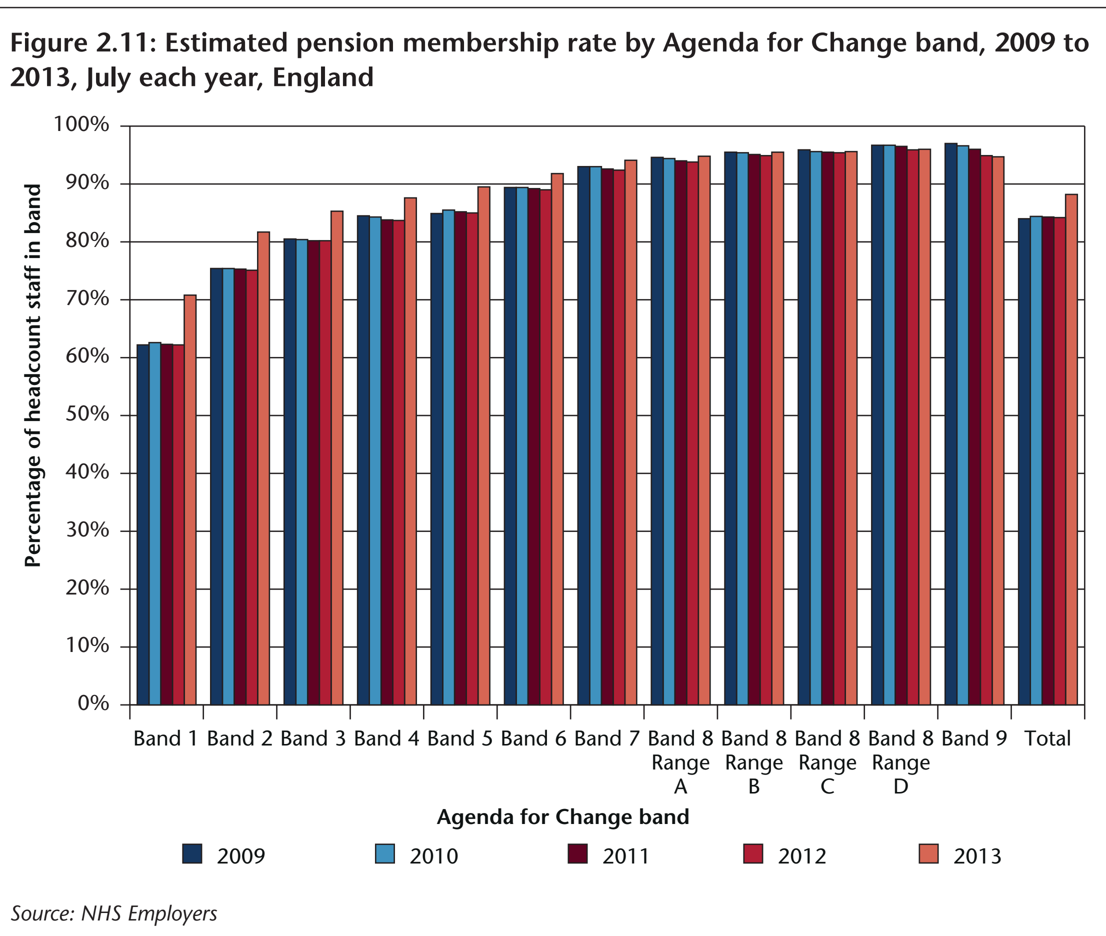
- those in lower pay bands regardless of whether at the bottom, middle or top of the Agenda for Change pay scale have had better protection in terms of illustrative take-home pay increases than those in higher Agenda for Change bands, primarily because the United Kingdom Government's policies relating to annual pay awards, pension contribution rates and tax changes have been relatively more favourable to those Agenda for Change staff in lower bands;
- the difference in illustrative take-home pay between 2010/11 and 2012/13 for these notional individuals ranged between -1.9 per cent and +13.9 per cent; and
- our analysis suggests that within pay bands the greatest relative reductions in illustrative take-home pay across the Agenda for Change pay band distribution have been for those at the top of their pay bands.

Membership of the NHS Pension Scheme

Evidence from the parties

2.42 **NHS Employers** told us that since March 2013, when new duties on employers for automatic enrolment of eligible employees commenced, membership of the NHS Pension Scheme increased and the level of opt out decreased. It provided estimates of scheme membership for non-medical staff in England, which showed that, overall, 88 per cent of staff contributed to the scheme in 2013, up 4 percentage points on 2012 with the largest increases in scheme participation in the lower bands. The percentage of staff contributing to the scheme tended to increase with Agenda for Change bands. (See Figure 2.11 below).

Figure 2.11: Estimated pension membership rate by Agenda for Change band, 2009 to 2013, July each year, England



Source: NHS Employers

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Our comment

2.43 The signs of economic recovery are much stronger now than when we last reported. While further economic growth is expected in 2014 it will, however, only restore the economy to its pre-recession size, with GDP per head still significantly below the position in 2008. Although the labour market has shown great resilience in recent years, there are few signs of recruitment and retention pressures, with the unemployment rate still above the level which might exert upward pressure on wages, and many employees wishing to work more hours. Consequently, pay growth is subdued.

2.44 Our assessment is that the economy and the labour market are not currently putting significant pressure on Agenda for Change pay. We note, however, the significant, above forecast, economic improvement on last year, and the expectation for further economic growth and labour market improvement. This is reflected in narrowing public-private sector pay differentials which are now expected to return to the pre-crisis level of 2007/08 in 2014/15, two years earlier than previously forecast. However, they are not yet forecast to return to levels seen in the early 2000s when parts of the public sector had difficulty in recruiting and retaining staff.

2.45 We continue to recognise the Joint Staff Side's argument on the effect of inflation in reducing real wages, although we note that this effect has been felt across the public and private sectors and not uniquely in the NHS. We also note that within our remit group, those adversely affected by inflation are generally staff at the top of pay scales and not receiving increments. As we said in our last report, we need to ensure that the NHS remains a competitive employer and is ready to respond quickly to ensure continued recruitment and retention of the quality of staff needed to deliver both quality of care to patients and the major changes required across the NHS. We return to this in Chapter 4.

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Chapter 3 – Funds Available to the Health Departments

Introduction

3.1 This chapter sets out the parties' evidence and our conclusions on the funds available to the Health Departments. The affordability of pay awards is a significant factor within our terms of reference and a key element of the overall approach to public sector pay by the Governments of the United Kingdom and the Devolved Administrations.

3.2 We consider below the evidence presented by the United Kingdom Government on the overall position of public finances, the specific financial considerations for the four Health Departments and employers' organisations, and views of the Joint Staff Side and individual unions on NHS finances. We also summarise a recent report from Monitor on NHS productivity. The related, but separate, cost of the incremental system and the issue of pay drift are addressed in Chapter 5.

Affordability

Evidence from the parties

3.3 The **Department of Health** stated that the United Kingdom Government remained committed to reducing the deficit and addressing the permanent structural deterioration in the public finances caused by the lasting impact of the financial crisis. It said that implementation of fiscal consolidation was well underway and by end 2012/13, around 70 per cent of the annual fiscal consolidation planned for the Spending Review 2010 period would have been achieved, with around 65 per cent of the spending and around 90 per cent of the tax consolidation in place.

3.4 The Department of Health told us that the Office for Budget Responsibility's March 2013 *Economic and fiscal outlook* concluded that the Government remained on course to meet the fiscal mandate to achieve cyclically-adjusted current account balance by the end of the rolling five-year forecast period. The Office for Budget Responsibility also forecast that public sector net debt as a percentage of Gross Domestic Product (GDP) would be falling in 2017/18, two years later than set out in the supplementary debt target. It stated that the United Kingdom's fiscal vulnerabilities argued strongly in favour of maintaining a credible path of deficit reduction. It said that public sector pay restraint had been a key part of fiscal consolidation so far and Budget 2013 announced that public sector pay awards in 2015/16 would be limited to an average of up to 1 per cent.

3.5 The Department of Health warned that the financial challenge facing the NHS was the biggest in its history. It said that despite real terms growth in its budget in successive years, it needed to continue to secure improved value from the taxpayers' investment, if it was to meet the growing pressures it faced in the years to come, both from an ageing and growing population and the need to improve the quality of care provided. Pay restraint had been, and would continue to need to be, a key part of delivering this. Although the NHS was forecasting significant savings from non-pay elements of expenditure, national pay frameworks and the occupational pension scheme represented about two-thirds of a trust's total expenditure at local level. Employers were therefore facing the consequences of a stark choice for staff on national pay contracts: either to pay staff more, accepting that this may do little to improve the quality of care for patients and was likely to restrict the number of staff employers could afford to employ; or to reform contracts to enable employers to use their pay bill, as part of their overall employment offer, to maintain safe staffing levels, with stronger links to performance, quality and productivity. The evidence noted that employers said that they wanted 'something for something', by making better use of their pay bill in return for better performance and productivity. The 1 per cent that Government had made available for

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pay, in the Spending Round, would in its view be best deployed in supporting modernisation of national pay frameworks. The Department of Health believed that employers could not pay staff more, improve quality and productivity and protect jobs. Careful and prudent management of the NHS pay bill was critical to maintain the right number of front-line staff with the right skills. It believed that more affordable employment contracts could help in the delivery of better care and improve job security.

3.6 The Department of Health provided background to the financial position for the NHS in England in 2014/15. Between 1999/2000 and 2010/11 NHS revenue expenditure increased by an average of 5.5 per cent in real terms. It told us that the first two years of the current spending review period (2011/12 and 2012/13) had shown subdued growth averaging 0.7 per cent in real terms. Table 3.1 shows the outturn figures from 1999/2000 to 2012/13 as well as the Departmental Expenditure Limits as agreed in Spending Reviews, for 2013/14 to 2015/16.

Table 3.1: NHS revenue expenditure since 1999/2000

Year		Revenue Net NHS Expenditure[5][6] £ billion	% increase	% real terms increase[7]
Resource Budgeting Stage 1[1]				
1999/2000	Outturn	39.3	–	–
2000/01	Outturn	42.7	8.6	7.9
2001/02	Outturn	47.3	10.8	7.9
2002/03	Outturn	51.9	9.8	7.3
Resource Budgeting Stage 2[2][4]				
2003/04	Outturn	61.9	–	–
2004/05	Outturn	66.9	8.1	5.2
2005/06	Outturn	74.2	10.9	8.9
2006/07	Outturn	78.5	5.8	2.8
2007/08	Outturn	86.4	10.1	7.4
2008/09	Outturn	90.8	5.0	2.2
2009/10	Outturn	97.8	7.8	4.9
Resource Budgeting – Aligned[3]				
2009/10	Outturn	94.4	–	–
2010/11	Outturn	97.5	3.2	0.6
2011/12	Outturn	100.3	2.9	0.6
2012/13	Outturn	102.6	2.3	0.8
2013/14	Plan	106.7	4.1	1.7
2014/15	Plan	109.6	2.7	0.8
2015/16	Plan	111.9	2.1	0.2

Source: Department of Health evidence.

1. Expenditure figures from 1999/2000 to 2002/03 are on a Stage 1 resource budgeting basis.
2. Expenditure figures from 2003/04 to 2009/10 are on a Stage 2 resource budgeting basis.
3. Expenditure figures from 2009/10 to 2010/11 are on an aligned basis.
4. Figures from 2003/04 include a technical adjustment for trust depreciation.
5. Excludes NHS annually managed expenditure.
6. Revenue is quoted gross of non-trust depreciation and impairments; prior to September 2007, revenue was quoted net of non-trust depreciation and impairments. This brings the Department of Health in line with HM Treasury presentation of the statistics.
7. Gross Domestic Product as at 27 June 2013.

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3.7 Table 3.2 shows the proportion of the increased funding that has been consumed by the Hospital and Community Health Services pay bill over time.

Table 3.2: Increases in revenue expenditure and the proportion consumed by pay bill

Year	Increase in revenue expenditure	Increase in HCHS pay bill	Proportion of revenue increase on pay bill	Increase in HCHS pay bill due to prices		Increase in HCHS pay bill due to volume	
	(£ billion)	(£ billion)	(%)	(%)	(£bn)	(%)	(£bn)
2001/02	4.6	2.4	51	*7.0*	1.4	*4.7*	1.0
2002/03	4.6	2.4	51	*5.0*	1.1	*5.5*	1.3
2003/04	6.5	2.6	41	*5.0*	1.3	*5.4*	1.4
2004/05	5.0	4.5	91	*5.0*	2.3	*5.0*	2.3
2005/06	7.3	2.5	34	*5.4*	1.5	*3.4*	1.0
2006/07	4.3	1.3	30	*4.3*	1.4	*-0.3*	-0.1
2007/08	7.9	1.3	16	*3.5*	1.2	*0.2*	0.1
2008/09	4.4	2.5	57	*3.0*	1.1	*4.0*	1.4
2009/10	7.1	2.8	39	*1.8*	0.7	*5.1*	2.1
2010/11	3.0	1.5	49	*2.4*	1.0	*1.2*	0.5
2011/12	2.8	-0.5	-18	*0.9*	1.5	*-1.2*	-2.0
2012/13	2.3	0.6	26	*1.0**	0.4*	*0.5**	0.2*
Average	**5.0**	**2.0**	**39**	***3.7***	**1.2**	***2.8***	**0.8**

Source: Department of Health evidence.
* Provisional.
Notes:
1. Revised 2010/11 to 2012/13, following accounts restatements and exclude inter-company eliminations.
2. Excludes arms length bodies and Department of Health core staff expenditure.
3. Excludes general practitioners.
4. Pay (price element) methodology changed from last year's evidence to maintain consistency of series.
5. Volume and price estimates changes methodology in 2010/11 to make use of a more detailed staff group breakdown from the Electronic Staff Record.
6. Figures may not sum due to rounding.

3.8 The Department of Health told us that on average, between 2001/02 and 2012/13, increases to the Hospital and Community Health Services[40] pay bill had consumed 39 per cent of the increases in revenue expenditure. Of this 39 per cent, pay effects had taken up around 23 per cent and volume effects around 16 per cent. It said that Hospital and Community Health Services pay was the largest cost pressure, accounting for 45 per cent of revenue expenditure in 2012/13. It believed that as pay represented such a large proportion of NHS resources, managing the pay bill was key to ensuring that the NHS lived within the funding growth it had been assigned in the next three years.

[40] All staff working in Hospital and Community Health Services.

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Table 3.3: Disposition of revenue increase across expenditure components

	Outturn			Plan	
	SR2004 £ billion	CSR2007 £ billion	First 2 years of SR2010 £ billion	2013/14 £ billion	2014/15 £ billion
Activity growth	2.9	1.1	0.8	2.2	1.8
Service development	1.6	1.7	0.3	0.5	0.5
Hospital and Community Health Services pay (price only component)	1.7	2.0	0.2	0.9	0.7
Secondary care drugs	0.3	0.4	0.3	0.4	0.0
Other (including central budgets)	0.3	0.1	-0.1	0.6	-0.5
Primary care drugs	0.3	0.3	-0.2	0.4	0.2
General dentistry, ophthalmic and pharmaceutical services	0.2	0.2	0.2	0.1	0.1
Procurement	0.1	0.1	0.9	0.3	0.1
General medical services	0.1	0.2	0.1	0.1	0.2
Funding for social care			0.5	0.2	0.2
Productivity	-0.3	-0.3	-0.4	-1.2	-1.3
Average annual increase in revenue	**7.2**	**5.7**	**3.7**	**4.2**	**2.5**

Source: Department of Health evidence.
Note:
Spending Review 2004 and Comprehensive Spending Review 2007 activity growth numbers exclude purchases of healthcare from non-NHS bodies, whereas they are included in the Spending Review 2010 figures.

3.9 Table 3.3 above shows how funding increases have been allocated across baseline pressures, demand and service developments in previous Spending Review periods. The Department of Health said that there were £2.5 billion of increased revenue resources available in 2014/15 for the NHS to meet in year pressures. This is lower than the previous three Spending Review periods, lower than the first two years of this Spending Review and lower than planned dispositions of resources for 2013/14.

3.10 The Department of Health expected demand pressure to consume £1.8 billion with the remaining £0.7 billion (equivalent to an increase in pay costs of 1.5 per cent) assumed to be available for pay. It stated that improvements in workforce productivity were essential to helping deliver the efficiency savings in this and the next Spending Review period. So far productivity savings had contributed 12 per cent of the total savings made in 2011/12 and 2012/13 compared to 23 per cent which had come from pay restraint. The workforce productivity share of total savings was expected to grow to 26 per cent in 2013/14 and 2014/15. It said that the Nuffield Trust had shown that despite improved productivity performance in the last two years there still existed wide productivity variation at trust level.[41] Levelling up performance as well as shifting the average trust performance upwards would help achieve the workforce productivity gains required. It said that although the NHS had received a better Spending Review settlement than most of the public sector, pay competed for fewer available resources and to restrict pay cost growth to 1.5 per cent in 2014/15, workforce productivity must increase faster than at any time over the last three Spending Review periods.

[41] Nick M Jones and Anita Charlesworth. *The anatomy of health spending 2011/12.* Nuffield Trust, 5 March 2013. Available from: http://www.nuffieldtrust.org.uk/publications/anatomy-health-spending-201112-review-nhs-expenditure-and-labour-productivity

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3.11 The Department of Health was working hard to deliver more savings from non-pay areas and service transformation and it would be setting out ambitious expectations on savings from procurement and outsourcing back office functions. It stressed that the proportion of total expenditure on pay and pension was significant and had real impact on the size of the affordable workforce. In essence, employers could either pay fewer staff more or more staff less. It said that increasing demand meant that employers needed staff to improve performance and productivity.

3.12 **NHS England** added that a £30 billion gap had been identified between likely available funding and expected demand levels on NHS services by 2020, and that projected costs outstripped projected funding from 2014/15 onwards.

3.13 **NHS Employers** argued that the NHS faced an unprecedented financial challenge, with the supply of funding struggling to match the growing demand for healthcare. It said that at the same time, the NHS had to deliver at least 4 per cent efficiency savings every year until 2015. The 2013 Spending Review had confirmed that financial pressures would increase in the years beyond 2015/16. Continuing restraint of earnings growth would be essential to ensure continued delivery of high quality patient services, and to minimise the loss of key frontline staff. It reported that most of the employers responding to its survey had expressed concerns that increased pay costs would be unaffordable, and would mean the need to identify additional efficiency savings. It told us that increases in pay bill costs would create considerable financial pressure, unless fully funded through the *Payment by Results Tariff*. For the past two years the tariff prices had decreased, which had driven the need to make further efficiencies. The ability of NHS organisations to compete successfully with new providers of healthcare continued to be of concern to NHS provider organisations, particularly those providing mental health and community services, where the market was more active. Procurement of some clinical activities would necessarily be dependent upon financial competitiveness, as well as the quality of the clinical services they could provide. This meant that if NHS organisations were to continue to provide some of the clinical services they currently provided, they would need the flexibility to reduce costs and improve efficiency. NHS Employers said that the NHS continued to show a wide gap across trusts between the biggest deficits and surpluses: 20 foundation trusts (approximately 14 per cent) had reported deficits that totalled £159 million, and five trusts (approximately 5 per cent) reported deficits totalling £139 million.

3.14 NHS Employers also drew our attention to a number of forthcoming cost pressures for employers from pensions. They told us that the recently published draft regulations to recalculate the value of public sector pensions would, unless amended, result in increases to employer pension contributions of around 4 per cent of the pensionable pay bill per year from April 2015. This represented a cost pressure of 1.55 per cent for a large foundation trust and a 1.96 per cent pressure on an ambulance trust. They said that auto-enrolment, was increasing membership of the NHS pension scheme and was estimated to cost £140 million across the NHS. They also noted the ending of contracting out from April 2016, which they said would increase employer National Insurance contributions by 3.4 percentage points. They believed that for the NHS, the only financially neutral option was to reduce employer contributions, through having fewer staff or the same number of staff being paid less.

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3.15 The **Foundation Trust Network** said that while the number of foundation trusts and NHS trusts reporting a deficit fell from 31 at the end of 2011/12 to 25 by the end of 2012/13, the worrying underlying position was that some NHS trusts may have broken even only because they received additional local revenue support, for example from the now-defunct strategic health authorities and primary care trusts. It noted that in its most recent review of the annual plans of foundation trusts, Monitor[42] had found that the majority had proven to be resilient. However, both the number of foundation trusts in financial distress and those struggling to meet operational demands (for example, accident and emergency waiting time requirements) had increased. It said that ongoing efficiencies through Cost Improvement Plans were becoming more difficult to deliver as opportunities for one-off savings, such as cuts in management costs, diminished. The largest savings over the current Quality, Innovation, Productivity and Prevention (QIPP) period had come from pay, and 54 per cent of surveyed Cost Improvement Plan savings in 2011/12 alone were in pay. The Foundation Trust Network stated that it was not sustainable to expect year on year savings without more significant workforce reform.

3.16 The Foundation Trust Network believed that there was a clear financial challenge, with a £30 billion funding gap from 2013/14 added to the existing £20 billion of efficiency savings. Increasing numbers of trusts faced the prospect of financial unsustainability as income streams dried up, and it said that in this context, further expenditure pressures from pay, on top of demand increases, would potentially tip the sector into financial distress.

3.17 The **Welsh Government** said that the scale of the financial challenge in Wales would mean that any award was unfunded and would place additional cost pressure on NHS Wales. It subsequently explained that the term unfunded related to both affordability and the delivery of existing and planned priorities. Whilst it had been announced that NHS Wales would receive additional funding this year of £150 million from the Welsh Government, it said that this only represented a contribution to delivering existing services within budget, ensuring patient safety. This did not mitigate the future requirement for NHS Wales to address the on-going financial challenges over the next two years, which were likely to include reducing the pay bill by £60 million per annum over each financial year. Furthermore, key priorities already planned by the service, could no longer be taken forward. For example, it had not yet been possible to take forward a planned extension of the Air Ambulance Service that would have complemented the reconfiguration of services across Wales, and had a potential impact on saving lives. It informed us that for 2013/14, Wales had received the most difficult budget settlement since devolution. It told us that in real terms, the revenue budget for the Health Service would be 12 per cent lower in 2014/15 than it was in 2010/11. Set against cost and demand pressures running at 4 to 5 per cent annually, it said that this would place real pressures upon the service. It noted that over the two years until March 2013 the NHS in Wales had successfully achieved savings of £490 million, but further savings were required to ensure that for the 2013/14 financial year the NHS in Wales was able to remain within budget. Modelling undertaken by the Welsh Government Finance Department had identified the scale of the financial challenge and the saving requirement of £540 million that needed to be achieved up to 2015/16. Across NHS Wales direct staff costs utilised around 62 per cent of revenue costs, consequently any changes in pay rates had a significant impact on the overall health board budget. It told us that the 1 per cent uplift in basic pay award in April 2013 for all staff covered by both the NHS Pay Review Body and the Review Body on Doctors' and Dentists' Remuneration cost in the region of £30 million. This uplift was unfunded and added a further cost pressure into the system.

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[42] *Annual plan review 2013/14*. Monitor, July 2013. Available from: http://monitor.gov.uk/sites/default/files/publications/Annual%20Plan%20Review%20(APR)%202013_0.pdf

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3.18 The Welsh Government drew our attention to the report published in 2010 by the Independent Commission on Funding and Finance for Wales (the Holtham Commission).[43] This examined the Barnet formula which is a non-statutory mechanism, by which changes to the funding of the Devolved Administrations are determined, based on changes to spending in United Kingdom Government departments and population share. The report proposed a methodology for the development of a needs-based formula, which when applied to Wales produced an estimate of Welsh need of 115 per capita where the value for England was 100. It suggested that if this needs-based formula were adopted Wales would receive around £400 million per year more than that currently provided by the application of the Barnet formula.

3.19 The **Scottish Government** told us that the financial position in 2014/15 would be challenging and the first call on additional funding would be meeting anticipated cost pressures within NHSScotland including pay, supplies, and drugs volumes. Additional pressures arising from demographics, new drugs and technology would again require NHS boards to deliver and retain efficiencies; NHS boards currently estimated that a total of 3.0 per cent cash-releasing efficiency savings would be needed in 2014/15, beyond the cash uplifts, to achieve financial balance. Achieving these efficiency savings would be difficult for NHSScotland and would require service redesign to be closely considered. It said that NHS boards would need to maintain and enhance the quality of care while also increasing efficiency. However, the Scottish Government confirmed that the application of Scotland's Public Sector Pay Policy was affordable in 2014/15. It told us that the resource cash budget would be raised by 2.5 per cent to £11.6 billion in 2014/15. Funding allocations would reflect the Scottish Government's commitment to protect frontline point of care services. However, the ageing population, new technology and the cost of drugs meant that the NHS would still face considerable budget pressures, meaning that the NHS would need to deliver maximum value from its investment through a focus on increased efficiency while protecting the quality of care.

3.20 The **Northern Ireland Executive** said that efficiency and productivity improvements would be essential to meet key targets within current resources going forward, given the very tight public expenditure position. The high proportion of Government expenditure accounted for by pay meant that trends in public sector pay costs had significant implications for the availability of resources to support staff and deliver public services in Northern Ireland. Public expenditure tightening had a particular impact in Northern Ireland because of the relatively large public sector workforce. It told us that although the budget allocations provided for an 8 per cent cash uplift by the end of the budget period, this represented a real terms decrease of 2.7 per cent when measured against 2010/11. There was a significant and widening gap between the resources available and the best estimate of the minimum costs of maintaining existing health and social care services, within the existing pattern. The scale of the funding gap in 2014/15 was considered to be some £160 million but the Northern Ireland Executive would aim to reduce this as far as possible. Broad measures requiring significant policy and service changes had been identified as ways to contribute to resolving the funding shortfall but it would take a considerable period of time to make such changes. It noted that underlying the minimum cost estimates for 2014/15 was £272 million of inescapable cost pressure arising from existing Ministerial commitments, demographic change and organisational restructuring. This included £22 million to meet anticipated increases in the Department of Health, Social Services and Public Safety pay bill, which for 2013/14 equated to £28 million. It stressed that the significant pressures on the budget meant that there was no flexibility to afford pay cost increases in excess of the £22 million identified (which covered a potential 1 per cent increase) without impacting directly on patient care by reducing resources available for service maintenance and improvement.

[43] Independent Commission on Funding and Finance for Wales. *Fairness and accountability: a new funding settlement for Wales.* July 2010. Available from: http://wales.gov.uk/docs/icffw/report/100705fundingsettlementfullen.pdf

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3.21 The **Joint Staff Side** commented that the NHS in England had achieved a surplus in every one of the last six financial years and that the cumulative value of those surpluses now stood at almost £8.6 billion. It said that the number of foundation trusts in deficit had risen from 15 to 16 trusts between March 2012 and March 2013, which had stayed in line with the consistently low level seen over the last three financial years. It acknowledged that there were financial challenges ahead but queried why, when (according to NHS Employers) five trusts accounted for the vast majority of the deficit, this should be used to freeze the pay of staff in all other organisations, particularly given that nearly £3 billion had been returned to the Treasury over the past two years.

3.22 The Joint Staff Side noted that in the Devolved Administrations the NHS in Wales had met its challenging financial targets in 2011/12 through a combination of a significant £285 million worth of savings reported by NHS bodies and some additional funding from the Welsh Government. It pointed out that Audit Scotland[44] had reported that by the end of the 2011/12 financial year, all Scottish NHS boards had broken even, which they were all obliged to do. It noted that a small surplus was recorded for NHSScotland as a whole, though the surpluses were small at less than 1 per cent of budget for all but one health board, and nine frontline boards had concluded the year with an underlying recurring deficit. The Joint Staff Side observed that in last year's evidence to us, Northern Ireland had identified that it had put aside part of the funding to address the erosion for the differential between Agenda for Change pay points 15 and 16. However, as this was not addressed in our recommendations, it believed that this allocation of money was under spent.

3.23 The **Royal College of Nursing** believed that efficiency savings had been achieved through freezing NHS Pay.

3.24 **Unison** said that the NHS in England had recorded a surplus of £1.6 billion for the 2012/13 financial year showing a six-year trend of underspend. It believed that NHS underspend was being clawed back by the Treasury rather than being recirculated into the NHS and that the NHS transition in England had cost the Department of Health £1.1 billion. In addition, it asked us to acknowledge the financial surpluses recorded by the NHS over recent years and recommend that this money be recirculated back into the NHS to improve service quality.

3.25 **Unite** expressed concern that despite the Treasury's clear statements that a payment of 1 per cent was affordable and available for staff this year, several of the parties had questioned this. Unite asked us to investigate these claims fully; for example, the Welsh Government's claims that the promised 1 per cent pay rise would be "unfunded". It pointed out that the Scottish Government had committed to fund the 1 per cent as well as the increase of £300 to the wages of the lowest paid. It noted that the response from Northern Ireland had also accepted that the 1 per cent would be implemented in some form. Unite added that the Foundation Trust Network evidence showed that 62 per cent of trusts were willing to pay the increase, however it was surprised that the umbrella organisations had rejected an uplift, which did not reflect the views of its member organisations. It continued to reject the Treasury's economic model as a whole, as it believed that the policy was driving up debt not reducing it, thus acting as a self-fulfilling prophecy for future cut backs and lack of affordability. In Unite's view a fair cost of living increase for NHS staff (Britain's largest employer) would have the impact of supporting and stimulating economic performance across the economy.

[44] Audit Scotland. *NHS financial performance 2011/12*. 2012. Available from: www.audit-scotland.gov.uk/docs/health/2012/nr_121025_nhs_finances.pdf

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Monitor Report – *Closing the NHS Funding Gap*

3.26 In Autumn 2013 Monitor, the sector regulator for health services in England, published a report *Closing the NHS funding gap: how to get better value health care for patients*.[45] The report set out where Monitor believed changes were needed to close the projected £30 billion funding gap in 2021 identified by the Nuffield Trust and NHS England, whilst continuing to provide good quality services for patients.

3.27 Monitor noted that over the next eight years or so the sector would face its greatest financial challenge in recent times. It believed that getting better value for patients meant improving productivity, which meant everyone working differently and smarter, altering or reshaping services and reinvesting the money saved in more and better services. Taking this approach could close the funding gap but it would not be easy as productivity growth in the NHS had lagged behind productivity growth in the economy as a whole. Monitor reviewed the best evidence available on improving health care productivity, identified where the biggest opportunities lay and estimated the potential gains they offered. Opportunities for significant recurrent productivity gains by 2021 fell into four main types: improving productivity within existing services (£6.5 billion to £12.1 billion); delivering the right care in the right setting (£2.4 billion to £4 billion); developing new ways of delivering care (£1.7 billion to £1.9 billion); and allocating spending more rationally (not costed). It also reviewed the evidence for non-recurrent savings on capital costs, which would yield a one-off gain of £7.5 billion and on wages.

3.28 The Monitor report stated that the pay freeze (2011/12 and 2012/13) and the 1 per cent pay cap (2013/14 and 2014/15) would together save an estimated £5 billion. It said that a large proportion of the efficiency gains achieved by the NHS since 2010 could be attributed to the pay freeze and pay cap, and that if the 1 per cent pay rise (for 2014/15) did not materialise, the savings would be greater. The report said that health systems across Europe had contained health spending in recent years using top-down wage freezes or reductions, rather than structural reforms to services. However, it said that the impact on the quality of patient care of freezing wages posed a significant challenge to countries pursuing such a policy. Monitor did not believe this to be a sustainable strategy for improving productivity in the NHS, noting that periods of wage restraint were generally followed by periods of 'catch up' with their trend level in subsequent years. It said that extended wage restraint impaired recruitment and staff retention.

Our comment

3.29 At its highest level, funding is a matter of political choice. We recognise and accept that Governments work within their political mandates. Our role is not to challenge this, but to seek to operate within our terms of reference for NHS staff, including taking into account the constraints of public expenditure policy on the one hand, and on the other the growing demand for high quality, patient-centred healthcare.

3.30 We have been impressed by the way that staff we have met on our visits have understood the need for pay restraint, notwithstanding the real and painful cuts to living standards for some, but, especially as the economy recovers this cannot continue to be the main mechanism by which the NHS achieves cost savings. Nonetheless, it is clear to us that growing financial pressures are a very significant issue for all four countries this year and that the position is likely to become more challenging in 2015/16 and beyond. Although all four countries had the 1 per cent for public sector pay allocated in the Spending Round there were a range of views on the affordability of a pay award for our remit group because of the varying cost pressures in each country and the requirements to make significant productivity improvements.

[45] *Closing the NHS funding gap: how to get better value health care for patients*. Monitor, October 2013. Available from: http://www.monitor.gov.uk/closingthegap

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3.31 Greater improvements in productivity are needed to meet increasing demand for healthcare and improvement in patient care following the Francis review. In England, a recent report by Monitor said that much of the efficiency savings to date had been achieved through the freeze on pay but this is a one off and trusts must look to the sorts of service transformation and improvement and other means identified by Monitor to cope with the growing pressures in the future. As the economy recovers, earnings in the NHS will need to keep pace with earnings in the economy generally for broadly comparable roles. Therefore, it is essential if the NHS is to confront its undoubted cost pressures that efficiencies are found in ways of working, thus increasing productivity, as well as having a pay system that rewards staff competence and supports the delivery of patient services over seven days.

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Chapter 4 – Recruitment, Retention and Motivation

Introduction

4.1 As part of our standing terms of reference we are required in reaching our recommendations to have regard to the need to recruit, retain and motivate suitably able and qualified staff as well as regional and local variations in labour markets and their effects on recruitment and retention of staff. This chapter therefore includes the parties' evidence and our analysis on the recruitment and retention position of our remit group, including: NHS workforce, vacancies and turnover; shortage occupations, Recruitment and Retention Premia (RRP); workforce planning and workload; appraisal and the Knowledge and Skills Framework; and staff engagement. Appendix C gives details of the composition of our remit group.

NHS Workforce, Vacancies and Turnover

Changes in staffing levels

4.2 Figure 4.1 and Table 4.1 show recent changes in the non-medical NHS workforce for the United Kingdom as a whole and for each of the four United Kingdom countries:

- the full-time equivalent (FTE) non-medical NHS workforce decreased by 0.3 per cent (3,600 FTE) between September 2011 and September 2012, to a total of 1.17 million FTE (1.36 million headcount);
- England, which accounts for 80 per cent of the FTE non-medical NHS workforce, was the only United Kingdom country to experience a decrease (-0.6 per cent or -5,300 FTE) in the FTE non-medical NHS workforce in the year to September 2012;
- Scotland, Wales and Northern Ireland (which account for 10 per cent, 6 per cent and 4 per cent respectively of the United Kingdom NHS workforce) experienced increases in their workforces of 0.4 per cent, 0.1 per cent and 2.1 per cent (or +500, +100, and +1,000 FTE) respectively over the same period;
- the only employee group to show an increase in its FTE numbers in each country of the United Kingdom was the professional, technical and social care staff group; and
- since September 2012, the total FTE non-medical workforce has increased in England[46] by 0.7 per cent, by 1.7 per cent in Scotland[47] and by 1 per cent in Northern Ireland.[48]

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[46] Health and Social Care Information Centre. *NHS Workforce Statistics – September 2013, provisional statistics*. December 2013. Available from: http://www.hscic.gov.uk/article/2021/Website-Search?productid=13832&q=September+2013&topics=13209&sort=Relevance&size=10&page=1&area=both#top

[47] ISD Scotland. *NHS Scotland Workforce Statistics, September 2013*. November 2013. Available from: https://isdscotland.scot.nhs.uk/Health-Topics/Workforce/Publications/2013-11-26/2013-11-26-Workforce-Report.pdf?86706179381

[48] As of March 2013, provided by the Department of Health, Social Services and Public Safety.

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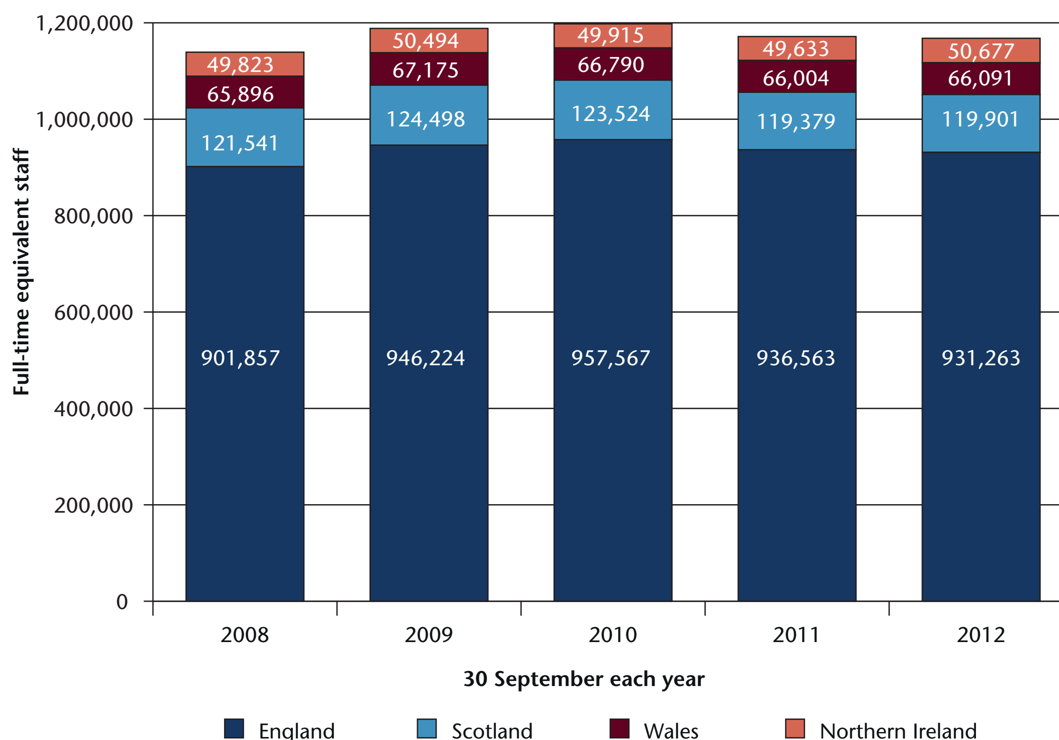
Figure 4.1: NHS non-medical workforce by United Kingdom country, September 2008 to September 2012



Sources: The Health and Social Care Information Centre; Welsh Government (StatsWales); Information Services Division Scotland; and Department of Health, Social Services and Public Safety Northern Ireland.

Table 4.1: Change in NHS non-medical workforce by United Kingdom country and broad staff group,[49] September 2011 to September 2012

Broad staff group	England	Scotland	Wales	Northern Ireland	United Kingdom
Qualified nursing and midwifery	-0.4%	-0.8%	0.2%	1.9%	-0.3%
Nursing and healthcare assistants and support	-0.8%	2.0%	0.8%	2.3%	-0.4%
Professional, technical and social care	0.5%	0.3%	0.8%	2.1%	0.6%
Ambulance	-2.0%	-0.1%	3.5%	0.5%	-1.4%
Administration, estates and managers	-1.4%	-1.5%	-1.5%	2.6%	-1.2%
Total[50]	**-0.6%**	**0.4%**	**0.1%**	**2.1%**	**-0.3%**

Sources: The Health and Social Care Information Centre; Welsh Government (StatsWales); Information Services Division Scotland; and Department of Health, Social Services and Public Safety Northern Ireland.

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

[50] The total also includes the "other" staff group. The numbers of "others" are volatile as they include unclassified and unknown staff groupings. This "other" staff group is therefore omitted from the table.

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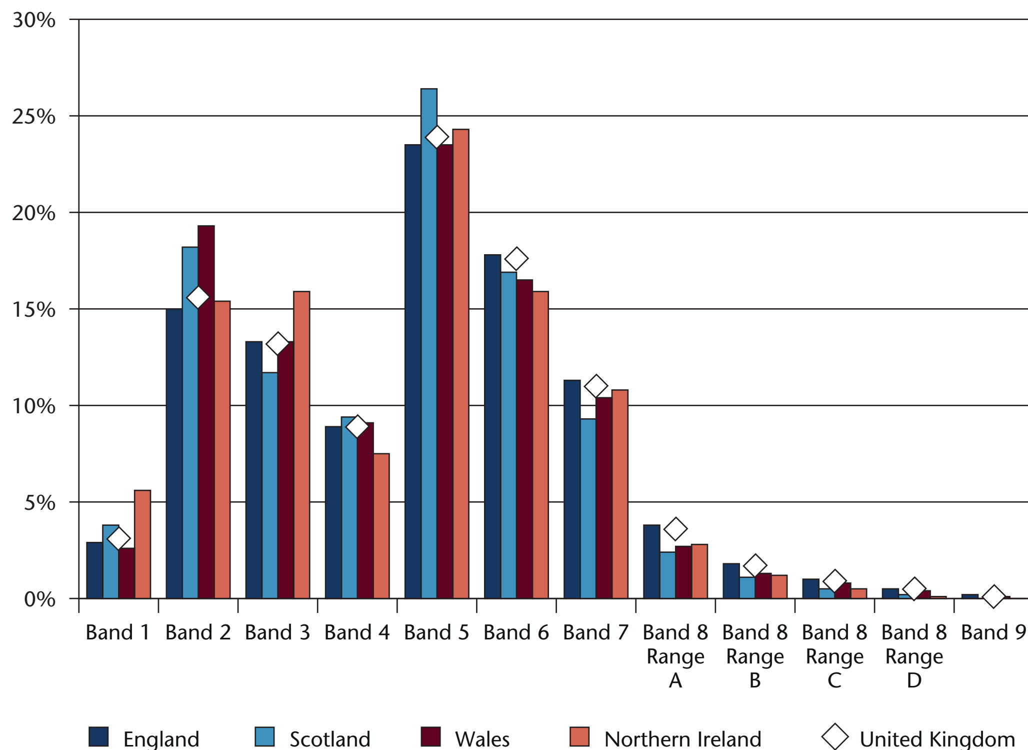
4.3 Figure 4.2 below shows the distribution of our remit group across the Agenda for Change pay structure. The pattern is similar for each United Kingdom country, with peaks at bands 2 and 5, reflecting the main entry bands for clinical support workers and professionally-qualified clinical staff respectively.

Figure 4.2: Distribution of full-time equivalent staff on Agenda for Change pay bands by United Kingdom country*



Source: Health Departments.

* Data for England relate to September 2012; Scotland, 2012/13 average; Wales, June 2013; Northern Ireland, June 2013.

4.4 Figure 4.3 below shows the percentage of staff at the top of each Agenda for Change pay band. Those who remain in their current posts will not receive an increment in subsequent years. The latest available data for the United Kingdom shows that 47 per cent of our remit group were at the top of their pay band, compared with 42 per cent in the previous year. The figures for individual countries ranged from 45 per cent of staff at the top of pay bands in England, 58 per cent in Northern Ireland, 56 per cent in Scotland, and 57 per cent in Wales.

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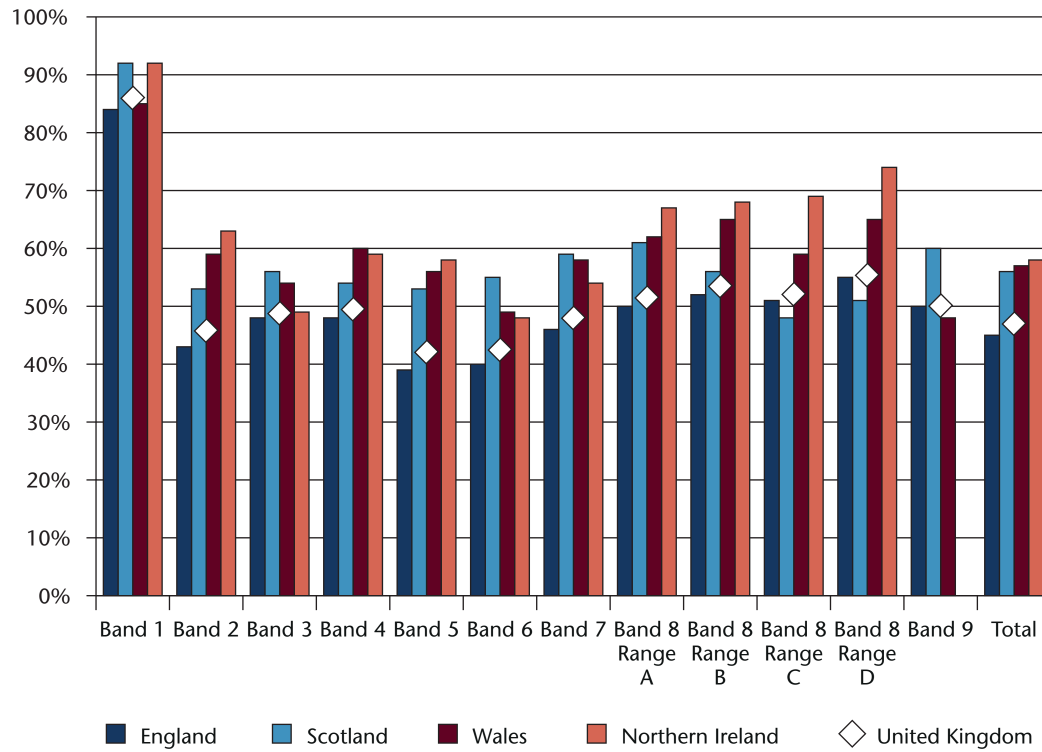
Figure 4.3: Percentage of full-time equivalent staff at the top of Agenda for Change pay bands by United Kingdom country*

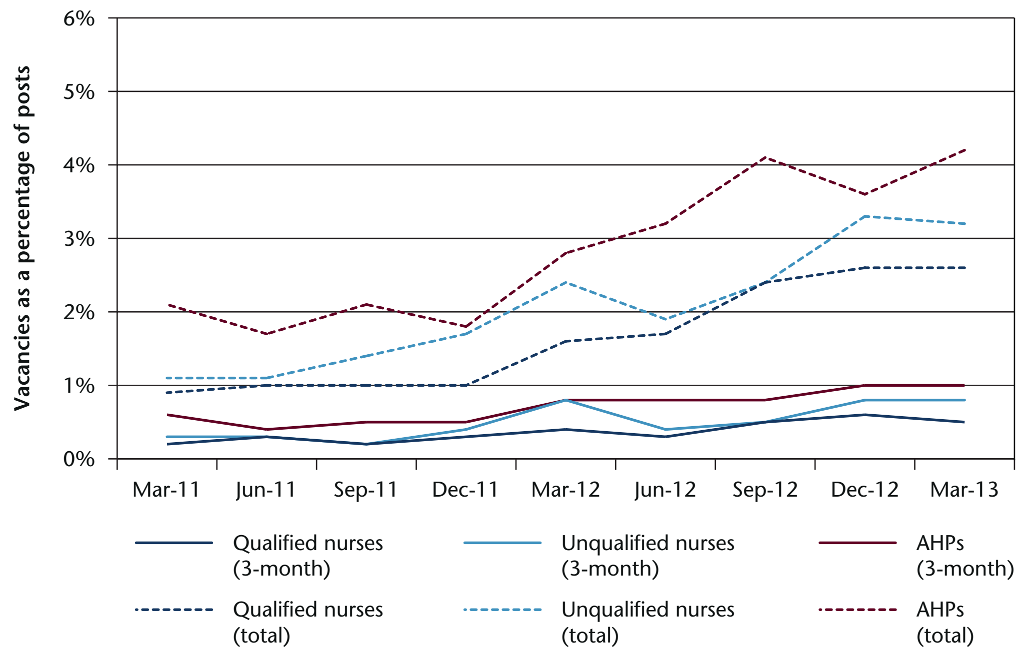


Source: Health Departments.
* Data for England relate to September 2012; Scotland, 2012/13 average; Wales, June 2013; Northern Ireland, June 2013.

Vacancy rates

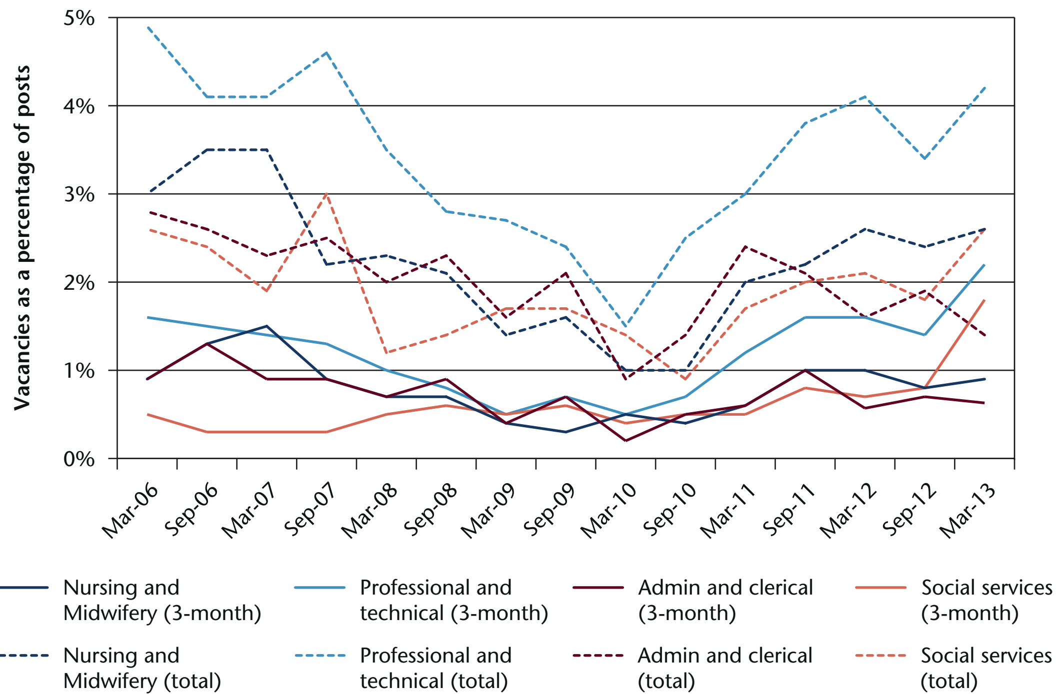
4.5 Vacancy statistics relating to our remit group are currently produced only for Scotland and Northern Ireland for a limited number of staff groups. Vacancy trends by staff group in Scotland can be seen in Figure 4.4, whilst trends in Northern Ireland can be seen in Figure 4.5.

Figure 4.4: Vacancy rates by main staff group, 2011 to 2013, Scotland



Source: Information Services Division Scotland

Figure 4.5: Vacancy rates by main staff group, 2006 to 2013, Northern Ireland



Source: Department of Health, Social Services and Public Safety Northern Ireland.

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Turnover

4.6 Table 4.2 shows the joining and leaving rates in England, Scotland and Northern Ireland in the last two years; figures for Wales are not available. In general there has been a decline in staff retention (increased leaving rates) in England and Northern Ireland but this has been offset by increases to England and Northern Ireland's joining rates. However, Scotland has seen changes since last year with lower leaving rates and higher joining rates. Leaving rates in the NHS are lower than the whole-economy average, according to a survey conducted by the Chartered Institute of Personnel and Development:[51] the median leaving rate among survey respondents was 12.7 per cent. The leaving rate of 10.1 per cent reported by public service respondents to the survey was also higher than for the NHS. However, there are some NHS staff groups in England that have leaving rates higher than the whole-economy average.

[51] Chartered Institute of Personnel and Development. *Resourcing and talent planning: annual survey report 2013.* CIPD, 2013. Page 47. The survey covers a sample of United Kingdom companies across 30 industry sectors. Available from: http://www.cipd.co.uk/hr-resources/survey-reports/resourcing-talent-planning-2013.aspx

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Table 4.2: Leaving and joining rates to the NHS by staff group (all figures based on headcount staff)

	Year to 30 June 2012		Year to 31 May 2013	
England	**Leaving rate**	**Joining rate**	**Leaving rate**	**Joining rate**
All NHS (including medical and dental staff but excluding bank, trainee doctors and locums)	8.0%	6.8%	8.5%	8.2%
Qualified nurses	8.2%	7.1%	8.7%	8.3%
Qualified midwives	7.4%	8.9%	7.8%	9.0%
Qualified health visitors	12.7%	15.0%	10.6%	16.8%
Qualified allied health professions	8.2%	8.2%	8.4%	9.4%
Qualified healthcare scientists	9.2%	7.5%	8.9%	8.6%
Other qualified scientific, therapeutic and technical staff	11.4%	14.0%	12.3%	14.2%
Qualified ambulance staff	5.7%	6.0%	6.3%	6.4%
Support to doctors and nursing staff	13.5%	11.8%	13.1%	13.6%
Support to scientific, therapeutic and technical staff	18.9%	18.0%	18.9%	18.0%
Support to ambulance staff	13.6%	10.0%	19.2%	17.4%
Managers and senior managers	18.3%	14.9%	28.3%	22.9%
Central functions	17.8%	15.0%	22.7%	18.6%
Hotel, property and estates	12.9%	10.3%	12.6%	12.1%
	Year to 31 March 2012		**Year to 31 March 2013**	
Scotland	**Leaving rate**	**Joining rate**	**Leaving rate**	**Joining rate**
All NHS (including medical and dental)	7.1%	5.3%	6.7%	8.1%
Nursing and midwifery	5.9%	4.7%	5.9%	6.5%
Allied health professions	6.4%	5.6%	5.7%	8.1%
Healthcare science	7.4%	3.2%	6.3%	5.3%
Other therapeutic services	7.2%	9.1%	6.9%	10.8%
Administrative services	7.5%	3.7%	7.0%	7.0%
Support services	10.6%	8.4%	8.5%	10.2%
	Year to 31 March 2012		**Year to 31 March 2013**	
Northern Ireland	**Leaving rate**	**Joining rate**	**Leaving rate**	**Joining rate**
All non-medical staff	4.3%	4.7%	5.2%	6.0%
Nursing and midwifery	3.9%	4.4%	4.5%	6.2%
Professional and technical	3.6%	7.3%	4.3%	7.5%
Social services	5.4%	3.1%	7.1%	4.0%
Administration and clerical	3.7%	6.7%	4.8%	5.7%
Estates services	5.5%	7.1%	11.5%	10.9%
Support services	5.9%	2.6%	5.2%	7.1%

Sources: The Health and Social Care Information Centre; Information Services Division Scotland; and Department of Health, Social Services and Public Safety Northern Ireland.

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Evidence from the parties

4.7 In their written evidence for us, the parties have drawn on the same data sources that we have highlighted above, as well as their own research. We summarise below the key conclusions that the parties have drawn from these data.

4.8 The **Department of Health** said that the recruitment and retention picture for the NHS remained strong. It suggested that NHS Jobs, an electronic jobs board for the NHS, may provide some useful data in the form of adverts opened and closed to be used as a proxy for data on vacancies.[52] However, it noted that the data available from NHS Jobs would not be able to identify when posts were filled or where posts have been vacant for three months directly, although it said that the dates associated with the adverts should provide a proxy measure.

4.9 **NHS Employers** told us that recruitment and retention continued to be generally stable across the country. It noted that the numbers of all major staff groups, apart from NHS infrastructure support, showed signs of stabilising following the NHS reorganisation of April 2013. They said that the overall number of joiners and leavers had remained relatively constant over a four year period. In 2012/13, it was possible to recruit the highest number of staff, with the fewest number of leavers since 2009. They believed that the ability consistently to recruit and retain staff indicated that Agenda for Change pay rates had remained competitive in relation to the wider labour market throughout the second year of the pay freeze.

4.10 NHS Employers said that the new NHS Jobs system to be launched in November/December 2013 would provide a robust data source, detailing vacancy rates at an individual occupation level. The existing NHS Jobs system provided data on the number of adverts placed on the NHS Jobs website, and the number of applications for each advert. From this, a monthly job advertisement rate had been calculated by expressing the number of FTE vacancies advertised on NHS Jobs, as a percentage of the total employed non-medical workforce (FTE) recorded in the Health and Social Care Information Centre census for each month. They reported that over the past four years the job advertisement rate had varied between around 2 per cent and 3.5 per cent. The slight increase in the number of job advertisements coincided with an overall reduction in Agenda for Change staffing levels. Therefore, this was likely to be indicative of reconfiguring the staff group mix, and as a result of the recent NHS reorganisation, rather than being a recruitment drive to increase staffing numbers overall. In addition, from April 2013, organisations from outside the NHS that had secured NHS funding, such as social enterprises and charities, had been allowed to advertise their health related vacancies on NHS Jobs. These posts may not be included in the Agenda for Change staffing levels. They told us that the number of applications per vacancy had remained relatively consistent, at around 14 applications per vacancy, for nearly four years.

4.11 We asked NHS Employers for their response to the Royal College of Nursing's predictions, in its recent *Labour Market Review*, which suggested nursing reductions of around 63,000 between 2013 and 2016. They responded that year on year the applications to nursing programmes had remained fairly constant; for example, in 2012 there were 212,572 applications with 23,836 acceptances (a ratio of 8.9 applications per acceptance).

[52] The Department of Health noted a number of factors that should be taken into account: not all adverts were vacancies (as some trusts recruit into pools so that they may appoint immediately as a post becomes available); some adverts were standing adverts and were not linked to a specific vacancy; jobs may be re-advertised as new vacancies; and some adverts were for multiple posts. Furthermore, if an advert did directly correlate to one post, there was no guarantee that the appointment would be recorded on NHS Jobs.

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4.12 The **Foundation Trust Network** reported that 20 per cent of respondents to its survey expected significant recruitment problems during 2014/15. This was an increase on last year when only 3 per cent of its members reported having significant recruitment problems for non-medical staff. However, it did not believe that the pay award alone could solve recruitment and retention problems where they existed.

4.13 The **Welsh Government** reported that there was a continuing healthy recruitment and retention position across Wales and that the number of staff in post had remained broadly stable both in terms of overall numbers employed and skill mix. There had been little change to the overall workforce since 2008 and over the past 12 months the number of staff employed by NHS Wales had continued to increase. However, it said that workforce plans indicated that this would not continue during the next financial year due to the financial constraints, although demand for health services continued to rise, placing strains upon the service. It noted that turnover had remained low and had decreased from 5.9 per cent in 2011/12 to 5.6 per cent in 2012/13. The workforce across NHS Wales had been relatively stable for the past five years and there were no indications from organisations that they had any significant issues with recruiting or retaining any staff groups within our remit group.

4.14 The **Scottish Government** reported that staff numbers in NHSScotland had gone through consolidation in the last few years, after a long period of expansion. There had been some modest increases in the previous 12 months. It confirmed that the recruitment and retention situation in NHSScotland remained healthy. All staff turnover figures showed a general downward trend over the last five years, which suggested that staff had become steadily less likely to leave the NHS and less likely to move posts within NHSScotland.

4.15 The **Northern Ireland Executive** told us that there were no particular recruitment difficulties within the relevant staff groups. It said that should any recruitment difficulties arise, they would be addressed under the local Recruitment and Retention Framework. It reported that provisional figures (March 2013) showed a slight decrease in current vacancies to 1,478 (1,246.9 FTE) compared to the same point the previous year. There were no particular regional recruitment difficulties within the relevant staff groups.

4.16 The **Joint Staff Side** told us that falls in staffing levels and diluted skills mix had occurred as the NHS had faced massive clinical pressure on services and in particular on accident and emergency services. It said that the non-medical workforce had shrunk across almost all parts of the United Kingdom since 2010, but due to the paucity of published information, it was unable to comment in any depth on vacancies and workforce shortages. However, it noted that the Care Quality Commission had reported that out of the NHS hospitals investigated in 2012 in England, 15 per cent were non-compliant on staffing standards.[53] The Joint Staff Side asked us to acknowledge that figures from Scotland indicated that vacancy levels were rising, and that work was needed to improve data collection on vacancy levels to enable effective workforce planning. It also reported that more than 10,000 NHS staff had been made redundant in the past three financial years, which it believed meant a huge loss of experience and skills.[54] It questioned how the Department of Health could not afford to have the right amount of staff given the issues raised in the Francis, Berwick and Keogh reports, which highlighted the importance of safe staffing levels. It believed that the increased number of recruitment and retention

[53] The Care Quality Commission standards state that: "In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity". See: Care Quality Commission. *Summary of regulations, outcomes and judgement framework.* March 2010. Available from: http://www.cqc.org.uk/sites/default/files/media/documents/guidance_about_compliance_summary.pdf

[54] Department of Health. *Tracking staff moves during transition*: *people tracker*. April 2013. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193156/Tracking_staff_moves_during_transition.pdf

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problems highlighted in the Foundation Trust Network's evidence should be taken as a warning sign of worsening recruitment and retention problems. It also said that the lessons from the Francis Inquiry and the Keogh Review were clear: the NHS needed to employ enough trained staff and engage them; and staff needed the necessary resources and support to do their jobs properly. The Joint Staff Side asked us to assess the longer term impact of the pay freeze and to consider the impact on the attractiveness of the NHS as an employer. It also called on us to assess the prospects for career progression in the NHS, given the increasing number of staff at the top of each Agenda for Change pay band, the use of down banding and squeezed training budgets.

4.17 The **Royal College of Midwives** said that in its survey of Heads of Midwifery, 76.6 per cent had said that there were vacancies in their trust/board. It noted that in previous evidence to us it had argued that it suspected that long term vacancies were not being filled or that the recruitment process was too lengthy to allow replacement staff to be put into place within three months. It said that there was a shortage of midwives in every region in England and Wales.

4.18 The **Royal College of Nursing** cited the Francis Report in drawing to our attention the dangers of low staffing levels and the impact on patient care. It also said that staff shortages led to nurses working overtime. It asked us to recognise the impact of and potential damage caused by shrinking nursing numbers and work intensification on patient care and service quality and on workforce morale and motivation, recruitment and retention. It noted that the Care Quality Commission had found that 16 per cent of NHS hospitals were failing to meet the regulator's staffing level standards; and reported that its own research suggested that almost 90 per cent of nursing staff did not think that staffing levels were always adequate to provide safe patient care. It said that there was growing evidence of a recruitment freeze, posts being unfilled and down banding of posts.

4.19 **Unison** told us that its 2013 pay survey had identified the increased use of bank and agency staff to plug staffing gaps and a greater use of zero hours contracts in the NHS. It said that for 51.7 per cent of survey respondents, staff shortages had frequently occurred in their workplace over the last 12 months. Furthermore, over 19.1 per cent of survey respondents from across the United Kingdom highlighted that recruitment and retention difficulties had been a major problem in their workplace. Unison was concerned that a quarter of respondents indicated that their employer did nothing to alleviate staff shortages. It asked us to recognise the need for published vacancy data for the NHS, consistent across the United Kingdom, for future planning of the NHS workforce. Reporting on its survey of members, it highlighted staff shortages in workplaces, with 70 per cent of respondents stating that they felt there were not adequate staffing levels in their workplace. It said that NHS trusts were recruiting nursing staff from other European Union countries due to a shortfall in nursing staff in the United Kingdom and that there was an increased use of agency and bank staff from the previous 12 months. It noted that the NHS workforce survey had shown that in February 2013 the NHS lost 800 more nurses.

4.20 **Unite** said that many of the claims in employers' and Government evidence lacked evidence or objective rationale and needed to be thoroughly interrogated by us. It also reported frequent staff shortages and told us that practice teachers were being required to support too many students and band 6 staff were now also being required to mentor students. It expressed concern about the outsourcing of staff which it considered costly and wasteful. It reported that its survey had overwhelmingly confirmed last year's trends of major problems with morale, workloads, unpaid overtime, staff shortages, restructuring, cuts to pay and resources that were affecting the standard of service delivery.

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Our comment

4.21 We do not see any current signs of general recruitment and retention issues, although we note the recent improvement in the strength of the overall economy and the marked fall in unemployment across all areas of the United Kingdom. Staff turnover is generally low. There is some evidence of skill shortages for specific occupations in certain areas, and we continue to believe that any particular shortages are best dealt with through RRP and improved workforce planning. However, we are less able to evaluate whether or not there has been any decline in the quality of new staff recruited, and we believe this aspect should be carefully monitored by employers as the economy strengthens.

4.22 We support the concerns raised by the Joint Staff Side and Unison about the need for improved and consistent data collection on vacancy and attrition levels to enable effective workforce planning. This has been a concern for us since 2011 when the Department of Health ceased to collect vacancy data. There are long term issues with data. We understand that in a constantly restructuring organisation vacancies may offer a welcome window for change. Nonetheless, post Francis, it is increasingly apparent that there is a need for better data so that trusts can closely monitor the adequacy of their staffing levels to ensure high quality and safe patient care. We need these data in making our recommendations and observations. Trusts need this information to make their decisions and to enable them to respond proactively to the challenges that are likely to emerge as the labour market tightens and as the consequences of any shortfall in training commissions become evident.

4.23 It is essential that our recommendations are based on robust statistics and evidence, so that they retain the confidence of Government, employers, the trade unions and staff. We remain very concerned about the continued absence of data on vacancies.

4.24 This is so central to our remit that we have decided to make a recommendation aimed at improving the data underpinning our deliberations on recruitment and retention. Though we are aware that the plan to introduce the new NHS Jobs website, as an alternative source of data on vacancies, is at an advanced stage, we are unclear as to whether this has the capacity to provide all the data we need and in a timely manner. Therefore, we recommend that the parties should take steps urgently to provide the necessary data to us on both long-term and short-term vacancies, to be available for consideration for our next review. All vacancies should be on a forward-looking basis relating to positions to be filled (i.e. not a historical model). We would expect the data available to allow us to identify whether there are any current and/or developing problems in specific geographies or sustained shortages in specific occupations.

Recommendation 1: We recommend that the parties should take urgent steps to provide data on both long-term and short-term vacancies, to be available for consideration for our next review. We would expect the data available to allow us to identify whether there are any current and/or developing problems in specific geographies or sustained shortages in specific occupations.

Shortage Occupations

Evidence from the parties

4.25 **NHS Employers** provided evidence on shortage occupations: pharmacists, health visitors, nurses and allied health professionals. They said that the position on pharmacist vacancies in England, as reported in the NHS Pharmacy Staffing Establishment and Vacancy Survey, remained stable. The three-month vacancy rates had not increased dramatically and there were indications that there may be a future oversupply of qualified pharmacists.

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4.26 With regard to health visitors, NHS Employers told us that although many employers had been able to meet the government target to increase the number of health visitors, some were experiencing more difficulties, particularly in London. Some employers had been using local RRP and the flexibilities within Agenda for Change to help retain staff, but there were more fundamental issues around the size of caseload, and the intensity of the safeguarding elements of the role that could not be addressed through financial reward. They told us that the last cohort of trainees that could have a positive impact on the workforce expansion target would enter health visitor training in January 2014. They believed that it was important to make sure that nurses and midwives were attracted into health visitor training and also retained in employment.

4.27 In the NHS Employers' workforce survey, 26 of the 43 organisations (out of 60 respondents) reported that staff shortages of qualified nurses were due to local or national skill shortages. The most frequently reported hard-to-fill vacancies were in specialist roles (acute, paediatrics, neonatal and theatre) but the numbers were small (less than 7 per cent of respondents reported hard-to-fill vacancies in any of these areas). Only one organisation reported that a shortage of qualified nurses was due to insufficient pay or reward. Hard-to-fill vacancies in paediatrics and neonatal were also identified in small numbers at band 6. NHS Employers said that this reinforced Centre for Workforce Intelligence data. It also told us that specialist nurses working in neonatal intensive care units had been retained as a shortage occupation in the most recent review of the Home Office list. Local actions by employers to manage the shortages of nurses had focused on recruitment campaigns and international recruitment, and to a lesser extent temporary staff.

4.28 Similarly, NHS Employers noted that of the 22 out of 60 organisations that had reported shortages of qualified allied health professionals; of these, 20 gave local or national skill shortages as the reason. Across this staff group there were hard-to-fill vacancies for sonographers across bands 5 to 7. Ten organisations (across North England, London and South England) reported shortages in this occupation (of between one and ten FTE), with 57 per cent of reported hard-to-fill vacancies being unfilled for over six months. National and local skills shortages were cited as the reasons for the difficulty in recruiting. Sonographers had also been retained on the Home Office *Shortage Occupation List*. Insufficient pay or reward was not given as a reason for this staff group; one respondent cited competition from other NHS organisations.

4.29 NHS Employers said that whilst generally recruitment or retention were not reported as problems in the Health Service Journal/NHS Employers Barometer Survey, a number of employers reported minor recruitment issues for some specialist roles, including: some emergency care, theatre and neonatal nurses; health visitors (in some places); sonographers and clinical coders. For nurses in particular, this had been addressed by some overseas recruitment. Local or national skills shortages were cited as the predominant reason for difficulty in recruiting, rather than levels of pay. This confirmed employers' understanding that these problems were either locality or speciality specific and were part of known labour supply problems.

4.30 The **Foundation Trust Network** reported that of those respondents who had described significant recruitment and retention issues, the following areas were described as problematic: band 5 nurses; accident and emergency staff; nursing recruitment in rural areas; mental health nurses; community nurses and health visitors; radiographers and sonographers.

4.31 The **Welsh Government** had concerns about the future provision of certain categories of nursing staff, allied health professionals and advanced practitioners.

4.32 The **Joint Staff Side** also commented on emerging signs of shortages in certain specialisms, for example for therapeutic radiographers and sonographers.

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Our comment

4.33 Some of the issues in the evidence suggest either that there is a need to redesign jobs, to employ more staff, or to raise the nature of qualification or certification. However, we find that there is not general cause for concern over recruitment and retention in the short term. There are some particular areas of shortage outlined in the evidence but if these are pay related, and often they are not, they can be addressed through RRP. However, it will be crucial for the medium term that workforce planning is both robust and accurate. In evidence, we heard a degree of suspicion about the robustness with which the new workforce planning arrangements are being put into action. We return to this issue later in this chapter.

4.34 As we have commented in previous reports, some occupational shortages are longstanding, notably those on the Home Office Migration Advisory Committee *Shortage Occupation List.* Should the labour market pick up, these could be the first to suffer retention problems and we remain concerned that, unless addressed, there is a risk that expensive pay solutions could be required in the longer term.

Recruitment and Retention Premia

4.35 Under the parties' Agenda for Change agreement we have a role whereby new RRP can be awarded on a national basis to particular groups based on our recommendation, where it can be demonstrated that there are national recruitment and retention pressures.[55] National RRP for a number of specified occupations, including for maintenance craft workers and chaplains, were agreed by the parties when Agenda for Change was negotiated with the NHS Staff Council, which was also responsible for their review and removal.

Evidence from the parties

4.36 **NHS Employers** noted that all national RRP were phased out completely on 31 March 2013. They said that as part of the negotiated agreement to withdraw the premia, it was agreed that the position would be reviewed again in the future, to determine whether changing labour market conditions could mean national RRP for maintenance craft workers were necessary again. The NHS Staff Council was currently considering this. However, employers had reported no labour market grounds for making additional payments in order to recruit and retain staff. Where there were known recruitment challenges, these were not related to the pay system and needed wider solutions. They stressed that local employers already had the pay flexibilities needed to address any local labour market challenges that arose.

4.37 NHS Employers reported a continuing decrease in the number of staff receiving RRP over the last three years: 2010, 5.8 per cent; 2011, 4.9 per cent; and 2012, 3.6 per cent. However, we note the regional variation in the proportion of staff receiving RRP (general or long term) in September 2012: the highest rates were in South East Coast (12.3 per cent) and South Central (10.4 per cent), with the lowest rates in the North East (0.7 per cent) and Yorkshire and Humberside (0.7 per cent). We also note from NHS Employers' evidence that the proportion of staff receiving RRP (general or long term) by occupation at September 2012 varied from qualified nursing, midwifery and health visiting staff (6.6 per cent) and hotel, property and estates (6.4 per cent) to support to scientific, therapeutic and technical staff (0.6 per cent) and qualified ambulance staff (0.4 per cent).

[55] NHS Staff Council. *NHS Terms and Conditions of Service Handbook.* Pay circular (AforC) 2/2013: amendment number 29. Section 5. Available from: http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf

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4.38 The **Foundation Trust Network** confirmed that the majority of its members did not use RRP for Agenda for Change staff; some respondents to its survey cited the fact that RRP only created competition on pay amongst neighbouring trusts and therefore drove wage inflation.

4.39 The **Welsh Government** said that a recent survey undertaken on behalf of the NHS Employers Unit within Wales had not found any evidence to suggest that a national RRP should be reintroduced for maintenance staff. It believed that any recruitment or retention issues arising within Wales could be dealt with by the application of a local RRP.

4.40 The **Scottish Government** reported that since the withdrawal of the national RRP, successful applications had been made by NHS Orkney, NHS Shetland, NHS Highland, NHS Grampian and the Scottish Ambulance Service in Aberdeen for RRP covering building craft workers analogous to the national RRP which were previously in place.

4.41 The **Northern Ireland Executive** had found no evidence to support a local RRP for maintenance craft workers since payment of the national RRP had ceased on 1 April 2013. It reported that a Northern Ireland Recruitment and Retention Framework was introduced in 2007 to address local recruitment difficulties; there were currently two long-term recruitment premia in place under these arrangements.

4.42 **Unite** told us that ancillary and maintenance staff were the most likely to rely on on-call payments and overtime to sustain their standard of living, and that these staff had reported some of the highest losses in take home pay. It said that 47.5 per cent of respondents to their survey had reported losses of 11 to 20 per cent, 8 per cent had reported losses of 21 to 30 per cent and 2 per cent losses of 31 to 40 per cent. It believed that much of this could be due to the removal of the estates and maintenance RRP, costing staff in these grades £3,277 per annum. It noted that some NHS trusts/boards were negotiating local RRP arrangements due to concerns about the impact on their workforce. Unite remained concerned about NHS chaplaincies who had also lost their national RRP. It believed that there was a case for the restoration of the housing allowance for chaplains, although it said that the NHS Staff Council had now rejected this. Unite said that it would support any investigation that we might make on the impact of these changes on recruitment and retention for chaplains across the NHS. It told us that it was working with the NHS Staff Council to further assess the issue of RRP for estates and maintenance staff; however, it would be welcome if we continued to investigate this issue.

Our comment

4.43 We have a continuing role under Section 5 of the Agenda for Change Agreement[56] to consider any new cases for national RRP, although none were presented for this report. We note Unite's concerns regarding RRP for chaplains and estates and maintenance staff, but we have received no evidence for this round to support national RRP for these groups of staff. We are also mindful that Unite is working with the NHS Staff Council on RRP for estates and maintenance staff, which we consider to be the appropriate route to address the matter.

4.44 Our view remains that shortages in specific occupational groups often arise from inadequate supply as a result of ineffective workforce planning and shortfalls in training commissions which may require expensive pay solutions in the future. Any cases for new national RRP must be accompanied by substantial and, where possible, joint evidence. In the meantime, we ask that the parties keep us informed of the NHS Staff Council's review of the national RRP for maintenance craft workers, which was withdrawn by March 2013.

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[56] NHS Staff Council. *NHS Terms and Conditions of Service Handbook.* Pay circular (AforC) 2/2013: amendment number 29. Section 5. Available from: http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf

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4.45 We commented extensively on local RRP in our *Market-Facing Pay* report.[57] Our analysis in that report of the usage of local RRP indicated that the majority were likely to be pre-Agenda for Change Cost of Living Supplements converted to long term RRP when Agenda for Change was introduced in 2004. Excluding these legacy payments suggested that the usage of local RRP was rare and did not show a distinct geographical pattern which might have been a reflection of the lack of recruitment and retention problems or constrained funding for local RRP. In addition, we have heard that, in some instances, it can be difficult to gain agreement for local RRP.

4.46 We repeat the recommendation in our *Market-Facing Pay* report on the appropriate use of local RRP as a key market-facing element of Agenda for Change and that local RRP should: have appropriate review mechanisms in place; reflect employers' local needs; be supported by robust data; be simple to operate; be fully understood by staff; and that good practice be shared.

Workforce Planning and Workload

4.47 Workforce planning does not directly form part of our terms of reference, but we view it as important because of its link to recruitment and retention in ensuring an adequate supply of suitably able and qualified staff for the future. Failures in workforce planning lead to skills shortages, which increase pay bill costs (for example, through the employment of agency and locum staff) which has a consequential impact on affordability. Workload has a similar connection to motivation and engagement.

4.48 We have reviewed the results of the 2012 NHS Staff Survey in England. We found that compared to the 2011 Staff Survey there have been increases in the percentage of staff saying that they work extra hours and increases in the percentage of staff suffering work-related stress. However, there was a decrease in the feeling of work pressure. A summary of the Staff Survey results can be found in Table 4.3, later in this chapter.

Evidence from the parties

4.49 **Health Education England**, which has taken over responsibility for the commissioning of education places from former strategic health authorities, explained that the 10 per cent reduction in commissions of nurses between 2010/11 and 2011/12 mirrored a reduction of registered nurses in the overall workforce, which it suggested may be reflective of Quality, Innovation, Productivity and Prevention (QIPP) priorities at the time. It said that a reduction in commissions did not necessarily mean a reduction in the workforce, nor did an increase in commissions necessarily mean an increase in the workforce; commissions set this year would not materialise in the workforce for three to five years for nursing. Between now and then, higher education institutions and Local Education and Training Boards had a responsibility actively to manage attrition and improve the quality of education. It told us that local employers had a responsibility actively to manage turnover, retention, recruitment and skill mix and ensure the current and future workforce supply was sufficient to meet the staffing levels required to ensure safe and quality patient services.

4.50 **NHS England** told us that the shape and structure of the NHS workforce had responded and modernised to meet new and emerging challenges throughout the history of the NHS. However, it believed that this would need to be accelerated at a significant pace and scale over the next decade if we were to see genuine transformations in quality and outcomes. Workforce planning was informed by commissioners' medium to long-term strategic intentions and NHS England would be working closely with Health Education England to achieve this.

[57] NHS Pay Review Body. *Market-facing pay: how Agenda for Change pay can be made more appropriate to local labour markets*. Cm 8501. TSO, 2012. Available from: https://www.gov.uk/government/publications/nhs-local-pay-2012

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4.51 We note from **NHS Employers** that from 2015, the commissioning of health visiting services would transfer to Local Authorities. They also told us of some instances where there had been over 100 applications per vacancy for administration or support roles, although the poor quality of applicants for vacancies in the support workforce was a recurrent theme for employers. During oral evidence, NHS Employers suggested that there was a need to change shift arrangements to help with workforce planning arrangements. We asked NHS Employers for an example of substantial service redesign. They provided the example of the development of the community support worker as provision shifted from acute to community care, and from registered nurses to support workers, as designed by NHS Leeds Community Healthcare.[58] It told us that this change was estimated to save between £5,294 and £12,800 in the first year, rising to between £8,500 and £16,000 in subsequent years, when support workers delivered diabetes care in place of registered nurses.

4.52 The **Foundation Trust Network** said that the planned 2 per cent increase in spending on staff by foundation trusts in 2013/14, reflected a net 2 per cent increase in FTE employees. In the subsequent two years, (2014/15 and 2015/16) staff costs were expected to fall by 0.5 per cent per annum, reflecting planned FTE reductions during this period. It told us that the majority of respondents, 69 per cent, were planning to recruit additional staff and this would largely be funded through increased income generated by additional volumes of activity.

4.53 The **Welsh Government** told us that due to the financial situation, organisations were planning to reduce overall staffing numbers during 2013/14 through turnover and the use of voluntary redundancy schemes.

4.54 We heard from the **Joint Staff Side** that staff were overworked and having to deal with greater stress caused by staff shortages. It said that the over reliance on staff to work extra hours was now the norm in the NHS, rather than the exception and that it was this over reliance on staff to go the extra mile for little recognition that was now eroding the goodwill of the NHS workforce. In the light of the Francis report, the Joint Staff Side believed that it was paramount that NHS organisations recognised that they could not continue to burden their staff with increased workloads and rely on their goodwill to work extra hours in order to meet financial targets. It noted that individual union surveys showed increasing workloads and staff under pressure. The main reasons for increased workload were similar for all three surveys (the Chartered Society of Physiotherapists, Unison and Unite) with many citing additional duties and responsibilities, insufficient cover and the impact of vacancy freezes. Rising workloads and pressures were clearly forcing staff to work additional hours to their contracts and there was a huge reliance on staff working unpaid overtime in the NHS. The Joint Staff Side told us that joint union surveys had consistently shown that members of staff in the NHS had been identifying year on year increases in workloads and stress attributed largely to vacancy freezes, redundancies and staff shortages. In addition, these surveys had also identified the decline in morale and motivation within the NHS workforce due to these increased workloads and pressure from managers to keep meeting annual financial and Government targets in an environment of dwindling resources.

4.55 Of considerable concern to the **Royal College of Midwives** was the amount of unpaid time midwives were working. While it was acknowledged that working beyond formal hours went with the role, alongside the other pressures faced, these unpaid hours, particularly working during breaks, were said to be increasingly resented, generating safety risks and impacting negatively on the midwives' general health and well being. It told us that maternity staff were required to work harder to meet the demands on services, including a growing amount of unpaid work, but the rewards that they received

[58] NHS Employers. *The support workforce: developing your patient-facing staff for the future.* Briefing 75. November 2010. Available from: http://www.nhsemployers.org/Aboutus/Publications/Documents/The%20support%20workforce.pdf

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were diminishing. It believed that this shift had a number of consequences including a detrimental effect on the quality of life for staff, falling living standards (staff reported working as bank staff during their holidays to make ends meet) and growing disillusionment. It argued that maternity units were facing unprecedented challenge; units were overworked and understaffed, and there had not only been a reduction in training but also a reduction in band 7 posts.

4.56 The **Royal College of Nursing** remarked upon the 16 per cent fall between actual commissioned places in 2009/10 and planned places for 2012/13. Its 2013 *Labour Market Review*[59] observed that cost containment actions had reduced the number of new nurses entering the United Kingdom labour market, and the job opportunities and career mobility for current nurses. The Royal College of Nursing's 2013 survey found a high level of anxiety about job security and negative responses regarding employment opportunities. The Royal College of Nursing called on us to recognise the impact of falling staffing numbers, reductions in commissioned education places, reductions in training budgets on the future supply of nurses, their job opportunities and career mobility. It drew our attention to the high level of overtime being worked that added to pressure. The Royal College of Nursing said that its 2012 Staff Survey had found that 80 per cent of nurses and 56 per cent of healthcare assistants worked longer hours than they were contracted to because, for most respondents, it was impossible to carry out the work if they did not. It called on us to acknowledge that there existed a health risk for nursing staff as their stress levels reached breaking point and a safety risk for patients and NHS organisations. It also pointed out that the Cavendish Review had stated that boundaries were increasingly blurring between registered nurses and healthcare assistants.

4.57 **Unison**'s 2013 pay survey found that over half of respondents worked over their normal contracted hours every week, but were not remunerated for this. The survey also found that: 86.4 per cent of NHS staff had experienced an increase in their individual workload in the last 12 months; the main reasons for this were: staff being given additional duties and responsibilities; and pressure to meet Government targets and waiting list times. In addition, over half of respondents to the survey indicated that their workplace was 'frequently' short-staffed and 42 per cent identified that increases in their workloads were now impacting on the quality of care each patient received.

4.58 **Unite** told us that its survey showed long hours, staff cut backs and poor morale across the NHS. For example, 61 per cent either frequently or always worked longer than their contractual hours, of which 41 per cent said that these hours were all unpaid; 85 per cent said that workloads had increased since the previous year, with 50 per cent saying they had increased a lot.

Our comment

4.59 The Francis Report has brought the question of staffing levels and quality of care into public focus. Many trusts, and the service as a whole, are seeking to balance the constraints of affordability with the increased demands and numbers of patients. Some of the parties have invited us to prioritise staffing levels above, and in place of, pay awards for staff; others have argued this would be a short-term view, which would lead to future difficulties in recruitment and retention of staff of the appropriate quality to give excellent care to patients, both in direct and support roles. This 'dilemma' has been at the heart of our deliberations this year.

4.60 We are also concerned by the lack of confidence expressed by some about the new arrangements for workforce planning in England, which we heard from the parties during oral evidence, although there is little hard evidence in this area. There is a need for

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[59] Royal College of Nursing. *Safe staffing levels: a national imperative. The UK nursing labour market review 2013.* September 2013. Available from: http://www.rcn.org.uk/__data/assets/pdf_file/0018/541224/004504.pdf

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robust, evidence-based workforce planning across the NHS as that has an impact on many aspects of recruitment, retention and motivation; for example, the move to seven-day services will increase demand for certain staff groups and could create staff shortages.

Appraisal and the Knowledge and Skills Framework

4.61 The NHS Knowledge and Skills Framework, which applies to all staff covered by Agenda for Change, is a tool for describing the knowledge and skills staff need to apply at work in order to deliver high quality services; it includes an annual system of review and development for staff. Despite the introduction of a simplified version of the Knowledge and Skills Framework in 2010, take up has been variable and we have expressed concern in our previous reports over this and the low rate of appraisals.

Evidence from the parties

4.62 **NHS Employers** said that results from the 2012 NHS Staff Survey showed that 83 per cent of staff had had an appraisal (up from 80 per cent in 2011). However, only 36 per cent reported that they felt that their review was well structured. It told us that in February 2013, the NHS Staff Council agreed changes to the *NHS Terms and Conditions of Service Handbook*, which covered staff on Agenda for Change contracts in England. The agreed changes came into effect from 31 March 2013. The new system made clear that incremental progression was conditional on meeting performance standards. It stated that progression for all pay points, was conditional on individuals demonstrating that they had met locally agreed performance requirements in line with the principles and criteria set out in Annex W[60] of the *NHS Terms and Conditions of Service Handbook*. For bands 8C, 8D and 9, pay progression would become annually earned while accelerated pay progression associated with preceptorship for staff joining pay band 5 as new entrants would be removed. It also told us that there was scope to put in place alternative, non-Agenda for Change, pay arrangements for bands 8C and above.

4.63 The **Welsh Government** reported that in the last 12 months just over half (55 per cent) of employees had indicated that they had had a personal development appraisal or Knowledge and Skills Framework review. A similar figure was reported by the **Scottish Government**.

4.64 The **Scottish Government** said that NHSScotland continued to view the NHS Knowledge and Skills Framework as an extremely valuable tool to support staff development, as it ensured that all staff had access to appropriate learning in order to develop the skills needed to do their job safely and effectively. It expected boards, as exemplary employers and in delivering their responsibilities under the Staff Governance Standard, to continue to ensure that staff had current Personal Development Plans in place and that they had yearly development review discussions. It expected that meaningful personal development planning, underpinned by the Knowledge and Skills Framework, would improve staff engagement, confidence and job satisfaction which would result in improved recruitment and retention.

4.65 The **Northern Ireland Executive** said that employers remained committed to the Knowledge and Skills Framework in line with the Agenda for Change national agreement.

4.66 The **Joint Staff Side** said that the Department of Health's claim that paying staff more "may do little to improve the quality of care for patients" was highly disappointing, given the relatively low application of the Knowledge and Skills Framework and inconsistent quality of appraisals across the NHS. It said that the statement also ignored the recent

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[60] NHS Staff Council. *NHS Terms and Conditions of Service Handbook.* Pay circular (AforC) 2/2013: amendment number 29. Annex W (England). Available from: http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf

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changes made to the Agenda for Change agreement in England linking performance to annual pay. It said that it would be disappointed if this meant that the Department of Health was not prepared to give the agreed changes sufficient time to take effect.

4.67 The **Royal College of Nursing** noted that the Francis Report suggested that nurses' pay should be tied to how well they looked after patients. The Royal College of Nursing believed that the existing Knowledge and Skills Framework provided an adequate mechanism for performance management. It also believed that the suggestion in the Francis Report was highly divisive, and would create divisions both between nursing staff and colleagues from other disciplines, and between nursing staff working in the same team.

4.68 **Unison** reported that only 71 per cent of respondents to its survey had received an appraisal or development review with their line manager.

Our comment

4.69 We support the increasing interest in linking pay and pay progression to performance. However, we are conscious that any such approach needs to be underpinned by a sound and trusted appraisal system and we find it disappointing that only 83 per cent of respondents to the Staff Survey in England and 55 per cent of staff in Wales reported having had an appraisal; and that only just over a third of staff in England who did receive one felt that it was well structured. Nevertheless, we recognise that this represents an increase in completion rates for staff appraisals in England and we welcome this trend.

4.70 We are mindful that performance can only be rewarded if it can be measured, which in turn requires a robust appraisal system. We also recognise that some parts of the NHS are still struggling with the Knowledge and Skills Framework and implementing appraisals and that there is increasing pressure all round on managers. Notwithstanding this, we are aware that some trusts have streamlined the Knowledge and Skills Framework and seem to have managed to do this without undue impact on the quality of the process. We welcome such streamlining if it can increase the use of the Knowledge and Skills Framework in an acceptable way. However, we suggest that NHS organisations do need to ensure that they have sufficient human resources capacity to enable the benefits of the Knowledge and Skills Framework to be realised.

4.71 We note that since we last reported the Staff Council has reached agreement for Agenda for Change staff in England, which makes incremental progression through all the pay points conditional upon individuals demonstrating the requisite knowledge and skills/competencies for their role based on standards of performance and delivery, as determined locally. We welcome this, although we were surprised to hear in oral evidence that it might take up to three years for some trusts to implement the changes. We urge the parties to speed up the pace of implementation and put in place a system of suitable performance and development reviews.

Staff Engagement

4.72 Our terms of reference require us to have regard to the need to motivate staff. However, we do not feel that we get sufficient evidence on motivation and that the evidence we do receive relates more closely to staff engagement. Each year one of the strongest themes in our evidence-gathering process, both through the written and oral evidence and especially through our programme of visits, has been the importance of fostering and improving staff engagement to deliver better and more cost effective patient care and to enable the transformational change required in the NHS. In this section we highlight the NHS Staff Survey results and the parties' evidence.

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Background research

4.73 Evidence[61] in previous years has shown links between higher levels of staff engagement and better patient outcomes. Monitoring staff engagement therefore makes up an important part in our decision process. We use the results of NHS Staff Surveys where these are available to monitor the trends in staff attitudes. However, each country produces its own staff survey on different timescales and frequency to the others, which makes comparisons between countries difficult. The trade unions also provide us with some of their own surveys. We urge the parties to provide timely data and to carry out a joint independent staff survey on a common set of questions, administered over the same period.

NHS Staff Surveys

England

4.74 A summary of results for the non-medical staff from the 2012 NHS survey[62] can be found in Table 4.3. For non-medical staff in England, between 2011 and 2012 we note that there were small increases in average scores for job satisfaction, while staff motivation remained flat. There also continues to be an improvement in the proportion of staff receiving appraisals. Although there has been an increase in the percentage of staff working extra hours, the percentage of staff feeling satisfied with the quality of work and patient care they were able to deliver has increased for the first time since 2009 when this question was first asked in the Staff Survey.

[61] Michael West et al. *NHS staff management and health service quality: results from the NHS Staff Survey and related data.* Department of Health, August 2011. Available from: https://www.gov.uk/government/publications/nhs-staff-management-and-health-service-quality

[62] National NHS Survey Co-ordination Centre. *2012 results.* Available from: http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2012-Results/

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Table 4.3: Summary results from the National NHS Staff Survey, 2007 to 2012, England, excluding medical and dental staff

Measure	2007	2008	2009	2010	2011	2012	Trend[1]
Workload							
Work pressure felt by staff[2,3]	3.17	3.09	3.07	3.06	3.09	3.06	
% staff working extra hours[2]	65.6	65.5	64.3	64.5	64.1	69.1	
% staff suffering work-related stress in last 12 months[2]	33.1	28.4	28.5	29.4	30.4	38.6	
Training and appraisals							
% staff receiving job-relevant training, learning or development in last 12 months	77.1	80.7	79.2	77.8	76.6	81.0	
% staff appraised in last 12 months	60.6	64.7	69.8	77.1	79.0	83.2	
% staff having well structured appraisals in last 12 months	24.5	27.9	32.0	35.2	34.8	36.7	
Engagement and job satisfaction							
Support from immediate managers[3]	3.64	3.64	3.68	3.70	3.68	3.66	
% staff reporting good communication between senior management and staff		28.1	28.9	30.5	28.4	27.9	
% staff able to contribute towards improvements at work		66.0	65.0	65.0	63.2	67.7	
Staff recommendation of the trust as a place to work or receive treatment[3]		3.52	3.51	3.50	3.47	3.57	
Staff motivation at work[3]			3.85	3.80	3.78	3.81	
Staff job satisfaction[3]	3.43	3.50	3.53	3.54	3.51	3.59	

Source: England NHS Staff Survey.

1 Trend lines do not have a common scale; they each show the general direction of travel of individual key findings (which may exaggerate fairly small changes), and must be viewed both in the context of the data in the preceding columns and the full range of possible scores for each measure.

2 Lower scores are better in these cases, however, in all other cases, higher scores are better.

3 Results are on a scale from 1 to 5.

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Wales

4.75 In 2013, all NHS staff in Wales were invited to take part in the latest staff survey[63] and it resulted in a response rate of around 27 per cent. However, as the last full survey of NHS Wales staff was completed in 2007 there are no comparisons available for trends over time.

4.76 Where possible, we have tried to compare these results with similar questions which were asked in England's NHS Staff Survey. In Wales, just over half (55 per cent) of employees indicated that they had had a personal development appraisal or Knowledge and Skills Framework review, whilst in England 83 per cent of staff said they had had an appraisal. Although we cannot make true statistical comparisons between countries we note that there were five questions on engagement which were common to staff surveys in England and Wales. The results of these engagement questions can be found in Table 4.4.

Table 4.4: Overall engagement results, comparison between Wales and England, all staff (including medical and dental staff)

	Wales	England
I look forward to going to work	49%	52%
I'm enthusiastic about my job	60%	68%
I am happy to go the extra mile at work when required	86%	Not Asked
I am able make improvements in my area of work, the work of my team/department (Wales question wording)	54%	
I am able to make improvements happen in my area of work (England question wording)		54%
I am involved in deciding on the changes that affect my work/area/team/department	37%	52%
I would recommend my organisation as a place to work	48%	55%
I am proud to tell people I work for my organisation	51%	Not Asked
OVERALL ENGAGEMENT INDEX SCORE (mean average of the above percentages)	**55%**	**56%**
Comparable index score (using questions asked in both countries)	**50%**	**56%**

Sources: England NHS Staff Survey and NHS Wales Staff Survey

4.77 In England, staff were not asked all seven of these questions (England did not ask the questions 'I am happy to go the extra mile when required' or 'I am proud to tell people I work for my organisation').

4.78 We compared England's engagement index of 56 per cent to Wales' results to the five common questions only, which gave a modified engagement index of 50 per cent in Wales. While we cannot produce a statistical comparison between countries, we are concerned about the relatively lower results in Wales. As the Wales survey was carried out in 2013, as opposed to England's 2012 survey, we will continue to monitor these trends in future years.

[63] *NHS Wales Staff Survey 2013: national overview.* Available from: http://www.wales.nhs.uk/nhswalesstaffsurveyresultspublished

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Scotland

4.79 The **Scottish Government** Staff Survey[64] took place between 27 May and 5 July 2013. Results were published in November 2013. There are few possible comparisons with other countries, so in general we have compared the latest results to Scotland's previous survey in 2010. Between 2010 and 2013, significant differences in results as a whole, for all NHSScotland, which includes staff outside our remit, show a decreasing trend in positive answers to the survey. In the analysis of 21 questions, with significant differences compared to 2010, only two had increased on 2010 levels. Furthermore, these two were relatively small improvements (+3 percentage points and +2 percentage points). The other 19 questions varied from reductions of between 1 percentage point and 15 percentage points.

4.80 Whilst there was no specific question or measure of engagement in Scotland, the following two questions were asked both in Scotland and Wales (and Wales used these within its engagement index):

- they are happy to go the 'extra mile' at work when required: overall 87 per cent of NHSScotland agreed, compared to 86 per cent in Wales; and
- they would recommend their board as a good place to work: overall 50 per cent of NHSScotland agreed, compared to similar questions in Wales and England where 48 per cent agreed in Wales and 55 per cent agreed in England.

Northern Ireland

4.81 The Department of Health, Social Services and Public Safety in Northern Ireland carried out a survey[65] of its Health and Social Care staff in 2012. Around 17,000 staff were surveyed and around 6,800 staff participated, representing a response rate of 40 per cent. The previous survey was in 2009.

4.82 There were several questions asked in Northern Ireland that can be broadly compared to similar questions that were asked in England. Table 4.5 gives a summary of some of the questions which are important to us and our terms of reference. In the comparison between countries, staff opinions were mixed; however, we are concerned by the large disparity between appraisal rates, with Northern Ireland being much lower than England, notwithstanding differences in question wording between countries.

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[64] NHSScotland. *Staff survey 2013: national report.* Available from: http://www.scotland.gov.uk/Publications/2013/12/4235/downloads

[65] *Health and Social Care Staff Survey 2012.* Available from: http://www.hscni.net/HSC_Staff_Survey_2012/

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Table 4.5: Comparison of some key questions, Northern Ireland and England, all staff (including medical and dental staff)

Survey question wording	Northern Ireland	England
In the last 12 months, have you had an appraisal or Knowledge and Skills Framework development review?	51%	
In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework development review?		82%
I would recommend my organisation as a place to work.	56%	55%
I am able to do my job to a standard I am personally pleased with.	63%	79%
I feel that my role makes a difference to patients/clients/service users.	89%	82%
Communication between senior management and staff is effective.	27%	35%
There are enough staff in this work area/team/department for me to do my job properly.	36%	
There are enough staff at this organisation for me to do my job properly.		30%

Sources: England NHS Staff Survey and Health and Social Care in Northern Ireland

Evidence from the parties

4.83 The **Department of Health** commented that measures of staff engagement in the Staff Survey remained good. It said that its pay strategy also included improving staff engagement, but there was a complex relationship between overall pay and levels of staff engagement, morale and motivation. The scores in the 2012 NHS Staff Survey suggested that some progress was being made despite the pressures on NHS staff having risen from 3.61 to 3.68 (out of 5). The variation across the service meant that there was plenty of scope for improvement. The Department of Health told us that the Francis report had highlighted the potential negative impact on patients of staff disengagement. It emphasised the need for leaders to create a culture that supported engagement. Staff engagement had been woven into work on the nursing strategy known as the 6Cs, especially around engaging staff in the delivery of compassionate care. Work was ongoing on the delivery of this strategy including areas such as appraisal. It reported that overall staff satisfaction with pay had remained positive, although less so than in 2011.

4.84 **NHS Employers** told us that on all key measures, staff engagement rose in the 2012 NHS Staff Survey compared with 2011. The data indicated that the fall in staff engagement (on which we had commented in our *Twenty-Fifth Report*[66]) had been reversed.

4.85 The **Scottish Government** said that the Scottish Public Sector Pay Policy re-affirmed its commitment to no compulsory redundancies, which it believed provided staff with an important element of reassurance during a time of economic uncertainty, thus allowing them to concentrate on the delivery of services.

4.86 The **Joint Staff Side** suggested that HM Treasury's announcement of two further years of pay caps for NHS staff at an average of 1 per cent a year up to 2015/16 was impacting heavily on staff morale, at a time when many were also coping with NHS restructuring, heavy workloads and work intensification. It called upon us to recognise the impact of the NHS work environment and organisational culture, and the public sector pay policy on NHS staff and their levels of work engagement. It also asked us to acknowledge that staff engagement was deteriorating and to acknowledge that failure to improve risked negatively impacting on recruitment and retention and ultimately, patient care. It told us that claims that the Care Quality Commission had covered up failures had shaken the public's trust in the NHS, leading staff to feel under ever more scrutiny and pressure. It

[66] NHS Pay Review Body. *Twenty-fifth report.* Cm 8029. TSO, 2011.

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said that recent union surveys and the NHS Staff Surveys showed that morale was being tested, following several years of reorganisations, pay cuts and pay freezes. The NHS Staff Surveys had shown that only around one third of staff in England, Wales and Northern Ireland were satisfied with their level of pay.

4.87 The Joint Staff Side considered the decline in morale and motivation across the NHS workforce to be a trend that showed no sign of improving, especially as the NHS was currently under pressure to deliver efficiency savings through workforce productivity. It said that surveys suggested that the main sources of anxiety and concern among the NHS workforce were increased workplace stress levels and the extent of reorganisation and restructuring within the NHS. The union surveys also pointed to cuts to terms and conditions as impacting on morale and motivation. It believed that the level of anxiety about work pressures, workload, standards of living and job security were impacting on how the NHS was viewed as a career choice. It noted that the Scottish Government had given a commitment to engaging staff within NHSScotland through the recently relaunched Staff Governance Standard. It did not believe that trusts were doing enough to improve staff engagement and show staff they were valued.

4.88 The Joint Staff Side believed that the continued pay freeze and cap; pension changes; NHS restructuring; and continued references to public sector workers versus taxpayers had contributed to a culture that did not value staff, and had resulted in staff feeling disengaged from the NHS. The continued real terms fall in NHS wages was damaging motivation, as evidenced in the 2012 NHS Staff Survey for England, which showed that just 41 per cent of staff were satisfied or very satisfied with the extent to which their organisation valued their work. It commented that the process of NHS reform in England had created a great amount of uncertainty over job security within the NHS workforce. It said that staff felt overwhelmed by the pace and extent of change and under pressure from increased workloads and staff shortages. It noted that the growing use of down banding across the NHS meant reduced opportunities for career progression across many health occupations.

4.89 The **Royal College of Midwives** reported that in the 2013 survey of Heads of Midwifery, 30.1 per cent of respondents answered that morale and motivation had decreased in the last 12 months. Respondents stated that the shortage of midwives, the increase in workload, the Government's pay policy, the lack of opportunities and the Government's policies for the NHS and maternity services were all having a negative impact on morale and motivation. It also reported that two thirds of respondents to its members' survey[67] conducted in June/July 2013 were dissatisfied or very dissatisfied with their level of pay: the equivalent figure in the NHS Staff Survey 2012 was only just over a third (37 per cent). The survey found that only 13 per cent of respondents were satisfied or very satisfied with their pay level. Almost all respondents (83 per cent) were dissatisfied or very dissatisfied with their last pay rise; only 5 per cent were satisfied with it (53 out of the 1,000 respondents) with none being very satisfied. It also noted that exactly three quarters of respondents were dissatisfied or very dissatisfied with how their pay rises were determined. The Royal College of Midwives said that the majority of respondents to its survey had expressed dissatisfaction with the recognition they received for 'good work' and the value placed on their work by the trust, with these levels of dissatisfaction much higher than those highlighted in the NHS Staff Survey, 2012.

4.90 The **Royal College of Nursing** said that there was a health risk for nursing staff as their stress levels reached breaking point, which in turn presented a safety risk for patients and NHS organisations. It also believed that staff engagement had been damaged by the NHS work environment and organisational culture. It called upon us to recognise the damaging impact of heavy workloads, and work pressures on the nursing workforce and

[67] Ian Kessler. *A study on the pay and the conditions of employment amongst members of the Royal College of Midwives.* September 2013. Available from: http://www.rcm.org.uk/EasySiteWeb/GatewayLink.aspx?alId=378483

their levels of engagement and to acknowledge the damaging implications for recruitment and retention in the NHS. It had received some negative responses to nursing as a career in its Employment Survey 2013, for example: 60 per cent had considered leaving their job in the past 12 months; 73 per cent of respondents said that they were under increased stress; and 80 per cent of respondents had increased workloads compared to 12 months previously. Job security and changes to terms and conditions were a cause of stress and the survey commented on the prevalence of presenteeism, with staff attending work when they were ill. It said that research for the NHS trade unions gave a survey picture of staff shortages, long hours and low morale. Royal College of Nursing members were shown to be under pressure, with a low wellbeing score (2.5 as opposed to 3.44 average). The Employment Survey in 2013 stated that 61 per cent of respondents were too busy to provide the level of care they would wish, as opposed to 55 per cent in 2011. The survey also showed increased dissatisfaction with working hours, work-life balance and ability to provide care, with too much time spent on non-nursing activities. Only 38 per cent of staff expressed satisfaction with their pay. It called on us to acknowledge that staff engagement had been damaged by the NHS work environment and organisational culture.

4.91 **Unison**'s survey found that 94.4 per cent of respondents had suffered from work-related stress. Furthermore, over half of respondents rated morale in their workplace as either 'very low' or 'low'; over 74 per cent of respondents felt morale had 'worsened' over the last 12 months; and the survey results indicated that cuts in NHS staff take-home pay had had an impact on their morale at work. It asked us to acknowledge the impact of continued pay restraint on the morale and motivation of the NHS workforce as well as the impact low morale was having on service quality within the NHS. It also asked us to note that morale and motivation of the NHS workforce had worsened significantly over the last 12 months and showed no signs of improving. It called on us to recognise the massive strains to the service caused by increasing demands and the pressure this was placing on the workforce and its implications on the standards of patient care.

4.92 **Unite** said that it was clear from union surveys that morale was also being affected by cuts to wider NHS terms and conditions across the country. In response to its survey of around 2,800 Unite members, 68 per cent of respondents reported that their morale/motivation was worse or a lot worse since last year. Morale in estates and maintenance staff was found to be extremely low, with 81 per cent reporting that morale was worse than last year. We asked Unite to explain why it considered morale and motivation to be a lot worse than last year when the NHS Staff Survey had shown that on all key measures, staff engagement had risen in 2012 compared to 2011. It told us that the difference was about how the questions were phrased and grouped together. It said that its members' survey showed that morale was particularly low due to pay and terms cuts, and reorganisation. That did not mean that they did not intrinsically value their job and the service delivered, rather it showed frustrations with the way that Government policy had impacted on their work and standard of living. It believed that this position was reflected in the NHS Staff Survey, as the question about job satisfaction related to pay, and the valuation of work by organisations was lower than satisfaction with intrinsic satisfaction with the job role (for example, relationships with immediate managers, service quality and patient care). It said that the NHS Staff Survey placed a different weighting on intrinsic job satisfaction and extrinsic job satisfaction factors and in some ways conflated the two.

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Our comment

4.93 Although the evidence on staff engagement differs between countries and some occupational groups, the overall historical position remains relatively stable. However, we recognise the stresses that staff face, and that society expects a lot from NHS staff, who must deliver to ever-higher standards and face greater scrutiny, particularly in the light of the Francis report. We note that satisfaction has risen on the England Staff Survey pay index in 2012, but we believe that, with the exception of estates and maintenance staff, pressures of work may be more important than pay in terms of motivation. For estates and maintenance staff we accept that pay may be a larger factor in their relative disengagement, following the removal of the national RRP. We also note that in Wales, ambulance staff also appear to be more disengaged than other groups of staff. We will continue to keep a close watch on this element of our terms of reference.

4.94 We include here some comments on the survey data presented to us as evidence. The Government Departments' surveys have large sample sizes and are designed to be representative of all staff in the NHS. We are grateful to the parties for the evidence provided, but we are concerned that different surveys have been interpreted in different ways to give us a mixed, and to some extent a contradictory set of evidence on staff engagement. We believe that it would help decision making, including our own, if all the parties could rely on a single independent set of evidence in the crucial area of staff engagement. It would be particularly useful if the questions used could be benchmarked with other organisations. If the parties wish to commission their own surveys, we suggest that they should be carried out for the purpose of addressing areas of questioning not covered in the Government surveys.

Future evidence requirements

The specific evidence requirements that we have identified in this chapter for our next review are:

- We ask that the parties keep us informed of the NHS Staff Council's review of the national RRP for maintenance craft workers, which was withdrawn by March 2013.
- We urge the parties to provide timely data and to carry out a joint independent staff survey on a common set of questions, administered over the same period.
- We believe that it would help decision making, including our own, if all the parties could rely on a single independent set of evidence in the crucial area of staff engagement. It would be particularly useful if the questions used could be benchmarked with other organisations. If the parties wish to commission their own surveys, we suggest that they should be carried out for the purpose of addressing areas of questioning not covered in the Government surveys.

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Chapter 5 – The Agenda for Change Pay Structure

Introduction

5.1 In this chapter we consider the parties' evidence and make observations on the diverging approaches on Agenda for Change in the four countries in the United Kingdom; we review the progress on the recommendations we made in our *Market-Facing Pay* report[68] in 2012; consider the effect of the compression of Agenda for Change pay points 15 and 16; look at some of the reforms to Agenda for Change, in particular moves towards a more seven-day service; address incremental progression and pay drift; and note some equal pay issues.

The Diverging Approach of the Four Countries

5.2 This year we have particularly noticed from the evidence that the approach of the four countries in the United Kingdom has diverged further than before. The remits for 2014/15 all asked for somewhat different outcomes. Agenda for Change was designed as a United Kingdom-wide framework, but at the same time we recognise that health is a devolved issue, and each of the four Governments is responding to its own political and economic priorities according to its own democratic mandate. We have had to decide whether to remain with United Kingdom-wide pay scales or recommend different awards for each of the four countries based on what appear to be somewhat different levels of affordability and/or different views on priorities for public spending.

Evidence from the parties

5.3 **NHS Employers** said that local employers were working to introduce revised performance management and appraisal arrangements, in response to the new agreement on linking pay progression and performance. They expected that there would be different approaches across the NHS in England, as employers strived to develop arrangements to meet local requirements. However, they believed that the initial impact of these changes would not be known until 2014/15.

5.4 The **Joint Staff Side** expressed concern about the divergence of approach between England and the other three United Kingdom countries and asked us to recommend that the Staff Council should undertake initial discussions to investigate the potential benefits of sub-Staff Council structures in England, particularly in relation to supporting the national agreement and preventing further divergence of approach. It also called on us to support the central recommendation made in the Work Foundation Report[69] that any attempt to "dismantle Agenda for Change as a national framework would be seriously misplaced and that effort would be best expended on improving on and adapting its core provisions through a process of negotiation and consent".

5.5 The Joint Staff Side said that many of the agreed freedoms within the Agenda for Change agreement, such as on-call and incremental progression, had so far had limited take up by employers, who had not fully exploited the freedoms available to them. It would expect local employers to use these freedoms before seeking further flexibilities in the national contract. It believed that the current pay system, including the recent changes to incremental pay progression in England and a focus on appraisals using the Knowledge and Skills Framework (or other system, based on the Knowledge and Skills Framework principles), had proven itself able to help drive up performance. However, this depended on local commitment and engagement, supported by high quality appraisals. The Joint Staff Side remained very concerned about the impact of making England-only

[68] NHS Pay Review Body. *Market-facing pay: how Agenda for Change pay can be made more appropriate to local labour markets*. Cm 8501. TSO, 2012. Available from: https://www.gov.uk/government/publications/nhs-local-pay-2012

[69] Jenny Gulliford et al. *Ten years of Agenda for Change.* The Work Foundation, August 2013.

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changes to the Agenda for Change agreement, both in terms of four-country bargaining and in considering longer term morale and motivational issues for staff in England who were all too aware of the emerging differences in the political approaches to the NHS workforce. It noted that cost pressures in Wales had resulted in discussions between ministers, health boards and trade unions on future changes to terms and conditions. It said that the discussions were at present exploratory and it was not yet known whether and how these could affect the Agenda for Change agreement, but it raised the prospect of further uncertainty amongst the workforce.

5.6 The Joint Staff Side made some further requests of us and asked us to: acknowledge the volume of work already undertaken in the last year to deliver the Staff Council work programme and maintain Agenda for Change; and recommend a strong policy position from central Government, supporting Agenda for Change as the standard package of terms and conditions for all providers of NHS services. It believed that this would mitigate industrial tension, promote consistency of treatment for staff in the four United Kingdom countries, and free up capacity at all levels to work on the longer term workforce challenges facing the NHS.

5.7 The **Royal College of Midwives** told us that a United Kingdom-wide system of pay was the most efficient and cost effective way of determining pay. It said that NHS organisations were better concentrating on improving outcomes and focusing on care rather than on local negotiations.

5.8 The **Royal College of Nursing** stated that it had evidence from Ian Kessler[70] of Templeton College Oxford, that national pay determination allied to Agenda for Change, had proven itself to be a robust, effective and efficient pay system.

5.9 **Unison** asked us to make a recommendation on pay that was United Kingdom-wide and would support United Kingdom-wide NHS pay determination, maintain the integrity of the existing pay system and reduce inconsistencies between the four countries.

Our comment

5.10 We recognise from the evidence received that the four countries of the United Kingdom have different policies for public sector pay. However, we have received no evidence pointing to the *need* for a separate system of pay for the four countries at this time. Indeed, we note that all the parties favoured continuation of a United Kingdom-wide Agenda for Change structure, although with the freedom to make changes, as they wish, within that framework. We have been struck by the fact that while England has made progress on changes to pay, terms and conditions, these have not been implemented in the other three countries. In addition, Wales and Northern Ireland, in particular, have expressed a willingness for what they perceive as a potentially unaffordable pay uplift rather than having different uplifts for each country. We have seen no evidence of particular labour market conditions in Scotland that suggest the need for a separate recommendation on the pay uplift. We have concluded, therefore, that pay levels for Agenda for Change should be maintained across the United Kingdom this year, and this is reflected in our observations and recommendations. Notwithstanding this, we cannot say that in future we will always recommend a common award across the United Kingdom as affordability and social or political issues in each country of the United Kingdom may lead to a divergence in pay.

[70] Ian Kessler. *National pay determination in the NHS: resilience and continuity.* [2012] Available from: http://www.rcn.org.uk/__data/assets/pdf_file/0006/534642/National_Pay_Determination_in_the_NHS_Final.pdf

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Follow up to Recommendations in our Market-Facing Pay Report

5.11 The recommendations in our *Market-Facing Pay* report 2012[71] were accepted by the United Kingdom Government and the Department of Health. While we concluded that the evidence did not justify investment in additional market-facing pay in the NHS at that time, we did emphasise the necessity of further development of Agenda for Change. We also reaffirmed Agenda for Change as the vehicle through which to develop market-facing pay mechanisms where necessary as it already has positive market-facing features.

5.12 Specifically, we recommended a fundamental review of High Cost Area Supplements (HCAS) and we set out the detailed areas for review relating to HCAS and some transitional and implementation considerations. We asked that the findings should be available in evidence for this pay round.[72] However, we are disappointed that it has taken over a year for the parties to agree the specification and to commission the research for the review. We understand that the research has only recently been commissioned and that it will be reported in the summer of 2014. We also understand that the research may be narrower in scope than we envisaged.

Evidence from the parties

5.13 **NHS Employers** told us that following discussions in the NHS Staff Council, the parties had agreed in principle to support an independent technical review of HCAS by a team with specialist research skills. It said that consideration still needed to be given to further national changes around the flexibilities in Annex K of the *NHS Terms and Conditions of Service Handbook*.[73]

5.14 The **Joint Staff Side** told us that the terms of reference for the review of HCAS proposed by us in our *Market-Facing Pay* report were agreed with NHS Employers at the beginning of October 2013. It said that the initial draft terms of reference proposed by the Department of Health and NHS Employers had extended beyond the fundamental review proposed by us to questions that it considered more appropriate questions for the NHS Staff Council to consider once the review had concluded, and that this had contributed to the delay in its agreement for the review to go ahead. It believed that the terms of reference agreed reflected our recommendations.

Our comment

5.15 We continue to be disappointed at the slow rate of progress being made on our market-facing pay recommendations, given that our recommendations were accepted, and we expect to see real and meaningful progress being made during 2014/15. We would like the parties to pick up the pace and look forward to receiving evidence from the parties for our next review that demonstrates substantial progress. With the economy showing some improvement and evidence that public-private pay differentials are narrowing faster than anticipated, we would expect to see the first signs of recruitment and retention issues emerging in London and the South East. We therefore see a clear need to keep this situation under close review.

[71] NHS Pay Review Body. *Market-facing pay: how Agenda for Change pay can be made more appropriate to local labour markets*. Cm 8501. TSO, 2012. Available from: https://www.gov.uk/government/publications/nhs-local-pay-2012

[72] NHS Pay Review Body. *Market-facing pay: how Agenda for Change pay can be made more appropriate to local labour markets*. Cm 8501. TSO, 2012. Page 121. Recommendation 4. Available from: https://www.gov.uk/government/publications/nhs-local-pay-2012

[73] NHS Staff Council. *NHS Terms and Conditions of Service Handbook*. Pay circular (AforC) 2/2013: amendment number 29. Available from: http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf

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Compression of Agenda for Change Pay Points 15 and 16

5.16 The compression of the Agenda for Change pay structure was an inevitable consequence of the United Kingdom Government's policy to offer some pay protection to lower paid Agenda for Change staff during the two-years' pay freeze in 2011/12 and 2012/13. In our last report,[74] we concluded that having considered the impact of the narrowed gap between Agenda for Change pay points 15 and 16, there was no evidence, particularly on recruitment, retention and motivation, that the gap had resulted in any specific concerns. We urged the parties to assess the position, specifically any consequences for career pathways, pay progression and impacts on other parts of the remuneration package, and asked for evidence to be presented for the current pay round.

Evidence from the parties

5.17 **NHS Employers** noted that following two consecutive years of targeted pay uplifts for those staff earning under £21,000 (points 1 to 15), there was now only a £123 gap between points 15 and 16 (0.6 per cent). However, they were not aware that the narrowed gap caused employers or staff any concerns. They said that staff who received a lower value increment this year would not be disadvantaged over the long term, as they would benefit from the larger incremental gaps in future years. They suggested that employers would not welcome any unnecessary additional cost pressure in the current financial climate and that the additional investment in addressing the issue would not result in any tangible benefit to patient care, or help to address local priorities.

5.18 The **Welsh Government** had no evidence of the need to address pay compression for pay points 15 and 16.

5.19 The **Royal College of Midwives** noted that following the two-year pay freeze for those earning over £21,000 and the £250 uplift for those earning less than £21,000, the difference in pay between pay points 15 and 16 had narrowed significantly.

5.20 **Unite** told us that distortions in the pay spine continued to be an issue for NHS staff. It said that in recent years the impact of the £250 increases on pay bands had meant that there had been squashing of points 15 and 16. It pointed out that percentage increases favoured the most well-off who were best able to cope with the increases in living costs. It said that it continued to be a strong advocate of a move away from percentage pay increases in the NHS. It told us that a flat monetary increase would mean that the difference between pay points would not stretch further, while a bottom loaded or staggered flat monetary increase could serve to reshape the pay spine. It said that in order to stop this stretching of the pay spine we should at least proceed with flat monetary increases to the pay spine while committing to a thorough investigation about the possibility of bottom loading/staggering the award so that lower paid staff could catch up the difference they had lost in relation to the highest paid. Unite said that it continued to support a linear pay rise being implemented, with more done to address low pay through a bottom loaded flat money sum to break what it saw as an "escalating inequality".

Our comment

5.21 The evidence presented to us has not given rise to concern that recruitment, retention and motivation are being adversely affected by the compression of Agenda for Change pay points 15 and 16, although we recognise that this may be an issue for those staff affected. Although we see no case for urgent action on this, we conclude that addressing this anomaly in the pay system should be part of the review of Agenda for Change and the incremental system to which we refer elsewhere in this report.

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[74] NHS Pay Review Body. *Twenty-seventh report.* Cm 8555. TSO, 2013. Paragraph 5.49. Available from: https://www.gov.uk/government/publications/nhsprb-report-number-27-2013

Agenda for Change Reform

5.22 Underpinning this chapter is the request from the **Department of Health** which said that it would be helpful if we made recommendations on how any pay award might be made dependent on the partners reaching agreement on Agenda for Change pay reform. Health Education England, NHS England and NHS Employers made similar proposals. However, the Department of Health went further, suggesting that any award should be deferred to next year by being tied to progress on reform of Agenda for Change. We address this issue later in this chapter and in Chapter 6.

Evidence from the parties

5.23 The **Department of Health** told us that although NHS Employers and the trade unions wanted to work together for the benefit of patients and staff, each party had different aspirations for pay reform, which meant that they may not be able to respond quickly to requests for change. It noted that in the current economic climate, reaching consensus on change could be difficult to achieve and sought our observations on those provisions of Agenda for Change which the partners should usefully address with pace and purpose. It said that it would also be helpful if we would make recommendations on how any pay award might be made dependent on the partners reaching agreement on Agenda for Change pay reform.

5.24 The Department of Health asked us to consider and make observations on: whether the Agenda for Change structure for out-of-hours payments supported its ambition for seven-day services; and whether the distribution of any pay award should take account of the differential impact on staff of the current Agenda for Change progression structure. It suggested that any award should be linked to reform of the pay system to enable service transformation. While it noted that parties on the Joint Staff Side (Royal College of Nursing and Unison) believed that no further change to Agenda for Change was required, the Department of Health said that there were pressing issues of affordability, quality and productivity for the NHS which trades unions and employers should consider as a priority. It told us that it was very difficult to see how change could be achieved without further reform of Agenda for Change. It stated that within a 24/7 healthcare service, to help make the provision of seven-day services more affordable, there was need for a review of the use of enhancements and the rate of overtime pay for evenings and weekends, for example, plain time rates for contracted hours wherever they might fall (with the exception of overnight working). It suggested consolidating pay, which might currently attract enhancements, into basic pay, without losing the flexibility the NHS needed to deliver 24/7 care. A further suggestion was to revise Annex K of the *NHS Terms and Conditions of Service Handbook*[75] which currently allowed foundation trusts additional flexibilities, but only where this maintained the overall value of Agenda for Change. It said that there was currently no flexibility for foundation trusts or NHS trusts to reduce the overall value of Agenda for Change, but it accepted that any change to national terms and conditions could not be made unilaterally and employers would have to consult staff and staff representatives to seek agreement.

5.25 **Health Education England** said that in the current climate of pay restraint, any increases or other changes to NHS pay and terms and conditions of service that we recommended should explicitly support and be linked to wider system reform as pay could be an effective lever to support the changes required.

5.26 **NHS England** said that if we did consider that an increase was appropriate, it strongly suggested that it was linked to progress being made on wider reforms to the pay system.

[75] NHS Staff Council. *NHS Terms and Conditions of Service Handbook*. Pay circular (AforC) 2/2013: amendment number 29. Available from: http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf

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5.27 **NHS Employers** said that further reforms of national pay and conditions were needed, to make them more supportive of the delivery of seven-day patient care, and to make them financially sustainable for the future. They told us that the key issue for employers was to prevent the delivery of extended services, in ways which would add unnecessary costs. To support this, employers would need to review and make adjustments to times of the working week that attracted unsocial hours premia. They believed that it was clear from their evidence that there was a desire for more flexibility around national conditions of service, which were often seen as more generous to comparable employers. In the longer term, they thought that changes might be needed to the pay structure, in relation to the number of pay points and the rules in relation to incremental progression. They told us in oral evidence that the provision of seven-day services was sustainable and affordable, but that enhancement payments would need to be removed for some periods such as evenings and Saturdays, and there would need to be transitional arrangements for staff on shift pay.

5.28 NHS Employers said that they would welcome our observations on the need for further reform of Agenda for Change as they believed that there was a clear, national aspiration to ensure that the NHS offered a more patient-focused service, with high quality care being made available seven days a week. Employers said that the current national conditions of service for NHS staff presented barriers to this necessary development of service provision. They reiterated their desire for more flexibility around conditions of service, which were often seen as more generous compared to other employers. They said that employers were keen to have further discussions on national changes around: adjustments to unsocial hours premia in order to support the development of services being provided across seven days; flexibility on annual leave entitlements; sick pay entitlements; redundancy entitlements; wider employee benefits in the total reward context, to fit a more commercial market to allow the NHS to compete with other providers; and the flexibilities in Annex K of the *NHS Terms and Conditions of Service Handbook*, and additional freedoms for NHS foundation trusts (this was a recommendation in our *Market-Facing Pay* report[76]).

5.29 The **Foundation Trust Network** said that there was widespread support for significant changes to pay, terms and conditions. It asked that our deliberations should focus on the pressing need for a shift to seven-day services in the NHS and the role that the pay system must play in enabling, rather than hindering, the shift. It told us that in a survey undertaken before the agreement on amendments to Agenda for Change in February 2013, it found that trusts were pursuing a range of measures to optimise their approaches to pay, terms and conditions but none thought that these had been completely optimised so far. It believed that there was further scope, in the areas of: pay progression and performance; local freedoms; and new staffing arrangements. The Foundation Trust Network also said that it would welcome further clarity on the Department of Health's proposal that the 1 per cent envelope for the pay award should be deployed in supporting the modernisation of national pay frameworks. In particular, that reform of Agenda for Change should seek to improve the quality of patient care and therefore outcomes by ensuring there was a better balance between pay, performance and productivity, rather than time served, which were all objectives that it supported.

5.30 The **Joint Staff Side** said that the Department of Health had not set out what the possible implications of changing the system might be, for example, which staff would be affected, and how their working patterns would change. It told us that without this information, it was impossible for the Joint Staff Side to make an assessment of its statement relating to the pay uplift. It suggested that the Department of Health had presented no evidence that the current pay system was impeding the change that it

[76] NHS Pay Review Body. *Market-facing pay: how Agenda for Change pay can be made more appropriate to local labour markets*. Cm 8501. TSO, 2012. Recommendation 6. Available from: https://www.gov.uk/government/publications/nhs-local-pay-2012

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required to move to seven-day working. It added that the Joint Staff Side was not opposed to seven-day working and noted that the trade unions had worked to facilitate the operation of the NHS on this basis where it was appropriate and where the need for seven-day working was supported by evidence. It added that any recommendation would need to reflect the existing arrangements in place as many staff already provided a seven-day service. It queried what evidence NHS Employers had that the current pay system was actively preventing employers from introducing seven-day services. The Joint Staff Side urged us to undertake independent research to analyse the financial impact of cuts to on-call payments, unsocial hours payments, changes in shift patterns and down banding on NHS employees in the immediate and longer term. It also told us that the Unite survey had shown a high proportion of respondents stating that there had been changes to terms and conditions within their workplace. The main changes reported related to unsocial hours payments and on-call payments. It said that given the widespread reliance on these payments, it appeared that a significant proportion of the NHS workforce was facing a reduction in take-home pay in addition to stagnant wage growth. The Joint Staff Side said that it would welcome our acknowledgement that clear policy expectations on the use of Agenda for Change would mean resources and expertise could be directed towards addressing longer term workforce challenges.

5.31 The **Royal College of Midwives** reminded us that any changes to Agenda for Change terms and conditions would need to be agreed with staff. It said that it was very concerned by the Department of Health's comments that suggested it wanted us to determine what the changes to Agenda for Change should be and for us to make the pay uplift dependent on the acceptance of certain changes. It added that maternity had always functioned as a 24/7 service. It believed that the pay system was designed to reflect that staff who had to work evenings, weekends and bank holidays had higher costs both financially through higher childcare costs during these periods and physically with the detrimental impacts that shift working, particularly night working, could have on an individual's physical health. It said that as over 99 per cent of the midwifery workforce was female, the costs of childcare were an important issue.

5.32 The **Royal College of Nursing** believed that further changes to Agenda for Change were unnecessary and called on us to recommend no further actions were taken to alter the structure of the Agenda for Change agreement. It also called on us to recognise that recent amendments to the Agenda for Change agreement had gone far enough and that any further centrally directed changes, particularly suggestions that nurses' pay should be tied to how well they looked after patients, were unnecessary.

5.33 **Unison** asked us to recognise and raise concern about the reported increase in the growing use of zero hours contracts in the NHS.

5.34 **Unite** requested that we should review proposals for seven-day working, particularly around issues of safety, funding and staffing numbers. It also believed that we should seek to reclaim our role by seeking to investigate the impact of changes to terms and conditions on different groups of staff. It said that Agenda for Change was still facing serious challenges from local trusts and health boards demanding ever increasing changes to staff terms and conditions, and this was being compounded by the transition of trusts to foundation status and the increases in outsourcing going on across England. It said that it fully endorsed the position outlined in the report by the Work Foundation on *Ten Years of Agenda for Change*,[77] which showed the continuing success and relevance of the Agenda for Change Agreement and the potential better to use the flexibilities built into it. Unite did not believe that the Department of Health had provided any evidence that the current pay system was impeding seven-day services; nor had it supplied any evidence showing the implications that changing the current structure would have on staff, working patterns and services.

[77] Jenny Gulliford et al. *Ten years of Agenda for Change.* The Work Foundation, August 2013.

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Our comment

5.35 We recognise that the Department of Health, Health Education England, NHS England, NHS Employers and the Foundation Trust Network all wish to see detailed observations from us on reforms to Agenda for Change, including a move to facilitate more seven-day working, and for us to link our recommendations for an uplift to progress on such change. The Department of Health went so far as to say that our pay recommendation should be tied to progress on Agenda for Change reform and the award deferred until next year. The staff bodies also asked us to comment on a number of aspects of work in the NHS, including weekend working and the use of zero hours contracts. We continue to hold the view that such matters are firstly the province of the NHS Staff Council, although we would assist in any way that all the parties felt was helpful.

5.36 As with any pay system, Agenda for Change needs to respond to the pressures and direction of operational strategy, including provision of seven-day services; we have not, however, been presented with either a specific remit or the necessary detailed evidence, including costs, to make other than the following general observations. We recognise that nursing and other healthcare staff on Agenda for Change terms and conditions already provide seven-day patient service cover through overtime, shift and on-call pay and working arrangements. We understand that current Agenda for Change shift and on-call payment systems were reviewed and implemented between 2008 and 2011 to ensure compliance with equal pay. However, we think that extending elective service provision in the evenings and over weekends is likely to require investment in additional staffing. It will therefore be necessary to review these arrangements to ensure that they are fit for purpose for 2015 and beyond, in enabling service provision to be extended during continued financial constraint. We suggest that as a priority the parties should clarify the changes needed to current pay agreements to enable multi-disciplinary teams of appropriately qualified staff to be deployed cost-effectively to deliver safe, efficient, patient care as needed over seven days. We believe that negotiations to implement these changes should be undertaken in tandem with the progress being made in negotiations on changes to medical staff contracts needed to facilitate seven-day working. Progress on a wider seven-day service is urgently needed. The parties should now rapidly negotiate and agree changes to Agenda for Change alongside negotiations for medical staff.

Observation 1: Progress on a wider seven-day service is urgently needed. The parties should now rapidly negotiate and agree changes to Agenda for Change alongside negotiations for medical staff.

Pay Structure and Incremental Progression in Agenda for Change

5.37 For our remit for this year the United Kingdom Government asked us to consider the impact of our remit group's progression structure and its distribution amongst staff in making our recommendations on the annual pay awards. The remit letter we received from the Department of Health also asked us to consider the level of incremental pay that staff who had not yet reached the top of their scale would receive. In their evidence the Department of Health and NHS Employers focused on the cost of incremental progression and together with the Joint Staff Side and Unite invited us to make observations on various aspects of the Agenda for Change pay structure including incremental progression. Figure 4.3, earlier in this report, shows the percentage of full-time equivalent (FTE) staff at the top of Agenda for Change pay bands by United Kingdom country.

Evidence from the parties

5.38 The **Department of Health** invited us to: consider and make observations on whether the current Agenda for Change progression structure, notwithstanding the recent Agenda for Change national agreement, could be reformed to help improve performance

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(so that staff were paid for what they did for patients) and productivity; and consider and make observations on whether any pay awards should be made to staff whose performance did not meet local standards. The Department of Health said that currently, Agenda for Change provided for annual pay progression, which meant that employers faced a 2 per cent (about £700 million per annum) pressure on the pay bill each year, even during a pay freeze. Last year, for example, in addition to the 1 per cent basic pay rise for Agenda for Change staff (which cost about £350 million), around 60 per cent of NHS staff on Agenda for Change pay, terms and conditions received pay progression of between 0.6 and 6.7 per cent averaging at about 3.5 per cent. It believed that this was out of step with its wider policy on public sector pay and the ambitions the Chancellor had set out in the Spending Round 2013. It noted that a typical Agenda for Change band 5 qualified nurse could expect seven years of pay progression averaging 3.9 per cent per year, which equated to basic salary increases of around £900 per year.

5.39 The Department of Health understood that NHS Employers and the NHS trades unions wanted to work together for the benefit of patients and staff. However, it believed that each party may have different aspirations from pay reform, which meant that the parties may not be able to respond quickly to requests for change. It said that our observations on those Agenda for Change provisions which the partners should usefully address with pace and purpose, would be helpful. It also sought our recommendations on how any pay award might be made dependent on the partners reaching agreement on Agenda for Change pay reform. The Department of Health believed that there was a need to look carefully at whether the current national pay framework, introduced in 2004, was able to keep pace with changes in the healthcare system. It told us that many employers preferred to use national pay frameworks but were frustrated that change at national level could often fail to deliver the change employers were looking for.

5.40 The Department of Health invited us to consider and make recommendations, building on the current Agenda for Change framework, on options for change which would remove or reduce the cost of incremental progression (2 per cent), that made a stronger link between performance, pay and productivity, and that the current system of out-of-hours payments reflected the Department's ambition for delivering, affordable seven-day services. It said that the areas, which were not exhaustive, should include recommendations on: progression pay; length of the pay bands; overlapping pay increments between bands; and plain time working and out-of-hours in the context of a 24/7 service.

5.41 The Department of Health suggested that affordability might be addressed by considering the total reward package (pay, pensions and non-pay benefits) as pay was not the only factor that might help recruit and retain staff. In addition, it said that Agenda for Change currently had 12 pay bands with numerous rates of pay between the bottom and top of each pay band. Within some pay ranges, it might be argued that some staff might be paid below or above the 'rate' for that job. It suggested that the rate of each job may not necessarily be the top of each pay band and a key consideration was the appropriate rate for a particular job. It said that a review of progression pay might allow for re-investment in a new pay structure with perhaps fewer pay points, though the challenge would be how to achieve change without additional investment.

5.42 The Department of Health disagreed with the views expressed by the Foundation Trust Network, Unison and the Scottish Government that incremental pay should not be part of our considerations about the level of annual pay awards. It said that the incremental pay system represented a significant cost to employers and it believed that in view of the financial challenges, the increases staff received in addition to any pay award were an important consideration. It was now almost a decade since the introduction of Agenda for Change and in the light of the Francis and Keogh reports, and its ambition to reward staff for what they did for patients rather than time served, trades unions, Government

and employers all had a shared interest in ensuring that Agenda for Change was affordable and continued to be the national pay framework of choice, helping employers to put patients right at the heart of everything the NHS did. It stressed that its evidence was clear and there was a straight trade-off between pay rises and jobs.

5.43 **NHS Employers** estimated that as a consequence of incremental pay progression rules, even without an increase of the pay scales in Agenda for Change, around 55 per cent of staff would receive basic pay increases in 2013/14, averaging 3.4 per cent. They said this added a pay pressure of around 2 per cent to the Agenda for Change pay bill. They told us that despite the pay freeze, incremental progression meant that average basic pay per FTE increased for non-medical staff by 1.0 per cent.

5.44 NHS Employers told us that the pay bill for Hospital and Community Health Services non-medical staff grew by 0.4 per cent in 2012/13, while the size of this workforce reduced by 0.4 per cent. Growth of the non-medical pay bill, despite a reduction in the overall numbers of staff, meant that there had been an increase in the cost per FTE, a 0.9 per cent growth in pay bill per FTE. Incremental progression was a key contributor to this pay bill growth. They noted that while an average of 55 per cent of staff had received an increment, there had been a steady increase in the number of staff at the top of their pay band over the last three years. Low turnover had contributed to this increase. They said that although staff reaching the top of their band reduced the rate at which the basic pay bill increased, it did not contribute to a negative pay bill pressure unless staff left and were replaced by staff lower down the band. They also noted that there was an average 3.4 per cent incremental increase for the 55 per cent of Agenda for Change employees who received an increment.

5.45 NHS Employers said that 0.5 per cent of pay bill growth was due to basic pay drift, which included the effect of incremental progression and the changing distribution of staff across pay points and grades. Employers believed that the most significant driver of this pay bill growth was incremental pay progression. They said that although the Department of Health metrics did not isolate the precise cost of incremental progression, a supplementary analysis by the Department of Health estimated that the specific cost pressure associated with incremental progression was around 2 per cent per year for both the non-medical and medical workforce. They told us that the full impact of incremental progression was not evident in the basic pay per FTE metric, as it was offset by negative pressures such as the changing distribution of staff across pay points. As the full costs of incremental progression were not visible in the bottom line, NHS Employers said that it was easy to underestimate their contribution to the ever increasing pay bill. Employers felt that the increased investment in the pay bill to fund incremental progression was not commensurate with improved performance or productivity and they would prefer a pay system where increasing investment in the pay bill was used to incentivise these improvements. They believed that there was an opportunity cost for each pound spent on incremental progression to be spent in an alternative way, which would improve value for money for the tax payer and/or improve the care that patients received.

5.46 NHS Employers stated that it might seem reasonable to suggest that turnover offset the cost of incremental progression, as there would be a theoretical point of equilibrium where the savings from turnover (the most highly paid and experienced workers, being replaced by less experienced and lower paid workers as they retired) perfectly offset the increased pay bill costs, due to annual payment of increments. However, they said that it was rare for this point of equilibrium to be reached as the Agenda for Change pay structure had no mechanism to reach or maintain zero incremental drift. They told us that keeping the cost of incremental drift close to zero was entirely dependent on turnover levels and staff distribution. The current basic pay per FTE drift (excluding staff group mix impact) of 0.5 per cent showed that at present the Agenda for Change pay system was not at a point of equilibrium. Current turnover levels were too low to entirely

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offset the increased costs caused by incremental progression. They said that when Agenda for Change was implemented in 2004, it might have been expected that the pay system would be closer to an equilibrium position by now. As there were no more than nine pay points in any of the pay bands, it could be expected that almost all staff would now be at the top of their band, and no longer in receipt of increments. In fact, only 45 per cent were now at the top of their band. They believed that in addition to some turnover, the main reason a higher proportion of staff were not at the top of their band was because, since 2004, there had been unprecedented growth in the NHS workforce. This had led to a distribution of staff with higher proportions lower down the band, and still in receipt of increments, than might have been anticipated.

5.47 The **Welsh Government** said that incremental drift alone was forecast to add 1 per cent to the overall pay bill which equated to £23 million for staff engaged on Agenda for Change contracts.

5.48 The **Scottish Government** did not agree with the approach to pay progression adopted by the United Kingdom Government and subsequently developed within the Department of Health's evidence. It believed that the pay settlement should be treated as a separate issue from pay progression. It said that progression formed part of staff terms and conditions and was therefore subject to its own negotiating procedure.

5.49 The **Northern Ireland Executive** told us that the cost of pay progression under Agenda for Change was estimated to be around 1 per cent of the pay bill. It also told us that a key feature of implementing pay policy was the need to honour contractual entitlements. Many local staff groups were contractually tied to United Kingdom nationally determined pay settlements or had clear contractual entitlements to progression/performance pay.

5.50 The **Joint Staff Side** said that despite the agreement made in early 2013, with NHS Employers in England, to alter Agenda for Change to enable pay progression to be more closely linked to performance and to modify out-of-hours sickness payments, it had heard through the Spending Review announcement in 2013, the intention that public sector workers should no longer receive incremental pay progression. It said that this not only risked undermining the efforts made by both trade unions and employers to come to an agreed position to amend Agenda for Change and but also served to heighten anxiety among NHS staff about their pay, terms and conditions.

5.51 The Joint Staff Side strongly disagreed that the NHS paid awards for time served. It said that incremental pay progression was a reflection of the increased knowledge, skills and expertise that staff developed within their roles. To remove the cost would involve raising all staff to the top of the band, which it considered to be the 'rate for the job'. It observed that the link between performance, pay and productivity had already been agreed and was in the process of being delivered in trusts by linking pay progression to performance. It emphasised that there were no automatic incremental pay increases in the NHS. Under the Agenda for Change agreement, and in particular following the changes agreed in England from 1 April 2013, NHS employers, working in partnership with local Staff Sides and using the national guidelines, could develop local criteria linked to appraisals to enable them to monitor staff performance and competencies. Where employers had not developed these systems or staff were not receiving appraisals, then staff would not be held back from incremental progression. It said that the Joint Staff Side had argued for years that all staff should be receiving appraisals and the right level of training and support to enable them to do their job well.

5.52 The Joint Staff Side wanted to come to an agreed definition on incremental pay, with all parties accepting that it was part of the negotiated agreement and not a 'drift' factor. It said that this evidence supported the Joint Staff Side's position that pay progression was separate from the annual pay award as it was linked to performance, increase in skills and experience. It added that incremental pay was not restricted to the public sector.

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5.53 The Joint Staff Side noted that the number of staff at the top of each Agenda for Change pay band had increased in recent years, and for some NHS occupational groups, this could mean that well over half were at the top of their band; such staff received no benefit from incremental progression and averaged 42 per cent across the United Kingdom. It told us that England had the lowest proportion at 40 per cent, while Scotland, Wales and Northern Ireland were all well above the average. Northern Ireland had 53 per cent of its staff at the top of their pay band, Scotland 51 per cent and Wales 48 per cent. It said that staff in pay bands 1 to 4 were particularly likely to stand at the top of their band. On average, 53 per cent of staff in bands 1 to 4 were at the top of their band in comparison to 42 per cent of staff in bands 5 to 9.

5.54 The Joint Staff Side called on us to review the structure of Agenda for Change, relating to the size and spacing of incremental pay points and pointed out that the final year of the 2008/11 agreement provided for the reduction of the length of pay band 5. It also provided for further talks on proposals to reduce the number of incremental pay points (starting with pay bands 6 and 7). It called for this agreement to be revisited as part of a wider examination of the structure of Agenda for Change and the length of pay bands.

5.55 The **Royal College of Midwives** also disagreed with the arguments made by NHS Employers that incremental progression could act as a substitute for an annual pay increase on basic pay. It reiterated that incremental progression represented reward for increased skill and experience as agreed under the Agenda for Change framework. It said that previously the Review Body had taken the position that incremental progression was a separate issue to basic pay and it asked us to confirm that this was still our view. It also asked us to acknowledge the agreed changes to incremental progression and recommend that they were implemented rather than making further changes. It believed that the comments by the Department of Health in its evidence ignored the agreed changes in the NHS and that it was unreasonable not to allow time for them to be implemented.

5.56 **Unison** said that incremental progression represented a staggering of payments to reach the correct rate for the job, not an annual award. Withholding progression would be seen as highly divisive and may have unintended consequences for motivation and morale in the workforce. It noted that 42 per cent of NHS staff in the United Kingdom were at the top of their pay band and dependent upon the annual pay uplift to meet growing costs. It pointed out that an Incomes Data Services report for Unison on *Pay Progression in the Public Sector*[78] had found that the cost of pay progression was cost neutral in the long term as higher paid employees left the organisation and new starters arrived at the bottom of their pay bands. Unison asked us to note our views and confirm the position on incremental pay progression described in our *Twenty-Sixth Report.*

5.57 **Unite** said that NHS pay awards were paid due to skills and expertise acquired. The aim of them was for newer staff to have development rates before they reached the fully trained "rate for the job" at the top of their band. It believed that it was also misleading to claim that pay progression did not exist in other jobs. Unite had members across all sectors of the economy and in many private sector companies pay progression was also taking place. Unite said that it wanted us to investigate thoroughly the impacts of performance related pay for staff increments. It also wished to see a review of the structure of Agenda for Change, relating to the size and spacing of incremental pay points. It noted that when the Agenda for Change pay spine was negotiated it was based on a system of evenly spaced spine points. However, the impact of percentage increases had been to stretch the differentials between pay spines and the difference now varied between 0.6 per cent and 6.7 per cent.

[78] Incomes Data Services. *Pay progression in the public sector: a research report for Unison.* August 2013. Available from: https://www.unison.org.uk/upload/sharepoint/Briefings%20and%20Circulars/IDS%20report%20on%20progression.pdf

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Pay drift

5.58 To inform our assessment of the affordability of pay awards we need to take into account the most accurate data available on pay drift. Pay drift is the movement in average unit cost of labour due to changes in overall staff mix (for example, relative proportions of senior staff and junior staff or relative proportions of specialist and non-specialist staff). It also includes changes to the amount of overtime and other allowances that providers pay to staff and changes to the cost of pension provision or any other staff related costs. Thus, it takes into account both the cost of incremental progression and the balance between joiners and leavers. The evidence we received on pay drift is set out below followed by pay drift data provided by the Health Departments in the four countries. Our comment is set out at the end of the section.

Evidence from the parties

5.59 The **Department of Health** said that pay was competing for fewer available resources and that to restrict pay cost growth to 1.5 per cent in 2014/15, workforce productivity must increase faster than at any time over the last three Spending Review periods. It said that alongside this, reductions in the growth rate of demand were required to retain financial balance. Any increase in pay costs above 1.5 per cent risked significant reductions in clinical staff to balance the financial position, which in turn may harm the ability to maintain access to and quality of NHS services to the public. It also told us that currently, Agenda for Change provided for annual pay progression, which meant employers faced a 2 per cent (about £700 million per annum) pressure on the pay bill each year even during a pay freeze. Last year, for example, in addition to the 1 per cent basic pay rise for Agenda for Change staff (about £350 million), around 60 per cent of NHS staff on Agenda for Change pay, terms and conditions received pay progression of between 0.6 and 6.7 per cent averaging at about 3.5 per cent.

5.60 **NHS Employers** told us that even with no increase to pay scales, the pay bill was expected to increase in 2014/15 due to the costs of incremental pay and other drift factors. They believed that the most significant driver of this pay bill growth was incremental pay progression.

5.61 The **Joint Staff Side** said that NHS accounts showed that much of the NHS had been recording surpluses over a sustained period and the number of trusts or health boards currently facing a deficit was extremely small. It believed that this suggested that accumulated reserves had been built up by trusts and health boards and that increases in the pay bill due to incremental progression were well within the allocated budgetary rises.

Pay drift data

5.62 The **Department of Health** has developed a methodology[79] for modelling the drivers of aggregate pay bill growth. It describes pay drift as the combined term for all of the factors, other than 'basic pay settlements', that explain changes in average pay bill per FTE. It states that pay drift might be more accurately labelled as *pay bill per FTE drift* and it can be thought of as having two main sources, workforce mix effects and unit cost effects each of which has its own range of factors which affect the pay bill. Within workforce mix effects, one of the factors is the increment mix or pay point mix within grades, which is affected by both incremental progression and the balance between joiners and leavers.

[79] Department of Health. *Hospital and Community Health Services paybill metrics and paybill driver quantifications*. Available from: https://www.gov.uk/government/publications/nhs-pay-2014-department-of-health-evidence-to-pay-review-bodies

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5.63 The Department of Health provided detailed analyses[80] by staff group of the Hospital and Community Health Services pay bill in England. The analysis shows the main drivers of pay bill growth and Table 5.1 summarises the analysis for our remit group. The table shows that the aggregate pay bill grew by 0.4 per cent in 2012/13, which comprised (though figures do not add exactly due to rounding) a reduction of 0.4 per cent due to change in the volume of FTE staff, an increase of 0.3 per cent due to the pay settlement (i.e. £250 to all those on £21,000 or below) and an increase of 0.6 per cent due to pay drift (*pay bill per FTE drift*).

Table 5.1: Change in costs of Hospital and Community Health Services non-medical staff pay bill, 2009/10 to 2012/13, England

	2009/10	2010/11	2011/12	2012/13
1 Pay bill per FTE Drift	**0.5%**	**0.7%**	**0.9%**	**0.6%**
of which:				
Basic pay per FTE drift	*1.0%*	*1.1%*	*0.8%*	*0.5%*
Additional earnings per FTE drift impact	*-0.5%*	*-0.5%*	*0.0%*	*0.1%*
Total on-costs per FTE drift impact	*0.0%*	*0.1%*	*0.1%*	*-0.1%*
2 Basic pay settlement (pay uplift)	**2.4%**	**2.2%**	**0.3%**	**0.3%**
3 Pay bill per FTE growth (1 + 2)	**2.9%**	**3.0%**	**1.3%**	**0.9%**
4 Average FTE growth (volume of staff)	**4.6%**	**0.8%**	**-1.9%**	**-0.4%**
Aggregate pay bill growth (sum of 1+2+4)	**7.6%**	**3.8%**	**-0.7%**	**0.4%**

Source: Department of Health's Headline Hospital and Community Health Services Paybill Metrics.
Note: All totals are derived from unrounded figures.

5.64 The **Welsh Government** said that the cost of incremental drift in 2013/14 was £29 million while the 1 per cent pay award cost £23 million. It told us that the estimated cost of incremental drift in 2014/15 was £25 million.

5.65 The **Scottish Government** modelled the costs of incremental progression for 2014/15 and provided data which showed the gross cost of progression for Agenda for Change staff in Scotland at 1.4 per cent and the net cost after allowing for staff turnover and promotion at zero.

5.66 The **Northern Ireland Executive** told us that the cost of incremental progression was estimated at around 1 per cent of the pay bill.

Our comment

5.67 The evidence we received from the Department of Health and NHS Employers implied that incremental progression cost 2 per cent. However, we understand that the net cost was 0.6 per cent in 2012/13 and may well be lower this year as more staff reach the top of their pay band. Therefore, we do not consider incremental pay to be costly, in net terms, because of new staff being recruited to the bottom of the scale, replacing, in general, staff at the top point.

5.68 We would not expect the pay system to reward underperforming staff as well as, or better than, high performers. If we are genuinely to support a patient-centred approach, this must change. However, much of the evidence provided to us, and summarised above, focused on the cost of incremental scales. We do not believe this is the right point for debate. We believe that the system is not costly; rather, the operation of the system is

[80] Department of Health. *Headline Hospital and Community Health Services paybill metrics (experimental).* Available from: https://www.gov.uk/government/publications/nhs-pay-2014-department-of-health-evidence-to-pay-review-bodies

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ineffective in rewarding performance because of widespread inadequacies in the appraisal and performance management system. We think that there is a pressing need to manage and apply the agreed pay progression arrangements properly through the application of a simplified Knowledge and Skills Framework in order to ensure that pay progression is linked to competency development and performance, as was intended within Agenda for Change.

Observation 2: There is a pressing need to manage and apply the agreed pay progression arrangements properly through the application of a simplified Knowledge and Skills Framework in order to ensure that pay progression is linked to competency development and performance, as was intended within Agenda for Change.

5.69 It is clear from the evidence presented to us by the parties that there is growing dissatisfaction with a range of factors around the progression structure of the Agenda for Change pay system. These include the number of points in each pay band, the spacing of those points, the inability to reward good performance for those at the top of scales, common pay points across bands, the appropriate rate for the job and the rigour and extent of the application of the Knowledge and Skills Framework system underpinning progression. We were also constrained in the actions we could recommend by the integrated nature of the Agenda for Change pay scale; for example, where the top pay point for one band is tied to a point in a subsequent band. Therefore, we urge the parties to agree quickly a thorough review of the Agenda for Change pay structure, including the operation of incremental scales, so that it might better support the challenges facing the NHS in terms of both patient care and affordability. We suggest that if the parties find it difficult to agree we would be prepared to look into this if given an appropriate remit and evidence. We should add that the incremental system is a fundamental part of the Agenda for Change structure and therefore primarily for discussion and agreement between the parties and outside our normal remit on pay uplift. However, we are finding it increasingly difficult to treat incremental progression distinctly from our considerations and recommendations on the pay uplift because of both affordability issues and the system's effect on pay strategy.

Observation 3: We urge the parties to agree quickly a thorough review of the Agenda for Change pay structure, including the operation of incremental scales, so that it might better support the challenges facing the NHS in terms of both patient care and affordability. We suggest that if the parties find it difficult to agree we would be prepared to look into this if given an appropriate remit and evidence.

5.70 We are grateful to the work undertaken by the parties to improve the quality of pay drift data we received. We consider the methodology used by the Department of Health to be robust and comprehensive as it disaggregates pay bill growth data into a number of drivers and provides the most appropriate estimate of annual pay drift for our purposes. We are not clear whether estimates provided by Wales, Scotland and Northern Ireland are comparable and for the next round we ask all the Health Departments to submit pay drift information on a basis consistent with the Department of Health.

Equal Pay Issues

5.71 As our terms of reference state that we should have regard to the principle of equal pay for work of equal value in the NHS, we always seek evidence on this important issue.

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Evidence from the parties

5.72 During oral evidence the **Department of Health** informed us that some staff nearing retirement had had cause for complaint over equal pay issues. We did not receive evidence of any concerns from the Employer Bodies or the Devolved Administrations.

5.73 However, the staff bodies raised several matters, which they regarded as equal pay issues. The **Joint Staff Side** called on us to revisit the agreement made at the time that Agenda for Change was introduced that there should be coordination between the different NHS Pay Review Bodies on equality issues. It said that this review should assess the proportion of funds allocated to key groups of staff across the different spines and the equality implications of this allocation.

5.74 The **Royal College of Nursing** raised a specific concern that staff employed on lower Agenda for Change bands could receive comparable, or even higher, take-home pay after working unsocial hours than nursing staff with management responsibilities.

5.75 **Unite** called for us to investigate equality issues across the NHS pay structures. It said that not enough attention had been given to the different rates of pay increase between the doctors and dentists, very senior managers and Agenda for Change staff. It said that between April 2006 and April 2012 the difference between the bottom of band 1 and the top of band 9 had expanded by over 9 per cent (the gap rising from £76,615 to £84,275), which it believed meant that the monetary value of previous years' pay rises had been far higher for the highest paid. It said that the value of job evaluation points had increased more higher up the spine, which it believed raised questions about fairness. This issue was compounded further when doctors, dentists and very senior managers were included and Unite believed that there may be equal pay challenges between the pay spines if all staff were not brought onto one job evaluation system; it believed that we should review this issue. In addition, it considered that we should investigate potential changes to the pay system that could be conducted with the aim to harmonise up and introduce greater pay equality. It also observed that performance pay, which it strongly opposed, was highly complex to introduce and had the serious potential to undermine the equality structures brought in by Agenda for Change.

Our comment

5.76 Equal pay is an important issue. We are clear that responsibility for adhering to equal pay principles rests with the parties. Our standing terms of reference, however, relate only to the remuneration of all staff paid under Agenda for Change and employed in the NHS; one element of these terms of reference states that in reaching our recommendations the Review Body should have regard to the principle of equal pay for work of equal value in the NHS. One of the key conclusions in our *Market-Facing Pay* report[81] was that Agenda for Change is perceived as fair and objective by Agenda for Change staff and is viewed by the parties as compliant with equal pay principles. We are mindful that equal pay for equal value is a different issue from pay equality. We are also conscious that the Pay Review Bodies are, by their very nature, independent; and that pay issues other than for Agenda for Change are outside our remit.

5.77 With regard to the Royal College of Nursing's point that staff employed on lower Agenda for Change bands could receive comparable or higher, take-home pay after working unsocial hours than nursing staff with management responsibilities, we see this as a feature of the current pay system, which pays a premium for unsocial hours working, rather than an equal pay issue.

[81] NHS Pay Review Body. *Market-facing pay: how Agenda for Change pay can be made more appropriate to local labour markets*. Cm 8501. TSO, 2012. Paragraph 7.17. Available from: https://www.gov.uk/government/publications/nhs-local-pay-2012

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5.78 We conclude that one of the strengths of Agenda for Change is that it is underpinned by a robust job evaluation system, which is transparent and fair, and there would be risks if this system was being used incorrectly in the interests of affordability or for any other reason. We will continue to monitor equal pay for work of equal value and ask the parties to draw to our attention for the next review, any specific concerns in this area that are within our terms of reference.

Future evidence requirements

The specific evidence requirements that we have identified in this chapter for our next review are:

- We look forward to receiving evidence from the parties for our next review that demonstrates substantial progress being made on our market-facing pay recommendations.
- We ask all the Health Departments to submit pay drift information on a basis consistent with the Department of Health.
- We will continue to monitor equal pay for work of equal value and ask the parties to draw to our attention for the next review, any concerns in this area that are within our terms of reference.

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Chapter 6 – Pay Proposals and Recommendations for 2014/15

Introduction

6.1 In this chapter we draw together the main strands of the evidence relating to the remit for this pay round and our standing terms of reference. We consider the evidence presented on pay proposals and arrive at our recommendations for 2014/15. In doing so we reiterate some of our conclusions from the earlier chapters on each element considered for this remit and, where relevant, the key themes, as set out in Chapter 1, that have influenced our conclusions.

Basic Pay Uplift

6.2 This section contains our main comments and recommendations on the basic pay uplift for 2014/15 for staff paid under Agenda for Change. This is the second year following the pay freeze for which the United Kingdom Government had announced in Autumn 2011 that public sector pay awards would average 1 per cent. The Department of Health, Health Education England, NHS England and NHS Employers all asked us to tie any award to progress on reform of Agenda for Change; as part of this, the Department of Health asked for the uplift to be deferred for a year. In the event of any award being made, the Welsh Government preferred a focus on the lower paid, including the Living Wage, and queried both whether awards should be made in addition to increments and the appropriateness of an award to the highest paid. The Scottish Government Public Sector Pay Policy also focused on the lower paid and included the application of the Scottish Living Wage and a £300 minimum uplift for those earning less than £21,000. The Northern Ireland Executive asked us to consider the continuing financial pressures, while NHS Employers and the Foundation Trust Network preferred a zero uplift. In contrast, the Joint Staff Side and the individual trade unions believed that a 1 per cent rise was insufficient and they also favoured the Living Wage. We address the remit letters in detail in Chapter 1 and the full remit letters are included at Appendix A. The evidence from the parties is summarised in the following paragraphs.

Evidence from the parties

6.3 The **Department of Health** believed that the priority for this pay round should be support for continued reform of national contracts so that they delivered improvements in performance and productivity, were affordable and fit for purpose. It stressed that putting patients at the heart of everything in the NHS meant ensuring services were available seven days a week and that staff were rewarded for what they did for patients, not time served. It said that they must also reward appropriate behaviours, i.e. compassionate, high quality patient-centred care. The Department of Health believed that the 1 per cent that the Government had made available for pay, in the Spending Round, would be best deployed in supporting the modernisation of national pay frameworks. In particular, that the reform of Agenda for Change should seek to improve the quality of patient care, and therefore outcomes, by ensuring there was a better balance between pay, performance and productivity, rather than time served. It informed us that the Government's view remained that basic pay increases should only be implemented if there was strong evidence that recruitment, retention, morale or motivation issues required this.

6.4 The Department of Health's pay strategy was aimed at ensuring the national pay, terms and conditions of service remained affordable and fit for purpose and were able to support employers across the NHS in delivering service priorities. It noted that pay accounted for £45 billion of the total NHS budget, and pay and pensions accounted for around two-thirds of running costs for typical NHS employers. It was essential that at a time of unprecedented financial challenge, the best possible value for money was

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obtained from this investment. It told us that the overall remuneration of public sector employees was above that of the market and that any changes to public service pensions, including the progressive increase in contributions from 2012/13, did not justify upward pressure on pay.

6.5 The Department of Health asked us to consider, if we believed an award was justified, how any such award might be made dependent on the NHS Staff Council reaching agreement on further Agenda for Change reform. In particular, how in the current economic climate and within the context of the overall expenditure on pay and pensions, Agenda for Change might be made more affordable. It proposed that any such recommendation should be tied to progress on Agenda for Change reform, with the parties invited to report on progress in their evidence to us next year, effectively deferring any award. It said that the priority for the Department of Health was to ensure that seven-day services were made more affordable by reviewing premium rates for working outside Monday to Friday. In addition, within the current Agenda for Change pay framework, it wanted the trades unions and employers to consider how the framework might make a stronger distinction between, for example, the rate for the job where staff were in development mode, when they were fully achieving the requirements of the role and where they may be exceeding the requirements of the role. It believed that change should not focus solely on saving money, but should consider how the cost of operating a national pay system, linked to performance, quality and productivity considerations, still within a framework of job evaluation, could be used differently.

6.6 The Department of Health told us that as pension was deferred pay it would not be appropriate to take into account any increase in pension contributions as part of the considerations about the appropriate level of any pay award. It believed that it was important to consider the overall value of the NHS employment offer, both pay and non-pay elements.

6.7 **Health Education England** said that in the current climate of pay restraint, any increases or other changes to NHS pay and terms and conditions of service that we recommended should explicitly support and be linked to wider system reform as pay could be an effective lever to support the changes required.

6.8 **NHS England** urged us to consider very carefully what, if any, uplift was appropriate for 2014/15. It said that if services continued to be delivered in the same way as now, this would result in a funding gap that could grow to £30 billion between 2013/14 and 2020/21. It told us that any increase in staff pay would take away resources which could otherwise be used on improving other aspects of patient care. However, it recognised that we would need to balance this against the potential risks to recruitment and retention issues in the longer term. It said that if we considered that an increase was appropriate, it strongly suggested that it was linked to progress being made on wider reforms to the pay system.

6.9 **NHS Employers** informed us of the disappointment of some employers who were concerned that the previous award had not taken sufficient account of the financial and efficiency issues they were facing. They said that there was continued, widespread employer agreement on the need for tight pay restraint and that further increases to national pay scales were not required on recruitment, retention or motivation grounds. They stressed that even without an increase to national salary scales, the majority of staff would continue to receive an incremental pay increase averaging 3.4 per cent during 2014/15. They asked us to make the difficult decision not to recommend an uplift to pay scales for 2014/15, but that in the event of us deciding to make an award, this should be only to facilitate further reform of terms and conditions, not awarded to base salary. They added that the general view, among employers responding to their survey, was that on the grounds of equity and fairness they did not want to have differential increases in pay

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between staff groups, both within Agenda for Change and in relation to medical staff as they might produce issues relating to compression of the gaps between pay points and/or leapfrogging.

6.10 The **Foundation Trust Network** told us that it wanted no pay award made to NHS staff in 2014/15. However, we note from its survey of members that 62 per cent of respondents (predominantly at Human Resources Director level) believed that a pay award *should* be made to NHS staff in 2014/15. The Foundation Trust Network told us that it had taken the decision to recommend that no cost of living pay increase should be made for a number of important reasons: other views canvassed outside the survey; a presumption among survey respondents that a pay award would not amount to an additional efficiency pressure; an acceptance amongst trusts that a 1 per cent award would be applied; the ongoing financial challenge; and because it believed that the focus should be on the shift to a seven-day service. The Foundation Trust Network said that if a pay award was made it should be applied equally across all staff groups. There was a feeling amongst this majority group that it was not worth tinkering with the pay system in order to distribute a limited, 1 per cent cost of living pay increase. A small number of respondents (16 per cent) believed that any award should be made differentially on a national basis, and 15 per cent said that they would prefer a differential award on a local basis. It reported that the majority (56 per cent) did not think the annual pay award decision should take account of incremental progression.

6.11 The Foundation Trust Network reported that the majority of its members (54 per cent) would support a move to non-consolidated pay awards. The reasons given for not supporting non-consolidated awards included: complexity of implementation; support for pensions calculated on whole pay; the view that this would only be tinkering around the edges of the pay system rather than the wholesale reform required; and the potentially unequal treatment of existing and new staff. It did not believe that a pay award could solve the recruitment and retention problems where they existed for Agenda for Change staff, nor that a pay increase was required on staff motivation grounds.

6.12 The **Welsh Government** asked us to consider whether in the current economic and financial climate it was appropriate for any award to be given. It requested that if we determined that an award was appropriate, that we should consider the following suggestions:

- confining any award to raising the starting rates for employees in the NHS to a salary equal to the Living Wage level;
- confining any award to staff on lower pay bands in recognition of the tackling poverty agenda;
- whether 43 per cent of staff should receive an annual pay award in addition to their increment; and
- whether it was appropriate to give an award to the very highest paid staff in the current economic climate.

6.13 The Welsh Government proposed that should any recommendation be made, it did not in total exceed 1 per cent of the salary bill in recognition of the financial pressures faced by the service. It also asked us to note that that any increase would be unfunded and would place additional pressures upon the service.

6.14 The **Scottish Government** notified us of its Public Sector Pay Policy for 2014/15. The key features were:

- provision for an increase in basic pay for all staff. This increase was subject to an overall cost cap of 1 per cent, although there was no assumption that this would equate to a 1 per cent uplift. The cost cap did not include pay progression or measures put in place for staff earning under £21,000;

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- continuing with specific measures for supporting the lower paid;
- maintaining the suspension of non-consolidated performance related pay;
- retaining discretion for individual employers to reach their own decisions about pay progression, outwith the 1 per cent cap on basic pay award; and
- maintaining the policy of no compulsory redundancy.

It told us that the Scottish Living Wage would be paid and the minimum uplift for all staff earning less than £21,000 would be increased to £300 (from £250) in both 2014/15 and 2015/16. It said that as a result, some low paid members of staff were likely to benefit from increases of 2 per cent in the coming year. The Scottish Government told us that the estimated cost of a 1 per cent uplift in 2014/15 in Scotland was £40.3 million. The tapered addition to ensure a total increase of £300 for staff earning under £21,000 was estimated to cost a further £6.1 million.

6.15 The **Northern Ireland Executive** told us that a key feature of implementing its pay policy was the need to honour contractual entitlements. It noted that many local staff groups were contractually tied to United Kingdom nationally determined pay settlements or had clear contractual entitlements to progression/performance pay. It was therefore not possible to impose a blanket pay freeze, or even pay cap, without first addressing these contractual arrangements. It stated that Northern Ireland supported the maintenance of a unified Agenda for Change pay system. It asked us to consider the continuing financial pressures and the lack of flexibility to afford pay cost increases in excess of 1 per cent without impacting directly on patient care and stressed that affordability was critical across health and social care in Northern Ireland. The Northern Ireland Executive told us that the significant pressures on the budget for the Department of Health, Social Services and Public Safety budget meant that there was no flexibility to afford pay cost increases in excess of the £22 million identified to meet anticipated increases in the Department of Health, Social Services and Public Safety pay bill, which covered a potential 1 per cent increase, without impacting directly on patient care. It noted that while funding equivalent to a pay increase of 1 per cent had been factored into the budget in Northern Ireland, this did not represent a commitment. It stressed that the overall financial position for Northern Ireland was extremely constrained and it was facing a significant budgetary pressure. It said that it would seek to identify ways to address this that would have minimum impact on the delivery of frontline services while ensuring appropriate remuneration of health and social care staff. It was in this overall context that it had asked us to consider whether an uplift was appropriate.

6.16 The **Joint Staff Side** called on us to ensure that all Agenda for Change staff received a pay uplift of at least 1 per cent. It called on us to protect the lowest paid staff by ensuring that none of its members were paid below the level set for the Living Wage and to ensure that all Agenda for Change staff received an uplift of at least 1 per cent. It questioned whether the money saved by not paying the 1 per cent uplift would be used for increased staffing as the Department of Health had provided no evidence on this matter.

6.17 The **Royal College of Midwives** told us that although it considered a 1 per cent uplift to be inappropriate, it did not agree that there should be an unequal pay increase across the bands; it believed that there should be the same uplift for all staff. It said that this year's proposed award of 1 per cent was still significantly less than inflation and represented a further decrease in the value of NHS workers' pay. It was concerned about the effects that consistently keeping pay below inflation would have on the workforce, the service and the wider economy.

6.18 **Unison** told us that according to Incomes Data Services, pay settlements were higher in the private sector and had averaged between 2.5 per cent and 3 per cent in comparison to the public sector where pay had either been frozen or capped. It said that NHS staff had not had a real-terms pay increase since 2006, with the exception of the eight months when the Retail Prices Index (RPI) was negative. It asked us to acknowledge the impact of

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continued pay restraint on the morale and motivation of the NHS workforce as well as the impact low morale was having on service quality within the NHS. It believed that the political decision to impose a 1 per cent cap on NHS staff pay uplifts for the next two years was perceived by members to be unfair and said that anger at the low level of the uplift from NHS staff was beginning to put immense pressure on industrial relations within the sector. Unison asked us to make a recommendation on pay that was United Kingdom-wide and which recognised that inflation, consistently running well above NHS pay awards year on year, coupled with the two-year pay freeze imposed on staff, followed by successive 1 per cent caps on NHS pay, had had a negative impact on the living standards of NHS staff. It asked for our recommendation to acknowledge that a fair pay rise for NHS staff would protect the value of NHS pay against prevailing inflation rates and address the deterioration in NHS earnings which it believed had now reached an average 10 per cent cut to pay in real-terms.

6.19 **Unite** believed that continuing pay caps at an average of 1 per cent until at least 2015/16 were a cumulative real terms loss of earning of around 15 per cent. It expressed concern that despite the Treasury's clear statements that a payment of 1 per cent was affordable and available for staff this year, several of the parties had questioned this. Unite thought that we should assert our independence and recommend that NHS staff should get a fair pay rise. It also called for us to make clear recommendations against what it described as "the Government's arbitrary pay policy". It said that our recommendations should highlight concerns about how pay was being set, the extent of pay and terms cuts across the NHS and the impact of this on staff morale and service users. It asked us to use our independent voice to send a clear signal that enough was enough. It believed that the Government's pay policy was unfair and unjust and that this should be acknowledged. It sought a fair uplift in pay, that recognised the commitment and dedication shown by staff to delivering services, and that did not cut pay in real terms. Unite said that its research showed the impact of Government policy on NHS services and staff: morale was at an all time low with a consequence for staff wellbeing; many staff were facing substantial cuts to terms and conditions; and services were being cut back and at risk. It said that we should conduct urgent research into changes to on-call, sickness benefits, Recruitment and Retention Premia (RRP), down banding and overtime, as well as the potential impacts of performance related progression in England. It also suggested that we should interrogate the evidence for the assertion from the Secretary of State that a further pay freeze would help increase quality for patients and help the Department of Health to realise its vision of an affordable seven-day service. It told us that it continued to believe that the costs of professional registration should be borne by the employer and pointed out that some staff now had to bear the additional costs of paying for Disclosure and Barring Service (Criminal Records Bureau) checks.

Our comment and recommendation

6.20 During our deliberations we have examined the evidence thoroughly over whether any pay uplift for 2014/15 is affordable. On affordability, we are in no doubt that trusts and some of the Devolved Administrations are in increasingly difficult financial circumstances. On the other hand, the Department of Health and the Scottish Government told us that funding was being made available to employers to cover a 1 per cent rise this year, and we hold to our view that it is neither desirable nor sustainable to substitute a pay squeeze for productivity and transformational reforms. Overall, we do not see any current signs of general recruitment and retention issues. There is limited evidence of early warning signals of potential recruitment or retention problems in certain specialisms or geographies, although as the United Kingdom economy improves, we believe these may become more serious.

6.21 In the light of this we have considered what impact the possible outcomes of our deliberations would have on patients, who are the people at the centre of the NHS. In particular, we recognise the connection between quality patient care and the morale

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and motivation of the staff delivering that care. Our conclusion was that Government statements have led staff to expect a pay settlement this year of around 1 per cent. If these expectations were to be dashed, patients would be impacted through declining staff morale and engagement.

6.22 We have also concluded that pay levels for Agenda for Change should be maintained across the United Kingdom this year, given that all the parties favoured continuation of a United-Kingdom wide Agenda for Change structure and that all Agenda for Change staff are expected to contribute to significant changes across the NHS.

6.23 Taking all these factors into account, we have concluded that it is appropriate to award Agenda for Change staff a flat 1 per cent pay increase for 2014/15, in line with the general public service rise. However, if any pay rise is to be recommended next year, we would expect to see much more urgency on innovative reforms in the NHS, including implementation of the agreed changes in England designed to increase the link between performance and pay; and a serious effort to raise management and leadership skills at all levels, particularly in the area of performance management. We would like to see far stronger evidence of effective workforce planning, including hard data on vacancies, skill shortages and attrition.

6.24 Having concluded that an uplift of 1 per cent is appropriate, we have deliberated at length upon the merits of a consolidated versus non-consolidated award. We are very conscious that the expectation within our remit group is for a 1 per cent consolidated award. We discussed with the parties the option of a non-consolidated award during oral evidence but in general received a lukewarm response. The Foundation Trust Network's written evidence supported a non-consolidated award, although it added that this would be tinkering round the edges of the pay system rather than the wholesale reform required. We are not persuaded that the short-term financial advantage to be gained from a non-consolidated award would outweigh the potentially adverse impact on staff engagement and motivation of a non-consolidated, non-pensionable uplift of what would be a relatively small amount of money for individual staff. Therefore, we recommend a 1 per cent increase to all Agenda for Change pay points from 1 April 2014. The recommended Agenda for Change pay scales, with effect from 1 April 2014, are at Appendix B.

Recommendation 2: We recommend a 1 per cent increase to all Agenda for Change pay points from 1 April 2014.

High Cost Area Supplements

6.25 In our *Market-Facing Pay* report we recommended a fundamental review of High Cost Area Supplements (HCAS) and we set out the detailed areas for review relating to HCAS and some transitional and implementation considerations. We asked that the findings should be available in evidence for this pay round[82] and are disappointed that the review has not yet taken place.

Evidence from the parties

6.26 The **Department of Health** told us that it had asked NHS Employers, on behalf of the NHS Staff Council, to commission researchers to undertake this review.

6.27 **NHS Employers** told us that it had had no representations from employers in relation to adjusting the value of the existing HCAS payments. It said that any increase to the percentages of pay used in the existing HCAS payments would add an unwelcome cost

[82] NHS Pay Review Body. *Market-facing pay: how Agenda for Change pay can be made more appropriate to local labour markets*. Cm 8501. TSO, 2012. Recommendation 4. Available from: https://www.gov.uk/government/publications/nhs-local-pay-2012

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pressure, and would put further pressure on service delivery. During oral evidence, NHS Employers told us that some trusts outside London had been destabilised by staff commuting to trusts in London where HCAS applied.

6.28 The **Joint Staff Side** called on us to ensure that HCAS was increased by at least 1 per cent. It added during oral evidence that the cost of living had risen in HCAS areas and that it was difficult to recruit experienced staff in some of these areas.

Our comment and recommendation

6.29 While we await the HCAS review, we have reviewed the levels of HCAS minima and maxima in line with our role under the parties' agreement as set out in the *NHS Terms and Conditions of Service Handbook*.[83] Our conclusions in the *Market-Facing Pay* report were that recruitment and retention indicators for Agenda for Change staff were relatively less favourable in London and surrounding areas and that our research pointed to more investment in pay in parts of London rather than outside. Furthermore, we do not consider that Agenda for Change staff at the HCAS minima and maxima should be disadvantaged when other staff receiving HCAS payments would receive the full effect of the 1 per cent increase to basic pay. We note that the Chief Secretary to the Treasury told us that the pay award should be applied to basic salary, based on the normal interpretation of basic salary in each workforce, and that this excluded overtime or any regular payments such as London Weighting, recruitment and retention premia or other allowances. However, we have concluded, as in previous years, that staff receiving HCAS payments will regard these as part of basic pay. Around 191,900 Agenda for Change staff (full-time equivalent (FTE) basis) are in receipt of HCAS in England, based upon the 1 April 2014 pay scale values we estimate that around 116,900 of these staff would receive a HCAS minima or maxima payment. We estimate that the additional cost to the Agenda for Change pay bill in England as a consequence of the 1 per cent uplift to the HCAS minima and maxima would be less than £5 million.

6.30 Each year the Office for National Statistics' Annual Survey of Hours and Earnings (ASHE) provides estimates of pay in the United Kingdom. The latest ASHE estimates[84] show that the median annual full-time gross pay in the public sector is 22 per cent higher in London than the equivalent figure in the United Kingdom as a whole, whilst the equivalent figure in the private sector is 36 per cent higher in London. These estimates are higher than the inner London HCAS rate (20 per cent) and we would not want to see this gap grow. We conclude that the evidence supports our usual and established practice of uprating of the HCAS minima and maxima by the overall pay uplift, which in this case is 1 per cent. We also conclude that we will need to continue to consider increasing HCAS until employers are ready to reform the system. Our recommendation produces the minima and maxima for HCAS zones in 2014/15 as shown below in Table 6.1.

Table 6.1: Recommended values of High Cost Area Supplements minima and maxima for 2014/15

HCAS zones	% of basic pay	Minimum	Maximum
Inner London	20%	£4,117	£6,342
Outer London	15%	£3,483	£4,439
Fringe	5%	£951	£1,649

[83] NHS Staff Council. *NHS terms and conditions of service handbook.* Amendment number 29. Pay Circular (AforC) 3/2013, Section 4. Available from: http://www.nhsemployers.org/SiteCollectionDocuments/AfC_tc_of_service_handbook_fb.pdf

[84] Annual Survey of Hours and Earnings. *2013 provisional results*. December 2013. Available from: http://www.ons.gov.uk/ons/rel/ashe/annual-survey-of-hours-and-earnings/2013-provisional-results/stb-ashe-statistical-bulletin-2013.html

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Recommendation 3: We recommend a 1 per cent increase to the High Cost Area Supplement minima and maxima from 1 April 2014.

Consideration of Whether the Award Should be Tied to Progress on Agenda for Change Reform

6.31 We have considered carefully whether the award should be tied to progress on Agenda for Change reform, as sought by the Department of Health, Health Education England, NHS England and NHS Employers and have addressed this issue more fully in Chapter 5. However, it is not clear to us in sufficient and open detail what specific changes the parties are seeking nor how we could best support them. We are uncertain whether the delays in making these changes are the result of reluctance by a variety of stakeholders or the lack of capacity or capability of employers. Furthermore, a 1 per cent uplift gives little room to attach conditions for reform of Agenda for Change. We have concluded that it would neither be appropriate nor feasible to make a recommendation specifically to tie the award to progress on reform of Agenda for Change. However, we are mindful that lack of progress on reform may well mean that prospective future awards may have to be ruled out on the grounds of affordability and/or priority and we will need to take this into account in our future reports.

Pay Structure and Incremental Progression in Agenda for Change

6.32 We were asked by the Secretary of State for Health to consider incremental pay for staff who had not yet reached the top of their pay scale. We have addressed this fully in Chapter 5 and repeat some of those conclusions here. Incremental pay is not a costly system, as such, in net terms, because of new staff being recruited to the bottom of the scale, replacing in general staff at the top point. Much of the evidence provided to us focused on the cost of incremental scales. We do not think this is the right point for debate. As we showed in Chapter 5, the system is not costly; rather, the operation of the system is ineffective in rewarding performance because of widespread inadequacies in the performance management system. There is a pressing need to manage and apply the agreed pay progression arrangements properly through the application of a simplified Knowledge and Skills Framework in order to ensure that pay progression is linked to competency development and performance, as was intended within Agenda for Change.

6.33 We have reflected upon whether we should recognise those staff at the top of the incremental scale, approaching half our remit group (47 per cent), who will not receive incremental progression. We recognise that this group of staff is increasing year on year and that those individuals, who have been at the top of the scale for some time, have been hardest hit by the pay freeze and subsequent pay restraint. We have considered whether to target a greater proportion, or all, of the pay award at this group of staff, even though the integrated nature of the Agenda for Change pay scale would make this complex. There is no evidence on grounds of recruitment and retention that we should single out one group at the expense of others. However, even more importantly, the argument for a 1 per cent increase on pay scales being expected because of Government statements, and any shortfall in that 1 per cent potentially leading to a decline in motivation and engagement, applies to all wherever they sit within the scales. We believe that recognition for those at the top of the incremental scale should be included as an important part of the review of the Agenda for Change pay structure referred to elsewhere and we will continue to monitor this situation closely.

6.34 As set out in this report, it is clear from the evidence presented to us by the parties that there is growing dissatisfaction around the progression structure of the Agenda for Change pay system. Therefore, we urge the parties to agree quickly a thorough review of the Agenda for Change pay structure, including the operation of incremental scales, so it

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might better support the challenges facing the NHS in terms of both patient care and affordability. We suggest that if the parties find it difficult to agree, we would be prepared to look into this if given an appropriate remit and evidence. We are mindful that the incremental system is a fundamental part of the Agenda for Change structure and therefore primarily for discussion and agreement between the parties and outside our normal remit on pay uplift. However, we are finding it increasingly difficult to treat incremental progression distinctly from our considerations and recommendations on the pay uplift because of both affordability issues and the system's effect on pay strategy.

Lower Paid Staff

6.35 Several of the parties raised the issue of lower paid staff in their evidence and the Welsh Government, Scottish Government and the Joint Staff Side all sought compliance with the Living Wage as part of Agenda for Change. The Living Wage is voluntary, and is intended to ensure a basic but acceptable standard of living; it is a higher rate than the National Minimum Wage, which is a statutory minimum for all employees aged 21 and over (with lower rates for younger workers), intended to prevent the exploitation of the lowest-paid workers. We note that in Scotland a Living Wage has been implemented in the NHS through not using the lowest pay point. Some individual NHS trusts have also implemented a Living Wage and have applied it to contracted-out staff in some cases.

6.36 The lowest rate of pay in the NHS (pay point 1) is £7.31 an hour from 1 April 2013, and fell behind the Living Wage when the latter was uprated from £7.20 to £7.45 an hour at the end of 2012. Pay point 2 was £7.49 an hour from 1 April 2013, which is also below the uprated United Kingdom Living Wage of £7.65 an hour for 2014. (See Table 6.2 below)

6.37 The adult National Minimum Wage was increased to £6.31 an hour from 1 October 2013. The Living Wage was increased to £8.80 an hour for London (from £8.55) and to £7.65 an hour for the rest of the United Kingdom (from £7.45) from November 2013 (see Table 6.2 below). The Scottish Living Wage is the same as the United Kingdom-wide rate. The parties' evidence was submitted prior to the recent uprating, so is based on the lower rates.

Table 6.2: Comparison of Agenda for Change hourly rates with the National Minimum Wage and the Living Wage

	Agenda for Change	National Minimum Wage	Living Wage
National rate	£7.31 (1 April 2013)	£6.31 (1 October 2013)	£7.65 (November 2013)
London rate	£9.07 (1 April 2013)	£6.31 (1 October 2013)	£8.80 (November 2013)

Sources: NHS Employers, Low Pay Commission, and Living Wage Foundation.
Note: Agenda for Change hourly rates are derived by the Office of Manpower Economics from pay point 1 of NHS Employers' published Agenda for Change pay scales.

Evidence from the parties

6.38 The **Department of Health** commented that when compared to the 2013/14 pay scales, introduced in April 2013, for NHS Hospital and Community Health Service staff, the hourly rates for the Living Wage suggested that only those staff on Agenda for Change pay point 1 and not in receipt of HCAS would have earnings below the Living Wage thresholds. It said that the number would vary over time, but it estimated that there were 15,000 to 20,000 staff in this situation. However, it stressed that affordability was critical across the NHS.

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6.39 **NHS Employers** told us that the clear view of employers was that further targeted increases to the lowest pay points to match Living Wage rates were not required on labour market grounds. Employers had consistently expressed concerns about the ability of NHS organisations to compete effectively for contracts with other providers and they believed that increasing the lowest pay rates would risk exacerbating this. They said that in the NHS, the lowest national pay point (band 1, point 1) was £7.31 per hour, which it said was 16 per cent higher than the National Minimum Wage (£6.31 per hour from 1 October 2013). They observed that in London, NHS staff received a basic salary that exceeded the London Living Wage.

6.40 The **Foundation Trust Network** added that those on the lowest pay points had received targeted uplifts during the public sector pay freeze. It highlighted that all Agenda for Change staff earned an hourly rate that was significantly above the National Minimum Wage. It told us that members of the Foundation Trust Network believed that targeted increases to the lowest pay points were not required on labour market grounds.

6.41 The **Welsh Government** said that the Living Wage was recognised as one of a range of positive actions to help alleviate the problems caused by low wages and in-work poverty, and it estimated that introducing the Living Wage in Wales would cost in the region of £0.4 million. In its evidence the Welsh Government asked us, in the event of an award being determined to be appropriate, to consider confining any award to raising the starting rates for employees in the NHS to a salary equal to the Living Wage level; also to confine any award to staff on lower pay bands in recognition of the tackling poverty agenda. Asked how it defined the 'lower pay bands' it said that these could be considered to be staff in pay bands 1 to 3, currently earning a full time equivalent salary of £19,268 or less, but that it would welcome our expert view as to what we would define as the 'lower pay bands'.

6.42 The **Scottish Government** informed us that the Scottish Public Sector Pay Policy mandated the continued application of the Scottish Living Wage, as in previous years, by making point 1 on the Agenda for Change pay matrix unavailable for use. In addition, the minimum uplift for all staff earning less than £21,000 would be increased to £300 (from £250) in both 2014/15 and 2015/16; this meant that some low paid members of staff were likely to benefit from increases of 2 per cent in the coming year. It said that while the Scottish Government recognised the need for pay restraint, it had also taken a conscious decision to continue in its attempts to protect the most vulnerable in the Public Sector Pay Policy for 2014/15, firstly, by application of the Scottish Living Wage and secondly by mandating a proportionately larger pay rise for staff earning under £21,000. It asked us to recommend a minimum pay uplift of £300 for staff earning less than £21,000 and said that the working assumption was that if our recommended pay award equated to less than a £300 uplift for those earning under £21,000, it would pay the balance as a non-consolidated sum.

6.43 The **Northern Ireland Executive** told us that currently, Northern Ireland's public pay policy did not mandate the application of a Living Wage, and that any adoption of a Living Wage, similar to that in Scotland and Wales, may have greater financial consequences in Northern Ireland because of the disproportionate number of lower paid public sector workers in the workforce. It told us that there were no plans to emulate this policy to Agenda for Change but it would expect this position to be kept under review. It emphasised that affordability was critical for the Health and Social Care Board in Northern Ireland.

6.44 The **Joint Staff Side** said that the pay cap, changes to benefits and welfare payments and rising inflation were affecting all workers, but lowest paid workers were hardest hit. It believed that, as a minimum, the NHS should commit to at least the Living Wage for all employees across the United Kingdom as a way of protecting the lowest paid workers. It called on us to protect the lowest paid staff by ensuring that no members were paid

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below the level set for the Living Wage and to ensure that all Agenda for Change staff received an uplift of at least 1 per cent. It told us that historically the lowest pay point on Agenda for Change had always been above the Living Wage, but this had changed in November 2012 when the Living Wage rose from £7.20 an hour to £7.45 an hour. It said that if pay point 1 were to be removed, as in Scotland, NHS pay would stay ahead of the Living Wage rate with only a minor cost to meet the increase for the 1.8 per cent of staff on pay point 1.

6.45 The Joint Staff Side said that while the 1 per cent uplift across the Agenda for Change pay scales had made a small contribution to the salary of NHS staff, the impact on low paid staff was still a major concern for the Joint Staff Side. It believed that the reduction in the value of their wage was still severe, especially for those on pay point 1 and had a greater impact on the ability to afford to cover the most basic aspects of expenditure on housing, food and energy and childcare costs. It added that the available evidence suggested that inflation for the low paid was running at an even higher level than the RPI. It believed that there was a rising public awareness and clear moral case for bringing in a Living Wage for low paid NHS staff. It saw this as an achievable goal because Scotland had already shown and such an outcome would serve the purpose of re-harmonising all the United Kingdom countries under the same pay regime.

6.46 The **Royal College of Midwives** told us that it would like to see all NHS staff paid the Living Wage.

6.47 **Unison** reported that in its pay survey, 62.7 per cent of respondents had said that they were dependant on unsocial hours payments to sustain their standard of living. Unison asked us to make a recommendation on pay that was United Kingdom-wide and which removed or uprated pay point 1 to make the NHS a Living Wage employer across the whole United Kingdom. It called for a fair pay rise for all, which delivered the Living Wage and reduced the impact of year on year cuts to the real terms value of NHS pay. It told us that it would cost approximately £5.73 million to implement the Living Wage across the United Kingdom. Unison cited the example of Sussex Community NHS Trust, which it said was the first NHS organisation in Sussex to become an accredited Living Wage employer.

6.48 **Unite** called for real support for the low paid in the NHS and said that at a bare minimum this should require all staff to get the Living Wage. It also believed that since many of the lowest paid roles had or were being outsourced to the private sector we should investigate and make recommendations about the need for payment of the United Kingdom Living Wage in the NHS supply chain and for all outsourced staff as part of NHS contracts.

6.49 Unite commented that Scotland's remit showed that there was more scope for a cost of living increase than the Treasury was prepared to admit. It said that although it did not consider that 1 per cent was a sufficient uplift, it believed that the Scottish Government had shown that it was able to prioritise pay increases, in contrast to the rest of the United Kingdom. It asked us to press the Scottish Government on what factors made this payment more possible in Scotland and not the rest of the United Kingdom.

Our comment

6.50 A number of parties raised the issue of the Living Wage in their evidence, but in our view the Living Wage is a matter of social policy for individual governments and employers, and we make no specific recommendation on this. However, we will continue to monitor its uptake in the NHS, and the use of the lowest pay points. We are mindful that evidence for the United Kingdom produced by the Institute for Fiscal Studies and the Office for National Statistics, and other academic research suggests that public-private sector wage differentials tend to favour the public sector at the bottom of the earnings distribution.

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6.51 In our report on market-facing pay, we recommended that each NHS trust should have a transparent and open pay and reward strategy contained within its business plan. However, anecdotal evidence from our visits programme suggests that many trusts and boards do not have a reward strategy. We would expect each employing body's policy on the Living Wage, including its appropriateness to the trust or board's individual circumstances, to be a part of this reward policy.

6.52 We ask the parties to note that our terms of reference relate only to staff paid under Agenda for Change and employed in the NHS. The NHS supply chain and outsourced staff are outside our remit.

Higher Paid Staff

6.53 The maximum point on the Agenda for Change pay scale, pay point 54, equates to a salary of £98,453.

Evidence from the parties

6.54 The **Welsh Government** asked us to consider whether it was appropriate to give an award to the very highest paid staff in the current economic climate. Asked to define 'the very highest paid', it responded that it would welcome our views regarding this point. It said that currently, 1 per cent of Agenda for Change staff employed within NHS Wales earned a salary of £65,922 or more, which equated to 712 staff. It added that if the figure of £80,000 promoted by the Scottish Government in last year's evidence was used, only 230 staff would be affected, i.e. less than 0.5 per cent.

Our comment

6.55 The evidence we received favoured a single recommendation for the whole of the United Kingdom and the Welsh Government was alone in suggesting that we make no award to the highest paid. We are also mindful that all the parties favoured continuation of a United Kingdom-wide Agenda for Change structure. Furthermore, evidence for the United Kingdom produced by the Institute for Fiscal Studies and the Office for National Statistics, and other academic research suggests that public-private sector wage differentials tend to favour the private sector at the top of the earnings distribution. Therefore, we have concluded that, on balance, our recommended award should include the higher paid.

The Role of the Review Body

Evidence from the parties

6.56 The **Joint Staff Side** said that it continued to oppose the Government's instruction to us, both in relation to the cap on the pay bill for Agenda for Change staff and the restriction of our remit. It perceived that our remit was now restricted to taking account of the economic climate, minimising its ability to reflect the impact of the Government's policies on the NHS workforce.

6.57 The **Royal College of Midwives** was opposed to decisions relating to pay that had not arisen from us, the most pertinent example being the decision by the Treasury to freeze the pay of public sector employees for two years; the imposed pay cap of 1 per cent for 2013/14; and the continuation of a pay cap of 1 per cent for the next two years.

6.58 **Unison** asked us to recognise the growing pressures that pay suppression was placing on industrial relations within the NHS and the perception among the workforce that the independence of the Review Body was being consistently undermined by the restricted remit.

6.59 **Unite** suggested that we should assert our independence from the Government by challenging the 1 per cent pay cap.

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Our comment

6.60 We have addressed the issue of Government constraints on our remit, through public sector pay policies, in Chapter 1, where we stated that we continue to think that our process has most value when we are able to bring independent and expert judgement to bear on all factors within our terms of reference. The reference to a specific figure by the Chancellor over two years has influenced expectations across the public sector and within the NHS. However, we recognise the effect that continued restrictions could have on the parties' perceptions of our independence, and it is of concern to us that some parties on the Joint Staff Side have expressed reservations about the independence of our approach. We reiterate that we do consider and balance *all* factors within our terms of reference in reaching our independent judgements.

Future evidence requirements

The specific evidence requirements that we have identified in this chapter for our next review are:

- We would like to see far stronger evidence of effective workforce planning, including hard data on vacancies, skill shortages and attrition.
- We ask the parties to note that our terms of reference relate only to staff paid under Agenda for Change and employed in the NHS.

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Chapter 7 – Next Steps

Introduction

7.1 In this chapter we look forward to our next pay round. We begin by looking at pay developments for the forthcoming year. We then conclude with a summary of the key messages that we consider cover the priority actions for the NHS going forward and that need to be addressed before the next round.

Pay Developments for 2014/15

Market-Facing Pay

7.2 We are disappointed at the slow rate of progress being made on the recommendations in our *Market-Facing Pay* report[85] and we expect to see real and meaningful progress being made during 2014/15. We look forward to receiving evidence from the parties in autumn 2014 that demonstrates substantial progress.

Our comment on Agenda for Change developments

7.3 The conclusions from our *Market-Facing Pay* report and the evidence for this report indicate strong continuing support for the Agenda for Change framework among the parties. However, as we have said before, the Agenda for Change framework continues to require regular review to respond quickly to NHS priorities and to changes in the labour market including the use of market-facing flexibilities. We said last year that we welcomed the discussions to develop Agenda for Change under the NHS Staff Council in England and that we would welcome clarification of how the Devolved Administrations intended to respond to the conclusions of these discussions. We stressed that such negotiations needed to take place quickly with impetus from employers and trades unions so that effective solutions could be implemented at a reasonable pace. We note that agreement for some changes in England has been made, but we are concerned that these do not seem to have been quickly considered and, if appropriate, taken up in the rest of the United Kingdom. We also note that implementation of the agreement in England has proceeded somewhat patchily.

7.4 In our view, it would be a mistaken course of action if pay restraint were to continue as the main source of NHS efficiency gains in 2014/15. For our next review we expect to receive further information on a range of Agenda for Change developments including: the outcome of the NHS Staff Council's discussions; further proposals for the development of pay and conditions over the longer term; and a clear pay strategy in all NHS trusts and organisations, which recognises the need to reward competence, and underpins staff engagement in both change and patient care. We also expect to see further developments in the light of the Francis report, which we recognise will have an impact on the Agenda for Change framework, staffing levels and staff engagement. We will continue to keep this under review and stand ready to play our part; for example, if the parties find it difficult to make quick progress themselves.

7.5 We continue to believe that Agenda for Change pay needs to be viewed in the context of strategic developments across the NHS, the policies of the Devolved Administrations and the organisational strategies for individual employers. The Agenda for Change framework has been in place since 2004 and has seen a number of developments, including the

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[85] NHS Pay Review Body. *Market-facing pay: how Agenda for Change pay can be made more appropriate to local labour markets.* Cm 8501. TSO, 2012. Available from: https://www.gov.uk/government/publications/nhs-local-pay-2012

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changes agreed for England last year.[86] We continue to encourage the use and development of existing Agenda for Change flexibilities. However, we believe that in order to achieve a more cohesive approach to Agenda for Change pay, a much more strategic view is required involving reward and engagement strategies, the human resource management capacity and capability to implement these strategies, and effective staff involvement and management at all levels of the NHS.

Key Messages for 2014/15

7.6 We conclude this report with a summary of the key messages that we consider cover the priority actions for the NHS in the future and that need to be addressed before the next round. Progress on these issues will enable us to have a clearer picture of how pay for Agenda for Change staff can play its full part in supporting the significant changes underway in the NHS.

- If the health budget does not increase in real terms for some time, greater improvements in productivity will be needed to meet the increasing demands for healthcare and the improvements in patient care following the Francis report; these will require high staff engagement and involvement, which in turn require an appropriate pay structure.
- There is therefore a need for further development of the Agenda for Change framework to enable it to play its role in supporting the wide-ranging programme of reforms across the NHS.
- There is also a need to ensure that progress along the Agenda for Change pay scales reflects competence development, and performance.
- Urgent negotiations, alongside the negotiations for medical staff, are needed to progress the implementation of the necessary changes to Agenda for Change to enable a fuller range of the seven-day delivery of patient services.

Future evidence requirements

The specific evidence requirements that we have identified in this chapter for our next review are:

- We look forward to receiving evidence from the parties in autumn 2014 that demonstrates substantial progress with the recommendations in our *Market-Facing Pay* report.
- We expect to receive further information on a range of Agenda for Change developments including: the outcome of the NHS Staff Council's discussions; further proposals for the development of pay and conditions over the longer term; and a clear pay strategy in all NHS trusts and organisations, which recognises the need to reward competence, and underpins staff engagement in both change and patient care.

[86] NHS Pay Review Body. *Twenty-seventh report.* Cm 8555. TSO, 2013. Paragraph 6.13. Available from: https://www.gov.uk/government/publications/nhsprb-report-number-27-2013

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Appendix A – Remit Letters

UNCLASSIFIED

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

Mr Jerry Cope
NHS Pay Review Body
Office of Manpower Economics
Victoria House
Southampton Row
London
WC1B 4AD

23 July 2013

Dear Jerry,

PUBLIC SECTOR PAY 2014-15

I would like to thank you for your work on the 2013-14 pay round. The Government greatly values the contribution of the NHSPRB in delivering robust, evidence-based pay outcomes for public sector workers.

2. At the 2011 Autumn Statement, the Government announced its policy that public sector pay awards will average 1 per cent for the two years following the pay freeze. The Government also asked certain Review Bodies to consider how to make public sector pay more responsive to local labour markets in their remit groups. The Government published these reports at the 2012 Autumn Statement and has accepted the key recommendations, including that there should be no new centrally determined local pay rates or zones but that there should be greater use of existing flexibilities.

3. The Government believes that the case for continued pay restraint across the public sector remains strong. Detailed evidence will be set out in the pay round, but at the highest level, reasons for this include:

a. Recruitment and retention: While recognising some variation between remit groups, the evidence so far is that, given the current labour market position, there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year.

b. Affordability: Pay restraint remains a crucial part of the consolidation plans that will help to put the UK back onto the path of fiscal sustainability – and continued restraint in relation to public sector pay will help to protect jobs in the public sector and support the quality of public services.

4. The Review Bodies will want to consider the evidence carefully in producing their report. In particular, what award is justified and whether there is a case for a higher

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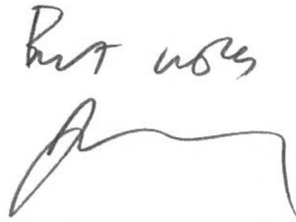
award to particular groups of staff, relative to the rest of the workforce, due to particular recruitment and retention difficulties.

5. Pay awards should be applied to the basic salary based on the normal interpretation of basic salary in each workforce. This definition does not include overtime or any regular payments such as London weighting, recruitment or retention premia or other allowances.

6. A number of Review Bodies will be considering additional elements of reward such as non-pay terms and conditions and specific allowances. These recommendations form an important part of managing the total reward package of public sector workers, and the Government welcomes the contribution of the Review Bodies in these areas.

7. Finally, in the 2013 Spending Review, the Government announced that substantial reforms to progression pay will be taken forward or are already underway across the public sector. The Review Body is therefore invited to consider the impact of their remit group's progression structure and its distribution among staff in recommending annual pay awards.

I look forward to continued dialogue with you in the future.



DANNY ALEXANDER

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Department of Health

From Dr Dan Poulter MP
Parliamentary Under Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

Jerry Cope
Chair
Pay Review Body – NHS
Office of Manpower Economics
6th Floor, Victoria House
Southampton Row
London
WC1B 4AD

06 AUG 2013

Dear Jerry,

NHS Pay Review Body Remit 2014/15

I am writing as a follow up to the letter you received from the Chief Secretary to the Treasury, Danny Alexander, in July confirming the Governments' approach to the 2014/15 pay round.

Once again, I would like to thank you and your colleagues for the vital and independent expert work undertaken by the NHS Pay Review Body (NHSPRB) in considering remuneration for employed NHS staff subject to the Agenda for Change pay system.

As always, while NHSPRB's remit covers the whole of the United Kingdom, it is for each of the UK administrations to make its own decisions on its approach to this years' pay review round and to communicate this to you directly.

We continue to keep in close touch with our counterparts in the other countries and my officials will do all they can to support you in handling any consequences that may arise as a result of different approaches taken by each country.

Following on from last year's arrangements, the Department will again provide high level evidence focussing on the economic and financial (NHS funding) context and strategic policy. Evidence will be provided separately by:

- NHS Employers – detailed evidence on the recruitment, retention, motivation and morale for Agenda for Change staff;

- Health Education England – detailed evidence on education, training and workforce capacity;

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- NHS England is considering the level of input in relation to Agenda for Change staff.

The Department will work closely with all these organisations and the NHS PRB secretariat to ensure that, overall, the evidence meets the needs of the NHS PRB.

You will be aware that in the 2013 Spending Round, the Government announced that substantial reforms to progression pay will be taken forward or are already underway across the public sector.

The Government is clear that time served is no longer an appropriate rationale for pay progression for staff in the public sector. In his remit letter the CST observes that:

".....in the 2013 Spending Review, the Government announced that substantial reforms to progression pay will be taken forward or are already underway across the public sector. The Review Body is therefore invited to consider the impact of their remit group's progression structure and its distribution among staff in recommending annual pay awards".

You will be aware that the NHS Staff Council, a partnership of NHS trade unions and NHS Employers, reached agreement in March this year on linking incremental pay more closely to performance for Agenda for Change staff. NHS employers have the freedom to develop their own local performance standards. The agreement means that employers should look to develop new or amended local performance standards for the 2014 performance round.

However, implementation across the service in England will take time and I ask that the NHS PRB consider the existing progression structure for Agenda for Change staff and its distribution among staff when considering and recommending the annual pay award.

As the Chief Secretary set out, the case for continued pay restraint across the public sector remains strong. The Government is clear that it is for each Pay Review Body to consider the evidence and affordability for each workforce. The Chief Secretary's letter also observes that:

"... there are unlikely to be significant recruitment and retention issues for the majority of public sector workforces over the next year".

" Affordability: Pay restraint remains a crucial part of the consolidation plans that will help to put the UK back onto the path of fiscal sustainability – and

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continued restraint in relation to public sector pay will help to protect jobs in the public sector and support the quality of public services".

"The Review Bodies will want to consider the evidence carefully in producing their report. In particular, what award is justified and whether there is a case for a higher award to particular groups of staff, relative to the rest of the workforce, due to particular recruitment and retention difficulties".

For the NHS, affordability and the level of incremental pay staff will receive, alongside recruitment and retention pressures, will be a critical element as the Review Body determines whether any award is justified.

I should be grateful if you would make recommendations for the basic pay of NHS staff falling within your remit. In doing so, you should consider evidence in respect of:

- The level of incremental pay staff that have not reached the top of their pay band will receive
  - 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 DH, 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; and
  - the overall strategy that the NHS should place patients at the heart of all it does and the mechanisms by which that is to be achieved.

I look forward to receiving your report on 2014/15 pay for your remit group in due course.

Best wishes,

DR DAN POULTER

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Cabinet Secretary for Health and Wellbeing
Alex Neil MSP

T: 0845 774 1741
E: scottish.ministers@scotland.gsi.gov.uk

Jerry Cope
Chair
NHS Pay Review Body
Office of Manpower Economics
6th Floor, Victoria House
Southampton Row
London
WC1B 4AD

12 September 2013

Dear Jerry

This letter follows announcement of the Scottish Government's Public Sector Pay Policy for 2014-15 by the Cabinet Secretary for Finance, Employment and Sustainable Growth on 11 September. A copy of that policy is included for ease of reference. It applies directly to the list of organisations at Annex A and is intended to inform considerations around pay for other public sector groups including NHSScotland staff.

The features of Scotland's Public Sector Pay Policy for 2014-15 which are of particular relevance to the NHS Pay Review Body process are:

- provision for an increase in basic pay for all staff. This increase is subject to an overall cost cap of 1%, although there is no assumption that this will equate to a 1% uplift. The cost cap does not include pay progression or measures put in place for staff earning under £21,000.

- a minimum increase of £300 for staff earning less than £21,000.

Beyond the parameters set out above, we would wish the Pay Review Body to be as free as possible in considering the issues and making recommendations for Scotland in 2014-15.

The Scottish Government's policies differ in a number of key respects from those contained in the letter of 23 July to the OME from the Chief Secretary to the Treasury, Danny Alexander, and the further letter of 6 August from Dr Dan Poulter, Permanent Under Secretary of State for Health, which set out the remit which the Department of Health wishes the Pay Review Body to work within for 2014-15. I recognise that this may present challenges for the Review Body in putting forward recommendations which will cover the whole of the UK. The Scottish Government's preference would be to maintain one unified Agenda for Change pay system. We took measures last year to facilitate this and would work hard to maintain this stance in 2014. You will appreciate, however, that all consideration on this issue must be informed by the policy framework which we have set for public sector pay in Scotland.

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.scotland.gov.uk

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Finally, let me take this opportunity to thank the members of the Review Body for their work and assure you that the Scottish Government continues to greatly value the independent voice which the Review Body offers on NHS pay.

ALEX NEIL

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.scotland.gov.uk

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Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref

Jerry Cope
Chair NHS Pay Review Body
Office of Manpower Economics
6th Floor
Victoria House
London
WC1B 4AD

25 September 2013

Dear Mr Cope

I would like to relay my gratitude to you and your colleagues on the NHS Pay Review Body for your work on the 2013-14 pay round. The Welsh Government values the work of the NHS Pay Review Body in delivering robust evidence and recommendations regarding remuneration for NHS Staff.

In accordance with your recommendations a 1% pay increases was applied to all A4C pay points for staff employed within NHS Wales with effect from 1st April 2013.

The intention is for the Welsh Government to submit evidence for the 2014/15 pay round by 27th September 2013. The evidence will focus upon the current pressures faced by NHS Wales in a environment of increasing demand for health services, combined with a budget that in real terms will be 12% lower in 2014/ 15 than it was in 2010/11.

In making your recommendations I would ask you to consider whether:

- In the current financial environment it is appropriate to uplift NHS salaries;
- Any award should be confined to the lower pay bands in recognition of the tackling poverty agenda;
- Any award should be confined to raising the starting rates for employees in the NHS to a salary equal to the 'living wage' level;
- It would be more appropriate to provide staff with fixed sum increase rather than a percentage uplift; and
- A pay freeze would be appropriate for higher earners if an award is given.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

English Enquiry Line 0845 010 3300
Llinell Ymholiadau Cymraeg 0845 010 4400
Correspondence.Mark.Drakeford @wales.gsi.gov.uk

Wedi'i argraffu ar bapur wedi'i ailgylchu (100%)

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Copies of this letter have been sent to the Secretary of State for Health and the respective Ministers in the devolved administrations.

Yours sincerely

Mark Drakeford

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA

Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
Tel: 028 90 520642
Fax: 028 90 520557
Email: private.office@dhsspsni.gov.uk

Mr Jerry Cope
Chair
NHS Pay Review Body
Office of Manpower Economics
Victoria House
Southampton Row
London
WC18 4AD

Our Ref: SUB/851/2013

Date: 18 October 2013

Dear Jerry

NHS PAY REVIEW BODY REMIT 2014/15

I welcome the opportunity to ask the NHS Pay Review Body to make recommendations on remuneration of Health and Social Care staff in Northern Ireland. I very much appreciate the valuable work undertaken by the NHSPRB in this important role.

The Northern Ireland Executive is responsible for setting public sector pay levels in Northern Ireland and has endorsed the principle of adherence to the UK Government's public sector pay policies. The Executive's control of public sector pay is based on the principle that the public sector should offer a pay and reward package that allows it to recruit, retain and motivate suitable staff. Public sector pay should also reflect the circumstances specific to the local labour market.

The Health and Social Care sector in Northern Ireland is facing significant financial pressure against a backdrop of increasing needs across health and social care services. In that context it is critical that we take every opportunity to ensure that we are making the best use of all available resources to deliver safe and effective patient care while ensuring appropriate remuneration for all HSC staff. It is in that overall context that I would ask the PRB to consider evidence as to whether it is appropriate to provide an uplift on HSC salaries in light of available resources and demands on the service. I confirm that Northern Ireland supports the maintenance of one unified Agenda for Change pay system and that the Northern Ireland position reflects the need for continued restraint.

I enclose Northern Ireland written evidence to support the 2014/15 pay round process. This letter is being copied to the Secretary of State for Health, the Cabinet Secretary for Health and Wellbeing in Scotland, the Minister for Health and Social Services in Wales and Simon Hamilton MLA, Minister for Finance and Personnel in the NI Assembly.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

Working for a Healthier People

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Appendix B – Recommended Agenda for Change Pay Scales (£) with effect from 1 April 2014

Point	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8				Band 9
								Range A	Range B	Range C	Range D	
1	14,437	14,437										
2	14,799	14,799										
3	15,163	15,163										
4		15,586										
5		16,010										
6		16,433	16,433									
7		16,979	16,979									
8		17,600	17,600									
9			17,972									
10			18,468									
11			19,027	19,027								
12			19,461	19,461								
13				20,147								
14				20,844								
15				21,477								
16				21,602	21,602							
17				22,236	22,236							
18					23,132							
19					24,063							
20					25,047							
21					26,041	26,041						
22					27,090	27,090						
23					28,180	28,180						
24						29,043						
25						30,057						
26						31,072	31,072					
27						32,086	32,086					
28						33,227	33,227					
29						34,876	34,876					
30							35,891					
31							37,032					
32							38,300					
33							39,632	39,632				
34							40,964	40,964				
35								42,612				
36								44,261				
37								46,164	46,164			
38								47,559	47,559			
39									49,968			
40									52,757			
41									55,548	55,548		
42									57,069	57,069		
43										59,606		
44										62,397		
45										66,582	66,582	
46										68,484	68,484	
47											71,338	
48											74,825	
49											78,629	78,629
50											82,434	82,434
51												86,390
52												90,537
53												94,883
54												99,437

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Appendix C – Composition of our Remit Group

Tables C1 to C7 show the composition of our remit group in each country and in the United Kingdom as a whole as at September 2012.[1] Detailed categories of staff in each country have been aggregated into broad staff groups, to enable cross-United Kingdom comparisons to be made.

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

[1] The most recent date for which United Kingdom-wide data were available at the time of writing.

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NHS full-time equivalent non-medical workforce as at 30 September 2012

Table C1: Qualified nurses and midwives

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Qualified nurses, HVs and midwives	305,060	Nurses and midwives bands 5-9	41,159	Qualified nurses, HVs and midwives	21,779	Qualified nursing and midwifery	13,915	**381,912**

Table C2: Nursing and healthcare assistants and support staff

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Unqualified nurses	62,012	Nurses and midwives bands 1-4	15,105	Unqualified nurses	6,236	Nurse support staff	3,945	
Healthcare assistants and support staff	117,721			Healthcare assistants and support staff	9,796			
	179,733		**15,105**		**16,033**		**3,945**	**214,815**

Table C3: Professional, technical and social care

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Qualified AHPs	63,198	Medical and dental support	1,903	Qualified AHPs	4,504	Professional and technical	6,767	
Qualified healthcare scientists	28,760	AHPs	9,422	Qualified ST&Ts	4,832	Social services	6,639	
Other qualified ST&Ts	40,911	Other therapeutic services	3,529	Unqualified ST&Ts	2,206	Home helps	1,859	
Unqualified ST&Ts	38,713	Personal and social care	896					
		Healthcare science	5,274					
	171,581		**21,025**		**11,542**		**15,265**	**219,413**

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Table C4: Ambulance

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Qualified ambulance	17,755	Emergency services	3,640	Qualified ambulance	1,385	Ambulance	1,039	
Unqualified ambulance	6,675			Unqualified ambulance	124			
	24,430		**3,640**		**1,509**		**1,039**	**30,618**

Table C5: Administration, estates and management

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Admin and clerical	202,210	Administrative services	24,137	Clerical and administration	12,009	Admin and clerical	10,927	
Maintenance and estates	8,869	Support services	13,703	Maintenance and works	990	Estates services	686	
Manager	24,954			Managers	1,395	Support services	4,865	
Senior manager	10,696			Senior managers	614			
	246,729		**37,840**		**15,009**		**16,478**	**316,056**

Table C6: Other

England	FTE	Scotland	FTE	Wales	FTE	Northern Ireland	FTE	UK FTE
Others	3,730	Unallocated/not known	1,133	Others	220	Generic	35	**5,117**

Table C7: Total NHS non-medical workforce

	England	Scotland	Wales	Northern Ireland	UK
FTE	**931,263**	**119,901**	**66,091**	**50,677**	**1,167,932**
Headcount	**1,075,035**	**142,294**	**78,195**	**61,684**	**1,357,208**

Sources: The Health and Social Care Information Centre, Welsh Government (StatsWales), Information Services Division Scotland, the Department of Health, Social Services and Public Safety Northern Ireland.

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Appendix D – The Department of Health's Pay Metrics

The following notes and tables D1 – D6 have been derived from the Department of Health's written evidence. The Department of Health's website[1] contains full explanatory notes[2] and tables.[3] Whilst the methodology for calculating these pay metrics has been shared with the Devolved Administrations, equivalent figures for Wales, Scotland and Northern Ireland are not currently available.

- A detailed data set is required for financial planning analysis, including assessments of pay bill drivers and the cost implication of pay decisions, but there is no ready made source available.
- Accounting data on pay bill costs are not available in sufficient detail. Highly detailed administrative data are available from the Electronic Staff Record Data Warehouse, but this information is not validated.
- The Health and Social Care Information Centre uses the Electronic Staff Record data, after the application of data validation processes, to produce and publish reasonably detailed estimates of staff numbers and average earnings.
- The Department of Health uses these published estimates of staff numbers and average earnings as the main basis for producing *Experimental headline Hospital and Community Health Service pay bill metrics*. The published material can be used to produce estimates of the aggregate cost of staff earnings, but it does not capture employer on-costs (employer National Insurance and pension contributions), which also need to be included in pay bill metrics.
- The Department of Health uses Electronic Staff Record data, after the application of data validation processes, to estimate staff group specific on-cost rates (expressed as a share of earnings). These on-cost rates are then applied to the aggregate earnings estimates, based on the published Health and Social Care Information Centre data, to estimate aggregate on-cost values.
- The Department of Health's *Experimental headline Hospital and Community Health Service pay bill metrics* are available back to 2008/09, but the Electronic Staff Record data (which underlies all the component data sources) are not available any earlier.
- They are termed experimental metrics as, whilst analogous to previous pay bill metrics, the methodology has been changed to accommodate and make best use of changes in a key data source (the Health and Social Care Information Centre earnings publication). A historical time series has been produced on the new basis, which replaces the previously available pay bill metrics for the period. The experimental tag allows for the possibility of further developing the metrics after user comments and resolving any issues that may emerge with the new approach.

[1] *NHS pay 2014: Department of Health evidence to pay review bodies*
Available from:
https://www.gov.uk/government/publications/nhs-pay-2014-department-of-health-evidence-to-pay-review-bodies

[2] *Hospital and Community Health Services paybill metrics and paybill driver quantifications.*

[3] *Headline Hospital and Community Health Services paybill metrics (experimental).*

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Table D1: Aggregate pay bill, Department of Health

	Aggregate pay bill (£ million)					*Percentage change on previous year*				Change on previous year (£ million)			
	2008/9	2009/10	2010/11	2011/12	2012/13	*2009/10*	*2010/11*	*2011/12*	*2012/13*	2009/10	2010/11	2011/12	2012/13
Total Hospital and Community Health Services non-medical staff	**30,476**	**32,784**	**34,046**	**33,816**	**33,964**	*7.6*	*3.8*	***-0.7***	***0.4***	**2,309**	**1,262**	**-230**	**148**
Qualified nursing, midwifery and health visiting staff	**11,762**	**12,425**	**12,829**	**12,850**	**12,883**	***5.6***	***3.2***	***0.2***	***0.3***	**664**	**403**	**22**	**33**
Qualified Midwives	846	898	935	958	976	*6.1*	*4.1*	*2.4*	*1.9*	51	37	23	18
Qualified Health Visitors	352	347	346	343	362	*-1.6*	*-0.1*	*-0.9*	*5.6*	-6	0	-3	19
Qualified School Nurses	40	44	44	46	48	*10.0*	*0.3*	*5.8*	*3.8*	4	0	3	2
Total qualified scientific, therapeutic and technical staff	**5,168**	**5,560**	**5,849**	**5,923**	**5,981**	*7.6*	*5.2*	*1.3*	*1.0*	**392**	**290**	**74**	**58**
Qualified Allied Health Professions	2,388	2,549	2,668	2,689	2,711	*6.8*	*4.7*	*0.8*	*0.8*	162	119	20	22
Qualified Therapeutic Radiography Staff	79	84	89	92	95	*6.6*	*5.7*	*3.3*	*3.0*	5	5	3	3
Qualified Diagnostic Radiography Staff	526	560	581	591	601	*6.6*	*3.7*	*1.7*	*1.7*	35	21	10	10
Qualified Speech and Language Staff	239	255	269	264	265	*6.7*	*5.3*	*-1.6*	*0.2*	16	14	-4	0
Qualified Healthcare Scientists	1,288	1,371	1,412	1,413	1,395	*6.4*	*3.0*	*0.1*	*-1.3*	82	41	2	-18
Other qualified scientific, therapeutic and technical staff	1,492	1,639	1,769	1,821	1,875	*9.9*	*7.9*	*2.9*	*3.0*	148	130	51	54
Qualified ambulance staff	**745**	**780**	**798**	**809**	**820**	***4.7***	***2.3***	***1.4***	***1.3***	**35**	**18**	**12**	**10**
Support to clinical staff	**6,349**	**6,866**	**7,188**	**7,159**	**7,227**	***8.1***	***4.7***	***-0.4***	***0.9***	**517**	**322**	**-28**	**68**
Support to doctors and nursing staff	4,990	5,351	5,562	5,521	5,589	*7.2*	*4.0*	*-0.7*	*1.2*	360	212	-41	68
Support to scientific, therapeutic and technical staff	1,043	1,161	1,251	1,263	1,267	*11.3*	*7.7*	*1.0*	*0.4*	118	90	12	4
Support to ambulance staff	316	355	375	376	371	*12.3*	*5.7*	*0.1*	*-1.3*	39	20	0	-5
NHS infrastructure support	**6,452**	**7,153**	**7,382**	**7,074**	**7,053**	***10.9***	***3.2***	***-4.2***	***-0.3***	**701**	**229**	**-308**	**-20**
Central functions	2,576	2,938	3,145	3,019	3,021	*14.1*	*7.0*	*-4.0*	*0.1*	362	207	-126	2
Hotel, property and estates	1,396	1,433	1,437	1,416	1,403	*2.6*	*0.3*	*-1.5*	*-0.9*	36	5	-22	-13
Senior managers	997	1,138	1,132	1,071	1,075	*14.2*	*-0.5*	*-5.4*	*0.4*	141	-6	-61	4
Managers	1,483	1,645	1,668	1,568	1,554	*10.9*	*1.4*	*-6.0*	*-0.9*	162	23	-100	-13

Source: Department of Health
Note: Small non-zero changes round to zero.

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Table D2: Aggregate total earnings, Department of Health

	Aggregate total earnings (£ million)					*Percentage change on previous year*				Change on previous year (£ million)			
	2008/9	2009/10	2010/11	2011/12	2012/13	*2009/10*	*2010/11*	*2011/12*	*2012/13*	2009/10	2010/11	2011/12	2012/13
Total Hospital and Community Health Services non-medical staff	**25,475**	**27,411**	**28,440**	**28,227**	**28,367**	***7.6***	***3.8***	***-0.7***	***0.5***	**1,936**	**1,029**	**-213**	**140**
Qualified nursing, midwifery and health visiting staff	**9,788**	**10,342**	**10,661**	**10,658**	**10,686**	***5.7***	***3.1***	***0.0***	***0.3***	**554**	**319**	**-3**	**28**
Qualified Midwives	701	744	773	791	806	*6.1*	*4.0*	*2.3*	*1.9*	43	30	17	15
Qualified Health Visitors	292	287	287	284	300	*-1.5*	*-0.1*	*-1.0*	*5.7*	-4	0	-3	16
Qualified School Nurses	33	36	36	38	40	*10.1*	*0.2*	*5.7*	*3.7*	3	0	2	1
Total qualified scientific, therapeutic and technical staff	**4,292**	**4,619**	**4,856**	**4,908**	**4,957**	***7.6***	***5.1***	***1.1***	***1.0***	**327**	**237**	**52**	**49**
Qualified Allied Health Professions	1,985	2,120	2,218	2,231	2,250	*6.8*	*4.6*	*0.6*	*0.8*	135	97	14	19
Qualified Therapeutic Radiography Staff	66	70	74	77	79	*6.7*	*5.7*	*3.1*	*3.1*	4	4	2	2
Qualified Diagnostic Radiography Staff	440	469	485	492	501	*6.7*	*3.5*	*1.4*	*1.7*	29	16	7	9
Qualified Speech and Language Staff	198	211	222	219	219	*6.8*	*5.3*	*-1.6*	*0.2*	13	11	-4	0
Qualified Healthcare Scientists	1,069	1,139	1,171	1,169	1,154	*6.5*	*2.9*	*-0.1*	*-1.3*	69	33	-2	-15
Other qualified scientific, therapeutic and technical staff	1,237	1,360	1,467	1,507	1,553	*9.9*	*7.8*	*2.7*	*3.0*	123	107	40	46
Qualified ambulance staff	**622**	**651**	**665**	**672**	**681**	***4.7***	***2.0***	***1.2***	***1.2***	**29**	**13**	**8**	**8**
Support to clinical staff	**5,389**	**5,830**	**6,094**	**6,084**	**6,145**	***8.2***	***4.5***	***-0.2***	***1.0***	**441**	**264**	**-10**	**61**
Support to doctors and nursing staff	4,237	4,545	4,718	4,693	4,754	*7.3*	*3.8*	*-0.5*	*1.3*	308	173	-24	61
Support to scientific, therapeutic and technical staff	885	986	1,060	1,074	1,078	*11.3*	*7.5*	*1.3*	*0.4*	100	74	14	5
Support to ambulance staff	267	300	316	317	313	*12.3*	*5.5*	*0.1*	*-1.3*	33	17	0	-4
NHS infrastructure support	**5,384**	**5,969**	**6,165**	**5,905**	**5,898**	***10.9***	***3.3***	***-4.2***	***-0.1***	**585**	**196**	**-260**	**-7**
Central functions	2,164	2,469	2,644	2,539	2,543	*14.1*	*7.1*	*-4.0*	*0.2*	305	176	-105	4
Hotel, property and estates	1,194	1,226	1,229	1,214	1,204	*2.6*	*0.2*	*-1.2*	*-0.8*	32	3	-15	-9
Senior managers	808	923	919	867	874	*14.2*	*-0.4*	*-5.6*	*0.8*	115	-4	-52	7
Managers	1,217	1,351	1,373	1,285	1,277	*11.0*	*1.6*	*-6.4*	*-0.7*	134	22	-87	-9

Source: Department of Health
Note: Small non-zero changes round to zero.

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Table D3: Full-time equivalent staff, average for the year, Department of Health

	Aggregate full-time equivalents					*Percentage change on previous year*				Full-time equivalent change on previous year			
	2008/9	2009/10	2010/11	2011/12	2012/13	*2009/10*	*2010/11*	*2011/12*	*2012/13*	2009/10	2010/11	2011/12	2012/13
Total Hospital and Community Health Services non-medical staff	**907,951**	**949,525**	**957,445**	**939,007**	**934,787**	*4.6*	*0.8*	*-1.9*	*-0.4*	**41,575**	**7,919**	**-18,438**	**-4,220**
Qualified nursing, midwifery and health visiting staff	**301,608**	**308,654**	**310,416**	**307,811**	**307,188**	***2.3***	***0.6***	***-0.8***	***-0.2***	**7,046**	**1,762**	**-2,605**	**-623**
Qualified Midwives	19,257	19,804	20,268	20,798	21,242	*2.8*	*2.3*	*2.6*	*2.1*	547	464	530	444
Qualified Health Visitors	8,592	8,230	8,066	7,963	8,462	*-4.2*	*-2.0*	*-1.3*	*6.3*	-362	-164	-103	499
Qualified School Nurses	1,057	1,131	1,108	1,157	1,187	*7.0*	*-2.0*	*4.5*	*2.5*	74	-23	50	29
Total qualified scientific, therapeutic and technical staff	**122,271**	**128,108**	**131,369**	**132,066**	**133,182**	***4.8***	***2.5***	***0.5***	***0.8***	**5,837**	**3,260**	**697**	**1,116**
Qualified Allied Health Professions	59,337	61,800	62,918	62,999	63,311	*4.2*	*1.8*	*0.1*	*0.5*	2,463	1,118	82	312
Qualified Therapeutic Radiography Staff	1,981	2,070	2,148	2,211	2,288	*4.5*	*3.8*	*2.9*	*3.5*	89	78	63	77
Qualified Diagnostic Radiography Staff	11,423	11,893	12,143	12,417	12,712	*4.1*	*2.1*	*2.3*	*2.4*	470	249	274	296
Qualified Speech and Language Staff	5,644	5,978	6,162	6,037	6,076	*5.9*	*3.1*	*-2.0*	*0.7*	334	184	-125	39
Qualified Healthcare Scientists	28,490	29,311	29,462	29,152	28,838	*2.9*	*0.5*	*-1.1*	*-1.1*	821	151	-310	-313
Other qualified scientific, therapeutic and technical staff	34,444	36,997	38,989	39,915	41,033	*7.4*	*5.4*	*2.4*	*2.8*	2,553	1,992	926	1,118
Qualified ambulance staff	**16,875**	**17,387**	**17,778**	**17,899**	**17,860**	***3.0***	***2.2***	***0.7***	***-0.2***	**512**	**391**	**121**	**-39**
Support to clinical staff	**278,263**	**292,493**	**296,556**	**290,801**	**290,140**	***5.1***	***1.4***	***-1.9***	***-0.2***	**14,231**	**4,062**	**-5,755**	**-661**
Support to doctors and nursing staff	219,480	229,188	231,027	225,937	225,904	*4.4*	*0.8*	*-2.2*	*0.0*	9,708	1,839	-5,090	-33
Support to scientific, therapeutic and technical staff	46,947	50,401	52,206	51,936	51,710	*7.4*	*3.6*	*-0.5*	*-0.4*	3,454	1,805	-269	-226
Support to ambulance staff	11,835	12,904	13,323	12,927	12,525	*9.0*	*3.3*	*-3.0*	*-3.1*	1,068	420	-396	-402
NHS infrastructure support	**188,932**	**202,885**	**201,327**	**190,430**	**186,417**	***7.4***	***-0.8***	***-5.4***	***-2.1***	**13,952**	**-1,558**	**-10,897**	**-4,012**
Central functions	92,240	101,625	103,224	97,220	95,294	*10.2*	*1.6*	*-5.8*	*-2.0*	9,385	1,599	-6,005	-1,925
Hotel, property and estates	57,688	58,878	57,924	56,582	55,605	*2.1*	*-1.6*	*-2.3*	*-1.7*	1,190	-954	-1,341	-978
Senior managers	11,593	12,890	12,071	10,929	10,659	*11.2*	*-6.4*	*-9.5*	*-2.5*	1,297	-818	-1,142	-270
Managers	27,412	29,491	28,108	25,699	24,860	*7.6*	*-4.7*	*-8.6*	*-3.3*	2,080	-1,384	-2,409	-839

Source: Department of Health

Table D4: Pay bill per full-time equivalent drift (excluding basic pay settlement), Department of Health

	Pay bill per full-time equivalent drift (percentage)			
	2009/10	2010/11	2011/12	2012/13
Total Hospital and Community Health Services non-medical staff	**0.5**	**0.7**	**0.9**	**0.6**
Qualified nursing, midwifery and health visiting staff	**0.8**	**0.4**	**1.0**	**0.5**
Qualified Midwives	0.7	-0.5	-0.2	-0.2
Qualified Health Visitors	0.3	-0.4	0.4	-0.6
Qualified School Nurses	0.4	0.1	1.3	1.2
Total qualified scientific, therapeutic and technical staff	**0.3**	**0.3**	**0.7**	**0.1**
Qualified Allied Health Professions	0.1	0.6	0.6	0.3
Qualified Therapeutic Radiography Staff	-0.4	-0.4	0.3	-0.5
Qualified Diagnostic Radiography Staff	0.0	-0.7	-0.6	-0.6
Qualified Speech and Language Staff	-1.7	-0.1	0.4	-0.5
Qualified Healthcare Scientists	1.0	0.2	1.2	-0.2
Other qualified scientific, therapeutic and technical staff	-0.1	0.2	0.5	0.2
Qualified ambulance staff	**-0.8**	**-2.2**	**0.8**	**1.5**
Support to clinical staff	**0.5**	**1.0**	**0.4**	**0.0**
Support to doctors and nursing staff	0.3	0.9	0.3	0.0
Support to scientific, therapeutic and technical staff	1.3	1.8	0.5	-0.2
Support to ambulance staff	0.6	0.2	2.1	0.8
NHS infrastructure support	**0.8**	**1.8**	**0.9**	**1.4**
Central functions	1.1	3.1	1.5	1.7
Hotel, property and estates	-1.9	-0.3	-0.4	-0.4
Senior managers	0.3	4.1	4.5	2.9
Managers	0.7	4.2	2.8	2.5

Source: Department of Health
Note: Small non-zero changes round to zero.

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Table D5: Pay bill per full-time equivalent (including basic pay settlement), Department of Health

	Pay bill per full-time equivalent (£)					*Percentage change on previous year*				Change on previous year (£)			
	2008/9	2009/10	2010/11	2011/12	2012/13	*2009/10*	*2010/11*	*2011/12*	*2012/13*	2009/10	2010/11	2011/12	2012/13
Total Hospital and Community Health Services non-medical staff	**33,565**	**34,527**	**35,559**	**36,012**	**36,334**	***2.9***	***3.0***	***1.3***	***0.9***	**962**	**1,032**	**454**	**321**
Qualified nursing, midwifery and health visiting staff	**38,997**	**40,256**	**41,327**	**41,748**	**41,940**	***3.2***	***2.7***	***1.0***	***0.5***	**1,260**	**1,071**	**421**	**192**
Qualified Midwives	43,953	45,334	46,125	46,049	45,937	*3.1*	*1.7*	*-0.2*	*-0.2*	1,381	792	-77	-112
Qualified Health Visitors	41,014	42,130	42,925	43,089	42,822	*2.7*	*1.9*	*0.4*	*-0.6*	1,115	796	163	-267
Qualified School Nurses	37,498	38,561	39,469	39,966	40,462	*2.8*	*2.4*	*1.3*	*1.2*	1,062	909	497	496
Total qualified scientific, therapeutic and technical staff	**42,266**	**43,398**	**44,526**	**44,847**	**44,905**	***2.7***	***2.6***	***0.7***	***0.1***	**1,132**	**1,128**	**322**	**58**
Qualified Allied Health Professions	40,242	41,252	42,412	42,679	42,816	*2.5*	*2.8*	*0.6*	*0.3*	1,010	1,159	267	136
Qualified Therapeutic Radiography Staff	39,971	40,773	41,547	41,691	41,502	*2.0*	*1.9*	*0.3*	*-0.5*	802	773	144	-189
Qualified Diagnostic Radiography Staff	46,011	47,109	47,840	47,557	47,257	*2.4*	*1.6*	*-0.6*	*-0.6*	1,098	732	-283	-301
Qualified Speech and Language Staff	42,368	42,679	43,602	43,792	43,577	*0.7*	*2.2*	*0.4*	*-0.5*	311	922	191	-215
Qualified Healthcare Scientists	45,220	46,764	47,913	48,483	48,384	*3.4*	*2.5*	*1.2*	*-0.2*	1,544	1,149	570	-99
Other qualified scientific, therapeutic and technical staff	43,309	44,314	45,377	45,614	45,684	*2.3*	*2.4*	*0.5*	*0.2*	1,004	1,064	237	70
Qualified ambulance staff	**44,125**	**44,853**	**44,882**	**45,222**	**45,891**	***1.6***	***0.1***	***0.8***	***1.5***	**728**	**29**	**341**	**668**
Support to clinical staff	**22,818**	**23,474**	**24,238**	**24,620**	**24,909**	***2.9***	***3.3***	***1.6***	***1.2***	**657**	**764**	**382**	**289**
Support to doctors and nursing staff	22,738	23,346	24,076	24,436	24,741	*2.7*	*3.1*	*1.5*	*1.2*	608	730	360	305
Support to scientific, therapeutic and technical staff	22,215	23,030	23,954	24,318	24,511	*3.7*	*4.0*	*1.5*	*0.8*	815	924	364	193
Support to ambulance staff	26,698	27,493	28,156	29,050	29,593	*3.0*	*2.4*	*3.2*	*1.9*	794	664	894	543
NHS infrastructure support	**34,150**	**35,258**	**36,667**	**37,147**	**37,837**	***3.2***	***4.0***	***1.3***	***1.9***	**1,109**	**1,409**	**480**	**690**
Central functions	27,928	28,912	30,468	31,057	31,706	*3.5*	*5.4*	*1.9*	*2.1*	984	1,556	589	648
Hotel, property and estates	24,207	24,331	24,813	25,019	25,226	*0.5*	*2.0*	*0.8*	*0.8*	124	482	205	208
Senior managers	85,967	88,266	93,777	98,034	100,881	*2.7*	*6.2*	*4.5*	*2.9*	2,299	5,511	4,257	2,847
Managers	54,097	55,776	59,336	60,996	62,515	*3.1*	*6.4*	*2.8*	*2.5*	1,680	3,560	1,660	1,519

Source: Department of Health

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Table D6: Total earnings per full-time equivalent, Department of Health

	Total earnings per full-time equivalent (£)					*Percentage change on previous year*				Change on previous year (£)			
	2008/9	2009/10	2010/11	2011/12	2012/13	*2009/10*	*2010/11*	*2011/12*	*2012/13*	2009/10	2010/11	2011/12	2012/13
Total Hospital and Community Health Services non-medical staff	**28,057**	**28,868**	**29,704**	**30,060**	**30,346**	***2.9***	***2.9***	***1.2***	***0.9***	**811**	**836**	**356**	**285**
Qualified nursing, midwifery and health visiting staff	**32,453**	**33,506**	**34,345**	**34,626**	**34,787**	***3.2***	***2.5***	***0.8***	***0.5***	**1,053**	**839**	**281**	**161**
Qualified Midwives	36,385	37,543	38,153	38,022	37,936	*3.2*	*1.6*	*-0.3*	*-0.2*	1,158	610	-131	-86
Qualified Health Visitors	33,953	34,918	35,577	35,660	35,470	*2.8*	*1.9*	*0.2*	*-0.5*	965	658	84	-190
Qualified School Nurses	31,138	32,042	32,764	33,152	33,544	*2.9*	*2.3*	*1.2*	*1.2*	904	722	388	392
Total qualified scientific, therapeutic and technical staff	**35,100**	**36,056**	**36,962**	**37,160**	**37,218**	***2.7***	***2.5***	***0.5***	***0.2***	**955**	**907**	**198**	**58**
Qualified Allied Health Professions	33,452	34,308	35,246	35,417	35,536	*2.6*	*2.7*	*0.5*	*0.3*	857	938	171	119
Qualified Therapeutic Radiography Staff	33,212	33,904	34,537	34,602	34,464	*2.1*	*1.9*	*0.2*	*-0.4*	692	633	65	-138
Qualified Diagnostic Radiography Staff	38,482	39,437	39,974	39,629	39,377	*2.5*	*1.4*	*-0.9*	*-0.6*	955	537	-346	-252
Qualified Speech and Language Staff	35,055	35,341	36,091	36,234	36,072	*0.8*	*2.1*	*0.4*	*-0.4*	286	750	143	-162
Qualified Healthcare Scientists	37,537	38,844	39,749	40,114	40,033	*3.5*	*2.3*	*0.9*	*-0.2*	1,307	905	364	-81
Other qualified scientific, therapeutic and technical staff	35,925	36,766	37,625	37,756	37,836	*2.3*	*2.3*	*0.3*	*0.2*	840	860	130	81
Qualified ambulance staff	**36,868**	**37,471**	**37,379**	**37,553**	**38,106**	***1.6***	***-0.2***	***0.5***	***1.5***	**603**	**-92**	**175**	**552**
Support to clinical staff	**19,367**	**19,933**	**20,550**	**20,921**	**21,180**	***2.9***	***3.1***	***1.8***	***1.2***	**566**	**616**	**371**	**259**
Support to doctors and nursing staff	19,303	19,830	20,420	20,772	21,044	*2.7*	*3.0*	*1.7*	*1.3*	526	590	352	272
Support to scientific, therapeutic and technical staff	18,861	19,559	20,307	20,672	20,853	*3.7*	*3.8*	*1.8*	*0.9*	698	748	366	181
Support to ambulance staff	22,560	23,236	23,751	24,512	24,978	*3.0*	*2.2*	*3.2*	*1.9*	675	516	761	466
NHS infrastructure support	**28,495**	**29,418**	**30,620**	**31,009**	**31,639**	***3.2***	***4.1***	***1.3***	***2.0***	**923**	**1,201**	**389**	**630**
Central functions	23,465	24,295	25,619	26,117	26,687	*3.5*	*5.4*	*1.9*	*2.2*	830	1,324	498	570
Hotel, property and estates	20,702	20,820	21,210	21,449	21,655	*0.6*	*1.9*	*1.1*	*1.0*	118	390	239	206
Senior managers	69,657	71,570	76,117	79,335	82,017	*2.7*	*6.4*	*4.2*	*3.4*	1,913	4,547	3,218	2,682
Managers	44,415	45,816	48,837	50,016	51,357	*3.2*	*6.6*	*2.4*	*2.7*	1,401	3,021	1,179	1,341

Source: Department of Health

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Appendix E – The Parties' Website Addresses

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

Department of Health	https://www.gov.uk/government/publications/nhs-pay-2014-department-of-health-evidence-to-pay-review-bodies
Foundation Trust Network	http://www.foundationtrustnetwork.org/influencing-and-policy/consultations-and-surveys/completed-consultations
Health Education England	http://hee.nhs.uk/2014/01/14/nhs-pay-review-body-for-201415-written-evidence-from-health-education-england/
Joint Staff Side	www.rcn.org.uk/support/the_working_environment/employment_relations_publications
NHS Employers	http://www.nhsemployers.org/SiteCollectionDocuments/NHSPRB_AfC2014_15.pdf
NHS England	http://www.england.nhs.uk/wp-content/uploads/2013/09/prb-evid.pdf
Northern Ireland Executive	http://www.dhsspsni.gov.uk/northern_ireland_evidence_to_the_nhsprb_pay_round_2014.pdf
Royal College of Midwives	http://www.rcm.org.uk/college/support-at-work/pay/
Royal College of Nursing	www.rcn.org.uk/support/the_working_environment/employment_relations_publications
Scottish Government	http://www.scotland.gov.uk/Topics/Health/NHS-Workforce/Policy/Pay-Conditions
Unison	http://www.unison.org.uk/news/unison-calls-for-living-wage-for-all-nhs-staff
Unite the Union	http://centrallobby.politicshome.com/fileadmin/epolitix/stakeholders/Unite_evidence_to_the_NHSPRB_2013.pdf
Welsh Government	http://wales.gov.uk/topics/health/publications/health/reports/pay/?lang=en

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Appendix F – Previous Reports of the Review Body

NURSING STAFF, MIDWIVES AND HEALTH VISITORS

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

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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 – unpublished	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
Market-Facing Pay, NHS Pay Review Body 2012	Cm 8501, December 2012
Twenty-Seventh Report, NHS Pay Review Body 2013	Cm 8555, March 2013

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Appendix G – Abbreviations

AHP	Allied health professionals
ASHE	Annual Survey of Hours and Earnings
CPI	Consumer Prices Index
CSR	Comprehensive Spending Review
FTE	Full-time equivalent
GDP	Gross Domestic Product
HCAS	High Cost Area Supplements
HCHS	Hospital and Community Health Services
Health Departments	Department of Health;
	Northern Ireland Executive, Department of Health, Social Services and Public Safety;
	Scottish Government, Health and Social Care Directorates; and
	Welsh Government, Department of Health and Social Services
HM	Her Majesty's; for example, HM Treasury
HV	Health visitor
NHS	National Health Service
QIPP	Quality, Innovation, Productivity and Prevention
RPI	Retail Prices Index
RRP	Recruitment and Retention Premia
SR	Spending Review
ST&T	Scientific, therapeutic and technical staff
TSO	The Stationery Office

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